Joint Reference Committee
May 31, 2014
Arlington, VA

DRAFT SUMMARY OF ACTIONS
As of July 15, 2014

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

JRC Members Present:

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

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

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

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

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

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

Jeffrey A. Lieberman, MD: Excused

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

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

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

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

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

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

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

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6.3	Maintaining Community Treatment Standards in Federal Correctional Facilities (ASMMAY1412.C) [Please see item 6, attachment 3] Action paper 2014A1 12.C asks • That the APA lobby the Bureau of Prisons to ensure any policies and procedures for the delivery of mental health services do no less than comply with existing federal regulations and community standards of evidenced-based treatment, and be it further, • That the APA ~~publicly~~ oppose any treatment guidelines that minimize the necessity of ~~biological treatment for~~ medical evaluation and treatment of prisoners with ~~of~~ severe mental health disorders ~~and its management by a medical provider be it further,~~ • That the APA lobby the Bureau of Prisons to increase the number of employed psychiatrists by increasing compensation packages for BOP employed psychiatrists on par with other federally employed psychiatrists and community psychiatrists. Will the Joint Reference Committee refer the Assembly action paper ASMMAY1412.C: *Maintaining Community Treatment Standards in Federal Correctional Facilities* to the appropriate Component(s) for input or follow-up?	The Joint Reference Committee revised portions of the action paper as noted. The action paper was referred to the Council on Psychiatry and Law with a request to make recommendations on what steps should be taken in addition to what their Work Group on Persons with Mental Illness in the Criminal Justice System is already doing. The Joint Reference Committee also referred the action paper to the Council on Advocacy and Government Relations to ascertain what the Bureau of Prisons is doing on the issue. A report to the Joint Reference Committee is expected at the October 2014 meeting.	Kristin Kroeger Lori Klinedinst Christopher Whaley	Council on Psychiatry and Law (LEAD) Council on Advocacy and Government Relations **Report to Joint Reference Committee October 2014** [Report deadline 9/24/14] Update to the Assembly November 2014
6.4	HIPAA and State Restrictions on Duty to Warn (ASMMAY1412.D) [Please see item 6, attachment 4] The action paper asks that the APA continue to work at the federal and state level to review and if appropriate, advocate for change to regulations and laws, such as HIPAA, in order to maximize the ability to hold psychiatrists harmless, who in good faith and in their best reasonable clinical judgment want to warn or report serious threat as a means to protect the public and our patients. Will the Joint Reference Committee refer the Assembly action paper ASMMAY1412.D: *HIPAA and State Restrictions on Duty to Warn* to the appropriate Component(s) for input or follow-up?	The Joint Reference Committee referred the action paper to the Council on Psychiatry and Law and asked them to weigh both sides of this issue and provide the Joint Reference Committee with recommendations for action. A report to the Joint Reference Committee is expected for the January 2015 meeting.	Kristen Kroeger Lori Klinedinst	Council on Psychiatry and Law **Report to Joint Reference Committee January 2015**

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6.5	Psychiatric Education with Respect to Patients at Risk of Violent Behavior (ASMMAY1412.E) [Please see item 6, attachment 5] The action asks that the APA promote expanded access to ongoing research findings with respect to etiology of dangerousness, and guidelines for self-protection of the treating psychiatrist. That promotion of the knowledge of these issues be accomplished through a track devoted to these topics at the APA Annual Meeting, a course on this topic at the Annual Meeting and articles in the AJP and attend to these topics in all relevant practice guidelines. Will the Joint Reference Committee refer the Assembly action paper ASMMAY1412.E: *Psychiatric Education with Respect to Patients at Risk of Violent Behavior* to the appropriate Component(s) for input or follow?	The Joint Reference Committee noted that this issue is included within a proposed Practice Guideline on the Assessment of Risk for Aggressive Behaviors as Part of the Initial Psychiatric Evaluation. The Joint Reference Committee referred this item to the Council on Medical Education and Lifelong Learning to consider including this within residency training education. The action paper was also referred to the Scientific Program Committee asking them to consider including courses on this topic at the Annual Meeting.	Kristen Kroeger Nancy Delanoche Joy Raether	Council on Medical Education and Lifelong Learning (LEAD) Scientific Program Committee **Report to Joint Reference Committee January 2015**
6.6	Psychiatrist Patient Relationship and Adverse External Influences in Resolving Danger (ASMMAY1412.F) [Please see item 6, attachment 6] The action paper asks that the APA promote expansion of length of stay for inpatient treatment, when necessary to determine if a patient is or remains at risk or to initiate or continue treatment to reduce potential for violence; and promotes expansion of coverage for outpatient treatment for patients at risk of harm to self or others. Will the Joint Reference Committee refer the Assembly action paper ASMMAY1412.F: *Psychiatrist Patient Relationship and Adverse External Influences in Resolving Danger* to the appropriate Component(s) for input or follow-up?	The Joint Reference Committee referred the action paper to the Council on Healthcare Systems and Financing to review the issue and provide recommendations on action back to the Joint Reference Committee.	Kristen Kroeger Becky Yowell	Council on Healthcare Systems and Financing (LEAD) **Update to Joint Reference Committee January 2015**

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6.7	Increasing Buprenorphine Prescribing Limits (ASMMAY1412.G) [Please see item 6, attachment 7] The action paper asks that the JRC refer the issue of increasing buprenorphine prescribing to the needed population to the Council on Addiction Psychiatry for further consideration such as increasing the limits on the prescriber and the number of prescribers and request a report back to the Assembly in November 2014. Will the Joint Reference Committee refer the Assembly action paper ASMMAY1412.G: *Increasing Buprenorphine Prescribing Limits* to the appropriate Component(s) for input or follow-up?	The Joint Reference Committee referred the action paper to the Council on Addiction Psychiatry and was informed that the Council on Addiction Psychiatry had already formed a work group to address increasing buprenorphine prescribing limits.	Kristen Kroeger Beatrice Eld	Council on Addiction Psychiatry **Report to Joint Reference Committee October 2014** [Report deadline 9/24/14]
6.8	No Punishment for Choosing Not to Adopt Electronic Medical Records (ASMMAY1412.H) [Please see item 6, attachment 8] The action paper asks that: 1. The APA will adopt as a general policy, and begin advocating for, the elimination of penalties of any kind for physicians who choose not to use EMRs. 2. The APA will begin immediate discussions with CMS and any other relevant governmental or private agencies regarding this policy. Will the Joint Reference Committee refer the Assembly action paper 2014A1 12.H: *No Punishment for Choosing Not to Adopt Electronic Medical Records* to the appropriate Component(s) for input or follow-up?	The Joint Reference Committee referred the action paper to the Council on Advocacy and Government Relations and requested that the Council weigh the pros and cons of the APA lobbying for no punishment for not adopting electronic medical records and making a recommendation to the Joint Reference Committee along with a rationale for the October 2014 meeting.	Kristin Kroeger Christopher Whaley	Council on Advocacy and Government Relations **Report to Joint Reference Committee October 2014** [Report deadline 9/24/14]
6.9	Patient Satisfaction Surveys and Physician Pay (ASMMAY1412.J) [Please see item 6, attachment 9] The action paper asks that APA shall advocate that patient satisfaction surveys should not be used as a basis for determining physician remuneration. Will the Joint Reference Committee refer the Assembly action paper ASMMAY1412.J: *Patient Satisfaction Surveys and Physician Pay* to the appropriate Component(s) for input or follow-up?	The Joint Reference Committee did not refer this action paper to a component. This issue is embedded within current APA practices and policies.		Closed

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

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

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6.13	<u>Area RFM Representative Modality and Opportunity for APA Updates and Education</u> (ASMMAY1412.N) [Please see item 6, attachment 13] The action paper asks that the Council on Communications be charged with the formulation of an APA approved PowerPoint slide set using the current information already established. That the slide set contains the following information: • APA goals and mission statement, • RFM membership benefits (i.e. discounts from APPI, etc.), • basic structure of the leadership hierarchy within the APA, • information about the PAC, • RFM key leaders with contact information, • RFM leadership opportunities within the APA, • RFM informational guides and/or handbook link, • a brief description of the APA Assembly and it's role/function, brief description/definition of an action paper and how to submit an action paper, and hot action paper topics (action papers that have passed the assembly)(the hot action paper topic slide can be very basic as this will change frequently). That this slide set be used as a template for RFM leaders to add further information specific to his/her area. That dissemination of the slide set be required of the RFM Representative after each Assembly Meeting. As a result, this requirement should be added to the job duties of the RFM Representative. Will the Joint Reference Committee refer the Assembly action paper ASMMAY1412.N*: Area RFM Representative Modality and Opportunity for APA Updates and Education* to the appropriate Component(s) for input or follow-up?	The Joint Reference Committee referred the action paper to the Office of the Chief Executive Officer and Medical Director. It was noted that these requests are being addressed by APA staff. The CEO will report to the Joint Reference Committee in October 2014 regarding progress on these endeavors.	Dr. Saul Levin Jon Fanning	Office of the Chief Executive Officer and Medical Director **Report to Joint Reference Committee October 2014** [Report deadline 9/24/14]
6.14	<u>ABPN 2015 Exam Expectations</u> (ASMMAY1412.P) [Please see item 6, attachment 14] The action paper asks that the APA ask the ABPN to use DSM-5 in its written examinations beginning in 2015. Will the Joint Reference Committee refer the Assembly action paper ASMMAY1412.P: *APBN 2015 Exam Expectations* to the appropriate Component(s) for input or follow-up?	The Joint Reference Committee referred the action paper to the Office of the Chief Executive Officer and Medical Director for discussion during the APA's ongoing meetings with ABPN. It was noted that ABPN has stated that this goal is not obtainable for 2015 but potentially for 2017.	Dr. Saul Levin Kristin Kroeger	Office of the Chief Executive Officer and Medical Director

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6.15	<u>APA Referendum Voting Procedure</u> (ASMMAY1412.S) [Please see item 6, attachment 15 and 15a] The action paper asks: 1. That the Assembly of the American Psychiatric Association requests that the ballot for a referendum be distributed not with the yearly officer election ballot, but with the yearly dues statement which is responded to by all APA members who wish to retain membership except those with dues-exempt status. Additionally, those voting members not getting a dues notice currently will need to be included in the mailing. 2. That it is the will and intent of the Assembly that this action paper, now reaffirmed, be passed on by the JRC to the Board of Trustees. Will the Joint Reference Committee refer the Assembly action paper ASMMAY1421.S: *APA Referendum Voting Procedure* to the appropriate Component(s) for input or follow-up?	The Joint Reference Committee forwarded this action paper to the Board of Trustees with a request that the Board have further discussions and weigh a variety of options.	Shaun Snyder Margaret Dewar Ardell Lockerman	Board of Trustees **July 2014**
6.16	<u>Creation of President's Awards for the District Branch and Area with the Highest Percentage of Voting</u> (ASMMAY1412.U) [Please see item 6, attachment 16] The action paper asks that: 1. APA institute and publicize a President's Award for the District Branch with the highest voting rate (highest percentage) in the election, and for the Area with the same criteria. 2. These awards (a trophy or plaque along with a certificate), be presented at the Annual meeting immediately following the election each year. 3. The awards and the presentation will be duly publicized in Psychiatric News and in other appropriate avenues. Will the Joint Reference Committee refer the Assembly action paper ASMMAY1412.U: *Creation of President's Awards for the District Branch and Area with the Highest Percentage of Voting* to the appropriate Component(s) for input or follow-up?	The Joint Reference Committee referred the action paper to the Assembly Executive Committee for their review and requested that they consider having this become an Assembly Award to be given to one District Branch and one Area each year.	Shaun Snyder Margaret Dewar Allison Moraske	Assembly Executive Committee **July 2014** FYI – Elections Committee

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

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

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

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

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

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

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

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

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

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

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

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
8.H.4	<u>Waive Copyright Restriction for DSM 5 Criteria</u> Will the Joint Reference Committee recommend that the Board of Trustees approve waiving the DSM 5 copyright restrictions for allied, non-profit education organizations for use in non-commoditized teaching/educational resources specifically for medical student education? ADMSEP has created on-line Clinical Simulation Educational Modules for teaching medical students using DSM 5. These modules are provided free on the ADMSEP website, and are also published on MedEdPortal for use by clerkship directors and medical students for general educational purposes and, in some cases, to meet LCME standards ED-2 and ED-8. For example, a module can provide the opportunity for a student unable to see a key condition in a clinical setting to learn about the condition and, therefore, meet clerkship requirements. The modules reference DSM 5. However, the fee that APA requires for use of DSM criteria is not affordable for ADMSEP (a non-profit allied education organization). There is no monetary gain to anyone from these modules. There is not charge for their use and they were developed with the sole goal of improving psychiatric medical student education. There are no additional costs to the APA to waive copyright restriction for the DSM 5 criteria.	The Joint Reference Committee referred this action to the Office of the Chief Executive Officer and Medical Director for a full cost and impact analysis. The Joint Reference Committee expects a detailed report including recommendations, with rationale, for their meeting in October 2014.	Dr. Saul Levin Shaun Snyder	Office of the Chief Executive Officer and Medical Director **Report to Joint Reference Committee October 2014** [Report deadline 9/24/14]
8.I	Council on Minority Mental Health and Health Disparities	The Joint Reference Committee thanked Dr. Walker and the Council for their report and updates.		
8.I.1	<u>Search Process for the Directory of the APA Division of Diversity and Health Equity</u> Will the Joint Reference Committee forward to the Board Executive Committee and the CEO/Medical Director the Council's urgent action item concerning the search process for the Director of the APA Division of Diversity and Health Equity, presented in item 8.I, attachment 1, p. 6?	The Joint Reference Committee considered input on this issue from various sources and concluded that the hiring of staff is properly within the purview of the CEO/Medical Director. The Joint Reference Committee recommends that Dr. Levin continue to seek input from the interested stakeholders without sharing confidential candidate information or changing the interview or hiring processes used for other APA director-level positions.	Dr. Saul Levin Shaun Snyder	Office of the Chief Executive Officer and Medical Director

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
8.I.2	<u>APA Website Navigation</u> Will Joint Reference Committee recommend to the Chief Operating Officer that the main page of the APA website contain Diversity as navigation item as illustrated in item 8.I, attachment 2, p. 8?	The Joint Reference Committee referred this item to the Office of the Chief Executive Officer and Medical Director for potential implementation in the ongoing enhancements to the APA website.	Dr. Saul Levin Shaun Snyder	Office of the Chief Executive Officer and Medical Director
	Referral Updates: ASMMAY1312.Q: Development of a resource document on human trafficking A draft of the document is currently in review by work group members. Feedback from interested persons on the Council on Children, Adolescents, and Their Families and Council on Psychiatry and Law, as well as other content experts is being sought at this time. The final document is expected to be submitted to Council by September. Ludmila De Faria, MD, is the chairperson of the work groups which are working on these projects	The Joint Reference Committee thanked the Council for this update.		
	Referral Updates: ASMNOV1212.U: The Development of a Resource Document on Rape – In progress. The work group is currently being reconstituted. Ludmila De Faria, MD, is the chairperson of the work groups which are working on these projects.	The Joint Reference Committee thanked the Council for this update.		
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	<u>Proposed Position Statement on Firearm Access, Acts of Violence and Relationship to Mental Illness and Mental Health Services</u> [Please see item 8.J, attachment #3] Will the Joint Reference Committee recommend that the Assembly approve Proposed Position Statement on Firearms Access, Acts of Violence and Relationship to Mental Illness and Mental Health Services, and if approved, forward it to the Board of Trustees for consideration?	The Joint Reference Committee referred the proposed position statement to the Assembly for consideration and if approved by the Assembly, forwarded on to the Board of Trustees. The Joint Reference Committee rearranged the order of the paragraphs in the position statement but did not alter the content of the position statement.	Shaun Snyder Margaret Dewar Allison Moraske Ardell Lockerman	Assembly **November 2014** Board of Trustees **December 2014**

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
8.J.2	Proposed APA Resource Document on Access to Firearms by People with Mental Disorders [Please see item 8.J, attachment #4] Will the Joint Reference Committee approve the Proposed Resource Document on Access to Firearms by People with Mental Disorders?	The Joint Reference Committee approved the resource document on Access to Firearms by People with Mental Disorders. The document will be sent to the Library and Archives for posting on the APA website.	Jon Fanning Gary McMillan	Library and Archives FYI – Board of Trustees
8.K	Council on Psychosomatic Medicine (Consultation-Liaison Psychiatry) Dr. Gitlin provided the Joint Reference Committee with a brief update on the issues before the Council. Subspecialty training in psychosomatic medicine is becoming more critical and consultation/liaison psychiatry is an important area for providing care. Recruiting more psychiatrists into this area as integrated care expands will be necessary. The Joint Reference Committee noted that psychosomatic medicine fits well with integrated care and psychiatry can be supportive to primary care doctors as the primary healthcare provider for medicine, including mental health care. The Joint Reference Committee noted the issue of how subspecialty groups view the APA.	The Joint Reference Committee thanked Dr. Gitlin and the Council for their report and updates.		N/A
8.L	Council on Quality Care	The Joint Reference Committee thanked Dr. Yager and the Council for their report and updates.		
8.L.1	Revision to APA's *Choosing Wisely® campaign* [Please see item 8.L, attachments #1 and #2] Will the Joint Reference Committee recommend updated language to item number five of the APA's *Choosing Wisely® campaign* list, which identifies targeted, evidence-based recommendations that can prompt conversations between patients and physicians about what care is really necessary?	The Joint Reference Committee recommended that the Board of Trustees approve the revisions to the *Choosing Wisely® campaign*.	Shaun Snyder Margaret Dewar Ardell Lockerman	Board of Trustees **July 2014**

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
8.L.2	Review of APA's Conflict of Interest Policy [Please see item 8.L, attachments #3 and #4 (page 6 of attachment #4)] Will the Joint Reference Committee recommend to the Board of Trustees that the APA COI policy be reviewed and aligned with policies for guideline development groups recommended by the Institute of Medicine (IOM) and the Council of Medical Specialty Societies (CMSS) now being adopted by most other medical specialties?	The Joint Reference Committee referred this action to the Board of Trustees for referral to the Conflict of Interest Committee for their review and development of recommendations for potential revision of the APA's Disclosure of Interests and Affiliations policy.	Laurie McQueen Colleen Coyle	Board of Trustees **July 2014** Conflict of Interest Committee
	Referral Updates: ASMNOV1312.D: Protecting Privacy and Confidentiality in the Age of the Electronic Medical Records Committee on Mental Health Information Technology (CMHIT) has discussed this and thinks some minor changes in wording of the position statement would be appropriate in terms of the security of the record. A discussion with the Council on Psychiatry and the Law and with Council on Healthcare Systems & Financing will occur in June, and final language will be developed and forwarded to JRC on completion	The Joint Reference Committee thanked the Council for this update.		N/A
	Referral Updates ASMNOV1212.B: Management of Sensitive Information within Health Information Exchanges (HIEs) • This area has been evolving quickly over the past 18 months, so the committee has waited for some new technical capabilities to be piloted and shown to be acceptable. CMHIT believes that now that this technology for improving the confidentiality of sensitive information has been proven, a useful position statement can be crafted. • CMHIT members, along with Glenn Martin, are preparing a draft paper for review and comment by Council on Healthcare Systems & Financing, Council on Advocacy & Government Relations, and Council on Psychiatry & the Law. A final draft is expected in July.	The Joint Reference Committee thanked the Council for this update.		N/A

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
8.M	Council on Research Dr. Evans provided the Joint Reference Committee with a brief update on the activities of the Council including the progress of the Council's various work groups. The patient registry work group recommended that the APA develop a pilot registry as this would be important to ACO's as well as individual practitioners. The Joint Reference Committee was informed of the Diagnostic Markers in Treatment Work Group under the aegis of the Council. The council is deferring work on its charge until the report of the BOT's Research Review Committee.	The Joint Reference Committee thanked Dr. Evans and the Council for their report and updates.		N/A

Joint Reference Committee

American Psychiatric Association
October 11, 2014
Westin Arlington Gateway
Arlington, VA

CONSENT CALENDAR

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cc 8.A.1 Retain Position Statement: Relationship Between Treatment and Self-Help

Will the Joint Reference Committee recommend that the Assembly retain the 2007 Position Statement *Relationship Between Treatment and Self Help* and if retained, forward it to the Board of Trustees for consideration?
Please see item 8.A, attachment #1

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

cc 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 2004 Position Statement *Recognition and Management of Substance Use Disorders Comorbid with HIV* and if retained, forward it to the Board of Trustees for consideration?
Please see item 8.A, attachment #2

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

cc 8.A.3 Retire Position Statement: Mental Health & Substance Abuse and Aging: Three Resolutions

Will the Joint Reference Committee recommend that the Assembly retire the 2004 Position Statement *Mental Health & Substance Abuse and Aging: Three Resolutions* and if retired, forward it to the Board of Trustees for consideration?
Please see item 8.A, attachment #3

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.

cc 8.E.1 Retire Position Statement Precepts of Palliative Care

Will the Joint Reference Committee recommend that the Assembly retire the 2008 Position Statement Precepts of Palliative Care and if retired, forward it to the Board of Trustees for consideration?
Please see item 8.E, attachment #1

Rationale: This statement was not written by the APA. It was written by a multi-disciplinary "Last Acts Palliative Care Task Force." It was endorsed as a position statement of the APA. It could be used as background information for a revised version of the "Core Principles for End-of-Life Care." The position statement *Core Principles of End-of-Life Care* is being rewritten by the Council on Geriatric Psychiatry.

cc 8.E.2 Retain Position Statement Elder Abuse, Neglect and Exploitation

Will the Joint Reference Committee recommend that the Assembly retain the 2008 Position Statement Elder Abuse, Neglect and Exploitation and if retained, forward it to the Board of Trustees for consideration?
Please see item 8.E, attachment #2

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

cc 8.E.3 Retire Position Statement Ensuring Access to Appropriate Utilization of Psychiatric Service of the Elderly

Will the Joint Reference Committee recommend that the Assembly retire the 2008 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?
Please see item 8.E, attachment #3

Rationale: The Council on Geriatric Psychiatry believes that this statement is dated and does not seem to serve a purpose.

cc 8.G.2 Retain Position Statement: Discriminatory Disability Insurance Coverage

Will the Joint Reference Committee recommend that the Assembly retain the 2009 Position Statement *Discriminatory Disability Insurance Coverage* and if retained, forward it to the Board of Trustees for consideration?
Please see item 8.G, pp 11, 22

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

cc 8.G.3 Retain Position Statement: Psychiatric Disability Evaluation by Psychiatrists

Will the Joint Reference Committee recommend that the Assembly retain the 2007 Position Statement *Psychiatric Disability Evaluation by Psychiatrists* and if retained, forward it to the Board of Trustees for consideration?
Please see item 8.G, pp 11, 23

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

cc 8.G.4 Retain Position Statement: Psychiatrists Practicing in Managed Care: Rights and Regulations

Will the Joint Reference Committee recommend that the Assembly retain the 2009 Position Statement *Psychiatrists Practicing in Managed Care: Rights and Regulations* and if retained, forward it to the Board of Trustees for consideration?
Please see item 8.G, pp 11, 24

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

cc 8.G.5 Retain Position Statement: State Mental Health Services

Will the Joint Reference Committee recommend that the Assembly retain the 2008 Position Statement *State Mental Health Services* and if retained, forward it to the Board of Trustees for consideration?
Please see item 8.G, pp 11, 25

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

cc 8.G.6 Retain Position Statement: Universal Access

Will the Joint Reference Committee recommend that the Assembly retain the 2004 Position Statement *Universal Access* and if retained, forward it to the Board of Trustees for consideration?
Please see item 8.G, pp 11, 26

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

cc 8.G.7 Retain Position Statement: Federal Exemption from the IMD Exclusion

Will the Joint Reference Committee recommend that the Assembly retain the 2007 Position Statement *Federal Exemption from the Institution for Mental Disease (IMD) Exclusion* and if retained, forward it to the Board of Trustees for consideration?
Please see item 8.G, pp 11-12, 27

N.B. the title of the Position Statement has been edited to identify what the abbreviation "IMD" stands for.

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

cc 8.G.11 Retire Position Statement: Access to Comprehensive Psychiatric Assessment and Integrated Treatment

Will the Joint Reference Committee recommend that the Assembly retire the 2002 Position Statement *Access to Comprehensive Psychiatric Assessment and Integrated Treatment* and if retired, forward it to the Board of Trustees for consideration?
Please see item 8.G, pp 13, 33

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."

cc 8.G.12 Retire Position Statement: Psychotherapy and Managed Care

Will the Joint Reference Committee recommend that the Assembly retire the 1999 Position Statement *Psychotherapy and Managed Care* and if retired, forward to the Board of Trustees for consideration?
Please see item 8.G, pp 13, 34

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

cc 8.G.13 Retire Position Statement: Guidelines for Handling the Transfer of Provider Networks

Will the Joint Reference Committee recommend that the Assembly retire the 1995 Position Statement *Guidelines for Handling the Transfer of Provider Networks* and if retired, forward to the Board of Trustees for consideration?
Please see item 8.G, pp 13, 35

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 "Access to Comprehensive Psychiatric Assessment and Integrated Treatment."

cc 8.G.14 Retire Position Statement: Active Treatment

Will the Joint Reference Committee recommend that the Assembly retire the 1978 Position Statement *Active Treatment* and if retired, forward it to the Board of Trustees for consideration?
Please see item 8.G, pp 13, 36

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.

cc 8.G.15 Retire Position Statement: Endorsement of Medical Professionalism in the New Millennium: A Physician Charter

Will the Joint Reference Committee recommend that the Assembly retire 2002 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?
Please see item 8.G, pp 13, 37-38

Rationale: The Council on Healthcare Systems and Financing recommends retiring this position. 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.

cc 8.G.16 Retire Position Statement: Desegregation of Hospitals for the Mentally Ill and Retarded

Will the Joint Reference Committee recommend that the Assembly retire 1975 Position Statement *Desegregation of Hospitals for the Mentally Ill and Retarded* and if retired, forward it to the Board of Trustees for consideration?
Please see item 8.G, pp 14, 39

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.

cc 8.I.1 Retain Position Statement: Abortion & Women's Reproductive Health Care Rights

Will the Joint Reference Committee recommend that the Assembly retain the 2009 Position Statement *Abortion & Women's Reproductive Health Care* Rights and if retained, forward it to the Board of Trustees for consideration?
Please see item 8.I, attachment #1

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.

cc 8.I.2 Retain Position Statement: Xenophobia, Immigration and Mental Health

Will the Joint Reference Committee recommend that the Assembly retain the 2009 Position Statement *Xenophobia, Immigration and Mental* Health and if retained, forward it to the Board of Trustees for consideration?
Please see item 8.I, attachment #2

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.

cc 8.I.3 Retain Position Statement: Sexual Harassment

Will the Joint Reference Committee recommend that the Assembly retain the 2007 Position Statement *Sexual Harassment* and if retained, forward it to the Board of Trustees for consideration?
Please see item 8.I, attachment #3

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

cc 8.I.4 Retain Position Statement: Right to Privacy

Will the Joint Reference Committee recommend that the Assembly retain the 2007 Position Statement *Right to Privacy* and if retained, forward it to the Board of Trustees for consideration?
Please see item 8.I, attachment #4

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

cc 8.J.5 Retire Position Statement: Juvenile Death Sentences

Will the Joint Reference Committee recommend that the Assembly retire the 2008 Position Statement on *Juvenile Death Sentences* and if retired, forward it to the Board of Trustees for consideration?
Please see item 8.J, attachment #6

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

cc 8.J.6 Retain Position Statement: Peer Review of Expert Testimony

Will the Joint Reference Committee recommend that the Assembly retain the 2007 Position Statement *Peer Review of Expert Testimony* and if retained, forward it to the Board of Trustees for consideration?
Please see item 8.J, attachment #7

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

cc 8.J.7 Retain Position Statement: Joint Resolution Against Torture

Will the Joint Reference Committee recommend that the Assembly retain the 2007 Position Statement *Joint Resolution Against Torture* and if retained, forward it to the Board of Trustees for consideration?
Please see item 8.J, attachment #8

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

cc 8.J.8 Retain Position Statement: Moratorium on Capital Punishment in the United States

Will the Joint Reference Committee recommend that the Assembly retain the 2007 Position Statement *Moratorium on Capital Punishment in the United S*tates and if retained, forward it to the Board of Trustees for consideration?
Please see item 8.J, attachment #9

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

cc 8.J.9 Retain Position Statement: Discrimination Against Persons with Previous Psychiatric Treatment

Will the Joint Reference Committee recommend that the Assembly retain the 2007 Position Statement *Discrimination against Persons with Previous Psychiatry Treatment* and if retained, forward it to the Board of Trustees for consideration?
Please see item 8.J, attachment #10

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

cc 8.J.10 Retain Position Statement: Insanity Defense

Will the Joint Reference Committee recommend that the Assembly retain the 2007 Position Statement *Insanity Defense* and if retained, forward it to the Board of Trustees for consideration?
Please see item 8.J, attachment #11

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

cc 8.J.11 Retain Position Statement: Psychiatric Participation in Interrogation of Detainees

Will the Joint Reference Committee recommend that the Assembly retain the 2006 Position Statement *Psychiatric Participation in Interrogation of D*etainees and if retained, forward it to the Board of Trustees for consideration?
Please see item 8.J, attachment #12

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

cc 8.J.12 Retain Position Statement: Death Sentences for Persons with Dementia or Traumatic Brain Injury

Will the Joint Reference Committee recommend that the Assembly retain the 2005 Position Statement *Death Sentences for Persons with Dementia or Traumatic Brain Injury* and if retained, forward it to the Board of Trustees for consideration?
Please see item 8.J, attachment #13

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

cc 8.J.13 Retain Position Statement: Mentally Ill Prisoners and Death Row

Will the Joint Reference Committee recommend that the Assembly retain the 2005 Position Statement *Mentally Ill Prisoners and Death Row* and if retained, forward to it to the Board of Trustees for consideration?
Please see item 8.J, attachment #14

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

cc 8.J.14 Retain Position Statement: Diminished Responsibility in Capital Sentencing

Will the Joint Reference Committee recommend that the Assembly retain the 2004 Position Statement *Diminished Responsibility in Capital Sentencing*?
Please see item 8.J, attachment #15

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

cc 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?
Please see item 8.J, attachment #16

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.

cc* 8.L.4 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

cc* 8.L.5 Retain Position Statement: Endorsement of the Patient-Physician Covenant

Will the Joint Reference Committee recommend that the Assembly retain the position statement *Endorsement of the Patient-Physician Covenant* and if retained, forward it to the Board of Trustees for consideration?
Please see item 8.L, attachment #6

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

cc* 8.L.6 Retain Position Statement: Provision of Psychotherapy for Psychiatric Residents

Will the Joint Reference Committee recommend that the Assembly retain the position statement *Provision of Psychotherapy for Psychiatric Residents* and if retained, forward it to the Board of Trustees for consideration?
Please see item 8.L, attachment #7

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.

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
(E-8.061) http://www.ama-assn.org/ama/pub/article/4001-4388.html

AMA CEJA Opinion. E-9.9011 Continuing Medical Education. http://www.ama-assn.org/ama/pub/article/4001-4237.html

AMA Council on Ethical and Judicial Affairs, Ethical Issues in Managed Care, JAMA January 25, 1995, 25(4): 330-335

American College of Physicians-American Society of Internal Medicine Position Paper: Physician-Industry Relations. Part I: Individual Physicians. Ann Intern Med 2002; 136: 396-402.

American Psychiatric Association: The Principles of Medical Ethics With Annotations Applicable to Psychiatry, Washington: APA, 2001

Report of the APA's Task Force on Research Ethics, Psychiatric Services 2006; 57 (4):550-556.

American Psychiatric Association. Opinions of the Ethics Committee on The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry 2001 Edition,

APA Research Ethics position .

Academy of Psychosomatic Medicine. Position Statement: Psychiatric Aspects of Excellent End of Life Care, 1998-1999.

American Psychiatric Association Commission on AIDS, AIDS policy: Position statement on confidentiality, disclosure, and protection of others. American Journal of Psychiatry 150: 852, 1993

American Psychiatric Association Guidelines for assessing the decisionmaking capacities of potential research subjects with cognitive impairment. American Journal of Psychiatry 1998; 155 (11): 1649-1650.

American Psychiatric Association Guidelines for legislation on the psychiatric hospitalization of adults, 1982.

Ethics Primer, American Psychiatric Association, 2001

Medical professionalism in the new millennium: a physician charter. Ann Intern Med 2002; 136(3):243-6

National Alliance for the Mentally Ill, NAMI statement on involuntary outpatient commitment. American Psychologist, 1987. 42: p. 571-584.

National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, The Belmont report: ethical principles and guidelines for the protection of human subjects of research. 1979, Government Printing Office: Washington, DC.

National Institutes of Health, NIH policy and guidelines on the inclusion of children as participants in research involving human subjects. 1998: Bethesda, MD.

National Institutes of Health. in Harm's Way: Suicide in America. 2001.

National Institute of Mental Health Genetics Workgroup: Genetics and mental disorders, National Institute of Mental Health, 1997.

U.S. Department of Health and Human Services, Code of Federal Regulations, Title 45: Public Welfare. Part 46: Protection of Human Subjects Regulation Governing Protections Afforded Children in Research (Subpart D). 1983

U.S. Department of Health and Human Services, Mental Health: A Report of the Surgeon General. 1999: Rockville, MD.

U.S. Department of Health and Human Services, Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda. 2000: Washington **DC.**

American Psychiatric Association

The Principles of Medical Ethics

With Annotations Especially Applicable to Psychiatry

2013 Edition

Manufactured in the United States of America
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The Principles of Medical Ethics

2013 Edition
(Previous editions 1973, 1978, 1981, 1984, 1985, 1989, 1992, 1993, 1995, 1995 Revised, 1998, 2001, 2001 Revised, 2006, 2008, 2009. 2009 Revised, and 2010

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THE PRINCIPLES OF MEDICAL ETHICS

With Annotations Especially
Applicable to Psychiatry
2013 Edition

In 1973, the American Psychiatric Association (APA) published the first edition of *The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry.* Subsequently, revisions were published as the APA Board of Trustees and the APA Assembly approved additional annotations. In July of 1980, the American Medical Association (AMA) approved a new version of the *Principles of Medical Ethics* (the first revision since 1957), and the APA Ethics Committee[1] incorporated many of its annotations into the new *Principles*, which resulted in the 1981 edition and subsequent revisions. This version includes changes to the *Principles* approved by the AMA in 2001.

Foreword

ALL PHYSICIANS should practice in accordance with the medical code of ethics set forth in the *Principles of Medical Ethics* of the American Medical Association. An up-to-date expression and elaboration of these statements is found in the Opinions and Reports of the Council on Ethical and Judicial Affairs of the American Medical Association.[2] Psychiatrists are strongly advised to be familiar with these documents.[3]

However, these general guidelines have sometimes been difficult to interpret for psychiatry, so further annotations to the basic principles are offered in this document. While psychiatrists have the same goals as all physicians, there are special ethical problems in psychiatric practice that differ in coloring and degree from ethical problems in other branches of medical practice, even

[1]The committee included Herbert Klemmer, M.D., Chairperson, Miltiades Zaphiropoulos, M.D., Ewald Busse, M.D., John R. Saunders, M.D., and Robert McDevitt, M.D. J. Brand Brickman, M.D., William P. Camp, M.D., and Robert A. Moore, M.D., served as consultants to the APA Ethics Committee.

[2]*Current Opinions with Annotations of the Council on Ethical and Judicial Affairs*, Chicago, American Medical Association, 2002–2003.

[3]Chapter 7, Section 1 of the Bylaws of the American Psychiatric Association (May 2003 edition) states, "All members of the Association shall be bound by the ethical code of the medical profession, specifically defined in the *Principles of Medical Ethics* of the American Medical Association and in the Association's *Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry*." In interpreting the Bylaws, it is the opinion of the APA Board of Trustees that inactive status in no way removes a physician member from responsibility to abide by the *Principles of Medical Ethics*.

though the basic principles are the same. The annotations are not designed as absolutes and will be revised from time to time so as to be applicable to current practices and problems.

Following are the AMA *Principles of Medical Ethics*, printed in their entirety, and then each principle printed separately along with an annotation especially applicable to psychiatry.

Principles of Medical Ethics
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.

Section 1
A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights.

Section 2
A physician shall 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.

Section 3
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.

Section 4
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.

Section 5
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.

Section 6
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.

Section 7
A physician shall recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health.

Section 8
A physician shall, while caring for a patient, regard responsibility to the patient as paramount.

Section 9
A physician shall support access to medical care for all people.

Principles with Annotations

Following are each of the AMA *Principles of Medical Ethics* printed separately along with annotations especially applicable to psychiatry.

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.[4]

Section 1
A physician shall be dedicated to providing competent medical care with compassion and respect for human dignity and rights.

1. A psychiatrist shall not gratify his or her own needs by exploiting the patient. The psychiatrist shall be ever vigilant about the impact that his or her conduct has upon the boundaries of the doctor–patient relationship, and thus upon the well-being of the patient. These requirements become particularly important because of the essentially private, highly personal, and sometimes intensely emotional nature of the relationship established with the psychiatrist.

2. A psychiatrist should not be a party to any type of policy that excludes, segregates, or demeans the dignity of any patient because of ethnic origin, race, sex, creed, age, socioeconomic status, or sexual orientation.

[4]Statements in italics are taken directly from the American Medical Association's *Principles of Medical Ethics*.

3. In accord with the requirements of law and accepted medical practice, it is ethical for a physician to submit his or her work to peer review and to the ultimate authority of the medical staff executive body and the hospital administration and its governing body. In case of dispute, the ethical psychiatrist has the following steps available:

a. Seek appeal from the medical staff decision to a joint conference committee, including members of the medical staff executive committee and the executive committee of the governing board. At this appeal, the ethical psychiatrist could request that outside opinions be considered.

b. Appeal to the governing body itself.

c. Appeal to state agencies regulating licensure of hospitals if, in the particular state, they concern themselves with matters of professional competency and quality of care.

d. Attempt to educate colleagues through development of research projects and data and presentations at professional meetings and in professional journals.

e. Seek redress in local courts, perhaps through an enjoining injunction against the governing body.

f. Public education as carried out by an ethical psychiatrist would not utilize appeals based solely upon emotion, but would be presented in a professional way and without any potential exploitation of patients through testimonials.

4. A psychiatrist should not be a participant in a legally authorized execution.

Section 2
A physician shall 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.

1. The requirement that the physician conduct himself/herself with propriety in his or her profession and in all the actions of his or her life is especially important in the case of the psychiatrist because the patient tends to model his or her behavior after that of his or her psychiatrist by identification. Further, the necessary intensity of the treatment relationship may tend to activate sexual and other needs and fantasies on the part of both patient and psychiatrist, while weakening the objectivity necessary for control. Additionally, the inherent inequality in the doctor-patient relationship may lead to exploitation of the patient. Sexual activity with a current or former patient is unethical.

2. The psychiatrist should diligently guard against exploiting information furnished by the patient and should not use the unique position of power afforded him/her by the psychotherapeutic situation to influence the patient in any way not directly relevant to the treatment goals.

3. A psychiatrist who regularly practices outside his or her area of professional competence should be considered unethical. Determination of professional competence should be made by peer review boards or other appropriate bodies.

4. Special consideration should be given to those psychiatrists who, because of mental illness, jeopardize the welfare of their patients and their own reputations and practices. It is ethical, even encouraged, for another psychiatrist to intercede in such situations.

5. Psychiatric services, like all medical services, are dispensed in the context of a contractual arrangement between the patient and the physician. The provisions of the contractual arrangement, which are binding on the physician as well as on the patient, should be explicitly established.

6. It is ethical for the psychiatrist to make a charge for a missed appointment when this falls within the terms of the specific contractual agreement with the patient. Charging for a missed appointment or for one not canceled 24 hours in advance need not, in itself, be considered unethical if a patient is fully advised that the physician will make such a charge. The practice, however, should be resorted to infrequently and always with the utmost consideration for the patient and his or her circumstances.

7. An arrangement in which a psychiatrist provides supervision or administration to other physicians or nonmedical persons for a percentage of their fees or gross income is not acceptable; this would constitute fee splitting. In a team of practitioners, or a multidisciplinary team, it is ethical for the psychiatrist to receive income for administration, research, education, or consultation. This should be based on a mutually agreed-upon and set fee or salary, open to renegotiation when a change in the time demand occurs. (See also Section 5, Annotations 2, 3, and 4.)

Section 3
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.

1. It would seem self-evident that a psychiatrist who is a law-breaker might be ethically unsuited to practice his or her profession. When such illegal activities bear directly upon his or her practice, this would obviously be the case. However, in other instances, illegal activities such as those concerning the right to protest social injustices might not bear on either the image of the psychiatrist or the ability of the specific psychiatrist to treat his or her patient ethically and well. While no committee or board could offer prior assurance that any illegal activity would not be considered unethical, it is conceivable that an individual could violate a law without being guilty

of professionally unethical behavior. Physicians lose no right of citizenship on entry into the profession of medicine.

2. Where not specifically prohibited by local laws governing medical practice, the practice of acupuncture by a psychiatrist is not unethical per se. The psychiatrist should have professional competence in the use of acupuncture. Or, if he or she is supervising the use of acupuncture by nonmedical individuals, he or she should provide proper medical supervision. (See also Section 5, Annotations 3 and 4.)

Section 4
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.

1. Psychiatric records, including even the identification of a person as a patient, must be protected with extreme care. Confidentiality is essential to psychiatric treatment. This is based in part on the special nature of psychiatric therapy as well as on the traditional ethical relationship between physician and patient. Growing concern regarding the civil rights of patients and the possible adverse effects of computerization, duplication equipment, and data banks makes the dissemination of confidential information an increasing hazard. Because of the sensitive and private nature of the information with which the psychiatrist deals, he or she must be circumspect in the information that he or she chooses to disclose to others about a patient. The welfare of the patient must be a continuing consideration.

2. A psychiatrist may release confidential information only with the authorization of the patient or under proper legal compulsion. The continuing duty of the psychiatrist to protect the patient includes fully apprising him/her of the connotations of waiving the privilege of privacy. This may become an issue when the patient is being investigated by a government agency, is applying for a position, or is involved in legal action. The same principles apply to the release of information concerning treatment to medical departments of government agencies, business organizations, labor unions, and insurance companies. Information gained in confidence about patients seen in student health services should not be released without the students' explicit permission.

3. Clinical and other materials used in teaching and writing must be adequately disguised in order to preserve the anonymity of the individuals involved.

4. The ethical responsibility of maintaining confidentiality holds equally for the consultations in which the patient may not have been present and in which the consultee was not a physician. In such instances, the physician consultant should alert the consultee to his or her duty of confidentiality.

5. Ethically, the psychiatrist may disclose only that information which is relevant to a given situation. He or she should avoid offering speculation as fact. Sensitive information such as an individual's sexual orientation or fantasy material is usually unnecessary.

6. Psychiatrists are often asked to examine individuals for security purposes, to determine suitability for various jobs, and to determine legal competence. The psychiatrist must fully describe the nature and purpose and lack of confidentiality of the examination to the examinee at the beginning of the examination.

7. Careful judgment must be exercised by the psychiatrist in order to include, when appropriate, the parents or guardian in the treatment of a minor. At the same time, the psychiatrist must assure the minor proper confidentiality.

8. When, in the clinical judgment of the treating psychiatrist, the risk of danger is deemed to be significant, the psychiatrist may reveal confidential information disclosed by the patient."

9. When the psychiatrist is ordered by the court to reveal the confidences entrusted to him/her by patients, he or she may comply or he/ she may ethically hold the right to dissent within the framework of the law. When the psychiatrist is in doubt, the right of the patient to confidentiality and, by extension, to unimpaired treatment should be given priority. The psychiatrist should reserve the right to raise the question of adequate need for disclosure. In the event that the necessity for legal disclosure is demonstrated by the court, the psychiatrist may request the right to disclosure of only that information which is relevant to the legal question at hand.

10. With regard for the person's dignity and privacy and with truly informed consent, it is ethical to present a patient to a scientific gathering if the confidentiality of the presentation is understood and accepted by the audience.

11. It is ethical to present a patient or former patient to a public gathering or to the news media only if the patient is fully informed of enduring loss of confidentiality, is competent, and consents in writing without coercion.

12. When involved in funded research, the ethical psychiatrist will advise human subjects of the funding source, retain his or her freedom to reveal data and results, and follow all appropriate and current guidelines relative to human subject protection.

13. Ethical considerations in medical practice preclude the psychiatric evaluation of any person charged with criminal acts prior to access to, or availability of, legal counsel. The only exception is the rendering of care to the person for the sole purpose of medical treatment.

14. Sexual involvement between a faculty member or supervisor and a trainee or student, in those situations in which an abuse of power can occur, often takes advantage of inequalities in the working relationship and may be unethical because:

a. Any treatment of a patient being supervised may be deleteriously affected.
b. It may damage the trust relationship between teacher and student.
c. Teachers are important professional role models for their trainees and affect their trainees' future professional behavior.

Section 5
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.

1. Psychiatrists are responsible for their own continuing education and should be mindful of the fact that theirs must be a lifetime of learning.

2. In the practice of his or her specialty, the psychiatrist consults, associates, collaborates, or integrates his or her work with that of many professionals, including psychologists, psychometricians, social workers, alcoholism counselors, marriage counselors, public health nurses, and the like. Furthermore, the nature of modern psychiatric practice extends his or her contacts to such people as teachers, juvenile and adult probation officers, attorneys, welfare workers, agency volunteers, and neighborhood aides. In referring patients for treatment, counseling, or rehabilitation to any of these practitioners, the psychiatrist should ensure that the allied professional or paraprofessional with whom he or she is dealing is a recognized member of his or her own discipline and is competent to carry out the therapeutic task required. The psychiatrist should have the same attitude toward members of the medical profession to whom he or she refers patients. Whenever he or she has reason to doubt the training, skill, or ethical qualifications of the allied professional, the psychiatrist should not refer cases to him/her.

3. When the psychiatrist assumes a collaborative or supervisory role with another mental health worker, he or she must expend sufficient time to assure that proper care is given. It is contrary to the interests of the patient and to patient care if the psychiatrist allows himself/herself to be used as a figurehead.

4. In relationships between psychiatrists and practicing licensed psychologists, the physician should not delegate to the psychologist or, in fact, to any nonmedical person any matter requiring the exercise of professional medical judgment.

5. The psychiatrist should agree to the request of a patient for consultation or to such a request from the family of an incompetent or minor patient. The psychiatrist may suggest possible consultants, but the patient or family should be given free choice of the consultant. If the psychiatrist disapproves of the professional qualifications of the consultant or if there is a difference of opinion that the primary therapist cannot resolve, he or she may, after suitable notice, withdraw from the case. If this disagreement occurs within an institution or agency framework, the differences should be resolved by the mediation or arbitration of higher professional authority within the institution or agency.

Section 6
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.

1. Physicians generally agree that the doctor-patient relationship is such a vital factor in effective treatment of the patient that preservation of optimal conditions for development of a sound working relationship between a doctor and his or her patient should take precedence over all other considerations. Professional courtesy may lead to poor psychiatric care for physicians and their families because of embarrassment over the lack of a complete give-and-take contract.

2. An ethical psychiatrist may refuse to provide psychiatric treatment to a person who, in the psychiatrist's opinion, cannot be diagnosed as having a mental illness amenable to psychiatric treatment.

Section 7
A physician shall recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health.

1. Psychiatrists should foster the cooperation of those legitimately concerned with the medical, psychological, social, and legal aspects of mental health and illness. Psychiatrists are encouraged to serve society by advising and consulting with the executive, legislative, and judiciary branches of the government. A psychiatrist should clarify whether he/ she speaks as an individual or as a representative of an organization. Furthermore, psychiatrists should avoid cloaking their public statements with the authority of the profession (e.g., "Psychiatrists know that").

2. Psychiatrists may interpret and share with the public their expertise in the various psychosocial issues that may affect mental health and illness. Psychiatrists should always be mindful of their separate roles as dedicated citizens and as experts in psychological medicine.

3. On occasion psychiatrists are asked for an opinion about an individual who is in the light of public attention or who has disclosed information about himself/herself through public media. In such circumstances, a psychiatrist may share with the public his or her expertise about psychiatric issues in general. However, it is unethical for a psychiatrist to offer a professional opinion unless he or she has conducted an examination and has been granted proper authorization for such a statement.

4. The psychiatrist may permit his or her certification to be used for the involuntary treatment of any person only following his or her personal examination of that person. To do so, he or she must find that the person, because of mental illness, cannot form a judgment as to what is in his/ her own best interests and that, without such treatment, substantial impairment is likely to occur to the person or others.

5. Psychiatrists shall not participate in torture.

Section 8
A physician shall, while caring for a patient, regard responsibility to the patient as paramount.

1. Psychiatrists' relationships with companies, organizations, the community, or larger society can affect their interactions with patients.

2. When the psychiatrist's outside relationships conflict with the clinical needs of the patient, the psychiatrist must always consider the impact of such relationships and strive to resolve conflicts in a manner that the psychiatrist believes is likely to be beneficial to the patient.

3. When significant relationships exist that may conflict with patients' clinical needs, it is especially important to inform the patient or decision maker about these relationships and potential conflicts with clinical needs.

4. In informing a patient of treatment options, the psychiatrist should assist the patient in identifying relevant options that promote an informed treatment decision, including those that are not available from the psychiatrist or from the organization with which the psychiatrist is affiliated.

Section 9

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

PROCEDURES FOR HANDLING COMPLAINTS OF UNETHICAL CONDUCT

INTRODUCTION

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 not only to patients but also to society, the profession, other health professionals, and to self. The *Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry (*hereafter referred to as the *"Principles")*, adopted from the American Medical Association, are not laws but standards of conduct that define the essentials of honorable behavior for the physician.

Complaints charging members of the American Psychiatric Association (APA) with unethical behavior or practices shall be investigated and resolved in accordance with procedures approved by the APA Assembly and the APA Board of Trustees. These procedures are congruent with the minimum requirements under the Health Care Quality Improvement Act. A District Branch (DB) of the APA may adopt additional requirements to comply with any additional or more stringent requirements of state law. A District Branch should notify the APA if additional requirements are adopted.

Ethics cases are confidential. The allegations, the names of the parties and other information are made available only to persons directly participating in the proceedings. Information regarding an ethics case is made public in limited circumstance as set forth in these procedures and only after a final determination has been reached when required by law or necessary to protect the public.

PART I: INITIAL PROCEDURES

A. The Complaint

1. An ethics complaint can be filed by a patient or guardian, a family member of a patient, an APA member or other individual with personal knowledge of the alleged unethical conduct.

2. The individual submitting the complaint is the "Complainant" and the APA member charged with ethics violations is the "Accused Member."

3. Complaints charging an APA member with unethical behavior shall be:

   a. In writing;

   b. Signed by the Complainant and

c. Addressed to the DB of the Accused Member. If addressed to the APA, the complaint shall be referred by the APA to the Accused Member's DB.

B. <u>Proceeding on Extrinsic Evidence</u>:

1. A complaint may be based on extrinsic evidence, including any documents attached to the complaint.

2. A DB may initiate an ethical proceeding without a Complaint based upon extrinsic evidence which it receives or otherwise becomes aware that a member has potentially acted unethically in violation of the *Principles.* In such proceeding, there is no Complainant.

3. Extrinsic evidence includes formal judicial or administrative reports, sworn deposition or trial testimony, medical or hospital records, and similar reliable documents.

C. <u>Review for Jurisdiction</u>

1. Once a complaint is received, the DB shall review the complaint to determine if the DB has jurisdiction over the matter. This review shall take place before the Accused Member is notified that a complaint was filed.

2. This review will consider:

   a. Is the Accused Member a member of the APA and the DB? Only complaints against APA members can be investigated. If the Accused Member is not a member, the DB shall notify the Complainant that it cannot pursue the complaint because the Accused Member is not a member of the APA and no further action can be taken.

   b. Is the Accused Member a member of the DB? If not, the complaint shall be forwarded to the APA Office of Ethics.

   c. Does the complaint allege unethical conduct that took place over ten (10) years ago? A complaint alleging unethical conduct must be received within ten (10) years of the alleged conduct. In the case of a minor patient, the ten (10) year limit will not begin until the patient reaches the age of 18. If the alleged conduct took place outside of the ten year limit, the DB shall notify the Complainant in writing that no further action can be taken.

3. If the complaint meets these jurisdictional standards, the DB shall evaluate the complaint as set forth in Part II below to determine whether it alleges conduct that violates the *Principles*.

4. The DB's determination that a complaint does not meet these jurisdictional standards is final and there is no review by the Chair of the APA Ethics Committee.

D. **Notice:** Any "Notice" required in these procedures should be sent by a delivery system that requires a verifying of receipt, such as certified or overnight mail.

PART II: REVIEW OF ALLEGATIONS

The DB Ethics Committee (DBEC) shall review the complaint to determine whether it alleges a recognized ethics violation of the *Principles*.

A. Preliminary Determinations

1. The DBEC shall determine whether the complaint alleges on its face an ethics violation(s) as set forth in the *Principles*.

2. This is not a determination on the merits of the complaint. Rather, it is a determination of whether a recognized ethics violation is alleged assuming the facts in the complaint are true. This review is limited to reviewing the allegations in the complaint and a determination of whether those allegations assert a recognized ethics violation as set forth in the *Principles*.

3. If the complaint alleges conduct that does not violate the *Principles*, the DBEC shall notify the Complainant in writing (with a copy to the APA Ethics Office) that no further action will be taken and also inform the Complainant that he/she may request within 30 days a review of this decision by the Chair of the APA Ethics Committee as set forth in Part II.C.1.

4. Before initiating this below Review phase, a signed Confidentiality Agreement shall be obtained from the Complainant (including any attorney representing the Complainant) by which the Complainant agrees that all information and documents concerning the ethical procedures and all communications from the APA and DB, including their ethics committees and Hearing Panels, are confidential and shall be used solely in connection with the ethical proceedings and not for other purposes or legal proceedings.

B. Review of Allegations

1. This phase is the period during which the DBEC begins to look at the

merits of the case. The purpose of this process is to assess all information provided by the Complainant and then evaluate whether there is a basis for the allegation of unethical conduct. The DBEC can choose whether or not to contact and advise the Accused Member of the ethics complaint during this stage.

2. The DB ethics chair shall appoint a member(s) to review the allegations in the complaint. The individual(s) shall submit a written or oral report to the DBEC.

3. To help ensure fairness, it is desirable that the DBEC arrange for those who do the review and those who serve on the hearing panel to be separate teams. Sometimes what surfaces during this review is not always relevant to or admissible at the hearing, and thus this separation of functions minimizes the chances that the hearing panel will have been influenced by an earlier phase of the case.

4. The review is accomplished by reviewing the allegations and any related materials provided to them by the Complainant. During the review phase, the reviewer(s) may seek additional information from the Complainant. The additional information can be obtained by written request, phone conference or in person interview.

5. During this Review of Allegations phase, the DBEC may, but is not required to, notify the Accused Member of the complaint and invite additional information from him or her. The additional information can be obtained by written request, phone conference or in person interview.

6. If the DBEC finds the complaint does state a potential ethics violation, it shall notify the Accused Member and invite additional information from him or her before proceeding with a formal investigation of the member pursuant to Part III.

7. If the DBEC finds the complaint does not state a potential ethics violation under the ethical standards established by the *Principles* and thus there is no basis to proceed, it shall notify the Complainant in writing of the conclusion. This Notice shall also inform the Complainant that he/she has 30 days to request a review of this decision by the Chair of the APA Ethics Committee as set forth in Part II.C.1.

8. If the DBEC determines there is a basis to proceed, it must notify the APA Secretary as well as the Complainant and the Accused Member and proceed to the exchange of information phase.

9. DBECs should postpone adjudication of ethics complaints until all other pending actions such as civil, criminal or licensing board proceedings have been resolved.

C. Review by the Chair of the APA Ethics Committee

1. If the DBEC determines the complaint does not allege an ethics violation of the *Principles,* the Complainant may request a review of a DB's decision by the Chair of the APA Ethics Committee. The request for a review must be sent to the DB and the Chair of the APA Ethics Committee within 30 days of the date of the Notice by the DB not to proceed.

2. If the Chair of the APA Ethics Committee determines that the complaint identifies a potential violation, he/she will request that the DB proceed with processing the complaint, and will provide the DB with a written explanation for this decision.

3. If the Chair of the APA Ethics Committee determines that the complaint does not warrant further action, then he/she will notify the Complainant and DB of this decision and that the case is closed.

PART III: EXCHANGE OF INFORMATION

A. Notice to Accused Member

1. If the DBEC decides to proceed, the DBEC must notify the Accused Member of the ethics complaint and that the DBEC will proceed to determine whether the Accused Member violated the *Principles*. The Notice should include:

   a. A copy of the complaint;

   b. All documents that were attached to the complaint or obtained during the initial review phase; and

   c. Copies of the Principles and Procedures for Handling Complaints of Unethical Conduct;

   d. The ethical principle(s) the Accused Member is accused of violating.

2. The DBEC should also notify the Accused Member of his or her due process rights. These include the right:

   a. To request a hearing;

   b. To be represented by an attorney or other person of the Accused Member's choice (hereafter referred to as "Counsel");

   c. To have a record made of the proceedings (but not the Ethics Committee's subsequent deliberations, which will not have been preserved), copies of which

may be obtained by the Accused Member upon payment of any reasonable charges;

d. To call, examine, and cross-examine witnesses;

e. To present evidence determined to be relevant by the hearing panel, regardless of its admissibility in a court of law;

f. To submit a written statement or make an oral statement at the close of the hearing;

g. To receive a written decision; and

h. To appeal any adverse decision to the APA Ethics Committee.

3. When applicable, the DBEC shall obtain and provide the Accused Member with valid written authorization(s) from the patient(s) involved to provide relevant medical records and other information about the patient, and, if applicable, psychotherapy notes.

B. Accused Member's Response

1. The Accused Member shall provide a written response to the complaint, including copies of all documents and a list of all witnesses he or she intends to present at the hearing. The Accused Member is not limited at the hearing to the evidence and witnesses identified in his or her response.

2. The DBEC may also consider additional information prior to any scheduled hearing. On the basis of information in the Accused Member's response, or other information that surfaces during the Exchange of Information phase but prior to the hearing, the DBEC may decide to dismiss the case. A decision by the DBEC to dismiss in this phase requires review by the APA Ethics Committee as set forth in Part VI.

3. The name of any member who resigns from the APA after an ethics complaint against him/her is received and before it is resolved shall be reported in *Psychiatric News* and in the district branch newsletter or other usual means of communication with its membership.

C. Appointment of Hearing Panel

The DBEC shall appoint a panel of no less than three members to hear the complaint. All members should be ethics committee members when possible, and at least one must be. One member of the panel shall be selected to chair the Hearing Panel (Hearing Panel Chair) and shall be a voting member of the panel. The Accused Member may request those with whom he/she has a conflict of interest be excused, and reasonable requests should be honored.

D. Notice of Hearing

1. No less than 30 days before the scheduled hearing, the DBEC shall provide a Notice to the Complainant and the Accused Member. The Notice should supply the following information:

   a. The place, date and time of the hearing;

   b. The names of the Hearing Panel Chair and the other panel members who will hear the case; and

   c. A list of witnesses expected to testify.

2. Any reasonable requests by the parties for alternative hearing dates should be honored.

E. Education Option

1. At any time before a final determination of whether the Accused Member violated the ethical standards established by the *Principles*, and with the agreement of the Accused Member, the complaint may be resolved in accordance with the Educational Option rather than determine whether the Accused Member violated the *Principles*. In deciding whether to use this approach, the DBEC shall consider such factors as the nature and seriousness of the alleged misconduct and any prior findings or allegations of unethical conduct.

2. If the DBEC decides to attempt to resolve the complaint by using the Educational Option as described in paragraph 1 above, it shall proceed only after:

   a. Accused Member has been informed (1) that he/she is entitled to proceed under enforcement procedures, and (2) that the DBEC reserves the right to proceed on the complaint to determine whether the Accused Member violated the *Principles* if, in its sole discretion, it determines that the Accused Member has not satisfactorily cooperated.

   b. Accused Member agrees to proceed under the Educational Option;

   c. There are appropriate education opportunities available and the DBEC has the resources to monitor compliance;

   d. The Accused Member will have the opportunity to respond to the suggestion to use the Education Option. The DBEC shall determine the procedures to be used to obtain the responses, including written submissions and/or meeting with the parties separately or together. However, in determining the procedure it will use, the DBEC shall seek to provide a format that will facilitate the Accused Member's understanding of the ethical issues raised by the complaint, including the reasons for or sources of the Complainant's concern, and to permit the DB to assess the Accused Member's understanding of these matters.

3. The DBEC shall identify a specific educational program including courses, reading and/or consultation for the Accused Member to complete within a specified period and shall notify the Accused Member and the APA Ethics Committee of the required program. The DBEC will monitor the Accused Member's compliance with any such educational requirements. The Accused Member's failure to complete the specified educational program may result in the proceedings being reopened to determine whether the Accused Member violated the *Principles*. It is preferable, but not required, that the subsequent proceeding be conducted by DBEC members other than those who participated in the process previously.

4. The DBEC shall retain records of complaints considered pursuant to this Part and of any education thereafter required of an Accused Member. The DB may consider such information in connection with a decision as to how to handle any later complaints involving the Accused Member.

5. Once the DBEC decides to resolve the complaint by using the Educational Option, it shall notify both the Complainant and Accused Member.

6. Upon completion of an Education Option requirements, the proceeding shall be terminated.

PART IV: THE HEARING

A. Basic Requirements

1. While the spirit of this process is a collegial one based on mutual respect among professional colleagues -- and not a court of law -- procedural safeguards are an integral aspect in order to preserve the rights of the Accused Member and provide fairness and respect for both the Accused Member and the Complainant.

2. If deemed useful and not likely to prejudice the panel, the Hearing Panel Chair may allow the individual(s) who did the review of allegations under Part II to present oral or written documentary and testimony evidence, subject to cross examination by the Accused Member or his or her counsel, for the panel's consideration. This reviewer(s) of the allegations should not participate any further in the hearing or be part of the panel's deliberations or voting.

3. Counsel's participation is subject to the continuing direction and control of the Hearing Panel Chair. The Hearing Panel Chair shall exercise his or her discretion so as to prevent the intimidation or harassment of the Complainant and/or other witnesses given the peer review nature of the proceedings. Panel members may ask questions of the Accused Member.

4. The Accused Member's voluntary waiver of a hearing shall not prevent the Hearing Panel from meeting with, and hearing the evidence of, the

Complainant and other witnesses, and reaching a decision in the case. The Accused Member may choose not to be present at the hearing and to present his/her defense through other witnesses and/or Counsel.

5. The Complainant must be present in person at the hearing to testify regarding his/her allegations unless excused by the Hearing Panel Chair, and this should occur only when, in the judgment of the Hearing Panel Chair, participation would be harmful to him/her or extrinsic evidence serves as the Complainant. Complainants may bring a support person to the hearing if approved by the Hearing Panel Chair. Complainants generally do not remain in the hearing once they have presented their testimony and evidence and been cross examined. The Hearing Panel Chair may have them wait outside during the remainder of the hearing in the event further information from the Complainant becomes needed.

B. <u>The Hearing</u>

1. The hearing may consist of:

   a An oral opening statement by the Complainant, and the Accused Member or his/her Counsel;

   b Testimony by the Complainant and any witnesses, and any written or oral cross examination by Accused Member or his/her Counsel;

   c Testimony by the Accused Member;

   d Questions by the Hearing Panel members; and

   e Presentation of any evidence determined to be relevant by the Hearing Panel Chair, regardless of its admissibility in a court of law.

2. The Accused Member or his Counsel shall be permitted to make an oral closing statement and/or submit a written statement at the close of the hearing or within a reasonable time thereafter.

PART V: DISTRICT BRANCH DECISION

After the hearing, the Hearing Panel shall meet and reach a decision based on the information presented at the hearing, including the testimony from the parties and any other witnesses, the documents submitted and any other evidence provided as part of the hearing. The decision shall consist of (A) a determination of whether the Accused Member violated the ethical standards established by the *Principles*, and (B) if so, then what sanction, if any, is appropriate.

A. Determination

1. After the conclusion of the hearing, the panel shall issue a written determination that sets forth the Hearing Panel's findings, recommendations, and reasoning.

2. In making its decision, the Hearing Panel should consider:

   a. The nature and seriousness of the alleged conduct;

   b. Whether or not there is a reasonable belief that an ethics violation occurred.

   c. The credibility of the Accused Member, Complainant and the other witnesses;

   d. Any documents submitted that the panel finds credible; and

3. The DB executive council (or the DB's governing body) must review the panel's determination. The DB executive council can accept or modify the panel's findings. In all cases, the DB shall seek to reach a decision as expeditiously possible.

4. Before notifying the Complainant and Accused Member, all determinations must be forwarded to the APA Ethics Committee for review pursuant to the procedures set forth in Part VI.

5. Unless the DBEC proceeds under the Education Option, there are two basic findings:

   a. The Accused Member did not act unethically; or

   b. The Accused Member acted unethically.

6. No Ethical Violation

   a. If the Hearing Panel decides after a hearing that no ethical violation occurred, it shall prepare a written explanation that sets forth the reasons for the determination. This determination shall be submitted to the DB executive council and the APA Ethics Committee for review as set forth in Part VI.

   b. If approved by the DB executive council and the APA Ethics Committee as set forth in Part VI, the DBEC shall notify the Complainant and Accused Member in writing of the determination.

   c. There is no appeal from this determination.

7. Ethical Violation

   a. If the panel decides after a hearing that Accused Member acted unethically, it shall prepare a written explanation that sets forth the reasons for the determination. It shall then proceed to determine the appropriate sanction. This determination shall be submitted to the DB executive committee and the APA Ethics Committee for review as set forth in Part VI.

   b. If approved by both the DB executive committee and APA Ethics Committee, only the Accused Member shall be notified in writing of the determination setting forth the reasons for the determination and the sanction. This Notice should be copied to the APA Ethics Office. This Notice shall also inform the Accused Member of his or her right to appeal the determination to the APA Ethics Committee within 30 days. The appeal right applies to all adverse findings.

   c. The Complainant is not notified of the determination until all appeals have been concluded or the time for the Accused Member to appeal has expired.

B. Sanctions

If the panel finds that an ethical violation has occurred, it must determine the appropriate sanction. This determination may include consideration of any mitigating or aggravating circumstances such as illness or prior findings of unethical conduct that are relevant to the current violation. The three (3) sanctions in increasing order of severity are: (1) Reprimand; (2) Suspension; and (3) Expulsion.

1. Reprimand

   a. A reprimand is an official admonishment by the APA. The reprimand shall identify the conduct considered unethical and the basis of the determination.

   b. The reprimand is confidential and is not published to the general membership of the DB or the APA, or to the general public.

   c. Additional conditions may be included with the reprimand as set forth Part V.C.)

2. Suspension

   a. Suspension is a serious sanction that will be made public. An Accused Member may be suspended for a period not to exceed five (5) years.

b. A suspended member shall pay dues and is eligible for APA benefits, except that such a member will lose his/her rights to hold office, vote, nominate candidates, propose referenda or amendments to the Bylaws, and serve on any APA committee or component, including the APA Board of Trustees and the APA Assembly. If the suspended member is a Fellow, Life Fellow, Distinguished Fellow or Distinguished Life Fellow, the Fellowship will be suspended for the same period of time.

c. Each DBEC shall decide which, if any, DB privileges and benefits shall be denied the Accused Member during the period of suspension.

d. Additional conditions may be included with the suspension as set forth in Part V.C.

e. The name of any member who is suspended for an ethics violation, along with an explanation of the nature of the violation, shall be reported by the APA Office of Ethics:

   i. In *Psychiatric News*;

   ii. To the DB to be included in the DB newsletter or other usual means of communication with its membership;

   iii. To the medical licensing authority in all states in which the member is licensed:

   iv. To the National Practitioner Data Bank.

f. The DB should also consult applicable state law to assure that it adheres to any requirements.

3. Expulsion

   a. Expulsion is the most serious sanction. As a result, all determinations to expel an Accused Member must be affirmed by the APA Board of Trustees.

   b. Once a decision to expel a member has been approved by the DB executive council and the APA Ethics Committee, and the appeal process under Part VII has been exhausted or expired the APA Ethics Committee Chair (or his/her designee) shall present the matter and the documentary record to the APA Board of Trustees at the Board's next meeting. The APA Board of Trustees may:

      i. Affirm the sanction;

      ii. Impose a lesser sanction;

iii. Remand to the APA Ethics Committee or DBEC for further action or consideration in which case these procedures shall apply to those actions; or

iv. Request further information from the DBEC before voting on the decision to expel.

c. A decision to affirm an expulsion must be by a vote of two-thirds (2/3) of those Trustees present and voting. A decision to impose a lesser sanction shall be by a majority vote.

d. If the APA Board of Trustees affirms expulsion, the APA Secretary shall notify the DBEC, and the DBEC shall in turn notify the Complainant and Accused Member of the decision and that it is final.. The Accused Member shall also be provided copies of the DBEC and/or panel recommendation(s) and reasoning.

e. The name of any member who is expelled from the APA for an ethics violation, along with an explanation of the nature of the violation, shall be reported by the APA Office of Ethics:

i. In *Psychiatric News*:

ii. To the DB to be included in the DB newsletter (APA Office of Ethics will provide DBEC with language) or other usual means of communication with its membership;

iii. To the medical licensing authority in all states in which the member is licensed:

iv. To the National Practitioner Data Bank.

f. The DB should also consult applicable state law to assure that it adheres to any state requirements.

C. Additional Conditions

Concurrent with the imposition of the sanctions of reprimand and suspension, additional conditions can be imposed. These conditions are designed to reinforce and facilitate ethical behavior.

1. Supervision

a. The DBEC may impose supervisory requirements on a suspended member. When such conditions are imposed, the following procedures shall apply:

i. If the DBEC imposes conditions, it shall ensure that the DB monitors compliance;

ii. If a member fails to satisfy the conditions, the DBEC may decide to recommend a new sanction; and

iii. If the DBEC determines that a member should be expelled for noncompliance with conditions, the APA Board of Trustees shall review the expulsion in accordance with the provisions set forth in Part VII. E. of these procedures.

b. In determining whether to require supervision, the Hearing Panel and/or the DBEC should consider the available resources to conduct and monitor such supervision.

2. Education Requirement

a. The DBEC may impose an Education Requirement as part of the sanctions of reprimand or suspension.

b. If the DBEC decides to impose an Education Requirement, the DBEC shall identify a specific educational program including courses, reading and/or consultation for the Accused Member to complete within a specified period and shall notify the Accused Member and the APA Ethics Committee of the required program. The DB will monitor the Accused Member's compliance with any such educational requirements. The Accused Member's failure to complete the specified educational requirement(s) may result in the proceedings being reopened (e.g., to determine if a greater sanction is indicated).

3. Personal Treatment

a. As part of any sanction, personal treatment may be recommended, but not required, and any such recommendation shall be carried out in accordance with the ethical requirements governing confidentiality as set forth in the *Principles*. In appropriate cases, the DBEC may also refer the psychiatrist in question to a program responsible for considering impaired or physically ill physicians.

PART VI: REVIEW BY THE APA ETHICS COMMITTEE

A. APA Ethics Committee Review

1. After the DBEC decision is confirmed by its DB executive council (or the

DB's governing body), the decision and any pertinent information concerning the procedures followed or relating to the action taken shall be forwarded to the APA Ethics Committee for review. This review applies to all decisions, including those where the DBEC finds that an ethics violation has not occurred.

2. The APA Ethics Committee will appoint a panel composed of at least three (3) voting members of the APA Ethics Committee to undertake these review functions on behalf of the full APA Ethics Committee. The review shall assure that:

   a. The complaint received a comprehensive and fair review;

   b. That the review was in accordance with the applicable procedures; and

   c. The sanction imposed was appropriate.

3. If the APA Ethics subcommittee concludes that these requirements were not satisfied, it shall so advise the DBEC, and the DBEC shall remedy the deficiencies and shall make further reports to the APA Ethics Committee until such time as the APA Ethics Committee is satisfied that these requirements have been met.

4. If the APA Ethics subcommittee concludes that the sanction should be reconsidered by the DBEC, it shall provide a statement of reasons explaining the basis for its opinion, and the DBEC shall reconsider the sanction. After reconsideration, the decision of the DBEC shall be final with the exception that Expulsions must also be approved by the APA Board of Trustees.

5. The Complainant and Accused Member shall not be notified of any decision until this review is completed.

B. Notification of Decision

1. After the APA Ethics Committee or subcommittee completes the review process, the following Notices will be sent:

   a. If the determination is that no ethics violation has occurred, the DB shall provide written Notice to the Complainant and Accused Member of the decision.

   b. If the determination is that an ethical violation did occur, the DBEC shall provide written Notice to the Accused Member of the decision and the sanction. The Accused Member shall be provided: (1) copies of the DBEC and/or panel recommendation(s), (2) the DBEC decision, and (3)

notice of his/her right to Appeal the decision within 30 days of receipt of the letter. The Complainant shall not be notified until all appeals or the time for all appeals has expired.

c. If the decision is to expel the member, the DBEC shall not provide Notice until the APA Board of Trustees has approved the expulsion pursuant to Part V.B.4. Once approved by the Board, the DBEC shall provide written Notice to the Complainant and Accused Member, with a copy to APA, that Expulsion has been approved by the Board of Trustees and that the decision is final.

PART VII: APPEALS

A. Appeal Panel

1. All appeals shall be considered and decided by a panel of three (3) members of the APA Ethics Committee who have not been involved in a review of the case pursuant to Part VI.

2. The Chair of the APA Ethics Committee may appoint a replacement if there are not three members of the Committee who have not been involved in the case who are able to serve.

B. Grounds for Appeal

All appeals shall be based on one (1) or more of the following grounds:

1. That there have been significant procedural irregularities or deficiencies in the case;

2. That *The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry* has been improperly applied;

3. That the findings of or sanction imposed by the DB are not supported by substantial evidence;

4. That substantial new evidence has called into question the findings and conclusions of the district branch.

C. Accused Member's Request For Appeal

1. The Accused Member's request for an appeal must be received within 30 days of the date the Accused Member is notified of the district branch decision. Upon receipt of the Accused Member's request for an appeal, the APA Ethics Committee shall request and the DB shall provide to the APA Ethics Committee a copy of the DB file, including the recording of the hearing. The APA Ethics Committee shall make a copy the DB file available to the Accused Member upon request and compliance with any conditions set by the APA Ethics Committee.

2. In appeals heard by an APA Ethics Committee appeals panel, the panel will review and decide the appeal solely on the basis of the DB's documentary record of its actions and decision and any written appeal statements filed by the Accused Member and the district branch. The Accused Member's statement will be provided to the DB, which may file a written response. Any DB response will be forwarded to the Accused Member, who will have the opportunity to respond in writing prior to the Ethics Committee's consideration of the appeal. Filing deadlines and other procedures governing the appeal shall be established by the APA Ethics Committee.

D. Decision by APA Ethics Committee Appeal Panel

1. After reviewing all documents, the APA Ethics Committee appeals panel may take any of the following actions:

   a. Affirm the decision, including the sanction imposed by the district branch;

   b. Affirm the decision, but alter the sanction imposed by the district branch;

   c. Reverse the decision of the district branch and terminate the case; or

   d. Remand the case to the district branch with specific instructions as to what further information or action is necessary. Remands will be employed only in rare cases, such as when new information has been presented on appeal or when there is an indication that important information is available and has not been considered. After the district branch or panel has completed remand proceedings, the case shall be handled in accordance with procedures in Part VI and VII.

2. After the APA Ethics Committee appeals panel reaches a decision, if the decision is anything other than to expel a member or remand, the Chair of the APA Ethics Committee shall provide Notice to the DB of the decision. The DB shall then provide Notice to the Accused Member and the Complainant of the decision and that it is final.

3. If the decision is to expel the member, the decision would be forwarded to the APA Board of Trustees as outlined in Part V.B.4.

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CEO Report to the JRC, October 11, 2014

Agenda Item #	Action	CEO/MDO Response	Staff Responsible	Status
4.1	Mental Health Parity Act Compliance & Insurance Accreditation Organizations [ASMNOV1212.C]	***Update:*** Currently, the APA is now in discussion with NCQA on issues surrounding integrated care, and as we move forward with strategies around parity in partnership with our allied groups, we will begin to discuss standards that demonstrate compliance with the Mental Health Parity and Addictions Equity Act.	Kristen Kroeger Sam Muszynski, JD	This action is ongoing.
4.6	Revitalizing the Public Perception of the APA and the Psychiatric Profession [ASMMAY1312.1]	***Update:*** • Jason Young as CCO was hired on July 1st • Following a review of Porter Novelli's audit; discussions with Administration leadership, communications team, and internal customers, a reorganization plan underway. The new infrastructure establishes three offices under Communications: "Corporate Communications & Public Affairs" as our voice to external audiences; "Member Communication" as our voice to current and prospective members and DB/SAs; and "Integrated Marketing" as our brand and how we market membership in the APA, our products (meetings, education and publications) and social action. • After briefing the BOT and receiving a unanimous vote from the Council on Communications in September to properly brand the APA, an RFP was let for a brand process that will include leadership, membership and stakeholder input. • Directors are actively being recruited to lead the three offices under Communications.	CEO and Medical Director (for information) Jason Young	This action is ongoing.

CEO Report to the JRC, October 11, 2014

Agenda Item #	Action	CEO/MDO Response	Staff Responsible	Status
4.7	Use of New CPT Codes in Health Insurance Exchanges [ASMMAY1312.S]	***Update:*** We will be monitoring what is happening in the exchange plans; all laws which address these issues have been compiled and based on a review of those laws, exchange plans have no special status. HIPAA already requires the use of CPT codes. APA regularly advocates access to all CPT codes using CPT coding conventions. To date any compliance issues with the new CPT coding conventions have been handled on a case by case basis. OHSF will continue to do outreach to the major payers. We will continue to monitor what is happening in the exchange plans through the APA Practice Management line. This will take some time to get a clear picture of how the exchange plans will operate as detailed information as of yet has been unobtainable. The issue of payment equity based on RVUs is not possible to analyze at present.	Kristen Kroeger Sam Muszynski, JD	This action is ongoing.
4.9	Council Communication to Members [JRCOCT138.F.1]	***Update:*** • The Council on Communications deliberated on this item and had requested briefings on Council reports underway; to date, the Council Chair has been briefed on a forthcoming GME report. • The Communications Division is creating and strengthening the organization's communications channels, including new channels better targeted to specific audience needs. • An Office of Member Communication is being established to manage communications with current and prospective members, including dissemination of relevant content from Council reports, and to continue to develop new, targeted channels.	Jason Young Shaun Snyder, JD	This action is ongoing.

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Agenda Item #	Action	CEO/MDO Response	Staff Responsible	Status
6.13	Area RFM Representative Modality and Opportunity for APA Updates and Education (ASMMAY1412.N) [Please see item 6, attachment 13] The action paper asks that the Council on Communications be charged with the formulation of an APA approved PowerPoint slide set using the current information already established. That the slide set contains the following information: • APA goals and mission statement, • RFM membership benefits (i.e. discounts from APPI, etc.), • basic structure of the leadership hierarchy within the APA, • information about the PAC, • RFM key leaders with contact information, • RFM leadership opportunities within the APA, • RFM informational guides and/or handbook link, • a brief description of the APA Assembly and its role/function, brief description/definition of an action paper and how to submit an action paper, and hot action paper topics (action papers that have passed the assembly)(the hot action paper topic slide can be very basic as this will change frequently). That this slide set be used as a template for RFM leaders to add further information specific to his/her area. That dissemination of the slide set be required of the RFM Representative after each Assembly Meeting. As a result, this requirement should be added to the job duties of the RFM Representative. Will the Joint Reference Committee refer the Assembly action paper ASMMAY1412.N*: Area RFM Representative Modality and Opportunity for APA Updates and Education* to the appropriate Component(s) for input or follow-up?	***Update:*** This was completed and distributed to ACORF.	Dr. Saul Levin Jon Fanning	This action is completed.
6.14	ABPN 2015 Exam Expectations (ASMMAY1412.P) [Please see item 6, attachment 14] The action paper asks that the APA ask the ABPN to use DSM-5 in its written examinations beginning in 2015. Will the Joint Reference Committee refer the Assembly action paper ASMMAY1412.P: *APBN 2015 Exam Expectations* to the appropriate Component(s) for input or follow-up?	***Update:*** As it has been noted that this could potentially happen in written examinations beginning in 2017, APA will address this concern with APBN during our annual joint meeting in January of 2015.	Dr. Saul Levin Kristin Kroeger	This action is ongoing.

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Agenda Item #	Action	CEO/MDO Response	Staff Responsible	Status
8.E.1	Resident Fellow Position on Council Will the Joint Reference Committee recommend that the Board of Trustees approve designating one member position on the Council to a Resident Fellow? A Resident Fellow position would parallel the member positions on the council designated for an ECP and an Assembly member. There is no additional cost to this change as the Resident Fellow member position would allocate an existing member position on the council to an RFM.	***Update:*** APA conducted a cost analysis of adding an RFM position to the Council, and it would cost $12,055.29 for all Councils. However, if one current seat is designated as an RFM position, then there is no additional cost. A cost analysis is provided for JRC's reference.	Dr. Saul Levin Shaun Snyder Margaret Dewar Laurie McQueen	This action is ongoing.

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

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Agenda Item #	Action	CEO/MDO Response	Staff Responsible	Status
8.G.2	Fall Component Meetings Plenary: Recommendations of the BOT Ad Hoc Work Group on the role of Psychiatry in Health Reform Will the Joint Reference Committee recommend to the appropriate APA body that a plenary session be held at the Fall Meetings (2014) focusing on psychiatry and health reform and the recommendations from the Ad Hoc Work Group on the Role of Psychiatry in Health Reform report? Financial Implications: Recognizing that not all Councils are meeting on the same days, the plenary should be scheduled during the group meal function with the maximum anticipated attendance (in an effort to reach the maximum number of attendees possible). The cost would be the audio/visual needs (microphone, power point setup, etc.). The presentation(s) would be done by individuals already in attendance. Background: The discussion noted above was followed by a suggestion to provide a plenary for all Councils at the fall meetings on the report (including the recommendations) from the Ad Hoc Work Group on the Role of Psychiatry in Health Reform. The plenary would provide a mechanism to provide the context for moving forward with specific recommendations and could inform discussion within and amongst Councils at the fall meetings.	***Update:*** Dr. Summergrad presented a plenary session about healthcare reform at the last September Components Meeting. The CEO and Medical Director's Office will continue to develop other ways this topic can be addressed in future Council Meetings.	Dr. Saul Levin Ian Hedges	This action is ongoing.

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Agenda Item #	Action	CEO/MDO Response	Staff Responsible	Status
8.G.3	Ad Hoc Group to Assist with APA Response to the Excellence in Mental Health Act/Demonstration Project [Please see item 8.G, 10-11] Will the Joint Reference Committee support the request of the CHSF to establish a qualified ad-hoc work group to collaborate with appropriate APA staff to advocate APA's position with regard to the Excellence in MH Act? Financial Implications: This would require member and staff time including 1 to 3 conference calls. The costs could likely come from existing budgets. Background: The Council discussed this legislation which creates a pathway for CMHCs to become CCBHCs (Certified Community Behavioral Health Centers) in eight states. These CCBHCs would provide "intensive, person-centered, multidisciplinary, evidence-based screening, assessment, diagnostics, treatment, prevention, and wellness services" among other requirements. CCBHC services then become federally eligible for Medicaid matching reimbursement. There are $25 million dollars in planning grants available to states looking to apply to serve as a demonstration state. The deadline for HHS to issue regulations on the criteria for eligible 'CCBHCs,' including staffing requirements, is September 1st, 2015. Feedback from multiple members of the Council on Healthcare Systems and Financing was that APA should be actively engaged and involved, as much as is permissible, in the rule writing process. This is an important activity and one that APA must take the lead on. Members were concerned that should APA fail to become engaged in the process that the organization would have missed an important opportunity to shape something psychiatrists will have to be actively involved in. It is critical to make sure psychiatrists in these new CCBHCs have responsibility for the overall quality of clinical services. Members expressed concern that this will not happen if other non-physician led organizations do this without our involvement.	***Update:*** The group advised APA Administration on a response to SAMHSA on the need for specific medical psychiatric involvement in CCBHCs. Following APA's response, members of the Administration met with Paolo del Vecchio, Director of CMHS to discuss our recommendations. Further dialogue with SAMHSA and HHS officials is planned.	Kristin Kroeger Becky Yowell	This action is ongoing.

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Agenda Item #	Action	CEO/MDO Response	Staff Responsible	Status
8.H.4	Waive Copyright Restriction for DSM 5 Criteria Will the Joint Reference Committee recommend that the Board of Trustees approve waiving the DSM 5 copyright restrictions for allied, non-profit education organizations for use in non-commoditized teaching/educational resources specifically for medical student education? ADMSEP has created on-line Clinical Simulation Educational Modules for teaching medical students using DSM 5. These modules are provided free on the ADMSEP website, and are also published on MedEdPortal for use by clerkship directors and medical students for general educational purposes and, in some cases, to meet LCME standards ED-2 and ED-8. For example, a module can provide the opportunity for a student unable to see a key condition in a clinical setting to learn about the condition and, therefore, meet clerkship requirements. The modules reference DSM 5. However, the fee that APA requires for use of DSM criteria is not affordable for ADMSEP (a non-profit allied education organization). There is no monetary gain to anyone from these modules. There is no charge for their use and they were developed with the sole goal of improving psychiatric medical student education. There are no additional costs to the APA to waive copyright restriction for the DSM 5 criteria.	***Update:*** The APA administration has agreed that paraphrasing the criteria would be acceptable for education purposes. APA will continue to provide coordination with the Council on Medical Education and Lifelong Learning (CMELL) and will work with CMELL to distribute guidelines to all educators around what is acceptable to use when teaching on the DSM.	Dr. Saul Levin Shaun Snyder	The action is completed.
8.I.1	Search Process for the Directory of the APA Division of Diversity and Health Equity Will the Joint Reference Committee forward to the Board Executive Committee and the CEO/Medical Director the Council's urgent action item concerning the search process for the Director of the APA Division of Diversity and Health Equity, presented in item 8.I, attachment 1, p. 6?	***Update:*** The position received many applicants, including some that were recommended to apply by the Council on Minority Mental Health and Health Disparities. A team of staff, led by Dr. Primm, interviewed 13 applicants via Skype. Two rounds of interviews resulted in a clear selection of two candidates.	Dr. Saul Levin Shaun Snyder	This action is ongoing.

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Agenda Item #	Action	CEO/MDO Response	Staff Responsible	Status
8.I.2	APA Website Navigation Will Joint Reference Committee recommend to the Chief Operating Officer that the main page of the APA website contain Diversity as a navigation item as illustrated in item 8.I, attachment 2, p. 8?	***Update:*** We are currently doing focus groups, user testing, identifying highly ranked websites to model, and working with consultants. So far, we know that an effective and easy to use search function will be helpful to our website visitors who are looking for information on diversity, health equity, cultural competence and related topics.	Dr. Saul Levin Shaun Snyder	This action is ongoing.
8.J.2	Proposed APA Resource Document on Access to Firearms by People with Mental Disorders [Please see item 8.J, attachment #4] Will the Joint Reference Committee approve the Proposed Resource Document on Access to Firearms by People with Mental Disorders?	***Update:*** As requested, the Resource Document on Access to Firearms by People with Mental Disorders was placed on APA's website for viewing by the general public.	Jon Fanning Gary McMillan	This action is completed.

	Recommendations	Currently Being Addressed, Include How	Not Currently Being Addressed, Include How They Could Be	Specific 'Products' under Development if Applicable (which are called for by the recommendations)	Prioritize the Recommendations: High, Med, Low	Other Feedback
I	**I. Integrated Care (IC): A Healthcare Reform Imperative**					
	Recommendations					
I.1	APA must actively lead the development of integrated models on several levels: with government and private agencies, academia, and researchers; at the implementation level where federal and private groups are piloting new systems; and at the advocacy and communication level to inform psychiatrists, other mental health professionals, the public, the media, and legislators about the changes at hand. To sit on the sidelines as healthcare reform evolves is not a viable option. (Council on Healthcare Systems and Financing, Council on Advocacy and Government Relations, Council on Communications)	**Council on Healthcare Systems and Financing (CHSF):** Workgroup on integrated care has been actively tracking. **Council on Communications (COC):** 1.) Psychiatric News print issue includes a "Psychiatry & Integrated Care" section; 2.) Psychiatric News Update: Sent weekly on Wednesday includes a section called: Integrated Care: What It Means to You; 3.) Integrated Care Newsletter produced by Health Care Systems & Finance featured in "Headlines" and promoted via APA's Social Media channels; 4.) Health Care Reform & Integrated Care Playlist on APA's YouTube; 5.) Integrated Care Roundtable April 2014 Playlist on APA's YouTube. 6.) Promoting the IPS Integrated Care Track	**COC:** 1.) APA councils must share with the COC what they want to distribute in order for the council to rationalize & recommend "how to"; 2.) Share with members the federal, private group pilot programs, models & new systems available around the country; highlight the programs that work not the evidence; 3.) Include an easily accessible section on APA's website that would take users to an integrated care section of well-organized resources. 4.) Highlight SAMSHA's Health Reform site, as to not reinvent the wheel. 5.) Highlight the Economic Impact of Integrated Medical- Behavioral Healthcare: Implications for Psychiatry, prepared by Milliman, Report (Access to the page on psychiatry.org is difficult to find). **CHSF:** APA should be doing more in each of these areas; how do we optimize this; clarification of the definitions of what the terms mean and related roles; should have documents that highlight what is needed.	**COC:** 1.) Better search capability on APA's website; 2.) OCPA will collect APA Integrated Care resources and organize an inventory of what exists.	**COC:** High	**CHSF:** Numerous specific liaison and communications efforts ongoing with key stakeholders ranging from CMMI to AHRQ to PCPCC.
I.2	APA should support the value of integrated medical and psychiatric care for patients with psychiatric illness in all treatment settings: This support should be based on best evidence regarding optimal care for all patients and care that is patient-centered and consistent with goals of the Triple Aim. Particular attention should be paid to the distinct needs of patients of varying ages, in different care settings and, in particular, in the public sector: o There is clear evidence from a large body of well-designed studies that psychiatrists have vital roles to play in integrated care models in a variety of settings. o These roles include oversight of population-based psychiatric care in integrated medical psychiatric settings, including the public sector, and an important consultative role with other primary care based specialists and other mental health caregivers. (Council on Healthcare Systems and Financing)	**Office of Publishing**: Several new books are in production that will relate directly to integrated care: • Integrated Care: Working at the Interface of Primary Care and Behavioral Health, by Lori Raney, MD • Preventive Medical Care in Psychiatry: A Practical Guide for Clinicians, by Robert McCarron • Handbook of Medicine in Psychiatry, Second Edition, by Peter Manu, MD **CHSF:** The Council is currently monitoring.				**CHSF:** These themes are consistently utilized but need more a deliberated communications strategy (including materials)
I.3	APA needs to produce a clear, simple set of statements for psychiatrists and their patients regarding integrated care; define the role of psychiatrists as team leaders and/or team partners and/or consultants; state how psychiatry's role in integrated care will benefit patients; and clarify this role vis-à-vis other physicians, allied health practitioners, and other mental health clinicians. (Council on Healthcare Systems and Financing)	**CHSF:** Under development for each distinct setting for which delineation is appropriate				
I.4	APA should consider developing a formal vision statement to address these recommendations. (Council on Healthcare Systems and Financing and Council on Communications)	**CHSF:** There is a vision statement for the IC workgroup (CHSF) - perhaps that can be revised and send it forward; "patient centered care team" - have the CHSF review and respond	**COC:** We cannot effectively create messaging until leadership outlines a vision/mission statement. Integrated care is a huge debate and discussion.		**COC:** High **CHSF:** Medium-Already Working On	**CHSF:** CHSF thinks the APA needs a more formal position statement on integrated care and health reform.
I.5	APA should develop a specific internal program function to monitor and ensure that it has input on policies and standards that will impact the practice of psychiatry as part of integrated care models. In addition, monitoring policy efforts at the state level in coordination with state associations and providing targeted expertise when requested will be essential. A number of key public and private entities are shaping standards, policy, and reimbursement for development of alternative delivery systems, which include various integrated care models. These include, but are not limited to, CMS, the Agency for Healthcare Research and Quality (AHRQ), the Center for Integrated Health Solutions (CIHS), the Medicare Payment Advisory Commission (MEDPAC), the Medicaid and CHIP Payment and Access Commission (MACPAC), the National Association of Medicaid Directors (NAMD), the Institute of Medicine (IOM), commercial payers, managed behavioral healthcare organizations (MBHOs), the Patient Centered Primary Care Collaborative (PCPCC), accrediting bodies, and so on. Currently, the APA does not have a deliberate, coordinated effort to monitor and advocate for issues of import to psychiatry concerning integrated care model development. (Council on Healthcare Systems and Financing and Council on Advocacy and Government Relations)				**CHSF:** High	
I.6	APA should maintain particularly close working relationships with the AMA, major primary care medical associations, and specialty collaboratives. APA should take a lead role with CMS and other federal agencies in developing any quality metrics for integrated care and the patient registries needed to implement these. This should include a priority focus on monitoring projects funded by CMMI. (Council on Healthcare Systems and Financing and Council on Quality Care)	**Council on Quality Care (CQC):** 1.) Registry Workgroup; 2.) Relationship with the AMA-PCPI; 3.) Other formal relationships with other med. Societies (AAN, AACAP); 4.) Practice Guidelines including multi-stakeholders on development workgroups; 5.) Patient Safety Workgroup focusing on Transitions of Care that involve various care providers; 6.) CMHIT exploratory effort with HIT; 7.) Patient Centered Care Collaborative holds five Councils; there is an APA member on each of the five councils.	**CQC**: 1.) APA should identify and organize members involved in efforts that support measure development and endorsement; 2.) APA should systematically review all organizations that develop or standadrize measures and/or standards and ensure we have and mantain effective representation on each of them; 3.) Create a Performance Measurement component, which would require the development of a clear charge, mandate and resource requirement statement; 4.) Look at where psychiatrists are participating in measure development efforts using the AMA master file.		**CQC:** First sentence of recommendation is of High Priority **CHSF:** High	**CQC:** 1.) Could the BOT be more specific about identifying funding streams on the ACA and Medicaid performance measurement and patient centered care?; 2.) The intentions (and feasibility) of the second sentence aren't clear. What would "lead role" entail? Several members of Council doubt that the APA should take on the primary role in developing quality metrics.

	Recommendations	Currently Being Addressed, Include How	Not Currently Being Addressed, Include How They Could Be	Specific 'Products' under Development if Applicable (which are called for by the recommendations)	Prioritize the Recommendations: High, Med, Low	Other Feedback
I.7	APA should establish an ongoing inventory of current models of integrated care for all populations and promulgate that information to psychiatrists, other physicians, healthcare leaders, and policy makers. This should include data on best evidence for integrated care and its implementation. The APA should work closely with psychiatric and medical specialty organizations in this effort. The APA should pay particular attention to models that achieve the Triple Aim, are well-designed, incorporate evidence-based care for psychiatric and medical-psychiatric care, and feature psychiatrists in leadership roles. The APA should establish an interdepartmental capacity to inform members and state associations/district branches about: o New models of care; o Results of current research; o Implications for their practices, including barriers to adoption; and o Ways to participate or at least influence the future practice of psychiatry given these reform initiatives. Guidance on related aspects of healthcare system change, including practice organization, contracting payer issues, coding, and related matters should be included to the extent legally permissible. Psychiatrists will need assistance in forming new practice relationships if healthcare reform shows evidence of significantly affecting the flow of and payment for clinical care. Although the Work Group does not believe that self-pay private practices or even insurance-based solo or small group practices will disappear, it is likely that control over payments and practices may shift to larger health system entities. Other specific recommendations related to assessing the exact nature of current psychiatric practice, EHR adoption, and financing are addressed elsewhere in this report. (Council on Healthcare Systems and Financing)	**CHSF:** Integrated Care News Notes currently distributed on opt in basis		**CHSF:** Inventory compiled and protocol for updating established. Will be posted on website.	**CHSF**: High	**CHSF**: Need broad internal communications plan for members.
I.8	Given the unique nature of psychiatric practice, including its direct access and public sector roles, a robust communications strategy will need to be a goal of these efforts. The APA should develop specific communications strategies to promote the value of integrated care and psychiatric physician leadership with key stakeholder audiences. (Council on Communications)		**COC:** 1.) Share with members the federal and private group pilot programs & new systems available. 2.) The COC strongly recommends that APA engage DB and area councils by outlining a regional strategy for them to implement; 3.) APA councils must share with the COC what they want to distribute in order for the Council to rationalize and recommend "how to". 4.) Highlight SAMHSA's Health Reform site, so as to not to reinvent the wheel; 5.) Educate our younger member audience on how Health Reform affects them in the future		**COC:** HIgh	
II	**The Financing of Psychiatric Care: Structure, Payment, and Administration**					
	(Council on Healthcare Systems and Financing)					
	Recommendations					
	We strongly support payer and insurance mechanisms that integrate the payment, use of standard CPT codes, and systems of managing psychiatric care with the broader medical healthcare budgets.					
II.1	In any system that integrates care, the value of psychiatric care in improving total healthcare quality and reducing costs needs to be accounted for in such a way that the psychiatric care system, our patients, and psychiatrists can benefit from the improvement in cost of total care.	**CHSF:** Conversations with CMS	**CHSF:** We need a strategic plan - objectives, identify stakeholders; resources needed to do it (time, people, different functions), etc. [do we need a financial expert, analyst, etc]		**CHSF:** High-Very	**CHSF:** Do we need a white paper on what currently exists? Payment reform models in certain states; depending on the type of funding coming - what are the different ways that could make this model work; will require a lot of resources; we need to determine where the gaps are - most things have been one -offs; collect info and see what the next steps must be. Will need outside assistance ($$); this effort needs to involve the Council on Quality of Care as well.
II.2	Appropriate payment arrangements that recognize necessary psychiatric clinical and case management functions as well as other infrastructure costs for care in integrated care models are essential. This is an absolute prerequisite for the sustainability and participation of psychiatry.	**CHSF:** Conversations with CMS			**CHSF:** High	**CHSF:** Carol Alter has a lot of background on payment from her CMMI project which would be helpful; Need a specific group appointed to develop this.
II.3	The APA should support payment streams for psychiatric care that are not carved out of existing medical budgets or, if carve-out payers continue to operate, the credentialing, CPT codes, and payment for psychiatric physician services must be integrated with the overall medical budget. Accreditation and related standards should be developed.	**CHSF:** Conversations with CMS			**CHSF:** High	**CHSF:** Council will be considering performance metrics for this issue.
II.4	The APA should work with other medical societies to support ongoing improvements to evaluation and management (E/M) coding to bring reimbursements for these codes in line with procedural valuations.	**CHSF:** Done through RBVS.				
II.5	Contracts for ongoing carve-out services should be structured in such a fashion as to place performance expectations on the quality and cost of medical as well as psychiatric care.		**CHSF:** Will address through the position paper process			
II.6	Integrated care budgets – particularly for public sector patients – must have formal budget and quality mechanisms to protect existing mental health budget resources.	**CHSF:** Conversations with CMS				**CHSF:** How detailed does APA want to be in defining standards?
II.7	The APA will need the capacity to track changes to payment systems, the results of demonstration projects, delivery and payment reform, and formal research and the impact on sustainability and various payment sectors. This will include alternative payment methodology developments and their implications for psychiatric care and reimbursement.	**CHSF:** Conversations with CMS				
II.8	The APA should develop a core program function that specifically monitors and reports on Medicare and Medicaid policy and related program developments regarding state Medicaid plans and program efforts directed at the dual-eligible population in support of federal advocacy and APA's state associations.	**CHSF:** Need for resources to do this			**CHSF:** High	**CHSF:** Becomes II.3
II.9	The APA needs a more active and strategic presence in the many nongovernmental groups that will define policy and accreditation standards. This will also require more intensive work with the employer community and a focused public relations strategy.				**CHSF:** High	**CHSF:** External communications plan needs to be developed. (quality issues as well)

	Recommendations	Currently Being Addressed, Include How	Not Currently Being Addressed, Include How They Could Be	Specific 'Products' under Development if Applicable (which are called for by the recommendations)	Prioritize the Recommendations: High, Med, Low	Other Feedback
II.10	The APA should continue strategic efforts to utilize MHPAEA to secure equity for psychiatrists and their patients.	**CHSF:** OHSF, DGR, and General Counsel actively engaged at all levels			**CHSF:** High	
III	**Quality and Performance Measurement**					
	(Council on Quality Care)					
	Recommendations					
	The recommendations that follow are rooted in the foregoing findings and their implications for the future credibility of organization and payment for psychiatric care.					
III.1	Clarify and articulate the APA's vision for mental health quality measures. Psychiatric measures must not be separated from the rest of medical care.	**Council on Quality Care (CQC):** 1.) By owning copyright, acting as steward, and developing measure statements within APA practice guidelines the APA can maintain itself as a guiding force for the development of performance measures that will effect clinician payment. 2.) The CQC reviewed and addressed the AHRQ draft technical brief: Use of Quality Measures and Improved Outcomes in the Seriously Mentally Ill that identifies the many pitfalls found in measuring quality of care in the SMI population.			**CQC:** Priority is high, but could be done by a Council workgroup as a policy statement	**CQC:** 1.)Psychiatric clinicians have the ability to participate in cross-cutting measures that apply to their practice. 2.) APA should be alert to measure efforts that only target the SMI population, because data on integrated care show that most of the healthcare system savings that integrated care is responsible for comes from the mild-to-moderate population. Advocating for this population should be an APA priority.
III.2	Undertake a systematic review and analysis of quality and performance measures that are used to accredit and/or certify alternative care delivery models and/or for healthcare reimbursement purposes.	**CQC**: The APA website, psych.org, currently hosts a webpage that consists of a large Excel spreadsheet that is an environmental scan of measures appropriate for psychiatric clinicians to complete for the purposes of internal quality improvement or accountability payment programs (e.g. CMS led PQRS).		**CQC:** The CQC will review what is currently posted on psych.org and see if the spreadsheet requires more	**CQC:** Priority is high.	
III.3	Broaden the range of quality measures to include outcome measures and measures of integrated care for individuals with multiple comorbidities.		**CQC:** 1.) PCORI, AHRQ, RWJ, or NIMH could have interest ideas for a future research agenda. 2.) It is a good idea to identify and suggest studies that ought to be done.		**CQC:** Medium	**CQC:** We might encourage APA members working on measure development in other organizations to give particular attention to this measure; or a WG might sketch out the broad outline of what such measures might look like. However, although having preliminary measures of this sort might be useful for developing pilot program evaluations, the absence of good outcome data for such measures virtually assures that proposals to NQF to institutionalize such measures would not pass.
III.4	Engage where appropriate in research activity on quality in psychiatric practice.	**CQC**: 1.) Workgroup on registries is focused on determining a way to develop an APA sponsored registry that's focus is on improving care quality. 2.) APA's PRN (Practice Research Network)is the primary mechanism for assessing the state of real-world psychiatric practice by conducting relevant health services research in the service of multiple APA components. 3.) The development of practice guidelines.			**CQC:** High	
III.5	The APA should consider a leadership role in the development of EHR and registry quality capacity.	**CQC:** 1.) Recently APA developed and executed a webinar for vendors as an effort to take on a leadership role in working with vendors to identify what works for psychiatry. 2.) Subsequent to an Assembly Action Paper by Dr. Daviss, the APA has been an organizational member of HL7, the international standards development organization for health IT that establishes EHR , HIE, and registry standards.			**CQC**: High	
III.6	Disseminate psychiatric outcome measures that are meaningful and actionable.	**CQC**: 1.) Shared support with other specialties for the registry 2.) Once we can identify meaningful, accepted measures (CMS, NQF), we should certainly let members know what they are, how to access and use them. Articles, webpostings, etc.				
III.7	Continue/expand educational outreach on performance measurement targeting APA membership.	**CQC:** 1.) APA administration accepts invitations to Council meetings to present the current state of measure development and management at the APA 2.) Update psych.org to reflect the public reporting program information. 3.) Field phone calls to members when questions come up around performance measurement and quality reporting.	**CQC:** Develop and present a talk about the different aspects of quality reporting and performance measurement (discuss different types of performance measurement: quality improvement, accountability, MOC, MOL).			

	Recommendations	Currently Being Addressed, Include How	Not Currently Being Addressed, Include How They Could Be	Specific 'Products' under Development if Applicable (which are called for by the recommendations)	Prioritize the Recommendations: High, Med, Low	Other Feedback
III.8	Continue/expand participation in national initiatives at all levels (federal, private insurance, local, etc.).					**CQC:** 1.) A gap analysis in this area would allow the group/organization what is going on in this space. 2.) A spreadsheet or HTML list that is kept up to date on a monthly basis and made available to members on the appropriate webpage would be extremely useful. This spreadsheet or list would list all known national initiatives, a link to the relevant webpage of the initiative, a basic description of why the initiative is relevant to APA members or to our patients, the name(s) of APA members or staff who serve on the initiative, and the email address for that APA member or staff. This would be linked to on an APA webpage, as well as the date that it was last updated so that members can ascertain how stale the information might be. 3.) A more advanced form of this document would also include an annotated list of links to the current relevant work product(s) from the initiative, as well as a listing of annotated links to current or future public comment periods as these become known and updated by APA staff. An ability to subscribe, via RSS feed or other mechanism, to any updates to this page or file, should be made available to all interested members.
III.9	Continue/expand APA efforts in monitoring and participation in health plan certification/accreditation.	**CQC: 1.)** The APA Workgroup on Standards and Survey Procedures has active involvement with certification and accreditation organizations via formal representation on The Joint Commission's Professional and Technical Advisory Councils (PTAC's) for both Hospital accreditation and Behavioral Health Care accreditation. This representation includes leadership positions on the PTAC for Behavioral Health Care and in turn involvement with The Joint Commission's Board of Commissioner's quarterly meetings in the past and present involvement with Joint Commission's Standards and Survey Procedures (SSP) Committee nationally. The APA also has representation with URAC, which includes involvement at leadership levels. Recently, URAC to added a Health Plan standard that required accredited health plans to demonstrate that they analyzed their operations to ensure that they were compliant with MHPAEA, and to maintain compliance with parity. This allows any member or patient to file a complaint with URAC if they believe an accredited plan is not compliant. NCQA has not added any parity standards to its relevant products, so the APA should encourage them to do so using their NCQA representative. **2.)** The APA's Workgroup on Patient Safety has focused on participating in standards development associated with patient safety, as exemplified by present work on transition of care, which is a Joint Commission National Patient Safety Goal in development.			**CQC:** Medium	
III.10	The APA will need to lead on quality metrics for psychiatric care and their consistent adoption across payers and other regulatory entities. This could be approached by identifying a few priority areas for improvement and/or by identifying a series of goals covering various areas of practice.	**CQC**: The CQC identified the document and the exercise of completing it as identifying priority areas.				**CQC:** Will have to wait for a QIPS Director to set overall strategy for scope as to exactly what APA might expect to take on. Again, unclear what taking the "lead" actually means.
IV	**IV. Electronic Health Records (EHR) and Related Technology**					
	(Council on Quality Care)					
	Recommendations					
	The Work Group believes that the failure to integrate psychiatric and medical records into EHRs subject to the limitations and safeguards noted below will permanently impair improvements in our patients' health and wellbeing. Recognizing the sensitivity of these issues, communication and education of the membership, patients, policy makers, and the general public is essential. Opt out provisions, limitations on sharing of psychotherapy notes as opposed to general psychiatric records, and ongoing recommendations regarding law and policy will be essential for the APA and its state associations. It is also essential that policymakers understand that more ambulatory psychiatric services are provided by non-psychiatric physicians than by psychiatrists or other mental health providers and that their electronic records already contain both mental health and other sensitive medical information.					

	Recommendations	Currently Being Addressed, Include How	Not Currently Being Addressed, Include How They Could Be	Specific 'Products' under Development if Applicable (which are called for by the recommendations)	Prioritize the Recommendations: High, Med, Low	Other Feedback
IV.1	The APA should develop resources that help members select, implement, maintain, and use EHRs and other forms of HIT. Possibilities could include written resources and online instruction videos, software reviews, accounts of members' experiences with HIT, telephonic consulting and technical support services, and in-person support services.	**CQC:** 1.) Recently developed Workgroup on Software Apps. 2.) EHR vendor webinar held in June, with planned future efforts to engage EHR vendors. 3.) The APA has partnered with AmericanEHR to provide EHR reviews by members. There is a link on APA EHR webpage to this member benefit. 4.) The APA EHR webpage has a number of useful links and resources, but the APA website search function does a poor job of finding these resources. 5.) It would be beneficial to hire a full-time HIT specialist with practical healthcare experience to manage the APA's efforts in health IT, ideally an informatics psychiatrist. This function was previously performed part-time by a physician who was the QIPS director. These positions should be split, as there is too much activity in each area to be handled effectively by one person. The work in this area is fast-moving and critical to our future, but attracting such a hire would be costly.			**CQC:** High	**CQC:** 1.) Additional help with using EHR between user and vendor; 2.) A live EHR help desk function would be a very useful member benefit for the APA to provide its members. Such a benefit may attract new members, and will address the growing needs of our current members. The challenge would be staffing and training EHR Help Desk staff, and the related costs. Contracting this service out to a REC may also be an option. Every state has a REC (Regional Extension Service) as required by the HITECH act, but these are funded to only provide assistance to primary care providers. Because RECs are seeking other funding opportunities, and because they are most knowledgeable about services in their area, it would be constructive for the APA to consider developing a contractual relationship with one REC within each of the seven Areas. The cost/benefits of doing this in-house versus outsourced could then be weighed.
IV.2	Standardized templates for electronic medical records and personal health records should include the data elements needed to manage and coordinate general medical care and mental health and substance abuse care. These systems must be carefully designed to ensure that critical information on health status and services can be extracted for measuring service patterns and performance.	**CQC**: 1.) The group discussed sharing templates and rating (via crowd source). The APA must be careful to delineate between endorsement and rating (legal issues); 2.) HL7 has a Structured Documents Workgroup that develops such health IT standards so that there is interoperability among health IT products. This would be a very good project for when the new health IT czar for APA is selected and hired. This project is much more complicated than it might seem (for example, there are 60 different ways that platelet count units are recorded across the world).			**CQC:** Medium	**CQC:** Much of what this statement is suggesting depends on the specific EHR product.
IV.3	The APA should continue/expand activities pertaining to HIT privacy. Activities include feedback to the federal government through submission of public comments and responses to requests for information, development of educational content on how to maintain HIT privacy and discuss privacy issues with patients, and talking to HIT vendors about privacy functionality.		**CQC:** 1.) Commenting when appropriate to URAC and the ONC (Office of the National Coordinator for Health Information Technology). 2.) The APA should have member representatives on the ONC's FACA committees, particularly the Health IT Standards Committee (HITSC) and the Health IT Policy Committee (HITPC). The APA has previously unsuccessfully submitted nominations for these very competitive and time-consuming committees. Getting a representative on each of the committees, or, at minimum, on relevant subcommittees, should be a high priority for the APA. It should be noted that the specialty of psychiatry is at the very bottom of the list of specialties who have adopted certified EHRs. If we do not assert leadership in the health IT area, other mental health organizations will.		**CQC:** High	
IV.4	The appropriateness and feasibility of APA developing patient registries for psychiatric patients should be explored. This should include due consideration of various structures and uses and recommendations as to options for the APA. The Council on Research and Quality Care will address this at its May 2013 meeting.	**CQC:** The APA Registry Workgroup is currently addressing this and their recommendations will be submitted to the CQC by the end of 2014.			**CQC:** High	
IV.5	The APA should explore developing an RFR to vendors with specific technical capacities that would be needed for endorsement and should consider evaluation of its role in the development of EHR products. This activity could be a valuable resource to members, but APA must be aware of the risks involved in dealing with an immature industry.					**CQC:** 1.) The group agreed it was best to stay away from the endorsement of vendors due to the potential for COI. 2.) It was discussed that the APA own and operate an EHR. The group agreed that this is not the way to go and that working with multiple vendors, rather than just one is the best option.
IV.6	The APA should continue/expand quality and performance measurement activities as under the quality performance measurement topic: Performance measurement is a key function of HIT and includes a variety of components related to payment, quality, and research through patient registries.	**CQC**: HL7, the organization that developed EHR standards is working with a CQC member to determine appropriate standards for psychiatric EMRs			**CQC:** High	
IV.7	The APA should assess the adoption of and impact of HIT on quality in psychiatric practice and identify strategies to maximize findings that indicate the positive impact.		**CQC**: The development of a mechanism to hear from solo practitioners to implement		**CQC:** High	

	Recommendations	Currently Being Addressed, Include How	Not Currently Being Addressed, Include How They Could Be	Specific 'Products' under Development if Applicable (which are called for by the recommendations)	Prioritize the Recommendations: High, Med, Low	Other Feedback
IV.8	The APA should develop policy and training on EHRs and privacy/confidentiality. The importance of electronic health records going forward is self-evident. There are, however, numerous privacy/confidentiality issues for psychiatric records. The Work Group believes that psychiatric records should be integrated into medical records provided there is patient consent and this is consistent with statutory requirements. (It must be noted that Medicare/Medicaid patients do not have the option to opt out of EHRs.) Confidentiality is essential to proper psychiatric patient care and psychiatrists will need to differentiate between psychiatric notes that can be included in the medical record and psychotherapy notes that cannot. APA members will need authoritative guidance on content/inclusion in the medical record and the role of state versus federal regulation.		**CQC:** 1.) There needs to be some guidance and training on what should and shouldnt go into the EHR or into the psychotherapy note section. 2.) There could be some cross-over assistance from the APA Office of Education for CMEs earned as member benefit.		**CQC:** High	**CQC:** CMHIT believes that psychiatric records should be integrated into medical records provided there is patient consent and this is consistent with statutory requirements. (It must be noted that Medicare/Medicaid patients do not have the option to opt out of EHRs.) Confidentiality is essential to proper psychiatric patient care and psychiatrists will need to differentiate between psychiatric notes that can be included in the medical record and psychotherapy notes that cannot. APA members will need authoritative guidance on content/inclusion in the medical record and the role of state versus federal regulation. 2.) A recent Action Paper on EHR privacy was addressed by several Components and a Position Statement developed. A key aspect is that "psychotherapy notes," which have special protection within HIPAA due to APA's efforts nearly ten years ago, have not been universally implemented within EHRs. Additionally, there is no standard or guidance yet developed to help mental health professionals know how to appropriately use the protection afforded by psychotherapy notes
IV.9	The APA should make policy development for confidentiality of MH/SUD records and HIT a priority matter. Development of training and technical assistance materials for members will be essential.				**CQC:** High	**CQC:** Please see IV.9 Feedback
IV.10	The APA should engage with Health Information Exchange (HIE) efforts. Currently, HIEs are forming at the local level, and each locale is handling psychiatric health information differently. In order to realize the potential of HIE to facilitate integrated care, APA could participate in oversight bodies at the national level and develop educational material for APA members.	**CQC:** 1.) Subsequent to an Assembly Action Paper, a Position Statement on the handling of sensitive health information within HIEs was recently developed by the CMHIT. The position is that HIEs should implement the Data Segmentation for Privacy (DS4P) standard that was approved as an international health IT normative standard by the HL7 standards group in May. This is a standard that was developed by SAMHSA in consultation with members of the CMHIT. 2.) An additional HL7 standard is being developed, called Consent to Share (C2S), which establishes a set of consent management technical standards that allow patients enhanced privacy and control over who can and cannot see their restricted sensitive information. APA is involved with this development process. 3.) The major challenge will be for the APA to exercise its influence in a manner that encourages or incentivizes the numerous HIEs across the country to implement the DS4P and C2S standards. Support from the AMA and other organizations will be needed to make this happen.	**CQC:** 1.) Should APA comment on what should be considered? 2.) The action paper from the CMHIT on Sensitive Information could guide local psychiatric societies on how to approach the health information exchange. 2.) Sharing position papers to district branches could be a start.			**CQC:** This is a moving target as the system is rapidly maturing.
IV.11	The APA should continue/expand efforts to develop resources that help members select, implement, maintain, and use Electric Health Records and other forms of HIT. Possibilities include an RFR process as noted above, written resources and online instructional video, software reviews, accounts of member experiences with HIT, telephonic consulting and technical support services, and in-person support services.					**CQC:** The material requested here can be included in the points in the IV.10
IV.12	The APA should continue/expand its efforts to advocate for expansion of HIT to all aspects of the mental healthcare system. Non-physician mental health clinicians and many specialty mental health settings are currently excluded from current national initiatives. Specific advocacy efforts are needed to correct federal policy.	**CQC:** The Murphy Bill has expanded the HIT incentive program to non-mental health professionals, but the potential for this bill succeeding appears to be low.				**CQC:** CMHIT is working on developing a collaboration with the similar colleagues at the American Psychological Association and other mental health provider organizations in an effort to coordinate some of our HIT projects to maximize our combined effort and not work at cross purposes.
IV.13	The APA should assess the feasibility of maintaining patient registries. Given CMS's interest, APA should do pilot work to assess these more fully. This assessment has begun through APA's Council on Research and Quality.	**CQC:** Part of the agenda and discussion of the APA Registry Workgroup.				
V	**V. Workforce, Work Environment, Medical Education and Training**					
	(Council on Medication Education and Lifelong Training)					
	Recommendations					

	Recommendations	Currently Being Addressed, Include How	Not Currently Being Addressed, Include How They Could Be	Specific 'Products' under Development if Applicable (which are called for by the recommendations)	Prioritize the Recommendations: High, Med, Low	Other Feedback
V.1	Future workforce: The APA should work with the American Association of Directors of Psychiatric Residency Training (AADPRT), the Academy of Psychosomatic Medicine (APM), and the American Academy of Child and Adolescent Psychiatry (AACAP) to facilitate the development and implementation of a curriculum for residents that includes the core competence/skill sets for integrated care practice, including the maintenance of core medical skills.	**Council On Medical Education and Lifelong Learning (CMELL):** CMELL is collaborating with the Council on Psychosomatic Medicine to discuss educational resources already developed. 1) Gitlin curriculum for general psychiatry residents 2) UME and GME recommendations from CMELL's white paper 3) Team-based learning as AAMC requirement for accreditation and 4) Lori Raney's WG report on maintenance of core medical skills. **Council on Addiction Psychiatry:** The council is working with the National Institute on Drug Abuse to develop open-source curriculum for general psychiatry training programs. In the coming months, a workgroup comprised of representatives of CAP, the Council on Medical Education and Lifelong Learning, and AADPRT will outreach to training programs to assess their needs, consider a variety of novel training approaches, and develop a funding proposal to NIDA. This project is intended to improve the quality of teaching, thereby preparing psychiatrists to function fully in new paradigms of care.		**CMELL:** CMELL's white paper, entitled "Training Psychiatrists for Integrated Behavioral Health Care" will include the following: (1) review literature to define the new skills and responsibilities for psychiatrists, (2) scans of undergraduate, graduate and continuing medical education environment to examine the extent & methods used to educate trainees, (3) discuss challenges and solutions for promoting training and (4) make recommendations to the APA and to educational programs. The paper will be ready for the JRC by the end of the year.		
V.2	The APA should work with the Accreditation Council for Graduate Medical Education (ACGME) to develop accreditation standards to establish specific milestones for psychiatric residents to achieve proficiency in core competencies for integrated care practice and settings, or highlight existing milestones that are relevant for these efforts.					
V.3	Current workforce: Within the healthcare reform movement, many opportunities exist for psychiatrists who have the necessary skills and experience to participate in the new models of integrated care. However, many lack the core competencies respecting a number of necessary skills.					
V.4	The APA should develop practice management modules (CME) for its members to enhance their skills in the following areas: reviews of common medical problems in general medical care and public sector populations, leading teams of mental health professionals, setting up and/or participating in integrated care settings, teaching PCPs about identifying and screening for mental health illnesses and substance use disorders, and health information technology.	**CMELL:** HealthCare Financing Seminar on Healthcare Reform and Integrated Care - Department of CME provided CME credit for a Fall 2013 seminar developed by the APA Department of Healthcare Financing that brought representatives of DBs up-to-date on this topic. DBs presented the seminar curriculum to their members at local meetings. 2) FOCUS. Psychosomatic Medicine and Integrated Care. Fall 2013, Vol. 11, No. 4 The Fall 2013 issue of FOCUS covered the topic of Psychosomatic Medicine and Integrated Care from a clinical view point for the general psychiatrist. 3) Primary Care Updates for Psychiatrists – Presented at IPS and developed as an Online Course November 2013 (free, up to 4 credits) 4) Integrated Care Track at Annual Meeting and IPS 5) Sessions at these meeting on IC topics		**CMELL**: More CME offerings which will include dedicated tracks at APA meetings (both Annual Meeting and IPS) and course development for the online Learning Management System.		
V.5	Non-psychiatrist physicians and allied practitioners: the APA should explore potential collaboration with primary care personnel (both MD and non-MD) regarding needed education and alliances regarding care delivery development (especially for shortage areas).	**CMELL**: APA convened a meeting with Education directors of various primary care associations to find ways to collaborate. Joint presentations are planned at various primary care association meetings. CMELL will collaborate with the Council on Psychosomatic Medicine and the HSF Department in planning the presentations. **Council on Addiction Psychiatry:** As a partner organization in the SAMHSA-funded Providers' Clinical Support System for Medication Assisted Treatment, APA plans and presents a webinar series that augments the 8-hour training required to treat opioid use disorders in an office-based setting. Webinars are presented once or twice per month for the benefit of psychiatrists, primary care physicians, and other interested clinicians. This program recognizes there is insufficient training on substance abuse treatment in psychiatry and primary care residencies and, consequently, many physicians feel underprepared and reluctant to treat opioid addicted patients. In light of the national epidemic of addiction to prescription drugs and heroin, this program aims to provide training and support that will benefit and encourage physicians to treat these patients.		**CMELL:** Dr. Cowley will lead a symposium at the 2015 Annual Meeting with This symposium entitled "Educating Psychiatrists for Work in Integrated Care: Focus on Interdisciplinary Collaboration" which will focus on inter-specialty collaboration in education and what psychiatry trainees and practicing psychiatrists need to learn/know in order to collaborate effectively with other specialties in the broad context of integrated care. Aside from psychiatrists, the panel will include an internist, a family physician, a pediatrician, and a psychologist.		
VI	**VI. Research and the Mental Health Evidence Base**					
	(Council on Research and relevant councils for feedback/other possible questions)					
	Recommendations					
	Clearly there are important research questions across the topical areas discussed in this report. The Work Group has identified many of what it considers important research questions. The Work Group believes this should be regarded as a starting point for further deliberation to identify priority areas and the development of a plan to advance an agenda regarding needed research. It is evident that a variety of entities will perform these needed research projects.					**CHSF:** The following are questions for what we discussed above; creates the research agenda to pull information. There should be a mechanism for Councils to seek help with services research. Included in that would be something similar to a Cochran review; or advocating for a review by AHRQ on specific issues.

	Recommendations	Currently Being Addressed, Include How	Not Currently Being Addressed, Include How They Could Be	Specific 'Products' under Development if Applicable (which are called for by the recommendations)	Prioritize the Recommendations: High, Med, Low	Other Feedback
	Research Issues Covering Topical Areas Involved in Health Reform					
VI.A	A. Integrated Care					**CQC:** 1.) VI.A 10 and 11 should also go to Council on Research 2.) These are important research questions, best answered by systematic funded research conducted via PCORI, AHRQ, NIH grants, Robert Woods Johnson or other institutional grants, but not by APA per se. We should nominate these topics for research to be conducted through those organizations
	1. Develop standards for classifying models of integrated care and measuring outcomes of such models.				**CQC**: Low	**CHSF:** CHSF would monitor and get information out and assist in identifying what information is needed.
	2. What is the effectiveness of integrated care in general medical and related psychiatric practice settings?				**CQC:** Low	
	3. What is the effectiveness of integrated care for those with severe mental illness? What models will work best in this population and help with medical disorders found in them?				**CQC:** Low	
	4. What models of integrated care can be used in rural areas with underserved populations?				**CQC:** Low	
	5. What models work best with various age groups (e.g., children and the elderly population)?				**CQC:** Low	
	6. What accounts for the effectiveness of integrated care – clinician integration, introduction of evidence-based practice, care management, system integration, etc.?				**CQC:** Low	
	7. What organizational models of care are best for certain populations and settings? (Note this goes beyond "integrated" care – perhaps there are other ways that work best for certain groups and settings.)				**CQC:** Low	
	8. What models could ensure sustainability?				**CQC:** Low	
	9. What other factors (e.g., clinician/staff beliefs) may impact effectiveness of integrated care models?				**CQC:** Low	
	10. Support increased research into the mechanisms of increased morbidity and mortality with co-occurring medical and psychiatric disorders.				**CQC:** High	
	11. Support/conduct epidemiologic studies of co-morbidity (medical, mental illness/substance use) including prevalence and impact of care				**CQC:** High for Support; Low for Conduct	
VI.B	B. Financing of Psychiatric Care					**CHSF:** Relates back to financing of Section II
	1. What is the cost-effectiveness of integrated care models in various populations and settings?					
	2. What are the best models for financing integrated care models?					
	3. What reimbursement models lead to the best outcomes for people with mental illness?					
	4. What models of financing will ensure appropriate care under healthcare reform for those within the current public mental health system?					
	5. What is the contribution of mental illness/substance abuse to overall healthcare costs and the effect of appropriate behavioral healthcare interventions on those costs? How do these differ by population (e.g., those with dual eligibility, co-morbid conditions)? How do different mental health clinicians affect these costs?					
	6. What models of payment by Medicaid/Medicare are best for those with mental illness?					
	7. What interventions should be covered? Identify those interventions with the highest cost-effectiveness and include not only clinical treatments but others like case management, peer navigators, etc.					
	8. How do various coding schemas affect delivery of care, costs of care, and outcomes?					
	9. What mental health and substance abuse interventions should be part of a basic package of insurance coverage (this becomes especially relevant with health exchanges and expansion of Medicaid)?					
	10. What are the barriers to the adoption of best practices?					
VI.C	C. Quality and Performance Measurement					
	1. Increase research to build an evidence base for treatment of various illnesses. There is a need to identify gaps in knowledge that should be a priority for clinical research. Which outcome measures most predict improvement, reduced morbidity and mortality from all causes?					
	2. What personalized treatment options are available now or could be developed in the near future?					
	3. Increase the number of quality and performance indicators with a clear link to improved outcomes in those with mental illnesses and substance use disorders.					
	4. Develop pay for performance models in MH/SUD, including integrated models.				**CQC:** Medium	**CQC:** 1.) This is better answered by Healthcare Systems and Finance. 2.) These models need to ensure they do not leave out patients with mild-to-moderated conditions, which are those most often seen in primary care and where identification and treatment can most reduce costly complications of comorbid medical conditions.
	5. Increase development of patient-centered outcome measures.	**CQC:** 1.) Patient involvement 2.) Become a steward for developing outcome measures to be proposed to the National Quality Forum.			**CQC:** Medium	

	Recommendations	Currently Being Addressed, Include How	Not Currently Being Addressed, Include How They Could Be	Specific 'Products' under Development if Applicable (which are called for by the recommendations)	Prioritize the Recommendations: High, Med, Low	Other Feedback
	6. What are the best risk adjustment models? (also relevant to financing)				**CQC:** Medium	**CQC:** 1.) This is better answered by Healthcare Systems and Finance. 2.) The APA should take a leadership role in participating with the many organizations that are doing this risk adjustment, such as 3M's Healthcare Division. Without thoughtful clinician involvement, these models will be constructed without adequate insight.
	7. What implementation/dissemination models are effective in improving practice?	**CQC:** Research and implementation science (develop an institute project)	**CQC:** 1.) Invite speakers to the annual meeting 2.) This is the basis of the Learning Healthcare System. The APA might consider getting involved in this work.		**CQC:** Medium	**CQC:** The Office of Education, Practice Guidelines, Council on Communication, etc., should be up on the best implementation-dissemination models to influence practice – to best get information to members -- and to get into member's heads -- about all sorts of things.
	8. What models of person-centered care lead to better outcomes for patients?				**CQC:** Medium	**CQC:** This could be something that interests PCORI, AHRQ and possibly NIH project
VI.D	D. Health Information Technology (HIT)					
	1. Develop EHR applications to improve quality of care in various treatment settings. What applications actually improve care and outcomes?				**CQC:** Low	**CQC**: In general, APA should be encouraging E.H.R. developers to attend to these issues, but we should not develop.
	2. Develop EHR applications that can monitor individual practice and patient outcomes.				**CQC:** Low	**CQC:** In general, APA should be encouraging E.H.R. developers to attend to these issues, but we should not develop.
	3. What EHR data related to those with mental health/substance use disorders are critical for improved treatment outcomes?	**CQC:** CMHIT has addressed this to some degree in its list of EHR Functional Requirements on the EHR webpage. The answers to these questions will come out of the work being done in the Registries workgroup, as well as the Integrated Care workgroups. If there is not significant HIT representation on the Integrated Care and Health Care Reform workgroups, this deficiency should be addressed.			**CQC:** Low	**CQC:** In general, APA should be encouraging E.H.R. developers to attend to these issues, but we should not develop.
	4. Develop large data network(s) to be used for research on various conditions and to monitor changes in population health.	**CQC:**This is being discussed in the Registry workgroup. The BOT will need to plan for the cost involved, probably in the $1M range to begin, with much less costs. Inclusion of patients seen in primary care and integrated settings would make this a much more valuable resource. These data networks and resulting analytics could eventually be a revenue center for the APA, but careful planning is required for privacy and security needs.			**CQC:** Medium	
	5. Expand practice-based research network for practice research. Incorporation of EHR and other data systems will expand opportunities within this network.	**CQC:** Data extraction and quality indicators are useful to participate in, but don't have the answers right now. the anticipation is this would be answered through Registries and through Health Information Exchanges. Having a full-time clinical informaticist would accelerate this work.			**CQC:** High	
	6. Expand support for novel and entrepreneurial capacity to assess wellbeing, symptoms, and response to treatment.		**CQC:** 1.) Advocate for the increased support for small business in this area. 2.) Consider how the APA can support its members who are currently involved in, or who want to begin, novel and entrepreneurial small businesses to address these activities. There is already a very small group of members involved in these areas, but there is no APA recognition or support for them to organize or even be identified by other members seeking their assistance.		**CQC:** Low	**CQC:** In general, APA should be encouraging others to attend to these issues, but we should not develop.
	7. Ethical considerations in HIT.	**CQC:** Yes			**CQC:** High	
VI.E	E. Workforce, Training, and Education					
	1. What is the projected demand for services given the increase in coverage under the ACA?					
	2. What is the projected available number of psychiatrists and other mental health care professionals?					
	3. What is the projected available number of primary care physicians, non-physician primary medical caregivers, and specialists who will be providing mental health and substance use disorder services?					
	4. What range of disorders will primary care physicians, non-physician primary care medical caregivers, and specialists treat? What are existing and expected skill sets and training they will need?					
	5. What skill sets are needed now for psychiatrists to practice in future models of health care?					
	6. What are unique skill sets for psychiatrists vs. other mental health clinicians vs. other physicians?					
	7. What recruitment and retention models work best to ensure an adequate number of psychiatrists?					
	8. What education models are most effective in training psychiatrists, primary care physicians currently practicing and those in training?					
VI.F	F. DSM-V					
	1. How does adherence to DSM-V criteria improve practice and outcomes for patients?					

	Recommendations	Currently Being Addressed, Include How	Not Currently Being Addressed, Include How They Could Be	Specific 'Products' under Development if Applicable (which are called for by the recommendations)	Prioritize the Recommendations: High, Med, Low	Other Feedback
	2. What changes need to be made in DSM criteria? (This would come from longitudinal studies once DSM-V is implemented.)					
	3. What new coding/payment/performance methods are most effective using DSM-V?					
VII	**VII. Healthcare Reform: Organizational Implications for the APA**					
	Recommendations					
VII.1	The APA should establish a set of health reform priority activities (developmental and implementing) consistent with the major findings and recommendations of this report and a strategy/plan of action to implement them.					
VII.2	The APA should establish an ongoing working group within the current governance structure to oversee this plan of action and regularly report on developments and actions. This should include a plan to ensure a rapid response capability.					
VII.3	The Medical Director/CEO, under the oversight of the board, should assess how current staff can best be configured to ensure that the functions of this work group are appropriately executed. This should include recommendations concerning additional staff and/or consultant expertise that may need to be retained (with the budget implications). There are various recommendations in other sections of this report that concern internal staffing. These should receive due consideration as part of this effort.					
VII.4	The APA should develop a communications campaign that addresses how to best advance the APA agenda, internally with its members and externally with key stakeholder audiences. This campaign will likely require external communications expertise. Psychiatry's value proposition for health reform is not self-evident to key policy/payer audiences and members. Moreover, a fully informed and educated membership will be essential to fulfill the demands for psychiatric services that the APA's agenda embodies.					
VII.5	A centralized strategy for assistance to the APA's state affiliates will have to be developed.					
VII.6	Governance implications of these efforts, including the rapid response capability, will need to be carefully and directly assessed.					

Item 4
JRC
October 11, 2014

Update on the Recommendations of the BOT Ad Hoc Work Group on the Role of Psychiatry in Health Reform
(May JRC, Item 8.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 (see attached).

Item #4
JRC
October 2014

RFM position on Councils

13 Councils
Standard Composition

12 members – one of whom is an ECP; one of whom is an Assembly member
Chairperson chosen from among the 12 members
Corresponding members
Consultants - limited

Option: #1

- Maintain 12 member council
- Use an existing member position on a council
- Cost neutral to a council
- One-quarter of the positions on a council are designated for a particular group

Option: #2

- Increase size of a council by one member
- One-third of the positions on a council are designated for a particular group
- Increase the cost of each council by approximately $927.33
    - 13 councils x 1 person

N.B.: RFM's who are in the APA fellowship programs are assigned to each council. One RFM from amongst those assigned to a council is chosen to act as a voting member of a council.

APA/Diversity Leadership Fellow
APA/SAMHSA Fellow
APA Public Psychiatry Fellow
APA/Leadership Fellow

From the 2015 Budget Call: component costs per member

Amount in the individual cost center

APA pays for Travel to the Fall Component Meetings only	
Airfare = priced per member	**$425**
Hotel = priced per member, per night	**$305**
PD = priced per member, per night	**$47.33**
Transportation = priced per member, per night	**$50**

Lunch at Annual meeting covers the cost of lunch per member at the Annual Meeting; Fall Component Meeting lunch costs are contained within Group Luncheon costs
Meeting room = priced at $75 per meeting, per day (assumes pay for meeting room at the Annual Meeting for 1 day) ONE FACE TO FACE MEETING PER YEAR
Conference calls = 4 calls per year @ **$90**/call
Postage = 2 mailings per year to both members and corr members @ **$10**/package
Listserv costs = IT maintenance costs for listserv

Cost per person = $927.33
Cost of adding one member across all councils = $12,055.29

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.

CORNELL
UNIVERSITY

Joan and Sanford I. Weill
Medical College

George S. Alexopoulos, M.D.
Director
NIMH Advanced Center for Interventions
and Services Research in Late-Life
Depression
Weill-Cornell Institute of Geriatric Psychiatry
21 Bloomingdale Road
White Plains, NY 10605
Phone: (914) 997 5767, Fax: (914) 682-6979

July 7, 2014

Sejal Patel
American Psychiatric Association
1000, Wilson Blvd. #1825
Arlington, VA 22209

Re: Nomination of Robert G. Robinson, M.D., for the Jack Weinberg Memorial Award

Dear colleagues of the Selection Committee:

It is a great honor and a personal pleasure for me to nominate Robert G. Robinson, M.D., for the Jack Weinberg Memorial Award for Excellence in Geriatric Psychiatry. I have followed Dr. Robinson's career for longer than 30 years and base this nomination on his groundbreaking research, his contributions to education and career development, and the exceptional clinical and organizational leadership he has provided to our field.

Since he began training as a post-doctoral fellow in the laboratory of Dr. Floyd Bloom at the National Institute of Mental Health, he has conducted both basic animal research and clinical research on cerebrovascular disease, a model entity for Geriatric Psychiatry research. His studies focused on cerebral infarction and the psychiatric consequences of stroke including the etiology, the clinical manifestations, the course and the treatment of stroke-related psychiatric disorders. He has also studied other disorders occurring in patients with ischemic brain injury including anosognosia, denial of illness, catastrophic reactions, irritability, and aggression. Among his studies was the first randomized control trial to demonstrate the treatment of post-stroke depression, the first demonstration of a brain asymmetry in neurotransmitter response to ischemic brain injury in rats, and the first empirical description of post-stroke depression associated with injury to specific brain regions, i.e., the left frontal lobe and left basal ganglia. Using positron emission tomography, he was the first to demonstrate asymmetries in S_2 serotonin response to injury in humans, and the first to document that depression influences adversely neurological recovery from stroke. In addition, he was the first to demonstrate that patients who develop depression after stroke have four times higher mortality than stroke patients who do not develop depression. Following a randomized controlled trial, Dr. Robinson reported that the antidepressant escitalopram can prevent development of depression after stroke.

His leadership in geriatric research has led to a world-wide interest in post-stroke depression and hundreds of publications throughout the world identifying the importance, manifestations and consequences of this disorder. His basic science and clinical papers have been published in the most prestigious journals in academic medicine including Nature, Science, the Archives of General Psychiatry, American Journal of Psychiatry, Biological Psychiatry, Molecular Psychiatry, Brain, Annals of Neurology, Neurology, Lancet and the Journal of the American Medical Association.

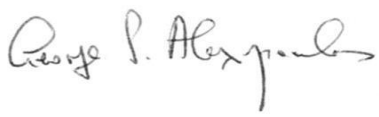
These major accomplishments in research have led to wide-spread recognition. He has received the Research Award from the American Psychiatric Association in 1999, which is the most prestigious research award in psychiatry. Other awards include, the American Association for Geriatric Psychiatry Distinguished Scientist Award in 2008, the Academy of Psychosomatic Medicine Research Award in 1999, the Johns Hopkins Society of Scholars Award in 2007, the American College of Psychiatrists Award for Research and Geriatric Psychiatry in 2009, and the Heathcoat Beecham Williams Professor of the Royal Australian and New Zealand College of Psychiatrists in 2010.

Teaching and career development is another area for which Dr. Robinson deserves special recognition. From the time he began as the Chair of the Department of Psychiatry in Iowa, he spent a minimum of two hours per week with the residents and one and a half hours per week with the medical students conducting case conferences, interviewing patients and discussing in a round table format, aspects of the examination, differential diagnosis, etiology, and treatment of geriatric and other psychiatric disorders. Over the past 32 years, Dr. Robinson has trained in his laboratory, 51 post-doctoral fellows who have become some of the most distinguished scientists in the world, including Dr. Helen Mayberg, Professor of Psychiatry at Emory University and recently inducted into the Institute of Medicine; Dr. Jeffrey Max, Professor of Child Psychiatry at the University of San Diego; Dr. Timothy Moran, Professor of Motivated Behaviors at Johns Hopkins University; Dr. Sergio Starkstein, Professor of Psychiatry at the University of Western Australia; Dr. Godfrey Pearlson, Professor of Psychiatry, Institute of Living at Yale University; Dr. Phillip Morris, Professor of Psychiatry, Melbourne University; Dr. Ricardo Jorge, Professor of Psychiatry at the University of Iowa; and Dr. Russell L. Margolis, Professor of Psychiatry at Johns Hopkins University.

Dr. Robinson has been the Chair of the Department of Psychiatry at the University of Iowa for 21 years. During his extended period of leadership, well beyond what most department chairs serve, Dr. Robinson raised the status of his Department enormously. His research on psychiatric syndromes related to cerebrovascular disease, although a geriatric theme, served as a nidus that led to the development of a research program with major influence in other aspects of psychiatry. As a consequence, the grant income of his Department increased from 2 million dollars annually to 25 million dollars annually during his administration; the Department now ranks 7th in NIH grant support among all Psychiatry departments of public universities.

In my opinion, Dr. Robinson is an exceptional leader in Geriatric Psychiatry who has had far greater influence in the broader field of Psychiatry. As a recipient of the 2008 Jack Weinberg Memorial Award, I would be greatly honored by the selection of Dr. Robert G. Robinson.

Sincerely,



George S. Alexopoulos, M.D.
SP Tobin and AM Cooper Professor
Department of Psychiatry

COLLEGE OF MEDICINE CURRICULUM VITAE

Robert G. Robinson, M.D
June 2014

I. EDUCATIONAL AND PROFESSIONAL HISTORY

A. Institutions Attended

09/63-06/67 B.S., Engineering Physics, Cornell University, Ithaca, NY.
09/67-06/71 M.D., Cornell University Medical College, New York, NY.
06/68-09/68 Cornell University Medical College, Dept. of Anatomy, Laboratory of Michael D. Gershon, M.D.
03/71-06/71 Cornell University Medical College, Dept. of Anatomy, Laboratory of Michael D. Gershon, M.D.
03/71-06/72 Medical Intern, Montefiore Hospital & Albert Einstein Medical Center, Bronx, NY.
07/72-06/73 Resident, Assistant Psychiatrist, Cornell University Medical Center, Westchester Division, White Plains, NY.
07/73-09/75 Research Associate, National Institute of Mental Health, Laboratory of Neuropharmacology Floyd E. Bloom, M.D., Director, St. Elizabeth's Hospital, Washington, DC.
07/75-06/77 Housestaff Fellow, Dept. of Psychiatry and Behavioral Sciences, Johns Hopkins University School of Medicine, Baltimore, MD.
Assistant Resident, Dept. of Psychiatry and Behavioral Sciences, Johns Hopkins Hospital, Baltimore, MD.
03/76-09/76 Maudsley Exchange Resident, Johns Hopkins Hospital, Baltimore, Maryland.
Registrar to Professor Michael Rutter, Children's Dept., Maudsley Hospital, Denmark Hill, London, England.
01/77-06/77 Chief Resident, Dept. of Psychiatry and Behavioral Sciences, Johns Hopkins University School of Medicine, Baltimore, MD.

Certification
National Board of Medical Examiners, 1972
American Board of Neurology and Psychiatry in Psychiatry, 11/78, Diplomate #18472
Am Board of Neurology and Psychiatry in Geriatric Psychiatry, 11/96, #2198, recertified 11/06
American Board of Neurology and Psychiatry in Psychosomatic Medicine, 2005, #328

Licensure
Iowa, 1/18/91, Perm, 27913, 5/1/11

B. Professional and Academic Positions

07/73-09/75 Surgeon, United States Public Health Service
07/77-12/80 Assistant Professor, Dept. of Psychiatry and Behavioral Sciences, Johns Hopkins University School of Medicine, Baltimore, MD
07/77-06/90 Active Staff, Dept. of Psychiatry and Behavioral Sciences, Johns Hopkins Hospital, Baltimore, MD
01/81-06/85 Associate Professor, Dept. of Psychiatry and Behavioral Sciences, Johns Hopkins University School of Medicine, Baltimore, MD
07/82-06/90 Active Staff, Dept. of Medicine, Rehabilitation Unit, Good Samaritan Hospital, Baltimore, MD
07/83-06/85 Associate Professor, Dept. of Neuroscience, Johns Hopkins University School of Medicine, Baltimore, MD
07/83-06/90 Clinical Assistant Professor, Dept. of Psychiatry, University of Maryland School of Medicine, Baltimore, MD
07/85-06/90 Professor, Dept. of Psychiatry and Behavioral Sciences, Johns Hopkins University School of Medicine, Baltimore, MD

07/85-06/90	Professor, Dept. of Neuroscience, Johns Hopkins University School of Medicine, Baltimore, MD
07/90-07/11	Professor and Head, Dept. of Psychiatry, University of Iowa College of Medicine, Iowa City, IA.
07/96—07/11	Paul W. Penningroth Professor and Head, Dept. of Psychiatry, University of Iowa College of Medicine, Iowa City
07/07-07/11	Paul W. Penningroth Chair, Professor and Head, Dept. of Psychiatry, University of Iowa College of Medicine, Iowa City, IA, 7/1/07-7/15/11.
7/11-present	Professor, Dept. of Psychiatry, University of Iowa Carver College of Medicine, Iowa City, IA.

C. Honors, Awards, Recognitions, Outstanding Achievements

1966-67	Dean's List Engineering School, Cornell University
1967	Mullen Engineering Scholarship Award, Cornell University
1969	Sandra Lee Shaw Award for Research in Neurology and Pharmacology, Cornell University Medical College
1977	Mellon Fellowship, Johns Hopkins University School of Medicine
1979-89	Research Scientist Development Award (type II) MHOOI63
1989-94	Research Scientist Award MHOOl63
1985	Fellow, American Psychiatric Association, Distinguished Fellow 2002
1995	Nelson Urban Research Award, Mental Health Association of Iowa
1996	Paul W. Penningroth Professor, Chair 2007
1997	American College of Neuropsychopharmacology Fellow Johns Hopkins Society of Scholars
1999	American Psychiatric Association-Award for Research Academy of Psychosomatic Medicine-Research Award
2005	Raine Visiting Professor, University of Western Australia, May
2008	American Association for Geriatric Psychiatry—Distinguished Scientist Award
2009	American College of Psychiatrists, Award for Research in Geriatric Psychiatry
2010	Heathcote Beetham Williams Traveling Professorship of Royal Australian and New Zealand College of Psychiatrists, September/October

II. TEACHING

A. Teaching Assignments

- Lecture to medical students in Introduction of Clinical Medicine
- Conduct medical student teaching rounds 1 hr/week
- Conduct resident physician teaching rounds 1 ½ hr/week

B. Students Supervised

- Ted Anfinson, M.D., Associate Prof, Psychiatry & Medicine, Emory U, Atlanta, GA
- Iren Belcheva, M.D., Ph.D., Research Scientist, Bulgaria Laboratory of Experimental Psychopharmacology, Institute of Physiology, Bulgarian Academy of Sciences, Acad. G. Bonchev Street, Building 23, 1113, Sofia, Bulgaria. irenata@iph.bio.acad.bg
- Ronald S. Black, M.D., Professor of Neurology, Cornell Weill Medical College I taught him research for 2 summers at Johns Hopkins while he was a med student & published 1 paper Wyeth Research Collegeville, PA 19426 blackr@wyeth.com
- Hirokazu Bokura, M.D., Professor, Neurology, Shimane Medical U. Japan Dept. of Neurology, Faculty of Medicine, Shimane University; and Shimane University Hospital Izumo, Japan. bokura@shimane-med.ac.jp
- Karen Bolla, Ph.D.*, Professor, Neurology, Bayview Med Ctr, Baltimore, MD Dept. of Neurology, Johns Hopkins University, Baltimore, MD
- Joseph B. Bryer, M.D., Private Practice, Delaware 2300 Pennsylvania Avenue SUITE 3B Wilmington, DE 19806

- Antonio Campayo, M.D. Assistant Professor, University of Zaragoza Hospital, Dept. of Psychiatry, Zaragoza, Spain acampayo.iacs@aragon.es
- Carlos Castillo, M.D., Group Practice, Cedar Center, Cedar Rapids, IA 1730 1st Avenue Northeast Cedar Rapids, IA 52402
- Keen Loong Chan, M.D. Associate Professor, Dept. of Psychological Medicine, Tan Tock Seng Hospital, Singapore
- Eran Chemerinski, MD, Assistant Professor, Dept. of Psychiatry, Mount Sinai School of Medicine, New York, NY and Bronx Veterans Affairs Medical Center, Bronx, NY (7/1/01) eran.chemerinski@mssm.edu
- Max de Carvalho, M.D. Dept. of Neurology, Hospital de Santa Maria, EMG Laboratory of Centro de Estudos Egas Moniz, 1600 Lisbon, Portugal. mamede@mail.telepac.pt
- Jack E. Downhill, M.D. Clinical Instructor, Mt Sinai School of Medicine, New York, NY Dept. of Psychiatry, Neuroscience PET Lab, Box 1505, Mount Sinai School of Medicine, One Gustave L. Levy Place, New York, NY 10029-6574
- J. Paul Fedoroff, M.D., Professor, Psychiatry, Clark Institute, Toronto, Canada Dept. of Psychology, University of Toronto, Ontario, CanadaE-Mail: paulbev@mac.com
- Alfred Forrester, M.D., Private Practice, Baltimore, MD 9515 Deereco Rd Ste 1001 Lutherville Timonium, MD 21093
- Andrew Frances, Ph.D., M.D., Assoc Professor, Psychiatry, SUNY, Stony Brook, NY
- Rafael Gomez-Hernandez, M.D., University Hospital, Zaragoza, Spain Servicio de Psiquiatria, Hospital Universitario Miguel Servet, Zaragoza. cpelegrinv@medynet.com 2001
- Rose Jampel (Cahit), M.D., Private Practice
- Ricardo Jorge, M.D., Associate Professor, Psychiatry, University of Iowa, Iowa City, IA
- Alan Justice, Ph.D., VA Pittsburgh, PA Center for Health Equity Research and Promotion, VA Pittsburgh Healthcare System, University Drive C 11E-124 (130-U), Pittsburgh, PA 15240
- Sang Hoon Kim, MD, Associate Professor, Chosun U, Korea Dept. of Psychiatry, Gyeongsang National University, College of Medicine and Gyeongsang National University Hospital, Chinju, Korea
- Mahito Kimura, M.D., Ph.D. Assoc Prof, Dept. Neuropsychiatry, Nippon School of Med, Japan
- Yasuhiro Kishi, M.D., Ph.D. Associate Professor, Nippon School of Medicine, Japan
- Kenneth L. Kubos, Ph.D., former Assistant Professor, Johns Hopkins, Baltimore, MD
- John R. Lipsey, M.D., Associate Professor, Psychiatry, Johns Hopkins, Baltimore, MD
- Facundo Manes, M.D., Director, Institute of Neuropsychiatry, Fleni, Buenos Aires, Argentina
- Russell L. Margolis, M.D., Professor of Psychiatry, Johns Hopkins School of Medicine I taught him research as a medical student at Johns Hopkins School of Med for 2 summers and published 2 papers based on this work Dept. of Psychiatry, Division of Neurobiology Laboratory of Genetic Neurobiology; Johns Hopkins University School of Medicine CMSC 8-121 600 N. Wolfe St Baltimore, MD 21287
- Jeffrey Max, M.D., Professor, Child Psychiatry, UC-San Diego
- Helen S. Mayberg, M.D., Professor, Psychiatry and Neurology, Emory University
- Timothy H. Moran, Ph.D., Paul R. McHugh Professor of Motivated Behaviors, Johns Hopkins University School of Medicine, Baltimore, MD
- Philip L. Morris, M.D., Ph.D.*, Professor, Gold Coast Medical Centre, Gold Coast, Australia
- Yuichi Murata, M.D., Ph.D. Assistant Professor, Tokyo School of Medicine, Tokyo, Japan
- Kenji Narushima, M.D., Assistant Professor, University of Tokyo, Ichikawa City, Chiba, Japan
- Tatsunobu Ohkubo, M.D., Akita University School of Medicine, Akita, Japan
- Nonna Otmakhova, M.D., Asst Prof., Dept. of Biology, Brandeis University, Waltham MA Dept. of Biology and Volen Center for Complex Systems, Brandeis University, Waltham, Massachusetts 02254
- Sergio Paradiso, M.D., Ph.D.*, Associate Professor, University of Iowa, Iowa City, IA

- Rajesh M. Parikh, M.D., Associate Professor, Dept. of Pharmaceutics and Pharmaceutical Technology L. M. College of Pharmacy, Navrangpura, Ahmedabad-380009, India
- Godfrey D. Pearlson, M.D. Professor, Psychiatry, Inst of Living, Yale University
- Kengo Shimoda, M.D., Ph.D. Asst. Professor, Nippon School of Medicine, Nippon, Japan
- Sergio E. Starkstein, M.D., Ph.D.*, Professor, Neuropsychiatry, Univ Western Australia, Perth, Australia
- Amane Tateno, M.D., Assistant Professor, Tokyo Medical School, Tokyo, Japan
- Kenji Takezawa, M.D., Assistant Professor, Tokyo University, Tokyo, Japan
- Javier Travella, M.D., Private practice, Buenos Aires, Argentina
- Katsu Mikami, Assistant Professor, Dept. of Psychiatry, Tokai U School of Medicine, Kanawaga, Japan.

*Supervision of Ph.D. thesis

C. Other Contributions to Institutional Programs
Organize research conference and grand rounds (weekly)

III. SCHOLARSHIP

A. Publications and Creative Works
Peer-Reviewed Papers

1. **Robinson RG**, Gershon MD: Histochemical study of 5-hydroxytryptamine in the myenteric plexus. Anat Res 163:251, 1969.
2. **Robinson RG**, Gershon MD: Synthesis and uptake of 5-hydroxytryptamine by the myenteric plexus of the guinea-pig ileum: A histochemical study. J Pharmacol Exp Ther 178:311-324, 1971. PMID: 4398295.
3. **Robinson RG**, McHugh PR, Bloom FE: Chlorpromazine induced hyperphagia in the rat. Psychopharm Comm 1:37-50, 1975. PMID: 1223991.
4. **Robinson RG**, McHugh PR, Folstein MF: Measurement of appetite disturbances in psychiatric disorders. J Psychiatr Res 12:59-68, 1975. PMID: 1056477.
5. **Robinson RG**, Shoemaker WJ, Schlumpf M, Valk T, Bloom FE: Effect of experimental cerebral infarction in rat brain: Effect on catecholamines and behavior. Nature 255:332-34, 1975. PMID: 1128692.
6. Gershon MD, **Robinson RG**, Ross LL: Serotonin accumulation in the guinea pig myenteric plexus: Ion dependence, structure activity relationship and the effect of drugs. J Pharmacol Exp Ther 198:548-561, 1976. PMID: 978458.
7. **Robinson RG**, Bloom FE, Battenberg ELF: A fluorescent histochemical study of changes in noradrenergic neurons following experimental cerebral infarction in the rat. Brain Res 132:259-272, 1977. PMID: 890481.
8. **Robinson RG**, Bloom FE: Pharmacological treatment following experimental cerebral infarction: Implications for understanding psychological symptoms of human stroke. Biol Psychiatry 12:669-680, 1977. PMID: 588647.
9. **Robinson RG**, Bloom FE: Changes in posterior hypothalamic self-stimulation following experimental cerebral infarction in the rat. J Comp Physiol Psychol 92:969-976, 1978. PMID: 730862.
10. **Robinson RG**, Coyle JT: Lateralization of catecholaminergic and behavioral response to cerebral infarction in the rat. Life Sci 24:943-950, 1979.
11. **Robinson RG**, Folstein MF, McHugh, P: Reduced caloric intake following small bowel bypass surgery: A systematic study of possible causes. Psychol Med 9:37-53, 1979. PMID: 424487.
12. **Robinson RG**: Differential behavioral and biochemical effects of right and left hemispheric cerebral infarction in the rat. Science 205:707-710, 1979.
13. **Robinson RG**, Coyle JT: The differential effect of right versus left hemispheric cerebral infarction on catecholamines and behavior in the rat. Brain Res, 188:63-78, 1980. PMID: 7189431.

14. **Robinson RG**, Folstein MF, Simonson M, McHugh PR: Differential antianxiety response to caloric intake between normal and obese subjects. Psychosom Med 42:415-427, 1980. PMID: 7443938.
15. **Robinson RG**, Shoemaker WJ, Schlumpf M: Time course of changes in catecholamines following right hemispheric cerebral infarction in the rat. Brain Res 181:202-208, 1980. PMID: 7350956.
16. Pearlson GD, **Robinson RG**: Suction lesions of the frontal cerebral cortex in the rat induce asymmetrical behavioral and catecholaminergic responses. Brain Res 218:233-242, 1981. PMID: 7196790.
17. **Robinson RG**, Benson DF: Depression in aphasic patients: Frequency, severity and clinical-pathological correlations. Brain Lang 14:282-291, 1981. PMID: 7306784.
18. **Robinson RG**, Stitt TG: Intracortical 6-hydroxydopamine induces an asymmetrical behavioral response in the rat. Brain Res 213:387-395, 1981. PMID: 7195764.
19. **Robinson RG**, Szetela B: Mood change following left hemispheric brain injury. Ann Neurol 9:447-453, 1981. PMID: 7271239.
20. **Robinson RG**: A model for the study of stroke using the rat. Surgical ligation of the middle cerebral artery in the rat. Am J Pathol 104:103-5, 1981.PMCID: 1903734.
21. Kubos KL, Pearlson GD, **Robinson RG**: Intracortical kainic acid induces an asymmetrical behavioral response in the rat. Brain Res 239:303-309, 1982. PMID: 7093686.
22. Peroutka SJ, Sohmer BH, Kumar AJ, Folstein MF, **Robinson RG**: Hallucinations and delusions following a right temporoparietooccipital infarction. Hopkins Med J 151:181-5, 1982. PMID: 7120722.
23. **Robinson RG**, Price TR: Post-stroke depressive disorders: A follow-up study of 103 outpatients. Stroke 13:635-641, 1982. PMID: 7123596.
24. Deckel AW, **Robinson RG**, Coyle JT, Sanberg PR: Reversal of long-term locomotor abnormalities in the kainic acid model of Huntington's disease by day 18 fetal striatal implants. Eur J Pharmacol 93:287-288, 1983. PMID: 6227491.
25. Kubos KL Kummel J, Moran TH, Sanberg PR, Bolduc PL **Robinson RG**: A positioning fixture for L-shaped rotating undercutting microknives. Physiol Behav 31:725, 1983. PMID: 6364190.
26. Lipsey JR **Robinson RG**, Pearlson GD, Rao K, Price, TR: Mood change following bilateral hemisphere brain injury. Br J Psychiatry 143:266-273, 1983. PMID: 6626839.
27. McHugh PR, **Robinson RG**: The two way trade - psychiatry and neuroscience. Br J Psychiatry 143:303-305, 1983. PMID: 6138113.
28. **Robinson RG**, Kubos KL, Starr LB, Rao K, Price, TR: Mood changes in stroke patients: Relationship to lesion location. Compr Psychiatry 24:555-566, 1983. PMID: 6653097.
29. **Robinson RG**, Starr LB, Kubos KL Price TR: A two year longitudinal study of poststroke mood disorders: Findings during the initial evaluation. Stroke 14:736-744, 1983. PMID: 6658957.
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202. **Robinson RG**. Vascular depression and poststroke depression: where do we go from here? 6th Annual Meeting of Intl Coll Ger Psychoneuropharmacology (ICGP) Hiroshima, Japan October 3-6, 2006.
203. Beglinger LJ, Adams WH, Paulsen JS, Paulsen, H, Kieburtz K, **Robinson RG**, Langbehn DR, Duff K, Fiedorowicz JG, Jorge R, Ramza N, Hanson J, Ellingrod V, Clarke W, Shoulson I (Sept., 2007). Citalopram and atomoxetine to enhance cognition in early Huntington's disease: Two pilot clinical trials. Oral presentation at the 3rd World Congress on Huntington's disease, Dresden, Germany.
204. **Robinson RG**, Jorge RE, Moser DJ, Acion L, Solodkin A, Small SL, Fonzetti P, Hegel M, Arndt, S. Escitalopram for prevention of poststroke depression. Hot Topic presented at 46th Annual meeting of ACNP, Boca Rotan, FL, December 2007.
205. **Robinson RG**. Risk factors in depression following brain injury. XIV International Symposium: Risk Factors in Psychiatry, Barcelona, Spain, April 2007.
206. **Robinson RG**. Update on the neuropsychiatry of stroke. APA annual meeting, San Diego, May 2007.
207. **Robinson RG**, Jorge RE, Moser DJ. Repetitive transcranial magnetic stimulation and vascular depression. APA meeting 2008.
208. **Robinson RG**, Lyketsos C, Jorge RE. Apathy in patients with late-life neuropsychiatric disorders: identification and treatment. Am J Geriatr Psychiatry 16(3):(Suppl 1) A26, 2008.
209. **Robinson RG**. Distinguished scientist Award Lecture: Development of the Neuropsychiatry of Stroke, 2008 AAGP meeting, Am J Geriatr Psychiatry 16(3):(Suppl 1) A17, 2008.
210. DeVries AC, Neigh GN, **Robinson RG**. Cerebrovascular disease and depression: a double whammy. Am J Geriatr Psychiatry 17:3(Suppl 1):A20, 2009.
211. Jorge RE, **Robinson RG**. Escitalopram enhances cognitive recovery following stroke. Am J Geriatr Psychiatry 17:3(Suppl 1):A90, 2009.
212. **Robinson R**. Prevention of post-stroke depression: escitalopram and problem solving therapy vs placebo in a randomized double-blind trial. World Psychiatry 8(Suppl 1):59, 2009.
213. **Robinson RG**. Advances in neuropsychiatric disorders associated with cerebrovascular disease. Presented at 2009 APA annual meeting, San Francisco CA.
214. **Robinson RG**. Management of depression in poststroke patients. Presented at 2009 CPNP meeting, Jacksonville, FL.
215. **Robinson RG**. Prevention of depression following stroke and 6 month follow-up. Int Psychogeriatr 21(Suppl 2):53-54, 2009.
216. **Robinson RG**. Psychiatry of stroke. RANZCP NA Conference, Rotorua Oct. 14-16, 2009, p 23
217. **Robinson RG**. The neuropsychiatry of stroke: 30 years of progress. Geriatric Research Award Lecture at the Am Col Psychiatrists annual meeting, Feb 28, 2009.
218. Starkstein S, Jorge R, **Robinson R**, Mechanism of depression and apathy after focal brain lesions. World Psychiatry 8(Suppl 1):58, 2009.
219. Paradiso S, Ostedgaard K, Vaidya JG, **Robinson RG**. Neural mechanisms of depression following left basal ganglia stroke. ACNP meeting 2010, p.218.

220. Rosen J, **Robinson RG**, Rovner BW, Lotrich F, Reynolds C. Preventing depression in at-risk elders. Am J Geriatr Psychiatry 18(3 suppl 1):84, 2010
221. **Robinson R**, Mikami K, Jang M, Jorge R. Prevention of anxiety disorder following stroke. ANPA meeting, 2011, p. 18.
222. **Robinson R**, Jorge R, Rovner B. Prevention of psychiatric disorder among the elderly with comorbid physical illness. AAGP meeting, 2012, S43.
223. **Robinson R**. Apathy and depression following cerebrovascular disease. Advances in Neuropsychiatry. The Neuropsychiatry of Emotion and Its Disorders Meeting, May 2012, p. 1.
224. **Robinson R.** Neuropsychiatric disorders in elderly patients with cerebrovascular disease. Advances in Geriatric Psychiatry. APA Program, p. 116, May 3-7, 2014.

B. Areas of Research Interest and Current Projects
Mood disorders associated with brain injury; Animal models of affective disorders; The mechanism and mood manifestations of brain asymmetry.
1. Mechanism of mood regulation in humans.
2. Mood disorders following traumatic brain injury.
3. Use of transcranial magnetic stimulation in the treatment of depression in the elderly.

C. Published Reviews of Scholarship

D. Grants Received
Current:
Vascular Function, Cognition, and Brain MRI in Atherosclerotic Vascular Disease
NIH – NIA, 5R01AG030417
$322,830
9/1/2008 – 7/31/2013
PI: Dave Moser
Role: Co-Investigator

Treatment Strategy to Prevent Mood Disorders following TBI
NINDS R01 NS055827
$1,120,101
4/01/2008-3/31/2013
PI: Ricardo Jorge, coinvestigator
10% effort, CAP

Completed:
Mood and Anxiety Disorders due to TBI among OIF/OEF Veterans
VA Merit Research Award 06050R
4/01/2008-4/01/2011
PI: Ricardo Jorge, coinvestigator
8% effort, CAP

Prevention of post-stroke depression-treatment strategy
NIMH R01 MH65134
$4,275,278
7/1/2002-6/30/2009
PI: Robert G. Robinson
12.7% effort, CAP

Vascular depression and magnetic stimulation therapy
NIMH R01 MH63405

$2,068,849
9/18/2001-8/31/2007
PI: Robert G. Robinson
10% effort, CAP

Emotional Regulation of Patients with Brain Injury
NIMH1 R01 MH52879
$922,581
8/1/1996-4/30/2002
PI: Robert G. Robinson
10% effort, CAP salary support

Mood Disorder Following Traumatic Brain Injury
NIMH 1 R01 MH53592
$968,424
4/1/1996-3/31/2002
PI: Robert G. Robinson
10% effort, 2% salary support

Mechanisms of post stroke depression
NIMH 1 R01 MH53316
$1,591,595
10/1/1994–9/30/1999
PI: Robert G. Robinson
10% effort

Model of depression induced by focal brain lesions
NIMH 1 R01 MH52796
$557,697
4/1/1996-3/31/2002
PI: Robert G. Robinson
5% effort

Neuroreceptor and metabolic changes in persons with mood disorders
NINDS 5 P01 NS015080-130008
1992
PI: Robert G. Robinson
10% effort

Mood disorders following stroke
NIMH 5R01 MH040355
$468,165
9/30/1991-8/31/1994
PI: Robert G. Robinson
10% effort

NARSAD Established Investigator
$93,953
7/1/1990–7/1/1996
PI: Robert G. Robinson
10% effort

Chemical & behavioral asymmetry after cerebral ischemia

NINDS 1R01 NS015178
$353,205
9/30/1980–8/31/1983
PI: Robert G. Robinson
20%

Changes in emotions and catecholamines after stroke
NIMH 5 K05 MH000163 Research Scientist Award
7/1/1989–6/30/1990
PI: Robert G. Robinson

Changes in emotions and catecholamines after stroke
NIMH 5 K02 MH000163 Research Career Development Award
7/1/1984–6/30/1989
PI: Robert G. Robinson

Changes in emotions and catecholamines after stroke
NIMH 5 K01 MH000163
7/1/1979–6/30/1984
PI: Robert G. Robinson

E. Invited Lectures
1. Speaking tour across China (5 cities) from May 8-24, 2014 regarding his stroke research.

F. Pending Decisions
Grants:
None

IV. SERVICE

A. Offices Held in Professional Organizations
Society for Neuroscience
American Psychiatric Association, Fellow 1985, Distinguished Fellow 2003, Distinguished Life Fellow 2009
American Association for the Advancement of Science
Sigma Xi, Scientific Research Society
Fellow, Stroke Council of American Heart Association
Association for Research in Nervous and Mental Diseases
Society of Biological Psychiatry
American Association for Geriatric Psychiatry
American Association of Chairmen of Depts. of Psychiatry
Johnson County Medical Society
American Medical Association
Iowa State Medical Society
Psychiatric Research Society
American College of Neuropsychopharmacology, Fellow 1997; Chair Finance Committee 1996; Chair Constitution & Rules Committee 2002, Chair Credentials Committee 2007
American Neuropsychiatric Association President elect 1996-98; president 1998-99, fellow 2000
Iowa Psychiatric Society
International Psychogeriatric Association
The Dana Alliance for Brain Initiatives
American Academy of Psychosomatic Medicine, Fellow 2001

Editorships

1985-97	International Journal of Psychiatry in Medicine Editorial Board
1986-99	Psychiatry Interpersonal and Biological Processes Editorial Board
1992-	Journal of Nervous and Mental Disease – Editorial Board
1994-	Journal of Neuropsychiatry and Clinical Neurosciences-Associate Editor
1995-04	Neurocase – Editorial Board
1995-05	International Psychogeriatrics - Associate Editor
1996-	Depression and Anxiety, Guest Editor of special issue: Depression in the context of physical disorders vol 7(4), 1998, Editorial board
1997	Guest editor of special issue: Case studies in neuropsychology, neuropsychiatry and behavioral neurology 3(2):93-156
2004-	European Journal of Psychiatry – N American Editor
2005-09	American Journal of Geriatric Psychiatry – Guest Editor, Post-stroke and vascular depression; Editorial Board (2006-present)
2005-09	Kaplan and Sadock's Comprehensive Textbook of Psychiatry – Contributing Editor (8^{th} & 9^{th} eds)
2011	Canadian Journal of Psychiatry, Guest Editor

Dept., Collegiate, or University Committees:

- Medical Council
- Faculty Practice Plan
- Hospital Advisory Committee
- College of Medical Lecture Committee, Chairman
- University Hospital Working Group for Referring Physician Relations
- University Hospital Ad Rehabilitation Planning Committee
- University Hospital Ad Hoc Work Group on a Primary Care Mission Statement
- University Hospital Ad Hoc Working Group on Emergency Medical Services
- Preferred Health Care Committee, College of Medicine
- Advisory Board, MEDCO, 1995-present
- Behavioral Neurosciences Review Committee, NIMH, Chairman, 1991-93
- Chairman, Dept. of Preventive Medicine Search Committee, 1995-96
- College of Medicine, Vice Chair, Faculty Practice Plan Management Committee, 2005-present
- College of Medicine, Joint Policy Committee, 2005-present

B. Clinical Assignments Since Last Promotion
Staff psychiatrist in University of Iowa Health Care
Private patient practice

University of Pittsburgh

Western Psychiatric Institute and Clinic
Advanced Center for Interventions and Services Research
for Late-Life Depression Prevention and Treatment

3811 O'Hara Street
Pittsburgh, PA 15213-2582
412-246-6440
Fax: 412-246-5991
slomkaka@upmc.edu

Charles F. Reynolds III, MD
UPMC Endowed Professor in Geriatric Psychiatry
Director

Mary Amanda Dew, PhD
Codirector

Steven M. Albert, PhD
Codirector

Kathy Slomka
Center Administrator

Jacqueline A. Stack, MSN
Administrative Director

Core Principal Investigators:

Charles F. Reynolds III, MD
Operations Core and Principal Research Core

Jordan F. Karp, MD
Operations Core

Mary Amanda Dew, PhD
Stewart J. Anderson, PhD
Richard Schulz, PhD
Research Methods Core

July 8, 2014

Sejal Patel
American Psychiatric Association
1000 Wilson Boulevard, Suite 1825
Arlington, Virginia 22209

Dear Sejal Patel,

Re: Robert G. Robinson, MD candidacy for 2015 Jack Weinberg Award

Please accept this letter as my unqualified endorsement of Bob Robinson's candidacy for the 2015 Jack Weinberg Award in Geriatric Psychiatry.

More than anyone else in our field, Dr. Robinson has contributed to our understanding of the pathophysiology, pathogenesis, treatment, and prevention of post-stroke depression, in a series of seminal publications over thirty years in the Lancet, JAMA, Archives of General Psychiatry, and the American Journal of Psychiatry. He is truly an outstanding psychiatrist-investigator, an exemplar of the physician scientist working creatively in the translational space of clinical neuroscience and geriatric psychiatry. His work and his life have had and continue to have an immensely powerful impact on the field as a whole. We are fortunate to count him among our colleagues.

Dr. Robinson's generativity also extends to his mentoring of younger colleagues as investigators and as clinician educators, during his service as the Penningroth Professor and Chair of Psychiatry at the University of Iowa. Under his leadership, the Department rose to become among the nation's preeminent centers of excellence in clinical neuroscience research, education, and practice. Bob has mentored generations of academic psychiatrists in geriatrics and neuropsychiatry who have gone on to distinguished careers of their own.

Thank you for considering my letter in your review of Dr. Robinson's credentials for the Weinberg Award. Both Dr. Robinson and the Weinberg Award would be appropriately honored by its conferral to him.

Sincerely,

Charles F. Reynolds III MD
2012 Jack Weinberg Awardee
UPMC Endowed Professor in Geriatric Psychiatry
Director, UPMC/Pitt Aging Institute (www.aging.upmc.com)

Peter V. Rabins, M.D., MPH
Professor of Psychiatry
Director

Division of Geriatric Psychiatry and Neuropsychiatry

Department of Psychiatry and Behavioral Sciences
600 N. Wolfe Street
Adolf Meyer Building / Room 279
Baltimore, Maryland 21287-7279
410-955-6736 Telephone
410-614-1094 Fax
pvrabins@jhmi.edu

JOHNS HOPKINS
MEDICINE

July 7, 2104

Re: Robert G. Robinson, MD

To Whom It May Concern,

I am writing with the highest level of enthusiasm to support the consideration of Robert G Robinson for the Weinberg Geriatric Psychiatry Award. Bob's career is an exemplar of a clinician researcher who has taken a clinical observation, demonstrated its importance, and advanced the clinical care of a large group of elders.

The best evidence of Bob's contribution is that a recent set of articles on stroke in the June 26, 2014 *Nature* included a whole article on post-stroke depression (PSD). Bob is quoted several times, and his research underlies many of the main points in the review article. Bob has studied post-stroke depression since the mid 1970's, Following up on the clinical observation that major depression seemed to be a sequella of stroke, Bob showed that, in rats, induction of a stroke was followed by the development of depression-like behavior. He then went on to show that in humans there is a high incidence of major depression following stroke, that stroke-induced disability does *not* correlate highly with the development of PSD, that lesion location *is* associated with the risk of developing post-stroke depression, and that the development of depression after stroke is associated with poorer functional outcomes. This work was followed by a series of studies showing that tricyclic and SSRI anti-depressants are more effective than placebo in treating PSD, and that starting an SSRI or CBT following stroke *prevents* the development of PSD.

Prior to Bob's work, PSD was seen as a "normal" response to stroke. Based on his work, stroke centers must demonstrate that they regularly screen for depression in order to receive national certification because PSD is a source of excess disability that can be prevented. This clearly demonstrates the impact and recognition of his research as well as its public health importance.

Bob has also played a role in the careers of other researchers, being the initial mentor of Helen Mayberg and Sergio Starkstein among others.

Today we take for granted the finding that major depression is an important concomitant of systemic vascular disease. I see this as a cornerstone of the field of "psychosomatic medicine." I believe Bob's continued focus on PSD played a major role in establishing the importance of this finding. It is of particular importance in Geriatric Psychiatry as the burden of stroke falls mainly in the elderly. Today, his research provides the only primary/secondary prevention strategy for major depression in the elderly that I know of. The inclusion of an article on PSD in a *Nature* series on stroke demonstrates the international recognition of his work, makes an important statement of the linkages between brain pathology and major depression, and supports, in my opinion, Bob's contribution to Geriatric Psychiatry and to the field of Psychiatry in general.

Peter V. Rabins, MD, MPH
Professor of Psychiatry and Behavioral Sciences
Member, Johns Hopkins Berman Institute of Bioethics
Joint appointments in the Bloomberg Johns Hopkins School of Public Health (Health Policy and Management, Mental Health) and Johns Hopkins School of Nursing

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

Bio:

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.

MASSACHUSETTS GENERAL HOSPITAL

HARVARD MEDICAL SCHOOL

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Boston, Massachusetts 02114
Tel: 617-726-3482
Fax: 617-726-2688
jrosenbaum@partners.org

Jerrold F. Rosenbaum, MD
Psychiatrist-in-Chief
Massachusetts General Hospital

Stanley Cobb Professor of Psychiatry
Harvard Medical School

June 18, 2014

Re: Chester M. Pierce, MD

Dear APA Human Rights Award Committee,

It is a pleasure for me to write a letter of recommendation for the nomination of Chester M. Pierce, MD, for the American Psychiatric Association Human Rights Award. 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 the distinction of being the first African American full professor at Massachusetts General Hospital. Dr Pierce has lived a "larger than life" life and he has done so with a degree of humility rarely seen. His accomplishments and stature, vision and creativity, range and depth of experience and enormous modesty have captured the imagination of several generations of Massachusetts General Hospital faculty and trainees. Indeed, it is fair to say he remains the most inspiring person in many of our lives. This will all become clear as this letter proceeds.

Chester M. Pierce was born in Glen Cove, New York on March 4, 1927. He received his undergraduate degree from Harvard College in 1948 and his medical degree from Harvard Medical School in 1952. One of his warmest memories of childhood was of sitting on the lap of Babe Ruth when the Sultan of Swat came through Glen Cove. Indeed, athletics became an important part of Dr. Pierce's life. As an undergraduate he was an outstanding athlete and earned his varsity letters from the Harvard College football, basketball and lacrosse teams. In 1947 the Harvard football team played an away game at the University of Virginia, which was an all White university at the time. Dr. Pierce became the first Black college football player to play a game below the Mason-Dixon Line. The undersized wide receiver on that team happened to be Robert F. Kennedy. Before Harvard's trip to Charlottesville, Virginia most integrated college football teams reluctantly agreed not to bring their Black players when traveling to the South. The host team would then bench a player of equivalent ability, but the racial environment of sports in America began to change in the spring on 1947 with the arrival of Jackie Robinson with the Brooklyn Dodgers. Some of the Harvard players who were World War II veterans learning of the game schedule wrote their Virginia counterparts lobbying on Dr. Pierce's behalf. Some accounts suggest that Virginia officials hoped Harvard would voluntarily exclude Dr. Pierce but the Harvard athletic director, Bill Bingham, insisted on his participation and the University of Virginia relented. Dr. Pierce needed to stay in a separate lodging and also needed to enter the dining room through a separate entrance. The Harvard team agreed that they would go where he went, and so they too stayed with him through the whole experience. Dr. Pierce said about the football game itself, "I don't recall a hint of anything racial on the field, I remember nothing different in that game from any other I played at Harvard; it was no big deal and took no courage". This experience would not be the last in which Dr. Pierce broke new ground in the fight for racial equality in our country. In 1997 the University of Virginia awarded Dr. Pierce its

Vivian Pinn Distinguished Lecturer's award, which is given for lifetime achievement in the field of health disparities.

After receiving his medical degree from Harvard in 1952, Dr. Pierce trained in psychiatry at the University of Cincinnati. Right after residency training he served in the United States Navy from 1954-1956 and was on active duty as a neuropsychiatrist at the Great Lakes Naval Station in Illinois. He retired with the rank of Commander in the US Navy Reserve. In the 1960s he was on the faculty of the Oklahoma University School of Medicine and was the Chief of the Psychiatry Service and research psychiatrist at the Oklahoma City VA Hospital. At the University of Oklahoma he became a professor in 1967. In 1968 he returned to Cambridge, Massachusetts where he first served on the attending staff at Boston City Hospital and Cambridge City Hospital and on the medical department staff at the Massachusetts Institute of Technology. From 1968 onward he was also a psychiatrist on staff at Massachusetts General Hospital. In 1969 he became a professor of psychiatry in the faculty of medicine at Harvard University and a professor of education in the graduate school of education at Harvard University.

Dr Pierce soon became a sought-after consultant. Over the years he was an advisor to the National Aeronautics Space Administration, United States Peace Corps, and to the ground-breaking children's television program Sesame Street. Meanwhile he was a member of the board of directors of the American Board of Psychiatry and Neurology, of the Polar Research Board of the National Research Council in Washington, DC, and of the Institute of Medicine of the National Academy of Sciences in Washington having been elected in 1971. He has also served as a national consultant to the United States Air Force Surgeon General.

Dr. Pierce has had an amazing academic career; he has published more than 180 journal articles, reviews, and books. His main area of research focus was on the psychological effects of extreme environments. This led him to do research while in the Navy, eventually focusing on Antarctica. As a result of his fine work in this area he had the honor of having a mountain named after him in Antarctica which is called Pierce Peak near the Filchner Ice Shelf. But perhaps he is best known for his important research on the effects of racism on the health of its victims. He first proposed the concept of racial micro-aggressions in 1970. A micro-aggression usually involves "demeaning implications and other subtle insults against minorities". He went on to describe these subtle nonverbal exchanges as "put downs" of African Americans by offenders and he suggested that they may play a role in justice system unfairness since micro-aggressions can influence jury decision making. This work has had tremendous influence on psychologists and psychiatrists. In 2012 researchers developed the Racial Micro-aggressions Scale (RMAS) to measure racial micro-aggressions. This is of great importance because it is becoming increasingly clear that racial micro-aggressions may represent a significant source of stress endured by people of color and that the accumulation of the stress and possible transcriptome changes may lead to something called allostatic loading and the future development of chronic stress related non-communicable diseases like cardiac disease and diabetes. It is clear that Dr. Pierce's seminal work on racial micro-aggressions lies at the heart of the relationship of human rights and human health.

But Dr. Pierce did not only seek to advance human rights through his academic medical career; he also put himself on the front lines during the civil rights movement by offering his services as a volunteer physician on marches through the South. This is part of his life he is reluctant to discuss.

Dr. Pierce is a natural born leader and so it is not a surprise that he rose to be the president of the American Board of Psychiatry and Neurology and of the American Orthopsychiatric Association. He is also the founding president of the Black Psychiatrists of America and was named chairperson of the Child Development Associate consortium. He has chaired committees for the National Institute of Mental Health, the National Research Council, the National Science Foundation, and the National Aeronautics Space Administration. He has won numerous awards from the National Medical Association, the American Psychiatric Association, the Black Psychiatrists of America, and the World Psychiatric Association. In addition, he has won national and international awards for film production. Dr. Pierce has been invited to lecture on all seven continents and has spoken at over 100 colleges and universities in the United States. He is a member of both the Institute of Medicine at the National Academy of Sciences and of the American Academy of Arts and Science. Here at Massachusetts General Hospital we have named our global division the Chester M. Pierce, MD Global Division of Psychiatry. There is also a Chester M. Pierce Research Society for Minority Investigators at Massachusetts General Hospital. In 1998 Ezra Griffith wrote a biography of Dr. Pierce call *Race and Excellence: My Dialogue with Chester Pierce*.

To this day Dr. Pierce remains an inspiration to all of us. There is no one who more seamlessly combines talent and accomplishment with humility and modesty and generativity. He is a visionary leader and we in the Department of Psychiatry at the Massachusetts General Hospital still benefit from his insights and admonitions. The world is a better place for having Chester M. Pierce, MD in it, and we are better people for having crossed paths with him. With all this in mind, I most heartily recommend that you award him the American Psychiatric Associations Human Rights Award for 2015.

If you would like to contact me please feel free to call at 617-726-3482.

Sincerely yours,

Jerrold F. Rosenbaum, MD

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:
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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 24th.

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

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**
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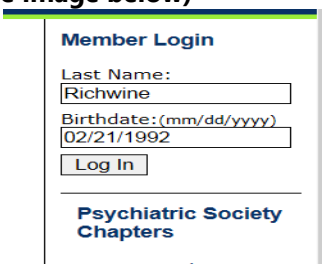

Last Name: Richwine
DOB: 02/21/1992

Description of the Committee's Selection Process:

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]

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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]

13. Chung K, Deisseroth K. **CLARITY for mapping the nervous system.** Nature Methods. June 2013. 10(6):508-13. [PDF]

14. Ahmari SE, Spellman T, Douglass NL, Kheirbek MA, Simpson HB, Deisseroth K, Gordon JA, Hen R. **Repeated Cortico-Striatal Stimulation Generates Persistent OCD-Like Behavior.** Science. June 7, 2013. 340:1234-9 [PDF | News & Views]

15. Steinberg EE, Keiflin R, Boivin JR, Witten IB, Deisseroth K, Janak PH. **A causal link between prediction errors, dopamine neurons and learning.** Nature Neuroscience. Advance Online Publication 2013 May 26. 16(7):966-73 [PDF]

16. Kempadoo KA, Tourino C, Cho SL, Magnani F, Leinninger G-M, Stuber GD, Zhang F, Myers MG, Deisseroth K, de Lecea L, Bonci, A. **Hypothalamic Neurotensin Projections Promote Reward by Enhancing Glutamate Transmission in the VTA.** J Neuroscience. May 1, 2013. 33(18):7618-26. [PDF]

17. Stroh A, Adelsberger H, Groh A, Ruhlmann C, Fischer S, Schierloh A, Deisseroth K, Konnerth A. **Making Waves: Initiation and Propagation of Corticothalamic Ca2+ Waves In Vivo.** Neuron. March 20, 2013. 77:1136-50 [PDF]

18. Chung K., Wallace J., Kim S.Y., Kalyanasundaram, S., Andalman A.S., Davidson T.J., Mirzabekov J.J., Zalocusky K.A., Mattis J., Denisin A.K., Pak S., Bernstein H., Ramakrishnan C., Grosenick L., Gradinaru V., Deisseroth K. **Structural and molecular interrogation of intact**

biological systems. Nature. Advance Online Publication 2013 Apr 10. [PDF | Supplementary Information | Nature Video | Stanford Video | Nature News | Stanford News | CLARITY images | SCOPE]

19. Kim SY, Adhikari A, Lee SY, Marshel JH, Kim CK, Mallory CS, Lo M, Pak S, Mattis J, Lim BK, Malenka RC, Warden MR, Neve R, Tye KM, Deisseroth K. **Diverging neural pathways assemble a behavioral state from separable features in anxiety.** Nature. Advance Online Publication 2013 Mar 20. [PDF | Supplementary Information | News & Views]

20. Zalocusky K, Deisseroth K. **Optogenetics in the behaving rat: integration of diverse new technologies in a vital animal model.** Optogenetics. Mar. 2013 [PDF]

21. Tye KM, Mirzabekov JJ, Warden MR, Ferenczi EA, Tsai HC, Finkelstein J, Kim SY, Adhikari A, Thompson KR, Andalman AS, Gunaydin LA, Witten IB, Deisseroth K. **Dopamine neurons modulate neural encoding and expression of depression-related behavior.** Nature. Advance Online Publication 2012 Dec. [PDF | Supplementary Information]

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25. Prakash R, Yizhar O, Grewe B, Ramakrishnan C, Wang N, Goshen I, Packer AM, Peterka DS, Yuste R, Schnitzer MJ, Deisseroth K. **Two-photon optogenetic toolbox for fast inhibition, excitation and bistable modulation.** Nat Methods. Advance Online Publication 2012 Nov 11. [PDF | Supplemental Information]

26. Packer AM, Peterka DS, Hirtz JJ, Prakash R, Deisseroth K, Yuste R. **Two-photon optogenetics of dendritic spines and neural circuits.** Nat Methods. 2012 Dec 7;9(12):1202-5. Epub 2012 Nov 11. [PDF | Supplemental Information]

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32. Threlfell S, Lalic T, Platt NJ, Jennings KA, Deisseroth K, Cragg SJ. **Striatal dopamine release is triggered by synchronized activity in cholinergic interneurons.** Neuron. 2012 Jul 12;75(1):58-64. [PDF | Supplemental Information]

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42. Mattis J, Tye KM, Ferenczi EA, Ramakrishnan C, O'Shea DJ, Prakash R, Gunaydin LA, Hyun M, Fenno LE, Gradinaru V, Yizhar O, Deisseroth K. **Principles for applying optogenetic tools derived from direct comparative analysis of microbial opsins.** Nat Methods. 2011 Dec 18;9(2):159-72. [PDF | Supplemental Information]

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45. Domingos AI, Vaynshteyn J, Voss HU, Ren X, Gradinaru V, Zang F, Deisseroth K, de Araujo IE, Friedman J. **Leptin regulates the reward value of nutrient.** Nat Neurosci. 2011 Nov 13;14(12):1562-8. [PDF | Supplemental Information]

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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

The Honorable Patrick J. Kennedy

CA-1 Part 1. 2014 PSAA Online Application Form

Applying Program Name

University of California, San Francisco Alliance Health Project

Program became fully operational 03 1984

Program Address
Box 0884 San Francisco CA 94143 USA

Program Director Lori Thoemmes, LMFT, lori.thoemmes@ucsf.edu

Facility Address
Clinic serving the City/County of San Francisco 1930 Market Street San Francisco CA 94102 USA

Director
James W. Dilley, MD, james.dilley@ucsf.edu Executive Director

Contact for Applying Program
Suzy Brady Community Resource Analyst

Contact Address
PO Box 0884 San Francisco CA 94143 United States

Description of Facility (type, size, catchment area served, etc.)
The UCSF Alliance Health Project (AHP), formerly the AIDS Health Project, is a community-based program of the Psychiatry Service of San Francisco General Hospital. AHP has provided HIV-related mental health services since 1984, when it helped to establish the San Francisco Model of Care—a system of care credited with helping many people with HIV and AIDS live longer, healthier lives. In 30 years, AHP has provided HIV prevention, education, counseling and psychiatric services to tens of thousands of HIV-infected men, women, youth, and their providers. More than 200,000 individuals have been treated and more than 80,000 health care professionals, educators, and students have been trained. AHP has long been committed to the emotional and psychological health and well being of LGBTQ people. Since 1984, we have reached out, in particular, to gay and bisexual men. Over the past several years, we have built our capacity to serve lesbians, bisexual women and transgender people of any sexual orientation. As of 2010, AHP is San Francisco's primary LGBTQ mental health clinic. The vast majority of AHP clients are low-income and under-insured individuals with 86 percent of our clients living on income of $20,000 or less per year and 78 percent living on $15,000 or less per year. Looking ahead, we have a vision of addressing health disparities for LGBTQ people through direct service and research to further understand the impact of stigma on this community. As a non-profit organization operating within the School of Medicine at the University of California, San Francisco (UCSF), AHP receives no program funding from the university, and instead must rely on a combination of grants and contributions from corporations, private foundations, government contracts and individual donors to fund our programs. All of AHP's client services are provided at the AHP Services Center located at 1930 Market Street (aside from mobile HIV testing and services provided at San Francisco General Hospital). Thanks to the leadership and commitment of foundation, corporate and individual supporters, in 1997 AHP was able to secure over $1,000,000 of in-kind and donated services to renovate what was an antiquated and poorly designed building into a modern 14,800 square

foot building re-designed as a mental health services center. The center now provides seven support group rooms, 15 individual counseling rooms, two meeting/conference rooms, and a large classroom/training room. In addition, there are nine single occupant staff offices, and nine shared staff offices. The Services Center features a modest décor with offices furnished as comfortable, therapeutic environments. Our facility is in compliance with the requirements of the federal Americans with Disabilities Act. All restrooms have been adapted for wheelchair use; it has an elevator to provide easy access to the second floor for disabled clients; and all rooms in which our staff meets with clients are wheelchair

Brief Statement of Program to be considered for award(100 words or fewer)
The UCSF Alliance Health Project (AHP) has been a pioneering advocate for integrated LGBT health care since its founding in 1984 as the AIDS Health Project. The mental health consequences of the AIDS epidemic have been considerable, effecting not only those who themselves have been infected or ill, but also those at risk of infection and those whose friends and loved ones have become ill and died. Over the years, AHP has pioneered a variety of programs that have become models within the city and throughout the country.

Select Award Final AHP APA Awd Part 2.pdf

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The UCSF Alliance Health Project (AHP), formerly the AIDS Health Project, is a community-based program of the Psychiatry Service of San Francisco General Hospital. AHP has provided HIV-related mental health services since 1984, when it helped to establish the San Francisco Model of Care—a system of care credited with helping many people with HIV and AIDS live longer, healthier lives. In 30 years, AHP has provided HIV prevention, education, counseling and psychiatric services to tens of thousands of HIV-infected men, women, youth, and their providers. More than 200,000 individuals have been treated and more than 80,000 health care professionals, educators, and students have been trained.

In a 1994 article published in the journal, *Psychiatric Clinics of North America*, Executive Director James W. Dilley, MD, discussed the development of AHP as a community psychiatry intervention designed to address the mental health consequences of the AIDS epidemic. AHP's early work extended from clinical services to individuals living with HIV/AIDS who suffered from a variety of mental health disorders to providing supportive services to others at risk of developing mental health disorders and, finally, educational and HIV risk reduction counseling efforts, with individuals and populations who are particularly at-risk for becoming infected with HIV.

Over the years, AHP has pioneered a variety of programs that have become models within the city and throughout the country. Today, AHP continues to provide HIV/AIDS mental health and prevention services and has broadened its mission, "to support the mental health and wellness of the LGBTQ and HIV-affected communities in constructing healthy and meaningful lives." AHP's expansion is the most recent example of our agency applying a community psychiatry approach, in this case, to the mental health consequences of minority stressors within the lesbian, gay, bisexual, transgender and queer (LGBTQ) communities.

As the Institute of Medicine's 2011 report, *The Health of LGBT People*, states, it is "clear that deleterious effects on the mental health of lesbian, gay and bisexual individuals result overwhelmingly from unique, chronic stressors due to the stigma they experience as a disadvantaged minority in American society." AHP's LGBTQ-affirming mental health, substance use counseling, and peer support to individuals, couples and groups counteract these stressors. As of 2010, AHP is San Francisco's primary LGBTQ mental health clinic. We are committed to meeting the unique needs of all members of the LGBTQ community, especially people living with chronic mental health disorders. AHP offers LGBTQ-affirming mental health services, substance use counseling, and peer support to individuals, couples, and groups. We also provide free HIV testing and STD screening at our services center and mobile test sites. Additionally, individual psychotherapy services and ongoing psychiatric clinical care, including medication evaluation and monitoring, are available. George Harrison, MD, is the lead psychiatrist and medical director of the AHP Services Center serving some 4,000 people annually.

National Impact: One of the earliest examples of AHP developing a program in response to community need occurred in 1985 when Dr. Dilley, also a psychiatrist, led AHP to develop an HIV counseling and testing protocol that became a national model. AHP argued forcefully for face-to-face counseling that would ensure individuals the chance to learn how to protect themselves and others from infection. This approach reflected the mental health orientation that our agency brings to HIV/AIDS treatment and was consistent with the principles AHP applied within existing group support programs: that successful HIV prevention counseling required discussion of an individual's personal fears and circumstances. This

model went into operation in June 1985 and has become the prototype widely used throughout the United States and abroad.

In 2002, Dr. Dilley led a California Endowment-funded systematic analysis of the HIV mental health system in San Francisco and developed recommendations for improving care. Particular focus was on identifying groups of clients who demonstrated unmet need, especially need that resulted in high cost public services in addition to individual suffering. This process revealed that AHP's client base was increasing in complexity, with a significant prevalence of "triple diagnosis" (HIV, mental illness, and substance abuse disorders).

Based on results from that study, AHP received funding from the federal Center for Substance Abuse Treatment (CSAT), to provide Assertive Case Management (ACM) to homeless people with HIV, most of who also struggled with mental illness, a substance abuse disorder or both. These clients were shown to be "high utilizers" of high-cost, high-acuity care in the public health system. ACM supported clients in stabilizing their complex housing, medical, and mental health needs, responding to potential problems before they reached a crisis point. As a result, these clients were shown to decrease their use of emergency room and psychiatric emergency services compared to their utilization prior to ACM achieved an increase in stable housing and their use of anti-retroviral drugs at six and 12 months post intervention. Similar programs have been implemented throughout the country.

A second innovative AHP program that has become a national model is the AIDS and Substance Abuse Program (ASAP) Plus. This program provides a supportive environment to people of color who are at risk of HIV or who have HIV and are seeking to address the impact of substance use on their ability to create meaningful and constructive lives. ASAP Plus offers individual substance abuse counseling, integrated mental health services, and group support services. This program incorporates several evidence-based practices, including Motivational Interviewing, along with a harm reduction approach, to promote the health and wellness of our clients. From 2009 to 2013, ASAP Plus was funded by another federal CSAT grant. The program is continuing with support from other sources, including SFDPH. AHP is also in the process of becoming eligible to receive Medi-Cal funding for ASAP services.

Through ASAP Plus, AHP learned more about how to best help the clients in our service population. The program adapted and evolved to include specific focus on housing, primary medical care and psychiatric medication management (provided at the AHP Services Center by Dr. Harrison and other psychiatry staff). The co-location of psychiatric, case management, substance use, and HIV prevention services helped ASAP Plus clients facing a complex constellation of health and life challenges build more stable lives. ASAP Plus staff needed to provide a great deal of support to clients managing the stress of the housing process, which often put pressure on their ability to maintain their abstinence from substance use. Using Motivational Interviewing to build a relationship with clients laid the foundation for helping them work toward and then maintain abstinence from alcohol and other drugs, improve their mental health, and address their health and housing needs. In January 2014, AHP submitted an *ASAP Plus Program Guide* to CSAT for distribution to other agencies as they implement similar programs.

Over our 30-year history, AHP has honed a commitment to quality improvement and program evaluation. ASAP Plus outcomes were measured through the use of SAMSHA's GPRA survey. The GPRA survey asks questions about substance use, mental health symptoms such as depression and anxiety, and inquires about housing and employment. The survey was administered by AHP staff at intake and at

six months after intake, if the client could be located and gave consent to be surveyed. The staff made a concerted effort to locate as many clients as possible, and interviewed 213 of the 272 ASAP Plus clients, for the six-month follow-up rate of 78.2%. This is a considerable achievement considering the highly mobile nature of the target population.

Every AHP program is based on a contract with goals and objectives related to that service, the population to be served, and the number of service hours to be delivered. Client data collection and analysis, annual client satisfaction surveys, and the use of behavioral and psychological rating scales are standard operating procedure. Program managers regularly review performance data and assess the progress of the program towards milestones and objectives. Performance results are reported to the staff and the agency director. This information is used to identify areas of concern and develop strategies to address them through program adjustments. In 2013, AHP held two focus groups with clients, family, and community members to request feedback on services. In addition, since 1986 a Community Advisory Board, made up of clients, mental health professionals, and AHP and LGBTQ allies, has acted as community advocates and a sounding board for agency ideas/initiatives.

A third AHP program that has become a national model is Personalized Cognitive Counseling (PCC), a single session HIV risk reduction counseling approach targeting gay and bisexual men who are repeat testers for HIV. PCC was developed, with Dr. Dilley as the primary investigator, based on a five-year study carried out at AHP with the participation of hundreds of gay and bisexual men who came to AHP for an HIV test.

By the mid-1980s, AHP program data showed that many gay and bisexual men who were counseled and tested for HIV were getting tested multiple times and receiving prevention counseling each time but were continuing to engage in high-risk sexual behavior. Data on seroconversion showed that the rate of new HIV infection among these men who were testing repeatedly was almost three times that of men who had not received multiple HIV tests. Dr. Dilley and other AHP staff recognized the need to provide a different counseling approach for repeat testers who engaged in risky behavior. PCC focuses on the self-justifications (thoughts, attitudes and beliefs) a person uses when deciding whether or not to engage in high-risk sexual behavior. The 30- to 50-minute intervention is conducted as a component of Counseling, Testing, and Referral Service (CTRS) for gay and bisexual men who meet the screening criteria.

In 2010 the Centers of Disease Control (CDC) endorsed PCC as one of the few effective behavioral interventions targeting gay and bisexual men. PCC has been adapted for use in health departments and community-based organizations around the country and is being distributed nationally by the CDC. AHP currently provides PCC to eligible clients at our HIV Counseling and Testing sites. In addition, under contract with the CDC, AHP's Publications and Training Program will develop online trainings to supplement nationwide in-person PCC trainings over the next three years.

Today, AHP seeks the funding that will support our expanded services to the LGBTQ communities because our clients, and our belief in the efficacy of community psychiatry, tell us these services are needed. The March 2011 Institute of Medicine report, *The Health of LGBT People* is part of the increasing acknowledgement, at a national level that LGBT individuals are ill served by status quo medical care. With our expansion, AHP is once again innovating—this time in service of LGBTQ mental health, substance use, and HIV prevention services. Please see the attached AHP document listing the agency's fiscal year 2013-14 revenue sources and amounts.

UCSF/SFGH Department of Psychiatry
02/12/2014

SFGH DEPARTMENT OF PSYCHIATRY ORGANIZATIONAL OVERVIEW

Matthew State, MD, PhD
Chair
UCSF Dept of Psychiatry

James Dilley, MD*
Chief
Vice Chair
Executive Director, AHP

Anna Spielvogel, MD, PhD*
Residency Training Site Director

Alicia Boccellari, PhD
Chief Psychologist

Mark Leary, MD*
Deputy Chief & Division Director, Acute & Emergency Services

Kathy Ballou, RN, MS*
Nursing Director for Behavioral Health

ADMINISTRATION & FINANCE

Margaret Paternek, PhD*
Director of Administration

Finance

Administrative Operations

Utilization Review & Contracts

Information Technology

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Carmen Masson, PhD
Valerie Gruber, PhD
Steve Dominy, MD
Substance Abuse & Addiction Medicine

Diane Coseo
CTN Manager

Alicia Lieberman, PhD
Patricia Van Horn, PhD
Child Trauma Research Program

Christina Mangurian, MD
Martha Shumway, PhD
Mental Health Services

Alicia Boccelari, PhD
Chief Psychologist

James Dilley, MD
HIV Prevention

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Alliance Health Project Division Director

Paul Dertien
Division Administrator

George Harrison, MD
Medical Director

Stephan Ouellette
Psychosocial Support and Prevention Services

Barbara Adler
HIV Testing & Counseling

Emily Leavitt
Psychiatry, Assessment, Crisis & Triage Services

Ramon Matos
ASAP Counseling & Case Management Services

Rob Marks
Publications & Training

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Program Manager

Valerie Gruber, PhD
Stimulant Treatment Outpatient Program

INFANT, CHILD & ADOLESCENT PSYCHIATRY

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Roger Mohamed
Division Administrator

TBD
ICAP Medical Director

Kadija Johnston, LCSW
Infant Parent Program

Alicia Lieberman, PhD
Patricia Van Horn, PhD
Child Trauma Research Program

PSYCHOSOCIAL MEDICINE

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Division Director, Division of Psychosocial Medicine

Jon Dean Green
Division Administrator

Herb Ochitill, MD*
Consultation and Liaison Service

Antionette Griffin, CNS
Consultation Liaison Nursing

Susan Scheidt, PsyD
Healthy San Francisco Psychosocial Program

Kathy O'Brien
ED Case Management

Alicia Boccellari, PhD
Trauma Recovery Center

Alicia Boccellari, PhD
Neuropsychology Service

Janet Hines, MS, PNP
Child & Adolescent Support Advocacy Resource Center

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Division Director, Division of Community Services

Constance Revore
Division Administrator

Fumi Mitsuishi
Medical Director
Community Focus/Citywide

Kathleen Connolly
CWCMF
Program Director

TBD
CLT
Program Director

Eric Brown
CWRT
Program Director

PSYCHIATRIC EMERGENCY SERVICES

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Christina Mangurian, MD
Community Liaison

Richard Sherwin, LCSW
Special Projects

Marina DiCerbo
PES Operations Analyst

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Inpatient Services

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Medical Director
Jail Psychiatric Unit (7L)

Mily Trabing, LCSW*
Director, Inpatient Psychiatric Social Work

Annette Pinto, OTR
Director
Occupational Therapy

Mindy Oppenheim
Vocational Rehab

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Nurse Manager
Inpatient Unit 7A

Suzette de Jesus, RN
Nurse Manager,
Inpatient Units 7B & 7C

Andrea Crowley, RN
Interim Nurse Manager, Psychiatric Emergency Services (PES) & 7L

Cecile Schwanke, MSN
Quality Improvement

*** Denotes Executive Committee Members**

 # Please note that Infant, Child, and Adolescent Psychiatry and Child Trauma Research also reports to Dr. Robert Hendren, DO, Director, Infant, Child and Adolescent Psychiatry, Vice Chair, Department of Psychiatry, Langley Porter Psychiatric Institute

UCSF Alliance Health Project

7/1/2012 - 6/30/2013

REVENUE

Source		Amount
Foundations		$103,087
Corporations		$48,800
Individual Contributions		$159,600
Fundraising Events		$158,235
Contracted Services		$21,667
Reimbursements		$0
Other: Interest Income		$27,709
Other: Publications		$0
Other: United Way, Combined Federal Campaign, etc		$5,000
Other: Government Contracts		
City/County		$1,582,970
State		$3,287,024
Ryan White CARE		$2,391,122
Other Federal Funds		$651,440
	Total Gov't Contracts	$7,912,556
TOTAL REVENUE		$8,436,655

ASAP Plus Program Guide

AIDS and Substance Abuse Program Plus

Project Director: James Dilley, MD
Program Director: Ramón Matos, LMFT
Evaluators: Tim Allen and Peter Loeb

The ASAP Plus project was funded by grant number TI 18771 from the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment.

University of California, San Francisco Alliance Health Project
1930 Market Street, San Francisco, CA 94102
(415) 476-3902
www.ucsf-ahp.org

PCC: Personalized Cognitive Counseling

REPLICATING Effective PROGRAMS

A Single-session Intervention for MSM Who are Repeat Testers for HIV

The Research

The Science Behind the Package

Personalized Cognitive Counseling (PCC) is a single-session counseling intervention designed to reduce high-risk behaviors among men who have sex with men (MSM) who are repeat testers for HIV. The ***PCC*** intervention is based on the work of cognitive psychologist Ron Gold and colleagues, hypothesizing that the decision to engage in high-risk sex happens when the person rationalizes the potential risk by minimizing the known risk.

Target Population

PCC is for MSM who are HIV-seronegative, who have had at least one HIV test before, and who report unprotected anal intercourse (UAI) in the past 12 months with a partner of unknown HIV serostatus or a partner who was HIV-positive. The intervention is for men 18 years of age or older of any race/ethnicity.

Intervention

PCC is delivered in the context of HIV test counseling in a 30 to 50 minute individual session. Typically the setting is a community HIV testing site. Counselors should be trained in HIV prevention counseling and testing and have at least one year of experience conducting HIV counseling. The process is aided by the ***PCC*** Questionnaire, a list of self-justifications that men often use to rationalize risky behavior. ***PCC*** is a five step process: 1) The client is assisted to recall a memorable episode of UAI. 2) The client completes the ***PCC*** Questionnaire with the specific incident in mind. 3) The counselor draws out the client's story about the incident, along with the thoughts and feelings the client experienced. 4) The counselor helps the client identify the self-justifications that facilitated the UAI. 5) The counselor asks the client what he will do in future similar situations to avoid risk.

Research Results

Two controlled studies of ***PCC*** were conducted at the AIDS Health Project (AHP) in San Francisco. In the first study, participants were 248 MSM eligible for ***PCC***. Two intervention groups received standard HIV test counseling plus the ***PCC*** cognitive behavioral intervention, delivered by mental health professionals, and two control groups received only standard HIV test counseling. A second similar study tested ***PCC*** versus standard HIV test counseling using experienced bachelors-level HIV test counselors who were trained in the ***PCC*** intervention. Participants were 336 MSM who were randomly assigned to ***PCC*** or standard HIV counseling in the second study. In both studies, the ***PCC*** intervention significantly reduced the number of UAI episodes with nonprimary HIV-positive or unknown status partners in the six months after counseling. In the first study, the average number of unsafe episodes significantly declined by about half at six month follow-up and maintained 12 months later. Men who participated in the second study were asked how helpful they found the services; those who received ***PCC*** were more satisfied with the services received.

For Details on the Research Design

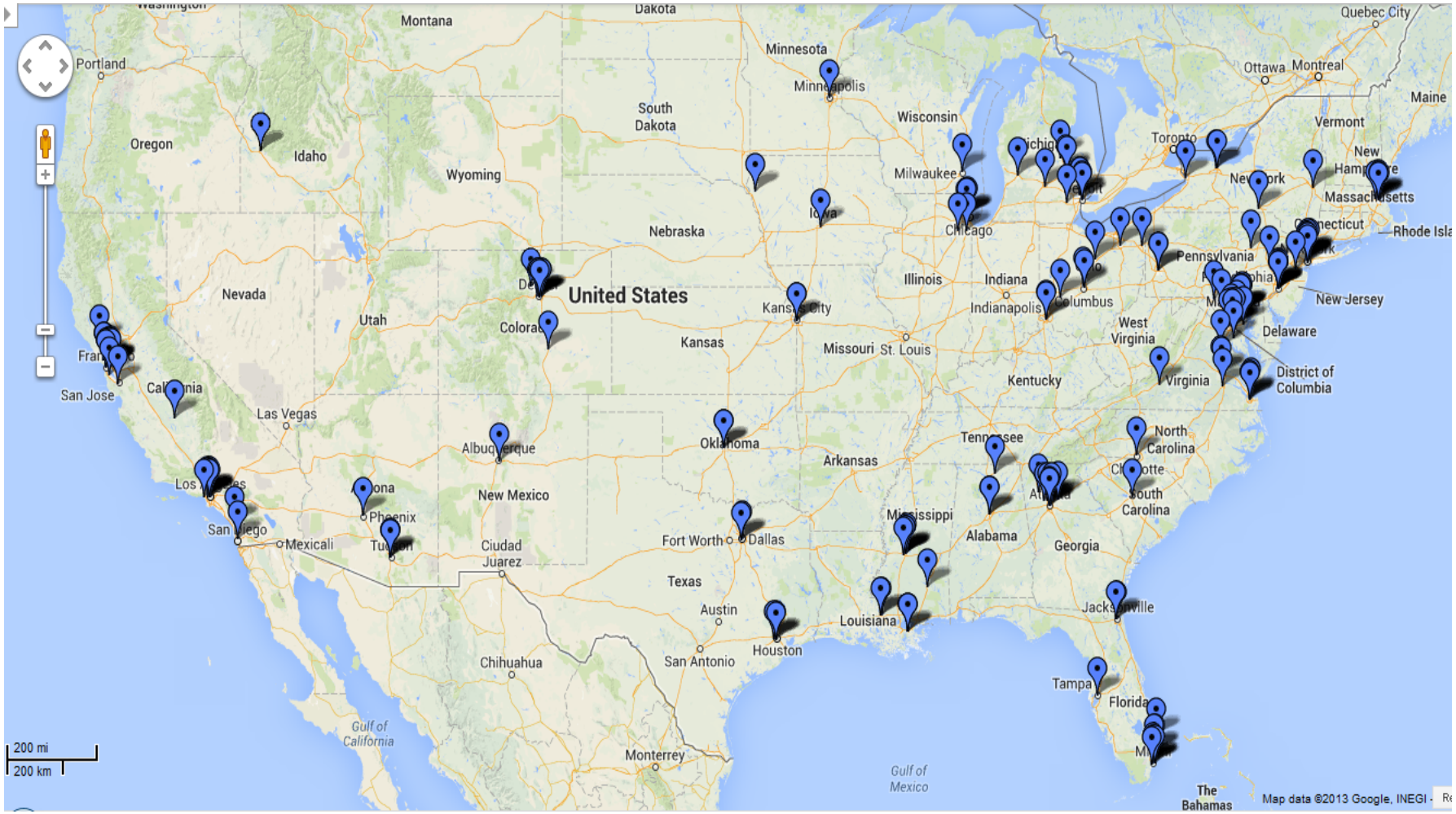
Dilley JW, Woods WJ, Sabatino J, Lihatsh T, Adler B, Casey S, et al. (2002). Changing Sexual Behavior Among Gay Male Repeat Testers for HIV: A Randomized, Controlled Trial of a Single-Session Intervention, *Journal of Acquired Immune Deficiency Syndromes*, 30(2), 177-86.

Dilley JW, Woods WJ, Loeb L, Nelson K, Sheon N, Mullan J, et al. (2007). Brief Cognitive Counseling With HIV Testing to Reduce Sexual Risk Among Men Who Have Sex With Men: Results from a Randomized Controlled Trial Using Paraprofessional Counselors. *Journal of Acquired Immune Deficiency Syndromes*, 44(5), 569-577.

National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
Division of HIV/AIDS Prevention

CS210399M

PCC Trainings thru 2012



*Puerto Rico & US Virgin Islands not shown

MA-1 Part 1. 2014 PSAA Online Application Form

Applying Program Name

Bridge for Resilient Youth in Transition Program

Brookline Community Mental Health Center

Program became fully operational 7 2004

Program Address
Brookline Community Mental Health Center
41 Garrison Rd Brookline MA 02445 USA

Program Director Henry White, MD
henrywhite@brooklinecenter.org

Facility Address
Brookline Community Mental Health Center 41 Garrison Rd Brookline MA 02445 USA

Director
Cynthia Price, DBA cindyprice@brooklinecenter.org Executive Director

Contact for Applying Program
Henry White, MD

Contact Address
41 Garrison Rd Brookline MA 02445 United States

Description of Facility (type, size, catchment area served, etc.)
Brookline Community Mental Health Center serves the evolving mental health needs of adults, children and families living in Brookline and Greater Boston, delivering culturally responsive, comprehensive care through a community health model. Since 1958, the Center has focused on treating people with limited access to mental health care, low and moderate income residents, those from diverse population groups, and individuals with serious mental illness. In addition to its clinical programs, the Center has developed a strong reputation for developing innovative programs that have become regional and national models of care. The Center offers a broad range of services including individual, family, group counseling and medication for children and adults, home-based services for families, and homelessness prevention programs. 4000 clients make 42,500 service visits to BCMHC each year. 75% of BCMHC's clients are from low to moderate-income families, 40% are at-risk youth. Our annual budget is $5.5 million; each year the Center provides $1.2 million in free and reduced care. BCMHC is an independent 501(c)3 facility, governed by a community-based Board of Directors. We have 5 psychiatrists, 20 psychologists, 35 social workers, 5 psychiatric nurses, 2 case managers, 6 mediators and 10 administrative/office staff.

Brief Statement of Program to be considered for award(100 words or fewer)
One of every ten adolescents has a serious emotional disorder that disrupts schooling, home life and friendships and often results in a hospitalization or prolonged absence from school. Bridge for Resilient Youth in Transition (BRYT) is a unique school-based response to help teens successfully re-enter school. A clinical and an academic coordinator work with students and families during a crisis and through the eight-week re-entry process, providing emotional, academic, and family support and coordination between students, school staff, and mental health professionals. A "Home-base" classroom in the school serves as a safe place where

students can check in as needed. Developed in 2004, the program has been replicated in 17 school districts in Massachusetts representing 30,000 students.

Documant Type	Document Name
Select Award_Other	Brookline Community Mental Health Center 2014 Psychiatric Services Award Application.pdf
Select Award_Other	bryt boston globe 3-23-2009.pdf
Select Award_Other	bryt boston globe 5-10-2011.pdf
Select Award	Brookline Community Mental Health Center 2014 Psychiatric Services Award Application.pdf
Select Award_Other	BRYT-Psychiatric Services Article.pdf

In the United States, one in every five adolescents has a serious emotional disorder and five to nine percent of teens have problems so severe that they are unable to function at school, at home, or in the community, necessitating hospitalization or resulting in prolonged absences from school.[1] Returning to school after an absence or hospitalization due to serious emotional disorder is a critical moment. School re-entry is fraught with problems -- students are at high risk for relapse, academic failure, and social rejection. Their families are often in crisis as well as they try to navigate a maze of medical and mental health systems. Schools are the right venue for providing services – teens spend most of their time in school – but the complex needs of these children require more support than most public schools are able to provide.

The groundbreaking model described below offers a new element within the continuum of care to smoothly re-integrate youth from intensive settings to community and school based care. Based on an extensive literature review, and conversations with school health centers and experts, there are no other models to help teens with serious emotional disorders from falling through the gaps between our mental health and education systems. Typically, teens experiencing a major psychiatric episode have brief stays in inpatient units or partial hospitals, then return directly to school. They are expected to take on the task of recovery while managing all the social and academic pressures.

As a result, these high risk adolescents are disproportionately likely to drop out of high school [2]; attempt suicide [3]; abuse alcohol and drugs[4] , and function poorly in a variety of areas including home, school, family relationships, and social life [5],[6]. For many, this disruption is the first episode of what may become a life-long mental disorder [7]. About half of these teens do not receive the help they need resulting in more severe and difficult-to-treat illnesses[8],[9] and disruption of academic, social, and cognitive development.

In 2004, the Brookline Community Mental Health Center (BCMHC) launched this unique school-based intervention program directed at helping at-risk teens heal, build resilience and complete high school. The Bridge for Resilient Youth in Transition (BRYT) program meets the needs of students re-entering school after absences due to serious emotional disorders or medical conditions. These students have a broad variety of mental disorders; most frequent are depression and severe anxiety. Initially, the program was designed with close involvement of family members and students; currently family members and students are actively involved in program planning participating in oversight, communication, and staff recruitment and hiring.

BRYT (pronounced 'bright') provides academic, family and emotional support and care coordination. Under the supervision of a psychiatrist, two Clinical Coordinators (social workers) and a Classroom Aide work closely with students and their families during a crisis and through the four- to eight-week re-entry process. The Coordinators provide clinical care, offer support and information, help families negotiate the service network, and facilitate communication with health care personnel and therapists and between students and teachers. A specialized "Home-base" classroom located right in the high school

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[1] Arch Gen Psychiatry. *2011;68(3):263-269.*

[2] U.S. Department of Education, Office of Special Education and Rehabilitative Services, Office of Special Education Programs. (2009). 28th annual report to congress on the implementation of the Individuals with Disabilities Education Act, 2006, vol. 1. Washington, DC.

[3] Office of Applied Studies. (2005). Results from the 2004 National Survey on Drug Use and Health: National findings (DHHS Publication No. SMA 05-4062, NSDUH Series H-28). Rockville, MD: Substance Abuse and Mental Health Services Administration.

[4] Substance Abuse and Mental Health Services Administration (SAMHSA), Office of Applied Studies. (2007). The NSDUH report: Depression and the initiation of alcohol and other drug use among youths aged 12 to 17. Rockville, MD.

[5] Substance Abuse and Mental Health Services Administration (SAMHSA), Office of Applied Studies. (2008). The NSDUH report: Major depressive episodes among youths aged 12 to 17 in the United States: 2004 to 2006. Rockville, MD.

[6] Kapphahn, C.; Morreale, M.; Rickert, V.; Walker, L. 2006. Financing Mental Health Services for Adolescents: A Position Paper of the Society for Adolescent Medicine. Journal of Adolescent Health 39: 456-458.

[7] Kessler, R. C.; Berglund, P.; Demler, O.; Jin, R.; Walters, E. E. 2005. Life-time Prevalence and Age-of-onset Distribution of DSM-IV Disorders in the National Co-morbidity Survey Replication. Archives of General Psychiatry 62: 593-602.

[8] Wang PS, Berglund P, Olfson M, et al. Failure and delay in initial treatment contact after first onset of mental disorders in the National Comorbidity Survey Replication. Arch Gen Psychiatry 2005;62:603.

9 Blue Cross Foundation of Massachusetts,,Accessing Ch ild ren's Mental Health Services in Massachusetts: Workforce Capacity Assessment 10.29.2009.

serves as a safe place where students can check in as needed during the day, receive tutoring, and get counseling and academic support. The program psychiatrist and care coordinators work together to create a plan that is tailored to their changing status. During the first weeks, students spend more of their time in the home-base classroom; as their condition improves, class attendance gradually increases to 100%. This slow steady transition helps insure success; over 95% of BRYT students graduate with their class to the next grade, graduate high school, and pursue higher learning or vocational training.

An initial program evaluation demonstrated that BRYT helps students and families access and use care, adhere to treatment plans, avoid relapse and re-hospitalization, and stay and succeed in school.[10] The program reduces the personal and family burden of serious emotional disorders and offers significant cost savings to both the health care and educational systems by reducing re-admissions and out of school placements – estimated to be between 4-5/year (BRYT costs approximately $2,500 per student per year compared to out of school placements cost of $50,000, so estimated savings are $150-200,000 annually per high school). Since inception, 600 Brookline students have received services from BRYT over ten years.

Program Replication and Sustenance

Since 2005, Brookline Community Mental Health Center has provided leadership and technical support to other communities seeking to replicate the BRYT program model, including technical assistance, a monthly group consultation, and an annual conference. These activities have borne fruit: at present, seventeen communities in Massachusetts[11] are replicating the BRYT program model in their high schools. These communities represent broad socio-economic and ethnic diversity and are located in both urban and suburban communities. Given that the entire school committee benefits from the program, BRYT now impacts more than 28,000 students and their families each year. To date, more than 1,500 teens and their families have been directly served by the BRYT program, with the 95% graduation rate holding. Five communities[12] (representing an additional 6,000 students) are actively planning to launch BRYT programs in the next academic year; and nine more are in the initial planning phase.

Replication of the BRYT program to date demonstrates the long-term viability of the model. Among schools that have developed BRYT programs, some started with grant funding and others with “soft” money. In all cases, the schools have decided to allocate funds for the program and make it a regular part of the school district’s operating budget. This has occurred even during the recession when other school programs were being defunded, and is a testament to the need for and the dramatic impact of the program.

BCMHC staff have presented the program model to national meetings of mental health professionals and policymakers [13],[14] and have fielded inquiries from school staff in several states and Canada. BRYT has attracted local and regional media coverage (refs).

National Replication:

Based on this success, in 2013 BRYT was awarded a substantial grant from the Robert Wood Johnson Foundation to create a growth plan for national replication of the BRYT model. This project is underway, with completion scheduled for December 2014. Site selection will begin soon thereafter with program start-up in other regions of the country occurring during the 2015-16 school year.

Innovativeness:

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10 White H, Langman N, Henderson S. **A school-based transition program for high-risk adolescents**. Psychiatr Serv. 2006;57(8):1211

[11] Acton- Boxboro, Amherst, Arlington, Billerica, Blackstone Valley Tech, Boston Latin, Brookline, Concord-Carlisle, Hingham, Lexington, Natick, Needham, Sharon, Wayland, Wellesley, Weston, Winchester.

[12] Andover, Bedford, Lincoln-Sudbury, Wrentham, Westford,

[13] Institute on Psychiatric Services, American Psychiatric Association 10/2006,

[14] American Psychological Association Annual Meeting, 8/2007

The BRYT program model is innovative ---to the best of our knowledge, there are no similar program currently in operation in the U.S. BRYT has been recognized by the DHHS Agency for Health Quality Research—it is listed in the Innovation Exchange, a registry of promising practices in health care.[15] Another recent comprehensive literature review of school-based programs indicates that the BRYT program is unique based on its focus on integrating adolescents with serious emotional disorders into the mainstream of school social and academic life[16], [17]. Recent conversations with staff of the University of Maryland Center for School Mental Health and the UCLA School Mental Health Project[18] confirm that the program is at the leading edge of school mental health programming.

Project Evaluation

Since inception, evaluation has been an integral and critical to the BRYT program design. In 2013, a formal, large scale, two year (2013-2015) evaluation study of the BRYT program was launched. With research consultation on study design, implementation, and data analysis by the Center for Health and Healthcare in Schools at George Washington University, BCMHC has carried out the evaluation. Using a quasi-experimental design, this study compares outcomes of students in seven high schools with BRYT transition programs with that of outcomes of students in four high schools that provide "usual care" (i.e. no transition program). Through the study, a formal evidence base will be established for this intervention and learn more about the social, academic, and health outcomes of adolescents with the most serious emotional disorders. In Year 1, we have collected data on a total of 430 students, including students' demographic and clinical status, service utilization, school attendance and academic performance. A variety of standardized measures (including CAFAS, CES-DC, YSS-F, and Pediatric Quality of Life) are used to determine program impact on student and family functioning, clinical outcomes, and program satisfaction. Initial data from year 1, shows a large impact on student functioning: average CAFAS score improved significantly; relapse rates were less than 10%, and 90% of students were able to graduate on schedule with their peers.

As part of the evaluation, we developed a scalable, secure web-based Electronic Medical Record that facilitates program management, data collection and analysis from remote sites. This has become an important quality management and utilization review tool that will extend beyond the life of the evaluation for all BRYT programs.

Program Funding Sources:

Funding sources supporting Brookline BRYT: Town of Brookline - $100,000; Brookline Community Foundation - $9,000; Brooklince Community Mental Health Center individual philanthropy - $20,000.
Other School-based BRYT programs: Local town/school budgets – 100%.
For initial launch year of a BRYT program, 2 school received $10-15,000 from local community foundations (Metro West Foundation).

The evaluation study and national replication efforts have been funded by:

- Klarman Family Foundation (currently at $125,000/year)
- Covidien Corporation ($25,000);
- Bennett Family Foundation ($20,000);
- Robert Wood Johnson Foundation ($625,000).

[15] http://www.innovations.ahrq.gov/content.aspx?id=2218ref
[16] Hoagwood, K. E., Olin, S. S., Kerker, B. D., Kratochwill, T. R., Crowe, M., & Saka, N. (2007). Empirically based school interventions targeted at academic and mental health functioning. Journal of Emotional and Behavioral Disorders, 15, 66-92
17 Calear AL, Christensen H., Systematic review of school-based prevention and early intervention programs for depression. J Adolesc. 2010 Jun;33(3):429-38.
[18] Bridgespan Associates, personal communication 4/2014

A School-Based Transition Program for High-Risk Adolescents

For adolescents who weather a mental health emergency or psychiatric hospitalization, the transition back to school and community can be an overwhelming challenge. Often discharged from brief hospital stays before symptoms have remitted, teens return to the community at high risk of relapse. Lack of intensive aftercare resources and a fragmented service system compound the difficulty of resuming academic work and reintegrating into the social milieu.

In Brookline, Massachusetts, an urban community with great economic and cultural diversity, school staff, a local community mental health center, and family members worked together to develop a novel approach for students reentering school. They believed that a timely intervention after psychiatric hospitalization, substance abuse treatment, a serious medical event, or incarceration might improve reintegration and prevent relapse, academic failure, and derailment of socioemotional development. About 120 (6 percent) of the school's 1,900 students were thought to be in need of such services.

The program provides intensive school-based support and care coordination during the first six to ten weeks after discharge. Staff consists of two master's-level social workers—called clinician coordinators—and a classroom aide. The program is located in a dedicated classroom, the "home base." Each clinician coordinator focuses on six to eight students at any given time and has the flexibility to provide the time-consuming set of services needed by students and their families. Services can include assessment, counseling, family support, case management, care coordination, and educational planning. Students are referred to the program by school guidance counselors or other staff; involvement is entirely voluntary.

Before reentry, the clinical coordinator meets with students and their families at school, their home, the hospital, or another community setting. Working with students, parents, mental health providers, teachers, and administrators, the coordinator helps parties reach consensus on short-term goals and plans, which can include schedule changes, referral to mental health or medical services, educational assessment, and tutoring.

Once the student has returned to the classroom, the clinical coordinator provides ongoing assessment and emotional support for students and families while facilitating communication between school personnel, mental health and substance abuse treatment providers, pediatricians, court personnel, and staff from other agencies. The full-time classroom aide helps students organize and complete assignments and keeps teachers informed about students' current status and capabilities. The home-base classroom offers a safe and manageable respite between classes and a quiet work environment and often serves as a first step toward reintegration. In addition to working with families individually, the program sponsors a parent support and psychoeducation group.

From the inception of the program in October 2003 through November 2005, a total of 99 adolescents were served. Most students had multiple diagnoses; the most frequent were mood disorders and substance abuse. Twenty-one students had special-education status. Length of involvement ranged from two to 20 weeks (median of eight weeks), during which, on average, students required 21 hours of care coordination and seven hours of family support.

Three months after joining the program, 88 students had remained successfully in the community for the entire period; 11 required rehospitalization. Follow-up information on educational status at three months was available for 67 of the students, all of whom had resumed studies. Of these, 59 students (88 percent) were attending school regularly and eight (12 percent) were receiving home tutoring. Students' functioning status improved significantly during their tenure in the program, as measured by the total score on the Child and Adolescent Functional Assessment Scale (CAFAS). The total CAFAS score decreased from a mean of 89 at admission to 64 at three-month follow-up ($t=6.00$, $df=44$, $p<.01$; range of possible total CAFAS scores: 0 to 240). Parents reported that having a single, reliable, and accountable point of contact, consistent communication, and assistance in negotiating complex systems of care resulted in substantial lessening of stress and improved their relationships with the school and the agencies involved. Direct program costs are estimated to be $1,400 per student, a modest amount compared with the expense of hospital care or out-of-school special education placements.

This innovative and replicable school-based program lies in the continuum of care between hospital and outpatient services. It is an effective mechanism to prevent relapse and hasten reintegration of students into their community and resumption of academic work. Because the program is fully integrated into the school environment, access is easy, acceptance of services by students and families is enhanced, and staff members are available immediately to respond to crises and emergencies. Individualized, flexible plans emphasize coordination and collaborative use of resources.

Our documented success in helping a population of students with great ethnic and clinical diversity suggests that this program design may be applicable to a broad range of schools and communities that are faced with the daunting task of reintegrating and caring for youths with very serious emotional disorders.

Henry White, M.D.
Nancy Langman, M.S., M.P.H.
Sarah Henderson, L.I.C.S.W.

Dr. White is program director of the Brookline High Risk Youth Taskforce (BHRYT) and clinical director of the Brookline Community Mental Health Center, 43 Garrison Road, Brookline, MA 02445 (e-mail: henrywhite@brooklinecenter.org). Ms. Langman, who is the BHRYT evaluation consultant, is chief executive officer of the Lee Mental Health Center, Fort Myers, Florida. Ms. Henderson is BHRYT program coordinator.

JOANNA WEISS

A bright spot for teens

EVEN IF you're one of the lucky, healthy kids, high school is hard: it's a fishbowl, filled with academic pressures and social pressures and hormones.

If you're a kid who struggles with mental illness, high school can be intolerable.

This is one of the lessons from the case of Phoebe Prince, the South Hadley High student whose tormentors took plea deals last week. As the bullies' case trudged through the courts and the media, one galling defense kept coming up: that Phoebe had a history of mental health problems, long before she hanged herself in the winter of 2010.

How Phoebe's illness could somehow have exonerated mean kids, or let adults off the hook for tolerating meanness, is a mystery. Phoebe was precisely the kind of person her school should have tagged as vulnerable, monitored closely, and taken extra pains to protect.

And what if that had happened — if South Hadley High had been a place where Phoebe went when she *wanted* to feel safe? There's a model for this sort of safety zone, and it has existed since 2003 at Brookline High School.

The program is called BRYT (pronounced "Bright"), and it stands for "Brookline Resilient Youth Team." It's a joint venture between the high school and the Brookline Community Mental Health Center, a room off the school lobby, staffed full-time by social workers. Pre-approved kids can go to that room whenever they need, no questions asked — to escape from daily pressures, confide in adults, manage schoolwork without having to go to class.

And while the program is clearly useful for bullying victims, it serves a larger population, too. Over the course of their high school careers, a whopping 10 percent of kids face emotional problems that are serious enough to keep them from functioning, says Dr. Henry White, the BRYT director.

Some of those kids are skilled at hiding their pain — until, for some reason, they can't. Last week, I spoke to Alice, a charming, chatty senior who has suffered from depression and anxiety since third grade. She was always a conscientious student, nonetheless. Most of her friends have no idea what she's been through. "I do an excellent job of looking extremely happy," she told me.

So when depression hit her like an anvil at the start of senior year — compounded by the stress of college applications, shifting friendships, and an illness in the family — she couldn't muster the energy to mask

> Program in the high school offers a safety zone for students with mental illness.

her sadness. Some mornings, she couldn't get out of bed.

That's when her mother signed her up for BRYT. Sometimes, Alice would spend entire days there, doing schoolwork at her own pace. Some days, she'd make it to a single class. The social workers listened, offered advice, worked with her teachers to modify assignments. If she'd had a rough morning, her mother could call and ask the adults to check in with her. One morning, when Alice felt too weak to travel into school, social worker Annie Eagle went to her house to pick her up.

As many kids do when they get the right support, Alice made it through the roughest patch. She emerged a confident 17-year-old who is headed to college next year, armed with uncommon self-knowledge. When she chose a college, she made sure to pick a place where mental health services are readily available, just in case.

BRYT isn't just for students with mental health issues; it also serves students with physical injuries or illnesses that keep them out of class for awhile. But for kids with depression or bipolar disorder, BRYT represents a special gift: proof that their school hasn't abandoned them at precisely the time when they need support the most.

Of course, there's a cost: BRYT costs $150,000 a year to run, a bargain when you consider that the students might otherwise be in special ed classes or private, off-site programs on the school system's dime. Red Sox manager Terry Francona is helping with a fundraiser.

And word about BRYT has steadily been spreading. There are now similar programs in Lexington, Natick, Needham, Sharon, Wellesley, and Wayland. Oklahoma City has inquired. So has a suburb of Cleveland.

Note to South Hadley High: They're ready to take your call.

Joanna Weiss can be reached at jweiss@globe.com

The Boston Globe

Welcoming back troubled students

Program eases transition after care for depression

By Linda K. Wertheimer, Staff Writer | March 23, 2009

BROOKLINE - Hannah Cummins rarely smiled during her freshman year at Brookline High School. She skipped classes, except for photography, where she found it soothing to develop pictures in the darkroom. There were days when she stayed in bed, afraid to face teachers she feared would be disappointed by her academic slide.

She seemed wrapped in sadness. "I was so hopeless," she said. "My self-esteem was so low."

Cummins disappeared from her school's radar, or so she thought, as she spent four months being treated for depression, first at Somerville Hospital, then at McLean Hospital.

But as her return to Brookline High neared two years ago, two Brookline social workers appeared in her hospital room and told her they would be there to help as part of the Brookline Resilient Youth Team. Created in 2004 as a partnership between the school and the town's mental health center, the program has worked with more than 200 teens after they were hospitalized for depression or other long-term medical issues. The social workers and a classroom aide help the students to make the transition, slowly, gingerly, back into the mainstream.

In a private room tucked in a corner near the school's main entrance, Cummins spent the last months of her freshman year making up missed work, receiving emotional support from the social workers, and meeting other teens with stories similar to hers.

At Brookline High, she found a sanctuary.

Now a junior receiving straight A's, the 17-year-old promotes her school's program as a solution for other teens. Cummins, as well as staff from the Brookline program and a similar effort in Wellesley, recently be seeched lawmakers to spread the effort to every large high school in the state. The program's creators view their efforts as saving lives; some students segue into the programs after hospitalization for suicide attempts or suicidal thoughts. Needham High also has a similar program, and Wayland High plans to start one this fall.

A pending budget amendment before the state Legislature would give $75,000 grants to help continue programs and start them at other high schools, said state Representative Ellen Story, Democrat of Amherst. But Story, who plans to keep championing the proposal, said budget constraints would make it difficult to pass the amendment this year.

Cummins, who testified at a recent state hearing, is a strong example of the need for more in-school services, Story said.

"Hannah has incredible prospects, and for a while, she needed a little extra help," she said. "If she hadn't gotten to that, the ending to her story or the next chapter in her story might have been very different."

When Cummins returned to Brookline High in March of her freshman year, the social workers tracked her progress for four to eight weeks. They posted her schedule on a bulletin board, acted as go-betweens with teachers to arrange make-up work and exams, and provided a sympathetic ear when being in the mainstream became too tough. And, they kept the door open for Cummins after her initial monitoring period ended.

"On my first day back at Brookline High, I was completely overwhelmed," Cummins recalled of the reentry to the

1,900-student school. "Because of my depression, I was on the verge of giving up my standard for being a good student."

Cummins, whose parents divorced when she was 11, first was diagnosed with depression in eighth grade and was hospitalized for two weeks. Her depression, she was told, stemmed from a chemical imbalance and problems at home. At the time, she lived with her father, while her younger sister lived with their mother.

During her hospitals stays her freshman year, counselors at McLean and Somerville hospitals taught her ways to cope when she began feeling emotionally overwhelmed. At Brookline High, like when they were in the hospital, Cummins and other teens can listen to music, sip tea, eat candy, or play board games during free periods in the Brookline Youth Resilient Team room. "I will not wait for a great day. I will make one," says one of several sayings posted in the room.

On a recent weekday morning, as she does almost every school day during her free period, Cummins, a wisp of a teen with straight, black hair, slipped quietly into the room and sat on the flowered couch in the back. She began reading a collection of short stories as another student worked on homework with the classroom aide.

Depression, she said, is something she still confronts. In the summer before her sophomore year, her father died, intensifying her depression to the point that she did not feel she could handle returning to the main campus. She spent the school year in an off-campus therapeutic program in Chestnut Hill.

Junior year, she returned to Brookline High, and once again, the team room provided a haven. She is comfortable confiding in the social workers, although not her teachers, most of whom know little about her past, she said. Brookline teachers, however, said they welcome the program's assistance.

"Two kids like this, even one, is overwhelming for the teacher. We don't know what our students are dealing with," said Jennifer Martin, a social studies teacher.

Cummins has let some of her photography work reveal a bit about her. Standing near a display of student photos in the high school's arts building, she pointed out a picture of her 12-year-old sister, Nina, walking alone on a beach in Ireland, where the sisters' father was born. The photo was taken last summer, around the first anniversary of their father's death.

"It's very solitary," Cummins said of the photo's scene. "It was so beautiful to me."

Many of her photos, she said, show a sadness she still feels.

"I feel outside of high school," she said.

Teachers, though, see a much happier teen, one who smiles at them now in the halls, said Katherine Houle, one of the social workers who visited Cummins in the hospital during her freshman year.

"Hannah walks with such confidence now. She looks like she has peace," Houle said.

Cummins's mother, an epidemiologist at Children's Hospital, said she and her daughter are still unraveling what happened to the teen in the past several years. But they also are looking ahead.

"It's like she's 180 degrees from where she was as a freshman," Patrice Melvin, her mother, said. "She was very emotionally fragile. She couldn't write. Now, she's just excelling."

Cummins speaks with hope about plans for a future that include college and maybe a major in social work."I'm at a different place now than I was two years ago," she said. "I'm able to see how far I've come." *Linda K. Wertheimer can be reached at wertheimer@globe.com.* ■

PA-1 Part 1. 2014 PSAA Online Application Form

Applying Program Name
Children's Community Pediatrics Behavioral Health Services in the Pediatric Medical Home

Program became fully operational 01 2008

Program Address
4401 Penn Avenue PA PA 15224 USA

Program Director Abigail Schlesinger (schlesingerab@upmc.edu)

Facility Address
11 licensed behavioral health therapists embedded in 16 pediatric practices work with 5 child psychiatrists and over 180 pediatricians providing integrated care for 188,800 children in Pennsylvania

11279 Perry Highway Suite 204 Wexford PA 15090 USA

Director
Kathy Guatteri(Kathy.Guatteri@chp.edu) Early Access to Behavioral Health Treatment in the Pediatric Medical Home

Contact for Applying Program
Abigail B Schlesinger, MD

Contact Address
211 Deer Run Dr Butler PA 16001 United States

Description of Facility (type, size, catchment area served, etc.)
Children's Community Pediatrics Behavioral Health Services(CCPBHS) has 11 licensed master's and doctoral level multi-disciplinary therapists embedded in 16 practices and providing integrated physical/behavioral healthcare to the children and families of more than 150 pediatricians(188,800 children and families in Pennsylvania). The therapists operate under the supervision of five child and adolescent psychiatrists(2.0 FTES) who themselves see patients in the primary care locations. Four regional access hubs provide service to children affiliated with 18 additional primary care practices. Over 10,370 behavioral health visits were provided by our therapists and psychiatrists in 2013. CCPBHS is a collaborative effort of multiple clinical, administrative, and community stakeholders and was designed by an empowered leadership team capable of integrating care processes in the medical home, and implementing ongoing improvement activities. The mission statement of CCPHBS: "to create a financially sustainable, integrated behavioral health service in the pediatric medical home that focuses on providing early access to empirically supported nonpharmacologic interventions (therapy), while simultaneously providing access to pharmacologic interventions" has been met. CCPBHS identifies children at a younger age than a local behavioral health service that is not integrated in pediatric primary care. In addition, children referred to more specialized behavioral health services in the same non-integrated behavioral health setting are younger if they come from CCPBHS than from other referral sources. This service is not meant to replace specialized behavioral health services in the community, but to augment and unburden those services, by identifying the needs of youth and families in their medical home, providing treatment for the youth who can respond to lower level interventions, providing access to appropriate

pharmacologic interventions, and providing successful hand-offs to higher levels of behavioral health care. Early intervention provided by an integrated behavioral/physical health system in the pediatric medical home can alter the trajectory of behavioral health problems, in order to prevent lifelong problems for children and families in any area of the state or country.

Brief Statement of Program to be considered for award(100 words or fewer)
Children's Community Pediatrics Behavioral Health Services is a collaborative effort of three health systems designed to provide timely access to behavioral health services in the pediatric medical home. Pediatricians, therapists, and child psychiatrists provide evaluations, treatment, and referral for youth and families. A leadership team with the power to break down traditional barriers between physical and behavioral health created this high quality integrated behavioral health system in the pediatric medical home that focuses on non-pharmacologic interventions(therapy), and provides access to evidence-based pharmacologic interventions. The primary focus of this program continues to be providing early access to appropriate behavioral health interventions.

Select Award APA_PSYCHSERVICES_v12.docx

Select Award_Other carepathways.pdf

Select Award_Other APPENDIX2.doc

Select Award_Other Appendix 3.docx

Select Award CCPBHS_FINAL.docx

Early Access to Behavioral Health Treatment in the Pediatric Medical Home

The Children's Community Pediatrics Behavioral Health Services(CCPBHS) is a collaborative effort of multiple clinical, administrative, and community stakeholders designed to provide early access to empirically supported interventions for children with behavioral concerns in the pediatric medical home. CCPBHS has 12 licensed master's and doctoral level multi-disciplinary therapists embedded in 13 pediatric primary care practices and providing integrated care in over 10,370 behavioral health visits in 2013. The behavioral health clinicians operate under the supervision of five child and adolescent psychiatrists(2.0 FTES) who themselves see patients in the primary care locations. A child and adolescent psychiatrist(CAP) medical director provides leadership, education, and clinical services. The service provides behavioral/physical health integrated services access to more than 188,800 children and families in Western Pennsylvania. Children who receive care at the additional 18 primary care practices can go to a regional access hub. No federal or local grant money has been provided to create or sustain the service, as the initial start-up costs were supported by the Children's Hospital of Pittsburgh, and at this point CCPBHS is supported entirely by third party billing and the infrastructure of the pediatric practices.

CCPBHS serves as a model for an integrated physical/behavioral health system in the pediatric medical home. The ultimate goal is to provide earlier access to quality evidence-based behavioral health interventions for youth. In order to achieve this goal we a) Identified an empowered leadership team; b) Integrated care processes in the medical home; and c) Implemented ongoing improvement activities.

a) Identify Empowered Leadership team: An empowered leadership team consisted of administrative, clinical, and family leaders and champions from the mental health and primary care system. This team had membership and commitment from the different systems represented in the service. The leadership team was aware that system change was necessary in order to both integrate the behavioral health services within the medical home and to provide linkage to specialized services. All members of the team had ownership for the success of the initiative and were responsible for identifying and eliminating barriers to integration. It was critical for physician leadership to lead the charge and for administrative leadership to embrace and overcome the myriad of institutional, regulatory, payment and operational challenges that a project of this scope entailed. This team has met quarterly since 2007, with subgroup meetings held more frequently to address operations, clinical issues, ongoing improvement performance measurement and quality improvement. The presence of high level administrative and clinical leadership created a committee with the power to reach beyond the traditional administrative, cultural and clinical boundaries between the primary and behavioral health care.

The leadership team drew upon the experience of local pilot projects, pediatrician & family focus groups and national data to propose a clear mission statement: "create a financially sustainable, integrated behavioral health service in the pediatric medical home that focuses on providing early access to empirically supported nonpharmacologic interventions (therapy), while simultaneously providing access to pharmacologic interventions." At the onset of planning, utilization of psychosocial therapy in tandem with evidence based pharmacotherapy had been decreasing in the pediatric population.(1) This trend continued despite evidence that psychosocial therapy could be effective for many common behavioral health problems in youth, and that combined medication and therapy could be most effective for moderate to severe depression, a disabling and prevalent condition that often begins in childhood.(2) Our pediatricians wanted to help provide integrated treatment for depression, especially when the rate of national youth suicides increased while the utilization of antidepressants decreased, and when growing evidence from the literature suggested that the risk-benefit ratio for antidepressants was favorable.(3) And yet, in the face of this evidence, pediatric primary care physicians in our region felt that they could not provide the adequate evaluation and treatment of

many of these conditions without the support of a behavioral health provider and the back-up of a pediatric psychiatrist.

The success of the leadership team can be measured not only it's longevity, but in its capacity to eliminate barriers and facilitate system change. The team worked together to overcome the administrative, legal, and procedural barriers to integrating the medical and behavioral health record, a key element of the project's success. It also continues to work to link this service system with more specialized behavioral health services in order to assure a warm-handoff into the formal mental health system. The psychiatric medical director from the mental health system and pediatric medical director from the primary care system, a clinical supervisor, and a clinical administrator have work hand-in hand in the formulation and implementation of the project.

b) Integrate Care Processes in the Medical Home: This newly designed behavioral health service in the medical home was designed to integrate behavioral health care and primary medical care, in order to facilitate the early identification and treatment of youth and families within the medical home. Simple co-location of services - although laudable in its own right- was not seen as enough to truly improve early access to services. A culture change was needed, and to that end integration was endemic and contagious in the planning and implementation of these services, and can be understood in terms of the integrated clinical, administrative and leadership processes that resulted.

- Clinical Care integration – The CAP medical director identified care pathways for the treatment and referral of children and adolescents with common presenting concerns.(Appendix #1) This required agreement on the conditions that should be targeted for treatment in primary care and those that should be referred to a more specialized level of care. The larger primary care and specialty group was educated about these care pathways. Pediatric primary care providers were encouraged to refer patients directly to more specialized services, if the needed service was clear, and to refer to the collaborating therapist (a) for treatment of targeted conditions OR (b)if there was uncertainty regarding diagnostics and/or treatment need. In order to provide transparency, clinical pathways and automated processes for referral, either to our CAPs or to a higher level of care, are in a shared medical record, breaking down one of the largest barriers for families and providers for coordinated care.
- Administrative support integration is a vital component of success for the project. The administrative functions necessary to support the clinical team are integrated at the practice level. The therapists and psychiatrists are seen as vital members of the team within the office. Appointments are made, and patients arrive utilizing the same mechanisms as an appointment for primary care. Administrative staff is educated about behavioral health managed care organizations and the specific insurance for which each provider is credentialed.

c) Implement ongoing improvement activities: In this model, therapists are a key link between the pediatrician, family and CAP. Although CAPs are available for supervision and consultation, it is the therapists' responsibility to refer to the psychiatrist via defined clinical pathways. Therapists that understand the medical culture and can help pediatricians move forward in the identification and treatment of common and impairing behavioral health concerns. Therefore training and supervision of the therapists is paramount. The behavioral health therapists and psychiatrists have regular administrative and clinical review meetings, and meet regularly to discuss the status of their practices and areas for improvements.

Supervision and initial education of all integrated providers, as well as opportunities for pediatricians and therapists to identify needs for improvement is an integral component of the integrated behavioral health program. The Pediatric Symptom Checklist(PSC 17), Screen for Children and Adolescent Anxiety Disorders(SCARED-5) and Adolescent Version of the Patient Health

Questionnaire(PHQ9A) are an integrated part of the record. Primary Care Physicians became interested in identifying and treating depression and anxiety in conjunction with treatment by therapist and with support from the child and adolescent psychiatrist. As the program matured, the pediatric group requested increased education about the appropriate interventions that they could provide for common behavioral health concerns-such as the internalizing disorders (i.e., depressive and anxiety disorders.) A four part pediatrician evening educational series occurred in the spring of 2011, which addressed identification, nonpharmacologic intervention, pharmacologic intervention, and medico-legal considerations in the treatment of internalizing disorders in primary care. The series was attended by >50% of the providers throughout the network, and >75% of those attending stated that they would be more likely to provide an empirically based intervention for depression or anxiety in their office within the next year. A follow-up chart review noted that there was a 50% increase in the use of SSRIs for internalizing disorders within the network.**Active physician participants in the integrated behavioral health program have improved their knowledge and utilization of evidence-based interventions**.

The capacity of the overall service to sustain and thrive is also dependent on ongoing investment from the practice-level administrators and clinicians. Each practice identifies a physician and administrative lead to help facilitate the integration of the project at the practice level. This, along with the pediatrician medical director, psychiatrist medical director, administrative director, and therapist lead participate in phone consultations that occur at least 6 times a year in order to review processes, identify educational needs, and provide a forum for feedback. Several training sessions were held at the beginning of the project in order to generally educate the administrative and physician staff regarding the model and how to utilize it.

OUTCOMES

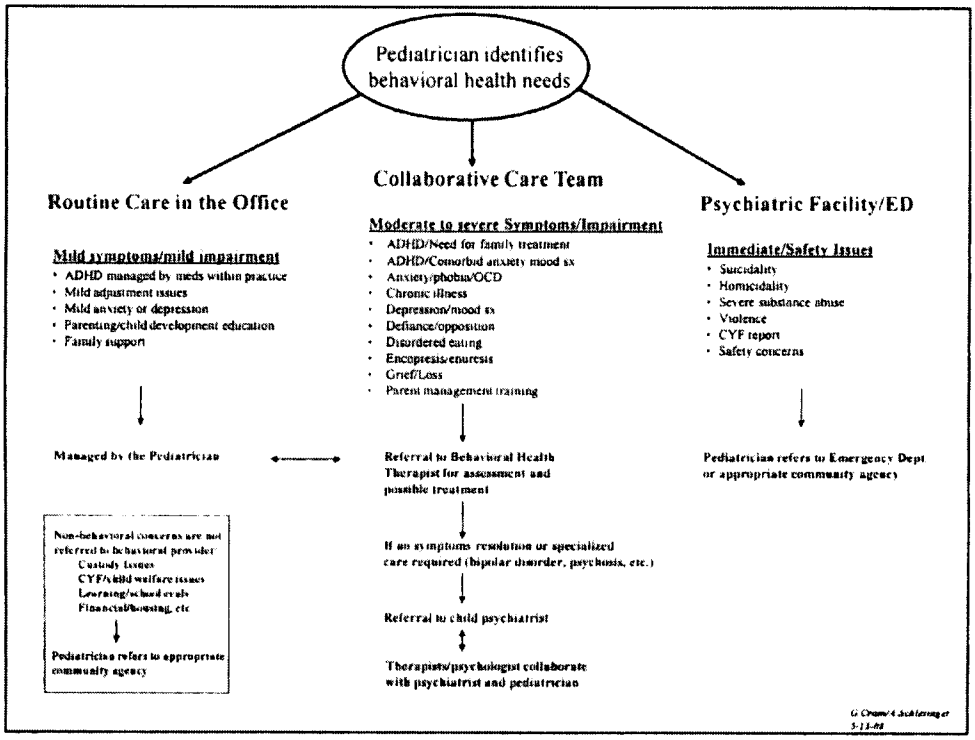
From the inception of the project we believed that truly integrated processes within the medical home would reduce stigma, increase patient and family engagement in services, and improve access to empirically supported interventions. The integrated service completed more than 10,370 behavioral health visits in 2013. Show rates for behavioral health visits at integrated sites are above 90% compared to national norms of 48%-62% for stand-alone community-based behavioral health clinics.(4) The average age of children seen by the integrated BH program is 10(Appendix 2 -Graph 1), this is lower than the average age of youth referred directly to the to a local behavioral health system (Appendix 2 – Graph 2). The integrated BH program has a prepubertal peak in care provided (Appendix 2 – Graph 1). This is consistent with literature that many common and potentially disabling childhood and adolescent behavioral health problems have their initial presentations prior to puberty. (5) Patients referred from the Integrated Program to a large local specialized behavioral health care center have a prepubertal peak in referral to specialized care, which is not reflected by the patients referred directly to specialized care. (Appendix 2 Graph 2). **All of this evidence converges to suggest that the integrated behavioral health program is identifying youth earlier than those youth that are referred directly to specialty mental health programs.** There is also an impact on medical utilization--in the year following engagement with the service a child is significantly less likely to have acute care visits to the pediatrician, while continuing to attend their well-child visits. **Thus the integration effort has increased and simplified access for families, as well as the breadth and quality of the care provided directly by pediatricians.**

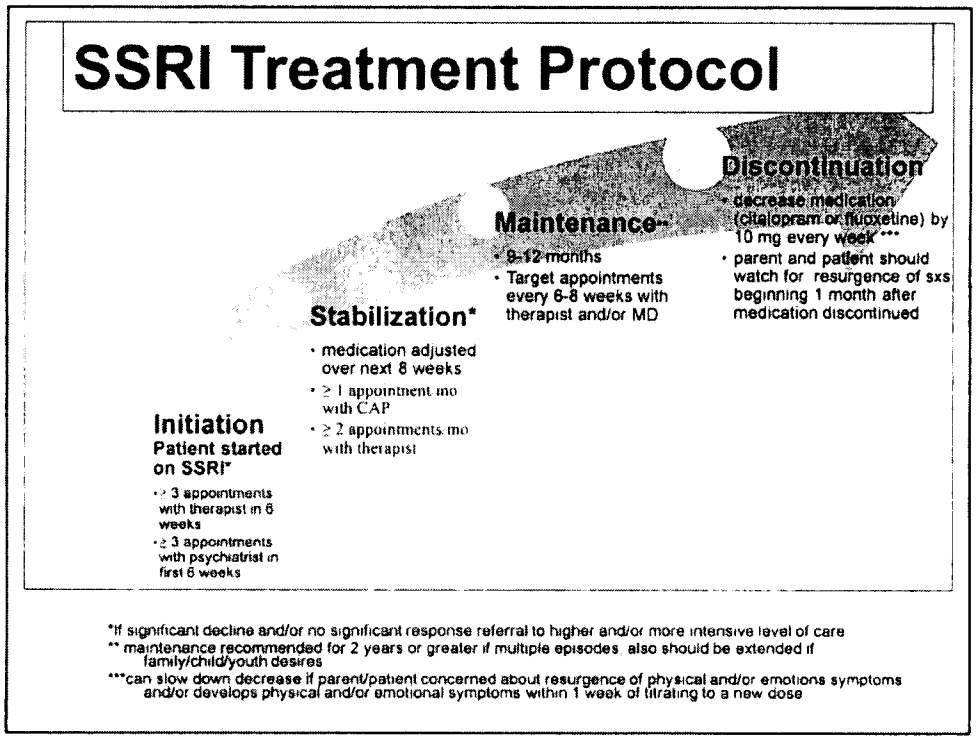
The cost effectiveness of integrated services is striking: the average number of ambulatory treatment visits billed at an affiliated specialized behavioral health provider was 12.5 per pediatric patient in 2011 compared to an average of 3 visits per behavioral health patient in the integrated setting. In addition, the average cost per visit was significantly lower in the medical home. Payers save money by diversion from specialty mental health care to services received in an integrated setting.

The CCP Behavioral Health Service has been so effective that in 2012 the Children's Hospital of Pittsburgh embarked on an ambitious strategy to extend the model from primary care clinics to the specialty clinics within the hospital. CCPBHS has received the Bronze Award for Transitions in Care from the Jewish Healthcare Foundation/Fine foundation, and both the patient care and innovations award from the Hospital Association of Pennsylvania. Data from the CCPBHS has been accepted for presentation at the 2012 National Behavioral Health & Addiction Conference and the 2012 American Academy of Child and Adolescent Psychiatry Conference. Our medical director has presented at the Michigan Primary Care Association's annual integration conference and has provided consultation to several other new integration programs across the nation.

The success of this project can also be measured in the increased ability of the pediatric behavioral health network to implement systematized screening programs for behavioral health and developmental disorders. Since the implementation of the integrated program there has been three successful screening efforts implemented network-wide including screening for autism in young children, depression in teenage girls, and postpartum depression in mothers within the first two months of delivery. Specifically, for the depression screening, a chart review revealed that >90% of target population were being screened with the PHQ-9. Plans to expand the screening effort are in process. This integrated behavioral health program in the pediatric medical home, with a focus on early access to empirically based interventions can be replicated by a) empowering a local leadership team with the capacity to identify and eliminate system barriers, b) implementing integrated care processes within the medical home, and the c) providing ongoing improvement activities. The patient care pathways presented in the attached appendix, as well as other training materials which could not be provided in this application, are transportable to other systems. This integrated program is not meant to replace specialized services in the community, but to augment those services, meet the needs of youth and families who can respond to lower intensity interventions, provide access to appropriate pharmacologic interventions and unburden the specialized mental health care system. Early intervention provided by an integrated behavioral/physical health system in the pediatric medical home can alter the trajectory of the behavioral health problems, in order to prevent lifelong problems for children and families in any area of the state or country.

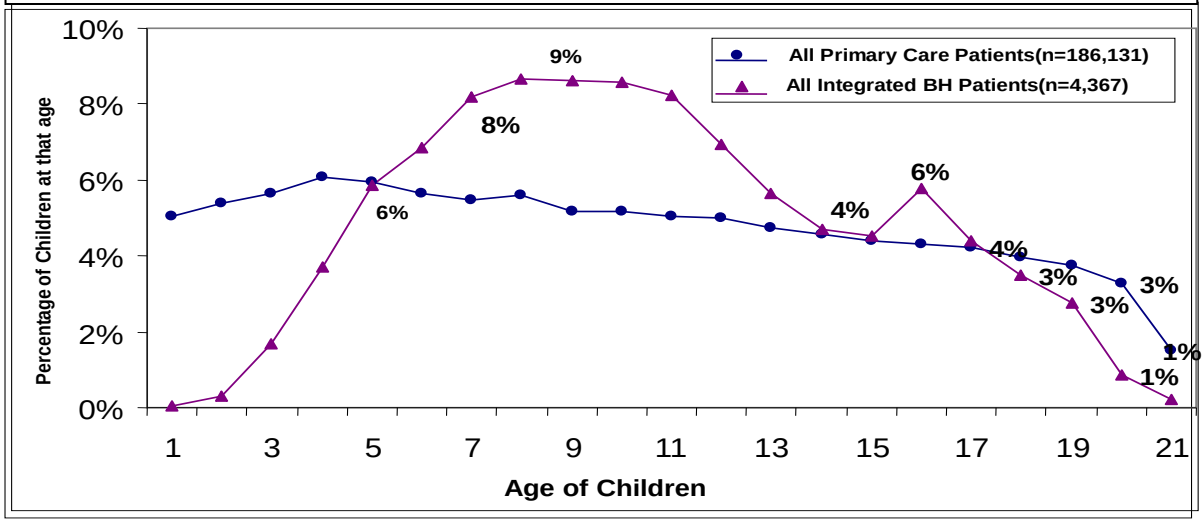
APPENDIX #1 – SAMPLE OF CLINICAL PATHWAYS





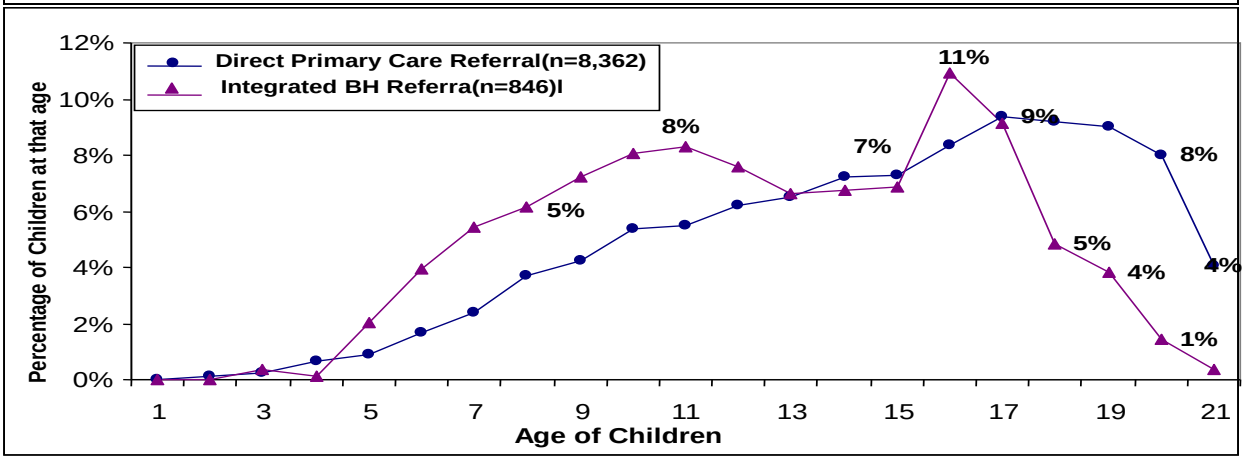
APPENDIX #2 – EVIDENCE FOR EARLY IDENTIFICATION OF BEHAVIORAL HEALTH PROBLEMS

Graph #1- Distribution of All Patients seen by Primary Care Providers and Integrated Behavioral Health Program



	All Primary Care	Integrated BH
Median Age	9	10
Std Deviation	5.8	4.3

Graph #2 – Distribution of Primary Care Patients seen in Segregated Service: A Comparison of Referral Source



	Direct PC Referral	Integrated BH Referral
Median Age	15	13
Std Deviation	4.2	4

Appendix 3 – References

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TX-1 Part 1. 2014 PSAA Online Application Form

Applying Program Name LifeWorks Shared Psychiatric Services (SPS)

Program became fully operational 01 2011

Program Address

835 N. Pleasant Valley Rd. Austin TX 78702 USA Program Director Julie Speir, julie.speir@lifeworksaustin.org

Facility Address
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Director
Julie Speir, julie.speir@lifeworksaustin.org Clinical Care Director, Shared Psychiatric Services

Contact for Applying Program
Terry V Arguello, MPH Director of Grants and Contracts

Contact Address
3700 S 1st St Austin TX 78704 United States

Description of Facility (type, size, catchment area served, etc.)
The Sooch Youth and Family Resource Center in East Austin is a five-star energy rated, three story, 31,500 square foot building constructed to meet the needs of clients and staff served by LifeWorks

The Shared Psychiatric Services (SPS) collaboration consists of three agencies, Communities in Schools, SafePlace, and LifeWorks the lead agency. SPS is housed in LifeWorks' recently-constructed Sooch Youth and Family Resource Center in East Austin (East Site). The office is purposefully located in East Austin due to the high concentration of low-income and underserved families. The area has been isolated economically, socially and politically and is known for having higher unemployment rates. Children attending public schools in this part of town are more likely to be economically disadvantaged than students in other Austin areas. The East Site is a five-star energy rated, three story, 31,500 square foot multi-purpose resource center constructed to meet the needs of staff/programs and their clients. Counseling offices, waiting areas, and youth meeting spaces are all designed to provide comfort and empower clients. The resource center is also the home of LifeWorks Intern Training Center for counseling and social work students from local universities. Counseling offices and group meeting spaces are wired with cameras directed toward staff. One group meeting area and one office have two-sided mirrors for observation. Interns also have a computer lab/lounge stocked with seven computers for their use. In addition to Counseling Services, the East Site supports thirteen LifeWorks programs that provide literacy, youth development, teen parent, young father, foster youth, and housing services. It has two co-locating agencies Capital IDEA and Central Texas Literacy Coalition that provide education and workforce training and resources for area literacy providers. Several other agencies such as Goodwill Industries and Foundation Communities use this site to assist clients and neighborhood residents with employment activities, free tax services and enrollment to national health insurance plans. While the Shared Psychiatric Services (SPS) staff members office at the East Site, youth and families are also served at public schools served by Communities in Schools throughout similar communities in Austin, Texas. Staff and contracted psychiatrists visit schools to consult with families and/or work with counselors and teachers. Clients may also be seen at their home, domestic violence shelter

overseen by SafePlace, and any other LifeWorks community-based center or residence in East, North or South Austin.

Brief Statement of Program to be considered for award(100 words or fewer)
SPS is a Clinical Care Model that addresses a lack of timely and sustainable access to psychiatric services by low-income and/or uninsured families. One psychiatrist serves each family member to coordinate and optimize family care. SPS provides psychiatric diagnosis and treatment, care coordination, case management, and transition to a medical home/long-term provider and paying source (insurance, Medicaid). Care is free and resources such as bus passes, reduced-cost prescriptions, and lab work are provided. Families identified as “ready for care” are referred by three school/community-based organizations to make efficient use of services and prevent escalation and costly treatment.

Select Award Part 2 LifeWorks Shared Psychiatric Services May 2014(3).pdf
Select Award_Other 1. LIFEWORKS SPS Ltr psychiatrist.pdf
Select Award_Other 2. LIFEWORKS SPS Letter St Davids Fdtn.pdf
Select Award_Other 3. LIFEWORKS SPS Recent Findings April 2014.pdf
Select Award_Other 4. LIFEWORKS SPS Arts Performance Photos.pdf

A. Verification that the submission is an ongoing program.

Shared Psychiatric Service (SPS) has been in operation since January 1, 2011. Evidence can be found on the LifeWorks website http://www.lifeworksaustin.org/sharedpsychiatric.html.

B. Evidence that SPS has made a significant contribution to the mental health field.

LifeWorks' Shared Psychiatric Services program has engaged hard-to-reach populations, treated the entire family, and achieved consistently positive results for its clients since its inception. In the last quarter alone, SPS served 65 clients, 60% of whom without an identified medical home at program entry were connected to a medical home upon case closure, and 100% of whom reported improvement in their primary presenting issue and its symptoms upon exiting the program (YTD: 240 clients, 48.6% connected to a medical home, 90.5% improvement in primary presenting issue). Despite these positive outcomes, SPS is dedicated to the continual improvement of its services and conducts regular evaluations of the program. As the result of a recent evaluation, SPS implemented programmatic changes aimed at screening for client readiness and expanding third-party billing efforts. Since these adjustments have been in place, significantly fewer clients have reported "no change" in their primary presenting issue upon exiting the program, and significantly more clients have experienced improvement in their GAF scores upon exit. Interestingly, the latter results can be fully explained by clients' length of involvement in the program, suggesting that the program's efforts to improve retention have translated into improved client outcomes.

As LifeWorks' Shared Psychiatric Services continues to make strides toward eliminating barriers to services and reducing clients' no-show rates, at-risk populations in the Austin area have been able to access services that were previously out of their reach.

The program director had the opportunity to share Shared Psychiatric Services' innovative approach to service delivery at the annual conference for the National Council for Behavioral Health, with the goal of inspiring other communities around the nation to adopt similar practices to improve clients' access to mental health services.

C. Evidence that the program provides a model for other mental health programs.

SPS was developed as a pilot or model for community-based psychiatric care for the entire family. The program has the following components that make it an ideal model for replication or training program for future providers.

Family Psychiatric Care – Every family member is eligible to receive care. The program takes the parent's emotional state into account, meeting their personal needs to make sure they can monitor their child's mental health and consistently administer medication.

Community Collaboration – Understands the environments in which children/families interact including: their homes (or shelter residence), extended families, and schools.

Case Management (CM) – Intensive CM is provided to promote comfort and confidence, understand family dynamics, reduce barriers to care, improve access to insurance and medications, and transition effectively to primary care providers or long-term care.

Holistic Care – In addition to psychiatric care, SPS also promotes the use of services available through its partner agencies. For example access to nutrition, exercise (yoga, cross training, dance classes), reference materials, and nutritional supplements. Families are invited to participate in youth development and counseling services including summer camps.

Staff – The program can be modified to fit various settings adding or reducing staff members as they are needed in a particular community or setting. (See G. below for staff roles.)

SPS is replicable – Available materials include collaborative agreements, a welcome letter, a service flow chart, data collection and evaluation procedures and manuals, job descriptions for staff and physicians, reports and policies that would benefit organizations seeking to replicate its efforts.

D. Evidence that the program is innovative.

Child psychiatry research shows that a family-focused approach to psychiatric care may help to improve client outcomes. Because parents/caregivers often feel disrespected by psychiatrists and mental health providers, actively involving parents in the treatment process may improve client retention and heighten the success of treatment (Kerkorian et al. 2006). What's more, ensuring that other family members in need of mental health services receive treatment may also promote positive outcomes for clients, both with respect to their mental health and their broader well-being. For instance, Garber et al. (2011) showed that children's depressive symptoms tend to mirror those of their parents—when parents show improvement in symptoms, children tend to as well. Children of parents whose depression remitted during the course of treatment saw a sharper drop in their own depressive symptoms compared to those whose parents' depression did not improve. These children also showed improvement in terms of academic and behavioral competence. To ensure a meaningful impact, Shared Psychiatric Services focuses on how family functioning can be improved even when it is the child that is presenting with behavioral and psychiatric issues. The comprehensive intake process often reveals underlying family issues including additional mental health concerns.

SPS is innovative because it provides cost-free, seamless psychiatric services for every family member, child and adult, in one collaborative program. Clients are screened and welcomed into the program and provided with intensive case management services. These services are geared toward building a solid relationship with each client and the entire family, even treating adults who have postponed their own care. The program operates a brief, strengths-based, solution-oriented approach and uses well-trained staff who promote a language of hope and positive expectations during intake, assessment, and throughout services. It has also integrated a multi-agency, multi-disciplinary team—comprised of psychiatrists, public school staff, primary care physicians, therapists, and case managers—all focused on supporting clients and families.

As a result of these strategies, SPS clients are: 1) Showing high attendance/retention with only a 17% "no show" rate compared to a national rate of 50% for services to youth under 17*; 2) Adhering to treatment regimens; 3) Exhibiting strong doctor/patient relationships, 4) Enhancing family relationships, 5) Improving behavior in school, and 6) Utilizing additional health and social services when offered (e.g. counseling, housing, and nutrition services).

*National Council for Community Behavioral Health: Service Process Quality Management National Data

E. Overcoming obstacles and barriers, extended resources and funding.

SPS has had to overcome several barriers since it started. These include difficulties finding medical homes for clients, high numbers of "no shows" or late cancellations, and the high cost of care per client. Finding medical homes for uninsured clients as they transition from the program has been challenging. However, SPS Psychiatrists and Case Managers have personally talked to Physicians, urged clients to make appointments and provided bus passes or cab vouchers for clients to assist with transportation. Psychiatrists consult with Primary Care Physicians who then monitor the medication regime upon program exit. The assurance from Psychiatrists that ongoing consultation is available to PCPs has resulted in securing medical homes for clients.

Client who "no show" or cancel appointments increase service costs. To increase utilization and decrease costs, the program created a wider pipeline of referrals and "double booked" clients when appropriate. It developed a focused profile of the client population which streamlined referrals, brought in an additional collaboration partner to add clients, and started to accept community and self-referrals of individuals who met the target profile.

To increase non-foundation revenue, SPS focused on increasing 3rd party fees. It identified common insurers and certified providers for those panels, advocated with insurers for higher reimbursement rates, and increased the efficiency of enrolling uninsured clients.

SPS has reduced both physical and attitudinal barriers to care by providing: 1) Psychiatric care for youth and their caregivers (if needed) 2) Case management (Bilingual), 3) Bus passes/cab vouchers, and 4) Translation services (Spanish/Sign). To extend family resources SPS: 1) Assists with medications, 2) Pays for lab work, and 3) Provides access to HEB Pharmacy to fill prescriptions more seamlessly and affordably. Additional leveraged resources for families such as books, nutritional supplements, art and dance activities, meditation, as well as linkages to other services including counseling (used by 60%), adult literacy, housing, and summer camps provide families with opportunities to improve behavioral health and family functioning.

F. Verification of the program's effectiveness and focus on quality improvement.

SPS uses the following methods to measure programmatic and clinical results: 1) Common Intake Data, 2) Client Satisfaction Surveys, 3) Efforts to Outcomes database to produce program and evaluation reports, 4) Arizona Self-Sufficiency Matrix, and 5) Approved outcome measures [St. David's Foundation (SDF)] including changes in the client's presenting issue and GAF Scores. (The GAF, eliminated by DSM-V, will be replaced with Vanderbilt and CESD, SCARED tools Oct. 2014.) SPS also has an in-house Director of Research and Evaluation who is a PHD-level evaluator.

External program evaluations have been conducted by an independent evaluator sponsored by SDF, Stephanie L. Rivaux, PH.D., LMSW (Feb. 2013). An outside analysis of business practices and program operations was conducted by Charles H. Boone (Tejas Behavioral Health Management, Nov. 2013). LifeWorks and its programs, including SPS are accredited by the Council on Accreditation (COA) through July 2017. COA named LifeWorks an "outstanding provider for meeting high performance standards and making a commitment to their stakeholders to deliver the very best quality services."

G. Documentation of the program's staffing and the role of each staff member

The Clinical Care Director receives referrals from collaborating agencies and serves as a liaison between the psychiatrist, families, counselors and associated professionals (e.g., teachers, primary care physicians) regarding the child/family behavioral health treatment. The clinical care staff (Clinical Care Specialists, Clinical Volunteers and SPS Interns) provides initial consultation with the family prior to contact with the psychiatrist, information about the SPS program, and routine follow-up regarding medication side effects and treatment compliance. The Clinical Care Director trains and supervises interns.

The two Psychiatrists contracted to work with SPS are board certified Adult, Child and Adolescent Psychiatrists. Each psychiatrist has experience working with marginalized populations and an invested interest in working with community-based integrated care.

The Psychiatrists provide children, youth and their families with urgent or routine care (not emergency care) including: assessments, diagnosis, prescription and monitoring of medication, parent education regarding the illness and medication, staff consultation and training, patient advocacy (caregivers/school) and consultation with other professionals (e.g., pediatricians) where indicated. The Psychiatrist does not provide psychotherapy for the child or family.

H. Documentation of involvement of consumers and/or family members.

Please see Part 3 Attachments.

I. Program's funding sources

St. David's Foundation, Austin, Texas - $516,230
Program Service Revenue (Insurance) - $23,393

Laurie Seremetis, M.D., M.P.Aff.
1016 Shelley Avenue, Austin TX 78703
(512) 925-5350
lseremetis@austin.rr.com

Dear American Psychiatric Association, April 25, 2014

I would like to enthusiastically support the Lifeworks Shared Psychiatric Services Program in its bid for the Psychiatric Services Achievement Award. I have worked within this program for nearly 3 years after working for many years (since 1993) in numerous psychiatric settings- private, public, and integrated- and as a community activist in the cause for improving access to and equalizing the opportunity for high quality behavioral healthcare. This is by far the most promising and effective program I have been associated with.

Children's behavioral health problems are often extremely complex, especially when working with the un- and under-insured. Most of the children and families we see have experienced significant stress and trauma, live in or close to poverty and have few supports or resources. Our children frequently have learning disorders, problems with aggression, disrupted families (e.g., incarcerated parents) and overlap with other systems (e.g., juvenile justice, child protective, special education). They are at risk of "access to care" barriers even within typical care settings. The typical behavioral health programs that are integrated into primary care settings are often not adequate to address these complex issues and needs in children, and I have become a "convert" to the belief that integration is more effective in partnership with an agency that can provide the access (e.g., transportation, home or school visits) and services (e.g., counseling, case management and coordination) that are an essential part of developing stability, which must be the foundation for healthy development and healing.

In speaking with many primary care doctors who work with these children, they agree that providing a brief psychiatric assessment or consultation for these patients is not enough and that they are beyond their level of comfort and expertise in treating these complex cases. What makes more sense to them and to me is the SPS model, where we are able to provide and coordinate the initial care and support (including communication and advocacy with primary care doctors, medical specialists, and other systems), and once the patient is stabilized and connected to appropriate supports and services, to transfer care to the primary care doctor (PCP) or long-term psychiatric provider. We can then provide ongoing support or consultation to the PCP (and other systems), and see the patient again if there is a need or request to do so, which allows the PCP to feel more confident to manage the psychiatric medications.

Sincerely,

L. Seremetis

Laurie Seremetis, M.D., M.P.Aff.

St David's FOUNDATION

811 Barton Springs Road, Suite 600
Austin, TX 78704

(512) 879-6600

www.stdavidsfoundation.org

May 8, 2014

Gerard Gallucci, M.D., M.H.S.
PSAA Selection Committee
American Psychiatric Association
1000 Wilson Boulevard, MS 1825
Arlington, VA 22209

Dear Dr. Gallucci:

It is my pleasure to write a letter of support for LifeWorks' application for the Psychiatric Services Achievement Award.

The St. David's Foundation has funded LifeWorks since 1998, and their Shared Psychiatric Services (SPS) since 2011. The Foundation chose LifeWorks to lead this initiative due to their long history of delivering high quality services in the community, along with their commitment to innovation and strong staff and board leadership.

LifeWorks consistently meets or exceeds the Foundation's expectations in terms of outcomes, and has demonstrated creative solutions to meeting the needs of underserved, low-income, multi-lingual/cultural families. The Foundation's long history with LifeWorks is the result of our belief in the strength of the organization, both clinically and administratively.

LifeWorks has a long history of providing effective and collaborative services to youth and families and most importantly has direct access to families with high physical, mental health and financial needs.

Thank you for your consideration of LifeWorks for the Psychiatric Services Achievement Award. I am confident that other organizations would benefit from learning more about this highly innovative and engaging model for families struggling with psychiatric illness.

Sincerely,

Kim McPherson

Kim McPherson
Program Officer, Healthy Minds

Recent Findings

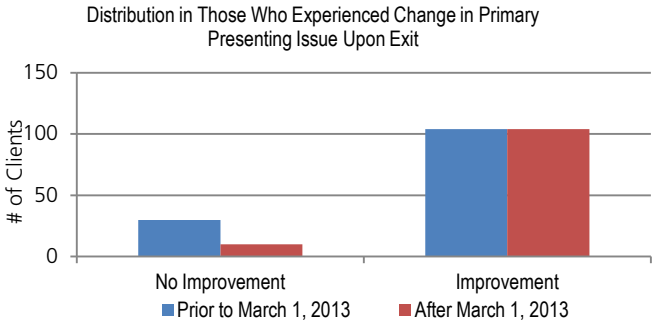
Upon receiving feedback from an external evaluator during February 2013, SPS implemented several programmatic changes in order to improve service delivery and client outcomes. Specifically, we introduced a "readiness assessment" into the referral process, allowing us to better identify clients who were ready for services; began billing insurance companies for services; infused our services with solution-oriented language; and introduced a client action plan, allowing clients to track their own progress over time.

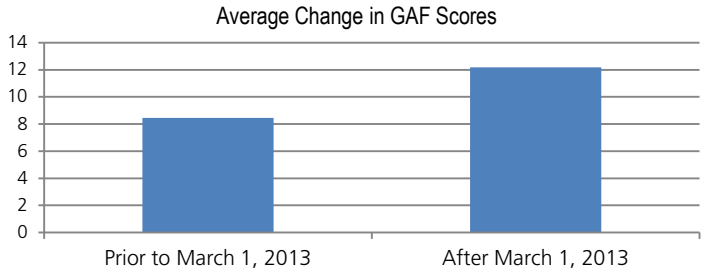
In order to determine whether these changes impacted client outcomes, we tested whether clients who exited the program after March 1, 2013, were more likely to experience an improvement in their primary presenting issue compared to those who exited the program prior to that date.[1]

As expected, these variables were significantly associated, $\chi^2(1, N = 248) = 8.44$, $p = .004$. Specifically, after the implementation of the programmatic changes described above, a smaller number of individuals experienced no improvement in their primary presenting issue than would be expected by chance ($z = -1.96$, $p = .05$). Prior to March 1, 2013, on the other hand, a somewhat greater number of people experienced no improvement in their primary presenting issue than would be expected by chance ($z = 1.80$, $p = .07$).

We also tested whether those who completed the program after March 1, 2013, showed greater improvement in their GAF scores relative to those who exited the program prior to March 1, 2013.

Indeed, clients who exited the program after March 1, 2013, experienced significant improvement in their GAF scores relative to those who exited the program prior to that date, $t(243.9) = -2.91$, $p = .004$, ($M_{Before} = 8.45$, $M_{After} = 12.18$).





Follow-up analyses revealed that, when the length of time that clients participated in the program was included in the model, clients' GAF scores at closing did not significantly differ as a function of whether they exited the program after the implementation of the programmatic changes described above. These findings provide suggestive evidence that the improvement in outcomes experienced by clients who have exited the program after March 1, 2013, can be explained (at least in part) by the amount of time they participated in services.

Results of the regression analyses, not controlling for clients' length of participation

Effect	*B (SE)*
Intercept	45.54 (4.32)***
Initial GAF	.40 (.07)***
Pre- v. Post-March 1	2.80 (1.00)**

$^{**}p < .01$. $^{***}p < .001$.

Results of the regression analyses, controlling for clients' length of participation

Effect	*B (SE)*
Intercept	43.33 (4.38)***
Initial GAF	.40 (.07)***
Pre- v. Post-March 1	1.53 (1.05)
Days in Program	.01 (.003)***

Indeed, clients who exited the program prior to March 1, 2013, participated in services for significantly less time compared to those who exited the program after we introduced programmatic changes that may have contributed to improved client attendance rates, $t(161.06) = -5.13$, $p < .001$.

Thus, it appears that our efforts to better assess client readiness for services and utilize third-party billing have translated into improved client outcomes.

[1] Clients who participated in SPS more than once were excluded from the analyses in order to eliminate any issues that may arise due to the inclusion of non-independent data. However, the pattern of results remained unchanged when these clients were included in the analyses.

Blue Lapis Light Performance at Long Center December 2012

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

---

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:
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: Bruno Lima Award

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

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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.

NEW JERSEY PSYCHIATRIC ASSOCIATION

A District Branch of the American Psychiatric Association

August 1, 2014

Charles R Marmar, MD
The Chair
Committee of Psychiatric Dimensions of Disaster
American Psychiatric Association
1000 Wilson Boulevard
Suite 1825
Arlington VA 22209

Nomination of Charles P Ciolino, MD – Bruno Lima Award

Dear Doctor Marmar:

I am writing this letter to recommend Doctor Charles Ciolino for the Bruno Lima Award. Dr Ciolino has a long history of service to the public as well as the professional community, and has made great contributions in the area of Disaster Preparedness.

He is currently serving his second term as President of the New Jersey Psychiatric Association, which he has navigated through significant changes in structure, advocacy, affiliations and membership.

Dr Ciolino has been a member of the NJPA Disaster Preparedness Committee for 12 years, and has chaired the committee for 8 years. He is a Red Cross volunteer since 2004, and helped with mental health disaster relief for Hurricane Irene, receiving the Governor's Certificate of Recognition (from Governor Chris Christie) for "vital contributions and relief efforts to community and state during Hurricane Irene".

He was involved in disaster relief for Hurricane Sandy in 2012, and the Newtown, Connecticut school shootings also in 2012.

He participated in VOAD, Volunteer Organizations Active in Disaster in NJ Conference in 11/12 regarding statewide response to Hurricane Sandy.

Not only has Dr Ciolino helped with "hands on" efforts at Disaster Relief, but has increased public and professional awareness and understanding. He has made many public appearances and communicated with the media about these issues.

Dr Ciolino has been a great help to many victims of disaster, helped with organizational efforts, improved preparedness, and improved public and professional understanding. He does all of this with strength, stamina and dedication, while maintaining a warm and positive attitude.

I believe he deserves the recognition of the Bruno Lima Award.

Sincerely

(Signed)

Steve Resnick, MD, DFAPA
Senior Vice-President

Charles P Ciolino, MD
597 Springfield Avenue
Summit, NJ 07901

Phone: (908) 654-7399
Fax #: (908) 654-7422

Curriculum Vitae

EDUCATION AND TRAINING:

Internship and Residency:	Department of Psychiatry Georgetown University Medical Center Washington, D.C. 1981 – 1985
Medical School:	Georgetown University School of Medicine Washington, D.C. 1977 – 1981 (Doctor of Medicine)
College:	Boston College Chestnut Hill, Massachusetts 1973 – 1977 (Bachelor of Science, magna cum laude)

CERTIFICATION:

Diplomate, American Board of Psychiatry and Neurology (in Psychiatry), 1987

MEDICAL LICENSURE:

District of Columbia #14025, 1983
New York #161351, 1985
New Jersey #51805, 1988
Pennsylvania #MD –048998-L, 1992

CURRENT POSITIONS:

Private Practice,
General Adult Psychiatry and Psychopharmacology,
597 Springfield Avuenue, Summit, New Jersey
(1994 to present)

Overlook Hospital, Summit, New Jersey:
Medical Staff (1989 to present)
Vice-Chairman and Clinical Chief of Psychiatry (2003 to 2006)
Chair, Atlantic Health System Council of Psychiatrists (2004 to 2005)
Executive Committee (2003 to 2006)
Chairman, Patient Care Committee (peer-review) (1999-2002)
Secretary, Department of Psychiatry and Behavioral Health(1999-2002)
Medical Director, Partial Hospitalization Program (1993-1996)

Consulting Psychiatrist:
Fairleigh Dickinson University, Wellness Center, College at Florham, Counseling Center, Madison, New Jersey (2001 to present)

Counseling Centers For Human Development, Cranford, New Jersey
(2001 to present)

Summit Medical Group, Berkeley Heights, New Jersey (2008 to present)

PRIOR PROFESSIONAL EXPERIENCE:

Hackensack University Medical Center, Department of Psychiatry,
Hackensack, New Jersey (1993 –1995)

Pascack Valley Medical Center, Department of Psychiatry,
Westwood, New Jersey (1993 – 1995)

Fair Oaks Hospital,
Summit, New Jersey (1988 – 1992)

Summit Medical Group, (psychiatric consultation-liaison to a large multi-specialty physician group) Summit, New Jersey (1988 – 1992)

Chenango Memorial Hospital, Attending Psychiatrist,
Norwich, New York (1985 – 1988)

Harry Stack Sullivan Mental Health Clinic, Staff Psychiatrist, Norwich, New York (1985 – 1988)
Chenango County, New York, Acting Director of Community Services for Commitments (1988)

MEMBERSHP IN PROFESSIONAL AND OTHER ORGANIZATIONS:

American Psychiatric Association:
Distinguished Fellow (2005 to present)
Fellow (2003 to 2005)
Member (1984 to present)

New Jersey Psychiatric Association:
President (2013 to present)
Executive Council (2006 to present)
Chairman, Disaster Preparedness Committee (2006 to present)
President, Tri-County Chapter (2005 to 2006)
Vice President, Tri-County Chapter (2003 to 2004)
Member (1988 to present)

Medical Society of New Jersey
Board of Trustees (2013 to present)

American Society of Clinical Psychopharmacology (2000 to present)

Alumni Admissions Committee of Georgetown University (1988-1992)

Board of Trustees: Contact-We-Care (a 24 hour crisis-intervention telephone program with special services for the deaf) (1990-1996)

The Columbians (an Italian-American philanthropic association)
(2001 to present)

AWARDS:

Georgetown University Psychiatry Award for most outstanding resident's research project "Cortical Lesion Location and Post-Stroke Depression." 1985

PUBLICATIONS:

Rosse RB, Ciolino CP: Dopamine agonists and neuropleptic malignant syndrome. American Journal of Psychiatry, 142: 270-271, 1985.

Ciolino CP: Advances in understanding pain and its management. Psychosomatics, 26: 158, 1985.

Rosse RB, Ciolino CP: Management of chronic pain in the elderly. Geriatric Medicine Today, 4(8): 32-42, 1985.

Rosse RB, Ciolino CP: Effects of cortical lesion location on psychiatric consultation referral for depressed stroke inpatients. International Journal of Psychiatry in Medicine 15(4): 311-320, 1986.

Rosse RB, Ciolino CP: Motor impersistence mistaken for uncooperativeness in a patient with right-brain damage. Psychosomatics, 27: 532-534, 1986.

Ciolino CP, Rosse RB: Controlling chronic pain – an integrated approach. Hospital Physician, 22 (8): 25-32, 1986.

Rosse RB, Ciolino CP, Gurel L: Utilization of psychiatric consultation with an elderly medically ill inpatient population in a V.A. hospital. Military Medicine, 151, 11: 583-586, 1986.

Ciolino CP: Substance abuse and mood disorders. In Gold MS and Slaby AE: Dual Diagnosis in Substance Abuse. New York: Marcel Dekker, Inc.: 105-115, 1991.

CHARLES P CIOLINO, MD – DISASTER RELATED SUMMARY

Nomination for Bruno Lima Award 2014

NJPA Disaster Preparedness Committee:

- Member, 2002 to present.
- Chair, 2006 to present

Red Cross

- Volunteer 2004 to present

Involved in mental health disaster relief for Hurricane Irene 2011, Hurricane Sandy 2012, and the Newtown, Connecticut school shootings 2012

Received the Governor's Certificate of Recognition (from Governor Chris Christie) for "vital contributions and relief efforts to community and state during Hurricane Irene" in 2011.

Participated in VOAD (Volunteer Organizations Active in Disaster in NJ) Conference in 11/12 regarding state-wide response to Hurricane Sandy.

Psychiatric News article (APA) for which I was interviewed regarding Hurricane Sandy:

http://psychnews.psychiatryonline.org/newsArticle.aspx?articleid=1484675

Conducted mental health outreach workshops in 2001 sponsored by Overlook Hospital for those adversely affected by 9/11.

Worked as a volunteer with Catholic Relief Services Dec 1980 and Jan 1981 to provide medical services to Cambodian and Laotian refugees in Refugee Camps in Thailand.

Worked with Flying Doctors of America as a volunteer in 1996 to provide medical and mental health assistance to the poor in Venezuela.

Attached is an article from the Star Ledger on March 20, 1994 which covered a seminar I conducted regarding professional education on dealing with disasters. I also used this material for a workshop I conducted at the NJPA Spring Meeting of 1994 on disaster mental health. (Dr. Andrew Slaby was scheduled to speak at the NJPA Meeting that year, but when he was unable to go, he sent me as his substitute, and I presented my own material)

Star-Ledger, The (Newark, NJ)

Star-Ledger, The (Newark, NJ)

March 20, 1994
DEALING WITH DISASTERS
Author: GABRIEL H. GLUCK
Edition: FINAL
Section: NEWS
Article Text:
PSYCHE DICTATES ABILITY TO HEAL
Americans have had to deal with numerous natural disasters in recent years - earthquakes on the West Coast, floods in the Midwest, hurricanes in the South and nor'easters in this region.

How individuals react and cope with disasters has as much to do with the person as it does the nature of the catastrophe, according to psychiatrist Dr. Charles Ciolino, medical director of Overlook Hospital's Department of Psychiatry and Behavioral Health Services.

For example, the suddenness and unexpectedness of the disaster can have a dramatic impact, he said, citing how a dam bursting may have far more impact on victims than the gradual rising of river waters, even though both events may ultimately result in loss of life or property. Ciolino noted people always have faced natural disasters. For ancient civilizations, the answer as to why bad things happen to good people was ascribed to gods. In Greek mythology, the three fates spun the destiny of mere mortals, while Shakespeare asked in Hamlet, why man suffers "the slings and arrows of outrageous fortune."

The word "catastrophe" literally means overthrowing, and "when the sudden order of things is overthrown," Ciolino said, man faces both physical and psychological challenges.

In the aftermath of a disaster, there can often be "psychic numbness" which can last from hours to days, as the mind practices almost a psychological conservation, temporarily ignoring the enormity of the experience as protection from further pain.

The victims of a natural disaster may struggle with feelings of impermanence, generated by the catastrophe, while others may find their religious faith shaken.

There are other issues. Survivors may feel guilty for being spared while loved ones were hurt or killed.

And when the disaster is not an act of nature, say the bombing of the World Trade Center, feelings of anger, rage and retaliation are normal.

While trauma can change an individual, it is the conjunction of the event and the person that produces the disorders. Pre-event variables such as personality, belief systems, existing psychological disorders, and post-event circumstances, such as the degree of social support, all can affect one's handling of the situation.

A catastrophe resulting from "the irresponsibility of other persons" can influence the situation, as can a situation where "pain is inflicted intentionally by another individual," Ciolino said.

"Whether the disaster is seen as preventable ... such as a coal mine explosion that the company could have prevented," is an important variable, as is "the isolation of the community" after the event and the extent of the destruction, he added.

While catastrophes can exacerbate pre-existing psychiatric disorders, the incident itself may result in post-traumatic stress, further complicating treatment.

Post-traumatic stress disorder (PTSD) sufferers not only experience an event, they re-experience it, whether through nightmares, flashbacks or intense discomfort triggered by reminders of the episode.

If people do not receive appropriate mental health treatment, the consequences can be very damaging. Psychic numbness can destroy relationships, even marriages, while the use of pain killers or barbiturates for a physical injury may develop into a chemical dependency, the doctor said.

Ciolino said that for disaster victims, there should be psychological intervention as soon as permissible.

The key is "active listening" by the therapist, the psychiatrist said, noting it is important for the victim "to ventilate the horror of the incident."

"He may need time to tell his story. And in telling and retelling his story, the victim becomes reinvolved in the event - but he becomes more of an active participant ... and (develops) more of a sense of mastery over events out of his control," the doctor said.

A victim "needs to feel people still care about him," he said, also noting the importance of reuniting victims with other family members as soon as possible.

While the vast majority of survivors will not require medication, psychotherapy may be an option for some, he said, noting that experiencing a disaster may profoundly affect how a person views life.

In assisting a victim in his struggle to restore meaning, a counselor or therapist must realize the individual has experienced "the stark realization of his finiteness."

Citing various philosophers' views, Ciolino said that for some, a disaster may shatter the suppression of vulnerability to death, and that our habits and routines are "the great veils over our routine existence."

"When the social fabric is rent, man is suddenly thrust outside (his) everyday familiar world and confronts complex and disturbing issues," he said.

Ultimately, a survivor's metaphysical or religious beliefs may have a "protective nature" in helping one to move on. "Out of suffering, hope may be reborn," Ciolino said. "This is our task as healers."

Ciolino spoke recently at a day-long series of seminars marking the opening of the Partial Hospitalization Program in Overlook's psychiatry and behavioral health services department. Based in a professional building on Morris Avenue in Springfield, the outpatient facility treats patients with emotional and substance abuse problems.

"The concept of stepping patients down from acute-care settings is one of the trends that has emerged from the new health care environment," said Overlook President Michael Sniffen. He stated there is a growing need for outpatient psychiatric and addictive services.

Record Number: sl199431251ddd200

IPS
Illinois Psychiatric Society
300 West Adams Street
Suite 424
Chicago, IL 60606

A District Branch of the
American Psychiatric Association

NOMINATION LETTER FOR BRUNO LIMA AWARD

This letter is written to nominate Jagannathan Srinivasaraghavan, M.D., D.L.F.A.P.A. (Dr. Van) for the Bruno Lima Award of the American Psychiatric Association. This nomination is based on his timely and much needed disaster relief and educational training that he provided following the Asian tsunami in Sri Lanka in April 2005 and immediately following the refugee boat disaster in Christmas Island in December 2010. Further he was one of two psychiatrists representing APA in a Disaster Mitigation conference in Chennai, India in April 2005, presenter as to lessons learned from the psychosocial interventions of survivors of Asian tsunami. at the World Psychiatric Association Regional Congress & 2nd Pan-American Congress on Child and Adolescent Mental Health in Havana, Cuba in March 2006 and chaired and presented on NGO (Non-Governmental Organizations) Response to Mental Health Consequences of Asian Tsunami, as an Issue Workshop at the Annual meeting of the American Psychiatric Association in Toronto, Ontario, Canada in May 2006.

Even though Dr. Van is originally from India, he chose to provide disaster relief and training in Sri Lanka as there were only 32 psychiatrists for 20 million people and he went to the eastern provinces (Batticaloa and Ampara districts) which had poorer infrastructure to reach and stay. He visited several relief camps interviewed survivors, trained community level volunteers based on WHO manual for community level workers to provide psychosocial support in three locations, networked with the only psychiatrist for 1.8 million people and visited tsunami affected areas and area hospitals in April 2005. He had to stay in a community volunteer's home as there were no hotels in one district. (Please see SIU School of Medicine news release and Psychiatric News article).

As a prelude to the Sri Lanka visit Dr. Van along with Ramaswamy Viswanathan, M.D. represented APA in Asia Pacific Congress on Disaster Mitigation: Capacity Building for effective intervention in Chennai, India and took part in a panel discussion. Following that he visited tsunami affected areas near Chennai and learnt of the relief work rendered by a local psychiatrist. (Please see the report sent to APA). Further Dr. Van was invited to present at the Council on Global Psychiatry the observations and recommendations.

At the annual meeting of APA in Toronto, Canada in May 2006 Dr. Van chaired and presented about the mental health consequences of Asian tsunami and had on his panel Professor Arshad Husain and Professor Bruce Singh (Melbourne, Australia) who provided services in Indonesia. He also had panelists from Thailand and India. Prior to that meeting he also presented on the disaster in the World Psychiatric Association Regional Congress and 2nd Pan-American Congress on Child and Adolescent Mental Health in Havana, Cuba in March 2006.

Last but not the least, in December 2010 he was involved in an unplanned disaster relief efforts as he was vacationing in Christmas Island in the Indian Ocean. A wooden boat carrying nearly 100 asylum seekers crashed on the rocks resulting in numerous deaths and injuries. Dr. Van was requested to help in the hospital where he spent many hours, interviewed the first survivor and worked with translators from many countries. He was interviewed by media and pictures he had taken are part of the historic documentation of the disaster. Australian newspaper Daily Telegraph listed Dr. Van as "Hero" and SERCO Australian Immigration Services had his picture among "Heroes of Rocky Point". (Please see newspaper articles with photo credit to Dr. Van and SERCO report).

In short, Dr. Jagannathan Srinivasaraghavan has personally rendered services in disaster areas, trained numerous community level volunteers in identifying psychopathology and providing support, presented in national and international conferences on disasters and psychosocial consequences. I believe he is well deserved to receive Bruno Lima Award of the American Psychiatric Association.

Sincerely,

Jim MacKenzie, D.O.
President, Illinois Psychiatric Society

JAGANNATHAN SRINIVASARAGHAVAN, M.D., D.L.F.A.P.A.
(ASHOK VAN)

ADDRESS:

Consultant Psychiatrist (Fee appointment)
Veterans Affairs Medical Center
2401 W. Main Street
Marion, IL 62959
Phone: 618 997 5311 Ext: 54161
Fax: 618 993 4172
jagvan@gmail.com Jag.Van@va.gov

Independent Contractual Psychiatrist
Wexford Healthcare Services
State of Illinois Department of Corrections
Big Muddy River Correctional Center
251 Illinois 37, Ina, IL 62846
Phone: 618 437 5300

Independent Contractual Psychiatrist
MHM Missouri Department of Corrections
Southeast Correctional Center
300 Pedro Simmons Drive
Charleston, MO 63834
Phone: 573 683 4409

CITIZENSHIP: U.S.A.

CERTIFICATION:

Educational Council for Foreign Medical Graduates (ECFMG):	July 1974
Federal Licensing Examination (FLEX):	December 1977
Diplomat, American Board of Psychiatry & Neurology in Psychiatry	June 1984
Added Qualifications in Forensic Psychiatry American Board of Psychiatry & Neurology	June 1996 (Valid until 2006)
Recertification in Forensic Psychiatry American Board of Psychiatry & Neurology	June 2006 (Valid until 2016)
State of Illinois Sex Offender Management Board Registration	2013-

LICENSURE:

State of Illinois	36-057049
State of Wisconsin	25715 (Inactive)
State of Missouri	2013032882

UNDERGRADUATE EDUCATION:

St. Joseph's College, Trichirappalli, India Pre-University Course, 1967, Thanjavur Medical College, Thanjavur, India University of Madras	M.B.B.S, 1967-1972,

POSTGRADUATE EDUCATION:

Thanjavur Medical College, Affiliated Hospitals, Madras Medical College and Government General Hospital, Madras, India	Rotating Intern: 1973-1974
University of Madras	Resident in Internal Medicine: 1974-1977
University of Health Sciences/Chicago Medical School, Affiliated Hospitals	Resident in Psychiatry: 1977-1980
St. Mary of Nazareth Hospital, Chicago, Illinois,	Chief Resident: 1979-1980

LEADERSHIP TRAINING:

Clinical Manager's Institute (3 weeks):	1996

RESEARCH TRAINING:

Research Methodology and Experimental Design Course, Department of Psychology UHS/The Chicago Medical School:	1992

ACADEMIC EXPERIENCE:

Veterans Affairs Medical Center Marion, Illinois 62959 Consultant Psychiatrist (Fee appointment)	2009-Present
Southern Illinois University School of Medicine	
Professor Emeritus	2008-Present
Professor & Director of Public & Community Psychiatry	2006-2008(Retired)
Professor & Chief, Division of Public & Community Psychiatry (including Forensic Psychiatry)	2000-2006
Professor	1998-2000
University of Rochester, School of Medicine and Dentistry, Clinical Associate Professor of Psychiatry:	1994-1998
University of Health Sciences/The Chicago Medical School, North Chicago, Illinois	
Associate Professor of Clinical Psychiatry	1992-1994
Assistant Professor	1982-1992
Assistant Director of Undergraduate Training	1982-1986
Instructor	1980-1982
Illinois Department of Human Services Clyde L. Choate Mental Health & Developmental Center Anna, Illinois 62906	
Medical Director	1998-2008
Southern Network Clinical Coordinator	2001-2008
Veterans Affairs Medical Center Poplar Bluff, Missouri 63901 &	1998-2000(Retired)

Community Based Outpatient Clinic,
Cape Girardeau, Missouri
Staff Psychiatrist

Veterans Affairs Medical Center
Canandaigua, New York 14424

Acting Mental Health Care Line Manager	1997-1998
Chief, Psychiatry Service	1994-1997
Director, Seriously Mentally Ill Training, Research & Training Center	1995-1998
ECT Unit Director	1996-1998
Acting Chief of Staff	September 1996 February-July 1997

Veterans Affairs Medical Center
North Chicago, Illinois 60064

Section Chief, Ambulatory Care Psychiatry	1994
ECT Unit Director	1990-1994
Acting Chief, Psychiatry Service	1993 (Feb.-Nov.)
Section Chief, Special Programs (Substance Abuse and Post Traumatic Stress Disorder Units- >100beds)	1990-1993
Section Chief, General Psychiatry (200 beds)	1989-1993
Staff Psychiatrist	1981-1986

VA/DOD Sharing Agreement, Great Lakes Naval Hospital

Head, Psychiatry Department	1988-1989
Staff Psychiatrist	1987-1988
Site Coordinator for Residents and Students	1987-1989

Robert R. McCormick University Clinics
University of Health Sciences/
The Chicago Medical School
Consulting Psychiatry 1983-1986

OTHER CLINICAL PROFESSIONAL EXPERIENCE:

Independent Contractual Psychiatrist 2013- Present
MHM Missouri Department of Corrections
Southeast Correctional Center
300 Pedro Simmons Drive
Charleston, MO 63834

Independent Contractual Psychiatrist 2010-2012
Wexford Healthcare Services
State of Illinois Department of Corrections
Pinckneyville Correctional Center
Pinckneyville, IL 62274

Tamms Coorectional Center 2011-2012
200 Supermax Road,
Tamms, IL 62988

Big Muddy River Correctional Center 2012-Present

251 N IL Highway 37
Ina, IL 62846

Southern Illinois Behavioral Services
Forensic Psychiatric Practice
Carbondale, Illinois
Consultant Forensic Psychiatrist 2000-2008

Alexian Brothers Medical Center
Elk Grove Village, Illinois
Attending Psychiatrist 1989-1992

Forest Hospital
Des Plaines, Illinois
Attending Psychiatrist 1982-1992

DuPage County mental Health
Crisis Unit, Lombard, Illinois
Consulting Psychiatrist 1991-1992

Elgin Mental Health Center
Elgin, Illinois
Forensic Psychiatrist 1988-1989

Memorial Hospital
Woodstock, Illinois
Consulting Psychiatrist 1985-1986

Family Counseling Clinic
Grayslake, Illinois
Consulting Psychiatrist 1981-1986

Youth and Family Services
Kenosha, Wisconsin
Consulting Psychiatrist 1983-1986

Family Therapy Research Institute
Kenosha, Wisconsin
Consulting Psychiatrist 1983-1984

Riveredge Hospital
Forest Park, Illinois
Attending Psychiatrist 1981-1984

Ridgeway Hospital
Chicago, Illinois
Attending Psychiatrist 1981-1984

Chicago Read Mental Health Center
Chicago, Illinois
Physician/Psychiatrist 1978-1982

Charter Barclay Hospital
Chicago, Illinois
Resident Psychiatrist 1978-1980

Cook County House of Corrections
Chicago, Illinois
Emergency Room Physician 1979-1980

Loretto Hospital
Chicago, Illinois
Physician 1979-1980

Louiseburg Hospital
Chicago, Illinois
Consulting Psychiatrist 1978-1980

COMMITTEES:

Governor's Rural Affairs Council, State of Illinois	Member	2003- 2008
World Psychiatric Association		
Section on Psychiatry & Public Policy	Member	2005- Present
Section on Developing Countries	Member	2005- Present
Section on Trans-cultural Psychiatry	Member	2005- Present
Section on Quality Assurance	Secretary	2012-Present
	Member	2008-Present
American Psychiatric Association		
Nominating Committee	Member	2009-2010
Joint Reference Committee	Member	2005- 2007
Council on Social Issues and Public Psychiatry	Member	2002- 2007
	Chairman	2005- 2007
	Corresponding Member	2007-2008
Council on Global Psychiatry	Corresponding Member	20005-2006
Presidential Task Force to Review Psychiatric Needs in Underserved Areas	Member	2006
Task Force on Ethics Regulation & Ethics Education	Member	2002
Assembly Committee of Minority/ Underrepresented Groups	Member	2002- 2009
	Chairman	2005- 2006
Assembly Nominating Committee	Member	2006-2009
Assembly Executive Committee	Member	2005-2006
Assembly Committee on Planning	Member	2005-2006
Assembly Committee on Public and Community Psychiatry	Member	2002-2004
		2006- 2008
Caucus of Asian-American Psychiatrists	Deputy Representative	2007- 2009
	Representative	2002- 2007
	President	1999-2002
Council on Psychiatry and Law	Member	1997-2002
	Consultant	1996-1997
Committee on International Education (Council on International Affairs)	Consultant	1994-1995

American Academy of Psychiatry & the Law

Executive Committee	Vice President	2008-2009
	Councilor	1999-2002
Cross-Cultural Issues in Forensic Psychiatry	Chairman	2005-2008
	Member	2008-Present
Program Committee	Member	1996-Present
	Chair	2006-2007
International Relations Committee	Chairman	1998-2002
	Member	1994-1998
		2002-2005
Suicidology Committee	Member	2003-Present
Geriatric Psychiatry & the Law Committee	Chairman	1997-1998
	Member	1994-1997
Nominating Committee (Presidential Appointee)	Member	1998
AAPL Newsletter	Associate Editor	1999-2004

Illinois Psychiatric Society

Executive Committee	Immediate Past President	2011-2013
	President	2010-2011
	President Elect	2009-2010
	Councilor	2001-2010
IPS Mind Matters	Editor	2003-2010
Southern Chapter of IPS	President	2006-2007
Nominating Committee	Member	2000-2002
Budget & Finance Committee	Member	2003-2011
Governmental Affairs Committee	Co-Chair	2000-2005
	Vice Chair	2005-2009
	Member	1999-2000
IPS Fall Meeting Program Committee	Co-Chair	2002-2003
	Member	1999-2002
Committee on International Medical Graduates	Member	1993-1994
Chronic Care Committee	Member	1993-1994
Geriatrics Committee	Member	1992-1994

International Academy of Law & Mental Health

Board of Directors	Member	2006-Present
International Scientific Committee	Member	2002, 2005-Present

Genesee Valley Psychiatric Association

Practice Research Network	Liaison	1997-1998
International Medical Graduates	Member	1997-1998

Clyde L. Choate Mental Health Center

Medical Staff Organization	President	1998-2008
Medical Executive Committee	Chair	1998-2008
Quality Leadership Council	Member	1998-2008
Credentialing & Privileging Committee	Chairman	1998-2008

Southern Network

Clinical Coordinator & Network Medical Leadership Group	Chairman	2000-2008

Southern Illinois University/Department of Psychiatry

Forensic Fellowship Selection Committee	Member	2000-2004

Western New York Consortium of		
VA Chiefs of Psychiatry	Member	1994-1995
Veterans Integrated Services Network (VISN-2)		
Mental Health Advisory Group	Member	1995-1997
Chronic Diseases Index/Preventive Index		
Committee	Member	1997
University of Rochester School of Medicine		
Dean's Committee	Member	1994-1998
Canandaigua VA Medical Center		
Executive Committee for Patient Care	Member	1995-1998
	Co-Chair	1996
	Chair	1997
Clinical Executive Board	Member	1994-1995
Administrative Executive Board	Rotating Member	1994-1995
Mental Health Council	Member	1994-1995
Research and Development Committee	Member	1994-1998
Pharmacy and Therapeutics Committee	Member	1994-1995
Utilization Review Committee	Member	1994-1995
Quality Improvement Council	Member	1994-1995
Professional Standards Board	Member	1994-1998
Search Committee for Chief of Staff	Chairman	1995
UHS/The Chicago Medical School		
Dean's Committee	Member	1993
Medical Student Admission Committee	Member	1990-1994
Student Education, Promotion & Awards Committee	Member	1990-1994
Core Educational Committee to Evaluate Residents	Member	1981-1994
UHS/The Chicago Medical School		
Department of Psychiatry		
Department Executive Committee	Member	1993-1994
Department Education Affairs Committee	Member	1988-1992
Residency Selection Committee	Member	1989-1994
Department Clinical Affairs Committee	Member	1988-1989
North Chicago Veterans Affairs Medical Center		
Clozapine Treatment Team	Chairman	1992-1994
Mental Health Behavioral Sciences Committee	Chairman	1993
Psychiatry Service Credentialing and		
Privileging Committee	Chairman	1990-1994
Quality Assurance Subcommittee	Chairman	1990-1993
Research and Development Committee	Member	1993-1994
House Staff Review Committee	Member	1993
Executive Committee of Medical Staff	Member	1993
Clinical Executive Board	Member	1993
Planning Committee	Member	1993
Mental Health Behavioral Sciences		
Drug Use Evaluation Committee	Member	1989-1991
Elgin Mental Health Center		
Clinical Advisory Committee	Member	1988-1989
Forest Hospital		
Educational Committee	Member	1985-1986

EXTERNAL REVIEWER:

University of Illinois School of Medicine at Chicago, Chicago, IL 2007-
University of Toronto Faculty of Social Work, Toronto, Ontario, Canada 2006-
Brody School of Medicine, East Carolina University, Greenville, NC 2006-
University of Illinois College of Medicine at Peoria, IL 2002-
Rosalind Franklin University of Medicine & Science, (Chicago Medical School), North Chicago, IL 2002-

SOCIETIES:

American Psychiatric Association	General Member	1982-1992
	Fellow	1993-2002
	Distinguished Fellow	2003-2014
	Distinguished Life Fellow	2014-
Genesee Valley Psychiatric Association	Member	1994-1998
Illinois Psychiatric Society	Member	1982-1994
	Member	1998-
American Academy of Psychiatry and the Law	Member	1984-
International Academy of Law and Mental Health	Member	1999-
	Board of Director	2006-
American Association of Psychiatrists from India (Indo-American Psychiatric Association)	Life Member	1986-
	Treasurer	1984-1996
	Secretary	1996-1998
	President-Elect	1998-2000
	President	2000-2003
	Board of Trustee	2003-
American Association of Psychiatrists from India, Midwest Chicago Chapter	Founding President	1993-1995
American Association of Physicians of Indian Origin	Life Member	2004-
South Asian Forum for Mental Health (USA Chapter)	Chair	2004-2010
National Association of V.A. Chiefs of Psychiatry (National Association of V.A. Psychiatrists in Administration and Leadership)		1993-1997
American College of Forensic Psychiatry		1991-1993
Association of Directors of Medical Student Education in Psychiatry		1982-1986
India Medical Association (Illinois)		1983-1986
Canadian American Medical Dental Association		1982-1984

COMMUNITY SERVICE:

Volunteer Physician following a refugee boat wreck In Christmas Island, Australia on December 15 2010	Physician	2010

Interviews of many Tsunami survivors for psychiatric disorders and appropriate referrals in Batticaloa & Ampara districts of Sri Lanka	Volunteer & Educator	2005
India Association of Southern Illinois	Vice-President Counselor	1999-2000 1998-1999
Rochester Tamil Society	President	1997-1998
Diversity Day, Glimpses of the World: Our Heritage Canandaigua VA Medical Center	Speaker	1995
Asian Pacific Week, Arts and Crafts Show North Chicago VA Medical Center	Chairperson	1993
Asian Pacific Week, Glimpses of Asia and Asian Culture North Chicago VA Medical Center	Keynote Speaker	1992
Physician of the Group		
Trek to Mount Kilimanjaro, Tanzania		1987
Trek to Mount Everest Base Camp, Nepal		1986
Trek to the Peruvian Andes		1986
North Pole Expedition		1985
Rotaract Club of Thanjavur, India	Member President	1970-1973 1973-1974
Health Check-up of students of St. Peter's High School, Thanjavur		1973
Eye Check-up of students of St. Anthony's High School, Thanjavur		1973
Health Check-up of Deaf & Dumb School, Thanjavur		1971-1973
Social & Preventive Medicine Educational Tour Organizer & Student Director Visited in 10 days Brittanica Biscuit Factory, Madras King Institute (vaccines), Madras Coca Cola Factory, Madras Surgical Instruments Factory, Madras National Institute of Mental Health & Neuro Sciences, Bangalore St. John's Medical College, Bangalore Tuberculosis Institute, Bangalore Central Food Technology Research Institute, Mysore Pasteur Institute (vaccines), Coonoor		1972

COMMUNITY EDUCATION:

Asia Pacific Week Celebrations V.A. Medical Center, Marion, IL	Glimpses of Asia & Pacific (Slide Show & Lecture) May 30 2012
Rotary Club International Anna, IL	Mental Health Services for Southern Illinois June 26 2008
National Association of Mentally Ill Harrisburg, IL	Depression - Recognition, Diagnosis and Treatment Resources May 27 2008

Education & Training of volunteers in Batticaloa, Akkaraipattu & Thambilvil, Sri Lanka	Community Level Workers in Psychosocial issues April 5, 7, 9 2005
National Association of Mentally Ill Carbondale, IL	Improving Quality of Care for Seriously Mentally Ill Working Collaboratively with the Legal System August 7, 2001
John A. Logan College (Psychology Students) Carterville, IL	Forensic Psychiatry April 20, 2001
National Association of Mentally Ill Carbondale, IL	Modern Electro Convulsive Therapy December 7, 1999
Unity Group: Chennai, India	Alcohol Rehabilitation January 17, 1999
Rotary Club of Anna Anna, IL	Future of Public Health Care in Southern Illinois September 10, 1998
Thornell Road Elementary School: Pittsford, NY	Fun Learning - Slide Show June 4, 1997
Thornell Road Elementary School: Pittsford, NY	African Wildlife - Slide Show December 2, 1996
Veterans & Community Advisory Team: Canandaigua VAMC	Halfway House: Alternate To Inpatient Care November 18, 1996
Rochester Tamil Sangam Deepavali Celebration:	Master of Ceremony November 16, 1996
Veterans & Community Advisory Team Canandaigua VAMC:	ECT March, 1996
Family/Visitor Council: Canandaigua VAMC	Discharge Planning Process May, 1995
Commander's Day Reception: Canandaigua VAMC	Overview of VA Psychiatry Service April, 1995
Family/Visitor Council: Canandaigua VAMC November, 1994	New Directions in Acute, Long Term Care and Outpatient Psychiatry
Chicago Tamil Sangam: January, 1991	Lecture on High Arctic and Antarctica
Chicago Tamil Sangam: July, 1991	Lecture on Trekking to Mt. Everest Base Camp
Rotary Club of Kodaikanal: India	Lecture on Antarctica to the North Pole November, 1990
Madras Photographic Society: India	Lecture on Travel around the World December, 1986

Sishya School, Madras: India December, 1986	Lecture on Exploring Antarctica, High Arctic, and the North Pole
Rotary Club of Thanjavur: India	Lecture on Traveling the Seven Continents December, 1986
Pushpam College, Poondi: India	Lecture on Antarctica to the North Pole December, 1986
Church Group at Pieterlen: Switzerland	Lecture on Travel in the Peruvian Andes, December, 1986
Community Meeting, Anchorage: Alaska	Lecture on Exploring Greenland September, 1986
Rotary Club of Coimbatore: India	Lecture of Health Care Systems October, 1980

HONORS AND AWARDS:

George Tarjan Award of the American Psychiatric Association Award of $500 & a lecture delivered at the Institute of Psychiatric Services meetiing in Philadelphia, Pennsylvania, October 2013	2013
Distinguished Service Award, American Academy of Psychiatry & the Law (Red Apple Award) in Boston, Massachusetts	2011
Testimony at the State of Illinois Joint Task Force on Access (August 29)	2006
Distinguished Service Award, Indo-American Psychiatric Association	2006
Who's Who in Science and Engineering	2006-
Testimony in the State of Illinois Senate Hearings (March 9)	2005
Excellence in International Service Award, Indo-Australasian Psychiatry Association & World Psychiatric Association	2004
Who's Who in the World	2004-
Profile of Excellence (Recognition of 25 prominent Indian-Americans) IAPA Souvenir at its Silver Jubilee Celebrations	2004
Nominated for President Elect, American Psychiatric Association	2003
Distinguished Fellow, American Psychiatric Association	2003
Who's Who in America	2002-
Nominated Representative of American Psychiatric Association to the American Medical Association's Workgroup on Gun Related Violence	2001
EXAMINER- American Board of Psychiatry & Neurology	2000-
Who's Who in Medicine & Healthcare	2000-

Paid Time off Award for Performance
Department of Veterans Affairs
John J. Pershing Medical Center
Poplar Bluff, Missouri 1999

Monetary Award for Performance
Department of Veterans Affairs
John J. Pershing Medical Center
Poplar Bluff, Missouri 1998

COMMENDATION -
Department of Veterans Affairs Medical Center
Canandaigua, New York
For Outstanding Service 1998

Exceptional Achievement Award from Network Director,
Veterans Integrated Service Network-2
(Western New York Network) 1997

International Who's Who in Professionals 1996

SPECIAL AWARD PLAQUE -
American Association of Psychiatrists from India
for Meritorious Contributions & Dedicated Service 1995

CERTIFICATION OF APPRECIATION -
Department of Veterans Affairs Medical Center
Canandaigua, New York
Exceptional Contribution for JCAHO Survey 1995

JUDGE - Science Fair at Canandaigua Middle School 1995-1997

FELLOW - American Psychiatric Association 1993

COMMENDATION -
Department of Veterans Affairs Medical Center,
North Chicago, Illinois
For Performance (Acting Chief Psychiatry Service) 1993

CERTIFICATE OF APPRECIATION -
DuPage County Mental Health Crisis Unit
Lombard, Illinois 1992

CERTIFICATE OF APPRECIATION -
Department of Veterans Affairs Medical Center,
North Chicago, Illinois
Key Note Speaker - Asian Pacific Week 1992

Selected Delegate & Prize Winner in Essay Competition
Rotary Youth Leadership Award Seminar
Vellore, Tamilnadu, India 1973

Selected Delegate From Rotaract Club of Thanjavur
First Asian Rotaract Convention, Hyderabad, India 1971

National Merit Scholarship,
National College High School, Trichy, India 1966
(Stood first in School of 250 students & 30th in State of more than 100,000 students)

RESIDENTS TEACHING: (SOUTHERN ILLINOIS UNIVERSITY)

Elective Rotation in Rural Inpatient Psychiatry for
PGY-2, 3 & 4 Residents 1998-2008

Clinical teaching of Forensic Psychiatry for
PGY-4 & 5 Residents (Fellows in Forensic Psychiatry) 2001-2004

MEDICAL STUDENTS TEACHING: (SOUTHERN ILLINOIS UNIVERSITY)

Third year clerkship in Inpatient Units of
Choate Mental Health Center
Anna, Illinois 1998-2008

Lecture to first year medical students in Behavioral Science Course
Southern Illinois University, Carbondale Campus 1999-2007

MEDICAL STUDENTS TEACHING: (UNIVERSITY OF ROCHESTER)

Third year clerkship in Post Traumatic
Stress Disorder Clinic,
Canandaigua V.A. Medical Center 1995-1997

LAW STUDENTS TEACHING: (SOUTHERN ILLINOIS UNIVERSITY SCHOOL OF LAW)

Classroom teaching in Health Law Course 2002-2004

COURSES TAUGHT RESIDENTS: (SOUTHERN ILLINOIS UNIVERSITY)

Psychopathology
Course Director & Principal Teacher 2000-2006

Forensic & Ethical Psychiatry 1999-2006

Geriatric Psychiatry 2004-2005

Social Cultural Issues 2005-2008

COURSES TAUGHT RESIDENTS: (UHS/CMS)

Acculturation for International Medical Graduates 1994
Alcoholism and Substance Abuse 1994
Forensic and Ethical Psychiatry
Course Director and Principal Teacher 1989-1994
Geriatric Psychiatry 1989-1994
Professional Issues and Identity 1989-1994
Forensic Psychiatry and
Introduction to ECT 1989-1994
Critiques of Treatment Modalities
Course Director and Principal Teacher 1982-1986
Lecture Series for First Year Residents 1982-1986

Journal Club for Residents		1982-1986

COURSES TAUGHT FOR MEDICAL STUDENTS: (UHS/CMS)

Forensic and Ethical Issues in Psychiatry Third Year Clerkship		1988-1994
Anxiety Disorder and Personality Disorder Board Examination Preparatory Course		1993
Cultural Aspects of Medicine in Psychosocial Factors in Medicine Course		1993
Forensic Medicine and Ethics in Psychosocial Factors in Medicine Course		1989-1993
Interview Conference Third Year Clerkship		1987-1993
Medical-Surgical Interviewing Course for second year medical students		1983-1986
Physical Diagnosis Course for second year medical students		1984
Clerkship Orientation and Fundamentals, Emergencies in Psychiatry, Personality Disorders and Temporal Lobe Seizures Third Year Clerkship		1982-1986

COURSES TAUGHT OTHERS: (USH/CMS)

Neuropsychiatry/ECT Fellows	Supervisor	1990-1994
Inpatient Practicum 4-6 weeks for Ph.D. Psychology students	Supervisor	1982-1986
Elective in ECT for Senior Resident from Illinois State Psychiatric Institute for one month	Supervisor	1990
Elective in ECT for Senior Resident from Medical College of Ohio at Toledo for one month	Supervisor	1992
Elective in Behavioral Neurology for Senior Medical Student from Rutgers Medical School for one month	Supervisor	1982
Elective in Psychiatry for Medical Student from Ireland for 8 weeks	Supervisor	1982
Elective in Psychiatry for Psychology Student from University of Southern California for 8 weeks	Supervisor	1982

CONSULTANT:

Eli Lilly Pharmaceuticals	1996
Pfizer Pharmaceuticals	2003
Center for Health Education and Culture, Baltimore, MD	2006

BOARD OF EXAMINER:

Ph.D. Thesis in Psychiatry of Dr. N. Shalini, M.B.B.S., D.P.M.,
Dr. M.G.R. University, Chennai, India 2006

PRESENTATIONS:

Evolution of Informed Consent and Right to Refuse Treatment. Invited Speaker at the Grand Rounds presentation at the University of Illinois, Peoria, Illinois on July 2 2014.

Tele-psychiatry: Discussant to a panel at the XXXIII International Congress on Law and Mental Health in Amsterdam, Netherlands July 14-19 2013.

South Asia Discussion Group: Jagannathan Srinivasaraghavan, M.D. (Chair) at the 166th Annual Meeting of the American Psychiatric Association in San Francisco, California on May 18-22 2013.

The Evolution of Informed Consent and its application across cultures. Invited Speaker at the Grand Rounds presentation at Nassau University Medical Center, East Meadow, New York on February 13 2013.

Consent, Informed Consent and Right to Refuse Treatment. Invited Speaker at the Grand Rounds in Flushing Hospital Medical Center, Flushing, New York on February 13 2013.

South Asia Discussion Group: Jagannathan Srinivasaraghavan, M.D. (Chair) at the 165th Annual Meeting of the American Psychiatric Association in Philadelphia, Pennsylvania on May 5-9 2012.

South Asia Discussion Group: Jagannathan Srinivasaraghavan, M.D. (Chair) at the 164th Annual Meeting of the American Psychiatric Association in Honolulu, Hawaii on May 14-22 2011.

Depression. Invited Speaker at the annual meeting of the American Tamil Medical Association in Bloomingdale, Illinois on August 13 2010.

Depression: Recognition and Diagnosis in Primary Care Practice. Invited Speaker at G.V. (Sonny) Montgomery V.A. Medical Center and University of Mississippi, Jackson, Mississippi on August 4 2010.

Addressing current needs within a long-term framework: A Ministry-Partners in Health (PIH) model for national development of community mental health care. Invited Moderator of a Panel at the Haitian Mental Health Summit in the University of Miami, Miami, Florida on June 26-27 2010.

Informed Consent: Evolution and Practice. Invited Speaker at the Dorn V.A. Medical Center and University of South Carolina, Columbia, South Carolina on June 23 2010.

South Asia Discussion Group: Arshad Husain, M.D., Jagannathan Srinivasaraghavan, M.D. (Co-Chairs) at the 163rd Annual Meeting of the American Psychiatric Association in New Orleans, Louisiana on May 22-26 2010.

Telepsychiatry in Action: A Panel discussion with Molli Rolli, M.D., Robert Sharpe, M.D. & Basil Spyropoulos, M.D., at the 1st Annual IPS/WPA Fall CME Meeting in Lake Geneva, Wisconsin on October 16-17 2009.

Detection of Malingering. Invited Speaker at Primer Congreso Internacional de Criminologia y Psiquitria Forense in Buenos Aires, Argentina on September 22 2009.

Telepsychiatry and Public Policy. Chaired and presented in a session at the XXXI International Congress on Law and Mental Health in New York, New York on July 3 2009.

Cultural Formulation in Forensic Psychiatry. Chaired a session and presented at the XXXI International Congress on

Law and Mental Health in New York, New York on July 1 2009.

Suicide by South Asians abroad in a Symposium Problem of Suicide in South Asia Chaired by JK Trivedi & Lakshmi Vijayakumar at the 61st Annual National Congress of the Indian Psychiatric Society at Agra, India on 9 January 2009.

Who is Informed? Who provides consent? Global Perspective on Informed Consent. Grand Rounds presentation at Royal College of Medicine, Regina General Hospital at Regina, Saskatchewan, Canada on July 22 2008.

Informed Consent and its Application in Different Cultures. Invited speaker at University of West Virginia, Charleston Division, Charleston , West Virginia on July 11 2008.

Overturning the Right to Refuse Psychotropic Medications in Illinois. Invited Speaker at University of Illinois College of Medicine at Rockford on December 17 2007.

Risk Assessments in Psychiatry. Invited presentation at University of Brunei Darussalam RIPAS Hospital on December 5 2007.

Current Status of Mental Health Laws and Policies from a Variety of Countries. Chaired and moderated a panel at the 30th International Congress on Law and Mental Health in Padua, Italy on June 25-30 2007.

Mental Health Legislation in Developing Countries: Problems and Solutions. Chaired a Special Forensic Psychiatry Symposium at the WPA Section on Psychiatry in Developing Countries in Lahore, Pakistan on February 15-19 2007.

Initiatives of WPA Section and South Asian Forum in Developing Countries. Co-Chaired a Plenary Session at the WPA Section on Developing Countries in Lahore, Pakistan on February 15-19 2007.

Euthanasia and Physician Assisted Suicide: US and International Perspectives. Grand Rounds at Southern Illinois University School of Medicine, Springfield, Illinois on January 19 2007.

Training in Psychiatry at Undergraduate and Postgraduate Level: South Asian Scenario. Discussant of a Symposium at the 59th Annual National Congress of the Indian Psychiatric Society in Chennai, India on January 4-7 2007.

Psychiatric Ethics in the Context of Developing Countries. Invited speaker at the International Symposium, Mental Health, Ethics and Social Policy in Montreal, Quebec, Canada on October 12-13 2006.

Euthanasia and Physician Assisted Suicide: International Perspectives. Invited Speaker at the 2nd International Cultural Psychiatry conference in Sydney, Australia on November 25-27 2005.

Schizophrenia – Recent Developments. Chaired and moderated a lecture by Dr. Afzal Javed in Psychiatry Update CME in Colombo, Sri Lanka on July 28-29 2005.

Euthanasia & Physician Assisted Suicide. Invited Speaker at the WPA Co-Sponsored International Conference on Psychiatry in Colombo, Sri Lanka on July 24-28 2005.

WPA Special Session – Future plans, Directions & Strategies in International Collaboration. Panelist with Prof. R.N. Mohan, Russell D'Souza, Pichet Udomratn, Mohan Isaac & Arun Ravindran at the WPA Co-Sponsored International Conference on Psychiatry in Colombo, Sri Lanka on July 24-28 2005.

Death Penalty I: Historical and Theoretical Perspectives. Chair of the Sessions at the XXIX International Congress on Law and Mental Health in Paris, France on July 4-8 2005

Psychiatric Ethics in Death Penalty Cases. Presented at the XXIX International Congress on Law and Mental Health in Paris, France on July 4-8 2005.

Are We Ready to Address the Cultural Diversity in The Elderly? Invited Spaeaker at the Fifth Annual Mental Health and Aging Conference at Schaumburg, Illinois on April 21-22 2005.

Indians: Issues and Solutions. The 151st Annual Meeting of the American Psychiatric Association, Syllabus and Proceedings Summary Issue Workshop 28, pages 232-233 in Toronto, Canada, May 30-June 4, 1998

Srinivasaraghavan J (Chairman), Weiner RD, Thompson JW. ECT in the USA: Clinical Practice, Legal Issues and Usage. 49th Institute on Psychiatric Services Syllabus and Proceedings Summary Workshop 43, pages 200-1 in Washington D.C., October 24-28, 1997

Srinivasaraghavan J (Chairman), Morphy MA, Nand SS, Alarcon RD, Holland GJ. Paradigm Shift in Psychiatric Training in the New Department of Veterans Affairs. 49th Institute of Psychiatric Services Syllabus and Proceedings Summary Workshop 47, pages 202-3 in Washington D.C.,October 24-28, 1997

Kim JJ, Tasbas HE, Srinivasaraghavan J. Caffeine and Nicotine Use following Alcohol Detoxification. 49th Institute of Psychiatric Services Syllabus and Proceedings Summary Poster 91, page 126 in Washington D.C., October 24-28, 1997

Tasbas HE, Kim JJ, Srinivasaraghavan J. Co-morbidity of Polydypsia and Alcoholism in Schizophrenia. 49th Institute of Psychiatric Services Syllabus and Proceedings Summary Poster 79, page 121 in Washington D.C., October 24-28, 1997

Srinivasaraghavan J, Mahableshwarkar A, Rockwell M, Nair S, Cohen M, Brunner J. Court-Ordered Psychotropics in Three Illinois State Hospitals. 28th annual meeting of the American Academy of Psychiatry and the Law Research in Progress #2, pages 30-1 in Denver, Colorado, October 23-26, 1997

Srinivasaraghavan J, Weiner RD. Practice of ECT in Veterans Affairs Medical Centers. The 150th Annual Meeting of the American Psychiatric Association New Research Program and Abstracts NR 297, page 147, in San Diego, California, May 17-22, 1997

Kim JJ, Tasbas HE, Srinivasaraghavan J. Caffeine and Nicotine use around Alcohol Withdrawal in Veterans diagnosed with Alcohol Dependence. The 150th Annual Meeting of the American Psychiatric Association New Research Program and Abstracts NR 318, page 153, in San Diego, California, May 17-22, 1997

Srinivasaraghavan J, Weiner RD. Utilization of ECT in Veterans Affairs Medical Centers. Seventh Annual Meeting of the Association of Convulsive Therapy in Convulsive Therapy Volume 13, Number 1, 1997 in San Diego, California, May 18, 1997

Srinivasaraghavan J (Chairman), Nora R, Arana G, Graeber D. Department of Veterans Affairs/Department of Defense Sharing Agreements: Promises and Problems. Issue Workshop 47, 150th Annual Meeting of the American Psychiatric Association Syllabus and Proceedings Summary pages 231-2 in San Diego, California, May 17-22, 1997

Srinivasaraghavan J, Bowerman D. Assessing ECT Volume in a Long Term Care V.A. Medical Center. 48th Institute on Psychiatric Services Institute Proceedings and Syllabus Summary (Poster 104), page 121 in Chicago, Illinois, October 18-22, 1996

Srinivasaraghavan J (Chairman), Swartz CM, Schrift MJ, Mahableshwarkar A. Clinical Practice of Inpatient and Ambulatory ECT. 48th Institute of Psychiatric Services Institute Proceedings and Syllabus Summary Half-Day Session 11, pages 36-37, in Chicago, Illinois, October 18-22, 1996

Kern S, Blum B, Spiro H, Srinivasaraghavan J. Geriatrics and the Law. 27th Annual Meeting of the American Academy of Psychiatry and the Law, 1996 Annual Meeting Program Panel S18, pages 54-55, San Juan, Puerto Rico, October 17-20, 1996

Srinivasaraghavan J, Mahableshwarkar A. Forced Psychotropic Medication: Five years Illinois, USA Data. Xth World Congress of Psychiatry, Abstracts Volume 2, page 397, at Madrid, Spain, August 23-28, 1996

Srinivasaraghavan J, Kossow L. Parameters Predicting Extended Full Leather Restraints. 149th Annual Meeting of the American Psychiatric Association New Research Program & Abstracts (NR 756), page 276 at New York, New

York, May 4-9, 1996.

Srinivasaraghavan J, Abrams R. Who Seeks and Who Receives Court Ordered ECT in Illinois? Sixth Annual Meeting of the Association of Convulsive Therapy at New York, New York, May 5, 1996.

Srinivasaraghavan J (Chairperson), Desai PN, Sierles F, Nasarallah H, Westermeyer J, Morphy M. The Changing VA System - Implications for Academic Affiliations. Issue Workshop 6, 149th Annual Meeting of the American Psychiatric Association Syllabus and Proceedings Summary, page 234, New York, New York, May 4-9, 1996

Srinivasaraghavan J, Mahableshwarkar A, Brunner JB. Who is Forced to take Psychotropic Medication in Illinois? Annual Meeting of the American Academy of Psychiatry and the Law, 26th Annual Meeting Program and Abstracts Research in Progress #4, page 79, Seattle, Washington, October19-22, 1995

Srinivasaraghavan J, Abrams R. Psychiatrists Who Seek Court Ordered ECT in Illinois. Annual Meeting of the American Academy of Psychiatry and the Law, 26th Annual Meeting Program and Abstracts Research in Progress #4, pages 79-80, Seattle, Washington, October19-22, 1995

Srinivasaraghavan J, Kossow L. Mitigating Factors in Extended Cuff and Belt Restraints. Annual Meeting of the American Academy of Psychiatry and the Law, 26th Annual Meeting Program and Abstracts Research in Progress #3, pages 64-65, Seattle, Washington, October 19-22, 1995

Srinivasaraghavan J, Abrams R. Court Ordered ECT for Incompetent Patients in Illinois. 47th APA's Institute on Psychiatric Services, Syllabus (Poster 79), page 95-96, in Boston, Massachusetts, October 6-10, 1995

Srinivasaraghavan J, Mahableshwarkar A. Illinois Experience with Court Ordered Psychotropic Medication. 47th APA's Institute on Psychiatric Services, Syllabus (Poster 80), page 96, in Boston, Massachusetts, October 6-10, 1995

Srinivasaraghavan J, Mahableshwarkar A. Court Ordered ECT at Veterans Affairs Hospitals in Illinois. 148th Annual Meeting of the American Psychiatric Association, New Research Program & Abstracts (NR 626), page 223, in Miami, Florida, May20- 25, 1995

Wong N, Leon R, Hamadani H, Dewan M, Srinivasaraghavan J, Carder S, Napoliello M. Challenges of International Education. Component Workshop 43. 148th Annual Meeting of the American Psychiatric Association, Syllabus & Proceedings Summary, summary page 186, in Miami, Florida, May 20-25, 1995

Srinivasaraghavan J, Alfano P, Abrams R. Controlled Study of Attitude Change Towards ECT. 148th Annual Meeting of the American Psychiatric Association, New Research Program & Abstracts (NR 501), page 189, Miami, Florida, May 20-25, 1995

Srinivasaraghavan J, Abrams R. Who Gets Court Ordered ECT in Illinois. Annual Meeting of the American Academy of Psychiatry and the Law 25th Annual Meeting Abstracts Research in Progress Sessions #4, page 75, Maui, Hawaii, October 20-23, 1994

Srinivasaraghavan J, Mahableshwarkar A, Abrams R. Forced Psychotropic Medication: Illinois Experience. Annual Meeting of the American Academy of Psychiatry and the Law 25th Annual Meeting Abstracts Research in Progress Sessions #4, page 76, Maui, Hawaii, October 20-23, 1994

Srinivasaraghavan J, Prosin C, Pure D, Bates H. Discharge Planning: An Interdisciplinary Indicator with Promise. Poster presentation at VA Clinical Indicator Symposium, San Antonio, Texas, August, 1993.

Atre-Vaidya N, Taylor MA, Jampala VC, Srinivasaraghavan J. Epileptoid Features, Psychopathology and Mood Disorders. A preliminary report. 146th Annual meeting of the American Psychiatric Association. New Research Program & Abstracts (NR 475), page 179, San Francisco, California, May 22-27, 1993

Atre-Vaidya N, Taylor MA, Jampala VC, Srinivasaraghavan J. Epileptoid Features, Psychopathology and Mood Disorders. A preliminary report. Annual Meeting of the American Psychopathological Association in New York,

New York, March, 1993

Mahableshwarkar A, Vedak C, Jampala VC, Srinivasaraghavan J. Intravenous Haloperidol for Treatment Resistant Mania. New Research Programs and Abstracts. 145th Annual meeting of the American Psychiatric Association, pages 77-78, in Washington D.C. May 2-7, 1992

Swartz CM, Abrams R, Lane RD, DuBois MA, Srinivasaraghavan J. Heart Rate Differences Between Right and Left Unilateral ECT. Paper Session. Biological Factors in Depression. 145th Annual Meeting of the American Psychiatric Association, page 80, in Washington D.C., May 2-7, 1992

Lane R, Abrams R, Swartz CM, DuBois MA, Srinivasaraghavan J. Differential Effects of Right and Left Unilateral ECT on Heart Rate. American College of Cardiology Annual Scientific Session. In Dallas, Texas, April 12-16, 1992.

GRANTS:

Professional Performance in the Court as a Factor in the Outcome of Court Decisions Involving Petitions for Psychotropic Medications Over Objection. Principal Investigator (Research Grant of $4800 from Central Management Services of Department of Human Services) 1999-2002.

Court Ordered Psychotropic Medication in Southern Illinois. Principal investigator (Research Grant of $5,000 from Central Management Services and Choate Mental Health Center) 1998-99.

Treatment of Post Traumatic Stress Disorder: Comparison of Fluoxetine and Nefazodone effects on Sexual Function. Principal Investigator. (Research Grant of $22,500 from Bristol Myers Squibb is received in January, 1997).

REVIEWER:

Journal of the American Academy of Psychiatry and the Law
(Bulletin of the American Academy of Psychiatry and the Law)

Journal of American College of Forensic Psychiatry

Behavioral Sciences and the Law (International Editor)

Psychiatric Services

Journal of Psychosomatic Research

INTERNATIONAL ADVISORY BOARD:

Indian Journal of Psychiatry

HOBBIES:

Travel - Visited 195 independent nations of 195;
317 Countries of 324 (Travelers Century Club) www.travelerscenturyclub.org

Distinction of being the first Asian to plant an Indian flag at the North Pole on April 23 1985
www.wiki.answers.com

Photography

Revised 07/26/2014

Summary
Council on Addiction Psychiatry

Information Items:

1. The Council reviewed the following position statements for currency and makes the following recommendations:

   Maintain:
   - Relationship Between Treatment and Self Help
   - Recognition and Management of Substance Use Disorders Comorbid with HIV

   Revise:
   - Adolescent Substance Abuse
   - Tobacco Dependence
   - Inclusion of Substance Use Disorders
   - Care of Pregnant and Newly Delivered Women Addicts
   - Treatment of Substance Use Disorders in the Criminal Justice System

   Retire:
   - Mental Health & Substance Abuse and Aging: Three Resolutions

   The Council will revise the indicated statements and consult with other Councils as appropriate.

2. The Council developed recommendations on expanding access to buprenorphine treatment and submitted them to the Office of National Drug Control Policy, SAMHSA, and NIDA (**Attachment #1**). The recommendations also address the intent of Assembly Action Paper, Increasing Buprenorphine Prescribing Limits, ASMMAY1412.G

3. Council is collaborating with NIDA, the Council on Medical Education and Lifelong Learning and the American Association of Directors of Psychiatry Residency Training to develop open-source curricula on substance use disorders for general psychiatry programs. A needs assessment will be undertaken as well as several other activities that will inform and shape the development of an R25 grant application to be submitted to NIDA in May 2015.

Referral Updates:

1. **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.

MINUTES
Council on Addiction Psychiatry
September 12, 2014
Arlington, VA

Attendance: Drs. Frances Levin (chair), Yetunde Akins, Elie Aoun, Hector Colon-Rivera, Smita Das, Karen Drexler, Timothy Fong, Marc Galanter, Shelly Greenfield, Kevin Hill, Petros Levounis, Leslie Marino, John Renner, Andrew Saxon, Mandrill Taylor, Mona Thapa
Guests: Renee Binder, MD; Lizbet Boroughs; Michael Botticelli (ONDCP); Wilson Compton, MD (NIDA); Robert Heubner, PhD (NIAAA); Dan Kivlahan, PhD (VA); George Koob, PhD (NIAAA); Kimberly Jeffries Leonard, PhD (CSAT); Robert Lubran (CSAT); Annelle Primm, MD; June Sivilli (ONDCP); Paul Summergrad, MD; and Douglas Ziedonis, MD
Council Staff Liaison: Beatrice Eld
Absent: Drs. Oscar Bukstein, Mark Gold, Robert Milin, Edward Nunes, Ronald Thurston

Meetings with APA Leadership:

- **APA President –** Paul Summergrad, MD

Dr. Summergrad expressed his appreciation to the Council for establishing a workgroup on tobacco use disorder. He looks forward to joining the workgroup chair, Doug Ziedonis, and Dr. Steven Schroeder, director of the Smoking Cessation Leadership Center, to present a symposium at the upcoming Institute on Psychiatric Services.

- **APA President-Elect -** Renee Binder, MD

Dr. Binder discussed the priorities for her presidential year, including reducing the stigma against those who have a mental illness and against psychiatrists and the role of psychiatrists in the 21st century. She anticipates that APA's advocacy efforts will be increasingly proactive and envisions the association drafting legislation and finding Congressional champions. She congratulated the Council on the many significant projects it has undertaken and thanked members for their mentorship of the future leaders of the field.

- **APA CEO and Medical Director -** Saul Levin, MD

Dr. Levin expressed appreciation to the Council for its many contributions to the APA. He urged the Council to pursue funding opportunities with NIDA and NIAAA for a research mentoring program and is pleased to learn of its collaboration with NIDA regarding development of substance abuse curriculum in general psychiatry programs.

White House Office of National Drug Control Policy – Acting Director Michael Botticelli

The Council welcomed Acting Director Michael Botticelli and June Sivilli, chief of the ONDCP treatment branch. Mr. Botticelli outlined the national drug strategy and invited the Council to contribute ideas and recommendations to the next iteration. The strategy utilizes a public health approach and focuses on prevention, treatment, and recovery, as well as reform of the criminal justice system. It is implemented by a number of Federal agencies that are required to align their budgets and programs with the drug control strategy.

Key areas addressed by Director Botticelli included: the misuse of prescription drugs and heroin and the resulting health consequences, including overdoses, dramatic increases in viral hepatitis and HIV, and neonatal abstinence syndrome; marijuana; and access to medication assisted treatment.

ONDCP initiatives include:

- Educating physicians on safe and responsible opioid prescribing ;
- Making overdose prevention kits more widely available and implementing Good Samaritan laws;
- Utilizing Prescription Drug Monitoring Programs, fully integrating PDMP data in electronic health records, and making the programs interoperable among States; and
- Expanding access to medication assisted treatment.

National Institute on Drug Abuse – Wilson Compton, MD, Deputy Director

Dr. Compton reviewed the status of NIDA's budget and several of the Institute's focus areas, including the epidemic of opioid addiction and the shifting marijuana policy environment.

The Collaborative Research for Addictions at NIH (CRAN) facilitates collaboration between NIDA, NIAAA, and the National Cancer Institute. CRAN is launching the Adolescent Brain and Cognitive Development (ABCD) study, which is built around need for better information on marijuana and other substances. The goal is to launch a large cohort study of children approximately 10 years of age, including repeated neuroimaging and clinical follow-up from adolescence through early adulthood. A Request For Applications will be released.

NIDA is pleased to be working with the Council and several of its members to discuss development of substance abuse curricula for general psychiatry training programs. APA's Council on Medical Education and Life Long Learning and the American Association of Directors of Psychiatry Residency Training will be briefed on the initiative and invited to participate and/or endorse the effort.

National Institute on Alcohol Abuse and Alcoholism – George Koob, Ph.D., Director and Robert Huebner, Ph.D., Director of Treatment and Recovery Research

Dr. Koob reviewed the budget and major initiatives of NIAAA, including the ABCD study, medication development, development of resources to address college binge drinking, and miniaturization of a device to measure blood alcohol levels.

NIAAA will present the featured research track at the 2015 APA Annual Meeting in Toronto. A series of about 13 sessions is being planned, including three lectures, symposia, workshops, and forums.

Veterans Health Administration – Karen Drexler, MD and Daniel Kivlahan, PhD

The VA has a new direction which is guided by a new Secretary and a new Undersecretary for Health. Highlights of recent developments pertinent to psychiatry include:

- To improve access, more mental health clinicians are being recruited, especially psychiatrists. Recruitment will be made easier through implementation of a loan repayment program for psychiatrists.

- Extended release naltrexone was added to the formulary in July 2014.
- Multidisciplinary advanced fellowships in addiction treatment are now available, but it is difficult to recruit psychiatrists.
- Alcohol pharmacotherapy in the VA includes acamprosate, oral and IM naltrexone, disulfiram, and topiramate. About 9% of veterans seen in the VA have a diagnosed substance use disorder; 29% of them receive specialty care and 6% with alcohol use disorders receive alcohol pharmacotherapy. There are ongoing efforts to improve this.
- Access to buprenorphine treatment is being expanded. About 29% of veterans diagnosed with opioid use disorders are being treated with buprenorphine or methadone.
- An opioid safety initiative has many prongs, including the overdose prevention. It is a multidisciplinary effort and includes partnerships with pharmacists, primary care, and others. Rescue kits have been distributed to Medical Centers. Additionally, mental health is working closely with primary care and they are attempting to make evidence-based changes in how opioids are prescribed.
- The use of Prescription Drug Monitoring Programs has been challenging but prescribers can now query those systems.

Center for Substance Abuse Treatment – Kimberly Jeffries Leonard, PhD, Deputy Director and Robert Lubran, Director, Division of Pharmacologic Therapy

The major foci of SAMHSA include suicide, prescription drug misuse, and medication assisted treatment.

- A Buprenorphine Summit will be held on September 22-23. The conference is co-sponsored by SAMHSA and NIDA. Participants are experts selected by a steering committee comprised of representatives of SAMHSA, NIDA, FDA, IHS, VA, ONDCP, and DOJ. About 80 people are expected to participate. Major topics will include patient access, patient capacity and quality of care, special populations, role of physician training, working with non-physician providers, and reimbursement.
- CSAT Director Westley Clark is involved in an interagency Federal workgroup on marijuana. Information regarding marijuana use by those in medication assisted treatment was distributed to the opioid treatment programs.
- A listening session regarding possible changes to the confidentiality provisions of 42 CFR was held on June 11. There were 1800 participants. SAMHSA is now considering next steps.
- SAMHSA's strategic plan was released for public comment.

Dr. Levin thanked SAMHSA for its support of the Providers' Clinical Support System-Medication Assisted Treatment. Council is very pleased to learn of SAMHSA's approval of AAAP's application to lead the Providers' Clinical Support System-Opioid Therapies. APA is a partner in each of these programs and contributes a significant amount of programmatic activity to both of them.

Federal support of training focuses on programs for non-physicians and non-specialists. There is a dearth of addiction psychiatrists, with just 50 people graduated from addiction psychiatry fellowships each year. A previous Career Teachers Award was very successful and reinstating a similar program could bolster the training and yield positive results.

A meeting with APA, AAAP, and key staff in the Center for Substance Abuse Treatment to discuss ways to bolster training in addiction psychiatry will be pursued.

SAMHSA reviewed the APA-AAAP-AOAAM proposal regarding patient limits. With the Center for Disease Control it submitted a proposal to the Secretary of Health and Human Services that was circulated through the Department for comment. There are three issues: the role of non-physician prescribers, the patient limits, and possible alternative pathways to qualify. The next steps will be at the direction from the HHS Secretary.

Expanding Access to Buprenorphine Treatment

In response to the epidemic of prescription drug and heroin addiction in the United States, SAMHSA, NIDA, and HHS are actively deliberating possible administrative changes to increase patient limits reflected in the Drug Addiction Treatment Act of 2000, as well as other potential mechanisms to increase access to buprenorphine treatment. To inform the deliberations, SAMHSA urged the DATA organizations (APA, AAAP, AOAAM, and ASAM) to submit recommendations for review and consideration.

Several conference calls were convened with representatives of the DATA organizations during which a series of recommendations drafted by Dr. John Renner were reviewed. The American Academy of Addiction Psychiatry and the American Osteopathic Academy of Addiction Medicine endorsed the recommendations and the APA-AAAP-AOAAM document (**Attachment #1**) was forwarded to SAMHSA, NIDA, and ONDCP for review and consideration. The American Society of Addiction Medicine opted to submit its recommendations to Federal officials separately. The document reflects proposed changes that will increase access to buprenorphine treatment by increasing the patient limits and authorize prescribing by physician extenders who are supervised by physicians certified in addiction psychiatry or addiction medicine. Additionally, it calls for Federal support for expanded training.

APA's Government Relations staff is actively discussing the APA-AAAP-AOAAM recommendations with US Senators Ed Markey and Carl Levin who have introduced legislation to expand treatment access.

Development of Curricula on Substance Use Disorders for General Psychiatry Residency Programs

Dr. Frances Levin provided an overview of NIDA's request that APA develop open-source curricula on substance use disorders for general psychiatry programs. Since the Council's last meeting, Dr. Frances Levin and Beatrice Eld met with key NIDA staff, including Deputy Director Wilson Compton, to discuss possible approaches and collaborators. The group agreed it is essential to reach out to APA's Council on Medical Education and Lifelong Learning (CMELL) and the American Association of Directors of Psychiatric Residency Training (AADPRT) to invite their input and buy-in. To that end, Drs. Compton and Levin, and Beatrice Eld met with the CMELL, who responded positively to the proposal. Two CMELL members volunteered to be a part of the planning group.

Member suggestions included:

- Contacting Dr. Sandra DeJong, the chair of AADPRT's program committee, to advocate that addictions be made a focus of the 2015 AADPRT Annual Meeting. This may be a keynote or at least one of the featured sessions;

- Providing small financial incentives to residency training programs to incorporate the addiction curricula developed under the NIDA grant; and
- Developing a summary of the literature pertaining to the insufficiency of SUD training in general psychiatry programs.

The curriculum work group will engage in a series of preparatory activities that will inform and shape an R25 grant proposal that will be submitted to NIDA in May 2015. It will review a similar initiative that developed innovative curricula in neuroscience and assess how/if it can be adapted for addiction psychiatry, develop a needs assessment of training directors, and actively outreach to AADPRT's leadership.

In addition to the curriculum initiative, members agreed to contact SAMHSA to advocate for training support for clinical faculty, similar to a former career teacher award program.

Draft Assembly Action Paper - Integrating Buprenorphine Maintenance Therapy With Primary Mental Health

Dr. Elie Aoun, APA Leadership Fellow, solicited the Council's input on an Action Paper he drafted. Members were supportive of the aims of the paper and thanked Dr. Aoun for developing it. After making a few clarifying edits, Dr. Aoun will submit it to the APA Assembly for consideration at its meeting in November.

Review of Position Statements

Members reviewed a series of existing APA position statements and recommended if each of them should be (1) retained as written, (2) revised, or (3) retired.

- Adolescent Substance Abuse – will be revised by Drs. Oscar Bukstein and Smita Das
- Tobacco Dependence – will be revised by the Council's Workgroup on Tobacco Use Disorder
- Inclusion of Substance Use Disorders – will be revised by Drs. Shelly Greenfield and Leslie Marino
- Care of Pregnant and Newly Delivered Women Addicts – will be revised by Drs. Mona Thapa, Hector Colon-Rivera, Yetunde Akins, and Shelly Greenfield.
- Relationship Between Treatment and Self Help – Maintain as written
- Treatment of Substance Use Disorders in the Criminal Justice System – will be revised by Drs. Karen Drexler, John Renner, and Elie Aoun. The Council on Psychiatry and Law will be invited to collaborate on the revision.
- Mental Health & Substance Abuse and Aging: Three Resolutions – Retire
- Recognition and Management of Substance Use Disorders Comorbid with HIV – Maintain

Workgroup on Tobacco Use Disorder – Douglas Ziedonis, MD

Dr. Douglas Ziedonis, chair, reported that the Workgroup on Tobacco Use Disorder met by conference call and discussed a number of potential projects that would benefit the association and psychiatrists. The group will update APA's position statement on nicotine dependence, organize a workshop for the APA Annual Meeting, and consider developing a new statement on electronic cigarettes. Further it will outreach to the American Psychiatric Nurses Association and the American Academy of Family Medicine to obtain information about their successful

initiatives and assess the potential of adapting them for use in psychiatry. Contact will be made with Dr. Steven Schroeder, Director of the Smoking Cessation Leadership Center, to seek a grant to support the Workgroup's activities.

The upcoming Institute on Psychiatric Services will feature two sessions related to tobacco use disorder. A lecture will be presented by Dr. Jill Williams and a symposium presented by Drs. Summergrad, Schroeder, and Ziedonis.

Council members urged the Workgroup to call psychiatrists' attention to the association between suicide and tobacco use disorder.

Update of the Division of Government Relations - Lizbet Boroughs

Ms. Boroughs reported that last year APA was able to get legislation introduced that would qualify psychiatrists for loan forgiveness in the VA and worked with several veterans service organizations to promote it. While some provisions were passed in an omnibus bill, work is ongoing to achieve additional provisions specific to psychiatrists. DGR has also spent considerable effort in advancing the use of prescription drug monitoring programs in the VA.

DGR staff met with representatives of Senators Ed Markey and Carl Levin regarding proposed legislation to expand access to buprenorphine treatment. Those discussions have been informed by the work of Council members.

The group, Friends of NIAAA, has been reinvigorated and will advocate for the Institute and its budget.

Activities of Relevance to the Recommendations of the Board Workgroup on Healthcare Reform

The Council on Addiction Psychiatry is currently engaged in or planning projects that have some relevance to the Workgroup recommendations on healthcare reform, particularly in the area of physician training and workforce development:

1. As a partner organization in the SAMHSA-funded Providers' Clinical Support System for Medication Assisted Treatment (PCSS-MAT), APA plans and presents a webinar series that augments the 8-hour training required to treat opioid use disorders in an office-based setting. Webinars are presented once or twice per month for the benefit of psychiatrists, primary care physicians, and other interested clinicians. This program recognizes there is insufficient training on substance abuse treatment in psychiatry and primary care residencies and, consequently, many physicians feel underprepared and reluctant to treat opioid addicted patients. In light of the national epidemic of addiction to prescription drugs and heroin, this program aims to provide training and support that will benefit and encourage physicians to treat these patients.

   Additionally, the PCSS-MAT has a clinical mentoring component. A number of psychiatrists who are clinical experts in opioid treatment are accessible to physicians for short and long-term mentorship.

2. The Council on Addiction Psychiatry is working with the National Institute on Drug Abuse to develop open-source curriculum for general psychiatry training programs. In the coming months, a workgroup comprised of representatives of CAP, the Council on Medical Education and Lifelong Learning, and AADPRT will outreach to training programs to assess their needs, consider a variety of novel training approaches, and develop a funding proposal to NIDA. This project is intended to improve the quality of teaching, thereby preparing psychiatrists to function fully in new paradigms of care.

Recommendations of the
American Psychiatric Association,
American Academy of Addiction Psychiatry, and the
American Osteopathic Academy of Addiction Medicine on
Revisions to the Drug Addiction Treatment Act of 2000

1. **<u>Replace practice limits of 30/100 patients with a 3 tiered system</u>**:

   - **Tier 1: Small Primary Care or Psychiatry practices: physicians can follow up to 30 patients at one time, as with the present system**. There will be <u>NO DEA INSPECTIONS</u> unless DEA or single state agency review of state PDMP data suggests the 30 patient limit has been exceeded (or other violations of standard clinical practice regulations have occurred).

     <u>Comment</u>: DEA inspections are frequently mentioned as a reason for physicians not prescribing. This change should expand the number of small prescribers. Data groups & SAMHSA should notify all individuals who have taken waiver training of this new option and widely publicize the change.

   - **Tier 2:**
     - ***OPTION ONE – SOLO PRACTICE MODEL* (this practice can occur in a group setting, or multiple physicians can practice within the same system)**
     - **After 1 year of practice, physicians can apply to go up from the 30 patient limit to 150 patients.**
     - Prescribers in this group would be required to:

       1. take 3 hours of approved addiction related CME annually,
       2. certify that they follow a nationally recognized set of standard evidence-based guidelines for the treatment of patients with substance use disorders, and
       3. would be subject to occasional DEA inspections as in the current system.

       <u>Comment</u>: This tier is comparable to the current system. The increase to 150 patients would immediately address identified need for additional services but not increase the numbers in individual practices to a range that is incompatible with good clinical practice.

     - ***OPTION TWO - MULTIDISCIPLINARY PRACTICE***
     - **After 1 year of practice, a physician can apply to go from the 30 patient limit to a range of up to 340 patients with the addition of up to three physician extenders to the**

practice (Physician Assistant, Nurse Practitioner). The physician would be capped at **100** patients, each physician extender would be capped at 80 patients, with the total practice capped at 180 to 340 patients depending on the number of physician extenders in the group. This group of practitioners would be required to:

1. take 3 hours of approved addiction related CME/CEU annually,
2. certify that they follow a nationally recognized set of standard evidence-based guidelines for the treatment of patients with substance use disorders, and
3. be subject to occasional DEA inspections as in the current system.

Physicians in this type of practice would be **required to be certified** in Addiction Psychiatry by the ABPN or in Addiction Medicine by ABAM or ASAM, or have subspecialty board certification in addiction medicine from the American Osteopathic Association (AOA), unless SAMHSA grants an exemption for non-specialists practicing in high-need rural areas.

Comment: In this type of multidisciplinary practice the physician would be required to supervise the physician extenders. ***To allow for the time for required supervision, should the physician be capped at 80 patients? This would drop the total maximum number for the practice to 320.***

- **Tier 3: Practices that are over 340 patients would require separate registration as a specialized Opioid Treatment Program, and would be monitored accordingly** with varying staffing requirements related to the number of patients being treated, much more specific regulation of practice, and would be subject to periodic reviews by DEA and CARF or The Joint Commission. Physicians working in such a setting would be required to be certified in Addiction Psychiatry by the ABPN or in Addiction Medicine by ABAM or ASAM or have subspecialty board certification in addiction medicine from the American Osteopathic Association (AOA),. SAMHSA/CSAT should call a meeting of the DATA groups, the DEA, CARF, The Joint Commission to work out the details of regulations for this class of OTP. Practices of this type could be staffed by one or more physicians and a mix of RNs, MSWs, PhDs, Pharmacists and drug counselors comparable to the staffing in a methadone maintenance program, or they could follow the staffing guidelines described for Tier 2/Option Two above.

  Comment: While this model is inconsistent with the intent of DATA 2000, it recognizes the need for expanded services and protects the integrity of the DATA 2000 system, which is much better suited for providing services that are integrated into standard mental health and primary care settings under the ACA.

2. **Permit buprenorphine prescribing by Physician Assistants and Nurse Practitioners** in those states or jurisdictions where such practice is permitted. Prescribers will be required to take a standard 8 hour face-to-face waiver course, practice under the supervision of a physician certified in Addiction Psychiatry by the American Board of Psychiatry and Neurology (ABPN) or Addiction Medicine by the American Board of Addiction Medicine (ABAM) or the American Society of Addiction Medicine (ASAM) or have subspecialty board certification in addiction medicine from the American Osteopathic Association (AOA), (unless exempted by SAMHSA for non-specialists working in high-need, rural areas), and take 3 hours of approved addiction related CME/CEU annually. See Tier 2/Option Two above.

3. **Explore options under telemedicine that would permit delivery of buprenorphine services in rural or underserved areas**. Those telemedicine programs treating more than 340 patients will be held to Tier 3 standards.

4. **Additional Federal funds are needed for buprenorphine training for physicians and physician extenders, and for ongoing CME programs to enhance the clinical skills of treatment providers. Additionally, set-aside funding is recommended for residency training programs to provide training in Medication Assisted Treatment and would also provide physician training in MAT through funding additional ABPN-approved addiction psychiatry fellowships, as well as general practice addiction medicine fellowships.**

5. **Funds are also needed to cover the costs for an expanded treatment system for uninsured individuals with opioid use disorders, as well as those covered under Medicaid programs.**

6. **This program should be enacted for a trial period and re-evaluated in three years to determine if it is successful in expanding treatment capacity and whether increasing the number of patients treated by each waivered physicians has a negative impact on the quality of treatment, or a negative impact on public health associated with increased diversion of buprenorphine or other unanticipated negative consequences.**

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

Position Statement on Recognition and Management of Substance Use Disorders and Other Mental Illnesses Comorbid with HIV

Approved by the Board of Trustees, July 2012
Approved by the Assembly, May 2012

"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

There is a high prevalence of substance abuse and psychiatric disorders among HIV-infected individuals. Importantly, drug and alcohol-use disorders are frequently co-morbid with depression, anxiety and severe mental illness. Not only do these disorders increase the risk of contracting HIV, they have also been associated with decreased highly active antiretroviral therapy (HAART) utilisation, adherence and virological suppression.

Position Statement

Recommendations:

1. Psychiatrists should attend to the HIV-related prevention and psychiatric and substance use treatment needs of their patients (see position statements for specific settings and patient groups). Psychiatrists treating patients with substance use disorders are encouraged to stay abreast of psychosocial and somatic interventions with proven efficacy for these problems and their negative consequences (e.g., antabuse, naltrexone, buprenorphine, motivational enhancement therapy, cognitive behavioral therapy, needle exchange programs, and methadone maintenance).
2. Psychiatrists are encouraged to collaborate with their medical colleagues (physicians and others) to provide comprehensive and integrated care for HIV-infected patients. This can include collaboration with the treatment of substance use disorders and other mental illnesses, pain, sleep, and sexual disorders. Coordination is essential to maximize adherence and minimize drug-drug interactions and overlapping medication toxicities. Such coordination may also need to take into account the treatment of medical disorders commonly association with HIV, such as Hep C, Hep B, and TB. For psychiatrists who regularly evaluate and treat HIV-positive patients, staying knowledgeable about current HIV-related medical care will enhance their abilities to meaningfully engage in these collaborations.
3. When a psychiatrist evaluates a change of mental status in an HIV-infected patient, consideration should always be given to disorders due to general medical conditions and substance-induced disorders as possible underlying causes.

Prepared by the Steering Committee on HIV Psychiatry.

See also the related resource document.

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

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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 professsionals 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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COUNCIL ON ADVOCACY AND GOVERNMENT RELATIONS

EXECUTIVE SUMMARY:
The Council on Advocacy and Government Relations (CAGR) met on Friday, September 12 during the American Psychiatric Association's September Component Meeting in Arlington, VA. The Council received updates from the Department of Government Relations staff on major federal and state legislative and regulatory issues, and also received an update on APA*PAC*.

The Council discussed several key issues including:

- Medicaid Payment Increase for Primary Care Services
- *Medical Evaluation Parity for Service Members Act of 2014* (MEPS Act)
- Scope of Practice: APA Assisting District Branches and State Associations
- 2015 Advocacy Leadership Conference.
- Jacob Javits Award for Public Service

The draft minutes from the meeting are attached (Attachment #1)

The Council brings the following Action Item to the Joint Reference Committee:

1. **JACOB JAVITS AWARD FOR PUBLIC SERVICE AWARD**
   Will the Joint Reference Committee recommend that the Board vote to approve the Council's recommendation to award the 2015 Jacob Javits Award for Public Service to California State Insurance Commissioner Dave Jones? (See meeting minutes - page 4; Attachment #2 and #3)

The Council brings the following Informational Items to the Joint Reference Committee:

1. **JRC REFERRAL: MULTIPLE CO-PAYMENTS CHARGED FOR SINGLE PRESCRIPTIONS**
   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.

2. **JRC REFERRAL: REMOVE BLACK BOX WARNING FROM ANTIDEPRESSANTS**
   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.

3. **JRC REFERRAL: PATIENT SAFETY AND VETERANS AFFAIR MEDICAL CENTER (VAMC) PARTICIPATION IN STATE PRESCRIPTION MONITORING PROGRAMS (PMP)**
   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.

4. **JRC REFERRAL: MAINTAINING COMMUNITY TREATMENT STANDARDS IN FEDERAL CORRECTIONAL FACILITIES**
   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.

5. **JRC REFERRAL: NO PUNISHMENT FOR CHOOSING NOT TO ADOPT ELECTRONIC MEDICAL RECORDS**
   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.

Council on Advocacy and Government Relations
September Component Meeting
September 12, 2014
Hilton Crystal City, Arlington, VA
Meeting Minutes

Members in Attendance:
Barry Perlman, M.D., *Chair*
John T. Bailey, D.O., *Vice-Chair*
Matthew Erlich, M.D.
Jerry Halverson, M.D.
Napolean Higgins, M.D.
Brenda Jensen, M.D.
Steve Koh, M.D.
David Lowenthal, M.D.
Cassandra Newkirk, M.D.
Charles Price, M.D.
Altha Stewart, M.D.
Jerome Rogoff, M.D.
Christina Arredondo, M.D.
Joshua Berezin, M.D.
Adeniyi Adelakun, M.D.
Yusuf Ali, M.D.
Wilsa Malveaux, M.D.
Obianuju Obi, M.D., M.P.H.
Robert Cabaj, M.D. *(Attendance via Conference Dial-in)*

Members Absent:
Craig Zarling, M.D.
Ronald Burd, M.D.

Guests in Attendance:
Paul Summergrad, M.D., APA President
Renee Binder, M.D., APA President-elect
Saul Levin, M.D., M.P.A., APA Medical Director and CEO

APA Staff in Attendance:
Kristin Kroeger Ptakowski
Rodger Currie, J.D.
Deana McRae
Jennifer Tassler, J.D.
Lizbet Boroughs
Matt Sturm
Jeffrey Regan
Pamela Thorburn
Janice Brannon
Scott Barnes
Naomi Watson

I. WELCOME & REVIEW OF AGENDA

Dr. Perlman welcomed the Council and provided an overview of the agenda. Following the introductions of the Council members, Dr. Perlman spoke about a new APA initiative that would help improve the experience of APA fellows on each Council. In light of qualitative data obtained from a spring 2014 survey to APA Leadership Fellows, APA leadership has asked each Council to work closely with their Council fellows in order for fellows to gain mentorship and leadership experience. Dr. Perlman immediately extended an invitation to three CAGR fellows to attend an upcoming New York State Psychiatric Association event. The Chair encouraged Council members to make geographic connections with fellows to stay involved.

The Chair moved and it was seconded for the approval of CAGR meeting minutes from the May 2014 APA Annual Meeting in New York, NY.

II. DEPARTMENT OF GOVERNMENT RELATIONS UPDATE

Departmental Hires

Kristin Kroeger, Chief of Policy, Programs and Partnerships, introduced Rodger Currie, the newly selected Chief of Government Relations. Ms. Kroeger elaborated on Mr. Currie's prior experience and background, and noted that he will be starting his new role with APA on October 6. Also, the department will be looking for a permanent hire to fill the position of the Deputy Director of Regulatory Affairs. Additionally, the Department will be reorganizing the staff's roles to be more concentrated on issues; allowing for staff to work in more cohesive roles and responsibilities.

Engage 2014

In August, APA announced a grassroots campaign, Engage 2014, designed to encourage members to advocate on behalf of the mental health community as well as increase participation in grassroots efforts among the APA membership. DGR will continue to operate the program through Election Day. In coming weeks, APA will be engaging its leaders and members to advocate on the impending Medicaid Bump. Several APA members have already been actively participating in Engage 2014 in their respective states.

III. APA*PAC* UPDATE

Scott Barnes, Director of *APAPAC*, informed the Council of the status of contributions made to APA*PAC*. During the current calendar year, APA*PAC* has raised $155,000, falling short of our goal for 2014. For the 2014 election cycle, the desired goal is to raise over $200,000. Participation rate continues to be an issue, with only 4% of APA members contributing to APA*PAC*. APA is near the bottom of physician specialties in money raised.

Mr. Barnes shared with the Council, a general forecast for the 2014 midterm elections. There are 36 Senate seats open this year. Republicans will need six seats to gain control in the Senate. There have been a number of surprising changes in the primaries for incumbent candidates, including Representative Eric Cantor's loss in Virginia and John Tierney in Massachusetts. It is likely Republicans will retain control of the House.

IV. JACOB JAVITS AWARD FOR PUBLIC SERVICE

Dr. Perlman read through the names of the six nominees shared with the Council prior to the September Component Meeting. The Council went through each nominee discussing the pros and cons each would offer to the mental health community, as well as continued commitment to mental health care. DGR shared with the Council relevant background information on the nominees, offering responses to whether the nominee would promote a mental health agenda.

After discussion of the nominees, Dr. Bailey moved to vote between the candidates. The motion was seconded. Dr. Perlman called for the vote.

Action Item #1
Will the Joint Reference Committee recommend that the Board vote to approve the Council's recommendation to award the 2015 Jacob Javits Award for Public Service to California State Insurance Commissioner Dave Jones?

V. GUEST SPEAKERS:

Renee Binder, M.D., APA President-elect

Dr. Perlman introduced Dr. Renee Binder, APA President-elect to the Council. Dr. Binder thanked the Council for the opportunity to speak about important issues impacting the APA. Dr. Binder emphasized the importance of the Council and advocacy efforts of all APA members. She shared with the Council her strategy to move forward as a proactive medical profession. APA will consider the future role and identity of psychiatrists and what our practice is going to be; psychiatrists are not the people who get marginalized to only prescribe medication. Dr. Binder thanked the Council for their time, and looks forward to hearing their feedback.

Paul Summergrad, M.D., APA President

Dr. Perlman introduced Dr. Paul Summergrad, APA President to the Council. Dr. Summergrad thanked the Council for providing time on their agenda for an update on APA activities. He expressed the key focus of APA is the role psychiatry will have in the implementation of healthcare reform. He continued by affirming that APA has a certain positional standing, where we need to be in the room. "We need to be mindful of how changes will affect APA membership across the spectrum. We are in a time of change for psychiatry and as the only medical mental health practitioners; we are the bridge to the house of medicine," Dr. Summergrad stated. He assured the Council on Advocacy and Government Relations of their role, along with APA's Department of Government Relations will be essential in addressing next steps, from the broad to Medicaid bump to workforce development to creating an Assistant Secretary for Mental Health under the Obama Administration.

Additionally, APA has started a transition process involving strategic planning of the board. The process will address: (1) service to our members; (2) more advocacy efforts across the organization; (3) diversity in the organization at every level. Most importantly, APA leadership welcomes thoughts and guidance from the Council. Dr. Perlman thanked Dr. Summergrad for his time and valuable insight. The Council and DGR staff will remain committed to advocating on behalf of the APA for smart healthcare reform.

Saul Levin, M.D., APA Medical Director and CEO

Dr. Perlman introduced Dr. Saul Levin, APA CEO and Medical Director to the Council. Dr. Levin thanked the Council and DGR staff for their continued work in advocacy. Speaking to the Council, Dr. Levin offered insight on his conversations had with Members of Congress and representatives from government agencies. The "Medicaid bump" is in the forefront of legislative activity and is a major priority for APA. The Council will be looked to for guidance on whether to support/oppose/acquiesce legislation that would prevent psychiatric physicians to benefit from the bump. Another major priority for APA is the discussions surrounding scope of practice. Many APA members recently learned of the passing of legislation in Illinois that would allow psychologists to prescribe psychotropic medication. Council members were concerned there would be repercussions, particularly if APA acknowledges this as an acceptable action, or the organization's

plan B. Dr. Levin reassured the Council the activities that took place are not the norm and will not be the contingency plan for psychiatry. Dr. Perlman suggested for APA to perform, or have performed, an assessment of the development and passing of the Illinois legislation. The Council should take a hard critique of actions, in order to know how to avert future occurrences. Dr. Levin thanked the Council for their time, and looks forward to hearing their feedback. Dr. Perlman thanked Dr. Levin for speaking to the Council and pledged that the Council would continue to work on implementing APA priorities.

VI. SCOPE OF PRACTICE: APA ASSISTING DISTRICT BRANCHES AND STATE ASSOCIATIONS

Dr. Perlman asked Janice Brannon, State Affairs Deputy Director, to speak about scope of practice activity at the state level. Ms. Brannon informed the Council about a number of states that will be considering legislation that will change the scope of practice upon the new legislative session. The Sunshine Committee in Arizona will address the issue by September 2nd. New Jersey scope of practice legislation has passed through the House, with potential to be passed through the Senate. APA has presented New Jersey with a CALF grant to continue lobbying against full passage of the bill. New York and Oregon are also facing scope of practice activity. The Council has requested for APA to track the number of registered psychologist prescribing in Louisiana and New Mexico. Dr. Price shared with the Council that prescribing psychologists are using the Indiana Health Service as a vehicle to work in other states.

VII. ACTION PAPERS:

Multiple Co-Payments Charged for Single Prescriptions *(JRC Item 6.1-12.A)*

Dr. Perlman opened the discussion to the Council on the action paper, "Multiple Co-Payments Charged for Single Prescriptions." As one of the authors of the action paper, Dr. Koh provided background on the paper. The author emphasized, as psychiatrists, we should advocate for our members, including whether pharmacies and insurance companies will fill prescriptions. The Council expressed concern of whether this was a national versus state matter. Dr. Perlman shared his concerns regarding the pharmacy shortage of prescription medication, triggering patients to make several trips to the pharmacy and often paying more than one co-payment for a single prescription. Many times, a pharmacy will have a short supply and will ask a patient to return at a later time to fill the remainder of the prescription inflicting an additional co-payment. According to Dr. Koh, there are a number of states that have individual case data; we should push for this information to be shared. The Council suggests the outcome should involve an advocacy position, increased communication and an APA position statement. The Council requires more data collection before providing a knowledgeable recommendation. DGR staff will work with the Office of Healthcare Systems and Financing. The Council should review that outcome of the investigation, see how parity is implemented, and then reengage around the broader issue of ensuring adequate levels of care across the spectrum.

Dr. Perlman moved to revisit the action paper following the collection of data from the Council on Health Care Systems and Financing. The move was seconded. The Council voted unanimously to revisit the action paper at a later date.

Remove Black Box Warning from Antidepressants *(JRC Item 6.10 – 12.K)*

Dr. Perlman opened the discussion to the Council on the action paper, "Remove Black Box Warning from Antidepressants." The Council is concerned about legislation between proprietary and generics. DGR staff offered feedback about the action paper, to which there is no formal mechanism for patient and/or provider advocacy groups to influence altering content or removal black box warnings. There is, however, an extensive process that would allow manufactures the ability to modify the content of the black box warning. With all the red tape around the issue, this

needs to be brought up to Congress, such as Joe Heck and Murphy. Also, Lamar Alexander has made FDA reform a top priority. Ms. Kroeger informed the Council that APA advocated against the removal of black box warning. If APA takes a stance on this issue, more decisions need to be made by looking at the research. The Council suggests not removing the black box, but rather revising the word content. Politically and legislatively, 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.

Dr. Perlman moved to revisit the action paper following receiving research findings from the Council on Research. The move was seconded. The Council voted unanimously to revisit the action paper at a later date. The JRC referral update is required by meeting in January 2015.

Patient Safety and Veterans Affair Medical Center (VAMC) Participation In State Prescription Monitoring Programs (PMP) *(JRC Item 6.18 – 12.X)*
Dr. Perlman opened the discussion to the Council on the action paper, "Patient Safety and Veterans Affair Medical Center (VAMC) Participation in State Prescription Monitoring Programs (PMP)." DGR staff provided background information regarding the action paper. Ms. Boroughs spoke about the VA software roll out to improve PMP communication directed to medical centers to verify pharmacies sharing information. Additionally, DGR staff has asked Senator Tester to include language in legislation to ensure this will happen.

Dr. Perlman moved to support the action paper. The move was seconded. The Council voted unanimously to support the action paper and recommended actions for the Council on Advocacy and Government Relations.

Maintaining Community Treatment Standards in Federal Correctional Facilities *(JRC Item 6.3 – 12.C)*
Dr. Perlman opened the discussion to the Council on the action paper, "Maintaining Community Treatment Standards in Federal Correctional Facilities." The Council members indicated the action paper was not clear in isolating a targeted issue. The Council on Psychiatry and Law has a Workgroup that considers action within correctional facilities. Members agreed to include the Council on Psychiatry and Law in future conversations regarding the action paper. DGR staff added Congressional members like Senator Dick Durbin partner with state and federal prisons to work on mental health care delivered in prisons. 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.

Dr. Perlman moved to postpone action until the opportunity to gather information from the author and regroup for a conference call to discuss further. The move was seconded. The Council voted unanimously to revisit the action paper at a later date.

No Punishment for Choosing Not to Adopt Electronic Medical Records *(JRC Item 6.8 – 12.H)*
Dr. Perlman opened the discussion to the Council on the action paper, "No Punishment for Choosing Not to Adopt Electronic Medical Records." DGR staff provided feedback and background information on the action paper. The action paper remains a controversial issue in the medical community. The Final Rule for FY2015 fee schedule will gradually escalate penalties, APA can ask for a slowdown of these escalating penalties. APA has submitted comments, along with the AMA, about the potential of hardship these penalties will bring with implementation. Additional concerns offered by the Council include the sense of difficulty from private practices that don't have access to consultants to assist in facilitating a transition. The Council suggested this is a larger membership

issue; APA should support all members, including the small practices. A Council member recommended APA should provide E.H.R. capability assistance as a member benefit. Dr. Bailey anticipates the issue will be brought to the floor in the Assembly in November. A member of the Council expressed they would favor a no penalty position; this is what APA should advocate for to the federal government. The Council favors a proposal for incentives; however, supports the recommendation for a "no penalty for non-adoption" position.

Dr. Perlman moved to approve the recommendation to move forward with advocacy efforts. The move was seconded. The Council motion was passed to move forward advocating for an extension, a delay or the complete removal of penalties.

VIII. POSITION STATEMENT: MANAGEMENT OF SENSITIVE HEALTH INFORMATION WITHIN HEALTH INFORMATION EXCHANGES

Dr. Perlman opened the discussion to the Council on the drafted position statement from the Committee on Mental Health Information Technology, "Management of Sensitive Health Information within Health Information Exchanges." Dr. Daviss and Dr. Martin asked for the Council to review the drafted statement and provide feedback as written before submitting to the Assembly. DGR staff shared some insight into the position statement forwarded to the Council. The statement moved through CMHIT with limited controversy. The Council emphasized the discussion on electronic health records is a growing issue in the health care industry; including shared access to patients' sensitive information and potential hacking of these records.

Dr. Perlman moved to postpone providing recommendations until having the opportunity to speak with Dr. Daviss on the next CAGR conference call. The move was seconded. The Council voted unanimously to revisit the action paper at a later date

IX. BOARD OF TRUSTEE AD HOC WORK GROUP ON HEALTHCARE REFORM

Dr. Perlman opened the discussion to the Council on the drafted recommendations from Board of Trustees Ad Hoc Work Group on Healthcare Reform. APA leadership has asked specific Councils to provide feedback on particular recommendations in the report. The Council reviewed Recommendation I.1, providing the following feedback: (1) integrated care is being hashed out nationally, if psychiatry doesn't get involved, the future will be dictated to us; (2) we would like to make sure psychiatrists are involved in discussions, because we are leaders in health care; (3) discussion on healthcare reform starts with public sector psychiatry; and (4) the field of psychiatry cannot be marginalized. The Council reviewed Recommendation I.5, providing the following feedback: (1) many of the current standards are unfriendly to the field of psychiatry; (2) psychiatrists are also a part of the house of medicine and should be recognized as such; (3) the Council is support of Recommendation I.5

X. 2015 ADVOCACY LEADERSHIP CONFERENCE

Ms. Kroeger provided the Council with an update of preparation for the 2015 Advocacy Leadership Conference. With additional funding, we are looking to bring residents from districts and potentially consumers to advocate along with members. This year we will be working closely with DB executives to ensure the appropriate participation and delegation at the Conference. The Council provided feedback to DGR staff regarding the success of the 2014 Advocacy Leadership Conference. The 2015 Conference will take place in Washington, DC on March 8 through March 11.

XI. COUNCIL ON ADVOCACY AND GOVERNMENT RELATIONS 2015 ANNUAL MEETING WORKSHOP

Dr. Perlman shared with the Council that CAGR has submitted a request to hold an advocacy workshop during the APA 2015 Annual Meeting in Toronto. Dr. Halverson will lead the workshop to providing Advocacy 101 training. The Chair encouraged CAGR fellows to participate.

XII. FEDERAL LEGISLATIVE UPDATE

Medicaid Bump

Jeffrey Regan, Deputy Director of Senate Affairs, provided the Council with an update of activity on the extension of Medicare-Medicaid parity payments to physicians for certain primary services. He suggested the issue will be an uphill battle with Congress in approving an extension, and is more likely to fall short. Currently, APA is working with obstetricians and neurologists presenting a strong specialty coalition. The American Congress of Obstetricians and Gynecologists has the most convincing data; though, APA has new data showing psychiatrists are willing to provide primary care services if rates are extended. Two key factors working against an extension: it is tied to the ACA and it is expensive measure. A clean extension will be cost $11 billion over two years; introducing additional specialty groups into the extension can increase the cost by more than 25 percent. The Obama Administration is in favor of a clean extension, and the primary care groups lead a major campaign to push an extension. The Council asked DGR to compile data of studies on the participation of the program, both physicians and consumers. As part of grassroots efforts, APA is asking members to serve as advocates on this issue.

Excellence Mental Health Act Demonstration Program

Mr. Regan updated the Council on the Excellence Mental Health Act Program. Earlier this year, the President signed into law a demonstration program under the *Excellence Mental Health Act*. The legislation establishes pilot programs in eight states to increase access to community mental health centers and improve the quality of care at those centers. The Centers for Medicare and Medicaid Services has been tasked with issuing guidance for the establishment of a prospective payment system that will apply to medical assistance for mental health services furnished by certified community mental health centers participating in the program. APA forwarded a letter to SAMHSA, CMS and ASPE containing five recommendations concerning the structuring and implementation of the demonstration. DGR staff expects the Department of Health and Human Services will have a public comment period.

Medicare Sustainable Growth Rate (SGR)

Mr. Regan shared with the Council an abbreviated update regarding SGR. AMA intends to make SGR their top priority following the election cycle. Many medical societies, including the AMA, expect the issue to be deferred to 2015.

Comprehensive Mental Health Reform

Matt Sturm, Deputy Director of House Affairs, provided the Council with an update regarding the *Helping Families in Mental Health Crisis Act*, introduced last December 2013 by Representative Tim Murphy (R-PA). Representative Murphy, a clinical psychologist, was tasked by House leadership to investigate the national mental health system in the wake of the tragic Newtown shooting. Upon introduction of this legislation APA wrote to Representative Murphy noting the clear emphasis it places on the provision of psychiatric services and research supports. In May 2014, Representative Ron Barber (D-AZ) along with a group of House Democrat mental health advocates introduced the *Strengthening Mental Health in Our Communities Act*. Regarding this legislation, APA's key interests include advocating for the House to move the process forward on bipartisan comprehensive mental health reform. Both CAGR and the Board of Trustees have dedicated significant time to discussions on contents of Murphy and Barber legislation, political implications, and APA's position. Over the past few months, during this campaign season, democrats have

curtailed promoting the Barber legislation; DGR anticipates talks will continue behind the scene. Representative Murphy has visited several states in congressional districts, including North Carolina and San Fran California, to a garner support for this legislation.

Medical Evaluation Parity for Service Members Acts

Mr. Sturm provided the Council with an update on the *Medical Evaluation Parity for Service Members* (MEPS) *Act* introduced in the House. This bipartisan bill institutes a pre-enlistment mental health assessment for all military recruits. Currently, there is no evidence that speaks to the relevance of the assessment affecting the service of the military members. The National Institutes of Health has been asked to study the impact of the mental health assessment; and for the Department of Defense to take the research outcomes into consideration before implementation of the process. DGR staff believes the bill will not pass the House, at least during the current legislative session. However, DGR staff will continue to work with Congressional members, including Senator Rob Porterman (R-OH), to establish a favorable proposal.

Appropriations

Lizbet Boroughs, Deputy Director of Federal Affairs, provided the Council with an update of federal appropriation. Congress will be voting on a measure to fund the federal government from October 1 to December 11. The measure is expected to provide flat funding to the majority of the federal agencies. An additional $80 million is expected to be included in the vote to address Ebola emergency assistance. Until Congress returns from the election cycle, DGR will continue to monitor draft legislation for Food and Drug Administration reauthorization and potential scope of practice bills in the Congressional Committees on Veterans. In July, the Department of Veterans Affairs experienced a scandal with criticism of the extended waitlist for military members seeking medical services. APA forwarded comments to both Congress and the VA addressing cultural competency training, psychiatric physician workforce shortages and community provider care.

XIII. State Legislative Update

Ms. Brannon provided the Council with an update on state legislative activity. DGR is tracking/monitoring legislation introduced in the legislatures, and working with DB/SA executives to provide assistance when possible. State Affairs has developed a trend map that shows state legislative activity, which can be found as a resource on the Government Relations webpage. Additionally, DGR is tracking activity surrounding the Illinois Firearm Owners Identification (FIOD) Mental Health reporting System. APA will be working with national organizations, such as AACAP, AMA, NAMI, IPS, and IMS, to track information and movement both in Illinois and other states.

XIV. Regulatory Update

Jennifer Tassler, Regulatory Lobbyist, informed the Council of the current regulatory landscape. APA has submitted three significant comment letters in the last few months. One comment letter, addressed to CMS Administrator Tavenner, expressed APA's appreciation of the CMS proposal to expand payment for telehealth services including psychotherapy codes. However, APA joined AMA in urging CMS to revise their proposal to compensate physicians for chronic care management (CCM), including the valuation of such codes and the required use of a certified EHR. APA also urged CMS to drop the two year opt-out policy for Medicare, to rework several important aspects of the Physician Compare website, and urged CMS to reconsider a recent policy change on the Open Payment system which would require reporting of accredited CME which had been previously excluded. APA also commented strongly on proposed changes to the PQRS system, both with regard to specific measures and the general move away from claims based reporting, which is most valuable to APA members participating in the PQRS. Further, APA commented the expansive

proposed use of the PQRS data in programs such as Physician Compare and the value-based modifier program will be at increased risk for payment penalties.

APA, also, submitted comments to CMS regarding the Inpatient Psychiatric Facilities Prospective Payment System Rule for FY 2015. In the letter to Administrator Tavenner, APA shared concerns regarding the rate at which the agency was adding new measures, many of which could negatively impact participation and inaccurately measure the quality of facilities. A few of the measures, such as: assessment of patient experience of care, 30-day psychiatric readmission, and use of electronic health record in the IPQFR program, were asked to be reconsider before moving forward with inclusion.

The third comment letter was submitted to VA Secretary Gibson regarding proposed changes by the Department of Veterans Affairs concerning health care for homeless veterans. The rule would amend the medical regulations relating to eligibility for the program. Specifically, the proposed rule would remove the requirement that homeless veterans be diagnosed with a serious mental illness or substance use disorder to qualify. Ideally, the changes will increase accessibility for all homeless veterans who are enrolled or eligible for VA health care. The Council offered feedback, expressing the system is already stressed generating expansive wait times. The program will not be able to handle the volume with the current resources.

An additional topic DGR is monitoring is the Final Rule by the Drug Enforcement Administration rescheduling Hydrocodone products as a means to combat abuse.

XIV. Old Business

Hospital Closures and Liability

Dr. Bailey provided the Council with background information on a topic discussed during the Council meeting in May. He shared that Florida has experienced a similar issue which came up with physicians who were employed and later leaving their employer with their hands tied. The concern is where medical records go when an employee is terminated. Dr. Bailey suggested we should seek legislative updates throughout the country. This topic remains to be a work in progress; expected to hear further in the Assembly.

XV. New Business

Coding

Dr. Higgins shared his experience, in which insurance companies are not paying for services coded 99214, so he finds himself coding 99213. The Council agreed this was a national issue. One member shared their experience with filing dual codes and their challenges with specific insurance companies. It has been a common concern for residents and fellows that the use of higher codes, even for medication management patients, may lead to an audit. Under-coding has become a common practice to prevent being audited. Has this become a parity issue for specialists? Dr. Bailey agreed this is an important issue for discussion and suggested to share with APA leadership. The issue will be tabled for discussion at future Council meetings.

Advocacy Efforts on the State Level

Dr. Koh informed the Council about the need for APA to encourage RFMs and ECPs to participate in legislative activity on the state and/or local level. There are other medical societies that assist RFMs in advocacy efforts, where they spend a day in an elected state official's office. Dr. Bailey suggested this could be a potential action paper. The CAGR fellows agreed it is a promising

opportunity for residents to be involved on a local level as well as a federal level. Dr. Arredondo recommended advocacy training should consist of writing op-eds, letters to elected officials, etc.

Legislative Representatives

Dr. Price brought to the Council the need to acknowledge that often District Branches have both a federal legislative and state legislative representative. This information should be appropriately categorized in the APA component directory. Ms. Kroeger suggested working with the District Branches, as well as distinguishing the representatives through the impending DGR survey.

State Level Lobbyists and PACs

Dr. Price requested APA to share information regarding District Branches/State Association utilization of contract lobbyists; as well as state level PAC participation by APA members. This becomes a bigger issue regarding CALF grants, is there enough money when applicants submit request for assistance in their states.

Member Survey

Dr. Perlman expressed the need for APA to develop a member survey that would reveal a more intimate understanding of our membership. Questions should specifically seek information on the variety of settings from each individual's various means of income. For example, if members hold part-time salaried positions, and have second incomes through a private practice or other means; this information should be divulged. Obtaining this information would allow APA to better lobby of behalf of the member's career and interests.

The Council adjourned at 3:55 PM

EXECUTIVE SUMMARY
Council on Children, Adolescents and Their Families

Council Overview

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

The Council met in Arlington, Virginia, on September 12, 2014

JRC Referrals

- At the meeting, the council determined that more time is needed to do a line-by-line critique of the recommendations made in the Board Work Group on Health Care Reform and the Role of Psychiatry. Dr. Hirsch agreed to write up the council's feedback for submission later. A cursory look revealed that reference is needed about the role of families in child care and that recommendations about some children's issues must stand on their own and should not be generalized. Not all child services are defined in the current ACA model and some contracting psychiatric services are left off. The general sentiment around the table was that recommendations specific to child and adolescent psychiatry need to be peer reviewed especially to determine if additional recommendations are needed.
- At the council meeting, several council members volunteered to individually evaluate the position statements related to youth that are due for a five-year review and to report their recommendations to the group in December.

Action Items

1. **Will the Joint Reference Committee accept the council's revision to the position statement on child abuse and neglect by adults? See Attachment A.**
2. **Will the Joint Reference Committee accept the council's revision to the position statement on college mental health? See Attachment B.**
3. **Will the Joint Reference Committee recommend to the Board of Trustees that APA fund on an ongoing basis the APA Child and Adolescent Psychiatry Fellowship? See Attachment C**

Council on Children, Adolescents, and Their Families
September 12, 2014 Meeting Minutes

Attendance

Members: Drs. Louis Kraus (chairperson), Michael Houston, Gabrielle Shapiro, Jean Thomas, Amy Ursano, and Sharon Hirsch

Consultants: Dr. Ara Anspikian

Residents: Diversity Leadership Fellows: Drs. Kara Bagot, Jonathan Lee, James Murray, Yang Xu; Public Psychiatry Fellows: Nicole Kozloff, Raj Loungani; SAMHSA Fellows: Jamie Ng, Sandra Peynado, Barbara Robles, Byron Young; Leadership Fellows: Misty Richards, Desiree Shapiro

Guests: Drs. Paul Summergrad, Renee Binder, Alan Axelson; American Academy of Child and Adolescent Psychiatrists (AACAP). Heidi Fordi, AACAP Executive Director, Ron Szabet, AACAP Director of Government Affairs, Carmen Head, AACAP Research, Training and Education Director

APA Administration: Dr. Saul Levin, Alison Bondurant

Guest Visits. Representatives from APA leadership gave greetings and updates about current BOT activities. Dr. Summergrad reported that APA is in the midst of a strategic planning effort that is focusing on diversity in APA, service to members, advocacy, research and evidence/scientific-based care. Dr. Binder related her presidential priorities to reaffirm/reclaim psychiatrists' identity and fighting stigma.

Heidi Fordi gave an update on AACAP activities, including its intent to do in the near future an analysis similar to APA's Milliman report but with a focus on the economics of child psychiatric care. Dr. Axelson advocated for a child registry.

AACAP. Dr. Kraus reiterated the council's ongoing goal of having a stronger relationship with AACAP, that child psychiatry is the sum of its parts. He cited the joint efforts on the *Autism Parent Medication Guide* and the *Choosing Wisely* blurb rewrite as examples of collaboration at its best. Drs. Binder and Levin concurred but also recognized that sometimes it is important for the sister organizations to take the lead in areas where they excel. Ron Szabet noted that a coalition approach toward advocacy among APA, AACAP and pediatric groups is imperative.

RFM Engagement. Visitors and council members marveled at the large number of RFMs on the council. Throughout the meeting, the residents were encouraged to continue and deepen their involvement in APA, especially through advocacy and donations toward scholarship and

advocacy funds. Dr. Binder announced that she has appointed ECP Steven Koh as the Scientific Program Chair in her bid to provide more growth opportunities for young APA members. Ms. Fordi mentioned that there are lots of opportunities for trainees at AACAP's October annual meeting and hoped that the residents will make AACAP their professional home. She also promoted *AACAP Connect*, a new journal for residents and medical students to submit articles. Carmen Head spoke of AACAP's extensive portfolio of programs for medical students and residents and indicated that she will pass on to the residents a list of AACAP committees on which they can seek membership.

JRC Referrals

- The council determined that more time is needed to do a line-by-line critique of the recommendations made in the Board Work Group on Health Care Reform and the Role of Psychiatry referred to council a few days earlier. A cursory look revealed that reference is needed about the role of families in child care and that recommendations about some children's issues must stand on their own and should not be generalized. Not all child services are defined in the current ACA model and some contracting psychiatric services are left off. The general sentiment around the table was that recommendations specific to child and adolescent psychiatry need to be peer reviewed especially to determine if additional recommendations are needed. Dr. Hirsch agreed to craft the council's response in time for the September 19 due date.
- With regard to position statements that are currently up for a five-year review, at this meeting the following council members volunteered to evaluate them and report back to the group in December.
    - Dr. Houston: *statement on psychiatric hospitalization of children and adolescents*
    - Dr. Hirsch: *statement on corporal punishment in schools*
    - Dr. Ursano: *statement on reactive attachment disorder*
    - Dr. Kraus: *statement on legal proceedings and access to psychiatric care of juvenile offenders*
- During this meeting, the council approved an update of the *position statement on child abuse and neglect by adults,* prepared by Elizabeth Newlin before her departure from the council last May. See Attachment A.
- The council also supported a mildly revised version of the *position statement on college mental health* submitted earlier in the week by Leigh White, chairperson of the College Mental Health Caucus. See Attachment B. Dr. Kraus noted that it would be good to have Dr. White on the council. A question was then raised as to the need for a position statement on transitional aged youth but only if AACP does not already have one. Ms. Bondurant reminded council that new positions also require an accompanying background document.

Dr. Kraus questioned the rarity of Assembly action papers pertaining to youth and challenged council members to rally their Area and DB reps to engage the Assembly in this regard. A

suggestion was made to invite AACAP's liaison to the Assembly to council meetings or to petition that the AACAP AOL become a regular position on this council.

Action Items

- Dr. Kraus circulated a proposal (see Attachment C) to request that APA fund the 12-year old Child and Adolescent Psychiatry Fellowship now that Shire Pharmaceuticals will no longer underwrite the program. RFMs on the council were particularly supportive of the program's continuance and will personally lobby APA leaders. The council overwhelmingly supported the proposal and resolved to ask:

  Will the JRC recommend to the Board of Trustees that APA fund on an ongoing basis the APA Child and Adolescent Psychiatry Fellowship?

- Dr. Houston presented the name of the individual selected by the Ittleson Award Committee for the 2015 APA Ittleson Award. Dr. Kraus shared the names of those selected for the McGavin Award for Prevention and for Career Distinction by that selection committee. Ms. Bondurant promised to pass on these names to the APF Board. (The names of the nominees are omitted as these minutes will be circulated prior to the Board's formal approval of the nominations.)

Unaccompanied Latino Youth

Dr. G. Shapiro reported that she has teamed with a number of coalitions and disaster psychiatry and legal aid groups aimed at providing treatment to the hundreds of Latino immigrant children in New York without their parents. Urban Strategies is an organization which has asked for APA's help identify psychiatrists (especially bilingual) to address the mental health needs of these young people who are being relocated around the country. She encouraged council members and residents to get involved and wondered if APA should set up an emergency task force around this issue. She added that she will be meeting with the Council on Minority Mental Health about this issue as well.

Legislative Update. Lizbet Boroughs acknowledged that activity on the Hill has been light of late but reported on a few governmental efforts, such as NIDA's plan to do a longitudinal study on adolescent substance use. She added that Senator Portman has introduced legislation to expand buprenorphine access and that the Council on Addiction is following this. Jeff Reagan reported that APA is working with AACAP to push for an extension of the "Medicaid pay bump" and for psychiatry's inclusion in the list of specialties eligible to receive the bump.

2015 Annual Meeting Workshop. Ms. Bondurant announced that she entered a placeholder for the council in the abstract submission system so that the council would be able to submit a proposal after the September 9 deadline. After brainstorming potential topics for a council presentation, such as on immigrant youth, advocacy for kids101, and collaborative care, the group settled upon on the topic of cannabis use – screening, prevention and the impact of

changes in marijuana laws. Drs. Gabrielle Shapiro and Sharon Hirsch volunteered to serve as workshop panelists. Diversity Leadership Fellow Kira Bagot volunteered to organize and submit the workshop.

Infant Caucus. Dr. Thomas reported that she requires just a few more letters of support for the formation of an APA infant and early childhood caucus and would appreciate if council members would write in. She hopes to collect enough letters in time to submit to JRC in October.

Next Meetings. The council decided to reconvene by conference call on December 10 at 9PM Eastern and to meet in person in Toronto on May 18, 2015, from 9 am to noon.

ATTACHMENT A

PROPOSED REVISION TO
Position Statement on Child Abuse and Neglect by Adults
(1991)

In May 2013 in response to the Council on Children's recommendation that the 1991 Position Statement on Child Abuse and Neglect by Adults be retained as written, the Assembly felt that the position statement did not take into sufficient account new information specifically on the data of adverse childhood experiences that would illustrate that there are other kinds of adverse health effects besides psychological effects associated with poor treatment in children.

The sections in strikethrough below are original text, passages in bold underscore is new, proposed language.

Position Statement on Child Abuse and Neglect ~~by Adults~~

Child abuse and neglect is a major public health problem. **The Child Abuse Prevention and Treatment Act (CAPTA) provides a federal definition of child abuse and neglect. At the state level, child abuse and neglect is further defined through civil and criminal statutes.** Although research, cultural, and forensic considerations have resulted in different definitions, the American Psychiatric Association (APA) maintains that child abuse and neglect exists whenever physical pain and injury, sexual exploitation, or psychological harm has been inflicted on a child ~~by any adult~~; the problem is only magnified when that adult is responsible for the child's protection and nurturance.

The spectrum of abusive and neglectful experiences includes inadequate food, clothing, or shelter; deprivation of adequate emotional attention and support; inadequacy of protective supervision; infliction of physically painful and damaging injuries under the guise of punishment on discipline; denial of adequate education or health care; exposure to sexual overstimulation or exploitation or other sexually abusive experiences; infliction of personally denigrating and humiliating experiences; and isolation from contact or communication with others, especially those who are emotionally important. No child is invulnerable; every child is affected by such experiences.

~~Extensive clinical experience has demonstrated the destructive effects on both child victims and child witnesses of abuse and neglect. Child maltreatment contributes to the development of lifelong anxieties, disturbance of behavior, depression, suicidal behavior, substance abuse, and severe disturbances in personality formation. These disturbances may include social isolation, withdrawal, and alienation; antisocial, hostile, and destructive character disorders; disruption of the ability to form or to sustain loving, caring relationships with others; development of paraphilias, including child-abusive aberrations; and inability to adequately parent the next generation of children. Sexual abuse is also a risk factor for HIV infection.~~

~~APA therefore states the following:~~

~~1. The goals of psychiatric intervention must be, first, the protection of children and other family members from maltreatment and, second, the provision of relevant treatments for children and their families with the aim of reversing the psychological and physical sequelae of the maltreatment, improving the quality of parenting, and preserving the family unit whenever possible.~~

~~2. Psychiatrists need to be informed of the mandatory reporting requirements of all applicable laws. The reporting of maltreatment to the appropriate agency is the responsibility of any psychiatrist, treating either on both children and adults. Psychiatrists should have access to legal consultation, to APA, and to their district branches when they have questions about reporting responsibilities and procedures.~~

~~3. The needs of children for adequate protection from abuse and neglect and for adequate treatment or cane in order to recover from the psychic trauma of victimization must supersede the support for the integrity, reintegration, on reunification of children's families.~~

~~4. Parental religious convictions should not stand in the way of providing children and adolescents with essential life-saving medical care, including such psychiatric care. Medical child neglect must be considered present if such care for children is refused by the parents.~~

~~5. Whenever alleged abuse or neglect of a child is of such magnitude as to warrant legal action, whether in a civil on a criminal court, it should be the obligation of that court to provide both independent advocacy for the child and psychiatric evaluations of the child and the child's primary caretaker(s) in order to guide the court regarding the protection of the child. These psychiatric evaluations should include recommendations to the court regarding the child's participation in legal proceedings; any need for psychiatric treatment for the child, for the perpetrator (parents or parent substitutes) of the child's alleged maltreatment, and for other family members; placement needs of the child; and/or the termination of parental rights.~~

~~6.While judicial action is frequently used to protect the victim and other children and to empower the traumatized victim, judicial action in all cases should not further abuse and victimize the child.~~

~~7. While policies and procedures of courts and child protective agencies provide useful guidelines, the uniqueness of each child and family must be respected. Individualized assessment of each child's needs and individualized prescriptions for treatment and for delivery of supportive and therapeutic services must be designed and implemented to meet the particular needs of each child and each child's family. Treating psychiatrists and agencies receiving reports of child maltreatment must closely coordinate their work. This close coordination, with the permission of families in treatment, should include feedback to the treating psychiatrist regarding investigations, as well as the ongoing collaboration between psychiatrists and child protective service and law enforcement agencies. This collaboration will assure the safety of children and minimize family disruption and the disruption of treatment for victims and their families.~~

Research combined with extensive clinical experience has demonstrated the destructive impact on those who are exposed directly or indirectly to abuse and neglect during childhood. Trauma or neglect experienced in the context of attachment relationships is particularly harmful as it evokes extreme distress and undermines the development of the capacity to regulate emotion and acquire new socio-cultural information through trusting, secure relationships. Child maltreatment disrupts normal developmental processes and increases the risk of developing a variety of psychological and behavioral disturbances. Child maltreatment contributes to the development of a number of anxiety, affective, and personality disorders. There is a known relationship between a history of exposure to abuse or neglect and self-destructive behaviors such as promiscuity, non-suicidal self-injury, and suicidality. Child maltreatment can result in a negative conceptualization of both self and others. In this way, child maltreatment may increase hostile and aggressive behavior, potentially creating a victimizer out of the victim. A paucity of protective relationships that reinforce healthy adaptations to stress as well as a reduced capacity to feel secure within such relationships combined with an accumulation of adverse life experiences results in psychic suffering and a physiological stress response that increases the risk for physical and psychiatric health problems later in life. A lack of internal resources or external relationships with which to manage their suffering, combined with high levels of experiential avoidance, may lead them to transmit emotional pain to their body in the form of somatization, eating disorders, or stress-related medical illnesses. Of additional concern, the Adverse Childhood Experiences study by Felitti et. al demonstrated that there is a strong graded relationship between exposure to stressful life events over the course of development and a variety of health problems in adulthood ranging from cardiac and reproductive health problems to addiction and other psychiatric disorders. Not only is there increased risk at the time of the exposure to neglect or abuse but there is increased risk of morbidity and premature death in adulthood.

APA therefore states the following:

1. Psychiatrists need to be informed of the mandatory reporting requirements of all applicable laws. The reporting of abuse or neglect to the appropriate agency is the responsibility of any psychiatrist. Psychiatrists should have access to legal consultation, to the American Psychiatric Association, and to their district branches when they have questions about reporting responsibilities and procedures.

2. The goals of psychiatric intervention include the provision of relevant treatments for children and their families with the aim of actively addressing the psychological and physical sequelae of abuse or neglect, improving the quality of parenting, and preserving the family unit whenever possible.

3. APA supports the efforts of public policy makers to protect children through the enactment of child abuse reporting laws and the development of civil child protective services and specialized child abuse and vice units in the criminal justice system. Legislation must include provisions for funding adequate individualized and comprehensive psychiatric assessment and treatment for the victimized child and for the child's family, including foster care when needed.

4. While policies and procedures of courts and child protective agencies provide useful guidelines, the uniqueness of each child and family must be respected. Individualized assessment of each child's needs and individualized prescriptions for treatment and for delivery of supportive and therapeutic services must be designed and implemented to meet the particular needs of each child and each child's family. Collaboration between treating psychiatrists and involved child protective agencies is essential to support the treatment and recovery of children and families.

5. The needs of children for adequate protection from abuse and neglect and for adequate treatment or care in order to recover from the psychic trauma of victimization must supersede the support for the integrity, reintegration, on reunification of children's families.

6. Parental religious convictions should not stand in the way of providing children and adolescents with essential life-saving medical care, including such psychiatric care. Medical child neglect must be considered present if such care for children is refused by the parents.

7. Whenever alleged abuse or neglect of a child is of such magnitude as to warrant legal action, whether in a civil on a criminal court, it should be the obligation of that court to provide both independent advocacy for the child and psychiatric evaluations of the child and the child's primary caretaker(s) in order to guide the court regarding the protection of the child. These psychiatric evaluations should include recommendations to the court regarding the child's participation in legal proceedings; any need for psychiatric treatment for the child, for the perpetrator (parents or parent substitutes) of the child's alleged maltreatment, and for other family members; placement needs of the child; and/or the termination of parental rights.

8. While judicial action is frequently used to protect the victim and other children and to re-empower the traumatized victim, judicial action in all cases should not further abuse and victimize the child.

Furthermore, APA recommends the following:

~~*Reporting laws and protective services.* APA supports the efforts of public policy makers to protect children through the enactment of child abuse reporting laws and the development of civil child protective services and specialized child abuse and vice units in the criminal justice system. (Such legislation must include provisions for funding adequate individualized and comprehensive psychiatric assessment and treatment for the victimized child and for the child's family, including foster care when needed.)~~

Training. At a minimum, the curriculum for training regarding child abuse and neglect would facilitate greater awareness of all forms of domestic violence and their frequent coexistence within the same family; delineate the physician's role and responsibility in prevention, detection, reporting, treatment, and consultation to and collaboration with social service, judicial, and police agencies; and stress the individual and family dynamics of

domestic violence in the teaching of diagnostic and intervention techniques for child victims, abusive and neglectful adults, and other members of these families.

Research. Research is vital for interrupting the intergenerational cycle of abuse. Such research necessarily includes biogenetic, neurophysiological, cognitive, and emotional sequelae of all aspects of child maltreatment and the effectiveness of intervention programs. (Such research must involve psychiatrists and must be supported by private and public agencies.) The uniqueness of each child and family must be respected in designing programs for their protection and treatment. Policies and procedures of courts and child protective agencies should include mechanisms for individualized assessment of each child and each family, and supportive and therapeutic services must be tailored. ~~to the particular needs defined during these assessments.~~

The members of the Committee on Family Violence and Sexual Abuse are Sandra Janet Kaplan, M.D. (chairperson), Marion Zucker Goldstein, M.D., Arthur H. Green, M.D., Elaine Carmen, M.D., Herschel D. Rosenzweig, M.D., Matilda Rice, M.D. (Assembly liaison), Mary Lystad, Ph.D., Howard Davidson (consultant), Christine B.L. Adams, M.D., Karen Taylor-Crawford (corresponding member), David Chadwick, M.D. (corresponding member), and Kathryn Jo Kotrla, M.D. (APA Burroughs Wellcome Fellow).

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ATTACHMENT B

PROPOSED REVISION TO

Position Statement on College and University Mental Health

A Presidential Task Force on Mental Health on College Campuses was appointed by the American Psychiatric Association (APA) in 2005. An earlier group, the 1972 APA Task Force on College Mental Health, issued a statement focusing on the need for psychiatrists working in college settings to understand the special nature of work in colleges. While we agree with the general thrust of these comments, changes in both psychiatric practice and the college student population necessitate a new policy statement:

The need for mental health services on college and university campuses is increasing. More students enter college already taking psychiatric medications and most colleges report increases in medications being prescribed at their mental health services. Further, most colleges report seeing increases in students with binge drinking, substance abuse, and severe psychopathology. Suicide is the second leading cause of death in college students. Going to college is often very stressful for late adolescents when faced with more intensive grade pressure, separation from parents and friends, and the continuing formation of one's identity. In addition, several disorders begin during late adolescence and early treatment is necessary.

There are institutional benefits ~~to providing excellent~~ as well as improving student's overall mental health ~~care on college~~ and ~~university campuses.~~ functioning. Data ~~show~~ show that treatment for mental health problems results in higher rates of student retention and graduation.

It is the position of the APA that all colleges and universities should:

1. have an established arrangement for timely access to necessary and appropriate psychiatric services for all students in need of mental health services. Such arrangements may include employed and/or consulting psychiatrists, as well as referral arrangements with local private practitioners. Arrangements should be in place for care to be coordinated in an appropriate manner.

2. ensure that psychiatrists have authority commensurate with their responsibility. This should include significant participation in assessment and treatment planning for students served in college and university mental health settings. This may also include membership in the leadership structure and on the University's behavioral threat assessment team.

3. assure that the treating psychiatrist role is clearly separated from the role of ~~psychiatrist~~ psychiatrists as ~~practitioners, hospitals,~~ decision-makers regarding academic matters including withdrawal from classes or from school. As there is a potential conflict of interest between the academic mission of the university and ~~health services~~ and~~/or community mental health centers. When students are referred out of their~~ that of treating the student, ~~health systems,~~ psychiatrists should serve in a consultative capacity in academic decisions but the final decision should rest with those not involved in the direct health care ~~should be taken to minimize the risk of confidentiality breeches and professional ethical conflicts~~of the student.

4. offer health insurance coverage programs to students that provide comprehensive coverage for mental health, including substance abuse treatment.

5. provide students, parents and staff with easily accessible and culturally sensitive orientation information and ongoing education regarding wellness, general health, and mental health issues (including information about accessing emergency services). This should include problems associated with re-entry of students who have had to interrupt their education.

6. educate student health personnel about recognition of mental health problems.

7. have comprehensive suicide risk reduction and substance abuse prevention programs.

8. establish clinically informed policies that are responsive to and consistent with the ADA (Americans with Disabilities Act).

9. work with psychiatric residency training programs to increase educational opportunities in college and university mental health services. Consideration should be given to the establishment of post-graduate fellowship programs in college psychiatry.

10. work to educate the public as to the challenges and risks related to the college years, in partnership with the appropriate agencies (such as NIMH, NIDA, SAMHSA).

11. work toward de-stigmatization of psychiatric illness and helping young people and their families make thoughtful choices about college.

12. support the expansion of research endeavors around college mental health issues and exploration of factors relating to prevention and resiliency.

Prepared by the Task Force on College Mental Health, May, 2005; revised by the Council on Children, Adolescents & Their Families, September 2005; and revised by the Joint Reference Committee, October 2005; Revised by the Council on Children, Adolescents and Their Families, October 2014

Attachment C

Will the JRC recommend to the Board of Trustees that APA fund on an ongoing basis the APA Child and Adolescent Psychiatry Fellowship?

Situation: Shire Pharmaceuticals withdrew funding for this fellowship program in 2014 after 12 years. The Council on Children, Adolescents and Their Families is requesting that APA meet this challenge by funding the fellowship, enabling the recruitment of more psychiatrists to work with children and adolescents.

Background: The APA Child and Adolescent Psychiatry Fellowship program cultivates interest in child and adolescent psychiatry careers by providing general psychiatry residents with specialized educational opportunities to interest them in working with children and adolescents.

The program was established in 2002 in response to the long recognized critical shortage of child and adolescent psychiatrists. According to the American Academy of Child and Adolescent Psychiatry there are about 7,000 practicing child and adolescent psychiatrists in a country with over 70 million children and adolescents.

The U.S. Surgeon General Report on Mental Health (1999) states that about 20 percent of children and adolescents have a mental disorder and that there are acute shortages in the numbers of mental health service professionals serving children and adolescents with serious emotional disorders.

To further complicate matters, the U.S. Bureau of Health Professions projects there will be about 8,300 child and adolescent psychiatrists in 2020, only two-thirds of the estimated 12,600 needed. Child and adolescent psychiatry recruitment continues to be a problem. Only an average of 300 child and adolescent psychiatrists complete training each year.

Specialized recruitment programs like the APA Child and Adolescent Psychiatry Fellowship foster interest in child and adolescent psychiatry and is one way to deal with this need for child and adolescent psychiatrists. Through this fellowship, the APA promotes interest in child and adolescent psychiatry and develops future leaders and researchers. These future leaders will guide the child and adolescent psychiatry discipline, improving care and teaching others. To effectively treat mentally ill children and adolescents, the supply of psychiatrists and development of new leaders must be addressed.

Program Overview
The APA Child and Adolescent Psychiatry Fellowship provides residents with career development opportunities through attendance and participation at the APA Annual Meetings and through on-going mentoring activities with senior child and adolescent psychiatrists. The fellows enjoy

unparalleled opportunities to meet and network with leaders in child and adolescent psychiatry and acquaint themselves with the field of child and adolescent psychiatry through exposure to the newest clinical research and most successful programs for the treatment of children and adolescents with mental disorders.

> *"I am so thankful for the Child and Adolescent Fellowship. It has allowed such a unique and invaluable opportunity to further explore interests within child psychiatry. I am most thankful for the professionals I have met through this program, the motivation it has provided me for my own professional development, and the perspective it has provided me in regards to matters of child and adolescent psychiatry on a national level."* **Nadia Charguia, MD, 2010-2011 Fellow**

> *"The APA Child and Adolescent Psychiatry Fellowship was a wonderful experience for me. My mentor through the program has been fantastic--guiding me through the process of creating a symposium for the APA and also giving me general career advice. He is also a great person to talk to about my research ideas. I never thought I would chair a symposium at the APA meeting as a PGY3--and it was an extra thrill to have a standing room only audience. In addition, I am thankful to have met all the other fellows and to get involved with the APA's council on children, adolescents, and their families. Prior to the fellowship I did not know much about the organization of the APA. Now I look forward to continued involvement in the APA. The fellowship was very important to me because it is extremely difficult to afford travel to the APA as a resident, especially these days when many of us have huge debt burdens."* **Laurie Gray, MD, 2010-2011 Fellow**

> *"The fellowship gave me a chance I would not otherwise have had to meet child psychiatrists who are leaders in their fields. It connected me with a mentor who has made an investment in my career in child psychiatry and opened doors I would not otherwise have had access to. Definitely one of the most important experiences of my residency"* Joanna Quigley, MD, 2010-2011 Fellows

> *"The APA child and adolescent fellowship allowed me to experience the APA meeting for the first time in two fabulous locations New Orleans and Hawaii. This was an incredible learning opportunity and a chance to meet new clinical and research mentors. As a part of my fellowship I connected with leaders in the field of pediatric bipolar disorder including Kiki Chang, Melissa DelBello, Cathyrn Galanter, and Harsh Trivedi. Together we presented a symposium on pediatric bipolar disorder which was incredibly well attended at the APA Annual Meeting May 2011 in Hawaii. Receiving the APA fellowship allowed me this chance to both create a symposium and present a talk on psychopharmacologic treatment of pediatric bipolar disorder. This fellowship was a crucial step in my goal to become a child and adolescent psychiatrist. I credit this fellowship with allowing me to broaden my understanding of pediatric psychiatric illness as well as deepen my personal and mentorship connections in the world of pediatric psychiatry research."* **Erin Soto, MD, 2010-2011 Fellow**

"We are incredibly grateful to Shire for their support of this program. It has provided us with the opportunity to give general psychiatry residents in depth exposure to child and adolescent psychiatry early on in their careers and thus strengthen and solidify their choices to pursue child and adolescent psychiatry." **Cathryn Galanter, M.D., Former Chairperson, Child and Adolescent Fellowship Selection Committee**

Program Description

The program is two years. Five fellows are selected each year. In the first year fellows attend the APA Annual Meeting as participants, are assigned a mentor who advise them of sessions to attend at the Annual Meeting that focus on child and adolescent psychiatry.

During the second year of the program, the fellows develop, with help from their mentors, a proposal for a program presentation in child and adolescent psychiatry at the next Annual Meeting. In addition, fellows attend the meeting of the APA Council on Children, Adolescents, and Families at the Annual Meeting. This experience provides additional networking and mentoring opportunities as well as exposing the fellows to the development of policy that will impact the psychiatry field and, in particular, the treatment of mentally ill children and adolescents.

Eligibility & Selection Criteria

The program is open to PGY1 to PGY3 residents in an ACGME-accredited residency training program in psychiatry. Residents who apply must be participating in a residency program (general psychiatry or child and adolescent psychiatry) for the years that they will be receiving the fellowship.

A selection committee made up of distinguished child and adolescent psychiatrists selects the fellows. The fellows are rated on the following criteria: (1) demonstrated interest in child and adolescent psychiatry as a career, (2) leadership potential, (3) likelihood of the candidate remaining in the child and adolescent psychiatry field and (4) relevance of fellowship to candidate's future.

Proposed Budget Request

5 fellows* in 2015 and 10 fellows 2016:

	2015*	**2016**
Fellows' Travel to APA Annual Meeting		
Airfare	$ 2,500	$ 5,000
Hotel	$11,000	$22,000
APA Meeting Registration	waived	waived
Per Diem	$ 2,000	$ 4,000
Fellows' Group Dinner w/Mentors	$ 700	$ 1,400
Fellows' Orientation Luncheon	$ 0	$ 1,400
TOTAL	**$ 16,200**	**$ 33,800**

to cover the final & 2nd year for the 5 fellows chosen in 2014

Position Statement on Child Abuse and Neglect by Adults

This statement was proposed by the Committee on Family Violence and Sexual Abuse[1] of the Council on Children, Adolescents, and Their Families. It was approved by the Assembly of District Branches in May 1991 and by the Board of Trustees in June 1991.

Child abuse and neglect is a major public health problem. Although research, cultural, and forensic considerations have resulted in different definitions, the American Psychiatric Association (APA) maintains that child abuse and neglect exists whenever physical pain and injury, sexual exploitation, or psychological harm has been inflicted on a child by any adult; the problem is only magnified when that adult is responsible for the child's protection and nurturance.

The spectrum of abusive and neglectful experiences includes inadequate food, clothing, or shelter; deprivation of adequate emotional attention and support; inadequacy of protective supervision; infliction of physically painful and damaging injuries under the guise of punishment or discipline; denial of adequate education or health care; exposure to sexual overstimulation or exploitation or other sexually abusive experiences; infliction of personally denigrating and humiliating experiences; and isolation from contact or communication with others, especially those who are emotionally important. No child is invulnerable; every child is affected by such experiences.

Extensive clinical experience has demonstrated the destructive effects on both child victims and child witnesses of abuse and neglect. Child maltreatment contributes to the development of lifelong anxieties, disturbance of behavior, depression, suicidal behavior, substance abuse, and severe disturbances in personality formation. These disturbances may include social isolation, withdrawal, and alienation; antisocial, hostile, and destructive character disorders; disruption of the ability to form or to sustain loving, caring relationships with others; development of paraphilias, including child-abusive aberrations; and inability to adequately parent the next generation of children. Sexual abuse is also a risk factor for HIV infection.

APA therefore states the following:

1. The goals of psychiatric intervention must be, first, the protection of children and other family members from maltreatment and, second, the provision of relevant treatments for children and their families with the aim of reversing the psychological and physical sequelae of the maltreatment, improving the quality of parenting, and preserving the family unit whenever possible.

2. Psychiatrists need to be informed of the mandatory reporting requirements of all applicable laws. The reporting of maltreatment to the appropriate agency is the responsibility of any psychiatrist, treating either or both children and adults. Psychiatrists should have access to legal consultation, to APA, and to their district branches when they have questions about reporting responsibilities and procedures.

3. The needs of children for adequate protection from abuse and neglect and for adequate treatment or care in order to recover from the psychic trauma of victimization must supersede the support for the integrity, reintegration, or reunification of children's families.

4. Parental religious convictions should not stand in the way of providing children and adolescents with essential life-saving medical care, including such psychiatric care. Medical child neglect must be considered present if such care for children is refused by the parents.

5. Whenever alleged abuse or neglect of a child is of such magnitude as to warrant legal action, whether in a civil or a criminal court, it should be the obligation of that court to provide both independent advocacy for the child and psychiatric evaluations of the child and the child's primary caretaker(s) in order to guide the court regarding the protection of the child. These psychiatric evaluations should include recommendations to the court regarding the child's participation in legal proceedings; any need for psychiatric treatment for the child, for the perpetrator (parents or parent substitutes) of the child's alleged maltreatment, and for other family members; placement needs of the child; and/or the termination of parental rights.

6. While judicial action is frequently used to protect the victim and other children and to re-empower the traumatized victim, judicial action in all cases should not further abuse and victimize the child.

7. While policies and procedures of courts and child protective agencies provide useful guidelines, the uniqueness of each child and family must be respected. Individualized assessment of each child's needs and individualized prescriptions for treatment and for delivery of supportive and therapeutic services must be designed and implemented to meet the particular needs of each child and each child's family. Treating psychiatrists and agencies receiving reports of child maltreatment must closely coordinate their work. This close coordination, with the permission of families in treatment, should include feedback to the treating psychiatrist regarding investigations, as well as the ongoing collaboration between psychiatrists and child protective service and law enforcement agencies. This collaboration will assure the safety of children and minimize family disruption and the disruption of treatment for victims and their families.

Furthermore, APA recommends the following:

Reporting laws and protective services. APA supports the efforts of public policy makers to protect children through the enactment of child abuse reporting laws and the development of civil child protective services and specialized child abuse and vice units in the criminal justice system. (Such legislation must include provisions for funding adequate individualized and comprehensive psychiatric assessment and treatment for the victimized child and for the child's family, including foster care when needed.)

Training. At a minimum, the curriculum for training regarding child abuse and neglect would facilitate greater awareness of all forms of domestic violence and their frequent coexistence within the same family; delineate the physician's role and responsibility in prevention, detection, reporting, treatment, and consultation to and collaboration with social service, judicial, and police agencies; and stress the individual and family dynamics of domestic violence in the teaching of diagnostic and intervention techniques for child victims, abusive and neglectful adults, and other members of these families.

Research. Research is vital for interrupting the intergenerational cycle of abuse. Such research necessarily includes biogenetic, neurophysiological, cognitive, and emotional sequelae of all aspects of child maltreatment and the effectiveness of intervention programs. (Such research must involve psychiatrists and must be supported by private and public agencies.)

The uniqueness of each child and family must be respected in designing programs for their protection and treatment. Policies and procedures of courts and child protective agencies should include mechanisms for individualized assessment of each child and each family, and supportive and therapeutic services must be tailored to the particular needs defined during these assessments.

[1] The members of the Committee on Family Violence and Sexual Abuse are Sandra Janet Kaplan, M.D. (chairperson), Marion Zucker Goldstein, M.D., Arthur H. Green, M.D., Elaine Carmen, M.D., Herschel D. Rosenzweig, M.D., Matilda Rice, M.D. (Assembly liaison), Mary Lystad, Ph.D., Howard Davidson (consultant), Christine B.L. Adams, M.D., Karen Taylor-Crawford (corresponding member), David Chadwick, M.D. (corresponding member), and Kathryn Jo Kotrla, M.D. (APA/Burroughs Wellcome Fellow).

Position Statement on College and University Mental Health

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

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

A Presidential Task Force on Mental Health on College Campuses was appointed by the American Psychiatric Association (APA) in 2005. An earlier group, the 1972 APA Task Force on College Mental Health, issued a statement focusing on the need for psychiatrists working in college settings to understand the special nature of work in colleges. While we agree with the general thrust of these comments, changes in both psychiatric practice and the college student population necessitate a new policy statement:

The need for mental health services on college and university campuses is increasing. More students enter college already taking psychiatric medications and most colleges report increases in medications being prescribed at their mental health services. Further, most colleges report seeing increases in students with binge drinking, substance abuse, and severe psychopathology. Suicide is the second leading cause of death in college students. Going to college is often very stressful for late adolescents when faced with more intensive grade pressure, separation from parents and friends, and the continuing formation of one's identity. In addition, several disorders begin during late adolescence and early treatment is necessary.

There are institutional benefits to providing excellent mental health care on college and university campuses. Data show that treatment for mental health problems results in higher rates of student retention and graduation.

It is the position of the APA that all colleges and universities should:

1. have an established arrangement for timely access to necessary and appropriate psychiatric services for all students in need of mental health services. Such arrangements may include employed and/or consulting psychiatrists, as well as referral arrangements with local private practitioners. Arrangements should be in place for care to be coordinated in an appropriate manner.
2. ensure that psychiatrists have authority commensurate with their responsibility. This should include significant participation in assessment and treatment planning for students served in college and university mental health settings.
3. assure that the treating psychiatrist role is clearly separated from the role of psychiatrist as practitioners, hospitals, university health services and/or community mental health centers. When students are referred out of their student health systems, care should be taken to minimize the risk of confidentiality breeches and professional ethical conflicts.
4. offer health insurance coverage programs to students that provide comprehensive coverage for mental health, including substance abuse treatment.
5. provide students, parents and staff with easily accessible and culturally sensitive orientation information and ongoing education regarding wellness, general health, and mental health issues (including information about accessing emergency services). This should include problems associated with re-entry of students who have had to interrupt their education.
6. educate student health personnel about recognition of mental health problems.
7. have comprehensive suicide risk reduction and substance abuse prevention programs.
8. establish clinically informed policies that are responsive to and consistent with the ADA (Americans with Disabilities Act).
9. work with psychiatric residency training programs to increase educational opportunities in college and university mental health services. Consideration should be given to the establishment of post-graduate fellowship programs in college psychiatry.
10. work to educate the public as to the challenges and risks related to the college years, in partnership with the appropriate agencies (such as NIMH, NIDA, SAMSA).
11. work toward de-stigmatization of psychiatric illness and helping young people and their families make thoughtful choices about college.
12. support the expansion of research endeavors around college mental health issues and exploration of factors relating to prevention and resiliency.

Prepared by the Task Force on College Mental Health, May, 2005; revised by the Council on Children, Adolescents & Their Families, September 2005; and revised by the Joint Reference Committee, October 2005

Item #8.D
Joint Reference Committee
October 2014

EXECUTIVE SUMMARY:

Council on Communications

The Council on Communications had the opportunity to meet Jason Young, the new Chief Communications Officer, and staff from the Office of Communications and Public Affairs, Psychiatric News and the Office of Integrated Marketing. The council discussed a range of activities underway in the new Communications Division. A review of the Porter Novelli executive summary offered insight to the communication strategic imperatives, APA's brand and message architecture. The council was unanimous in its support for branding the APA consistently, finding that the current approach is lacks coordination and is confusing. Senior council members discussed working with the younger fellows appointed and staff highlighted APA's public education/outreach opportunities available to them. The status of social media, video production, and publishing events/activities were discussed as well as the status of APA's website. The council conversed about actions referred to them and they also had a chance to meet with leadership: Drs. Summergrad, Binder and Levin.

The Council on Communications brings forth three actions to the JRC.

ACTION: Will the Joint Reference Committee recommend to the Board of Trustees vote to approve amending the charge of the Council on Communications to include the entirety of the new APA Communications Division (the Office of Corporate Communications & Public Affairs, the Office of Member Communication and the Office of Integrated Marketing), as well as internal and external communications strategies? (Page 2 & Attachment #1)

ACTION: 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? (Page 7 & Attachment # 2)

ACTION: Will the Joint Reference Committee recommend that the Board of Trustees vote to 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? (Page 7 & Attachment # 3)

REFERRAL UPDATE:

The council discussed in great detail the JRCOCT138.F.1 action titled: : Explore timely avenues of Communication for Council Reports. 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.

Minutes of
Council on Communications
September Component Meetings 2014

I. Introductions & Approval of Minutes

The Council on Communications (COC), chaired by J. Raymond DePaulo, M.D., met at the 2014 SCM on Friday, September 12 from 1-5 pm and September 13th from 9 am-3:30 pm. The meetings of the council were held at the Hilton Crystal City, Williamsburg Room.

Four members of the council were not in attendance. APA Leadership visited the council: Drs. Saul Levin (CEO & Medical Director), Paul Summergrad (APA President), and Renee Binder (APA President Elect). Paul Burke, Executive Director of APF was introduced as well as the administration of the Division of Communication.

Members of the council were asked by Dr. DePaulo to introduce themselves and to highlight their work in communications. Fellows were invited to tell why they wanted to serve on the council, their training program affiliation, and special interest in communications. A few fellows mentioned that they didn't have any formal training in communications but were specifically interested in assisting with the creation of a variety of APA's outreach and educational initiatives such as: revisions of APA's website, and the creation of mental health educational and anti-stigma resources for the public/patients.

The introductions clearly disclosed that the council represents members who engage in variety of timely communicative media formats: authors; editors; radio & television talk show hosts; bloggers; website design, video gaming and app technology. Members expressed that they enjoy engaging in these sorts of communication outlets.

The time spent on introductions offered members and especially the RFM's a better sense of the expertise of each council member. Such interaction allowed RFM's an opportunity to align their communication interest and mentors accordingly. Additionally, the council roster was distributed to assist in facilitating outreach and communication with each other. These efforts were done in adherence to the recent call to improve mentorship opportunities with RFM's.

The minutes from the May 2014 Annual Meeting were presented and Dr. DePaulo asked if there were any amendments or changes required. Hearing none, a motion to accept the minutes passed unanimously.

II. Mission of the Council on Communications

The council reviewed the council charge and they unanimously agreed that it should be amended to include the entirety of the new APA Communications Division (the Office of Corporate Communications & Public Affairs, the Office of Member Communication and the Office of Integrated Marketing).

> **ACTION: Amend the Council on Communications Charge**
> The Council on Communications would like to inform the Joint Reference Committee that the Council proposes to amend its charge to include the entirety of the new APA Communications Division (the Office of Corporate

Communications & Public Affairs, the Office of Member Communication and the Office of Integrated Marketing), as well as internal and external communications strategies.
(COC Current Charge Attachment 1)

III. Paul Summergrad, MD, APA President

Dr. Summergrad thanked council members for attending the SCM and he especially thanked Dr. DePaulo for taking on the responsibilities as chair. He stated that the council's work is critical and asked if they could think about when the APA should or should not speak out on a particular subject in the media. APA needs a consistent voice, and Dr. Summergrad said that he seeks the advice and expertise of the council to that end.

IV. Division of Communications

Jason Young, Chief Communications Officer, discussed the recommendations of the Porter Novelli audit. Jason referenced the new Communications Office which unified the Office of Communications and Public Affairs, Psychiatric News and Integrated Marketing. The administration of the new communications team introduced themselves accordingly. Jason said that the improved and empowered communications infrastructure will advance APA's strategic communications plan.

Porter Novelli was asked to help the APA create a best-in-class communications capability in order to better address current and future communication needs. The framework of the audit offered an analysis of the media/digital channels and message assessment, as well as input from interviews with APA leadership and external stakeholders.

Recommendations from the audit stipulated that the APA must enhance its strategic communications capabilities and re-energize the APA as a leading voice. Jason highlighted the strategic imperatives that offered a clear sense that APA must take the lead by assuming they are the voice of mental health by proactively reaching out to lead and empower staff and members as brand ambassadors. Identifying the priority audiences will dictate the effective communications strategy implemented to reach them. Branding the association will convey what the APA stands and in addition brand identity will align the present and future of psychiatry.

V. OCPA Media Relations

Erin Connors, Senior Media Relations Specialist, shared the number of media requests the office has received since 2011. So far this year the top media requests have been: ADHD, Autism (ASD), Depression, *DSM-5, Parity and SAD.* When Erin receives a media call or a request by email she employs a consistent procedure to gain the necessary information to properly vet and answer the request.

Erin told the council that her next steps include deciding who should be interviewed as well as the interview logistics. She mentioned who APA's main spokespeople were: Drs. Summergrad, Binder and Levin. She also pointed out members of the council who serve as spokespeople, as well as the extensive member expert list that's updated on a regular basis.

How the story impacts the APA or the perception of mental illness and psychiatry is always considered she explained. Erin coordinates interviews by conference call and she will accompany APA media experts for an on-camera interview. In addition, Erin said she'll step in if an interview takes a turn and will monitor the story's coverage.

She asked if anyone on the council was interested in speaking with the media, their area of expertise and if they've ever had media training? Many of the Fellows inquired about how to get media training and Dr. Bernstein told fellows to leverage their connection with their institution's PR dept. - media training could be offered as well as social media interaction.

Erin explained the importance of preparing for an interview. She told members to be friendly, honest and to keep their audience in mind. She stressed, nothing is off the record and members should ask for interview questions in advance. In conclusion, members were told to challenge questionable facts/assumptions, state your key message more than once, and it's ok to say, "I don't know." Erin offered her contact information and told members to contact her if they have any questions about the media. Dr. Khan asked if APA offered media training similar to the state advocacy training offered by Pamela Thorburn in DGR and the DSM-5 "Train the Trainers" media training program offered at APA's annual meeting in 2013. Jason said media training will be facilitated by his office shortly.

VI. Public Education & Outreach, Social Media Update, Healthy Minds Blog

Debbie Cohen, Senior Writer, OCPA, shared with the council a list of the APA public education outlets and resources available, including APA's recent national observances, programs & events. Debbie explained and showed how all public and member driven outreach initiatives are cross promoted via all of APA social media platforms (Twitter, Facebook, Healthy Minds, Healthy Live Blog, YouTube and LinkedIn). There are social media platforms for the public and for members, and the message determines which Facebook or Twitter account the message will posted too. Analytics showed the number of page views/followers for each social media platform, including the most popular blogs, mental health topics, and videos viewed. Jason polled members by asking which social media platform they prefer and/or use frequently. The majority said their Facebook account is used primarily for personal reasons, they don't tend to read blogs, nor do they tend to use LinkedIn – many prefer Doximity, while some were not yet aware of that platform, which is for physicians only. Comments suggested that Twitter was ideal for rapid outreach/communication. Fellows access YouTube frequently to seek instructional guidance and clinical questions they have. Social media is a big part of Dr. Kramer's life but Dr. Bernstein asked what platform is the legitimate source for information - so many ways to access information and as a result she's on system overload. There was a brief discussion about Google + social networking site and how Mayo Clinic has utilized this site to promote their brand and services by engaging a huge community of followers. OCPA is evaluating Google+.

Debbie concluded her presentation by asking members of the council to contact her if they are interested in contributing to the Health Minds Healthy Lives blog. She also told the council that she needs their assistance in writing/reviewing/revising the public education content on APA's website and the Let's Talk Facts brochures.

VII. Psychiatric News Update & Healthy Minds TV Show

Dr. Borenstein gave a brief report on Psychiatric News (PN). Since he became editor in January 2012, the newspaper has diversified its products and the channels through which it delivers news and feature stories.

The design of the PN website has permitted PN to move to an online-first workflow—that is, content can be posted as soon as it is approved and no longer has to wait until the print version has been published. The homepage was designed to pull readers into the site through use of attractive graphics, streamlined navigation bars makes it easier to find the news in which site visitors are interested, and content that is updated daily. Article views for the past six months were 995,154 and the average time spent on a page was 1:29. The top articles viewed in 2014 have been the integrated care series.

The Psychiatric News Alert is an electronic daily news service covering major studies in psychiatry, APA advocacy activities that impact psychiatric practice, and other practice-related information. Subscriptions are on an opt out basis. The subscriber base is about 29,220; in addition to APA members, it includes members of the public and media. The open rate for the past 30 days was 325,083 and 90 days, 762,074. The alerts' open rates are well above 30%, and a number of alerts in the past 90 days exceeded 50%. The open rate for the daily (5) annual meeting alerts were above 20%. Dr. Borenstein said that the current group of ECPs are better informed because of the alerts.

The Psychiatric News Update is distributed via e-mail each week to APA members; average of 33,200. The open rate for the update is 24% and it pushes out links to PN videos and audio reports.

The print edition of PN was redesigned last year with an emphasis on increased use of graphics, summaries, and key-points boxes to make it easy for busy readers to identify the content of most importance to them. Also, content was refocused to emphasize coverage of clinical and research news and now includes multimedia reports.

Jeffrey Borenstein, M.D., updated the council on the Healthy Minds TV show, which he hosts. Since the premiere of the series on WLIW21 in 2006, Healthy Minds has been received numerous awards, including three silver and two bronze Telly Awards and a Fair Media Council Folio Award. The series includes 13 half-hour episodes, each focusing on a particular mental health topic including field pieces about mental health in the community. The TV show broadcast in over 60 percent of U.S. households and features interviews with mental health practitioners, patients and their advocates, celebrities and ordinary people who are making a difference in the community. National distribution of Healthy Minds was made possible by a grant from APF. The theme for the 4th season includes conversations in the homes of people who have, and/or care for family members who suffer from mental illness.

VIII. Actions Referred to the Council on Communications

Staff distributed the three actions referred to the council for review and discussion.

Staff shared the PowerPoint template that was created in response to the assembly action: ASMMAY1412.N- RFM Modality & Opportunity for APA Updates and Education. Members of the council particularly the fellows thought the slide set was very informative and they requested access to it to share with colleagues. Staff emailed the template and

the link to the Resident & Fellows page located on APA's website so that they could have direct access to other resources.

The council also discussed in great detail the JRCOCT 138.F.1 action titled: Explore timely avenues of Communication for Council Reports. 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 council was also asked to review sections of the BOT Ad Hoc Work Group on the Role of Psychiatry in Health Reform - BOT 8.G.1. In response to the assigned sections intended for the COC's review, members were in agreement that they cannot consider or create effective messaging until leadership outlines a vision/mission statement relative to psychiatry role in Health Reform. They did stress how important it is for members to be informed about the federal and private group pilot programs & new systems available, as well as highlighting SAMSHA's Health Reform site. APA councils must share with the COC what they want to distribute in order for the council to rationalize & recommend "how to". In addition, the COC recommends that it's important to educate the younger member audience on how Health Reform will affect them in the future.

Staff provided an account of all the integrated care resources currently available via APA's communications outlets.

- Psychiatric News print issue includes a "Psychiatry & Integrated Care" section
- Psychiatric News Update: Sent weekly on Wednesday includes a section called: Integrated Care: What It Means to You
- Integrated Care Newsletter produced by Health Care Systems & Finance featured in "Headlines" and promoted via APA's Social Media channels
- **Health Care Reform & Integrated Care** Playlist on APA's YouTube
- **Integrated Care Roundtable April 2014** Playlist on APA's YouTube
- Promoting the IPS Integrated Care Track

The council also offered the following recommendations to the workgroup moving forward:

- APA councils must share with the COC what they want to distribute in order for the council to rationalize & recommend "how to".
- The Council on Communications recommends that APA engage district branch and area councils by outlining a regional strategy for them to implement.

- Share with members the federal, private group pilot programs, models & new systems available around the country; highlight the programs that work not the evidence.
- Include an easily accessible section on APA's website that would take users to an integrated care section of well-organized resources.
- Highlight SAMSHA's Health Reform site, as to not reinvent the wheel.
- Highlight the Economic Impact of Integrated Medical- Behavioral Healthcare: Implications for Psychiatry, prepared by Milliman, Report (Access to the page on psychiatry.org is difficult to find).

IX. The State of APA's Brand and Message Architecture

Jason presented a PowerPoint that council members said was powerful and provided insight; it was a visual display of "iconic" company brands and taglines that are seen daily, meant to convey best practices. He identified the emotional connection to a host of taglines and the concealed visual elements included in legendary logos. The history of the APA brand (Ben Rush seal) and the APA family of brands clearly showed APA's need for a unified brand identity, the council said. Jason shared the RFP that's been developed and which the BOT has been briefed on, and Dr. DePaulo sought the council's view and approval on moving a branding initiative forward. The council voted unanimously in favor.

> **ACTION:** Will the Joint Reference Committee recommend that the Board of Trustees vote to approve the Council on Communications recommendation and support APA's branding initiative to help brand the APA consistently and demonstrate the value of membership? (Attachment 2)

X. Member Communications Award

In anticipation of this agenda item the council received the five entries submitted for 2014 Member Communications Award including the links/URLs to each communication format submitted. John Luo, MD, Vice Chair of the COC and Chair of the award sub-committee discussed the award process as well as stating that a Survey Monkey review was created to facilitate an easier review process for the sub-committee. Next year, the council suggested streamlining the award process by honoring only one nominee from the five award categories.

The following DB/SA's participated in this year's award for the following award categories:

- Georgia Psychiatric Physicians Association – eNewsletter category
- Maryland Psychiatric Society - eNewsletter category
- North Carolina Psychiatric Association-Innovative & Emerging Technology
- Ohio Psychiatric Association- Website Category
- Pennsylvania Psychiatric Society – eNewsletter Category

Following the sub-committee's review, it was decided to award Ohio for Website, North Carolina for Innovation & Emerging Technology and Pennsylvania for the eNewsletter category and the council concurred.

ACTION: Will the Joint Reference Committee recommend that the Board of Trustees vote to 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. (Attachment 3)

XI. Renee Binder, M.D. APA President Elect

Dr. Binder thanked council members for serving on the council and she outlined her 2015 initiatives. She plans to combat the mental health stigma patient's face as well as the stigma associated with the practice of psychiatry. She said that the climate has changed for HIV since the 80's and the same messaging efforts can change the perception of psychiatry. Dr. Binder's theme for the 2016 Annual Meeting will be, "Claiming Our Future: Psychiatrists in the New Era." She plans to meet the needs of the younger audience and continue to align members to mentor and pay attention to our future leaders.

XII. Website Update

The council was given a brief update on that fact that a redesign of APA's main website, psychiatry.org, has commenced and that a vendor is in place.

XIII. APA Video Production

The council reviewed a series of videos recently produced by Psychiatric News and OCPA. Jason asked members to offer their honest opinion about the video production quality, content and wanted to know if members had watched any of the videos posted on APA's website or promoted via social media. Members were skeptical of the effectiveness of the formats (usually "talking head" style videos). They also –said the videos are too long. Members said they tend to watch videos that offer an educational element, an immediate use, or a cohesive message.

The council also said videos could be valuable in educating patients and their families. APA should consider producing videos that would change the image of psychiatry by showing diversity, age differences, and interaction with patients outside of an office setting. In addition, the council suggested that APA consider an Instagram campaign. The campaign could promote short videos for public education that would highlight diversity within psychiatry, what to expect from your psychiatrist, this is depression and an explanation of health care reform. Videos should include multimedia components/animation, titles and display a relative hash tag such as #IAMAPA.

XIV. Annual Meeting & IPS Communications

Lisa Fields, Senior Digital & Editorial Content Developer, OCPA worked again this year with Tri Star Publishing to offer an open sales model for APA's turnkey products; Daily Bulletin (Preview & 3 print issues), and the Mobile App. Staff shared that the Daily Bulletin featured meeting highlights, leadership speeches and promoted scientific sessions and local attractions. Marketing of the digital ePreview issue was done by posting the link in Psychiatric News digital outlets, as well as APA social media and email blasts. Print issues were distributed in the doctor's bag, hotel door drops and included in the bulletin racks throughout the convention center and selected hotels.

The open sales model instituted again this year generated APA revenue and covered the costs of each product; Daily Bulletin and the app.

Staff shared the increase number of the annual meeting app downloads since its inception in 2011. In 2013 the download numbers of the IPS app (1,723) in comparison to the number of IPS registrants (1,509) clearly displayed its usage.

In response to the success of both the Annual Meeting and IPS app, APA will launch in late September an APA Meetings App. The APA Meetings App will house both the IPS and Annual Meeting apps under one roof. Users will download one app, where all APA meetings are accessible, including past & future meetings. Meetings will be conveniently organized by availability, and users will download the "APA Meetings App" by simply updating the app to access new meetings as they launch.

Lara Cox, M.D., a member of the BOT, reported on a resident-led initiative to develop a multi-purpose app. The council agreed that the app was a good idea and would align well with the meeting app that is soon to launch, as well as the redesign of psychiatry.org.

XV. Other Business:

The Council on Communications is tentatively scheduled to meet at the APA Annual Meeting APA Toronto, Canada, May 16-20, 2015 on Sunday, May 17, from 1-5 pm & on Monday, May 18, 9am-12 noon.

Summary

Council of Geriatric Psychiatry

Description of the Council:

The Council provides leadership in the field of geriatric psychiatry and undertakes this task by initiatives related to geriatric psychiatry education, research, and clinical care. The Council also strives to work collaboratively with other professional and advocacy groups to develop best practices in geriatric psychiatry while providing education and training to other physicians (including but not limited to psychiatrists), residents, and medical students, as well as to other allied mental health professionals (including but not limited to nurses and social workers) at scientific meetings and in other settings focused on the special needs of geriatric populations with mental illness.

Information Items:

- The Council reviewed five position statements that have come due for review between 2012 and 2014. The recommendation was that two be retired, two revised, and one retained in its current form. The Council will work on these statements and submit proposed revisions by the end of November.
- The Council proposed a minor revision to the "Choosing Wisely" item related to the use of antipsychotics since the current document makes a categorical statement that antipsychotics should not be used as first-line treatments for behavioral and psychological symptoms of dementia and in fact there are instances in which it may be an appropriate first-line treatment.

Referral:

Establishing Guidelines for Interacting with Caregivers (ASMNOV1312.C; JRCJAN146.1)

The Joint Reference Committee has 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.

Council of Geriatric Psychiatry- September Component Meeting
Hilton Crystal City, Washington DC
Wednesday, September 10, 2014

Council Members Present:

1. Robert Roca, MD (Chair)
2. Anand Kumar, MD (Vice Chair) (Joined via conference call)
3. Brent Forester, MD
4. Bruce Saltz, MD
5. Bret Rutherford, MD
6. Sherrie Godbolt, MD
7. Keith Stowell, MD
8. Alex Threlfall, MD
9. Maria Llorente, MD

Staff in Attendance:

- Sejal Patel (Staff), APA

Council Members Absent with excused absence

- Susan Schultz, MD
- Ipsit Vahia, MD
- Helen Lavretsky, MD
- David Steffens, MD

Council Members Absent with unexcused absence

- Mohit Chopra, MD
- Olivia I Okereke, MD

Guests in Attendance:

1. Christopher Woods, Executive Director, American Association of Geriatric Psychiatrists
2. Karen Sanders, HCFI, APA
3. Samantha Shugarman, HCFI, APA
4. Susan Keller, APA
5. Seung-Hee Hong, APA
6. Matt Sturm, APA
7. Deborah Cohen, APA

The meeting began with introductions of all the participants and review of the agenda items for the meeting.

1. Guidelines for Interacting with Caregivers

In response to an Assembly action paper "Guideline for Caregivers", the Council is working with the Council on Psychiatry and Law to develop a resource document to guide members on how to interact with caregivers of the persons with mental illness. The Workgroup has prepared a first draft document which was circulated to the council members for their feedback. The Council reviewed the draft document and came up with a few suggestions for revisions, including the addition of language specifically relevant to geriatrics. The plan is to solicit feedback from the Assembly member who wrote the action paper and to submit the document to the JRC this fall.

2. Government Relations Update:

Matt Sturm summarized APA Advocacy initiatives undertaken in last six months. APA's Department of Government Relations initiated a project called Engage 2014 — a grassroots campaign encouraging APA members to advocate on behalf of the mental health community. APA is providing members with a list of opportunities that will allow them to interact with legislators. Many APA district branches and their members have already taken action to ensure the mental health community is engaged in the legislative and political process. He also informed the members that the APA had submitted comments to the Obama Administration in response to Substance Abuse and Mental Health Services' (SAMHSA) draft 3-year (2015-2018) Strategic Plan. In the letter to the Obama Administration, the APA made strong recommendations concerning better care for people with serious mental illness, healthcare integration, parity, and the psychiatric workforce.

3. Report from AAGP

Dr. Brent Forester, as a current AAGP Board Member, provided a brief update on AAGP activities. He talked about the 2015 AAGP Annual Meeting to be held March 27-30 in New Orleans. The theme of the meeting is Interprofessional Practice: Working Together to Meet the Mental Health Needs of Older Adults. He also gave an update on the GMHF Scholars Fund Program, which exposes medical students and young physicians to the field of geriatric psychiatry in order to increase the number of medical professionals trained to care for the elderly population. He also talked about the AAGP's Alumni session at the Annual Meeting where former Honors Scholars provide a presentation on the scholarly project they completed as part of the Scholars Program. Christopher Woods, new Executive Director of AAGP, also attended the meeting and interacted with the Council Members.

4. Meeting with CMS

CMS called for a meeting to seek assistance from APA in their work to develop regulations and metrics associated with their initiative to reduce antipsychotic use in nursing homes by 15%. This is the first input they have received from psychiatrists on this issue. Dr. Robert Roca attended the meeting with Karen Sanders and Irvin Muszynski and shared the resource document on this topic developed by the Council earlier this year. Karen and Dr. Roca briefed the Council about the meeting. The Council expressed concern about the unintended consequences of poorly chosen metrics. CMS officials said

that they often look to practice guidelines when they seek to develop measures, and they want to speak to us again when the new APA practice guidelines on this topic become available next year.

5. Update on Integrated Care

Karen Sanders presented an update on Integrated Care. She informed the group about the new code implemented by CMS for chronic care management. Last year CMS authorized a new billing code for chronic-care management to compensate physicians for tasks such as developing a care plan, referring patients to colleagues, and working with home-care agencies. Beginning next year, Medicare will pay for managing a patient with two or more chronic conditions.

She also encouraged the members to give their feedback on the BOT Workgroup recommendations on the Role of Psychiatry in Health Reform. The Council began reviewing the document and is preparing a detailed response to the questions. The members agreed that the APA should be working to ensure that psychiatrists have the right roles in evolving models of care and that psychiatrists are trained to play these roles. Members felt that the APA should participate actively in the development of the specific metrics that will drive reimbursement for psychiatric services in the emerging world of pay-for-performance, value-based purchasing, and similar payment models. The APA should consider putting resources into the creation and testing of the measures of effectiveness and value by which our services will be judged and paid for.

6. Update: Practice Guidelines on use of antipsychotics in elderly

Susan Keller and Seung-Hee Hong of APA gave a progress report on the development of the practice guidelines on the use of antipsychotics in patients with dementia. The Workgroup created a survey to capture the attitudes and practices of experts regarding the use of antipsychotics in the treatment of dangerous and non-dangerous agitation and psychosis among persons with dementia. The survey has been sent out to 600 individuals who were selected using snowball sampling. Currently the Workgroup is analyzing the data received from this survey, and the draft document is expected to be available in the beginning of next year for the Council's review. Susan also requested the members to help identify other organizations whose input would be useful. The Council inquired about how the Workgroup is planning to keep the guidelines updated on regular basis.

7. Choosing Wisely:

The Council is planning to propose minor revisions to the "Choosing Wisely" item related to the use of antipsychotics. The current document makes a categorical statement that antipsychotics should never be used as first-line treatments for treatment of behavioral and psychological symptoms of dementia. While the members agree that they should rarely be used first, there are situations in which this is necessary. The Council believes that the document should allow for these circumstances.

8. Position Paper Review:

The Council is assigned the task to review following five position statements that have come due for review between 2012 and 2014. The members reviewed each statement and recommended changes.

1. Precepts of palliative care
2. Core Principles for End-of-Life Care

3. Elder abuse, neglect, and exploitation
4. Role of the psychiatrist in assessing driving abilities
5. Ensuring access to appropriate utilization of psychiatric services of the elderly

The position statement on Core Principles of End-of-Life Care is not well written and requires revision.

The "Precepts of Palliative Care" paper can be retired as a free-standing position statement and can be appended to the revised paper on End-of-Life Care as background material.

The Council also recommends retiring the position statement on Ensuring access to appropriate utilization of psychiatric services of the elderly.

The paper on "Role of Psychiatrists in Assessing Driving Ability" needs be revised.

The Council will work on the statements on end-of-life care and driving ability and submit revised draft statements by the end of November.

The position paper on elder abuse should be retained.

9. Developing Educational Contents for APA Members:

Miriam Epstein and Trang Smith gave an overview of the e-focus and other potential educational projects which can be supported by the Council. Several Council members have shown interest in working on contents for e-focus and other educational programs. The Council discussed working with AAGP to identify AAGP Scholars who may be interested in assisting Council members in developing educational materials. This would be an excellent opportunity to collaborate with AAGP on a specific work product.

10. Geriatric Psychiatry Webpage Contents:

The members reviewed the contents posted on the Geriatric Psychiatry webpage for its relevance and agreed that more resources should be made available, especially the training resources. The Council will develop a list of recommended resources that can be posted on the webpage. Deborah Cohen briefed the Council about the potential changes that may take place in the structure of the website to make it more user-friendly.

11. Awards in Geriatric Psychiatry

The Council formed a subcommittee to review the nominations received for two awards: Hartford-Jeste Award for Future Leaders in Geriatric Psychiatry and Jack Weinberg Memorial Award in Geriatric Psychiatry. Seven applications were received for the Jack Weinberg Memorial Award and four for the Hartford-Jeste Award. The recommendations of the subcommittee were reviewed by the entire Council, and proposed honorees were selected for consideration by the JRC.

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.

Position Statement on Ensuring Access to, and Appropriate Utilization of, Psychiatric Services for the Elderly

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*.

The American Psychiatric Association stands as an advocate for access to and delivery of quality psychiatric care for aging populations. Psychiatric treatments have been shown to be effective in the management of the emotional and mental disorders of late life. While older Americans benefit from access to psychiatric treatment, they still do not have adequate access to these services.

The American Psychiatric Association endorses the following fundamental principles regarding the treatment of older Americans with psychiatric illnesses:

1. All older Americans should have access to timely psychiatric consultation and treatment.
2. Treatment of older adults with psychiatric illness must be provided with respect and compassion.
3. Psychiatric physicians caring for older adults must adhere to the ethical standards of the American Psychiatric Association and provide treatments that are appropriate and effective.
4. Psychiatric physicians have unique skills in the provision of psychotherapeutic, psychopharmacologic, social and family interventions. Elderly patients benefit when a psychiatric physician participates in a multidisciplinary treatment team for evaluation and for delivery of treatment services.
5. Additional research (basic and clinical) is necessary to develop new treatments for the elderly that are safe and effective.

Revision of the 1997 position statement by the Council on Aging.

Council on International Psychiatry

The Council on International Psychiatry was established by the APA Board of Trustees at their October 2013 meeting. The initiative for the establishment of the Council stemmed from an Assembly action paper and with the support of the Board Ad Hoc Work Group on International Psychiatrists was approved by the Board of Trustees. The charge of the Council (Attachment 1) was subsequently approved by the Board of Trustees at their March 2014 meeting. At present, the Council has one reporting component, the Caucus on Global Mental Health and Psychiatry.

The Caucus on Global Mental Health and Psychiatry was also established through an Assembly initiative and approved by the Board of Trustees at their December 2013 meeting as a special interest group of the APA. The Caucus focuses on global mental health education, research, and advocacy for improved mental health care for all through collaboration with health and mental health professionals. Per APA policy, the Caucus Chairperson, Milton Wainberg, M.D., was appointed by then APA President, Jeffrey Lieberman, M.D., and met for the first time at the 2014 APA Annual Meeting in New York City. After the meeting, several Caucus members collaborated to submit an abstract on models of education and training on global mental health for the 2015 APA Annual Meeting. The Caucus is also currently in the process of organizing journal article submissions for a special edition of the publication *Academic Psychiatry*.

Appointments to the 2014-2015 Council on International Psychiatry (Attachment 2) were made by then APA President-Elect, Paul Summergrad, M.D., and the Council met for the first time during the 2014 September Components meeting in Arlington, VA. As it was the first meeting of the Council with a new charge focused on international membership growth, the Committee focused on reviewing current APA international activities including the following:

- **Education:** Domestic/International Live Learning and e-Learning Opportunities, Annual Meeting Attendance Figures and Annual Meeting Attendee Experience
- **Membership:** International Category Figures, Member Benefits, Recruitment Programs and International Dues Structures
- **Publications:** International Content and Distribution
- **Training:** Domestic/International Global Mental Health and Psychiatry Training Curriculums and Fellowship Opportunities

The Council plans to discuss several issues raised and captured in the minutes (Attachment 3) during the September meeting corresponding to each of the categories listed above in order to begin to formulate a strategy to influence international membership growth. The Council was unanimous in agreeing that a strategy should incorporate both measurable and sustainable objectives and that the APA should work organization-to-organization, rather than organization-to-individual or individual-to-individual, on programs and projects. This includes the Council working Component-to-Component on issues, such as with the Membership Committee on international membership dues structures and the Council on Medical Education regarding the development of fellowships and curriculum models and training opportunities on global mental health.

ATTACHMENT 1: Council Charge

The charge of the Council on International Psychiatry is as follows:

The purpose of the Council is to facilitate understanding of problems facing international psychiatrists and their patients. It will do so by focusing on international membership in the APA, and through increased membership in the APA, avail all members of the opportunities in education, advocacy, prevention and clinical care that membership in the APA provides.

1. *The Council works in collaboration with the Membership Committee to recruit international members.*
2. *The Council ensures APA policies and positions on international issues are current and appropriate.*
3. *The Council, working in collaboration with the Council on Research, provides recommendations and strategies to enhance the scientific base of international psychiatric care and global mental health.*
4. *The Council identifies opportunities for partnership with other organizations to foster the creation of financially self-sustaining international programs that will benefit all members of the APA and their patients.*
5. *The Council will strive to establish mutually beneficial relationships between the APA and other internationally focused psychiatric organizations. The Council may facilitate collaborative development of clinical, research, training, and forensic guidelines by these various organizations, including the APA, for use by psychiatrists globally, with appropriate modifications for specific countries or regions. The Council may facilitate publication of news about these organizations and their activities in Psychiatric News.*
6. *The Council promotes engagement to enhance shared learning and leadership to achieve participation of all APA members.*

The Council members are experts with experience in global mental health and who are broadly representative (geographically and culturally) of the APA international body. The Council has a standard council composition. APA members who have membership in international organizations may be appointed as corresponding members and serve as liaisons to their international organizations. The Council will utilize freely available electronic communication technology to interact and coordinate with organizations and individuals outside of the United States in lieu of international travel. No APA funds will be budgeted nor used for travel outside the United States by members of this council for the work of this council.

ATTACHMENT 2: 2014-2015 Council Composition

The 2014-2015 composition of the Council on International Psychiatry is as follows:

Chairperson	Dilip V. Jeste, MD	La Jolla, CA
Vice Chairperson	Ann Becker, MD, PhD	Boston, MA
Member	David Baron, DO	Altadena, CA
Member (ASM)	Ken Busch, MD	Chicago, IL
Member	James Griffith, MD	Washington, DC
Member	Nalini Juthani, MD	Scarsdale, NY
Member	John McIntyre, MD	Rochester, NY
Member	Samuel Okpaku, MD, PhD	Nashville, TN
Member (ECP)	Uyen-Khanh Quang Dang, MD, MS	San Francisco, CA
Member	Michelle Riba, MD, MS	Ann Arbor, MI
Member	Pedro Ruiz, MD	Miami, FL
Member	Allan Tasman, MD	Louisville, KY
Consultant	Edmond Pi, MD	Hacienda Heights, CA
Consultant	Mounir Soliman, MD, MBA	La Jolla, CA
Corresponding Member	Solomon Rataemane, MD	Pretoria, South Africa
Corresponding Member	Vihang Vahia, MD	Mumbai, India
Corresponding Member	Eliot Sorel, MD	Washington, DC
Fellow	Bibhav Acharya, MD	San Francisco, CA
Fellow	Mawuena Agbonyitor, MD	Baltimore, MD
Fellow	Suni Jani, MD, MPH	Houston, TX
Fellow	Michael Morse, MD	Washington, DC
Fellow	Lianne Smith, MD	Bronx, NY
Fellow	Christopher White, MD	Moss Beach, CA
Fellow	Rachel Winer, MD	Palo Alto, CA

ATTACHMENT 3: Council Meeting Minutes

Council Name: Council on International Psychiatry
Date: September 11, 2014
Time: 8:00 AM – 3:00 PM
Location: Arlington, VA

Council Members Present: B. Acharya, M. Agbonyitor, D. Baron, A. Becker, J. Griffith, S. Jani, D. Jeste, N. Juthani, M. Morse, S. Okpaku, E. Pi, U.K. Quang Dang, M. Riba, P. Ruiz, L. Smith, M. Soliman, E. Sorel, C. White

Council Members with Excused Absences: K. Busch, J. McIntyre, S. Rataemane, A. Tasman, V. Vahia

Council Members with Unexcused Absences: None

Guests in Attendance: W. Azeem (via video conference), R. Binder, S. Levin, B. Rao (via video conference), P. Summergrad

Staff in Attendance: J. Fanning, R. Juarez, S. Kuper, R. Rinehart, C. Stoute

Summary

The Council on International focused on reviewing and evaluating current international activities by the APA and other organizations through presentations by APA staff, Council members, and guests to better understand the landscape of international psychiatry at the APA. Subjects reviewed included current membership and meeting figures and trends, international membership structures and benefits, and a review of international education and training initiatives and gaps for consideration. This assessment will lead to the development of a strategy to increase APA international membership through measurable and sustainable outcomes.

Education

Domestic/International Live Learning and e-Learning Opportunities, APA Annual Meeting International Attendance Figures, APA Annual Meeting International Attendee Experience

APA Education: Ricardo Juarez, APA Associate Director of International Affairs, presented on international initiatives in continued education and professional development at the APA based on findings by the World Health Organization (WHO) and the Organization for Economic Co-operation and Development (OECD) regarding the number of psychiatrists in the world. An estimated half of the near 250,000 psychiatrists in the world reside in the European region, a little more than a quarter in the Americas region, which includes the US/Canada, a little less than a quarter in the Western Pacific Rim region and the remaining spread across the Eastern Mediterranean, South East Asia, and African regions. In conjunction with the concentration of half of the world's psychiatrists in Europe, an existing agreement between the American Medical Association (AMA) and the European Union of Medical Specialists (UEMS) and European

Accreditation Council for Continuing Medical education supports continued medical education (CME) and continued professional development (CPD) of physicians through live learning events and e-learning opportunities. It was noted that CME and CPD requirements in Europe are mandatory in 21 countries, voluntary in 13 countries, with 8 countries in the process of implementing a relicensing process similar to the maintenance of certification (MOC) process in the US. The APA is planning to highlight the agreement allowing for a one-for-one exchange of credits earned at AMA accredited events, such as the APA Annual Meeting, by attendees from Europe as an additional benefit. In addition, in order to capitalize on the e-learning aspect of the agreement, e-learning modules are in development as a possible international member benefit to support earning and completing CME and CPD credits. While organization of such modules by psychiatric core competencies and sub-specialty is favorable, it was determined that the use of a title category of "international" or "global" may not best describe the content being developed or the intended audience.

APA Annual Meeting: Ricardo Juarez, APA Associate Director of International Affairs, presented on international attendance trends over the past several years at the APA Annual Meeting. The Netherlands maintain the highest attendance followed by Brazil, Argentina Australia, Sweden, United Kingdom, China, Mexico, Colombia, Spain, and South Korea. These attendance trends generally follow the trend of countries with the majority of APA international members. It was noted that the Annual Meeting includes several international activities including a New International Member Networking Reception, an invitation to all international psychiatric organization presidents to attend the meeting with special designated area at the Opening Session, an international time zone wall with organized regional "meet ups" and an International Psychiatry Track which lists scientific programs with international presenters. Also highlighted at each Annual Meeting, through APA TV, are segments reflecting the research and work of international psychiatry and neurology institutions around the world. The Annual Meeting also serves as a meeting place for international leadership meetings such as the APA-WPA leadership meeting. It was suggested that having an international space for international to congregate may enhance international attendee experience as well as exploring the possibility of translating select sessions, perhaps anything related to DSM-5, to a different language such as Spanish.

APPNA MERIT: Dr. Waqar Azeem and Dr. Babar Rao of the Association of Physicians of Pakistani Descent of North American (APPNA) presented, via video conference, on their MERIT program which utilizes video conferencing technology to facilitate the transfer of medical education, research, and training between physicians around the world, including the United States/Canada, and medical schools, universities and other institutions in Pakistan and the Middle East. While it was noted that the system, Cisco WebX, has the capacity of connecting 200 institutions to lecturers, currently the MERIT program coordinates about 45 lectures a year with 30 organizations, including a monthly lecture on psychiatric specialties, with about 8-15 organizations joining each lecture for real time interaction. The cost of the system is about $30,000/year with funding provided by APPNA and private donations from physicians with identified lecturers and system administrators participating voluntarily. Participating institutions do not provide funding for participation. The curriculum is set through correspondence with

heads of training programs regarding their educational needs. While there has been no attempt to create a financial or business model of the MERIT program for countries able to provide funding, a Child Psychiatry Fellowship has been developed to begin in 2015 and a process for certification in dermatology is in development. It was noted that the ACGME and ABPN may be able to provide models of certification based on the determined curriculum. While each lecture is recorded and made available as necessary, participant follow up regarding lecture content and discussions are left to be accomplished on an individual and personal basis. Drs. Azeem and Rao submitted an abstract for the 2015 APA Annual Meeting on their work which may be considered for sponsorship after review by the Council. It was also noted that Dr. Azeem will connect with Dr. Riba to include their work in a special edition of the publication *Academic Psychiatry*.

Membership

International Membership Category Figures, International Member Benefits, International Member Recruitment Programs, International Membership Dues Structures

APA Membership: Susan Kuper, APA Membership Director, presented on international membership trends, international membership categories and Membership Committee activities. Overall international membership has grown steadily over the past several years with currently 1,760 International Members, 145 International Fellows, and 63 International Distinguished Fellows.

A discussion of international membership dues structure, which is currently based on the World Bank classification of countries of Low Income, Lower Middle Income, Upper Middle Income, and High Income, posed possible variable for consideration to enhance the international dues structure. While it was noted that the current structure based on a country wide income level may not properly reflect an individual's level of affordability, it was suggested that waiving fees for Low Income and Lower Middle Income may increase membership in those countries. More information including the breakdown of international members by income category group was requested to further evaluate the current dues structure. Considerations for enhancement included medical student and resident membership categories, honorary memberships for physician non-psychiatrists and non-physicians, affiliate membership with organizations or institutions, group memberships, and a mechanism for individuals to pay a "lump sum" one-time amount.

It was noted that while the APA exhibits at several international psychiatric meetings including the World Psychiatric Association World Congress of Psychiatry and International Congresses in addition to the Royal College of Psychiatrists, though the return on investment for exhibiting is variable to the size of the meeting. The same minimal membership recruitment was noted with the International Ambassador Program which utilizes a peer-to-peer recruitment strategy. It was suggested that presentations by APA leadership at international meetings may include information specific to the target audience as an opportunity for recruitment.

Initiatives of the Membership Committee with regards to increased international membership growth include the addition of an International Membership Work Group to focus on international

issues brought to the Committee. Presented for consideration was a proposal from an outside organization for pharmaceutical companies to fund/sponsor international psychiatrist memberships to the APA. The Council discussed that it would be preferable to receive payment directly from prospective members and that the APA should not play the role of intermediary with pharmaceutical funded initiatives for group membership.

Board Work Group on International Psychiatrists: Dr. Riba, Chair of the Board Ad Hoc Work Group on International Psychiatrists reported on the final report of the Work Group to the Board of Trustees regarding recommendations to forward to the Council on International Psychiatry. It was noted that the recommendations were meant for consideration by the Council rather than immediate action.

Recommendation 1: Facilitate collaborations with international psychiatric organizations to submit abstracts for presentation at the APA Annual Meeting. Recommendation 2: Reach out to international psychiatrists for regular contributions to publications including journals and other periodicals. Recommendation 3: Develop a training model for psychiatric training programs on global mental health and international psychiatry. Recommendation 4: Secure external funding for the development of an international fellowship program to send APA RFMs to World Psychiatric Association meetings. Recommendation 5: Secure external funding for the development of an international fellowship exchange program funding international members to attend the APA Annual Meeting. Recommendation 6: Develop and implement a survey of international organizations regarding their standards for continued medical education and continued professional development. Recommendation 7: Develop and implement a survey of international members regarding their standards for continued medical education and continued professional development. Recommendation 8: Develop and implement a survey of international members regarding their needs and requirements to fulfill and enhance their professional objectives.

Other members of the Work Group noted several perspectives for the Council to take into consideration including approaching international membership on a regional level rather than on a country level and incorporating a strategic business model for growth with measurable and sustainable outcomes. It was also noted that in order to maintain and protect the ethical standards of the APA that organization-to-organization collaborations may be best. With regards to the recommendation related to psychiatric training programs it was noted that psychiatry resident training programs in the US have the least amount of opportunities to send residents abroad for training.

Publications

International Journal Content, International Book and Journal Distribution and Sales

APA Publishing: Becky Rinehart, APA Publisher, and Cecilia Stoute, Licensing and Permissions Manager, presented on international distribution/subscription figures for APA books and journals with figures on sales distribution. It was noted that the American Journal of Psychiatry and the Journal of Neuropsychiatry and Clinical Neurosciences have the majority of their distribution outside the US. Regions with high distribution included Europe, Asia and

Australia/New Zealand. Figures indicating the number of international submissions accepted for publication in each journal indicated a level on par with acceptance rates for submissions from authors in the US/Canada, though the majority of published content is generally from US/Canada. It was suggested that those submissions not accepted may be contacted to submit abstracts for consideration by the Scientific Programs Committee for presentation at the APA Annual Meeting.

Translations are underway in 18 languages including Chinese, Croatian, Czech, Danish, Dutch, French, German, Greek, Hungarian, Italian, Japanese, Korean, Portuguese, Romanian, Serbian, Spanish, Swedish, and Turkish. AJP, JNP and FOCUS have local editions in Argentina, Spain, China, Mexico, Brazil and the Middle East with several journal abstracts available in Japanese. While English content licensing is limited, the APA partners with trusted partners in certain territories to have a better reach. This is done with DSM-5 in the Middle East and Korea. It was also noted that the APA makes journals and e-books available through the WHO HINARI programme to low and lower middle income countries through institutions.

While it was noted that an editor from Harvard was planning to meet with AJP to discuss a collaboration piece on global mental health, it was suggested that a discussion with editors of psychiatric journals regarding the role they can play with developing new models of psychiatric care may be beneficial. In addition, providing a standard template inviting international submissions on the publications international webpage may increase international submission rates.

Several topics for follow up included reviewing international book sales figures, earned royalties and working closely with the APA Publisher to coordinate organization to organization collaborations to promote publications such as through the World Psychiatric Association.

Training

Domestic/International Global Mental Health and Psychiatry Training Curriculums and International Fellowship Opportunities

M. Soliman: Dr. Mounir Soliman presented on the benefits of international membership as existing through the close working relationships of APA components, such as the Council on International Psychiatry, with and other organizations, noting the importance of international strategic planning. With respect to the possibility of planning programs for international training, it is necessary to address issues of (1) Professional Development (including leadership and shared learning), (2) Patient Care Services (including standardized care and safe outcomes), and (3) System Development (including patient rights and mental health acts). An ideal program addresses questions of who, what, where and when to teach and is based in structures and institutions driven by sustainable outcomes. The incentive of international membership was described as the organization to organization relationship that can support international training models. For example, changing the site of training by incorporating two months abroad as part of training rotations serves as an institutional benefit that could be offered by the APA. The components for model development were expressed as being external assessment, internal evaluation, network planning and peer consultation. It was noted that models used by other

organizations to offer training of psychiatrists abroad may be beneficial to research for evaluate as an enhanced benefit to international membership. Several Council members agreed to work together to bring together successful training program models and submit an abstract for a future Annual Meeting. It was also suggested to review the possibility of establishing a global mental health fellowship and mentoring early career psychiatrists in global mental health.

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

Members of the CHSF had a robust meeting in September. The focus of the discussion was on health reform, emerging models of care, emerging payment models, and the increasing role quality measures and medical costs play in payment reform.

The joint position statement Role of Psychiatrists in Reducing Physical Health Disparities in Patients with Mental Illness: The CHSF voted to reaffirm their support of the proposed joint position statement ***Role of Psychiatrists in Reducing Physical Health Disparities in Patients with Mental Illness***. The primary authors of the position statement are: Lori Raney, MD, Erik Vanderlip, MD, Jeffrey Rado, MD, Robert McCarron, MD, the APA Workgroup on Integrated Care, the APA Council on Healthcare Systems and Financing, Association of Medicine and Psychiatry (AMP). The following APA Councils and external organizations have approved this statement as submitted: APA Councils on Psychosomatic Medicine, Geriatric Psychiatry, and Medical Education and Life Long Learning; and the Association of Medicine and Psychiatry (AMP), American Academy of Community Psychiatry (AACP), and the Academy of Psychosomatic Medicine (APM).

Will the Joint Reference Committee recommend that the Assembly vote (in an up or down vote) to approve the Joint Position Statement titled *Role of Psychiatrists in Reducing Physical Health Disparities in Patients with Mental Illness*? (p. 10, 42-43)

Position Statement Review (pp. 11-14, 18-41): Members of the CHSF reviewed the following position statements and made the following recommendations:

RETAIN
The CHSF voted to recommend the following position statements be retained as written as they remain relevant to current practice:

<u>Discriminatory Disability Insurance Coverage</u>

Will the Joint Reference Committee recommend that the Assembly vote to retain the position statement titled Discriminatory Disability Insurance Coverage? (p. 11, 22)

<u>Psychiatric Disability Evaluation by Psychiatrists</u>

Will the Joint Reference Committee recommend that the Assembly vote to retain the position statement titled Psychiatric Disability Evaluation by Psychiatrists? (p. 11, 23)

<u>Psychiatrists Practicing in Managed Care: Rights and Regulations</u>

Will the Joint Reference Committee recommend that the Assembly vote to retain the position statement titled Psychiatrists Practicing in Managed Care: Rights and Regulations? (p. 11, 24)

State Mental Health Services

Will the Joint Reference Committee recommend that the Assembly vote to retain the position statement titled State Mental Health Services? (p. 11, 25)

Universal Access

Will the Joint Reference Committee recommend that the Assembly vote to retain the position statement titled Universal Access? (p. 11, 26)

Institution for Mental Diseases
The CHSF recommends that the position statement on Federal Exemption from the IMD Exclusion be retained with one minor edit. The CHSF recommends adding the term Institution for Mental Diseases to the title of the paper. The title would read Federal Exemption from the Institution for Mental Diseases (IMD) Exclusion.

Will the Joint Reference Committee recommend that the Assembly vote to retain the position statement titled Federal Exemption from the IMD Exclusion and update the title to read as follows - Federal Exemption from the Institution for Mental Diseases (IMD) Exclusion? (pp. 11-12, 27)

REVISE
The CHSF voted to recommend the following revisions to position statements to ensure they are in line with current practice:

Employment Related Psychiatric Examinations
Members of the CHSF revised the position statement on Employment Related Psychiatric Examinations to include a statement on ensuring the patient has a clear understanding of the reason for the exam. The title was also revised to reflect the purpose of the statement which is to clarify the role of a psychiatrist in an employment related psychiatric exam.

Will the Joint Reference Committee recommend that the Assembly vote to approve the revised position statement on Employment Related Psychiatric Examinations and update the title to read as follows – Psychiatrists' Role in Employment Related Psychiatric Examinations? (p. 12, 28)

Patient Access to Treatments Prescribed by Their Physicians
Members of the CHSF revised the position statement to update the names of the currently recognized drug compendia. The remainder of the statement remains current.

Will the Joint Reference Committee recommend that the Assembly vote to approve the position statement on Patient Access to Treatments Prescribed by Their Physicians as revised? (p. 12, 29-30)

Medical Necessity Definition (Endorsed AMA Policy)
Members of the CHSF revised the position statement to reflect AMA policy as currently written.

Will the Joint Reference Committee recommend that the Assembly vote to approve the position statement on Medical Necessity Definition (Endorsed AMA Policy) as revised to reflect the current AMA policy? (p. 12, 31-32)

RETIRE
The CHSF voted to recommend the following position statements be retired:

Access to Comprehensive Psychiatric Assessment and Integrated Treatment
The CHSF recommends retiring this position statement as it is an earlier iteration of the 2009 position statement "Access to Comprehensive Psychiatric Assessment and Integrated Treatment".

Will the Joint Reference Committee recommend that the Assembly vote to retire the 2002 position statement titled Access to Comprehensive Psychiatric Assessment and Integrated Treatment? (p. 13, 33)

Psychotherapy and Managed Care
The CHSF recommends retiring this position statement. The key elements of this paper are captured in the position statement "Access to Comprehensive Psychiatric Assessment and Integrated Treatment".

Will the Joint Reference Committee recommend that the Assembly vote to retire the position statement titled Psychotherapy and Managed Care? (p. 13, 34)

Guidelines for Handling the Transfer of Provider Networks
The CHSF 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 "Access to Comprehensive Psychiatric Assessment and Integrated Treatment."

Will the Joint Reference Committee recommend that the Assembly vote to retire the position statement titled Guidelines for Handling the Transfer of Provider Networks? (p.13, 35)

Active Treatment
The CHSF recommends retiring this position. The points made in this position statement are covered in other, more current, statements.

Will the Joint Reference Committee recommend that the Assembly vote to retire the position statement titled Active Treatment? (p.13, 36)

Endorsement of Medical Professionalism in the New Millennium: A Physician Charter
The CHSF recommends retiring this position. 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.

Will the Joint Reference Committee recommend that the Assembly vote to retire the position statement titled Endorsement of Medical Professionalism in the New Millennium: A Physician Charter? (p.13, 37-38)

Desegregation of Hospitals for the Mentally Ill and Retarded
The CHSF 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.

Will the Joint Reference Committee recommend that the Assembly vote to retire the position statement titled Desegregation of Hospitals for the Mentally Ill and Retarded? (pp.14, 39)

REFER
The CHSF voted to recommend the following position statement be referred:

Bill of Rights: Principles for the Provision of Mental and Substance Abuse Treatment Services
The CHSF recommends referring this position statement 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.

Will the Joint Reference Committee refer the position statement titled Bill of Rights: Principles for the Provision of Mental and Substance Abuse Treatment Services to CAGR for review? (pp. 14, 40-41)

June JRC/July BOT Action Items: Review of the Recommendations from the APA BOT Workgroup on Health Reform and the Request from the APA BOT on the role of psychiatry in health reform: The following three motions came out of the CHSF discussion on health reform:

In reference to discussions about quality/performance measures:

1. The Council on Healthcare Systems and Financing recommends that the Council on Quality review the performance measures currently in place on integrated care to determine what measures are needed. This includes URAC measures and measures from other organizations that establish standards for care (i.e., NCQA, The Joint, NQF).

This motion was made by Joe Mawhinney, MD, and seconded by Lori Raney, MD. The motion passed.

Will the JRC refer the request from the CHSF to the Council on Quality Care to review the performance measures currently in place on integrated care to determine what measures are needed? (pp. 15-17)

Financial Implications: This would require some member and staff resources.

In reference to the discussion about the current state of evidence or lack of evidence for integrated care:

2. The Council on Healthcare Systems and Financing recommends that the Council on Research review the current health services literature on integrated care models, including physician-led and nonphysician-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.

This motion was made by Joe Mawhinney, MD, and seconded by Sue McLeer, MD. The motion passed.

Will the JRC refer the request from the CHSF to the Council on Research to review the current health services literature on integrated care models, including physician-led and nonphysician-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? (pp. 15-17)

Financial Implications: This would require member and staff resources to review, summarize and organize the literature.

In reference to the discussion of the role of psychiatrists:

3. The Council on Healthcare Systems and Financing requests that the Council on Psychosomatic Medicine work with the CHSF to identify the roles and responsibilities of psychiatrists across the spectrum of models and settings for medical care delivery.

This motion made be Sabina Lim, MD, and seconded by Sue McLeer, MD. The motion passed.

Will the JRC refer the request from the CHSF 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? (pp. 15-17)

Financial Implications: This would require member and staff resources. Communication could be done by conference call and email.

American Psychiatric Association
Council on Healthcare Systems & Financing
Harsh Trivedi, M.D., M.B.A., Chair
Hilton Crystal City (at Washington Reagan National Airport)
Yorktown, Lobby Level
Friday, September 12, 2014 10:00 AM – 4:30 PM
Saturday, September 13, 2014 9:00 AM – 12:00 NOON

Draft Minutes

Participants
Council Members: Harsh Trivedi, MD, MBA, Chair; Sabina Lim, MD; Susan McLeer, MD; Joseph Mawhinney, MD; Grant Mitchell, MD; Lori Rainey, MD; and Bruce Schwartz, MD; Eliot Sorel, MD

Consultants: Carol Alter, MD

Fellows: Debanjana Bhattacharya, MD; Jason Schweitzer, MD; Joseph Tasosa, MD; Uche Achebe, MD; Azeesat Babajide, MD; Jerome Taylor, MD; Arshya Vhabsadeh, MD

APA Leadership: Paul Summergrad, MD (President); Renee Binder, MD (President-Elect); Saul Levin, MD, MPA, APA CEO/Medical Director

APA Administration: Sam Muszynski, JD; Maureen Bailey; Samantha Hawkins; Ellen Jaffe; Karen Sanders; Melissa Staats; Caroline Williams; Becky Yowell; (OHSF); Kristin Kroeger (APA Chief Policy, Programs, Partnerships); Samantha Shugarman (QIPS); Eve Moscicki, PhD (Office of Research)

Guests: Gregory Dalack, MD (Council on Quality); Steve Daviss, MD; Alan Axelson, MD; Erik Vanderlip, MD; Michael Schoenbaum, PhD

Absent (Excused)**:** Mary Anne Badaracco, MD; Ole Thienaus, MD; Paul Wick, MD, Anand Pandya, MD

Absent (Unexcused): Barry Herman, MD

Friday, September 12, 2014

Welcome/Administrative Matters
Council chair, Harsh Trivedi, MD, called the meeting to order at 10:00 AM. Council on Healthcare Systems and Financing (CHSF) members and guests introduced themselves.

Dr. Trivedi reviewed the agenda. The minutes from the May 2014 meeting, which were approved on a prior conference call, were reaffirmed as written.

Invited Speakers
The CHSF invited a number of individuals to speak to the group.

Michael Schoenbaum, PhD, *Senior Advisor for Mental Health Services, Epidemiology, and Economics, Office of Science Policy, Planning and Communications National Institute of Mental Health*
Dr. Schoenbaum, a health services researcher and economist with expertise in the area of mental health, highlighted a key role for the APA in creating an environment that supports evidence-based collaborative care. He began his presentation with some background information: The majority of people with a clinical indication of depression are seen in primary care and receive no care. Of those who do get care, half of them receive subtherapeutic care. Collaborative Care has been shown to improve the care provided to those patients with mental illness who are seen in primary care settings. It may or may not result in cost savings, but the cost per unit of outcome is good.

Collaborative Care (i.e. IMPACT, DIAMOND) is a specific "model" of integrated care. It is the only model with an evidence base. There is no significant evidence that other forms of integrated care (i.e. co-location, the person-centered medical home, telehealth) are effective. Dr. Scheonbaum stressed that Collaborative Care is an organized delivery structure in which the individual components alone are not sufficient to achieve the outcomes evidenced by science (IMPACT and 40 additional randomized trials). The model is only effective when all of the components are done together. This includes diagnosis and outcomes tracking and a subsequent response—"stepped care". The two major components are case management and a consulting psychiatrist. Psychiatrists manage the care of the vast majority of patients, roughly 90%, collaboratively, working with the primary care physician and their clinical staff; only approximately 10% of patients are actually seen for a face-to-face visit by a psychiatrist. Reimbursement of the non-face- to-face work is a critical issue and one that must be addressed in order for this model to succeed.

Currently, there is some funding for services that can be done through an "a la carte" process. This includes using CPT codes that describe individual services (some of these codes not currently reimbursed. However, he suggests the best way to pay for Collaborative Care is on a case rate basis for the "bundle of services that comprise Collaborative Care". Both methods involve developing an inventory of the necessary elements/work. Accountability must also be a factor in reimbursement; payment made on the basis of maintaining the fidelity of the model. The DIAMOND model in Minnesota created a new procedure code and developed case rate which was paid to those providers who stuck to the model.

Schoenbaum stressed that the "better mousetrap" has been built (i.e. IMPACT/DIAMOND model) but there has been minimal uptake. He projects that 3,733 psychiatrists would be needed to roll out Collaborative Care nationwide.. He went on to suggest that psychiatrists should be overall leaders of the programs/models l. Psychiatry should "sit on the top". He concluded that the APA should promote Collaborative Care as the "real thing"—the only evidence-based model – and should be very vocal about the science and the role psychiatry plays. He believes strongly there is a "collective responsibility to make this happen".

Gregory Dalack, MD, Chair of APA Registries Workgroup
Dr. Dalack summarized the charge of the Registries Workgroup, which is to develop a written report with recommendations as to the nature of registry activities that should be supported by

the APA. The workgroup's members are psychiatrists with experience in developing registries and/or developing electronic information systems. Lori Raney, MD; Joseph Parks, MD; and Jurgen Unutzer, MD, MA, MPH are members of the workgroup along with others. Dr. Dalack noted that the discussions to date have been focused on the breadth of data to consider, the question of whether or not the registry should be seen as a revenue stream for the APA, and the problem of addressing the needs of members with wide ranging practices. Any registry will require the inputting of data and the need to facilitate adoption to the greatest extent possible to ensure robust data collection. The initial focus has been on the development of a depression registry. It was mentioned that NYC has a registry for first-break psychosis, which in parts aids in identifying patients who may need care management services. The workgroup is looking at existing registries in the mental health arena as well as those developed by other medical specialty societies. The group will be submitting its report at the March BOT meeting.

Saul Levin, MD, MPA, APA CEO and Medical Director
Dr. Levin thanked the Council for its important work on behalf of APA members and their patients. He noted that current advocacy efforts include lobbying Congress to expand eligibility for the Medicaid bump (in place as part of the ACA) to include psychiatry along with other primary care physicians. There is current legislation on the Hill to expand that group to include psychiatrists, neurologists, and OBGYNs. In addition the legislation seeks to extend the bump beyond December 2014 when it is set to end. APA is also advocating for evidence-based collaborative care, including mechanisms to pay for time spent by psychiatrists in a collaborative role. Dr. Levin noted that payment is one reason psychiatrists have opted out of treating patients in Medicare and Medicaid.

Paul Summergrad, MD, APA President
Dr. Summergrad dropped in to say hello to CHSF members and let them know that he considers the work they do to be "very essential." He thanked them for their ongoing efforts.

Joseph Parks, MD, Missouri State Medicaid Director
Dr. Parks began by recounting his recent experience at a national meeting of state Medicaid Directors. A poll of the group prior to the start of the meeting revealed that 2/3 of those present said they were most interested in discussing behavioral health issues. It is Dr. Parks view that managed care plans seem to be talking about integrating medical and behavioral health most on an administrative management level rather than through payment incentives.

Dr. Parks went on to say that payers are looking for more and more opportunity to provide integrated services. Everyone agrees that access is a problem; there are concerns about the workforce. Dr. Parks thinks the only way to address this is to change the delivery model, increasing outpatient consultation liaison activities. Offering higher pay doesn't mean there are enough bodies to fill the available openings.

Missouri is looking at a number of ways for psychiatrists to work collaboratively with others (i.e., nurses, PAs). This includes offering a rate bump for practices that are co-located or doing collaborative care, or paying for an outpatient consultative non-face- to- face service. In terms of the non-face-to-face work, Missouri is considering offering the same base rate for the equivalent amount for what would have been spent in a face-to-face visit.

Dr. Parks noted the value of creating educational materials (including teaching videos) to promote the adoption of evidence-based care. He also suggested that it would be valuable to have some sort of certification to show a group has met certain standards. He is currently

working to identify internal state programs so they can come up with and maintain a list of certified providers. If APA has standards they would be helpful in identifying those groups that have met recognized standards. Quality measures are also important. From his vantage point Dr. Parks says he would look for two or three utilization and cost measures (i.e., ER utilization, hospital utilization). He concluded by welcoming continued collaboration with the CHSF.

Renee Binder, MD, APA President-Elect

Dr. Renee Bender, APA president-elect, stopped by to speak with the Council on Saturday morning about ideas she has about what she'd like to do as president when her term begins in 2015. She noted that at this point her ideas are just that, ideas. She expressed her desire to increase the diversity in the APA to reflect who psychiatrists and their patients are in the 21st century. She is concerned that psychiatric work be appropriately defined and effectively publicized. She said she plans to emphasize the training of future psychiatrists and to raise the issue of stigma as it attaches to both psychiatrists and their patients. She pointed out the changes in attitudes toward cancer and HIV/AIDS that have been achieved through effective communications and marketing campaigns.

Dr. Binder reported that the theme of the 2016 APA Annual Meeting, which will coincide with her presidency, will be "Identities and Roles of Psychiatry in the 21st Century," and announced that Steve Koh, MD will be the program chair for the meeting.

Old Business/Reports

NPRM on the 2015 Medicare Physician Fee Schedule – APA Comments

Mr. Muszynski, Ms. Yowell, and Ms. Staats summarized the recent comments from the APA on the CMS proposed rule on the 2015 Medicare Fee Schedule. They briefly summarized the CMS activity around payment for non face-to-face services. CMS continues to emphasize primary care management services by beginning to make separate payment for chronic care management (CCM) services beginning in 2015. Eligible patients are those with two or more chronic conditions. Chronic care management services include regular development and revision of a plan of care, communication with other treating health professionals, and medication management. There is also a proposal to require practices meet certain standards for electronic health/medical records to be eligible to bill for this service. The proposed payment rate for these services is $41.92. This code as currently described can be billed only once (one time by one physician) per 30 days once the time spent on care management activities (as defined by CMS) has exceeded 20 minutes of staff or professional time. Rather than adopt the existing CPT code that describes care management activities, CMS has proposed a G code. APA has been working collaboratively with a group of primary care and specialty organizations to encourage CMS to either adopt a higher value (i.e. the RUC recommended value) for this work or develop a code that can be used to distinguish care coordination for the more complex patient. CMS will finalize their proposal in their Final Rule in November.

Mr. Muszynski and Ms. Staats emphasized that there were a number of CMS initiatives that will negatively impact physicians—including psychiatry. For example, CMS proposes to eliminate the incentive and increase the penalty for insufficient participation in Physician Quality Reporting System (PQRS). CMS also proposes to implement the Value-Based Modifier for all group and solo practitioners by 2017 (the Value Based Modifier will be phased in—groups of 100 or more; 2015 and 25 – 99; 2016). Initially, the maximum penalty for the Value Based Modifier was -2%. That has been increased to -4%. There is an incentive component as well (maximum +4%--highest quality/lowest cost). Attribution is a critical factor in the development of the cost and

quality scores that are used to determine the Value-Based Modifier. Utilization of a certified electronic health record (EHR) is another area for which CMS will impose penalties beginning in 2015. In total, the CMS proposals could amount to a -11% decrease in Medicare reimbursement. In its comments to CMS, APA opposed the removal of the PQRS claims based reporting option—given its high utilization of physicians. The APA also opposed the implementation time line of the value-based modifier because CMS has not adequately tested the data that will be used to establish the associated quality and cost measures (Quality and Resource Use Report—QRUR).

Role of Psychiatrists in Reducing Physical Health Disparities in Patients with Mental Illness
Dr. Raney reported that the APA Councils on Psychosomatic Medicine, Geriatric Psychiatry, and Medical Education and Life Long Learning reviewed and approved the **JOINT position statement** titled *Role of Psychiatrist in Reducing Physical Health Disparities in Patients with Mental Illness*. Members of the Council had approved the statement at a previous meeting. Members voted to re-affirm their support. This document will be forwarded to the JRC for review with a request to recommend the Assembly vote to approve it (as written).

The primary authors of the position statement are: Lori Raney, MD, Erik Vanderlip, MD, Jeffrey Rado, MD, Robert McCarron, MD, the APA Workgroup on Integrated Care, the APA Council on Healthcare Systems and Financing, Association of Medicine and Psychiatry (AMP).

The following organizations have approved this statement as submitted: Association of Medicine and Psychiatry (AMP), American Academy of Community Psychiatry (AACP), and the Academy of Psychosomatic Medicine (APM).

The following APA councils (in addition to the CHSF) reviewed and approved the statement as submitted: Councils on Psychosomatic Medicine, Geriatric Psychiatry, and Medical Education and Life Long Learning.

Will the Joint Reference Committee recommend that the Assembly vote (in an up or down vote) to approve the Joint Position Statement titled *Role of Psychiatrists in Reducing Physical Health Disparities in Patients with Mental Illness*? (pp. 42-43)

Joint Statement on Medicaid Reform Principles
Ms. Sanders reviewed the Joint Statement on Medicaid Reform Principles document and processes. She explained that a coalition of mental health organizations (NAMI, National Council, MHA) is revising a document originally created in 2008. The purpose of the document is to provide the involved organizations with an opportunity for policy discussion at the state level.

Members of the Council reviewed the document and proposed edits from APA administration. The first edit is related to the “Enrollment in appropriate level of coverage” bullet. The suggestion was made that the document be precise in identifying which individuals are exempt. The language from the ACA was included. The second edit/comment is related to the “Quality assurance” bullet. A suggestion was made that the patient advocacy organizations consider emphasizing and separating “evidence based” from “emerging best practices”. This suggestion has created some discussion among the other organizations; some felt that the separation would stifle emerging best practices if funding is based solely on evidence (randomized trials).

Members of the CHSF discussed the wording of the principle statement "…ensure that public or private insurance coverage, including Medicaid managed care and expansion plans must provide "adequate coverage for mental health and addiction treatment". Members found the word *adequate* insufficient. Suggested alternatives included "comprehensive spectrum of services" and the inclusion of language around the essential health benefits.

The Council approved the document with changes as identified above. Ms. Sanders will continue to inform the Council as the process continues.

Position Statement Review (chart pp. 18-21)
Members of the CHSF broke into small groups to review the over 30 position statements that had last been reviewed five or more years ago. Recommendations as to whether the position should be retained, revised or retired were put forward to the full Council for a vote. The following actions represent our work to date. The CHSF has begun to revise specific position statements and will continue the process until all are complete.

RETAIN
The CHSF voted to recommend the following position statements be retained as written as they remain relevant to current practice:

Discriminatory Disability Insurance Coverage

Will the Joint Reference Committee recommend that the Assembly vote to retain the position statement titled Discriminatory Disability Insurance Coverage? (p. 22)

Psychiatric Disability Evaluation by Psychiatrists

Will the Joint Reference Committee recommend that the Assembly vote to retain the position statement titled Psychiatric Disability Evaluation by Psychiatrists? (p. 23)

Psychiatrists Practicing in Managed Care: Rights and Regulations

Will the Joint Reference Committee recommend that the Assembly vote to retain the position statement titled Psychiatrists Practicing in Managed Care: Rights and Regulations? (p. 24)

State Mental Health Services

Will the Joint Reference Committee recommend that the Assembly vote to retain the position statement titled State Mental Health Services? (p. 25)

Universal Access

Will the Joint Reference Committee recommend that the Assembly vote to retain the position statement titled Universal Access? (p. 26)

Institution for Mental Diseases
The CHSF recommends that the position statement on Federal Exemption from the IMD Exclusion be retained with one minor edit. The CHSF recommends adding the term Institution

for Mental Diseases to the title of the paper. The title would read Federal Exemption from the Institution for Mental Diseases (IMD) Exclusion.

Will the Joint Reference Committee recommend that the Assembly vote to retain the position statement titled Federal Exemption from the IMD Exclusion and update the title to read as follows - Federal Exemption from the Institution for Mental Diseases (IMD) Exclusion? (p. 27)

REVISE
The CHSF voted to recommend the following position statements be revised to ensure they are in line with current practice: Access to Comprehensive Psychiatric Assessment and Integrated Treatment (2009), Codification of Medical Evaluation and Management Services in Psychotherapy, Medical Psychotherapy, *Employment Related Psychiatric Examinations*, The Need to Maintain Long-Term Mental Hospital Facilities, *Patient Access to Treatments Prescribed by Their Physicians*, Pharmacy Benefit Management, Pharmacy Benefit Management/Pharmacy Benefit Managers (PBM), *Medical Necessity Definition (Endorsed AMA Policy)*, Call to Action for the Chronic Mental Patient, Carve-Outs and Discrimination. (Those in italics have been revised and revisions submitted in this report.)

This JRC report includes proposed revisions to the following position statements:

Employment Related Psychiatric Examinations
Members of the CHSF revised the position statement on Employment Related Psychiatric Examinations to include a statement on ensuring the patient has a clear understanding of the reason for the exam. The title was also revised to reflect the purpose of the statement which is to clarify the role of a psychiatrist in an employment related psychiatric exam.

Will the Joint Reference Committee recommend that the Assembly vote to approve the revised position statement on Employment Related Psychiatric Examinations and update the title to read as follows – Psychiatrists' Role in Employment Related Psychiatric Examinations? (p. 28)

Patient Access to Treatments Prescribed by Their Physicians
Members of the CHSF revised the position statement to update the names of the currently recognized drug compendia. The remainder of the statement remains current.

Will the Joint Reference Committee recommend that the Assembly vote to approve the position statement on Patient Access to Treatments Prescribed by Their Physicians as revised? (p. 29-30)

Medical Necessity Definition (Endorsed AMA Policy)
Members of the CHSF revised the position statement to reflect AMA policy as currently written.

Will the Joint Reference Committee recommend that the Assembly vote to approve the position statement on Medical Necessity Definition (Endorsed AMA Policy) as revised to reflect the current AMA policy? (p. 31-32)

RETIRE
The CHSF voted to recommend the following position statements be retired:

Access to Comprehensive Psychiatric Assessment and Integrated Treatment
The CHSF recommends retiring this position statement as it is an earlier iteration of the 2009 position statement "Access to Comprehensive Psychiatric Assessment and Integrated Treatment".

Will the Joint Reference Committee recommend that the Assembly vote to retire the 2002 position statement titled Access to Comprehensive Psychiatric Assessment and Integrated Treatment? (p. 33)

Psychotherapy and Managed Care
The CHSF recommends retiring this position statement. The key elements of this paper are captured in the position statement "Access to Comprehensive Psychiatric Assessment and Integrated Treatment".

Will the Joint Reference Committee recommend that the Assembly vote to retire the position statement titled Psychotherapy and Managed Care? (p. 34)

Guidelines for Handling the Transfer of Provider Networks
The CHSF 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 "Access to Comprehensive Psychiatric Assessment and Integrated Treatment."

Will the Joint Reference Committee recommend that the Assembly vote to retire the position statement titled Guidelines for Handling the Transfer of Provider Networks? (p. 35)

Active Treatment
The CHSF recommends retiring this position. The points made in this position statement are covered in other, more current, statements.

Will the Joint Reference Committee recommend that the Assembly vote to retire the position statement titled Active Treatment? (p. 36)

Endorsement of Medical Professionalism in the New Millennium: A Physician Charter
The CHSF recommends retiring this position. 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.

Will the Joint Reference Committee recommend that the Assembly vote to retire the position statement titled Endorsement of Medical Professionalism in the New Millennium: A Physician Charter? (p. 37-38)

Desegregation of Hospitals for the Mentally Ill and Retarded
The CHSF 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.

Will the Joint Reference Committee recommend that the Assembly vote to retire the position statement titled Desegregation of Hospitals for the Mentally Ill and Retarded? (p. 39)

REFER
The CHSF voted to recommend the following position statement be referred:

Bill of Rights: Principles for the Provision of Mental and Substance Abuse Treatment Services
The CHSF recommends referring this position statement 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.

Will the Joint Reference Committee refer the position statement titled Bill of Rights: Principles for the Provision of Mental and Substance Abuse Treatment Services to CAGR for review? (pp. 40-41)

TO BE REVIEWED
The CHSF will review the following position statements on a future conference call:
Minimum Necessary Guidelines for Third-Party Payers for Psychiatric Treatment, Any Willing Physician statement.

Outstanding Assembly/JRC Action Items (IV.D)
6.1 Adequacy of Health Insurance Provider Networks (ASMNOV1212.A)
The APA AMA Delegation put forward a resolution asking the AMA to study the issue of network adequacy including tiered and narrow networks and report back with recommendations. A report is anticipated for the November 2014 AMA Interim Meeting. This, along with any substantive information from the PRN data will be shared with members of the CHSF. There was also a discussion regarding obtaining specific examples of violations and that perhaps APA should focus activities on a state by state basis with Attorneys General.

6.21 Proposed Position Statement on Improving Patient Access to Psychiatric Services through MCO Provider Panels (JRCJUNE128.F.2; ASMNOV124.B.5)
The CHSF will review this item in conjunction with the AMA report and PRN data noted above.

6.3 Mental Health Parity Act Compliance & Insurance Accreditation Organizations (ASMNOV1212.C)
OHSF continues to monitor and respond to parity compliance issues. In the discussion of this issue members raised concerns about the lack of any incentive for standards /accreditation bodies (NCQA, URAC) to do anything. Parity regulations do not deem entities in compliance with the law because they are accredited. A suggestion was made that legislation may be required. Data collection needs to continue to fully understand the scope of the issues.

Questions were raised as to whether the Council on Quality could play a role in working with certifying organizations.

6.4 Update on 2002 Position Statement on Carve- Outs & Discrimination (ASMNOV1212.D)
The current APA position statement will be revised to reflect changes as a result of Mental Health Parity and Addiction Equity Act (MHPAEA). A review of the existing evidence will be undertaken as well. Consideration as to what the necessary clinical, fiscal and administrative benchmarks are needed in either a carve-out or carve-in will be included as part of the process. This will be updated as part of the position statement review process.

6.19 Managed Care Misuse of FDA Labeling (ASMNOV1212.EE)
Discussion by the CHSF confirmed there is a need to document the problem. Is this a misinterpretation of the guidelines? Will consider this matter as the position statements on pharmacy issues are reviewed. Will outreach to pharmacy benefit managers as well.

6.17 Use of New CPT Codes in Health Insurance Exchanges (ASM Item # 2013A1 12.S)
We will be monitoring what is happening in the exchange plans; all laws which address these issues have been compiled and based on a review of those laws, exchange plans have no special status. HIPAA already requires the use of CPT codes. APA regularly advocates access to all CPT codes using CPT coding conventions. To date any compliance issues with the new CPT coding conventions has been handled on a case by case basis. OHSF will continue to do outreach to the major payers. We will continue to monitor what is happening in the exchange plans through the APA Practice Management line. This will take some time to get a clear picture of how the exchange plans will operate as detailed information as of yet has been unobtainable. A follow-up study to the National Study of Psychiatric Practice Under Health Care Reform would be helpful in terms of gauging the impact of reform. The issue of payment equity based on RVUs is not possible to analyze at present.

NEW BUSINESS

Video from the National Council for Behavioral Health
Dr. Raney shared a recent video from the National Council for Behavioral Health titled “What is Integrated Care”. Members expressed concerns about the promotion of a simplistic view of integrated care and a model (co-location) for which there is insufficient evidence. The video also appears to ignores/minimize the psychiatric complexities (bipolar disorder and SUD) of the patient which seem to go untreated/undertreated.

June JRC/July BOT Action Items: Review of the Recommendations from the APA BOT Workgroup on Health Reform and the Request from the APA BOT on the role of psychiatry in health reform
Members of the CHSF reviewed the charge and membership of the latest workgroup focused on health reform. There was a discussion of the relevant sections of the excel spreadsheet containing the recommendations from the first APA BOT Workgroup. Members also had a general discussion as to how to move the work relating to health reform forward. Individuals noted that they had some ideas as to how the recommendations could be reorganized.

A suggestion was made to start with the development of a white paper on financing. Issues of terminology and definitions were raised as well. There was a brief discussion of the challenges of training/educating members on a topic that is complex with many local variations and

implications. Suggestions of breaking down the materials developed for the train the trainer program in June into discreet segments (including examples of existing payment models) for online webinars was made in lieu of face-to-face trainings. The supporting materials from the June event will be circulated to the CHSF members for review.

There was acknowledgement of how important quality/performance measures were, both in terms of general payment reform, and more specifically in terms of encouraging the practice of evidence- based medicine.

There was also a discussion about the need to better define the role of psychiatry. Dr. Vanderlip noted the 2010 white paper from the American College of Physicians on the Medical Neighborhood. He suggested collaborating with the Council on Psychosomatic Medicine on the development of a similar document that would speak to the role of psychiatry within all settings of medical care. The question of identifying barriers for psychiatrists was raised. One potential barrier relates to liability concerns. A suggestion was made to promote/widely distribute the recently approved resource document on *Risk Management and Liability Issues in Integrated Care Models.*

The following three motions came out of the discussion:

In reference to discussions about quality/performance measures:

1. The Council on Healthcare Systems and Financing recommends that the Council on Quality review the performance measures currently in place on integrated care to determine what measures are needed. This includes URAC measures and measures from other organizations that establish standards for care (i.e., NCQA, The Joint, NQF).

This motion was made by Joe Mawhinney, MD, and seconded by Lori Raney, MD. The motion passed.

Will the JRC refer the request from the CHSF to the Council on Quality Care to review the performance measures currently in place on integrated care to determine what measures are needed?

In reference to the discussion about the current state of evidence or lack of evidence for integrated care:

2. The Council on Healthcare Systems and Financing recommends that the Council on Research review the current health services literature on integrated care models, including physician-led and nonphysician-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.

This motion was made by Joe Mawhinney, MD, and seconded by Sue McLeer, MD. The motion passed.

Will the JRC refer the request from the CHSF to the Council on Research to review the current health services literature on integrated care models, including physician-led and

nonphysician-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?

In reference to the discussion of the role of psychiatrists:

3. The Council on Healthcare Systems and Financing requests that the Council on Psychosomatic Medicine work with the CHSF to identify the roles and responsibilities of psychiatrists across the spectrum of models and settings for medical care delivery.

This motion made be Sabina Lim, MD, and seconded by Sue McLeer, MD. The motion passed.

Will the JRC refer the request from the CHSF 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?

Proposed Position Statement on Confidentiality of Electronic Health Information
Members of the CHSF approved the position statement on Confidentiality of Electronic Health Information as written.

Update from the Dept of Government Relations - Jeffrey Regan, Deputy Director, Senate Affairs
Mr. Regan summarized APA's current advocacy agenda:

Medicaid bump for primary care: Legislation, as part of the ACA, was put in place to pay primary care physicians at the Medicare level for treating Medicaid patients. The bump in payment, which ends at the end of 2014, will cost about 11 billion dollars. The President has included this item in his budget for the next two years. There is support from the family and internal medicine physicians to continue the bump. However, those groups do not support legislation put forward by the APA, American Academy of Neurology, and the American College of Obstetricians and Gynecologists that expands eligible physicians to include psychiatrists, neurologists, and OBGYNs.

Excellence in Mental Health Act: The APA sent a letter to HHS Secretary Sylvia Burwell identifying five key recommendations on how psychiatry best fits in the community behavioral health setting. The letter stressed the need for strong evidence-based quality metrics, psychiatrist leadership, and the need for the clarification of terms. It is important to note that SAMSHA is tasked with overseeing the implementation of this Act. APA will continue to work with the APA ad-hoc work group established to monitor and review activities related to this legislation going forward to offer more input.

SGR repeal: The AMA is going to make SGR repeal a top priority. The current patch to the physician fee schedule expires next March (2015). It is unlikely Congress will address this issue until then given it is an election year. It is likely that nothing is going to happen until some budget agreement between the President and Congress is reached – the current cost of repeal is $130 billion. It will likely be with us for some time and will likely usher in a new wave of payment reforms.

Wrap Up/Future Planning/Adjournment
Dr. Trivedi challenged the group to think about useful products the Council could produce. He encouraged the Fellows to become involved in meaningful ways. The CHSF will meet next via conference call on October 21 at 3:00 PM Eastern.

Position Statement Summary Document

YEAR APPROVED	YEAR TO BE REVIEWED	POSITION STATEMENT Policy Statement	CURRENT STATUS	ADDT'L INFO	APPROVALS	RECOMMENDATION RETAIN	REVISE	RETIRE	RATIONALE
2009	2014	Discriminatory Disability Insurance Coverage	ACTIVE	Revised 1999 Discriminatory Employer-Sponsored Disability Insurance	BOT APPROVED Sept 2009; ASM Approved May 2009	X			The CHSF recommends RETAINING this position statement as written as it remains relevant to current practice.
2007	2012	Psychiatric Disability Evaluation by Psychiatrists	ACTIVE		BOT APPROVED - July 2007 ASSEMBLY APPROVED - November 2007	X			The CHSF recommends RETAINING this position statement as written as it remains relevant to current practice.
2009	2014	Psychiatrists Practicing in Managed Care: Rights and Regulations	ACTIVE	Revised 1995 PS: Preferred-Provider Panel Physicians Bill of Rights	BOT APPROVED Sept 2009; ASM Approved May 2009	X			The CHSF recommends RETAINING this position statement as written as it remains relevant to current practice.
2007	2012	Federal Exemption from the IMD Exclusion	ACTIVE		BOT APPROVED - July 2007 ASSEMBLY APPROVED - Nov 2005	X			The CHSF recommends RETAINING this position statement as written as it remains relevant to current practice. The CHSF made one minor edit, spelling out the first instance of IMD.
2008 (Revision of the Orignal 1970 PS)	2013	State mental health services	ACTIVE	Revision of the 1970 Position Statement	BOT Approved December 2008; ASM Approved November 2008	X			The CHSF recommends RETAINING this position statement as written as it remains relevant to current practice.
2004		Universal Access to Health Care	ACTIVE		BOT APPROVED - 2004	X			This remains relevant to current practice.
2009	2014	Access to Comprehensive Psychiatric Assessment and Integrated Treatment	ACTIVE	BOT APPROVED Sept 2009; ASM Approved May 2009	BOT APPROVED Sept 2009; ASM Approved May 2009		X		The CHSF recommends REVISING this position statement to account for those instances where non-physician mental health care providers are doing the initial evaluation – important for the patient's medical needs to be assessed. Discussion of adding language to require evaluation by a physician/psychiatrist to evaluate the patient's medical needs.
1997		Codification of medical evaluation and management	ACTIVE	REVISE Position Statement	Revision to JRC June 2008		X		The CHSF recommends the Comm on RBRVS will review and revise if

Position Statement Summary Document						RECOMMENDATION			
YEAR APPROVED	**YEAR TO BE REVIEWED**	**POSITION STATEMENT Policy Statement**	**CURRENT STATUS**	**ADDT'L INFO**	**APPROVALS**	**RETAIN**	**REVISE**	**RETIRE**	**RATIONALE**
		services in psychotherapy		1/2008 (HCSF report)					necessary.
1995		Medical psychotherapy	ACTIVE		BOT Retained July 2013; ASM Retained May 2013		X		The CHSF recommends the Comm on RBRVS will review and revise if necessary. Discussion of the term "integrated"; may need to come up with a different term.
2009 (Revision of the 1984 Original PS)	2014	Employment Related Psychiatric Examinations	ACTIVE		BOT APPROVED Sept 2009; ASM Approved May 2009		X		The CHSF recommends REVISING this position statement to add an additional statement on the need to be certain the patient clearly understands the purpose of the examination.
1974		Long-term mental hospital facilities , the need to maintain	Active	REVISE Position Statement 1/2008 (report)	Revision to JRC June 2008		X		The CHSF recommends REVISING this position statement.
2007	2012	Patient Access to Treatments Prescribed by Their Physicians	ACTIVE		BOT APPROVED - July 2007 ASSEMBLY APPROVED - May 2007		X		The CHSF recommends REVISING this position statement to update the terminology on the compendias. The key points are still relevant to current practice.
2007	2012	Pharmacy Benefit Management	ACTIVE		BOT APPROVED - July 2007 ASSEMBLY APPROVED - May 2007		X		The CHSF recommends reviewing, and REVISING (to consolidate) this position statement and the position statement titled Pharmacy Benefit Management/Pharmacy Benefit Managers (PBM)
2002		Pharmacy Benefit Management/Pharmacy Benefit Managers (PBM)	Active - in Revision	REVISE Position Statement 12/1/2007 (report) Oct 2008 - HCSF revising			X		The CHSF recommends reviewing, and REVISING (to consolidate) this position statement and the position statement titled Pharmacy Benefit Management
2008 (Retained Original 2000 PS)	2013	Medical Necessity Definition (Endorsed AMA Policy)	ACTIVE		NONE - PS RETAINED 2008		X		The CHSF recommends REVISING this position statement to reflect the current AMA definition of "medical necessity." This remains relevant to current practice.

Position Statement Summary Document						RECOMMENDATION			
YEAR APPROVED	**YEAR TO BE REVIEWED**	**POSITION STATEMENT Policy Statement**	**CURRENT STATUS**	**ADDT'L INFO**	**APPROVALS**	**RETAIN**	**REVISE**	**RETIRE**	**RATIONALE**
1978		Chronic mental patient, call to action for the	ACTIVE	REVISE Position StatementJRC January 2008 (HCSF report)via BOT Work Group	Social Issues (revision to JRC January 08)		X		The CHSF recommends REVISING this position statement. The CHSF will establish a workgroup with expertise in treating the SMI population to review and revise.
2009 (Retained Original 2002 PS)	2014	Carve-Outs and Discrimination	ACTIVE	After review/revision by HCSF; ASM preferred original 2002 PS retain original PS	NONE - PS RETAINED 2009		X		The CHSF recommends REVISING this position statement to reflect the changes due to parity legislation; including adding a section on the accountability points; if there is collaborative care going forward we don't want there to be structural barriers; look at URAC clinical integration standards - would provide info and language etc.
2002		Access to Comprehensive Psychiatric Assessment and Integrated Treatment	NEEDS TO BE RETIRED?	-	NEEDS TO BE RETIRED			X	The CHSF recommends RETIRING this position statement. This is an earlier iteration of the 2009 position statement "Access to Comprehensive Psychiatric Assessment and Integrated Treatment"
1999		Psychotherapy and managed care	ACTIVE	REVISE Position Statement Oct 2008 - HCSF needs more revision 12/1/2007 (report);	Revision to JRC June 2008; Assembly failed to pass revision			X	The CHSF recommends RETIRING this position statement. We believe the key elements of this paper are captured in the Position Statement "Access to Comprehensive Psychiatric Assessment and Integrated Treatment"
1995		Guidelines for handling the transfer of provider networks	ACTIVE	REVISE Position Statement 1/2008 (HCSF report) 6/2008	Revision to JRC June 2008; Assembly failed to pass revision			X	The CHSF recommends RETIRING this position statement. We believe there have been changes in healthcare delivery methods or in the healthcare system which make the subject and current position no longer relevant. Elements of this are covered in the 2009 "Access to Comprehensive Psychiatric Assessment and

Position Statement Summary Document						RECOMMENDATION			
YEAR APPROVED	**YEAR TO BE REVIEWED**	**POSITION STATEMENT Policy Statement**	**CURRENT STATUS**	**ADDT'L INFO**	**APPROVALS**	**RETAIN**	**REVISE**	**RETIRE**	**RATIONALE**
									Integrated Treatment."
1978		Active treatment	Active	Retire Position Statement (Quality Care) JRC November 2007 CHCSF - recommends REVISE Position Statement JRC January 2008	The Joint Reference Committee referred this position statement to the Council on Healthcare Systems and Financing for review to look at billing and finance considerations of the position statement and for a recommendation about its currency and relevancy. Report to JRC January 2008			X	The CHSF recommends RETIRING this position. Members believe the points made in this position statement are covered in other, more current, statements.
2002		Charter on Medical Professionalism	ACTIVE					X	The CHSF recommends RETIRING this position. Members believe the key points made in this position statement are covered in other, more current, statements.
1975		Desegregation of Hospitals for the Mentally Ill and Retarded	Active					X	The CHSF 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
2007 (Retained Original 1997 PS)	2012	Bill of rights: principles for the provision of mental and substance abuse treatment services	ACTIVE	RETAIN Position Statement 12/1/2007 (report)	NONE - PS RETAINED 2007		X	X	The CHSF recommends **REFERRING this position statement to the Council on Advocacy and Government Relations** for review. The CHSF recommends RETIRING this statement unless CAGR thinks it necessary for the APA to have a position on this issue. If so, CAGR should revise this statement.
2007 (Retained Original 2002 PS)	2012	Minimum Necessary Guidelines for Third-Party Payers for Psychiatric Treatment	ACTIVE	RETAIN Position Statement 12/1/2007 (report)	NONE - PS RETAINED 2007				The CHSF will review this on a future conference call.
2007 (Retained Original 1995 PS)	2012	Any willing physician statement	ACTIVE	RETAIN Position Statement12/1/2007 (report)	NONE - PS RETAINED 2007				The CHSF will review this on a future conference call.

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 Psychiatric Disability Evaluations by Psychiatrists

Approved by the Board of Trustees, July 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*.

Psychiatric disorders impair social and occupational functioning. Attention to disabilities must be included in a comprehensive plan of psychiatric care for adults, children and adolescents. When a disability application is completed as part of a disability adjudication process, this is often most effectively and efficiently done by a psychiatric physician. Disability evaluations by psychiatrists must be reimbursed at appropriate rates so as not to discriminate or discourage them.

APA Official Actions

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

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

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

Contract Issues

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

Psychiatrist-Patient Relationships

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

Relationship with managed care organizations

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

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

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

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

APA Official Actions

Position Statement on State Mental Health Services

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

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

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

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

APA Official Actions

Position Statement on Universal Access to Health Care

Approved by the Board of Trustees, March 2004

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

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

APA Official Actions

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 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 (excludeing medication costs) from all sources, e.g., state's DMH, DPH, DMA, DMR, DOC, DSS, DYS, other) at a level no less than the state's average expenditure over the preceding five years.

APA Official Actions

Position Statement on the Psychiatrists' Role in Employment-Related Psychiatric Examinations

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*.

1. Prior to beginning an employment-related psychiatric evaluation the psychiatrist should obtain informed consent from the individual being examined. The patient being examined should have a rational and factual understanding of the purpose of the examination. Such informed consent includes the following:
   a. The purpose of the required examination, the referral source, and the reason for the referral.
   b. The nature of the report to be prepared and limitations of confidentiality.
   c. The party, or parties, to whom the report will be provided and the nature of the evaluee's access to the report in accordance with applicable state and federal law.
2. If, in the judgment of the examining psychiatrist, the individual referred for an employment-related examination is in need of treatment, when possible, the individual should be referred to another psychiatrist for such treatment.

This is a revision of the 1984 position statement.

Developed by the Corresponding Committee on Psychiatry in the Workplace (Andrea G. Stolar, M.D., Chair, Marilyn Price, M.D., CM, Marie Claude Rigaud, M.D., Marcia Scott, M.D., Jeffrey P. Kahn, M.D., and Aron S. Wolf, M.D., members).

APA Official Actions

Position Statement on Patient Access to Treatments Prescribed by Their Physicians

Approved by the Board of Trustees, July 2007
Approved by the Assembly, May 2007

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

The APA affirms strong support for the autonomous clinical decision-making authority of a physician and for a physician's lawful use of an FDA-approved drug product or medical device for an unlabeled indication when such use is based upon sound scientific evidence in conjunction with sound medical judgment; APA further affirms that when the prescription of a drug or use of a device repre- sents safe and effective therapy, third party payers, including Medicare, should consider the intervention as reasonable and necessary medical care, should fulfill their obligation to their beneficiaries by covering such therapy, and should be required to cover appropriate "off-label" uses of drugs on their formularies. The APA recommends the following:

Prescribing and Reimbursement for FDA-Approved Drugs and Devices for Unlabeled Uses

1. APA reaffirms the following policies:

a. A physician may lawfully use an FDA-approved drug product or medical device for an unlabeled indication when such use is based upon sound scientific evidence and sound medical opinion;

b. When the prescription of a drug or use of a device represents safe and effective therapy, third party payers, including Medicare, should consider the intervention as reasonable and necessary medical care, irrespective of labeling, and should fulfill their obligation to their beneficiaries by covering such therapy; and

c. APA encourages the use of th~~ree~~ current drug compendia recognized by the Centers for Medicare and Medicaid Services (American Hospital Formulary Service Drug Information, Gold Standard Inc. Clinical Pharmacology Compendium, NCCN Drugs and Biologics Compendium, Thomson Micromedex DrugDex® Compendium, Thomson Healthcare DrugPoints® Compendium) ~~AMA's *Drug Evaluations**; *United States Pharmacopeia Drug Information*, Volume I*; and *American Hospital Formulary Service Drug Information*)~~ in conjunction with the peer-reviewed literature for determining the medical acceptability of unlabeled uses. ~~(*These two compendia currently are being merged as the result of an alliance between the American Medical Association and the United States Pharmacopeia.)~~

i. **Dissemination of Information about Unlabeled Uses of Drugs and Devices by Manufacturers**

2. APA strongly supports the need for physicians to have access to accurate and unbiased information about unlabeled uses of drugs and devices, while ensuring that manufacturer-sponsored promotions remain under FDA regulation.

3. APA supports the dissemination of independently derived scientific information about unlabeled uses by manufacturers to physicians, if the independent information is provided in its entirety [including comprehensive results of relevant clinical trials], is not edited or altered by the manufacturer, and is clearly distinguished from manufacturer-sponsored mater- ials. Dissemination of information by manufacturers to physicians about unlabeled uses can be supported under the following conditions:

a. **For Reprints** of independently derived articles from reputable, peer-reviewed journals, the following criter- ia must be met:

i. The article should be peer reviewed and published in accordance with the regular peer review procedure of the journal in which it is published;

ii. The reprint should be from a peer-reviewed journal that both has an editorial board and utilizes experts to review and objectively select, reject, or provide comments about proposed articles; such experts should have demonstrated expertise in the subject of the article under review, and be independent from the journal;

iii. The journal should be recognized to be of national scope and reputation, as defined by an advisory panel to the FDA; among its members, this advisory panel should have representatives from national psychiatric societies;

iv. The journal must be indexed in the *Index Medicus* of the National Library of Medicine;

v. The journal must have and adhere to a publicly stated policy of full disclosure of any conflicts of interest or biases for all authors or contributors;

vi. When the subject of the article is an unlabeled use, or the article contains information that differs from approved labeling, the industry sponsor disseminating the reprint must disclose that the reprint includes information that has not been approved by the FDA and attach a copy of the FDA-approved professional labeling with the reprint;

vii. If financial support for the study and/or the author(s) was provided by the industry sponsor disseminating the reprint, and this is not already stated in the article, then this information should be clearly disclosed with the reprint.

b. **For Reprints of monographs or chapters from the three compendia** ~~(AMA's *Drug Evaluations*; *United States Pharmacopeia-Drug Information*, Volume I; and *American Hospital Formulary Service-Drug Information*)~~ named in federal statutes for determining the medical acceptability of unlabeled uses, the following criteria must be met:

i. The monograph or chapter should be reprinted in entirety by the publisher of the compendia, and the reprints then sent to the requesting industry sponsor;

ii. The reprints of the monographs or chapters should not be altered in any way by the industry sponsor;

iii. The industry sponsor disseminating the reprint of the monograph or chapters should disclose that the reprint includes information that has not been approved by the FDA and should attach a copy of the FDA-approved professional labeling with the reprint.

c. **For Complete Textbooks** the following criteria must be met:

ii. The reference text should not have been written, edited, excerpted, or published specifically for, or at the request of, a drug, device, or biologic firm; when financial support is provided by a drug, device, or biologic firm, it should be disclosed clearly in the textbook;

iii. The content of the reference text should not have been edited or significantly influenced by a drug, device, or biologic firm, or agent thereof;

iv. The reference text should be generally available for sale in bookstores or other distribution channels where similar texts are normally available and should not be distributed only or primarily through drug, device, or biologic firms;

v. The reference text should not focus primarily on any particular drug(s), device(s), or biologic(s) of the disseminating company, nor should it have a significant focus on unapproved uses of drug(s), device(s), or biologic(s) marketed or under investigation by the firm supporting the dissemination of the text;

vi. Specific product information (other than the approved package insert) should not be physically appended to the reference text.

d. **For Proprietary Information** indicating that a drug is ineffective or unsafe when used for a specific unlabeled indication, manufacturers should report to the FDA and share with all physicians all of the proprietary information.

e. **For Continuing Medical Education (CME) activities and information**:

i. The FDA should continue to support principles in the FDA Draft Policy Statement on Industry-Supported Scientific and Educational Activities (Fed. Reg. 1992; 57:56412-56414); the FDA Draft Policy Statement acknowledges the importance of relying on professional health-care communities, rather than the FDA, to monitor independent provider activities;

ii. The FDA should continue a policy of regulatory deference for industry-supported CME activities conducted by organizations accredited by the Accreditation Council for Continuing Medical Education (ACCME), state medical societies, and specialty societies such as the American Psychiatric Association (APA), that follow the Essentials and Standards of the ACCME and that may be certified for AMA PRA credit under the auspices of the American Medical Association Physician's Recognition Award program.

vii.

4. APA strongly supports the responsibility of physicians to interpret and put into context evidence received from all sources [including pharmaceutical manufacturers], before making clinical decisions (i.e.., prescribing a drug for an unlabeled use).

Improving the Supplemental New Drug Application (SNDA) Process

5. APA strongly supports the addition to FDA-approved labeling those uses of drugs for which safety and efficacy have been demonstrated.

6. APA strongly encourages the US Congress, the FDA, pharmaceutical manufacturers, the United States Pharmacopeia, patient organizations, APA and other medical specialty societies to work together to ensure that Supplemental New Drug Applications (SNDAs) for new indications (efficacy supplements), including those for uses in populations with mental disorders , are submitted and acted upon in a timely manner. Specific recommendations include:

a. **User fee legislation should be re-authorized** to ensure that the FDA has the necessary resources to act on all efficacy supplements within six months of submission;

b. **The SNDA process should be streamlined** as much as possible without compromising the requirements for substantial evidence of efficacy and safety;

c. **Legislation should be enacted** that provides extensions of marketing exclusivity for a product to manufacturers who conduct supplemental research [i.e., Phase IV studies] and submit efficacy supplements gaining FDA approval for additional indications; the legislation should place a limit on total length of extended marketing exclusivity;

d. **For drugs no longer under patent and for which generic versions are available**, the FDA, other governmental agencies (e.g., the National Institutes of Health), the pharmaceutical industry, the United States Pharmacopeia, patient organizations, the APA and other medical specialty societies should discuss and mutually agree on alternative mechanisms to ensure that efficacy supplements based on relevant research findings will be submitted to and acted upon by the FDA in a timely manner.

viii.

Encouraging Clinical Research in Child and Adolescent Psychiatry

7. APA urges pharmaceutical manufacturers and the FDA to work with the American Psychiatric Association, the American Academy of Child and Adolescent Psychiatry, and the American College of Neuropsycho-pharmacology and other experts in pediatric medicine to identify those investigational drugs that should have pediatric indications and set up a mechanism to ensure that necessary pediatric clinical studies are completed prior to submission of NDAs for approval of these drug products.

APA Official Actions

Position Statement on Medical Necessity Definition

Approved by the Board of Trustees, October 2000
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 American Psychiatric Association endorses the statement from the American Medical Association which defines "medical necessity" as:

"… Health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, or its symptoms in a manner that is: (1) in accordance with generally accepted standards of medical practice; (2) clinically appropriate in terms of type, frequency, extent, site, and duration; and (3) not primarily for the economic benefit ~~convenience~~ of the health plans and purchasers or for the convenience of the patient, treating physician, or other health care provider. "

The current version of the AMA Policy Statement, H-320.953—Definitions of "Screening" and "Medical Necessity" (CMS Rep. 13, I-98; Modified: Res. 703, A-03; Reaffirmation I-06) can be found online at the AMA PolicyFinder: http://www.ama-assn.org/

AMA Policy on “Medical Necessity”

H-320.953 Definitions of "Screening" and "Medical Necessity"

(1) Our AMA defines screening as: Health care services or products provided to an individual without apparent signs or symptoms of an illness, injury or disease for the purpose of identifying or excluding an undiagnosed illness, disease, or condition.

(2) Our AMA recognizes that federal law (EMTALA) includes the distinct use of the word screening in the term "medical screening examination"; "The process required to reach, with reasonable clinical confidence, the point at which it can be determined whether a medical emergency does or does not exist."

(3) Our AMA defines medical necessity as: Health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is: (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate in terms of type, frequency, extent, site, and duration; and (c) not primarily for the economic benefit of the health plans and purchasers or for the convenience of the patient, treating physician, or other health care provider.

(4) Our AMA incorporates its definition of "medical necessity" in relevant AMA advocacy documents, including its "Model Managed Care Services Agreement." Usage of the term "medical necessity" must be consistent between the medical profession and the insurance industry. Carrier denials for non-covered services should state so explicitly and not confound this with a determination of lack of "medical necessity".

(5) Our AMA encourages physicians to carefully review their health plan medical services agreements to ensure that they do not contain definitions of medical necessity that emphasize cost and resource utilization above quality and clinical effectiveness.

(6) Our AMA urges private sector health care accreditation organizations to develop and incorporate standards that prohibit the use of definitions of medical necessity that emphasize cost and resource utilization above quality and clinical effectiveness.

(7) Our AMA advocates that determinations of medical necessity shall be based only on information that is available at the time that health care products or services are provided.

(8) Our AMA continues to advocate its policies on medical necessity determinations to government agencies, managed care organizations, third party payers, and private sector health care accreditation organizations. (CMS Rep. 13, I-98; Reaffirmed: BOT Action in response to referred for decision Res. 724, A-99; Modified: Res. 703, A-03; Reaffirmation I-06)

APA Official Actions

Position Statement on Access to Comprehensive Psychiatric Assessment and Integrated Treatment

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*.

For patients referred for the treatment of mental illness:

- Restricting access to assessment by a psychiatrist and integrated treatment is not cost-effective.
- Delegating treatment to various specialties is a medical, not a procedural administrative or 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 should be properly screened and be seen by a psychiatrist early enough for meaningful clinical input towards the patient's comprehensive psychiatric assessment and to ensure attention and coordination of medical care for associated medical needs.
- Treatment planning should be based on a comprehensive assessment using the 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.

Prepared by the APA 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., and Joel Johnson M.D.

This is a revision of the 2002 position statement.

NOTE:
The above position statement is the 2009 version. The 2009 version supersedes the original 2002 which was never officially retired. This is included to give you an idea of the subject matter. The action being requested is to officially retire the 2002 document.

APA Official Actions

Position Statement on Psychotherapy and Managed Care

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

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

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

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

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

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

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

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

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

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

APA Official Actions

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

Approved by the Board of Trustees, December 1995

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

Preamble

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

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

Objectives

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

Procedures

As soon as the transfer is planned:

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

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

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

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

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

Am J Psychiatry 136:5, May 1979

Position Statement on Active Treatment

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

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

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

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

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

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

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

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

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

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

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

[1]The Council on Mental Health Services included J.M. Stubblebine, M.D., chairperson, Mildred Mitchell-Bateman, M.D., Israel Zwerling, M.D., Hayden H. Donahue, M.D., Alan Elkins, M.D., Aubrey Dent, M.D. (observer-consultant), Jack Kremens, M.D. (Assembly liaison), Robert W. Gibson, M.D. (Board liaison), Donald G. Langsley, M.D. (Board liaison), Richard T. Rada, M.D. (consultant), and Donald Hammersley, M.D. (staff assigned).

[2]This task force included Warren S. Williams, M.D., chairperson, Roy M. Coleman, M.D., Lino Covi, M.D., and Roger Peele, M.D.

APA Official Actions

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

Approved by the Board of Trustees, 2002

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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 commit- ment 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 guide- lines 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.

I. 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.

[1]The Council on National Affairs included Harold M. Visotsky, M.D., chairperson, James M. Bell, M.D., vice-chairperson, Hiawatha Harris, M.D., Jean Shioda Bolen, M.D., Frank M. Ochberg, M.D., Hector Jaso, M.D., Assembly of District Branches liaison, Esther P. Roberts, M.D., observer-consultant, and Marshall Belaga, M.D., Ezra Griffith, M.D., and Russell Phillips, M.D., Falk Fellows.

APA Official Actions

Endorsement of *Principles for the Provision of Mental Health and Substance Abuse Treatment Services: A Bill of Rights*

Approved by the Board of Trustees, November 1996
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*.

Our commitment is to provide quality mental health and substance abuse services to all individuals without regard to race, color, religion, national origin, gender, age, sexual orientation, or disabilities.

RIGHT TO KNOW

Benefits
Individuals have the right to be provided information from the purchasing entity (such as employer or union or public purchaser) and the insurance/third party payer describing the nature and extent of the mental health and substance abuse treatment benefits. This information should include details on procedures to obtain access to services, on utilization management procedures, and on appeal rights. The information should be presented clearly in writing with language that the individual can understand.

Professional Expertise
Individuals have the right to receive full information from the potential treating professional about that professional's knowledge, skills, preparation, experience, and credentials. Individuals have the right to be informed about the options available for treatment interventions and the effectiveness of the recommended treatment.

Contractual Limitations
Individuals have the right to be informed by the treating professional of any arrangements, restrictions, and/or covenants established between third party payers and the treating professional that could interfere with or influence treatment recommendations. Individuals have the right to be informed of the nature of information that may be disclosed for the purposes of paying benefits.

Appeals and Grievances
Individuals have the right to receive information about the methods they can use to submit complaints or grievances regarding provision of care by the treating professional to that profession's regulatory board and to the professional association.

Confidentiality
Individuals have the right to be guaranteed the protection of the confidentiality of their relationship with their mental health and substance abuse professional, except when laws or ethics dictate otherwise. Any disclosure to another party will be time limited and made with the full written, informed consent of the individuals. Individuals shall not be required to disclose confidential, privileged or other information other than: diagnosis, prognosis, type of treatment, time and length of treatment, and cost.

Entities receiving information for the purposes of benefits determination, public agencies receiving information for health care planning, or any other organization with legitimate right to information will maintain clinical information in confidence with the same rigor and be subject to the same penalties for violation as is the direct provider of care.

Information technology will be used for transmission, storage, or data management only with methodologi4es that remove individual identifying information and assure the protection of the individual's privacy. Information should not be transferred, sold or otherwise utilized.

Choice
Individuals have the right to choose any duly licensed/certified professional for mental health and substance abuse services. Individuals have the right to receive full information regarding the education and training of professsionals, treatment options (including risks and benefits), and cost implications to make an informed choice regarding the selection of care deemed appropriate by individual and professional.

Determination of Treatment
Recommendations regarding mental health and substance abuse treatment shall be made only by a duly licensed/certified professional in conjunction with the individual and his or her family as appropriate. Treatment decisions should not be made by third party payers. The individual has the right to make final decisions regarding treatment.

Parity
Individuals have the right to receive benefits for mental health and substance abuse treatment on the same basis as they do for any other illnesses, with the same provisions, co-payments, lifetime benefits, and catastrophic coverage in both insurance and self-funded/self-insured health plans.

Discrimination
Individuals who use mental health and substance abuse benefits shall not be penalized when seeking other health insurance or disability, life or any other insurance benefit.

Benefit Usage
The individual is entitled to the entire scope of the benefits within the benefit plan that will address his or her clinical needs.

Benefit Design
Whenever both federal and state law and/or regulations are applicable, the professional and all payers shall use whichever affords the individual the greatest level of protection and access.

Treatment Review

To assure that treatment review processes are fair and valid, individuals have the right to be guaranteed that any review of their mental health and substance abuse treatment shall involve a professional having the training, credentials and licensure required to provide the treatment in the jurisdiction in which it will be provided. The reviewer should have not financial interest in the decision and is subject to the section on confidentiality.

Accountability

Treating professionals may be held accountable and liable to individuals for any injury caused by gross incompetence or negligence on the part of the professional. The treating professional has the obligation to advocate for and document necessity of care and to advise the individual of options if payment authorization is denied. Payers and other third parties may be held accountable and liable to individuals for any injury caused by gross incompetence or negligence or by their clinically unjustified decisions.

Participating Groups

American Association for Marriage and Family Therapy
American Counseling Association
American Family Therapy Academy
American Nurses Association American Psychiatric Association
American Psychiatric Nurses Association
National Association of Social Workers
National Federation of Societies for Clinical Social Work

Supporting Groups

National Mental Health Association American Group Psychotherapy Association
National Depressive and Manic Depressive Association

Title: Joint* Position Statement on the Role of Psychiatrists in Reducing Physical Health Disparities in Patients with Mental Illness

*The following organizations have approved this statement as written: Association of Medicine and Psychiatry (AMP), American Academy of Community Psychiatry (AACP), and the Academy of Psychosomatic Medicine (APM)

Issue: Patients with mental illness, including those with serious mental illnesses, experience disproportionately high rates of medical disorders such as tobacco-related pathology, obesity, hypertension, hyperlipidemia and diabetes. Some psychotropic medications contribute to this excess morbidity in addition to the challenges of poverty, social exclusion, sedentary lifestyles, poor dietary choices and other unhealthy behaviors. Additionally, there is a lack of access to high quality primary, secondary and tertiary medical care including preventive health and screening for common medical conditions. As a result, premature mortality in those with mental illness is significantly increased relative to the general population, contributing to a widening gap in life expectancy.

Psychiatrists have medical training as physicians that distinguish them from other mental health disciplines. As such, they play a particularly important role on the behavioral health treatment team regarding clinical care (assessment, diagnosis and treatment), advocacy and teaching related to improving the health status and medical care of their patients. As part of the broader medical neighborhood of primary care and specialist providers, psychiatrists have a role in the care management and care coordination of a subset of their patients because of the chronicity and severity of their patients' illnesses and their barriers in accessing traditional primary and preventive healthcare. For patients in specialty psychiatric services, psychiatrists are often the only physicians they routinely see. In this vein, psychiatrists are similar to other medical specialists charged with coordinating and sometimes providing chronic care to individuals with specialty-specific illnesses (e.g. nephrologists caring for patients on dialysis, or oncologists caring for patients with cancer).

In addition, as health care reform moves traditional behavioral health treatment settings towards Behavioral Health Homes and Certified Behavioral Health Centers, psychiatrists must be prepared to serve as medical leaders of these systems designed to improve not only the mental health but also the physical health of patients.

Position: It is the joint position of the American Psychiatric Association (APA), the Association of Medicine and Psychiatry (AMP), the American Academy of Community Psychiatry (AACP), and the Academy of Psychosomatic Medicine (APM) that:

1. **Screening for common medical conditions, counseling patients to reduce preventable cardiovascular risk factors, limiting harm that can come from use of psychotropic medications (including use of existing APA/ADA guidelines[1]), and monitoring the medical care being delivered by other medical providers are essential components of psychiatric practice.**

2. **Psychiatrists should identify patients receiving no or suboptimal primary care and may intervene when most appropriate based on their identified competencies, local resources and patient preferences for care. Co-management of common medical conditions when**

clinically necessary should be recognized as a potential component of the overall care of patients with mental illnesses (when this occurs appropriate reimbursement should also be made).

3. **Appropriate primary care training in the treatment of common medical conditions, including the leading determinants of mortality in populations with serious mental illnesses, should be made available to psychiatrists seeking to better manage physical health conditions in patients with mental illnesses. Furthermore, the APA and partner organizations such as the AMP should increase efforts to provide adequate training and clinical experience throughout the spectrum of medical education from residency and fellowship levels to Continuing Medical Education (CME) for the current psychiatric workforce.**

4. **The scope of this endeavor should include development of measurable competencies in the screening for common medical disorders, knowledge of age and culturally appropriate disease prevention concepts, and current approaches to the treatment of common medical conditions.**

5. **The APA and AMP support the development of partnerships between primary care providers and psychiatrists to provide consultation and oversight in the management of chronic medical conditions in a variety of settings.**

6. **The APA and AMP support the development of guidelines that clarify the clinical circumstances in which psychiatrists may become involved in the management of common medical disorders for a subset of their patients.**

7. **The APA and AMP advocate for appropriate funding for training psychiatrists in primary care skills to work confidently and competently in a variety of settings, both traditional and nontraditional, such as in public mental health clinics and outreach services to immigrant and homeless populations.**

8. **The APA and AMP should continue to support the research, development, and wider implementation of integrated models of health care including outcome studies for psychiatrists treating the conditions contributing to increased mortality.**

Authors: Lori Raney, MD, Erik Vanderlip MD, Jeffrey Rado, MD, Robert McCarron, MD, the APA Workgroup on Integrated Care, APA Council on Healthcare Systems and Financing, Association of Medicine and Psychiatry (AMP).

This Position Statement was reviewed and approved by the Council on Geriatric Psychiatry, the Council on Psychosomatic Medicine, and the Council on Medical Education and Lifelong Learning.

[1] Consensus development conference on antipsychotic drugs and obesity and diabetes. (2004). *Diabetes Care*, *27*(2), 596–601.

COUNCIL ON MEDICAL EDUCATION AND LIFELONG LEARNING
September 12, 2014

Attendance:
Richard Summers, MD – Chairperson
Mark Rapaport, MD – Vice-Chairperson
Justin Hunt, MD, Member
Steven Fischel, MD, Member
Sarah Johnson, MD, Member
Edward Silberman, MD, Member
Lisa Mellman, MD, Member
John Q. Young, MD, Member
Marcia Verduin, MD, Member
Art Walaszek, MD, Member
Benoit Dube, MD, Consultant
John Luo, MD, Corresponding Member, AAP
Christopher Varley, MD, Corresponding Member, AADPRT
Kara Brown, MD, APA/Diversity Leadership Fellow
Vera Tate, MD, APA/Diversity Leadership Fellow
Lisette Angelica Rodriguez-Cabezas, MD, APA/Diversity Leadership Fellow
Rashad Hardaway, MD, APA/SAMHSA Fellow
Alicia Barnes, DO, APA/SAMHSA Fellow
Elizabeth Homan, MD, APA/SAMHSA Fellow
Juliet Muzere, MD, APA/SAMHSA Fellow
Jose Rengifo, MD, APA/SAMHSA Fellow

Guests:
Renee Binder, MD, APA President-Elect
Wilson Compton, MD, NIDA
Bea Eld, Staff Liaison, Council on Addiction Psychiatry
Jon Fanning, APA Chief of Membership and RFM/ECP
Frances Levin, MD, Chair, Council on Addiction Psychiatry
Saul Levin, MD, APA CEO and Medical Director
Eve K. Moscicki, ScD, MPH, Director, Practice Research Network
Rebecca Rinehart, APP Publisher
Robert Rymowicz, President, PsychSIGN
Paul Summergrad, MD, APA President

Staff:
Nancy Delanoche, MS
Kristen Moeller
Judith Carrier, PhD
Kay Acevedo
Annelle Primm, MD
Kristin Kroeger

Call to Order: Dr. Summers called the meeting to order at 9:00 a.m. The minutes of the May 2014 meeting were approved.

APA Administration – Dr. Levin visited the Council meeting to thank the members for their hard work and dedication. He also thanked AADPRT and ADMSEP for helping with the position description for the new Education Director. Interviews will be conducted shortly with candidate selection in December. He commended the Council on the integrated care meeting held in June.

Jon Fanning, APA's Chief of Membership and RFM/ECP Officer came to the meeting to report on new initiatives and projects:

- "Building a Career in Psychiatry" resource guide. Its purpose is to help medical students, residents, fellows and early career physicians successfully prepare for the transition points
- Work with doctors and others to create a streaming video library
- Develop learning modules for residents and members
- Learning management system being revamped with completion in early 2015
- Medical Student/Resident membership up 20%
- Discussion on what should be free to all/ payment based or member benefit.

DSM Licensing for ADMSEP Learning Modules – Becky Rinehart, APP's Publisher, discussed the copyright/licensing agreement for DSM-5 material. Ms. Rinehart noted that paraphrasing the text will avoid trademark violation and is not a violation of Fair Use. However, the Council believes that further clarification is needed on the parameters and limitations on using the DSM-5 material for printed and online purposes. A workgroup was formed to get clarification on this issue.

Addiction Psychiatry Curriculum for General Residency - Drs. Wilson Compton and Frances Levin came to the meeting seeking interest from other councils to establish curriculum to help residents monitor and screen for addictions. They would like to use the neuroscience curriculum model to collaborate with various groups. Ms. Bea Eld suggested setting up a workgroup and doing a needs assessment. Drs. Sarah Johnson and Juliet Muzere volunteered to be part of the workgroup.

APA President – Dr. Paul Summergrad visited the Council to discuss his areas of focus during his Presidency:

- Importance of residents to the future of psychiatry and commission of an APA Board of Trustees Workgroup on Education and Training
- Health Care Reform Advocacy
- Working with Chairman Upton to accelerate drug development
- Murphy Bill – overhaul the mental health system

APA President-Elect – Dr. Renee Binder presented her goals and initiatives:

- Increase diversity in the APA - in membership, leadership roles – with an emphasis on age. She appointed an ECP, Steve Koh, MD, to be chairperson of the 2016 Scientific Program Committee.
- Erase stigma against patients, psychiatrists and disorders
- She chose the theme "Identities and Roles of Psychiatrists in the 21st Century" for the 2016 APA Annual Meeting.

Psychiatric Education with Respect to Patients at Risk of Violent Behavior (ASMMAY1412.E)
The Action Paper asks:

- That the APA promote expanded access to ongoing research findings with respect to etiology of dangerousness, and guidelines for self-protection of the treating psychiatrist.

- That promotion of the knowledge of these issues be accomplished through a track devoted to these topics at the APA Annual Meeting, a course on this topic at the Annual Meeting and articles in the AJP and attend to these topics in all relevant practice guidelines.

The JRC referred this action paper to the Council and noted that this issue is included within a proposed Practice Guideline on the Assessment of Risk for Aggressive Behaviors as Part of the Initial Psychiatric Evaluation. The JRC referred this paper to CMELL to consider including this within residency training education and also referred to the Scientific Program Committee asking them to consider including courses on this topic at the Annual Meeting.

The Council has already 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 and is intended to be taught in the first year of residency training.

According to the Scientific Program Committee, a new topic was added "***Aggressive Behaviors: Etiology, Assessment & Treatment"*** in the online abstract submissions system and 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 telephone /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.

Recent developments include:
Curriculum by Robert Feinstein from the University of Colorado
CDC materials on violent patients

Council White Paper on Education for Integrated Care – Dr. Summers asked for feedback on the draft paper entitled "Training Psychiatrists for Integrated Behavioral Health Care" which covers the spectrum from undergraduate medical education to GME to CME. The paper also includes discussion on inter specialty education and training. Member feedback includes:

- Psychiatrists need training to lead in integrated care settings.
- Role of psychotherapy in integrated care
- Possibly have levels and training recommendations for each level (i.e. Level 1 Didactics in PG4.)
- Unsure as to how soon integrated care changes will go into effect (system/payer not ready)
- Address leadership building post-residency for mid-career psychiatrists
- Use of inter professional and inter specialty versus inter discipline

Dr. Summers will produce second draft in 2-3 weeks and circulate. To promote the publication of this report, APA's new Communications Chief suggested that the Council produce a 5 page summary, a 1 page summary, graphics and bullet points.

Mentorship of APA Fellows
Dr. Summergrad asked each Council chair to help improve the experience of APA fellows who are on Councils by welcoming the fellows at the meeting and encourage Council members to actively seek out fellows to join in on projects/workgroups, as well as encourage APA fellows to volunteer for projects.

Dr. Summers met with the fellows separately where they identified Council members who will be their mentors. The following assignments were made:

Mindy Young -- Kara Brown
Mark Rapaport -- Vera Tate
John Luo -- Lisette Angelica Rodriguez-Cabezas
Benoit Dube -- Rashad Hardaway
Lisa Mellman -- Alicia Barnes
Sarah Johnson -- Juliet J Muzere
Art Walaszek -- Jose Rengifo
Edward Silberman - Elizabeth Homan

The expectation of mentors is to send an email to the fellow to follow up meeting in person at the Components meeting, let the fellow know that they are the point person for any questions throughout the year, and communicate every 2-3 months and prior to the Annual Meeting to help to support the fellow's APA activities.

Work Group on the Role of Psychiatry in Healthcare Reform – the JRC referred the following recommendations to the Council on Medical Education and asked that the Council discuss and address each recommendation as follows:

- Currently Being Addressed, Include How
- Not Currently Being Addressed, Include How They Could Be
- Specific 'Products' under Development if Applicable (which are called for by the recommendations)
- Prioritize the Recommendation (High, Med, Low)
- Other Feedback

The recommendations are:
1) Future workforce: The APA should work with the American Association of Directors of Psychiatric Residency Training (AADPRT), the Academy of Psychosomatic Medicine (APM), and the American Academy of Child and Adolescent Psychiatry (AACAP) to facilitate the development and implementation of a curriculum for residents that includes the core competence/skill sets for integrated care practice, including the maintenance of core medical skills.

Response: Currently Being Addressed

- Gitlin curriculum for general psychiatry residents
- GME recommendations from CMELL's white paper
- Team-based learning as AAMC requirement for accreditation and
- Lori Raney's WG report on maintenance of core medical skills

2) The APA should work with the Accreditation Council for Graduate Medical Education (ACGME) to develop accreditation standards to establish specific milestones for psychiatric residents to achieve proficiency in core competencies for integrated care practice and settings, or highlight existing milestones that are relevant for these efforts.

Response: Currently Being Addressed
The ACGME milestone on integrated care already exists as follows:

SBP4 Consultation to non-psychiatric medical providers and non-medical systems (e.g. military, schools, businesses, forensic
A: Distinguishes care provider roles related to consultation
B: Provides care as a consultant & collaborator
C: Specific consultative activities
Level 4.1/B Provides integrated care for psychiatric patients through collaboration with other physicians

3) Current workforce: Within the healthcare reform movement, many opportunities exist for psychiatrists who have the necessary skills and experience to participate in the new models of integrated care. However, many lack the core competencies respecting a number of necessary skills.

4) The APA should develop practice management modules (CME) for its members to enhance their skills in the following areas: reviews of common medical problems in general medical care and public sector populations, leading teams of mental health professionals, setting up and/or participating in integrated care settings, teaching PCPs about identifying and screening for mental health illnesses and substance use disorders, and health information technology.

Response: Currently Being Addressed

- HealthCare Financing Seminar on Healthcare Reform and Integrated Care - Department of CME provided CME credit for a Fall 2013 seminar developed by the APA Department of Healthcare Financing that brought representatives of DBs up-to-date on this topic. DBs presented the seminar curriculum to their members at local meetings.
- FOCUS. Psychosomatic Medicine and Integrated Care. Fall 2013, Vol. 11, No. 4 The Fall 2013 issue of FOCUS covered the topic of Psychosomatic Medicine and Integrated Care from a clinical view point for the general psychiatrist.
- Primary Care Updates for Psychiatrists – Presented at IPS and developed as an Online Course November 2013 (free, up to 4 credits)
- Integrated Care Track at Annual Meeting and IPS
- Sessions at these meeting on IC topics

5) Non-psychiatrist physicians and allied practitioners: the APA should explore potential collaboration with primary care personnel (both MD and non-MD) regarding needed education and alliances regarding care delivery development (especially for shortage areas).

Response: Currently Being Addressed
APA convened a meeting with Education directors of various primary care associations to find ways to collaborate. Presentations are planned at various PC meetings. Dr. Cowley will chair a symposium at the 2015 APA Annual Meeting on interspecialty collaboration in education entitled "Educating Psychiatrists for Work in Integrated Care: Focus on Interdisciplinary Collaboration"

APA Board of Trustees Workgroup on Education and Training – Dr. Summergrad created a new Board Ah Hoc Workgroup on Education and Training. The Workgroup will have its first conference call on September 22nd.

Background: The mission of the APA is to advance and represent the discipline of psychiatric medicine and to serve the professional needs of its members and interests of its patients. To do this, the APA must conduct and monitor activities in the fields of education, training, mental health care, public

health, health systems and its professional workforce. Included in this scope of activities, the APA also provides support for lifelong learning and Continuing Medical Education (CME).

Charge: The workgroup will 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.

Proposed Members: Eight to eleven members with relevant expertise in a diverse range of education and training areas and who hold relevant positions in the APA, ABPN, AADPRT, AAP, ADMSEP, AACDP, and the CEO as an ex-officio member.

Proposed Process: The workgroup will conduct a review virtually through tele or web conferencing, and by in person meetings, if required. The APA education staff will prepare and provide to the committee all relevant information and materials requested or deemed necessary for the review. The review will be completed in time for a report to be made to APA BOT at its December 13-14, 2014 meeting in Arlington Virginia.

Resources Provided: Administrative support for scheduling conference calls and obtaining conference line will be provided. Funds may be requested as needed for in person meetings.

Members:
Richard Summers, MD - Chairperson
Laura Roberts, MD - Member
Michele Pato, MD - Member
Sheldon Benjamin, MD - Member
John Sargent, MD - Member
Jed Magen, DO, MS - Member
Christopher Thomas, MD - Member
Carol Bernstein, MD - Member
Glenda Wrenn, MD - Member
Tami Benton, MD - Member
Lara Cox, MD - Member
Carlyle Chan, MD - AAP Representative
Gregory Briscoe, MD - ADMSEP Representative
Mark Rapaport, MD - AACDP Representative
Christopher Varley, MD - AADPRT Representative
Jeffrey Lyness, MD - ABPN Representative
Staff support: Annelle Primm, MD, MPH , Kristin Kroeger and Nancy Delanoche, MS

REPORT: CME and MOC – Dr. Mark Rapaport and Ms. Kristen Moeller gave the report on APA's CME and MOC activities and led the discussion:

CME Mission Statement: The goal of the APA continuing medical education program is to engage members and other practitioners in educational activities in order to improve patient care. Such educational activities will address established knowledge and emerging new knowledge derived from research, technical advances, and clinical practice. The program will be provided in an environment which encourages lifelong learning in psychiatry.

The APA will accomplish these goals by the following means:

A. Dissemination of this knowledge through major publications, national scientific meetings, and a variety of enduring materials, including online activities and journal-based CME.
B. Encouragement of CME programs at the District Branch level through joint sponsorship of District Branches with appropriately trained representatives.
C. Education of members in ethical standards and their application in various clinical settings.
D. Ongoing assessment of member needs and of the effectiveness of the programs offered.
E. Delivery of programs that address the integration of knowledge from various disciplines, as applicable to the clinical practice of psychiatry.
F. Creation of innovative programs of individualized study and self-assessment.
G. Development of specific educational programs for candidates preparing for certification and Maintenance of Certification (MOC), which incorporate evolving ABPN requirements.
H. Creation of educational activities that promote and maintain competence.
I. Exploration of new methodologies for assessing knowledge attainment and measuring practice change.
J. Regular review of application of new assessment technologies.

<u>APA CME Programs</u>

In addition to the APA Annual Meeting, IPS, and District Branch meetings, APA offers CME to psychiatrists through a variety of programs and formats such as American Journal of Psychiatry CME, the Online Learning center at apaeducation.org, the FOCUS Program of Lifelong Learning which includes the FOCUS Journal, FOCUS Self-assessment, Performance in Practice Chart Review Modules, and FOCUS books and innovative programs such as eFOCUS; a series of webinars live and archived on addiction topics; and HIV and psychiatry education (September 2014) that meets state licensure requirements.

<u>APA MOC Programs</u>

(The 24 member boards of the American Board of Medical Specialties participate in MOC)

APA MOC Part II (CME, Self-Assessment, and Patient Safety)

- FOCUS Self-Assessment Examination (four topics covered in each exam year)
- APA Annual Meeting Self-Assessment in Psychiatry
- eFOCUS: Understanding the Evidence for Off-Label Use of Atypical Antipsychotics
- 2014 Annual Meeting Master Course: Psychopharmacology Self-Assessment
- Patient Safety * new winter 2014

APA MOC Part II and Part IV (Self-Assessment and Chart Review)

- FOCUS MOC Workbook: Major Depressive Disorder
- FOCUS MOC Workbook: Posttraumatic Stress Disorder * new August 2014

APA MOC Part IV (Chart Review and Improvement)

Physician Practice Assessment Tools for:

- Screening of Adults with Substance Use Disorder
- Assessment and Treatment of Adults with Substance Use Disorder
- Assessment and Treatment of Adults at Risk for Suicide and Suicide-Related Behaviors
- Care of Patients with a Diagnosis of Schizophrenia
- Care of Patients with Major Depressive Disorder
- Care of Patients with Posttraumatic Stress Disorder

2014 Annual Meeting Master Course: Psychopharmacology

- PIP: Measures For Use of Selected Antidepressant Medications
- PIP: Measures For Use of Second Generation Antipsychotics Medications
- PIP: Measures For Use of Lithium/Anticonvulsant Mood Stabilizing Medications
- PIP: Measures For Use of Benzodiazepine Medications

In 2014 ABPN made changes to its MOC requirements.
The changes are described on the ABPN website at: http://www.abpn.com/faq_quarterly_archives.html

- There are new ways to meet MOC requirements.
- Feedback modules require feedback from one source only.
- There is a new safety course requirement (begins in 2015)
- The ABPN has reduced the amount of MOC activity needed to meet the requirements for the 2015 through 2021 MOC examinations.
- Some C-MOC program requirements may be waived for those who pass the subspecialty certification exam in 2012 or later.
- Diplomates are no longer required to enter the details of their MOC activities in the ABPN Physician Folios system. Diplomates will now attest to having completed the MOC requirements.

Participation in APA MOC programs

MOC Program Participant Counts Report Start Date: 1/1/2013 Report End Date: 9/3/2014	***Enrollments Completed SAT***
FOCUS Self-Assessment 2012 exam - aggregate through June 2014	761
FOCUS Self-assessment 2013 exam - aggregate through June 2014	664
FOCUS Self-Assessment 2014 exam - available October 2014	
PIP: Clinical Module for the Care of Adults with Schizophrenia - Stage A	472
PIP: Clinical Module for the Care of Patients with Major Depressive Disorder - Stage A	313
PIP: Clinical Module for the Care of Patients with Posttraumatic Stress Disorder - Stage A	87
PIP: FOCUS Major Depressive Disorder Maintenance of Certification (MOC) Workbook – Depression PIP Stage A	366
PIP: Measures For Use of Benzodiazepine Medications - stage A enrolled	44
PIP: Measures For Use of Lithium/Anticonvulsant Mood Stabilizing Medications - Stage A - enrolled	24
PIP: Measures For Use of Second Generation Antipsychotic Medications - Stage A - enrolled	31
PIP: Measures For Use of Selected Antidepressant Medications - Stage A - enrolled	45
PIP: Physician Practice Assessment Tool for the Assessment and Treatment of Adults at Risk for Suicide and Suicide-Related Behaviors - Stage A	372
PIP: Physician Practice Assessment Tool for the Assessment and Treatment of Adults with Substance Use Disorder-Stage A	184
PIP: Physician Practice Assessment Tools for Screening of Adults with Substance Use Disorder - Stage A	189

2014 APA Annual Meeting Self-Assessment in Psychiatry	1096
Understanding the Evidence: Off Label Use of Atypical Antipsychotics: Self Assessment Activity	1278
4501 users participating in MOC Part II or Part IV programs January 1 2013 – September 3 2014	

2014 MOC Programs

Understanding the Evidence: Off Label Use of Atypical Antipsychotic Medication (MOC Part II)

The Agency for Healthcare Research and Quality (AHRQ) awarded the APA a grant (#5R18HS021944) to create and offer physicians a FREE CME and Self-assessment program to educate them about evidence for effectiveness of atypical (second generation) antipsychotics reviewed in the 2011 AHRQ Report as well as newer evidence. The goal of the program is to help physicians make informed treatment decisions when using these medications "off label". This interactive CME program includes a multiple choice Self-Assessment test and a series of 10 multimedia clinical vignette self-assessment modules The program is available at www.apaeducation.org. (provides up to 25 credits)

Focus: Journal of Lifelong Learning in Psychiatry (MOC Part II and Part IV)

The FOCUS program: the Journal, the annual self-assessment, Performance in Practice Chart Review Modules and eFOCUS clinical vignettes, as well as FOCUS books, help psychiatrists fulfill Maintenance of Certification (MOC) Requirements, stay up to date, and participate in a program of lifelong learning. APA members contribute as editors, authors, peer reviewers, consultants, and question writers.

2014 FOCUS topics

Disorders of Sleep
Psychopharmacology: Evidence and Treatments;
Psychotherapy: New Evidence and Approaches
Eating Disorders

2015 Topics

Bipolar and Related Disorders
Obsessive-Compulsive and Related Disorders
Substance Related and Addictive Disorders
Psychiatry and Society

Integrated Care Programs

HealthCare Financing Seminar on Healthcare Reform and Integrated Care

Department of CME provided CME credit for a Fall 2013 seminar developed by the APA Department of Healthcare Financing that brought representatives of District Branches up-to-date on this topic. District Branches were encouraged to present the seminar curriculum to their members at local meetings. Several District Branches who participate in the APA Joint Sponsorship program presented the information from the seminar at their own District Branch events.

FOCUS. Psychosomatic Medicine and Integrated Care. Fall 2013, Vol. 11, No. 4

The Fall 2013 issue of FOCUS covered the topic of Psychosomatic Medicine and Integrated Care from a clinical view point for the general psychiatrist. Guest Editor Deane Wolcott M.D., Topics included Process of Psychiatric Consultation in the Medical Setting; Psychopharmacologic Treatment of Depression in Patients with Cancer; Supportive Oncology: New Models for the Role of Psychiatry in Cancer Care; Collaborative Care Models for Comorbid Medical and Behavioral Health Conditions. Ethical Issues in Psychosomatic Medicine; and Effective Interprofessional Collaboration in Health Care Teams.

Primary Care Updates for Psychiatrists – Presented at IPS and developed as an Online Course November 2013 (free, up to 4 credits) 263 people completed this course online. Chair, Lori Raney M.D., with presentations by dual-boarded med-pysch physicians in the field. The course consists of slides plus audio presentations recorded at the APA Institute for Psychiatric Services, October 2013.

Basic Preventive Medicine
Diabetes
High Blood Pressure
Dyslipidemias
Smoking Cessation
Interactive Case Discussion

Integrated Care Track at 2014 Annual Meeting

Advances in Medicine
Top 10 Medical Stories 2013: A Comprehensive and Practical Review of What We Need to Know
Medical Mysteries and Practical Med Psych Updates: Is It 'Medical', 'Psychiatric' or a Little of Both...?
Course: The Integration of Primary Care and Behavioral Health: Practical Skills for the Consulting Psychiatrist
Interactive Session: Integrated Care Models: The Development of Collaborative Care
Presidential Symposia:
Epidemiology and Treatment of Patients With Comorbid Psychiatric and Medical Illness
Collaborative Care: New Opportunities for Psychiatrists
Scientific and Clinical Report: Challenges in Integrating Medical Care Into a Community Mental Health Center
Seminar: Primary Care Skills for Psychiatrists
Symposia: Comorbidity of Depression and Diabetes: The Challenge and the Response
Workshops:
Risk Management and Liability Considerations in the Integrated Care Setting
Health and Wellness: A Holistic Approach to Treatment of Patients With Serious Mental Illness
Comprehensive Care for Patients With Medical and Psychiatric Comorbidity: A New Model of Care and Opportunity for Psychiatrists
Psychiatric Leadership in the Behavioral Health Home
Interdisciplinary Treatment Team: A Psychodynamic Systems Approach

REPORT: American Association of Directors of Psychiatric Residency Training (AADPRT) – Dr. Chris Varley reported on the following AADPRT programs and initiatives.

ACGME/RC LIAISON: General Psychiatry joined Phase II of the ACGME Next Accreditation System on July 1, 2014. There have been already many questions re the practical implementation of the Milestones and AADPRT is working closely with the ACGME to clarify policies in a clear and timely manner. They have participated in the Work Groups with Dr. Varley as a member of the overall Advisory Group and key AADPRT members in each of the Work Groups to define Milestones for each of the Psychiatry Subspecialties. A draft has been submitted to the field for comment with a plan to finalize them by December, 2014, in anticipation of starting them July 1, 2015. AADPRT has responded to the proposed changes in the ACGME psychiatry and child and adolescent program requirements.

APA AD HOC WORK GROUP ON TRAINING AND EDUCATION: AADPRT is looking forward to participating in this important initiative. Dr. Varley is the AADPRT representative, with the intent to solicit broad input

from their organization. This initiative is especially timely in light of the recent Institute of Medicine report on Graduate Medical Education which includes recommendations that may challenge funding in graduate education in psychiatry.

AADPRT at the APA meeting: AADPRT has again been invited to present a symposium at the 2015 APA Annual Meeting which has been enthusiastically accepted. Adrienne Bentman, MD, AADPRT past president, is coordinating the presentation with participation from the organization's president and several past presidents.

AADPRT ANNUAL MEETING 2015: The 44th annual meeting will be held in Orlando, Florida on March 5 - 7, 2015 with the related BRAIN conference on March 4. Sandra DeJong, MD is the program chair. A theme and plenary speakers have been identified.

ADMINISTRATIVE DIRECTOR: There was a major personnel change in AADPRT this year with the appointment of Sara Stramel - Brewer as Administrative Director in May, 2014. AADPRT wishes to formally welcome Sara.

REPORT: Association for Academic Psychiatry (AAP) – Dr. John Luo reported on the following AAP programs and initiatives:

The 2014 Annual meeting September 17-20, 2014 in Portland, OR
Meeting theme is 'Accountable Education Across the Continuum', President Jon Lehrmann, MD

The 2015 Annual meeting September 16-19, Hyatt Regency San Antonio, San Antonio, TX
Meeting theme is 'New Releases and Classic Vintages for the Educator's Palate', President John Luo, MD
Workshop solicitations will be sent in October 2014

- Plenary Session TBD
- Master Educator program theme TBD
- Plan for 1 joint AAP-AADPRT session
- Plan for 1 joint AAP-AACDP session
- Mentorship Breakfast
- CV Boot Camp

AAP continues its endeavors in these primary areas:

- Mentorship
- Career development
- Collaboration
- Diversity

AAP is working on several initiatives

- Leadership development
- Improving educational offerings throughout the year
- Sponsoring educational workshops with allied organizations such as APA, AADPRT, ADMSEP, etc.
- Upgrading website to include more materials for members
- Added leadership position of communications director

REPORT: American Board of Psychiatry and Neurology (ABPN) - Dr. Faulkner was unable to attend but sent his report.

New ABPN Director - Dr. Joan Anzia from Northwestern University was elected to replace Dr. Barbara Schneidman on January 1, 2015.

International Examinations - The first ABPN Singapore Examinations was successfully administered on August 2, 2014. The ABPN voted to support the proposal for the ABMS-I program involving the Middle East consortium (Qatar).

Certification Fees - Candidate certification fees were decreased by 12% in 2008 (No increase in 2006, 2007, 2009, 2010, 2011, or 2012), were decreased another 10% in 2013 and another 7% in 2014, and will remain the same in 2015.

ABPN Office Building - The ABPN approved the formation of a Task Force to proceed with the planning process for the construction of an ABPN office building.

Combined Training - The ABPN established a Combined Program Oversight Committee to develop policies and procedures for the approval and review of combined training programs and to update guidelines for existing combined programs. Once developed, policies, procedures, and recommended guideline changes will be shared with other relevant Member Boards (ABFM, ABPeds, ABIM) for their feedback.

Requirements to Re-issue Invalidated Certificates - diplomates who have had restrictions placed upon their medical licenses and thus had their ABPN certification invalidated must now fulfill specific requirements to have their certificates reissued:

- Have all of their medical license restrictions removed (rare exceptions)
- 24 Self-assessment CME credits
- 90 CME Category 1 credits
- 1 PIP Unit (Clinical and Feedback Modules)
- Completion of patient safety requirements
- Passing score on the MOC Examination

"Board Eligibility"

- Graduates of ACGME-accredited or ABPN-approved residencies have 7 years to become board certified.
- Began January 1, 2012
- Must meet all ABPN credentialing requirements
- Graduates of residencies prior to January 1, 2012 will have until January 1, 2019 to become to become board certified.
- If the deadlines for certification are not met, additional credentialing requirements must be fulfilled again to become eligible.
- 90 CME Category 1 credits
- 24 Self-assessment CME credits (can count toward the required 90 CME
- Credits)
- 1 PIP Unit
- Repeated in-residency evaluations
- Patient safety requirements

ABPN Statement on Professionalism - the ABPN adopted the following statement on professionalism: *"Professionalism forms the basis of medicine's contract with society. The ABPN is concerned with those aspects of professionalism that are demonstrated through a physician's clinical competence, commitment to lifelong learning and professional improvement, interpersonal skills, and ethical understanding and behavior. In its credentialing, certification, and MOC programs, the ABPN seeks to assess and document that its candidates and diplomates possess and maintain these aspects of professionalism."*

Continuous MOC Program - Began for diplomates certified or recertified in 2012 with no end date on certificate. Requirements for Continuous MOC:

- Unrestricted medical license(s)
- Cognitive examination every 10 years
- Specific MOC activities every 3 years
- 24 CME hours of Self-assessment activities
- 90 CME hours (includes the 24 SA CME)
- 1 PIP Unit (Clinical and Feedback Modules)
- Annual registration on the ABPN Folio.
- Annual MOC fee ($175 for 2014).
- No additional fee for one MOC cognitive examination in 10 years.

Reporting Diplomate MOC Status - beginning in 2012, all ABPN diplomates were reported as one of the following:

- "Meeting MOC Requirements"
- "Not Meeting MOC Requirements"
- "Not Meeting MOC Requirements and Not Required To Do So" (for "life- time" certificate holders)

MOC Credit for Diplomate Activities - "Meaningful participation" in the ABMS Portfolio Program (1 PIP credit). Completion of ACGME-accredited subspecialty fellowship and passing ABPN subspecialty examination (3 years of MOC credit). Participating in institutional QI activities that fulfill ABPN MOC Part 4 requirements.

ABPN Non-CME Self-assessment Activities - ABPN diplomates may now have 8 SA CME credits waived for completing one of the following activities:

- Certification/MOC examination
- Peer reviewed grant
- Peer reviewed paper
- Non-CME patient safety SA
- Peer supervision (4 hours)
- Peer review

A maximum of 16 SA CME credits may be waived every 3 years.

ABPN MOC Feedback Requirements - ABPN diplomates may now choose one of the following types of Feedback Modules they want to complete every 3 years (*Must include at least 5 evaluators):

- Patient Surveys (at least 5 patients selected by diplomate)
- Peer Surveys (of General Competencies)*
- Institutional Peer Review (of General Competencies)*
- Supervisor Evaluation (of General Competencies)

- Resident Evaluations (of General Competencies)*
- 360˚ Evaluation (of General Competencies)*

ABPN Patient Safety Course Requirements - part of the 2015 ABMS MOC Standards.

- Begins for diplomates certified or recertified in 2016.
- Diplomates must complete an ABPN-approved Patient Safety Course prior to certification or in the first 3-year period of the Continuous MOC Program.
- Patient Safety Courses must include didactic information, questions, and performance feedback.
- Must include Required Topics and Optional Topics (See ABPN website).
- May or may not earn CME credits.
- Non-CME Patient Safety Courses must be developed and give by accredited institutions (e.g., hospitals, clinics, training programs).

ABPN Faculty Fellowship - the ABPN established a new Faculty Fellowship Program to promote innovative education and/or evaluation initiatives for psychiatry and neurology residents or practitioners. Four psychiatry and four neurology faculty will be supported per year. Each ABPN Fellow will receive $50,000 per year for two years. The first four ABPN Faculty Fellows were selected for 2014, and applications for 2015 will be reviewed in October.

ABPN Senior Resident Administrative Fellowship - the ABPN established a Senior Resident Administrative Fellowship for one senior psychiatry resident and one senior neurology resident each year. Fellows will spend three months at the ABPN office under the direct supervision of the President and CEO and will learn about the structure and function of the ABPN, complete a research project of their choice, participate in a weekly administrative seminar, and accompany the President and CEO to professional meetings. Salary (if necessary) and living and travel expenses will be paid by the ABPN. The first ABPN Fellows were selected for the 2014-2015 year and applications for 2015-2016 will be reviewed in December.

ABPN Crucial Issues Forums - the ABPN decided to fund a series of Crucial Issues Forums during which representatives from various professional organizations and perspectives will discuss important issues pertinent to the ABPN. The first ABPN Crucial Issues Forum on Subspecialties was held on April 6-7, 2014. An ABPN Crucial Issues Forum on Resident Competence Requirements will be held on May 3-4, 2015.

REPORT: Association of Directors of Medical School Education in Psychiatry (ADMSEP) – Dr. Dube reported on behalf of Dr. Nutan.Vaidya who was unable to attend.

Mission and Overview - ADMSEP's mission is to champion excellence in medical student psychiatric education. Our members range from individual preceptors to course directors who are involved in education across the four years of the medical school curriculum, from behavioral science courses to psychiatry clerkships, 4th year electives, and career advising. We currently have 173 Active members, 2 Emeritus members, 30 Clerkship Administrator members, and 16 House Officer members, representing 99 LCME-accredited medical schools.

Professional Development - Supporting our members' professional development is a long-standing focus of ADMSEP.

1. For the past several years our annual meeting has been preceded by a pre- meeting "Toolkit for Early Educators," which is aimed specifically at junior faculty.

2. This year we graduated first class of our education scholars program intended for middle career faculty. The Education Scholars Program consists of a 2-year sequence of workshops on-site during ADMSEP annual meetings as well as ongoing one-on-one mentoring with the goals of developing participants' skills in the area of educational research and completing individual scholarly projects. Four members completed the program and 5 started their first year at the 2014 meeting.

3. On-going committees and task forces focusing on other aspects of our members' professional development include the Awards Committee, Research and Scholarship Committee, Membership Committee, Milestones Task Force, Clinical Simulation Initiative Task Force, and Clerkship Administrators Task Force.

Curricular Innovation

ADMSEP also emphasizes the sharing of innovative teaching and assessment strategies.

1. The Clinical Simulation Initiative (CSI) Task Force is charged with developing online case-based learning modules to provide a database for use in teaching Psychiatry to medical students. The CSI Task Force has completed 9 peer-reviewed modules (eight of which are published on MedEdPORTAL), with several more in progress. An ADMSEP Editorial Board was initially providing peer review for posting on this website and consideration for online publication by MedEdPORTAL. This has since been discontinued in lieu of using MedEdPORTAL's editorial process because many of the same individuals are reviewers for MedEdPORTAL.

2. ADMSEP also fosters research in education by giving ADMSEP Research & Scholarship Grant to its members. This year Drs. Jonni Gerkin and Erin Malloy received the grant.

Liaisons

ADMSEP continues values its relationships with other educational organizations.

1. Within psychiatry we liaison with other sister organizations such as AACDP, AADPRT, and AAP and medical student organization PsychSIGN .We are also sponsoring organization of Academic Psychiatry.

2. ADMSEP continues to be involved with the Alliance for Clinical Education (ACE), the multidisciplinary group comprised of representatives from each specialty group's medical student education association. We have consistently been represented on the ACE panel presentations at AAMC. This year the panel will be presenting on "Student Mistreatment".

3. We are also participating in APA's Ad Hoc Work Group on Education and Training. Dr. Greg Briscoe ADMSEP Secretary/Newsletter Editor and webmaster is representing ADMSEP on this important Project

Annual Meeting

ADMSEP members come together every June for our annual meeting, which nourishes and energizes participants in a particularly warm and collegial atmosphere.

1. Our most recent meeting in Keystone Resort Colorado had 143 registered participants and featured a keynote address by Dee Fink PhD, a nationally and internationally recognized consultant on higher education and faculty development.

2. During our annual meeting we had a change in officers. Dr. Nutan Vaidya is President for 2014-2015, Dr. Brenda Roman is President Elect and Dr. Greg Briscoe is Secretary/Newsletter Editor . We also have 2 new councilors Dr. Howard Lu and Dr. Benoit Dubé.

3. Our 2015 meeting will take place in StoweFlake Mountain Resort in Vermont on June 18-20, 2015.

REPORT: Psychiatry Student Interest Group Network (PsychSIGN)– Robert Rymowicz, current PsychSIGN President, gave the current programs and initiatives from this student group:

- Working on getting higher membership and establishing clubs in areas that are currently inactive.
- National membership database being established
- Residency Fair at 2014 Annual meeting was a success
- Reaching out to organizations that have no affiliation to PsychSIGN or psychiatry
- Areas of concern from current leadership: website issues, funding for their regional meetings, accepting outside financial sponsorship and management of funds.
- They further requested that a permanent member be assigned as faculty liaison.

A workgroup was formed with ADMSEP and other Council members to discuss:

- Becoming automatic member of PsychSIGN with APA membership
- Funding
- Travel awards
- Encouraging APA membership
- Permanent APA member as liaison

Addressing the Shortage of Psychiatrists with Sources of Funding (ASMMAY1412.M) - The action paper asks: That the Assembly and the Board of Trustees create a task force, or designate an APA component to create such a task force, to investigate the feasibility of the establishment of scholarship funds or other means of reducing debt for qualified students who will commit themselves to completing a psychiatry residency and who might, for example, agree to practice as a psychiatrist for a defined number of years in an underserved area.

The JRC referred the action paper to CMELL and requested that they discuss the pros and cons of the action paper and present the JRC with recommendations for action (with rationale) for their Joint meeting in January 2015. The Council was asked to confer with the American Psychiatric Foundation about the potential for obtaining outside funding.

The Council supports the spirit of the Action Paper especially the mal-distribution of psychiatry in underserved areas. However, the Council questions whether the funding for this type of program should come from the APA or the Foundation. Federally-funded programs already exist that addresses the AP author request (psychiatry practice in an underserved area of a specific number of years.)

- National Health Service Corps http://www.psychiatry.org/practice/professional-interests/underserved-communities/national-health-service-corps

- NIH Loan Repayment Program for clinical research http://www.lrp.nih.gov/about_the_programs/intramural/Introduction.aspx
- State loan repayment and/or forgiveness scholarship programs (maintained by the AAMC) - https://services.aamc.org/fed_loan_pub/index.cfm?fuseaction=public.welcome&CFID=7563505

The Council believes in advocating for creation of more federal reimbursement programs and refers this to the Council on Advocacy. However, if the American Psychiatric Foundation were to identify and obtain outside funding for scholarships, the Council will support this as well.

IOM Report on GME Funding – Dr. Jed Magen wrote a thoughtful analysis of the report which was reviewed by the Council prior to this meeting (attached to the minutes.)

The Council believes that more discussion is necessary and that a conference call will be scheduled in 2-3 months and invite staff from with Advocacy, Health Care Systems and Finance.

Position Statement Review: "Consistent Treatment of all Applicants for State Medical Licensure" – the Council was asked to review the position statement on "Consistent Treatment of All Applicants for State Medical Licensure" and make recommendations to retain, revise, retire the statement.

The statement, approved by the Board of Trustees on July 2008, reads as follows:

The APA fully endorses the need for an equitable, fair and consistent treatment for those applicants who graduated from medical school in the state they are applying, graduated from a school in another state or graduated from a school in another country.

The Council would like to get the background information on the creation of this Position Statement prior to making a decision.

Jeanne Spurlock Minority Fellowship Achievement Award 2015 – the Council reviewed and voted to approve the selection of Dr. Sheryl Kataoka as the 2015 recipient of the Jeanne Spurlock Minority Fellowship Achievement Award. The award recognizes the outstanding achievements of former fellows of the APA Minority Fellowships Program (APA/NIMH, APA/CMHS, APA/SAMHSA, APA/AstraZeneca or Diversity Leadership fellows). It also encourages continued involvement in the fellowship program.

This award will be presented to an alumnae/alumni of the minority fellowships who has made (or is making) significant contribution(s) to psychiatry and/or commitment to serve minority and underserved populations.

New Business

Discount for Residents at Annual Meeting Courses
Requested offering discounts for RFMs at Annual Meeting courses

- 50% discount for RFMs to buy ticket for course on the day of the course only (of seats are still available)
- Need to better advertise this opportunity
- Will refer this issue to next Division Director and have him/her come up with a proposal to submit to the SPC

Resident Suicide

The discussion was brought upon by recent resident suicides in New York City. It was suggested that support for trainees be available such as access to counseling. A Work Group was formed to study this issue and any recommendations for APA action.

Work Groups Formed:

- Use of DSM5- Educational and Intellectual Property Concerns
    - Art (Chair)
    - Sarah
    - Lisette
    - Annelle
    - APPI staff (Becky Rinehart)
    - Kristen (staff)

- Addiction Psychiatry Curriculum (collaboration with Council on Addiction Psychiatry)
    - Sarah
    - Juliet

- Health Care Reform (collaboration with Council on Psychosomatic Medicine)
    - Rick

- CME and MOC
    - Mark
    - Mindy
    - Kristen (staff)

- PsychSIGN Support
    - Benoit
    - Elizabeth
    - Marcy
    - Robert
    - Rashad
    - Nancy

- Resident Suicide
    - Lisa
    - Alicia
    - Marcy
    - Vera
    - Kara
    - Jose

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Committee

Executive Summary
Council on Minority Mental Health and Health Disparities

Council Overview

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

Action Items

None

Referrals

- **BOT Work Group on Health Care Reform Recommendations**. A subgroup of council members and fellows (Drs. Lu, Petersen, and Mangurian) was formed to review the recommendations made in the report by the Board Work Group on Health Care Reform and the Role of Psychiatry. This subgroup will report its findings to council within the week. The Board work group's current recommendations rarely mention diverse populations and this is a serious concern for the council. Healthcare reform has to result in systems that are relevant to the intended user. Diversity issues in workforce are also not addressed. Leadership roles for psychiatrists in integrated patient care settings need more emphasis. NB: the council subsequently submitted extended commentary to Yoshie Davidson.
- **Resource documents on human trafficking** (ASMMAY1312.Q) and **on rape** (ASMNOV1212.U) – final editing is in progress.
- **Position Statement on Violence Against Sikh Americans** (ASMNOV1312.F). The council struggled with the Assembly's request for a position statement addressing a particular group or groups of people as targets of discrimination, specifically violence against Sikh Americans. There was a difference of opinion among council members with regard to whether to put this statement forward or not doing so and writing a more inclusive statement. The council acknowledged that unfortunately, there will likely be a need for taking a position against discrimination and violence against successive groups who may be current and future targets of such crimes. The council resolved that more time is needed to work through this issue.
- **Five-Year Review of Position Statements.** The council reviewed several slightly dated position statements for timeliness and recommended that the following be **retained**:
    1. Abortion & Women's Reproductive Health Care Rights
    2. Xenophobia, Immigration and Mental Health
    3. Sexual Harassment
    4. Right to Privacy

The council formed work groups to review and recommend revisions for the following older position statements: bias related incidents, diversity, psychiatrists from underrepresented groups in leadership, and affirmative action. The council also will review the APA position statement on domestic violence from a diversity perspective in light of the overrepresentation of black male faces in recent media stories about domestic violence.

Council on Minority Mental Health and Health Disparities
September 12-13, 2014

MEETING MINUTES

Attendance:
Members:
Drs. Sandra Walker (chairperson), Brian Benton Ludmila DeFaria, Helena Hansen, Christina Mangurian, Dinesh Mittal, Nyapati Rao, Jose Vito, Donald Williams, Edmond Pi, and Francis Lu

Resident Fellows:
Drs. Aaron Clark, Stacia Mills, Pamela Montano, Jared Taylor, Daena Petersen, Roberto Montenegro, Annabelle Simpson, Willie Siu, and Paula Smith

Guests:
Drs. Paul Summergrad, Saul Levin, Renee Binder, Altha Stewart, Gabrielle Shapiro; Carmen Head

APA Administration:
Dr. Annelle Primm, Kristin Kroeger, Alison Bondurant and Kiondra Broadway

After introductions and disclosures notices (no conflicts), Dr. Walker opening the meeting by reviewing the charge of the council and encouraging members to reach out to their allied organizations and the APA MUR Caucuses for liaison purposes

Guest visitors

- Dr. Summergrad emphasized that diversity is key in his administration. The Board is clear that APA needs representation and that evidence of change in real and concrete ways is in store. He called on the council to continually help him realize his goals.
- Dr. Levin thanked the council for input regarding the development of the position description for the Director of the Division of Diversity and Health Equity (DDHE). He updated the council on the search to date, which he hopes to conclude in November. He indicated that a cultural issues tab on the APA website is being researched but stressed that all APA departments should be looking at diversity and health equity issues. Dr. Levin also invited council to identify tags or keywords for APA diversity-related documents in order to heighten the precision of APA's new online policy finder. He congratulated council member Dr. Pi for being a candidate for office in the World Psychiatric Association's upcoming election.
- Dr. Binder described two of her most important presidential priorities, that of diversifying leadership in the APA and fighting stigma, adding that Jason Young, APA's new Chief of Communications, is passionate about this issue. She urged council members to contact her directly about any issue of concern.
- Carmen Head, AACAP Director, Research, Training & Education, would like to strengthen partnerships between AACAP and other mental health and legal groups around issues of culture and diversity. She added that AACAP is planning a conference on minority children and in doing so wants to channel resources across disciplines. She welcomed the idea of working with the council in this regard.

- Gabrielle Shapiro, from the Council on Children, Adolescents and Their Families, informed council of a group called Urban Strategies wanting psychiatric volunteers to do assessments on unaccompanied Latino children in the immigration system. She asked interested members of the council to contact her offline for more information. Dr. DeFaria volunteered to promote this topic on the Women's Caucus listserve.
- Kristen Kroeger introduced herself and reviewed her role and responsibilities as Chief of APA Policies, Programs and Partnerships. She offered her assistance to the council whenever needed.
- Altha Stewart is working with the Board on APA strategic planning around a diversity mental health initiative. APA is working on being intentional about diversity across multiple levels. She requested that the council share ideas with APA leadership and to take a personal challenge to find out from colleagues who are not APA members what would make them join the association. She concluded by noting that she will chair a symposium at the IPS on the impacts of the civil rights movement on psychiatry.

JRC REFERRAL/Health Care Reform Recommendations. A subgroup of council members and fellows (Drs. Lu, Petersen, and Mangurian) was formed to review the recommendations made in the report by the Board Work Group on Health Care Reform and the Role of Psychiatry. This subgroup will report its findings to council within the week. The Board work group's current recommendations rarely mention diverse populations and this is a serious concern for the council. Healthcare reform has to result in systems that are relevant to the intended user. Diversity issues in workforce are also not addressed. Leadership roles for psychiatrists in integrated patient care settings need more emphasis.

DDHE Update. Dr. Primm gave an update on the many DDHE activities of late, including but not limited to: the inauguration of Diversity Mental Health Month in July; the search for new DDHE Director in which she is involved; and the production of a short video highlighting the October 2013 IPS session on "Tuskegee to Trayvon," and the initiation of a several faith/mental health collaborative projects. Dr. Primm mentioned a proposal to establish an APA ECP Asian American psychiatrist research fellowship, supported by a gift from the Otsuka family who has designated the funds for this purpose. Some on the council felt that singling out one racial group like this contributes to structural discrimination (to the extent that some groups lack the wealth to underwrite such lucrative propositions).

APA MUR Caucuses. Dr. DeFaria, the council's liaison from the Women's Caucus, conveyed that caucus's resistance to the Hispanic and Black Caucus restrictive membership rule. Those council members who concurred formed a work group to look at mechanisms for inclusion of members who identify as affiliated with MUR groups but who do not want to identify with only one caucus. Some on the council also disagreed with the practice that only registered members of MUR caucuses may vote for the MUR Board Trustee, believing that all APA members should vote. They cited the fact that there may be members from MUR groups who do not belong to a caucus but may want to have a say. The work group will share the concerns with caucus leaders and report back to the council in May. Dr. DeFaria will bring this forward at the November meeting of the Assembly MUR Committee. (The work group is comprised of Drs. Mangurian, Petersen, Mills, DeFaria, and Vito.)

IMG Summit. Dr. Rao reported that the May IMG Summit in New York identified several workforce issues that the APA has to deal with: closing of the pipeline for new IMGs; decline in

interest of IMGs in practice and further training in the US which is now perceived as inhospitable; impact on the delivery of care with declining numbers of IMG clinicians; and xenophobic stereotypes of IMGs. The presentations will be published in an international journal if the APA consents to such use of its work product. Dr. Rao added that he would like to work with the new government relations chief around advocacy for IMG workforce concerns. Dr. Primm pointed out that APA commented about IMG issues in its comments to the IOM Report on the Future of GME Financing.

JRC REFERRAL/Position Statement on Violence Against Sikh Americans. The council reviewed the latest draft of this position statement and the background document. The council struggled with the Assembly's request for a position statement addressing a particular group or groups of people as targets of discrimination, specifically violence against Sikh Americans. There was a difference of opinion with regard to whether to put this statement forward or not doing so and writing a more inclusive statement. The council acknowledged that unfortunately, there will likely be a need for taking a position against discrimination and violence against successive groups who may be current and future targets of such crimes. The council considered hyperlinking this position statement/background on violence against Sikhs to other topic-related position statements including the statement on bias related incidents, the statement on xenophobia, immigration and mental health, and the statement on racism and racial discrimination and its adverse effects on mental health. The council resolved that more time is needed to work through this issue.

JRC REFERRAL/Five-Year Review of Position Statements. The council reviewed several slightly dated position statements for relevancy and recommended that the following be retained: abortion, xenophobia, sexual harassment, and the right to privacy. The council formed work groups to review and recommend revisions for the following older position statements: bias related incidents, diversity, psychiatrists from underrepresented groups in leadership, and affirmative action. The council will review the APA position statement on domestic violence from a diversity perspective in light of the overrepresentation of black male faces in recent media stories about domestic violence.

JRC REFERRAL. The rape and human trafficking resource documents are currently in draft form. Dr. DeFaria, coordinator of these papers, asked the council to suggest edits in time for the anticipated submission of the documents to JRC on September 24.

Cultural Psychiatry Clearinghouse/APA Website. Dr. Walker reported on Dr. Sakauye's behalf that the work group had been challenged to populate the inaugural clearinghouse of cultural psychiatry training resources. More than that, the work group realized that the upkeep of the clearinghouse will be substantial. Upon learning that the APA website is being revamped, the council decided to table this effort. There was agreement to assist in efforts to identify keywords to attach to diversity-related material on the website in order to improve search capacity. Dr. Primm added that the website-is moving toward development of products and tools that the average member can use in their practice, such as clinical toolkits. Ms. Bondurant asked council to assess current diversity-related content on the web in this regard and to think about better and more suitable resources for our members. A suggestion was made that APA consider posting resources about specific communities applicable to each district branch.

Other Discussion

- Dr. Rao requested that APA support his nomination to the Board of the Educational Commission for Foreign Medical Graduates. Staff will seek advisement from the CEO's office.
- Dr. DeFaria announced that she is co-chairing a work group with Dr. Stephen McLeod-Bryant to set up a national mentor network for MUR ECPs as a mechanism to develop leaders. She is seeking participation from potential mentors and mentees. Newly assigned RFMs on the council were encouraged to connect with council members for mentoring, with Dr. Walker reminding everyone to attend the evening's MFP Minority Mentors Network reception.
- The council is considering requesting a budget increase to pay for internet access during meetings. At this meeting Francis Lu allowed 10 people to connect to the internet through his personal hot spot.
- Dr. Lu recalled the training he and Russell Lim gave last spring at AADPRT on cultural issues in DSM5. Publication in Academic Psychiatry is anticipated. RFM Stacia Mills reported that she had adapted the training for residents and presented the material to residents at her institution. She also will be presenting a poster on the subject at the Black Psychiatrists of American meeting in Barbados. RFM Aaron Clark is presenting it to residents at his institution. Other sites are anticipated.
- Council approved the nominations for the 2015 Bolivar, Fuller, Tarjan, Pfister, Symonds and Soo Awards. Ms. Bondurant reported that the Fryer Award committee will be submitting its selection in a few days. Dr. Walker advised the group that the names are confidential until the Board vets the nominations in December. Dr. Rao expressed concern over the few nominations received for the Tarjan Award.

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.

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.

Position Statement on Sexual Harassment

Approved by the Board of Trustees, June 1992
Approved by the Assembly, May 1992
Reaffirmed, 2007

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

The APA opposes and condemns all forms of harassment in the workplace; and further votes to advocate and lobby for legislative and judicial action to recognize and facilitate any necessary treatment for victims of workplace harassment.

Position Statement on the Right to Privacy

This statement was proposed by the Committee on Gay, Lesbian, and Bisexual Issues[1] *of the Council on National Affairs. It was approved by the Assembly of District Branches in November 1991 and by the Board of Trustees in December 1991.*

The American Psychiatric Association supports the right to privacy in matters such as birth control, reproductive choice, and adult consensual sexual relations conducted in private, and it supports legislative, judicial, and regulatory efforts to protect and guarantee this right.

[1] The members of the Committee on Gay, Lesbian, and Bisexual Issues are Richard A. Isay, M.D. (chairperson), Margery Sved, M.D., Rochelle L. Klinger, M.D., Robert M. Kertzner, M.D., Debbie Rene Carter, M.D., Kenneth Ashley, M.D. (APA/NIMH Fellow), and Robert P. Cabaj, M.D. (Assembly liaison and corresponding member).

Inquiries about Diagnosis and Treatment of Mental Disorders in Connection with Professional Credentialing and Licensing

Position Statement

The APA recognizes the important role served by licensing boards, institutional privileging committees, insurance credentialing panels, and other entities charged with protecting the public from impaired physicians, attorneys, and other licensees. In discharging their responsibilities, these entities legitimately may inquire about current functional impairment in professional conduct and, when relevant, current general medical or mental disorders that may be associated with such impairment. However, the APA believes that prior diagnosis and treatment of a mental disorder are, *per se*, not relevant to the question of current impairment and that oversight entities should not include questions about past diagnosis and treatment of a mental disorder as a component of a general screening inquiry.

The APA recommends the following principles to guide licensing boards and other regulatory agencies, and training programs.

1. General screening inquiries about past diagnosis and treatment of mental disorders are overbroad and discriminatory and should be avoided altogether. A past history of work impairment, but not a report of past treatment or leaves of absence, may be requested.

2. The salient concern for licensing entities is always the professional's current capacity to function and/or current functional impairment. Questions on application forms should inquire only about the conditions that currently impair the applicant's capacity to function as a licensee, and that are relevant to present practice. As examples of questions that might be asked, the following are suggested:

> Question: Are you currently using narcotics, drugs, or intoxicating liquors to such an extent that your ability to practice [law / medicine / other profession] in a competent, ethical and professional manner would be impaired? (Yes/No)
>
> Question: Are you currently suffering from any condition that impairs your judgment or that would otherwise adversely affect your ability to practice [law / medicine / other profession] in a competent, ethical and professional manner? (Yes/No)

3. If a relevant impairment of functioning has been acknowledged by the applicant or documented by other sources, inquiries about mental health treatment may be appropriate for the sole purpose of understanding current functioning and future performance.

4. If conduct that would otherwise provide grounds for denial or revocation of a professional license or privileges has been documented or acknowledged by the applicant, it would also be appropriate to ask the applicant whether a disorder or condition was raised to explain that conduct.

5. Applicants must be informed of the potential for public disclosure of any information they provide on applications.

From the Council on Psychiatry and the Law. Written by Richard Bonnie, Paul Appelbaum, and Patricia Recupero.

Background

Professional licensing agencies have traditionally made wide-ranging inquiries into applicants' past psychiatric histories. Although the passage of the Americans with Disabilities Act in 1990 raised serious doubts about the legality of these inquiries, licensing agencies have been reluctant to abandon them, notwithstanding official statements disapproving them by the American Bar Association in 1994[1] and the American Psychiatric Association in 1997. The issue has recently received renewed attention in the press, in the legal literature and in the courts. Against this backdrop, the Department of Justice's Civil Rights Division launched a formal investigation of Louisiana's attorney licensure system in 2011, culminating in a settlement agreement in August, 2014.[2] The provisions of this agreement significantly clarify the position of the Justice Department regarding the scope and type of questions about mental health histories and current condition that may be used in professional licensing inquiries. In light of these developments, it is likely that responsible licensing and privileging agencies will be reconsidering their current practices. This Position Statement is designed to summarize the key principles that ought to guide these agencies as they review their questionnaires and protocols.

The APA's Position Statement is congruent, in principle, with the 1994 Resolution adopted on this subject by the American Bar Association, which states:

BE IT RESOLVED, That the American Bar Association recommends that when making character and fitness determinations for the purpose of bar admission, state and territorial bar examiners, in carrying out their responsibilities to the public to admit only qualified applicants worthy of the public trust, should consider the privacy concerns of bar admission applicants, tailor questions concerning mental health and treatment narrowly in order to elicit information about current fitness to practice law, and take steps to ensure that their processes do not discourage those who would benefit from seeking professional assistance with personal problems and issues of mental health from doing so.

BE IT FURTHER RESOLVED, That fitness determinations may include specific, targeted questions about an applicant's behavior, conduct or any current impairment of the applicant's ability to practice law.

The prefatory paragraph of the APA's Position Statement briefly reaffirms the basic anti-discrimination principle that lies at the heart of the ADA. Overly broad inquiries about past behavioral health treatment discriminate against applicants by: making overbroad and unwarranted inquiries regarding applicants' behavioral health diagnoses and treatment; subjecting applicants to burdensome supplemental investigations triggered by their behavioral health status or treatment; making unwarranted licensure or admissions recommendations based on stereotypes of persons with disabilities; imposing additional financial burdens on people with disabilities; failing to provide adequate confidentiality protections during the licensing or admissions process; and implementing burdensome, intrusive, and unnecessary conditions on licensure or admissions that are improperly based on individuals' behavioral health diagnoses or treatment.

The APA's Position Statement enunciates 5 principles:

- The first principle declares that open-ended inquiries about past mental health diagnosis and treatment, or proxy questions pertaining to leaves of absence, are unacceptable. The DOJ-Louisiana Settlement Agreement acknowledges this principle.

- The second principle declares that inquiries about the person's current mental and physical condition are acceptable if and only if they relate to the person's current capacity to carry out professional functions. The illustrative questions are similar to the questions used by the National Conference of Bar Examiners and were specifically endorsed in the DOJ-Louisiana Settlement Agreement. The meaning of "current" condition is not defined in the Settlement Agreement or the APA Position Statement.

- The third and fourth principles are designed to address the limited circumstances under which licensing agencies may inquire about past mental health history and treatment. They may do so only when they are exploring the current and future significance of past impairments of functioning or misconduct documented in the record or acknowledged by the applicant. The kinds of questions that would be compatible with these principles are illustrated in paragraph 14 of the DOJ-Louisiana Settlement Agreement which specifically endorses question 27 on the National Conference of Bar Examiners questionnaire:

  27. Within the past five years, have you engaged in any conduct that:

  (1) resulted in an arrest, discipline, sanction or warning;
  (2) resulted in termination or suspension from school or employment;
  (3) resulted in loss or suspension of any license;
  (4) resulted in any inquiry, any investigation, or any administrative or judicial proceeding by an employer, educational institution, government agency, professional organization, or licensing authority, or in connection with an employment disciplinary or termination procedure; or
  (5) endangered the safety of others, breached fiduciary obligations, or constituted a violation of workplace or academic conduct rules?

  If so, provide a complete explanation and include all defenses or claims that you offered in mitigation or as an explanation for your conduct.

- The fifth principle is designed to assure that applicants are advised of the circumstances under which information obtained during the agency's inquiry are accessible to the public

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[1] ABA Bar Admissions Resolution, 18 Mental and Physical Disability Law Reporter 597 (1994)

[2]Settlement Agreement Between the United States of America and the Louisiana Supreme Court under the Americans with Disabilities Act, August 13, 2014, http://www.ada.gov/louisiana-supreme-court_sa.htm

Position Statement on Patient Access to Electronic Mental Health Records
Draft September 22, 2014
JRC Submission

Health care systems, including the Veterans Administration health care system, have begun to allow patients to access their treatment records online.

Systems that provide patients with online access to their mental health records must implement appropriate procedures. These include: (a) methods for ensuring that treating psychiatrists in the system are notified when their patients access their records, (b) methods for ensuring that information likely to result in harm to the patient or others will not be disclosed, (c) methods for ensuring that information provided in confidence by third parties will not be inadvertantly disclosed, (d) methods for facilitating patients' comprehension of disclosed information, and (e) methods for ensuring that current inpatients may only access their records in consultation with the attending psychiatrist.

Background

"Health records" refers to evaluations, progress notes, discharge summaries, and other clinical documentation that is created by health professionals for the purpose of evaluation and treatment for a specific patient. As established by law, patients have a right to access their health records.[1] The establishment of electronic medical records in some medical care systems has led to the availability of online access to personal medical records. This access has positive and negative implications.

Positive implications of access include:

[1] The HIPAA Privacy Rule provides an exception to patients' right to access for "psychotherapy notes." As defined by the Rule, psychotherapy notes are those notes made by mental health professionals documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. To qualify as psychotherapy notes, the documentation must exclude information regarding medication prescription and monitoring, counseling session start and stop times, the modalities of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. HIPAA-defined psychotherapy notes are not equivalent to psychotherapy progress notes - they are akin to process notes. State laws may grant patients the right to greater access; psychiatrists should familiarize themselves with the laws of their jurisdiction.

- A benefit to treatment by promoting active patient engagement. Ideally, patients will discuss questions about their care directly with their treating psychiatrist. Such discussions are important therapeutic opportunities that provide the psychiatrist with insight into their patients' hopes, fears, and concerns about their illness, treatment, and prognosis.
- A written source of information to patients about their care, rather than patients relying on their own memory of an office visit.
- An opportunity to improve accuracy of historical information.
- Facilitation of the transfer of information from a past treatment episode to a new treating clinician and facilitation of emergent or other care. Access by other treating physicians has been shown to be associated with fewer readmissions.
- When there is no ongoing treatment relationship with a facility, online access may provide information to individuals that helps them understand their health problems and, in some cases, prompt them to seek ongoing care.

Negative implications of access include:

- Potential for confusion or misinterpretation of documentation when patients read their records independently. Involvement of the treating clinician may be necessary to enable patients to understand the documentation and may reduce confusion. For example, the treating clinician can explain medical jargon and abbreviations and interpret the context in which medical information has been recorded. Confusion may also be lessened if the patient has ready access to online sources of information regarding psychiatric terminology and abbreviations commonly used in medical records.
- Electronic medical record systems with online portals may enable patients to access their medical records, including mental health records, on their own, in any location, and at any time. As a result, clinicians may not be aware that the patient has accessed their records, and the opportunity for a therapeutic exchange may be missed.

Concerns specific to mental health treatment

The nature of mental health problems increases the likelihood that emotionally charged topics will be raised in treatment and reflected in clinical documentation. Mental health treatment also includes assessment and treatment of disorders involving psychosis or other such findings by the clinician with which the patient may not yet agree. These mental health specific issues may amplify the previously described negative implications of access to records.

Medical records in institutional settings are more likely than those in private offices to contain a wider range of information from many writers, and possibly outside informants. The often wider range of sensitive information, varying styles of documentation, and material that could be provocative to the patient in hospital and

clinic settings, suggests that a higher threshold may be appropriate for allowing the patient unsupervised or non-redacted access to records in those settings.

Relative to other medical fields, third party information regarding the individual in treatment is more common in mental health treatment and may sometimes be provided to mental health professionals as a direct result of third party concerns about safety. Patients may read information provided in confidence by third parties. This may damage the therapeutic relationship or undermine family or other supportive relationships. In some cases, unanticipated disclosure may lead to patient distress or to problematic behavior toward third parties. A related concern is safety of mental health professionals, such as instances where patients have been violent towards clinicians. In these scenarios, there should be a mechanism to restrict patient access to records.

Given the probability that psychiatric inpatients are acutely ill, and that the information accessed will include recent notes by psychiatrists, nurses, and other staff that may be disturbing to patients during acutely symptomatic periods, immediate access should not be routinely granted. As psychiatrists and other treatment staff are readily available, access should be granted by clinical discretion and, when deemed necessary, under the supervision of treatment providers. In cases in which there are disputes about access, resolution via mechanisms such as patients' ombudsmen, offices of patients' rights, or similar bodies should be available.

If safeguards are not in place to prevent inappropriate access to information, clinicians may intentionally restrict the scope and detail of documentation to that which is minimally necessary. As a result, allied caregivers and subsequent treating psychiatrists may not have access to a rich record of treatment. This unintended outcome may be prevented by ensuring that electronic health records provide a mechanism to maintain highly sensitive information in a domain that is not generally accessible to patients through online access. Documenters need to be sensitive about language and clinical descriptions within their documentation. Additional education about patient-sensitive documentation may be necessary.

Developed by the Workgroup on Access to Mental Health Records, Council on Psychiatry and Law. Grace Lee, MD (Chair), Elizabeth Ford, MD, Mark Komrad, MD, Steven Daviss, MD, Andrea Stolar, MD, Jenny Boyer, MD, Richard Milone, MD, and Brenda Jensen, MD.

DRAFT STATEMENT

Position Statement on Segregation of Juveniles with Serious Mental Illness in Correctional Facilities

Juvenile detention and rehabilitation facilities sometimes use segregation for disciplinary or administrative reasons. The term "segregation" refers to conditions of confinement characterized by an incarcerated juvenile generally being locked in a cell for 23 hours or more per day without access to facility programming such as attending school or the opportunity to interact with others.

Segregation of detained juveniles with a serious mental illness should be avoided, with rare exceptions, due to potential emotional and developmental harm to the juvenile, including an increased risk of suicide in isolation. Efforts to avoid segregation, including behavioral treatment, psychotherapy, pharmacotherapy, and other developmentally appropriate interventions and efforts to identify and address precipitants to segregation should be proactively implemented.

Background

Approximately 100,000 juveniles are in custody on any given day (Sickmund 2005). Nearly 70% of female detainees and 60% of male detainees have a psychiatric disorder other than conduct disorder (Teplin et al. 2002). Approximately 3% of juveniles in detention have a psychotic illness and nearly 11% of boys and 29% of girls suffer from major depressive disorder (Fazel 2008). Incarcerated male juveniles have higher rates of self-harm behavior than the general adolescent community population (Chowanee et al. 1991) and approximately 50% of all juvenile suicides in confinement occur in some type of room confinement (e.g., time-out, isolation, or segregation) (Hayes 2009).

There are serious concerns regarding the potential impact of segregation on the mental health of detained youth. The rationale for segregation includes disciplinary placement and isolation from other inmates for administrative or protective reasons (Metzner et al. 2007). Placement of a juvenile with a serious mental illness in segregation can be contraindicated because of the potential for the juvenile to clinically deteriorate or not improve. Juveniles who are at high suicide risk or demonstrating active psychotic symptoms should not be placed in segregation and instead should be transferred to an acute psychiatric setting for stabilization. If there is a concern that segregation is a result of a serious mental illness, transfer to a mental health facility is strongly recommended.

The following principles should be observed when a juvenile with a serious mental illness is to be placed in segregation: 1. The juvenile should not be placed in segregation solely because the juvenile exhibits symptoms of a serious mental illness; 2. The juvenile who is placed in segregation must have access to psychiatric and medical services that meet the juvenile's medical and psychiatric needs; 3. The juvenile who is suffering from a psychiatric crisis, including psychosis, severe mood disturbance, or suicidality, should

be removed from segregation and will likely need transfer to a mental health facility. 4. The juvenile should be assessed on a regular basis by qualified mental health practitioners to identify and respond to emerging crises at the earliest possible moment. Correctional mental health authorities should work closely with administrative custody staff to maximize access to clinically indicated programming, including recreational and physical activities for these juveniles.

For the purposes of this position statement, the definition of serious mental illness (SMI) below closely parallels the definition of SMI included in the American Psychiatric Association's document titled "Psychiatric Services in Correctional Facilities" (American Psychiatric Association, Psychiatric Services in Correctional Facilities, in preparation) with the addition of disorders particularly relevant for detained children and adolescents.

In particular, psychiatric disorders that include psychotic symptoms, at least on an intermittent basis, are uniformly considered to meet criteria for SMI. Schizophrenia, schizoaffective disorder, and delusional disorder are examples of such serious mental illnesses. Other mental disorders, such as major depression, bipolar disorder, autistic spectrum disorder, and posttraumatic stress disorder, that result in serious distress or serious functional impairment, whether acute or chronic, almost always meet criteria for SMI. Some juveniles with cognitive disorders or adjustment disorders may meet criteria for SMI, either acutely or chronically, depending on the level of resulting functional impairment.

Clinical judgment must always be employed in determining the appropriate care for a juvenile whether or not they meet SMI criteria. In addition, a juvenile's development and maturity level should be considered in any decision that involves placement in segregation. Input from family members, when reasonably available, may provide an important source of information about potential behavioral intervention strategies that can serve as a successful alternative to administrative segregation.

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Psychiatric Services in Correctional Facilities

Council on Psychiatry and the Law, Work Group on Mental Illness and Criminal Justice

Third Edition
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The American Psychiatric Association Work Group to Revise the APA Guidelines on Psychiatric Services in Correctional Facilities

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PART 3 Special Applications of the Principles and Guidelines

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PREFACE

This document was a long time in the making. In the 15 years since the last edition, there has been an evolution in correctional mental health care, continued and increasing rates of incarceration of individuals with mental illness, ongoing criminalization of substance use disorders, and a lack of accessible and appropriate care in the community. The contributors to this document spent many hours in reviewing the issues, challenges, and concerns of correctional psychiatrists in this evolving field. We have worked to get input from multiple sources and perspectives. Given the challenging nature and scope of this endeavor, it may be surprising that so much of the content was reached with consensus support. I believe it also reflects the fact that the field itself is maturing.

Several items bear noting here. The first is the obvious change in the name from the second edition: no longer limited explicitly to just jails and prisons, but incorporating lock-ups and adult detention centers into the more global term of “Correctional Facilities.” This change reflects the Work Group’s belief that the Guidelines herein apply appropriately to all of these adult incarceration settings.

All of the sections were reviewed and were extensively rewritten to reflect changes and current status. Many new sections were added to address evolving challenges and concerns. These sections include clinical issues such as non-suicidal self-injury, infectious disease, sleep disorders, and attention deficit disorders. Clinically significant populations that are now specifically addressed include lesbian, gay, bisexual and transgender (LGBT), veterans, and individuals with intellectual or developmental disabilities. New management and programmatic topics include hospice, mental illness and segregation, seclusion and restraint, telepsychiatry, and spiritual lives of inmates.

These Guidelines are just that: guidelines. This document is not a set of standards, policies, or procedures. It is intended to serve and support psychiatrists working in correctional settings as they grapple with the many opportunities to care for very disadvantaged populations in environments whose primary focus is safety and security. We hope it provides a useful resource to the many dedicated and talented psychiatrists providing care and shaping the mental health services in the thousands of correctional settings throughout the United States.

Robert L. Trestman, Ph.D., M.D.

INTRODUCTION

Overview

When the first edition of these guidelines was published in September of 1989, an editorial in *The American Journal of Psychiatry* noted, “On any day, our nation’s jails and prisons hold an estimated 1.2 million men and women.” In 2012, this number had almost doubled to 2.2 million. Contributing factors to this substantial increase include harsher sanctions associated with the “war on drugs” and the general public’s attitude toward “getting tough on crime.” In addition, more rigid sentencing policies removed judicial discretion regarding sentence lengths and limited parole board discretion in the release of inmates.

Many studies have consistently demonstrated that about 16% of inmates in jails and prisons have serious mental illnesses and are in need of psychiatric care (Diamond et al. 2001; Ditton 1999; Fazel and Danesh 2002; Steadman et al. 2009; Trestman et al 2007). Upwards of 700,000 men and women entering the U.S. criminal justice system each year have active symptoms of serious mental disorders, and studies have suggested that up to 3% (approximately 66,000) are actively psychotic. Approximately three of every four incarcerated people with a serious mental illness have a co-occurring substance use disorder (e.g., Baillargeon et al. 2010). Inmates with mental illness are likely to stay incarcerated longer, and return to prison more rapidly, than persons without mental disorders (Cloyes et al. 2010). What are our duties and responsibilities as psychiatrists to address this situation? How do we live up to our personal moral principles, our professional ethics, and our public service obligations in the face of these overwhelming numbers? These questions drove the creation of this document as the American Psychiatric Association (APA) seeks to provide leadership in addressing the needs of this often disenfranchised group and guidance to psychiatric and mental health professionals working in correctional settings.

The vast majority of psychiatrists who practice in jails and prisons function almost exclusively as diagnosticians and prescribers, yet a need and an important opportunity exist for psychiatrists to expand their roles. As a profession, we must address the relationship between mental illness and incarceration. Given our extensive training and broad skillset, psychiatrists may benefit systems by assuming greater leadership positions. As physician leaders, managers, and directors, psychiatrists can more effectively advocate for their patients and help to shape optimal care delivery systems that empower patients and support successful transition back to the community.

This document is intended to encourage action and to provide comprehensive guidance on how to fulfill these responsibilities to ourselves, our profession, and these often underserved patients. We have new technology for treatment and care coordination. We have the knowledge base and the skillset to effectively intervene. Yet limited resources and public and professional resistance often impede an appropriate response. We hope that this document will help mobilize additional resources and encourage informed action that overcomes resistance to enhanced care. We feel inspired by the high quality and humane services delivered by our dedicated colleagues across the United States, and we believe that even greater involvement by our profession can make an enormous difference.

Clarification of Terms

Correctional Facilities

For the purposes of these guidelines, *correctional facilities* include:

- Lockups
- Jails
- State and Federal prisons
- U.S. Immigration & Customs Enforcement (ICE) detention centers
- Bureau of Indian Affairs (BIA) detention centers
- U.S. Military prisons, jails, and detention centers

When a psychiatrist treats individuals, regardless of setting, they become patients. All ethical obligations to patients therefore hold. Individuals in correctional settings are generally referred to as detainees (pre-trial) or offenders (post-sentencing). For ease of discussion, this text uses the term *inmates* to refer to both populations. The terms *psychiatric, mental health,* and *behavioral health* are commonly used to describe clinical services provided to persons with psychiatric conditions in correctional facilities. These guidelines define the term *psychiatric services in correctional facilities* as all mental health services, including substance use services, provided in correctional facilities with emphasis on the unique role of psychiatrists in the delivery of these services.

Jails, Lock-ups, and Detention Centers

A jail generally is defined as a facility where an individual is confined either while awaiting trial or, in most jurisdictions, while serving a sentence of 1 year or less. These facilities are usually under the jurisdiction of the county or municipality in which they are located. Jails, lock-up, and detention centers are high-volume facilities. There are about 3,350 jails around the country, processing approximately 10 million people each year. Jails differ greatly in size, ranging from facilities holding fewer than fifty inmates to complexes capable of holding more than ten thousand. Lock-ups are typically small, short term holding areas in a police station for individuals awaiting arraignment in a court. Detention centers are here broadly defined as institutions where people are held (generally) for short periods, in particular illegal immigrants or refugees. Confinement in a jail, lock-up, or detention center may occur for different reasons. Some jurisdictions use jails, for example, to house people for civil charges, public health reasons, detention for ICE, or as temporary housing for state and federal inmates. Each purpose can result in differing periods and conditions of confinement.

Confinement in a jail, lock-up, or detention center usually takes place shortly after arrest, and the stress level and health needs of detainees may be extremely high. Furthermore, conditions that may have been present at the time of the arrest, such as intoxication or psychosis, are likely to still be acute. These factors increase the risk of suicidal behavior, violence, and death--often related to intoxication with drugs or alcohol. Individuals with acute mental health needs require an immediate response. In addition, inmates may experience mental health problems or psychiatric crises during their incarcerations. Issues may arise concerning treatment, restraint

and seclusion, safety of the staff and detainees, or emergency medical and psychiatric needs of inmates. Psychiatrists may need to file court petitions for involuntary treatment with medication or involuntary hospitalization on release from these facilities.

In jails, lock-ups, and detention centers the core components of essential psychiatric services are screening, referral, assessment, evaluation, treatment, and community reentry planning. Communities throughout the United States are seeing a decrease in the number of inpatient psychiatric hospital beds and an increasing number of acutely mentally ill persons in these settings. Community hospitals frequently refuse to accept violent or aggressive inmates forcing jails, lock-ups, and detention centers to provide more complicated services to meet the needs of these inmates.

Prisons

A prison is generally defined as a correctional facility where an individual is confined to serve a sentence, usually in excess of 1 year. In contrast to jails, which are usually under the jurisdiction of the county or municipality in which they are located, most prisons are operated by state governments. The federal government also operates its own prison system, the Federal Bureau of Prisons. There are many fewer prisons than jails, and prisons usually house many inmates (often more than 1,000).

In contrast to inmates in jails, lockups, and detention centers, prison inmates often have been in the criminal justice system for an extended period. By the time inmates arrive at prison, they often have spent a long time in custody and have different mental health issues from recently arrested inmates. For example, they may have a lower incidence of acute psychotic states and better psychological adaptation to the loss of liberty, but more stress due to recent sentencing, facility transfer, or greater geographic separation from family and friends. The prevalence of long-term psychotic illnesses in prison, however, is comparable to that in other correctional facilities, and prison inmates recently apprehended for parole violations have mental health issues commonly seen in other facilities. The components of essential mental health services in prisons are the same as in other correctional facilities: screening, assessment, referral, evaluation, treatment, and community reentry planning.

Serious Mental Illness

Healthcare organizations define serious mental illness (SMI) in different ways, based upon distinct perspectives and purposes (e.g., Society of Correctional Physicians [SCP], The National Institute of Mental Health [NIMH], The National Commission on Correctional Health Care [NCCHC], Substance Abuse and Mental Health Services Administration [SAMHSA]). Although these differences are a natural reflection of an evolving field, they contribute to challenges in developing consensus positions necessary to advance and standardize correctional mental healthcare practice. Establishing a consistent definition of SMI in the correctional context is important for epidemiological purposes, needs assessment, and mental health system planning.

Psychiatric disorders that include psychotic symptoms, at least on an intermittent basis, are uniformly considered to meet criteria for SMI. Schizophrenia, schizoaffective

disorder, and delusional disorder are examples of such serious mental illnesses. Other mental or emotional disorders (examples include major depression, bipolar disorder, and posttraumatic stress disorder) that result in serious distress or serious functional impairment that substantially interferes with or limits one or more major life activities, whether acute or chronic, almost always meet criteria for SMI. Some prisoners with severe personality disorders, cognitive disorders, or adjustment disorders will meet such criteria either temporarily or chronically.

Clinical judgment must always be employed in determining the appropriate care for individuals whether or not they meet SMI criteria.

A Roadmap

This third edition of the APA*'s Psychiatric Services in Correctional Facilities* has three sections. The first section, Principles Governing the Delivery of Psychiatric Services in Correctional Facilities, discusses foundational principles that apply to providing care in all correctional facilities. The second section, Guidelines for Psychiatric Services in Correctional Facilities, outlines three basic types of services that should be provided: 1) screening, referral, and evaluation; 2) treatment; and 3) community reentry planning.

The third section, Special Applications of the Principles and Guidelines, applies the principles and guidelines established in the first two sections to specific disorders/ syndromes, patient populations, housing locations, treatment modalities, and special needs of inmates.

PART 1
Principles Governing the Delivery of Psychiatric Services in Correctional Facilities

Introduction

The principles outlined below are intended as a foundational framework to guide the delivery of psychiatric services in correctional facilities. These principles are necessary elements of constitutionally acceptable provision of care. They serve only as compass points for psychiatrists navigating the complex landscape of correctional mental health care. They are not intended to serve as operational standards.

The Legal Context

A basic understanding of the legal context of psychiatric services in correctional facilities helps frame the principles and guidelines that follow. This context is unique: in no other setting is treatment constitutionally required. The following discussion provides a brief overview of legal decisions that drive the provision of clinical services in correctional settings. A more extensive treatment of this subject is available elsewhere (e.g., Cohen 2011).

Right to Treatment

Incarcerated persons have a constitutionally derived right to treatment for their serious medical needs, which include serious mental illness. Whenever a county, state, or federal governmental entity takes custody of a person, it has a duty to provide for the necessities of life that the person otherwise is unable to obtain. Such necessities include food, clothing, shelter, and medical care. Failure to provide medical care in this context has been interpreted as cruel and unusual punishment. The United States Supreme Court has recognized that pretrial detainees have a due process right not to be punished and that convicted inmates have a right to not be punished in a cruel and unusual manner. Courts have interpreted the Due Process clause of the 14th amendment as the constitutional standard regarding the right to treatment of pretrial detainees. The Eighth Amendment of the U.S. Constitution prohibiting cruel and unusual punishment serves as the basis for a prisoner's right to treatment. In the landmark case *Estelle v. Gamble* (1976), the U.S. Supreme Court held that it is unconstitutional for prison officials to be deliberately indifferent to the serious medical needs of those in their custody. Subsequent decisions established the dimensions of this constitutional right and the government's duty to provide it. *Bowring v. Godwin* (4th Cir. 1977) was the first federal court decision to extend this requirement to psychiatric care by equating mental health care with medical treatment. Since then, numerous federal and state court decisions have equated medical and psychiatric care, although the Supreme Court has yet to specifically address this issue. The Court later defined the federal standard as deliberate indifference in *Farmer v. Brennan* (1994): a knowing disregard of an excessive risk to an inmate's health or safety.

A common method for addressing asserted violations of inmates' rights is the federal civil rights statute 42 U.S.C. § 1983 with claims filed in federal court. Physicians can be sued for violating the constitutional rights of inmates under Section 1983. For the psychiatrist practicing in a correctional setting, it is important to know that beyond providing for inmates' constitutional rights, physicians have an additional duty to

practice within the standard of care for their profession. Negligence in failing to provide services within the standard of care may not support a constitutional claim, but may be pursued as a malpractice claim based on state law and filed in state court.

Adequate Care

Federal decisions that establish the framework and specific criteria for constitutionally adequate psychiatric care in jails and prisons within their geographic jurisdictions include the U.S. Supreme Court case *Ruiz v. Estelle* (1980), a class action suit which established six essential elements of minimally adequate mental health services:

- Systematic screening and evaluation
- Treatment that is more than mere seclusion or close supervision
- Participation by trained mental health professionals
- An accurate, complete, and confidential record
- Safeguards against psychotropic medications that are prescribed in dangerous amounts, without adequate supervision, or otherwise inappropriate administration
- A suicide prevention program

In *Langley v. Coughlin* (1989), the Court established specific criteria that, if not met, could provide a basis for successful inmate legal claims. Many of these criteria explicitly require providing for secondary or supportive rights that are necessary to facilitate the primary right to a diagnosis and treatment. Examples include taking a psychiatric history, maintaining a medical record, diagnosing mental conditions properly, and placing inmates experiencing a mental health crisis in an observation setting. *Langley* also explicitly requires that treatment not be limited to psychotropic medication.

Madrid v. Gomez (1995) added several factors that may determine the constitutionality of a correctional mental health system:

- Inmates must have a means of making their needs known to the medical staff.
- There must be sufficient staffing to allow individualized treatment of each inmate with serious mental illness.
- An inmate must have speedy access to services.
- There must be a system of quality assurance.
- Staff must be competent and well trained.
- There must be a system of responding to emergencies and preventing suicides.

Many correctional systems, related to both court orders and good practice, have developed quality improvement programs, which are expected to incorporate a quality assurance component.

Treatment over Objection

The U.S. Supreme Court in *Washington v. Harper* (1990) recognized a

constitutionally permissible model under which an inmate in a prison may be administered treatment over objection. The Court held that an appropriate internal administrative hearing rather than a judicial review satisfies due process requirements. This decision led to the development of so-called Harper hearings that provide a review by an independent committee with procedural safeguards including a right to notice, an opportunity for the prisoner to present evidence and to cross examine witnesses, to have the assistance of an advisor, and to have a right to appeal. *Harper* does not require a lack of decisional competence or consideration of less intrusive means of intervention. In jurisdictions that do not require transfer to a psychiatric hospital to initiate treatment over objection, some jail systems have also adopted a *Harper* process for treatment over objection.

The substantive and procedural approach found permissible in *Harper,* however, fails to meet legal standards in all jurisdictions. For example, some states require lack of decisional competence and a judicial determination of best interest or substituted judgment before any individual, including inmates, can receive involuntary psychotropic medications in non-emergency situations. Correctional psychiatrists need to be familiar with the legal standards where they practice.

Conditions of Confinement

Rates of incarceration have escalated over several decades, straining the ability to house the numbers of individuals placed in correctional systems. Overcrowding is commonplace and contributes to barriers to accessing care and basic services. The psychological and emotional impact of resulting conditions of confinement has received increasing attention. In *Brown v. Plata* (2011), the U.S. Supreme Court found that overcrowding was a significant contributing factor in creating barriers to delivering adequate health care in the California Department of Corrections and Rehabilitation. The Court held that a mandated population cap was necessary to address the violation of inmates' rights.

In addition to constitutional mandates, other legal requirements apply to mental health services in correctional facilities. These include federal statutes such as the Americans with Disabilities Act (ADA), and state requirements established through state constitutions, statutes, and regulations. Further, the Civil Rights of Institutionalized Persons Act (CRIPA) provides an avenue for the U.S. Department of Justice to investigate alleged violations in state institutions.

Access to Mental Health Care and Treatment

Timely and effective access to screening, evaluation, and mental health treatment is the hallmark of adequate mental health care. The first edition of these guidelines emphasized this fundamental principle of adequate mental health care in correctional facilities. Investments in clinical resources and programming will have little impact if barriers to assessment, diagnosis, and follow up care exist. Adequate and appropriate access to mental health treatment means that patients have no unreasonable barriers to receiving services. Examples of unreasonable barriers include: disincentives, including fees that deter a patient from seeking care for legitimate mental health needs; interference with the prompt transmittal of a patient's oral or written request for care; unreasonable delays before patients are seen by mental health staff or

outside consultants; insufficient custody staff to transport inmates to clinic; inadequate waiting room space; and punishment for seeking or refusing care.

Clinical autonomy is another key element of appropriate access to mental health care. Clinical autonomy occurs when clinical decisions and actions regarding mental health care provided to inmates are the sole responsibility of qualified mental health professionals (QMHP). A QMHP is someone privileged for independent assessment based on discipline-specific professional standards and state statutes.

Every correctional system should have a mechanism for monitoring access to psychiatric care. Efforts to improve access include routine orientation and training for custody staff on common manifestations of mental illness and for inmates on how to use the institutional health care system. Encouraging and supporting a collaborative relationship and good communication between mental health and custody staff will maximize the likelihood of delivering quality clinical services. Mental health clinicians, nursing and other health care staff, and custody personnel are partners in providing safe and effective services to inmates. It is essential that they align their efforts to identify inmates with mental illness and coordinate an effective response.

Quality of Care

The fundamental policy goal for correctional mental health care is to provide the same quality of mental health services to each patient in the criminal justice system that *should be available* in the community. This policy goal is deliberately higher than the "community standard" that is called for in various legal contexts because resource restrictions on community care can sometimes limit the adequacy of available services. Correctional systems provide additional challenges not present in the community given that incarcerated persons have no other options for care other than what is provided in the correctional facility.

Quality Assessment and Performance Improvement

It is imperative that facility staff gather and assess information about the prevalence and incidence of mental illness, including demographic and clinical characteristics associated with such illness. This information is critical for needs assessments, program administration, and advocacy within and outside of the correctional setting.

Each facility or administrative authority should prepare a regularly updated quality improvement plan that systematically sets out to review and improve the quality of mental health services. The efficiency and effectiveness of the use of staff and resources in service delivery are key elements in such a plan. Quality assurance and improvement activities include credentialing, review of service access and use, documentation and review of records, resource management, morbidity and mortality review, continuing education opportunities, identification and prevention of risk, and monitoring and review of high-risk critical procedures such as overriding treatment refusals and responding to emergencies. It is recommended that psychiatrists involved in direct patient care, supervision, and management be involved in the creation of the quality improvement plan. Only psychiatrists have the depth and breadth of training to assess fully the needs of inmates with mental illness.

Facilities are encouraged to participate in relevant accreditation programs that

provide guidance and quality of care oversight. There are several national accreditation programs including the National Commission on Correctional Health Care (NCCHC) and the Joint Commission, along with state-specific and local accrediting agencies. Although such accreditation does not guarantee adequate mental health services or compliance with recommended guidelines, regular monitoring represents an effort to enhance the quality of care.

Prioritizing Resources

Many factors determine allocation of correctional mental health treatment resources, including resource availability, facility size, service organization, facility mission, inmate length of stay, and governing legal action or court oversight.

The highest priority for care should be patients with serious mental illnesses, whose symptoms lead to dangerous, self-harming, or other problematic behavior and who may require triage to a higher level of care. However, these individuals typically represent a minority of patients. Inmates without serious mental illness or are not behaving in a manner that places others, themselves, or the institution at risk may still experience profound suffering and should receive appropriate resources and treatment planning.

There is a frequent tension between security and treatment in correctional settings. Facility administrators and clinicians should attempt to make the best use of resources to deliver priority care without unduly compromising safety or security.

Staffing

Adequate numbers of appropriately trained mental health professionals, performing duties for which they are trained and authorized, must be present in every correctional facility. Staffing must be adequate to ensure that every inmate with serious mental illness or in psychiatric or emotional crisis has timely access to evaluation by a competent mental health professional. Psychiatrists must play an integral leadership role in the development, implementation, delivery, and quality oversight of this care.

Psychiatrists are a critical and necessary component of any correctional mental health delivery system. Diagnostic evaluation and prescription of psychotropic medications are frequently the most significant mental health treatment interventions for inmates with serious mental illness. Psychotropic medications can be prescribed and monitored most effectively and safely by psychiatrists, who are trained in the medical evaluation and management of mental illness and co-morbidities. In addition, psychiatrists are uniquely trained to assess and address the bio-psycho-social needs of inmates with mental illness, who frequently have disturbances in all three of these dimensions. This is particularly important given the high rates of serious mental illness and acute and chronic medical conditions in correctional facilities. Psychiatrists receive considerable foundational and continuing education in providing care that meets the best interests of their patients, in navigating the complex landscape of confidentiality, and in maintaining professional integrity in challenging health care environments. Psychiatrists are held to high ethical standards (American Psychiatric Association, Principles of Medical Ethics with Annotations Specific to Psychiatry, 2013) and frequently assume leadership roles.

Psychiatry staffing levels in correctional facilities are complicated algorithms that

vary based on clinical acuity and patient needs, system organization, physical plants, acuity of care delivery, resource availability, and population characteristics. The factors that impact psychiatric staffing in correctional settings are facility specific. These factors include: type of facility (jail, intake facility, prison), size of facility (e.g., average daily population (ADP) less than 50; ADP greater than 1000), inmate turnover rate, location of facility, program space availability, security level of facility (higher security demands restrict movement and may significantly reduce clinician productivity), and care delivery model (e.g., team vs. individual practitioner). Specifically, a few of the many factors that may reduce psychiatric productivity through reduced access to patients include the need to: individually cuff, shackle, and escort some inmates by custody personnel; have limited numbers of inmates in any waiting area; wait for count and other locked-down time periods; and wait for multiple doors along the path from cell to examination room to be unlocked by central control staff. Higher security facilities and high-risk patient populations pose additional safety-related challenges in staff recruitment, retention, and productivity. Small, medium-security prisons with stable populations allow for greater productivity.

There are no prevailing national standards for psychiatric staffing in correctional or other settings. Nevertheless, courts and regulatory agencies, court monitors, and health consultants, frequently seek to establish staffing ratios in correctional settings in order to comply with constitutionally mandated minimally acceptable medical care. Governmental agencies with oversight of correctional settings often seek such ratios to assess their budgetary needs. Correctional facilities have historically not had enough psychiatrists to adequately provide the services described in the sections above.

In practice, a facility-specific staffing needs analysis is a fundamental step in determining the actual psychiatric staffing required in any given facility to meet the standards of care.

Correctional administrators and other leaders need guidance about adequate psychiatric staffing. Needs and type vary based on patient acuity and treatment need, patient volume and turnover, facility location (whether services will be provided on site, via telepsychiatry or a combination of both modalities), the role and function of the facility and the targeted inmate population, any unique or specialized unit or facility treatment/rehabilitative mission and changes to any of the above. While it is very difficult to establish exact psychiatrist-to-patient ratios, the amount of psychiatric time must be sufficient to ensure that there is no unreasonable delay in patients receiving necessary care, and all relevant and necessary psychiatric functions must be met. Based on 15 years of experience in the field since the publication of the 2nd edition of *Psychiatric Services in Jails and Prisons*, the following are recommended basic guidelines about psychiatric staffing requirements:

Jails

- For general population needs: 1 full-time equivalent (FTE) psychiatrist for every 75 to 100 SMI patients on psychotropic medication prescribed for a mental health diagnosis.

- For residential treatment units or the equivalent (where a mental health diagnosis is a requirement for admission): 1 FTE psychiatrist for every 50

patients.

Prisons

- For general population needs: 1 FTE psychiatrist for every 150 to 200 SMI inmates on psychotropic medication.

- For residential treatment units or the equivalent (where a mental health diagnosis is a requirement for admission): 1 FTE psychiatrist for every 50 patients.

Please note well: These corrections-specific recommendations do not apply to other types of community or institutional facilities, where different degrees of acuity and varying patient needs may require different levels of staffing.

Many correctional facilities and systems require remedial efforts. Additional psychiatric time will be necessary for staff education and training, to establish needed linkages with outpatient providers, to review and revise formularies, and for other quality improvement activities.

Education and Training

Professional development for psychiatrists working in correctional facilities is essential. Participation in the educational and training program of the facility, and in other continuing medical education activities, benefits the facility, the practitioner, and the patients.

Educational and training programs of the facility should include substantial cross training between custody and clinical staff. Psychiatrists will benefit from training and orientation by custody staff to the correctional culture, including such matters as social order, gang affiliations, risk classification, chain of command, policies on use of force and solitary confinement, management of specific populations, attitudes of correctional officers, and the perceived role of the mental health practitioner in the system. Correctional officers will benefit from training and orientation by clinical staff to such matters as basic mental health principles, signs and symptoms of major mental illness, suicide risk assessment, and violence reduction strategies. Required annual (or more frequent) refresher training courses should supplement mandatory initial training courses.

In addition to intra-facility education and training, psychiatrists should seek additional training from local and national organizations and should be familiar with the relevant literature of the discipline. Training in areas overrepresented in correctional mental health populations (e.g., substance use disorders, trauma, sexual disorders, and personality disorders) is encouraged. Membership in national organizations, such as the American Academy of Psychiatry and the Law (AAPL) and the NCCHC, offers useful sources of collaboration and support amongst clinicians working in the field.

Collegial supervision, discussion, and support, along with dedicated time for teaching and mentorship of younger practitioners and trainees, may lessen frustration and burnout and serve as ongoing education. The employment agreement with the facility or system should specifically provide for such activities.

Given the rates of mental illness in correctional facilities, medical schools and

psychiatric residencies should provide education and training in correctional psychiatry. The Accreditation Council on Graduate Medical Education already requires that fellowship programs in forensic psychiatry include a substantial experience caring for individuals under correctional supervision. Psychiatrists working in correctional facilities are encouraged to embrace their roles as supervisors and instructors for these trainees. An active liaison and/or affiliation with an academic-medical or other educational institution(s) is advantageous in recruitment, retention, continuing education, career satisfaction, and achievement and maintenance of high-quality services.

Cultural Awareness

Correctional facilities differ from most community settings in gender, racial, ethnic, cultural, and sociodemographic factors. They have high percentages of male inmates, minority ethnic groups, and homeless or impoverished individuals. This contributes to cultural differences among clinical staff, inmates, and security staff. Some psychiatrists practicing in correctional settings have received training outside of the United States and this may also contribute to important cultural differences. As in any treatment setting, incarcerated individuals deserve equal care regardless of gender, gender preference, racial/ethnic background, socioeconomic status, education, or other cultural factors.

Correctional facilities should provide training to ensure sensitivity to cultural differences and support efforts to overcome impediments to the delivery of mental health services. Such training can foster positive attitudes and acceptance of other cultures by means of didactic and experiential components. The goals and objectives of such training should relate to attitude, knowledge, and skills. Positive attitudes and acceptance of other cultures increases with exposure to and awareness of other belief systems. Desired outcomes include improved acceptance of diverse populations, empathy for the minority experience (including the internalization of experiences of prejudice), and an understanding of concepts of ethnocentric bias and its potential effects.

The general overview of the program should contain information common to minority and ethnic groups and information about the specific ethnic groups with which an individual clinician will most often interface. Themes to pursue may include demographic information and epidemiology, the psychological aspects of immigration, the psychological aspects of minority status, religious and other beliefs and attitudes about psychiatric treatments, sources of misdiagnosis, and frequently misdiagnosed problems. The didactic curriculum should include the presentation of biological, psychological, sociological, economic, ethnic, gender, religious/ spiritual, sexual orientation, peer relations, and family factors that significantly influence physical and psychological development (e.g., trauma and juvenile justice exposure).

Informed Consent

Respect for the individual is a core value of the practice of medicine and psychiatry. Obtaining informed and voluntary consent for treatment interventions, regardless of setting, reflects respect and meets the standard of care in psychiatry. The inherently coercive settings of lockups, detention centers, jails, and prisons, by nature of the deprivation of liberty, make it more challenging to obtain voluntary consent, but

inmates retain the ability to make treatment decisions within the scope of individual and institutional safety considerations. The principles of informed consent as embodied in the APA's Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry (2013) remain applicable in correctional facilities. Patients should participate, to the extent possible, in decisions about evaluation and treatment. Psychiatrists should offer to discuss with their patients the nature, purpose, risks, and benefits of treatment options.

Exceptions to the need for informed consent include emergency treatment interventions when obtaining consent is not possible, court-ordered treatment, a patient's knowing waiver of informed consent, and, in very rare and extreme circumstances, therapeutic privilege in the service of avoiding a negative patient outcome. Policies and documentation procedures concerning the right to refuse treatment should conform to the rules and procedures of the jurisdiction in which the facility is located.

Confidentiality and Privacy

Patient privacy in correctional facilities may at times and of necessity be compromised. Nevertheless, the usual principles of confidentiality as embodied in the APA's Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry (2013) should be goals in the delivery of psychiatric services. This position is supported by the NCCHC's Mental Health Standards (2008). Very limited modifications may be necessary given institutional security requirements that govern these settings, the responsibilities of the custody staff to protect inmate and staff safety and prevent escape, and the involvement of security staff, at times, in treatment activities (e.g. providing security at the medication window, monitoring outdoor recreation or indoor temperatures for individuals receiving psychotropic medications and who may be heat sensitive). Nevertheless, all reasonable efforts should be made to keep patient information confidential. Confidentiality may be particularly important to groups that are frequently encountered in correctional settings and may be at increased risk of victimization from inappropriate disclosure (e.g., persons with HIV/AIDS, persons who have experienced sexual violence, sex offenders, individuals charged with or convicted of high profile crimes).

As in the community, psychiatrists working in correctional settings must clearly specify limitations on confidentiality prior to rendering treatment services, except in emergency situations. These limitations for encounters and disclosure include situations when the patient is:

- At risk for self-injury or suicide
- At risk for assaultive behavior or committing homicide
- Gravely disabled and unable to care for him/herself

Additional limitations on confidentiality that may be warranted in a correctional setting include situations when the patient:

- Presents a significant risk of escape or threat to the security of the institution, active illicit drug use, or significant contraband use

- Has sustained a serious injury warranting investigation
- Requires coordinated care including movement to a special unit or off-site treatment facility for observation, evaluation, or treatment of an acute psychiatric episode

This list is not meant to be all-inclusive and may be supplemented in accord with the special needs of each patient or the institution.

The importance of private space for confidential doctor-patient interactions cannot be overstated. Inmates with mental illness may be vulnerable or targeted by other inmates. Without the assurance of privacy some patients may not seek mental health services or adhere to treatment. However, efforts to speak privately should not be pursued at the risk of reducing patient access to care. For example, a patient may refuse to come out of the cell to attend the clinic for an appointment, but wish to speak with the psychiatrist at cell-side. Psychiatrists need to ensure that such refusals to come out do not arise from external disincentives, such as cell shake-downs occurring during psychiatric appointments. Patients should be encouraged to speak in private settings, but clinicians must use their judgment regarding safety considerations, unit rules, access to treatment, patient wishes, and the therapeutic alliance.

Psychiatrists working in correctional settings may perform non-treatment related services such as assessments for in-custody disciplinary housing placement. Complex ethical issues arise when a treating psychiatrist participates in the disciplinary process to determine whether a patient should be sanctioned for an infraction or rules violation. If asked to participate, the psychiatrist should obtain the informed consent of the patient and limit involvement solely to providing an opinion on whether there is a psychiatric condition that contributed to the behavior leading to an alleged infraction (i.e., mitigating circumstances) or related to the issue of competency to proceed in the disciplinary hearing process. With few exceptions, the evaluating clinician should not be the inmate's treating clinician due to potential conflicting roles. It is the responsibility of the evaluating psychiatrist to clearly set forth to the inmate any such limitations on confidentiality as part of the informed consent process. Treating psychiatrists must not participate in making decisions about discipline, as this crosses ethical boundaries.

Psychiatrists should share relevant confidential information with facility administrators (on a "need to know" basis) when the information has a significant impact on the management of an inmate, safety and security issues, or an inmate's ability to participate in programs. In deciding what information to disclose, it is important that the psychiatrist consider:

- The need to balance the therapeutic needs of the patient with the security and stability of the institution
- The challenges inherent in accurately predicting violence and dangerousness, both to self and others
- The impact of any breach of confidentiality on the relationship with the patient

Psychiatrists working in correctional settings must be able to access patients' relevant community medical and mental health records in order to provide continuity of quality care. The Health Information Portability and Accountability Act (HIPAA) Privacy Rule (45 CFR Subtitle A, 164.512) allows for community providers to provide protected health information without authorization to law enforcement and correctional officials in order to provide health care, maintain inmate and staff safety, and maintain security of the correctional facility.

Psychiatrists must also have efficient access to records from other sites within the same correctional facility (e.g., records from the administrative segregation unit or the infirmary) and to communicate relevant confidential information with the consent of the inmate to community providers when the patient is released. Facilities must have mental health record systems that are accessible, comprehensive, and support timely service provision.

Psychiatrists in these settings also must be able to provide appropriate information when conducting continuous quality improvement reviews with correctional leadership. This would occur when psychiatrists participate as members of committees such as Special Needs Accommodations, Pharmacy and Therapeutics, Morbidity and Mortality, Quality Improvement, and other related activities.

In light of these special considerations, facilities need written policies on confidentiality and privacy. In facilities where no written policy exists, psychiatrists are encouraged to clarify these issues with the institutional authorities and help develop working policies on the degree to which confidentiality of information can be shared.

Suicide Prevention

The risk of suicide is higher among correctional inmates than among the population at large. Suicide is the leading cause of death in jails and the 5th leading cause of death in prisons (Noonan and Ginder 2013). Suicide risk is also increased in individuals with mental illness, a growing percentage of whom are found in correctional facilities. All nationally recognized correctional mental health standards, including these guidelines, require that each facility have a suicide prevention program for identifying and responding to suicidal inmates.

An inmate may become suicidal at any point during incarceration. High-risk periods include the time of admission; following new legal problems (e.g. new charges, additional sentences, institutional proceedings, denial of parole); following the receipt of bad news (e.g. a serious illness in the family or the loss of a loved one); after a traumatic event (e.g. sexual assault); after experiencing rejection (e.g. by a significant other); or during worsening symptoms of mental illness. Increased suicide risk may also occur during the early phases of recovery from depression or psychotic illness and while housed in administrative segregation or other specialized single-cell settings.

Although there are many more suicide attempts and incidents of non-lethal self-harm than completed suicides, any threats of self-harm or self-injurious behavior must be taken seriously. Self-harm behaviors, regardless of motivation, can result in significant morbidity and mortality. For this reason, even behaviors that do not lead to injury should be taken seriously, and not dismissed as merely "suicidal gestures."

An adequate suicide prevention program must include the following components in a written policy and procedure that all staff can easily access:

- Training all staff who interact directly with inmates to recognize warning signs and intervene appropriately with individuals at risk for suicide.
- A formal and detailed suicide risk assessment process.
- Identification of inmates at increased risk of suicide through screening at or near the time of admission to the facility and through referral at any time during an individual's incarceration.
- An effective and well-understood referral system that allows staff and inmates to bring a suicidal inmate to the prompt attention of a mental health clinician
- Timely evaluation by a mental health clinician to determine the level of risk posed by a referred inmate.
- Timely implementation of monitoring interventions such as close observation (at least every 15 minutes), continuous monitoring, alternative housing, or referral to a higher level of care (e.g., infirmary or hospital). When indicated, a psychiatrist – either on-call or in-person – assists in the decision about interventions. Any mental health clinician may order an increase in monitoring level, but a decrease in level may be ordered only by a psychiatrist or doctoral level mental health clinician after an in-person evaluation.
- Housing options that allow for adequate monitoring of suicidal inmates by staff. Suicidal inmates should not be placed in isolation settings without continuous monitoring. Continuous monitoring for active suicidality occurs regardless of housing location. Supervision aids such as video-monitoring may be used as a supplement to, but not as a replacement for, active staff monitoring.
- Communication among mental health, correctional, medical, and other staff of the specific needs and risks presented by a suicidal inmate
- Timely provision of mental health services, including medication, individual and group therapies, and crisis intervention, for chronically or acutely suicidal inmates
- Accurate, behaviorally-specific, and highlighted documentation in the medical record of behaviors or statements that indicate suicide risk
- Quality improvement reviews with psychiatric staff participation of suicide attempts and completed suicides to help prevent future occurrences.
- Critical incident support, opportunities for peer-to-peer discussion, and availability of Employee Assistance Program support for completed suicides to assist staff and inmates to deal with feelings of guilt, fear, grief, and anger

Mental Health Treatment

Constitutional and statutory law, and these guidelines, requires that all inmates have timely and effective access to mental health treatment regardless of where they

are housed. Faced with the risk of costly and time-consuming litigation, correctional leaders have increasingly opted for compliance with national health standards and achieving accreditation (Anno 2001; Rold 2008). Jails, prisons, juvenile detention, and other correctional facilities may be accredited by the NCCHC (an offshoot of the American Medical Association), the Joint Commission, the American Correctional Association (ACA), or a combination of the above. Since 2008, NCCHC has published standards specifically for mental health services (NCCHC 2008). These parallel the standards for health services in jails (NCCHC 2014a) and prisons (NCCHC 2014b) in format and substance, but explicitly specify the standards for adequate delivery of mental health services in nine general areas: governance and administration, safety, personnel and training, health care services and support, inmate care and treatment, health promotion, special mental health needs and services, clinical records, and medical-legal issues. Although national accreditation is typically voluntary, it is often a contractual requirement for universities, other health care systems, and private vendors who provide mental health care services to correctional systems. In addition, when facilities undergo investigation or litigation, or are placed under federal oversight, they are often mandated to establish and maintain national accreditations. This section of the principles governing the delivery of psychiatric services in correctional facilities seeks to clarify the purposes of such treatment and the modalities that may be employed.

The principles and guidelines for psychiatric services in correctional facilities outlined herein seek to ensure that inmates have such access to care to meet their serious mental health needs. The parameters of access to care include an identified responsible mental health authority, appropriate screening, referral, mental health evaluation and treatment, clinical autonomy, and ensuring that mental health services are coordinated and delivered in an effective, safe, timely and responsive fashion. This requires establishing and implementing policies for clinical aspects of the mental health program; monitoring the appropriateness, timeliness, and responsiveness of mental health care and treatment; and ensuring appropriate follow-up (NCCHC 2008, 2014a,b). Administrative decisions (such as utilization review) are coordinated, if necessary, with clinical needs so that patient care is not jeopardized. Finally, custody and administrative staff support and do not interfere with the implementation of clinical decisions and treatment services.

Mental health treatment in the correctional setting, like that in any setting, is defined as the use of a variety of mental health therapies, including biological, psychological, and social to alleviate symptoms that cause distress or interfere with a person’s ability to function. An additional and unique dimension within corrections is the need for timely communication on a patient’s mental health needs with other clinical and non-clinical staff. This communication with non-clinical staff may seem counter-intuitive to psychiatrists and other mental health staff who are well-versed in the need for privacy of protected health information and the confidential nature of mental health treatment. Privacy and confidentiality concerns may result in reluctance to share vital information with non-health care staff. Information about an inmate’s significant mental health needs, however, has relevance to correctional classification, housing, work and program assignments, admissions to and transfers from institutions, transportation, disciplinary measures and proceedings, and other

custodial decisions (Appelbaum et al 2001). Communicating this information helps preserve the health and safety of that inmate, other inmates, and staff while maintaining the correctional systems' primary focus and need for custody and control. Mental health treatment involves more than just prescribing psychotropic medication, and psychiatrists should not be limited to this role.

The fundamental policy goal for correctional mental health treatment is to provide timely access to mental health services to all inmates who need them, wherever they are housed. Inmates must have access to appropriate mental health treatment equivalent to that which should be available in the community. Further, patient autonomy generally requires that inmates, in consultation with qualified mental health professionals, make their own decisions regarding their mental health care. The purposes of mental health treatment in correctional settings include:

- Relieving suffering and impairment caused by mental illness
- Enhancing safety for the inmate and others
- Improving the inmate's ability to participate in educational, treatment, and other programs offered

In pretrial settings, treatment might include a jail-based restoration of competency program or transfer to an off-site forensic unit or state hospital for restoration of competency to stand trial. The return of the inmate from the off-site forensic psychiatric setting may pose challenges regarding continuity of care and medication adherence. In a correctional setting, the inmate might return to a general population housing setting with the ability to participate in programs, including suitable outpatient mental health programs, and preparation for release. Another placement might be to transition an inmate with a chronic mental illness who has achieved clinical stabilization within an intensive psychiatric unit setting to a less restrictive "sheltered" or specialized mental health housing treatment program within the correctional environment.

Treatment modalities should be provided in a way that is consistent with generally accepted psychiatric practices and with institutional requirements. Examples of specific psychiatric treatment services include psychiatric diagnostic evaluation, case consultation, and medication treatment services. Examples of other mental health treatment services include the development of a continuum of mental health screening and triage, outpatient, inpatient, crisis management, and specialized programs as needed. Psychoeducation (education about mental illnesses and management) and skills training are additional important mental health treatment components. Nation-wide implementation of the Prison Rape Elimination Act of 2003 (PREA) is now generating mental health and medical referrals of offenders who disclose past/recent victimization and/or perpetration of sexual abuse. The final rule on implementation guidelines was published in 2012 (Prison Rape Elimination Act Final Rule 2012).

Many correctional adaptations of disease-specific protocols now exist. These rely on nationally promulgated evidence-based disease management guidelines, clinical guidelines, and position statements from such organizations as the NCCHC and Society of Correctional Physicians (SCP). A clinical guideline is a consensus

statement designed to help practitioners and their patients make decisions about appropriate health care for specific clinical circumstances. Clinical guidelines contain up-to-date information and evidence-based recommendations on best practices for the clinical management of specific medical and mental health conditions. The application of guidelines nevertheless requires clinical judgment as some situations may appropriately fall outside of guideline boundaries.

Referral for Mental Health Treatment

Referral is the process by which an individual is provided the opportunity for a mental health evaluation. Referrals may be generated through reception screening, mental health intake screening, or later processes (including self-referral, referral by custody or other clinical staff, concerns raised by other offenders, or requests from family members, judges, lawyers, or legislative staff). As noted above, referrals must be timely, be reviewed by a clinician, receive a professional clinical judgment, and deliver the care that is ordered (NCCHC 2008, 2014a, 2014b).

The referral process may be simple or complex, depending on the policies and procedures, size and type of facility, clinical urgency of the situation, and available mental health coverage. The referral process should be specifically defined and the roles of the participants clearly delineated.

Referrals should be time-constrained: a maximum time for response to each referral, suitable to the situation (i.e., routine, urgent, emergent), should be set out in the facility's operating standards. Timely referral and response should be designated as indicators of quality care. Whenever possible a continuous quality improvement (CQI) program monitors and improves mental health care delivered in the facility.

Mental Health Evaluations

The nature and characteristics of mental health evaluations depend on context. In a lockup setting, where the major focus may be the timely identification and transfer of an inmate with severe mental illness to a designated correctional psychiatric unit or off-site psychiatric facility, evaluations tend to be more brief and focused. In a jail or prison setting that has additional levels of mental health housing and treatment services or alternative off-site arrangements, evaluations and interventions may be more detailed and extensive. At a minimum, a mental health evaluation includes information related to current symptomatology, past treatment, suicide and violence risk, current medications, co-morbid medical problems, and substance use.

Therapeutic Milieu

To the extent possible, mental health treatment should be provided in a setting that is conducive to the achievement of its goals. This includes the physical setting and the social-emotional setting, in which an atmosphere of empathy and respect for the dignity of the patient is maintained. Mental health services are conducted in private and carried out in a manner that encourages the patient's subsequent use of services. A therapeutic milieu implies the following conditions:

- A sanitary and humane environment

- Written procedures
- Adequate medical and mental health staffing
- Adequate allocation of resources for the prevention of suicide, self-injury, and assault
- Adequate observation, treatment, and supervision
- Social interactions that foster recovery

Providing privacy for mental health services and cell-side mental health encounters is a special challenge. According to the NCCHC Mental Health Standards (2008), when the patient poses a probable risk to the safety of staff or others, security personnel must be present. Nevertheless, adequate privacy should be provided (e.g., use of a programming cell). The patient-psychiatrist relationship may be eroded if privacy is not provided during clinical encounters. Mental health triage commonly occurs at cell-side. If the triage discussion becomes more involved, the clinician should maintain privacy by moving the patient to a clinical setting.

Transfer to a correctional mental health unit or off-site mental health facility must be available when clinically indicated. As safety and security allow, self-help and peer support programs or activities that contribute to the overall goals of the mental health services should be promoted and encouraged by clinical staff.

Levels of Care

Mental health services are generally provided in a continuum of treatment settings or levels of care. These levels of care include outpatient, residential, crisis intervention, infirmary, and inpatient services. Outpatient treatment is the least intensive level. Patients live in a general population housing unit with other inmates, many of whom do not need psychiatric care. Residential treatment programs are more intensive and usually exist in dedicated housing. As with similar programs in the community, residential treatment is provided for patients with chronic and serious mental illness who do not require acute care, but do need enhanced services. These designated housing units provide a therapeutic environment for those who may not function adequately in general population.

Crisis intervention includes supervised stabilization and/or diagnostic assessment, often in an infirmary setting, and short-term counseling. A psychiatric inpatient program is the most intensive level of care. Many systems provide this through collaboration with a local or state psychiatric hospital.

Community Reentry Planning

There is increased recognition of the risk for reincarceration of individuals with serious mental illness (Baillargeon et al. 2008). Timely and effective discharge planning is essential to continuity of care and an integral part of adequate mental health treatment. This is true whether the patient is released into the community or transferred to another correctional facility. Because discharges (e.g., from jails) or transfers (e.g., between prisons) may occur on short notice, discharge planning needs to begin as part of the initial treatment plan. Discharge planning is provided for all inmates with serious mental health needs as well as other mental health caseload inmates whose release is imminent although the nature of the discharge planning

process will vary based on the inmate's needs. For planned discharges health care or other designated staff should arrange for a sufficient supply of current psychotropic medications to last until the patient can be seen by a community health care provider. Patients with critical medical and/or mental health needs must have appointments scheduled with community providers, including arrangements for psychiatric hospitalization as needed (NCCHC 2008, 2014a, 2014b). Confidentiality concerns should be addressed to facilitate sharing of information among providers in different settings.

Part 2 of these guidelines lists essential services for community reentry planning. These include assessments, appointments, and linkages to community-based services. In addition, reentry planning may include help with obtaining financial benefits (e.g., Medicaid) and housing (because of the high incidence of homelessness in correctional populations). Finally, it is recommended that the family and other community-based resources and supports, when available, be included in the community reentry planning process.

Ethical Issues

Ethical issues have particular concern for psychiatrists practicing in correctional facilities because of their inherently coercive environments and the pervasiveness of complex problems of dual loyalty. The terms *dual loyalty* or *dual agency* describe those situations in which a psychiatrist is subject to more than one authority or moral principle. Correctional psychiatrists sometimes face conflicts between two distinct roles and responsibilities: those as the patient's treating physician versus those as an employee or agent of the correctional facility. Conflicts can arise when the psychiatrist's duties to the patient clash with duties to the correctional organization. Evaluations for legal purposes (e.g., competence to stand trial, parole eligibility, or responsibility for disciplinary infractions) present heightened conflicts for a treating psychiatrist. Forensic and clinical roles have different professional responsibilities and ethical duties. NCCHC accreditation standards explicitly prohibit health care workers from collecting forensic information (NCCHC 2014b, p149). Although NCCHC standards make an exception for court-ordered psychiatric or psychological evaluations with the informed consent of the inmate, we recommend that psychiatrists not conduct court-ordered evaluations on the patients they treat or have treated. A mental health professional who has no treatment relationship with the inmate may conduct these evaluations in settings that require staff to do them. The section on Confidentiality and Privacy above reviews psychiatrist involvement in the disciplinary process.

The introduction to the first edition of these guidelines (1989) noted that "the psychiatrist practicing in these settings is *always* bound by the standards of professional ethics as set out in the APA's Annotations Especially Applicable to Psychiatry to the AMA's Principles of Medical Ethics. These are the most fundamental statements of the moral and ethical foundations of professional psychiatric practice" (p. 5). This document's latest edition (2013) continues to have only two annotations that specifically apply to psychiatrists practicing in a criminal justice setting. The first annotation relates to a period of time very early in the criminal justice process: before an individual has been arraigned. Annotation 13 to Section 3 of the *Principles of Medical Ethics With Annotations Especially for Psychiatry (2013)* states "ethical considerations in medical

practice preclude the psychiatric *evaluation* of any person charged with criminal acts prior to access to, or availability of, legal counsel. The only exception is the rendering of care to the person for the sole purpose of medical *treatment*". It is significant to note that here too, at the very beginning of the legal process—even before the arraignment process—there is a distinction made between a treating responsibility and an evaluation obligation. The point is that before a person who has been arrested has been before a judge (and usually has not spoken to a lawyer and been informed of the charges and apprised of his or her rights), a forensic psychiatric *evaluation* should not be performed.

The only other annotation relating to correctional psychiatry relates to a time at the end of the criminal justice process: when the inmate is to be executed. Annotation 4 of Section 1 of the *Principles of Medical Ethics with Annotations Especially for Psychiatry (2013)* states "a psychiatrist should not be a participant in a legally authorized execution." Here, too, it seems that a distinction is being drawn between the psychiatrist's responsibility to treat the inmate (and the responsibility to benefit the patient) and a duty or responsibility to the state.

The American Academy of Psychiatry and the Law (AAPL) has addressed matters relating to correctional psychiatry in more detail. Under the heading of confidentiality, *The Ethics Guidelines for the Practice of Forensic Psychiatry* (AAPL 2005) state that:

> . . . in a *treatment* situation, whether in regard to an inpatient or to an outpatient in a parole, probation, or conditional release situation, the psychiatrist should be clear about any limitations on the usual principles of confidentiality in the *treatment* relationship and assure that these limitations are communicated to the patient. The psychiatrist should be familiar with the institutional policies in regard to confidentiality. Where no policy exists, the psychiatrist should clarify these matters with the institutional authorities and develop working guidelines to define his role. (*emphasis* added)

As regards consent, *The Ethics Guidelines for the Practice of Forensic Psychiatry* of the American Academy of Psychiatry and the Law (2005) state that "consent to *treatment* in a jail or prison or other criminal justice setting must be differentiated from consent to *evaluation.* The psychiatrists providing treatment in these settings should be familiar with the jurisdiction's rules in regard to the patient's right to refuse treatment." Then, more broadly, the guidelines state, "A *treating* psychiatrist should generally avoid agreeing to be an expert witness or to perform an *evaluation of his patient for legal purposes* because a *forensic evaluation* usually requires that other people be interviewed and testimony may adversely affect the therapeutic relationship." Here too, a clear distinction is made between treatment and evaluation.

Finally, we note that there is one code of ethics that seeks to apply ethical principles specifically to clinical practice in correctional settings: that of the American Correctional Health Services Association (ACHSA 1990). While the ACHSA Code of Ethics does not explicitly distinguish between treatment and evaluation functions, this distinction is implicit in three separate sections: collecting and analyzing specimens only for diagnostic purposes; only correctional health professionals not in a provider/patient relationship may perform body cavity searches; and the injunction to honor custody

procedures but not participate in actions such as inmate escort, security supervision, or strip searches.

Hunger Strikes

Hunger strikes in prisons and detention facilities (especially those that house illegal immigrants or political prisoners) have become more common in the United States and around the world. Hunger strikes are considered a medical emergency and psychiatrists are often asked to evaluate inmates to determine if they have the mental capacity to make an informed decision regarding continuation of the hunger strike (Daines 2007). Psychiatrists can perform evaluations to rule out underlying mental illness as a cause of the hunger strike (e.g., suicidal depression, delusions regarding prison food). There is currently no consensus to guide psychiatrists in the United States on the ethical standards of force-feeding to end hunger strikes in correctional facilities (Crosby et al. 2007; Keram in press). While the World Medical Association and the American Medical Association, with limited exceptions, have taken stands against the practice (World Medical Association 2006; Lazarus 2013), the Supreme Court of Connecticut, in *Commissioner of Correction v. Coleman* (2012) found that the state's interest in the inmate's health and legitimate penological interests in the safety of the facility outweighed the inmate's right to autonomy. Further, the court ruled that force-feeding did not violate constitutional rights to free speech and privacy.

Research

Research provides the basis for development of best practices and quality care standards for patients. Psychiatric research contributes to the community at large by investigating methods to improve treatment outcomes for offenders with mental illness. Psychiatric research may assist mental health practitioners in their clinical work and help inmate patients. Other types of research design, including epidemiological and non-invasive studies, can yield useful information about the precursors of mental illness in offenders, incidence and prevalence of mental illness, program design, physical plant design, and planning for services. However, research with prisoners as subjects requires special legal safeguards and clinical considerations.

In addition to usual precautions for patients in studies, researchers must provide extra safeguards for inmates because incarceration is an inherently coercive setting that undermines an inmate's ability to provide freely given informed consent for participation in research. As a result of significant rights violations in the use of prisoners as research subjects in the United States in the wake of World War II, the U.S. Code of Federal Regulations (CFR) has a section for the protection of human subjects in research (Title 45, Part 46) specifically dedicated to the protection of prisoners (Code of Federal Regulations 2009). Subpart C, which has not changed significantly since the late 1970's, highlights four areas of acceptable research on prisoners: 1) the study of the possible causes, effects, processes of incarceration, and of criminal behavior, 2) the study of prisons as institutional structures or of prisoners as incarcerated persons provided that the study presents no more than minimal risk or inconvenience, 3) the study of conditions particularly affecting prisoners as a class (i.e. alcoholism, drug abuse, sexual assault), and 4) research on practices, both innovative and accepted,

which have the intent and reasonable probability of improving the health or well-being of the subject. The guidelines set forth in the CFR should be strictly observed for any projects receiving federal funding. The majority of state-sponsored and academic institutions also follow similar guidelines and should be observed. All pharmacological research must comply with U.S. Food and Drug Administration (FDA) regulations that control the conduct of drug trials with prison populations.

For psychiatrists interested in research or results of research in this population, more resources are now available. More governmental and philanthropic organizations now recognize the benefit and results of research in the appropriate and timely treatment of this population. Organizations such as the Council of State Governments, the Academic Consortium on Criminal Justice Health, and the Academic and Health Policy Conference on Correctional Health provide forums for presentation and encouragement of research in this area.

Administrative Issues

Access to mental health services in correctional settings requires a balance between security and treatment needs. There is no fundamental incompatibility between security and treatment. It should be universally recognized that good treatment can contribute to good security and good security can contribute to good treatment (Appelbaum et al. 2001).

Health Services Administration

The effective provision of mental health services requires integration of mental health administration into the overall management of the facility. Close integration of clinical, substance abuse, and security services fosters comprehensive treatment.

A qualified health care administrator with a sound clinical background should have supervisory authority over professionals who work with mental health patients and specified authority over security staff on specialized mental health units. Mental health administrative personnel need written policies on critical issues such as staffing patterns, admission, referral, discharge criteria, health care management, information management, and interagency and intra-agency communications, especially on confidential medical and mental health information.

Psychiatrists can provide administrative leadership and clinical care. Even when control may be in the hands of non-psychiatrists, attention to quality care serves the best interests of the patient.

Relationship with Custody Administration

Mental health professionals require training in and understanding of security needs and issues. Clinical leadership and sufficient staffing and resources help create an environment that promotes therapeutic interactions. The same occurs with good working relationships among all disciplines (e.g., nurses, psychologists, psychiatrists, social workers, correctional officers, and correctional counselors), especially when an administrator with clinical experience serves as the coordinator for mental health disciplines. Clinical input also has value regarding decisions about work and housing assignments and institutional transfers.

Mental health professionals work within their professional scope of practice, as defined in that jurisdiction’s licensure process (usually by the state), and within the

bounds of training, expertise, and skills. As such, mental health professionals provide services within a standard of care. However, chronic shortage of professional resources is a common problem in correctional settings. At the very least, a psychiatrist's responsibility includes communicating shortcomings and resource needs to the appropriate authority.

Mental health staff need knowledge about and sensitivity to the concerns of security staff. They get information about security through education and training for working in these settings. Similarly, organized programs can teach and train custody personnel about mental health issues. Programs that especially benefit from carefully administered integration include those on developmental disabilities, neurological impairments, alcohol and drug abuse, and sex offenses.

Interprofessional Relationships

Delivery of mental health services in correctional settings requires cooperation by all professionals, including psychiatrists, psychologists, social workers, nurses, other health care staff, correctional counselors, and correctional officers. The manner in which these professionals interact is critical to provision of care. Psychiatrists working in correctional institutions need to recognize the importance of safety and security of inmates and staff. Interprofessional relationships may become strained if mental health or medical interventions conflict with correctional practices.

Mental health services require strong leadership. Even facilities where crisis intervention is the primary mode of mental health service provision, with only one or two clinicians on staff, need a supervisor, even if not located on-site. Facilities with several mental health staff and different levels of mental healthcare can have a designated mental health administrator, who understands the interprofessional roles of custody, medical, and mental health staff. The mental health administrator functions as a leader to oversee the development of mental health policies and procedures that are coordinated with custody's policies and medical services. Good mental health leaders communicate well among custody, medical, and mental health staffs. They become the conduit for all interprofessional relationships that effect delivery of services. They solve problems and compromise in difficult situations without sacrificing the care of the patient. Doing this requires a healthy respect for the correctional environment and the challenges faced by correctional professionals.

Thoughtful mental health professionals respect each other's expertise and contributions and work well together. They consult on a formal and informal basis and share their special skills in an atmosphere of mutual confidence and trust. The mental health administrator serves a crucial role in assuring that all mental health professionals work together as a team.

Supervisory Roles

Administrative supervision and clinical supervision of staff require different types of expertise. Not all psychiatrists have administrative expertise Administrative issues, such as inmate housing and on-call coverage, sometimes impinge on clinical decision-making. Correctional settings use different models of supervision. Regardless of the model used, psychiatrists have a major role to play in supervising delivery of mental health services and they retain professional independence for their clinical decisions.

Jail Diversion and Alternatives to Incarceration

More than 500,000 persons with serious mental illnesses are admitted to U.S. jails each year. Mental health diversion programs designed to transfer people from the criminal justice system to community-based mental health and substance abuse services are growing in number. There are two types of diversion programs: pre-booking and post-booking. *Pre-booking* programs involve police and emergency mental health responses that provide alternatives to booking people with mental illness into jail. *Post-booking* programs generally comprise three subtypes: 1) dismissal of charges in return for agreement for participation in a negotiated set of services, 2) deferred prosecution with requirements for treatment participation, and 3) post-adjudication release in which conditions for probation include requirements for mental health and substance abuse services.

Some individuals with mental illness must be held in jail because of the seriousness of the alleged offense and/or their histories of nonappearance in court. They need access to mental health treatment within the jail. However, many individuals with less serious, nonviolent crimes can safely be diverted from jail to community-based mental health programs.

People who receive mental health treatment in the community usually have a better long-term prognosis and less chance of returning to jail for a similar offense than people who remain in jail. In addition, diversion of individuals with mental illnesses from the criminal justice system helps promote smooth jail operations.

The best diversion programs view detainees as citizens of the community who require a broad array of services, including mental health care, substance abuse treatment, housing, and social services. They recognize that some individuals come into contact with the criminal justice system because of fragmented services, the nature of their illnesses, and the lack of social support and other resources. They know that people should not be detained in jail simply because they have a mental illness. Only diversion programs that address this fragmentation by integrating an array of mental health and other support services, including case management and housing, can break the unproductive cycle of decompensation, disturbance, and arrest.

PART 2
Guidelines for Psychiatric Services in Correctional Facilities

Introduction

The following guidelines for psychiatric services in correctional facilities are based on the principles governing the delivery of psychiatric services presented in Part 1 of this document. Part 3 applies these guidelines to special populations of inmates. These guidelines supplement, but do not replace, the standards developed by the NCCHC. The broad outline of these guidelines includes three basic types of services: 1) screening, referral, and evaluation; 2) treatment; and 3) community reentry planning.

Reception Mental Health Screening and Referral

All newly admitted inmates have a reception (or receiving) mental health screening within four hours of arrival at a facility. Most facilities follow written protocols and procedures and use a standardized form to document information and observations. In smaller facilities this information may be gathered by a correctional officer with additional health training. Larger facilities may use registered nurses or other health professionals with additional mental health training. All health encounters other than general rounds should be conducted in private settings. Mental health professionals who have safety concerns can request a correctional officer to stand at a reasonable distance outside of a partially open door or, if necessary, to be present in the room during the examination. Facilities can require that all custody staff sign confidentiality agreements at the time of their employment and that initial and annual mental health training of all staff include reviews of guidelines on confidentiality of inmate health information. Inmates with abnormal behaviors or positive findings on the reception mental health screening need triaged referrals for further evaluation, either on an emergent or urgent basis, with time frames defined by policy.

Essential Components of Reception Mental Health Screening:

- Occurs within four hours of the inmate's arrival.
- Observation and structured inquiry into mental health history and symptoms, including questions about suicide history, ideation, and potential; prior psychiatric hospitalizations and treatment; and current and past medications, both prescribed and actually taken
- May be conducted by the booking officer, other custody personnel, supervisors, or medical intake nurse. The screener must have training in mental health screening and referral. For jails, lock-ups, and detention centers information about the inmate's behavior leading up to and during the arrest should be obtained from the arresting officer if available.
- Referrals for emergent or urgent evaluations for inmates with findings.
- Referral to nursing staff for inquiry about reported active prescriptions. Correctional facilities can verify prescriptions by calling the prescribing agency, pharmacy, or sending facility and obtain bridging medication orders for inmates until they can be seen and assessed by an authorized prescriber.

- Use of a standardized procedure with observations and responses documented on a standard form in the permanent health record.
- Policies and procedures specify required actions and time frames after positive screening findings.
- Psychiatrists may have limited roles in direct provision of this service, and may participate in the following activities:

    a. Development of screening forms and procedures
    b. Training officers and health care personnel to use the screening instrument and to make appropriate referrals
    c. Development of written referral procedures for inmates identified during the screening as being at high risk
    d. Monitoring the quality of the intake process, including efficacy of identification of inmates needing referral and timeliness of referrals
    e. Prescribing appropriate verified medications, or reasonable formulary substitutions, and monitoring laboratory studies until the patient can be seen, customarily within 10 business days for non-acute issues and sooner if clinically indicated

Intake Mental Health Screening and Referral

Intake mental health screening is defined as a more comprehensive examination of each newly admitted inmate within 14 days of arrival at an institution. It includes a review of the reception mental health screening, medical screening, behavioral observation, review of mental health history, assessment of suicide potential, and mental status examination. Frequently detainees are booked into jails late at night and while intoxicated. They often give negative responses to questions on the receiving screening in order to speed up the booking process. In prisons, similar issues may occur because of inmate anxiety in a new setting. The intake mental health screening can reveal chronic medical and mental health problems that were not reported upon entry into the facility and lead to referrals to chronic care clinics or mental health clinics to ensure identification and treatment of the inmate's health issues.

Essential Components of Intake Mental Health Screening

- Conducted by a qualified mental health care professional (QMHP) privileged for independent assessment based on discipline specific professional standards and state statutes.
- Use of a standardized procedure with observations and responses documented in the permanent health record.
- Policies and procedures specify required actions and time frames after positive screening observations.
- Inmate receives detailed information about access to mental health services.
- The psychiatrist generally has a limited role in the direct provision of this service, but may participate in the following activities:

    a. Development of intake mental health screening forms and informational

material.

b. Training health care staff to use intake mental health screening forms and informational (orientation) materials.
c. Developing written referral procedures for inmates identified as requiring mental health evaluation.
d. Monitoring the quality of the referral process to a mental health professional/psychiatrist and whether identification and referral assessments are timely.

Post-Classification Referral

The initial classification gathers information needed to assign inmates to appropriate housing and programs. Inmates not referred during receiving or intake mental health screening may subsequently need mental health services. Post-classification referral is defined as the process by which such individuals are brought to the attention of mental health staff for brief mental health assessment or comprehensive mental health evaluation.

Essential Services

- The referral process may be simple or complex, depending on the facility, the urgency of the situation, and the mental health coverage provided. Facility mental health services plans include written procedures for these referrals.
- Mental health emergency services must be accessible upon referral on a 24-hour basis.
- Inmates awaiting emergent or urgent mental health evaluation or transfer may require special safety precautions, including continuous observation or staggered observation at least every 15 minutes, often conducted by security staff, until the evaluation or transfer occurs.
- Training of health care and custody staff occurs at time of hire and during annual updates and includes how and when to use the referral process.
- Inmates receive timely orientation and explanation of the referral process.
- Psychiatrists assist in developing referral policies and procedures and in training staff in the use of the referral system.

Routine Segregation Clearance and Rounds

Segregation is a high risk housing area with a disproportionate number of suicides compared to general housing units. Inmates may be placed in segregation for protective custody, disciplinary infractions, or administrative reasons (e.g., affiliation with a gang, assault history). Prior to placing inmates in segregation, facilities need to provide mental health screening that includes a suicide risk assessment and a determination of whether the inmate’s serious mental illness is likely to worsen in this environment. Smaller facilities usually provide only a nursing assessment, but those with sufficient mental health staff use a QMHP to complete these assessments. In addition, facilities provide nursing rounds and mental health rounds with a frequency determined by the degree of isolation of inmates. These rounds increase access to health services for the segregated inmate and monitor for signs of decompensation

(See Appendix). Please refer to the section on Mental Illness and Segregation in Part 3 for additional guidance.

Essential Services

- A registered nurse or a QMHP (when available) usually performs the pre-placement assessment.
- Medical or mental health staff conduct segregation rounds at least weekly for inmates who have regular access to social contacts. Inmates in extreme isolation need at least daily medical rounds and weekly mental health rounds.
- Psychiatrists can participate in quality improvement projects on segregation rounds and provide supervision and training to mental health staff that conduct rounds to ensure completion of appropriate risk assessments. Psychiatrists are encouraged to periodically participate in the mental health rounds to be familiar with the setting and establish a positive presence with both inmates and custody staff.

Brief Mental Health Assessment

A brief mental health assessment is defined as a mental health examination appropriate to the level of services needed.

Essential Services

- Brief mental health assessments occur within 72 hours of a positive screening and referral. Urgent cases receive immediate evaluation after referral. Each individual whose screening reveals mental health problems has a brief mental health assessment in an office with sound privacy whenever possible, with a written recommendation for a comprehensive mental health evaluation and treatment if indicated (see next section). When clinically appropriate, an individual may be referred directly for a comprehensive mental health evaluation without a brief mental health assessment.
- The findings of brief mental health assessments are documented in the confidential health record.
- Trained and privileged mental health professionals conduct the brief mental health assessment, which includes a mental status examination, diagnostic formulation, recommendations, and treatment plan if indicated.
- Psychiatrists can have a direct or indirect role in providing this service, including:

    a. Development of policies and procedures
    b. Performing the mental health evaluation or consultation
    c. Supervision and training of the mental health staff

Comprehensive Mental Health Evaluation

A comprehensive mental health evaluation consists of a face-to-face interview in an office with sound privacy and a review of available health care records and collateral

information. It concludes with a diagnostic formulation and, at least, an initial treatment plan.

Essential Services

- A comprehensive mental health evaluation occurs when the brief mental health assessment is not adequate.
- The time frame for completion of the comprehensive mental health evaluation depends on level of urgency.
- The findings of the comprehensive mental health evaluation are documented in the confidential health record.
- Psychiatrists or other appropriately licensed or credentialed mental health professionals conduct the comprehensive mental health evaluation.
- Psychiatrists can have a direct or indirect role in providing this service, including the following:

    a. Performing all or part of the comprehensive mental health assessment when appropriate or necessary (e.g., when an inmate is taking psychotropic medications)
    b. Supervision and training of the mental health staff

- Comprehensive mental health evaluations include access to psychological, neuropsychological, medical, laboratory, and neuroimaging services.

Mental Health Treatment

The definition of mental health treatment appears in Part 1 of this document. Short-term jail confinements generally emphasize crisis intervention, psychotropic medications, brief or supportive therapies, patient education, and suicide prevention (see section on suicide prevention in Part 1). Longer term jail settings and prisons provide these services plus more extensive treatment services, including verbal therapies and skill building activities. Use of psychoactive medication requires thoughtful management in correctional settings. Concerns include side effect management (e.g., heat tolerance, environmental factors, and potential work restrictions) and potential security implications (e.g., diversion or extortion; McKee et al. 2014).

Essential Services

- Inpatient care in the correctional facility or in an external hospital.
- Seven-day-a-week mental health coverage (including coverage with a board-certified or board-eligible psychiatrist).
- Written treatment plans for each inmate receiving mental health services.
- A full range of psychotropic medications with the capacity to administer them, including involuntarily in an emergency where state laws allow.
- Psychotropic medications prescribed and monitored by a psychiatrist or appropriately supervised mid-level prescriber.

- Distribution of psychotropic medications by qualified medical personnel.
- Seven-day-a-week, 24-hour nursing coverage in housing areas for inmates with acute or emergent psychiatric problems.
- Special observation, seclusion, and restraint capabilities in housing areas for inmates with acute or emergent psychiatric problems
- Supportive verbal interventions, in an individual or group context as clinically appropriate.
- Programs that provide productive, out-of-cell activity and teach necessary psychosocial and living skills.
- Training for custody staff in the recognition of mental disorders

Community Reentry and Transfer Planning

Reentry planning coordinates community-based resources and services for inmates in need of continuing mental health care. In jail settings, continuing needs of inmates at the time of transfer to a prison must be documented and coordinated with the receiving facility. Due to the unpredictability of release/transfer from jail settings, community reentry planning should begin at intake.

Essential Services

- Appointments arranged with mental health agencies for inmates with serious mental illness, especially those receiving psychotropic medication.
- Arrangements made with local mental health agencies or prison reception centers to share records, as appropriate, and to have prescriptions renewed or evaluated for renewal.
- Designated staff carry out discharge and referral responsibilities in accord with the facility's protocol.
- Inmates receiving mental health treatment have assessments for community referral prior to release.
- Notification of prison classification/intake staff of the treatment history and current clinical condition of transferred inmates.
- Service contracts, whenever possible, that ensure access to continuity of care in the community.

Part 3: Special Applications of the Principles and Guidelines

Introduction

Some inmate populations have unique evaluation and treatment needs due to their disorders, demographics, or other characteristics. They include individuals with substance use disorders, co-occurring disorders, trauma, non-suicidal self-injury, infectious diseases, sleep disorders, attention deficit hyperactivity disorder, and terminal illnesses. They also include females; youths in adult correctional facilities; geriatric inmates; lesbian, gay, bisexual, and transgender inmates; people with intellectual or developmental disabilities; and veterans. This section addresses the characteristics that must be considered to ensure access to appropriate mental health services for each of these groups. The section also addresses issues related to segregation, seclusion and restraint, telepsychiatry, and spirituality in the lives of inmates.

Other groups and conditions not addressed in may also need special clinical policies and procedures developed by psychiatrists. The important issue of mental health services in juvenile correctional facilities requires its own analysis, which is beyond the scope and expertise of this Task Force report.

Treatment Issues: Specific Disorders/ Syndromes

Substance Use Disorder

Substance use disorder refers to signs and symptoms (ranked from mild to severe) related to the use of legal and illicit substances such as tobacco and methamphetamine. In the correctional setting, substance use disorders are the most frequently diagnosed mental disorders and often co-occur with serious mental illness.

Over two-thirds of offenders may have a substance use disorder at the time of their entry into the criminal justice system (Karberg and James 2005). Criminal behavior often occurs when an individual is under the influence of alcohol or other drugs or may be related to efforts to procure or sell substances. Much of the increase in the American prison population is ascribed to criminal activity related to substance use and the implementation of harsher sentencing guidelines for these activities.

Screening and Assessment Assessment of, and screening for, substance use disorders, particularly associated intoxication and withdrawal, are critical at entry and transfer to correctional facilities. While jails and lock-ups are the point of entry for most individuals entering correctional settings directly from the street, many parole violators proceed directly back to prison. Given the availability of substances of abuse in correctional facilities, individuals transferred between facilities should not be presumed to be drug free.

Screening instruments for substance use may be part of a larger mental health screen or administered separately. Instruments should include, at a minimum, questions about the individual’s use of alcohol and other drugs and the patterns of use with particular attention to signs or symptoms of intoxication or recent use that require a withdrawal protocol. Severe intoxication with some substances (e.g. alcohol, opiates, stimulants) and withdrawal from others (e.g. alcohol, barbiturates, benzodiazepines) can be life threatening and require quick management in collaboration with trained medical staff in a setting appropriate to the acuity.

Jail suicide is closely linked to substance use. Half of all individuals who complete suicide in lock-ups and detention facilities have a history of substance abuse (Hayes 2010). This number is likely an underestimate because of the limitations of screening procedures. Many of these suicides are related to complications of intoxication or withdrawal. A positive substance intoxication or withdrawal screen should trigger an immediate mental health assessment for suicide risk factors, including mood symptoms and suicidal ideas. Individuals with substance use disorders may also present with medical, neurological, or psychiatric problems. For example, hepatitis, HIV, neuropathies, dementia, and mental illness are frequently comorbid with chronic and/ or severe substance use.

Psychiatrists can play an important role in developing the receiving screening instrument (s), training staff in its use, and educating correctional security, medical, and mental health staff about the signs and symptoms of intoxication and withdrawal.

Diagnosis and Treatment An evaluation by a psychiatrist or qualified mental health professional helps ensure recognition and management of substance use disorders and avoids misdiagnosing their sequelae as major mental illness (e.g. psychosis as a result of hallucinogen intoxication).

Psychotropic medications prescribed by a psychiatrist or other physician, or another authorized prescriber, may be required during detoxification for management of symptoms associated with withdrawal. Benzodiazepines or methadone/ buprenorphine (as appropriate) may help prevent or attenuate withdrawal symptoms and using them short-term at tapering dosages lessens the likelihood that the prescribed medication serves as a substitute for the substance of abuse or is diverted or used inappropriately. Facilities need to avoid formulary restrictions that lead to lead negative clinical outcomes for patients. Other psychotropic medications, including antipsychotics and mood stabilizers, for individuals with no history of mental illness require judicious use. Such treatment should begin only after detoxification and reasonable substance-free periods. Clinical judgment regarding continuity of care must be used on a case-by-case basis for individuals prescribed psychotropic medications in the community.

Individuals may enter correctional facilities from opioid maintenance programs (e.g. methadone or suboxone) in the community. Facilities vary in their willingness to continue prescribing these medications, but abrupt cessation or an overly rapid taper must be avoided.

Inmates need access to individualized substance use treatment services, including therapy, group psychotherapy, therapeutic communities, skills training, community support and self-help groups (e.g., Alcoholics Anonymous), and family support. Self-help, 12-Step, and peer support groups and networks play an important role in rehabilitation of alcohol and other drug users in the correctional system. Allowing outside community support self-help meetings into the correctional setting permits integration and identification with the community upon release.

Rehabilitation takes time and must extend past incarceration in order to have a positive impact on criminal recidivism and the sequelae of substance use. Discharge planning includes referral to community-based substance use treatment services where providers know about the risk of accidental overdose and death for individuals leaving a correctional facility.

Co-Occurring Disorders

Co-occurring mental illness and substance use disorders often go undetected in people in contact with the criminal justice system. This failure is typically due to the absence of effective screening and assessment and the difficulty of identifying the often-complicated symptom picture with which this population presents. Non-detection of one or more co-occurring disorders may exacerbate behavior problems, criminogenic risks, and the risk of suicide. Furthermore, it may result in poor outcomes in treatment during incarceration, and lead to increased risk of rearrest and reincarceration.

Mental health services in correctional facilities need an integrated and coordinated system of screening, referral, assessment, and diagnosis for co-occurring mental illness and substance use disorders that includes active collaboration between security staff and treatment staff to share information on signs and symptoms of co-occurring disorders at transition points (e.g., arrest, booking, jail, prison reception) throughout the system. Evidence-based screening tools can help identify individuals who need further assessment. Some screening tools require a clinician to complete, but many can be completed quickly even by non-clinical staff.

Detection of one type of disorder (i.e., substance use or mental illness) should trigger further assessment of the other type of disorder because either can mimic, overshadow, or interfere with detection, or affect the presentation of the other.

Persons with co-occurring mental illness and substance use disorders who become justice-involved are a particularly service-intensive group. We recommend the following strategies for treating co-occurring disorders. These strategies require adaptation to different settings.

- Integrate treatment that simultaneously addresses mental illness and substance use disorders.
- Treat each disorder as primary, with a simultaneous focus on understanding the interaction.
- Address psychosocial problems and skill deficiencies with individualized programming based on comprehensive assessment and consultation with the patient, treatment provider, and family members (where accessible and with informed consent of the patient).
- Delay starting new psychotropic medications until after detoxification unless required by acute symptoms (e.g., psychosis, suicidality).
- Design interventions that differ in intensity, length, and type of services for the particular setting e.g., prison, jail, or community corrections) and focus on engagement with patients and strength-based, recovery-minded interventions. Extend treatment services into the community, with special attention in discharge planning for co-occurring disorders, housing, employment, and family reconnection.
- Medication Assisted Treatment (MAT), when available, can be an effective intervention to help reduce the chance of relapse of the substance use disorder and recidivism, especially when an inmate is close to release.

- Integrate treatment with self-help groups and support networks that can assist treatment participants in maintaining their commitment to daily alcohol and drug abstinence.

Trauma and Posttraumatic Stress Disorder

Traumatic events are widely defined but, according to the DSM-5, encompass "exposure to actual or threatened death, serious injury or sexual violation" (APA 2013). Exposure can be direct or indirect, as in witnessing an event occurring to another, learning of the event happening to a close friend or family member, or first-hand exposure to disturbing details of the event. Inmates have a high risk for direct and indirect exposure to traumatic experiences (e.g. violence, sexual assault, separation from loved ones) while incarcerated. They also often have developmental histories that include physical, sexual, and emotional abuse and neglect. Rates of current and past traumatic exposure are even higher for individuals with mental illness or substance use disorders in correctional settings. Many of them have experienced chronic stressors such as poverty, homelessness, and social isolation. Individuals with mental illness are more likely to be victimized and to receive additional punishment for rule violations in correctional facilities. Given the risks, rates of post-traumatic stress disorder (PTSD) and many of its complex variants are, not surprisingly, higher in correctional populations than in the general population.

Reactions to trauma, including the development of serious mental illness or PTSD, can significantly affect an incarcerated individual's behavior, medical conditions, response to therapeutic interventions, and risk for violence, self-injury, and suicide. It is therefore important that correctional intake facilities incorporate comprehensive trauma histories into their assessments. Clinicians and custody staff also need training about the impact of trauma and the implications for treatment and management. Because of the high prevalence of lifetime exposure to trauma in correctional populations, particularly physical and sexual abuse, all interventions should involve trauma-informed care and clinicians need training to assess the psychological consequences of childhood and adult abuse. For example, self-injurious behavior may result from dissociative phenomena or flashbacks of abuse rather than psychotic symptoms or poorly controlled impulsivity.

The use of seclusion, restraint, or forced medication raises special concerns in the context of trauma histories. These methods of control may inadvertently re-traumatize inmates who have had similar experiences in the past, both in and out of institutional settings. These measures may be less traumatic if discussions are held with inmates early in their treatment and incarceration. Mental health clinicians can work with patients to develop interventions that will best help calm them down in the event of later agitation. If prophylactic measures are not successful, verbal de-escalation, supportive measures, and recognition of the underlying emotional issues can help avoid use of force.

The use of force is disproportionately used with inmates who are mentally ill. It is increasingly common that mental health staff are requested to attempt face to face verbal intervention with inmates prior to the use of calculated (i.e., planned use of force) with all inmates, especially those with mental illness. Chemical agents (e.g., pepper spray) should rarely be used in healthcare settings such as infirmaries or special needs

units for inmates with mental illness. Psychiatrists may play a key role by participating in staff training in de-escalation techniques.

In addition to training in trauma-informed care and de-escalation techniques, clinicians and custody staff need training about gender differences relevant to the etiology of and response to trauma (Moloney et al 2009). Studies consistently indicate that incarcerated women have higher rates than men of serious mental illness, substance use disorders, and diagnoses of PTSD (e.g., Fazel and Danesh 2002; Trestman et al 2007). Women also have higher rates of victimization, including childhood sexual abuse, domestic violence, prostitution-related violence, and sexual assault in correctional settings. Men have perpetrated much of this violence. Wherever possible, same-gender staff should be available particularly during times of vulnerability (e.g., when inmates are unclothed or are being restrained). Custody and clinical administrators need to ensure that staff responsible for the safety and security of women in correctional facilities minimize the chance of inflicting further trauma.

Incarcerated men have high rates of childhood physical and sexual abuse and direct and indirect exposure to community-related (e.g., gang) and correctional violence. Men and women may respond differently to trauma and to being re-traumatized while incarcerated. Women have a higher risk of developing anxiety-related symptoms, sleep disturbances, and PTSD. Men may respond to trauma with more subtle symptoms but may also act out aggressively in response to traumatic triggers. National attention to the importance of trauma sustained in correctional settings, particularly sexual abuse, has increased. The implementation of PREA now generates more medical and mental health referrals and enhances the potential for intervention, support, and treatment for traumatized inmates.

Identifying and treating incarcerated individuals who have symptoms or disorders because of exposure to traumatic events is important for maintaining a safe correctional environment for patients and staff and for preventing criminal and traumatic recidivism upon release. Traumatized individuals, especially those with incarceration histories, are more likely to offend again (e.g. arrests for substance-related crimes, prostitution, or violence) and to return to substance use, and less likely to actively engage community mental health resources.

Non-suicidal Self-injury

As used in this report the term non-suicidal self-injury (NSSI) refers to acts intended to cause bodily harm but not death. Such acts include cutting, burning, self-hitting, self-biting, hair pulling, head banging, and ingesting or inserting foreign objects, but exclude tattooing, body piercing, risky sexual behaviors, and other behaviors that have non-harmful motivations. Differentiating between NSSI and suicide attempts often poses challenges. Self-reports of intent have limited reliability and some NSSI behaviors may inadvertently result in death.

Diagnoses commonly associated with NSSI include personality (Cluster B and mixed), mood, psychotic, cognitive, and developmental disorders. The behaviors seen with each condition frequently have distinguishing characteristics (e.g., relief of distress with borderline personality disorder, stereotypic behaviors with intellectual or developmental disorders, and significant tissue damage with psychotic disorders).

NSSI may also occur in the absence of an underlying psychiatric disorder.

Interpersonal and environmental factors often trigger and reinforce these behaviors among inmates. Segregation and other lock-down settings have the highest rates, and conflicts with staff or other inmates sometimes precipitate NSSI. Responses that reinforce the behavior can include attention, relief of boredom, change in housing, infirmary or hospital visits, and access to analgesics or other medications. Inmates have limited autonomy, but self-injury offers a way to affect their environment, cope with stress, communicate anger, retaliate against staff by disrupting operations, or meet other needs (Appelbaum et al. 2011).

Labeling and dismissing NSSI as manipulative can be dangerous to the inmate and lead to missed management opportunities. Instead, identification of triggering and reinforcing factors provides the first step toward planning interventions. Such interventions might include creative use of privileges, property, or housing. Effective management always involves shared responsibility and partnership among mental health, medical, and custody personnel.

Psychiatrists must play an active role in addressing NSSI. They can help ensure completion of an adequate diagnostic assessment. Depending on the findings, this may lead to treatment, when appropriate, or working with custody staff to clarify behavioral motivations unrelated to a psychiatric disorder. Psychiatrists can also help develop evidence-based behavioral interventions with realistic goals, such as diminution, but not extinction, in the frequency and severity of NSSI. Accomplishing this requires close collaboration with custody staff and may include explaining the lack of indications for medication or other treatment, acknowledging adverse emotional reactions to the inmate, fostering a dispassionate understanding of the behavioral dynamics, and modeling a professional approach focused on problem-solving instead of dominance and control.

Infectious Disease

Adults with mental health and coexisting medical problems are overrepresented in correctional populations. The number of offenders with mental illness and chronic (e.g., cardiac disease, hypertension, diabetes, cancer, end stage liver and kidney disease) and infectious diseases continues to grow.

HIV and AIDS, hepatitis B and C, tuberculosis, influenza A (H1N1) virus, methicillin resistant staphylococcus aureous (MRSA), sexually transmitted diseases (STD), norovirus, and other gastro-intestinal borne agents, are infectious diseases common to correctional settings. HIV and AIDS, viral hepatitis, and tuberculosis, each of which has complex management problems in the community, present even more complicated challenges in correctional settings, including recognizing the need for medical, mental health, and psychiatric services. The risks of social stigma and issues of personal safety complicate confidentiality for the infected inmate, other inmates, and correctional and clinical staff. The usual cultural differences among inmates and security and health care staff may be exacerbated in cases of inmates with these infections, especially HIV/AIDS. Education of staff and inmates about infectious diseases and the means of transmission is especially important for both personal and population health risk reduction. Inmates need access to health educational materials and resources on prevention of transmission and consequences of continued high-risk behaviors for HIV and viral hepatitis such as promiscuity, unprotected intercourse, intravenous drug use,

and respiratory transmission of tuberculosis.

Correctional facilities that seek accreditation by NCCHC, ACA, the Joint Commission, or a combination of the above, routinely monitor for hepatitis, HIV, STD's and tuberculosis and must have an effective infection control program. For example, NCCHC has an essential standard requiring the responsible health authority to have a written exposure control plan approved by the responsible physician and reviewed and updated annually.

Inmates need access to mental health treatment regardless of their housing arrangements. Housing restriction (and, particularly in the case of tuberculosis, the need for respiratory isolation) may exacerbate inmates' feelings of abandonment and may lead to a worsening of symptoms of coexisting mental illness.

HIV: Estimated rates of HIV infection in U.S. prison populations have consistently exceeded rates in the general population. There has been a national effort to implement new treatments for HIV, such as combination therapy with multiple antiretroviral drugs, and to develop evidence-based standards of care. These efforts have been highly effective in delaying progression of the disease and transforming HIV into a chronic, manageable condition in most cases. These favorable outcomes come at a price. Medication costs for HIV treatment for prisoners continues to be one of the largest single components of pharmacy expenses for many systems. Further cost increases are expected with the addition of newer classes of antiretroviral drugs.

From a clinical perspective, the most common psychiatric manifestations of HIV/AIDS include early signs of dementia, paranoia, and other psychotic and depressive symptoms. For these reasons, correctional mental health systems might initiate surveillance, outreach programs, or periodic rescreening for early detection and to foster early use of mental health services.

Hepatitis C Virus: Current challenges of Hepatitis C virus (HCV) in corrections include the large number of infected offenders, the increased use of medications, and more sophisticated and expensive treatment standards. Several strategies promote uniform, cost-effective processes for managing the often-complex psychiatric and medical needs of HCV infected offenders. These include chronic care clinics, a case management program, evidence-based disease management guidelines, and formulary controls.

The prevalence of HCV infection is higher among correctional populations than among the general U.S. population (Spaulding et al 2013). Although most HCV-positive offenders are asymptomatic, those who develop a chronic infection risk serious complications and death. Chronic HCV infection is the leading cause of end-stage liver disease in correctional settings. More cases of liver failure are expected as the proportion of older offenders continues to increase.

HCV-infected offenders who progress to end-stage liver disease require frequent and costly hospitalizations and emergency room services for treatment of bleeding, abdominal fluid retention, and other serious complications. Ultimately, the only viable option for some of these offenders will be liver transplantation, a procedure with substantial initial and subsequent costs. From a clinical perspective, increased ammonia level is commonly associated with behavioral disturbance and presents as a delirium with waxing and waning symptoms that requires timely medical intervention.

Chronic HCV infection is a risk factor for liver cancer and a contributing factor in

many liver cancer deaths. Many correctional healthcare system providers are facing unprecedented challenges in addressing the growing HCV epidemic. These challenges revolve around financial and logistic impediments to evaluating and treating such a large number of HCV-infected offenders along with a constantly evolving consensus about how to best manage the disease in the correctional setting. Meeting these challenges has enormous public health implications because most HCV-infected offenders eventually return to their home communities with the potential to infect others.

Accepted standards of care for the management of HCV infection recommended by the National Institutes of Health and other key groups are rapidly evolving. Until recently selective treatment with a combination of ribavirin and pegylated interferon to eradicate the virus from the bloodstream and liver biopsy to determine which offenders are most likely to benefit from antiviral therapy was a recommended standard of care. The use of interferon required mental health screening and evaluation when clinically indicated for the development of depressive symptoms and suicidal ideation. This increased the mental health and psychiatric service need demands for correctional facilities. Some systems have limited antiviral treatment options, and some limit treatment to those patients at highest risk for developing cirrhosis and subsequent liver failure.

Offenders with end stage liver disease and associated conditions are particularly difficult to treat. They may not need medical hospitalization, but require specialized housing (often with supplemental oxygen, vital sign and cardiac monitoring, and on-site nursing and medical staff) specialists who can manage end state liver disease and associated complications, access to laboratory studies), and coordinated treatment by nursing, medical, psychiatry and mental health staff.

Many correctional systems struggle to meet the costs of newer HCV medications. Most prison systems treat only a small fraction of infected inmates. Current and emerging therapeutic agents might cure HCV infection in most patients. Mathematical modeling also shows that expanded HCV screening and treatment are cost-effective from the societal perspective (Spaulding et al. 2013). Correctional health leaders and policy-makers must carefully weigh the costs of these medications, associated clinical equipment and testing, and staffing. Some newer medications require refrigeration, administration with food, and multiple daily dosing, but other more costly agents can be administered once a day with purportedly fewer side effects. Some agents require treatment for 24 weeks and rigid compliance for treatment efficacy.

Other chronic infectious diseases present similar challenges for the delivery of psychiatric services, and the principles stated above may also apply to them.

Sleep Disorders

Inmates often seek health care for sleep problems. While many studies of sleep-wake disorders have been conducted on the general population and different patient groups, studies in correctional settings are limited.

Sleep-wake disorders in DSM-5 include ten conditions characterized by disturbed sleep and ‘distress as well as impairment in daytime functioning’ (American Psychiatric Association 2013, pp 361-422). In the United States, at least 10 per cent of the population has sleep problems (Kraus and Rabin 2012). Of the ten sleep-wake disorders, insomnia has the most relevance for inmates. It can have serious

consequences, such as increased risk of depression and hypertension and impaired daytime functioning.

Acute, short-term insomnia (i.e., less than three months) is often caused by situational stress and medical or psychological disorders. Health care personnel need to discuss acute stress with patients and provide appropriate education. Short-term treatment strategies encompass sleep hygiene and, if needed, prescription of sedative hypnotics, usually a benzodiazepine (BZD) (Cunnington et al. 2013).

For insomnia disorder (i.e. sleep problems that persist at least three nights per week for at least three months), empirical evidence supports two treatment strategies. In the past, the predominant approach was pharmacological. However, studies have proven that medication alleviates symptoms at most for the first six weeks. Side effects of benzodiazepines include habituation and tolerance, as well as paradoxical effects in the ageing population.

Psychological interventions, commonly cognitive behavioral therapy (CBT), typically yield enduring, clinically significant benefit whether used alone or in combination with pharmacological treatment (Mitchell et al. 2012). CBT for insomnia can be used in individual or group sessions or as self-administered written or audiovisual material. In addition to CBT, sleep hygiene, progressive muscle relaxation, and cognitive therapy have demonstrated efficacy (Morin and Benca 2012).

Some correctional facilities use guidelines to reduce prescriptions of benzodiazepines. Sometimes, this results in alternative medications being ordered. These medications can themselves have significant side effects and management concerns.

Insomnia may be related to the conditions of confinement, fears for personal safety with associated hypervigilence, pre-existing psychiatric or medical disorders, caffeine intake, drug misuse, lack of physical activity, and daytime napping. Correctional psychiatrists should assess such factors and work to intervene while taking into consideration the possibility of misuse and diversion.

Attention Deficit Hyperactivity Disorders

Research suggests that criminal justice populations have an elevated prevalence of attention deficit hyperactivity disorders (ADHD). Although most studies of this population have methodological shortcomings that limit their reliability, ADHD can persist into adulthood and does occur among inmates. Diagnosis and management pose challenges in correctional settings, as they do in the community.

Characteristic symptoms of ADHD such as inattention, restlessness, poor planning, poor frustration tolerance, and impulsivity occur with other psychiatric and medical disorders and as part of ordinary, non-pathological human experience. When due to ADHD, these symptoms have identifiable persistence and severity that significantly disrupts success in social, academic, and vocational areas in both the community and correctional environments. Accurate diagnosis of ADHD generally requires a comprehensive assessment that includes a history of childhood symptoms, review of educational records, use of symptom rating scales, collateral information from reliable third parties who know the patient, and a thorough diagnostic interview with assessment of alternative explanations for the patient's symptoms. Correctional facilities often have limited resources to readily accomplish this detailed assessment.

Along with diagnostic challenges, correctional psychiatrists face obstacles to treating ADHD with standard stimulant medications. The high prevalence of substance use disorders among inmates can lead to false or exaggerated presentations of symptoms to obtain stimulants for abuse or diversion. Assessments in these cases consume valuable psychiatry time. In addition, some inmates apply intense pressure (i.e., coercion or extortion) to obtain controlled substances from peers receiving appropriately prescribed stimulant medications. Custody personnel must remain alert to deliberate misuse of these medications and to coerced diversion. Special handling and documentation of controlled substances also consume nursing time. Thus, the assessment and management of ADHD symptoms can increase workloads for clinical and custody staff.

ADHD, however, is a psychiatric condition that can significantly impair an inmate's functioning. Inattention to directives, poor planning with diminished consideration of consequences, poor frustration tolerance, and impulsivity can lead to dysfunction, disruptive behavior, and disciplinary infractions. ADHD diminishes an inmate's ability to participate in work, education, and programming. Despite the effect on staff workload, clinicians should consider ADHD in the differential diagnosis of an inmate's presentation, apply efforts to confirm or exclude it, and treat it when necessary to improve inmate functioning and diminish facility disruption.

Treatment modalities for ADHD include psycho-education, cognitive behavioral therapies, and controlled and non-controlled medications. Therapy-based interventions can assist with the inmate's adaptation to the challenges of the correctional environment while having symptoms of inattention. The effectiveness of stimulants in reducing the symptoms of ADHD is well established. A ban on stimulants deprives inmates with legitimate needs from access to effective treatment.

Inmates with significant impairment in current participation in work, education, programming, or other meaningful activities due to ADHD should receive appropriate treatment. This includes access to stimulant medications if other interventions, including non-stimulant medications, are contraindicated or insufficient to adequately improve functioning. Evidence of active misuse of substances in the correctional setting, however, contraindicates prescription of stimulants. Whenever possible, observations from correctional officers, work supervisors, programming staff, teachers, and others can help confirm the presence of current functional impairment and response to treatment.

A recommended approach (Appelbaum 2009) to deciding which inmates to treat for ADHD begins with a review of current activities and functioning. Because of the challenges and risks associated with prescribing controlled substances, only those inmates actively engaged in, or attempting to engage in, productive work, education, and programming would have potential eligibility for treatment with stimulant medications. Difficulty in leisure activities alone, for example, would not meet this criterion. In addition, treatment based solely on disruptive behavior due to ADHD runs the risk of encouraging harmful acts by inmates seeking stimulants. Accordingly, inmates who have, or seek, no involvement in meaningful activities need no further work-up for stimulant treatment.

In contrast, those inmates who have persistent inattention and/or hyperactivity-impulsivity that interferes with current productive functioning do warrant further

assessment. The assessment typically includes obtaining observations by third parties (e.g., correctional officers, work supervisors, teachers) and a review of childhood information and records if available. As resources permit, use of observer and self-report rating scales and neuropsychological testing can help identify functional deficits and aid with diagnosis and monitoring. During the clinical examination, the psychiatrist also must assess for comorbidity and alternative symptom etiology.

When supported by the complete evaluation, the psychiatrist may begin pharmacologic treatment with non-stimulant medications unless contraindicated or unsuccessful for the inmate. If stimulants prove necessary, use of shorter acting and crushable agents can lessen the risk of diversion. Some of these considerations may involve off-label, but evidence-based, pharmacotherapy. The psychiatrist should usually make continued prescription of stimulant medications contingent on the inmate's engagement in any recommended non-pharmacologic interventions for ADHD (e.g., education and therapy) and absence of current use of illicit substances.

A systematic approach to assessment and decision-making can lessen unwarranted administrative and clinical burdens and reduce the risk of medication misuse while still ensuring that inmates with legitimate needs receive treatment.

Treatment Issues: Specific Populations

Women

The number of incarcerated women is rising at a rate that exceeds the rate for men. Although men still comprise the overwhelming majority of incarcerated individuals, access to medical and mental health care is equally important for women. Historically, psychiatric and other treatment programs for women have been based on treatment models designed for men. Studies show that the rates of serious mental illness for women entering a jail or prison setting are significantly higher than for women in the community and are greater than the rates for incarcerated men (Fazel and Danesh 2002; Steadman et al. 2009). While rates of major mood and psychotic disorders are high, posttraumatic stress disorder (PTSD) is particularly prevalent (Trestman et al. 2007).

Female inmates frequently encounter different stressors before, during, and after incarceration than their male counterparts. Most women in correctional settings are mothers and have at least one child for whom they have been the primary caregiver prior to incarceration. Women who are pregnant during their incarceration are especially vulnerable. Over 75% of women entering correctional settings report a history of emotional, physical, or sexual abuse as a child or adult (Moloney et al 2009). They have higher rates of domestic violence victimization than men. Incarcerated women have greater risk than men for sexually transmitted diseases and HIV because of prostitution, higher rates of substance use disorders and drug offense arrests, and are more likely to be victims of sexual assault while incarcerated.

Women, in general and in correctional settings, have a higher degree of treatment engagement in mental health services than men. Clinical staffing ratios have to reflect the relevant needs, including consideration of gender-specific stressors described above and willingness to participate in services. For example, facilities need to provide comprehensive post-partum mental health evaluations to minimize the risk of

postpartum depression and psychosis; education for all staff and inmates about what constitutes sexual harassment and abuse; and access to adequate psychotherapeutic modalities, including cognitive-behavioral and group interventions.

Clinical and custody staff require training in gender-specific issues when working with female inmates. This training helps staff to recognize different symptom presentations, respond to different coping styles, provide appropriate treatment, and be sensitive to histories of abuse and trauma, especially when considering the use of forced medication or seclusion/restraints. Male inmates face many of the same challenges and the above principles may also apply to them.

Youth in Adult Correctional Facilities

For the purposes of these guidelines, youth is defined as an inmate under the age of 18. The United States still tries some juveniles in adult criminal courts. At the time of this writing, New York and North Carolina automatically charge individuals 16 years of age and older as adults; ten other states plus the District of Columbia automatically charge individuals 17 years of age and older as adults. In many states, certain felony offenses committed by adolescents are moved to adult criminal court. This practice has led to an increase in the detention and incarceration of younger offenders in adult jails and prisons. Data reflect rates of serious mental illness among incarcerated adolescents that are substantially above those found in the community (Fazel et al. 2008).

Although there is limited systematic data on the number and ages of youth in adult correctional facilities, there appears to be an increasing national trend for incarcerating younger individuals. Recent scientific inquiry and legal recognition focuses on differences between adolescents and adults, especially in brain development. This emerging literature on adolescents reveals developmental immaturity, increased risk taking, testing of rules and limit-setting, behavioral dyscontrol, and heightened desire for peer group affiliation and validation (all of which may pose challenges to staff, administrators, and clinicians within correctional settings).

Youth have a wide range of chronological and developmental maturity. This has clinical implications complicated by differences in (1) seriousness of offense ; (2) stage of court proceeding and legal status (whether the juvenile will be tried in juvenile/family court or waived/transferred to adult criminal court); (3) legal history (e.g., first-time offender versus repeat offender, multiple incarcerations); (4) gang affiliation; (5) family and psychosocial resources or other supports; (6) youth and family's attitudes toward law enforcement, the court, state social services, or medical and mental health services; and (7) diversity issues such as race, culture, ethnicity, religion, sexual activity, and gender identity (Penn and Thomas 2005).

The presence of young inmates, who may be physically and emotionally immature, has led to a plethora of challenges for correctional systems. Youth with mental disorders present a special challenge. Only juveniles charged with the most serious crimes or with the most extensive and violent criminal histories are typically transferred to an adult court. As a group, they are likely to be especially impulsive, treatment resistant, and potentially violent. The presence of these youthful offenders in adult settings causes important and challenging problems for correctional administrators and custody and clinical staff (Penn and Thomas 2005). These problems include the

likelihood that these youth have engaged in a pattern of high risk-taking activities, substance abuse, school truancy, and other delinquent behaviors. Many have histories of physical and sexual victimization and exposure to traumatic events. There is the real possibility of re-victimization either by adults or by fellow minors.

Because of their developmental immaturity and impulsivity, youthful offenders often engage in oppositional and defiant behaviors. Some observers have reported high levels of psychopathology, learning disorders, low intelligence, other developmental delays, fetal alcohol effects, neurological impairment, and disruptive behavior disorders such as ADHD, oppositional defiant disorder, and conduct disorder among young inmates. While housed in jail settings awaiting their legal disposition and possible waiver/transfer to the adult system, many adolescents face great anxiety based on the uncertainties of their cases and terrifying myths or fantasies about the jail or prison experience. Convicted felons whose sentences represent a relatively higher percentage of their life (e.g., a 16-year sentence feels like “life” in prison to a 16-year-old boy) may perceive themselves as having “little to lose,” which increases their risk of self-harm, attempted or completed suicide, impulsivity, behavioral dyscontrol, and dangerousness within the facility.

The Juvenile Justice and Delinquency Prevention Act (JJDPA; 1974) outlines requirements for juveniles in the criminal justice system. The JJDPA is currently the primary federal law intended to protect such youth. The JJDPA has four core requirements for state systems: deinstitutionalization of status offenders; separation of juveniles from adults in secure facilities; removal of juveniles from adult jails and lockups; and reduction of disproportionate minority contact (DMC) in the juvenile justice system.

Due to the JJDPA, the Prison Rape Elimination Act (PREA), and the risk of state and federal litigation, most correctional systems have attempted to increase the safety of minors in adult correctional settings through sight and sound separation from adult prisoners. This response, however, may create barriers to educational, recreational, and treatment programming; limits contact exclusively to other youth who are equally immature, impulsive, and potentially violent; risks isolation when the peer group is very small; and precludes contact with more mature incarcerated adults who might model adaptive and prosocial prison behaviors. In contrast, youth with unsupervised access to older inmates have a greater risk of exploitation or of a strengthening of their identification with a criminal lifestyle.

Justice-involved youth have a high prevalence of risk factors for suicide. Many young prisoners have experienced severe physical, sexual, and emotional abuse and neglect, leading to trauma-related anxiety and depressive disorders, especially PTSD, that require mental health intervention. Some confined youth engage in self-injurious behavior and suicide attempts, and facilities need comprehensive suicide prevention policies and programming that reduce this risk.

Screening is no less important for youths than for adults. A system can expect many positive screens and may presume that each youth will require some mental health evaluation and referral, even when there is no identifiable history of mental health or medication treatment. Adult correctional systems that house youth typically require mental health evaluation of every minor. The evaluation should include special attention to intelligence, history of mental health treatment, special educational needs, and

histories of emotional disturbances that often may have gone undetected.

Ideally, adult correctional facilities housing youthful offenders should have access to mental health professionals with experience in working with adolescents. At the very least, staff who work with these youths need additional or specialized training in identification of emerging emotional problems and when and how to refer youth for additional mental health and psychiatric treatment. They also will need special orientation to community services, if any, that will be available to the youth upon release.

Incarceration of juveniles in adult settings, however tragic, presents some opportunities. For example, conditions nearly untreatable in an adult may be treatable in a teenager. Many youth with learning disabilities, school truancy, or expulsion have severe educational deficits that can be remedied in this setting. Further, legal mandates for educational programming for adolescents actually may increase the resources available for this population.

When evaluating an incarcerated youth, psychiatrists need to use a bio-psycho-social model with attention to unique adolescent developmental, peer, gender, cultural, religious, and family issues. The assessment includes history of trauma, peer and family relationships and functioning, and family psychopathology (domestic violence, physical and sexual abuse, family criminality, substance abuse, or mental illness). A detailed assessment of the youth's past exposure to violence and perpetration of violent or illegal behaviors is essential. Psychiatrists should also carefully elicit any history of high risk behaviors – unprotected intercourse, promiscuity, multiple partners, gang activities, prostitution, running away – and comorbid eating, somatoform, and gender dysphoria disorders.

Psychiatrists often evaluate youthful offenders presenting with insomnia, depression, disruptive behaviors, or other symptoms. Many youth in the juvenile justice and adult correctional system are on multiple medications when initially detained, but others have never received medications; a comprehensive psychiatric assessment, when clinically indicated, provides an opportunity to reassess their treatment needs.

Psychotropic medication use requires caution and review of the potential risks, benefits, side effects, and alternatives with the youth and the youth's parent or legal guardian if the youth is still a minor. State mental health codes usually require a signed informed consent for minors. Use of multiple psychotropic medications – polypharmacy –requires caution because of potential risks, medication interactions, and side effects. Newly detained youth on psychiatric medications need careful assessment and monitoring, including serially reevaluations or gradual reductions in the number of medications while housed in a contained, structured, and supervised setting. Ideally, to ensure that the treatment trial proceeds safely and under supervision, medication changes follow clarification or resolution of a youth's legal disposition and placement.

Informed consent poses challenges because many youth have limited legal ability to consent to treatment and have "burned bridges" with their families of origin by the time they reach adult corrections. Special attention must be paid to gaining legally adequate informed consent, often through the use of treatment guardians. Similarly, clinicians may have conflicting duties to inform parents about the youth's care and, concomitantly, to maintain the youth's confidentiality.

With or without family involvement, these young prisoners are likely to have

intense psychological and social work needs relating to their families of origin. These needs may include confronting intense anger over past neglect, abuse, and inconsistent or unavailable parenting, and negotiating better relationships in the future, especially regarding family visitation, helping with problem solving for the receipt of bad news, identification and management of disappointment and frustration regarding cancelled or no show visits, family inconsistency, lack of support, and when release to the community is imminent.

Because of their involvement in the juvenile and adult justice systems, many of these high-risk youth may not have had the opportunity to experience normal developmental and maturational steps. Interestingly, many desire structure, rules, reliable adult role figures, and a predictable daily schedule. They may do very well with clear and consistent rules and consistency, and with behavioral incentives.

Clinicians should recognize that while all seek the "best interests" of an incarcerated juvenile, a dynamic tension exists between the safety, security, and punishment approach of custody staff and the rehabilitative or therapeutic approach of clinicians. Each of the institutional service areas has its own legal mandates. Thus it is paramount to learn the strengths, weaknesses, communication patterns, and relationships among mental health clinicians, direct-care and other professional staff, outside agencies that interface with or provide other services to the juvenile correctional facility, educational staff and systems, and local medical staff (e.g., nursing, pediatric, dental).

The formulary, too, has to reflect the needs of these younger patients. Pharmacy and therapeutic committees and leaders that make decisions about formulary medications need to review the risks and benefits of medications that are typically restricted in adult correctional settings (e.g., psychostimulants, alpha-2 adrenergic agents, newer mood stabilizer and antidepressant agents, atypical antipsychotics) and the likelihood of polypharmacy and off-label medication treatment of youth in the community.

Special challenges often arise when youth approach community release. Because they may never have been able to "make it on the street," or because of intense familial conflict or unavailability, gang conflicts, or other psychosocial stressors, many youth offenders become extremely anxious, and even self-destructive, as their release date nears. Some will commit obvious and easily detectable infractions in order to forestall release. Mental health clinicians may be crucial in easing this transition through psychotherapy and referral to support services in the community.

Geriatrics

Effective access to mental health services for older inmates requires recognition of the special challenges facing inmates and mental health professionals, especially as the number of offenders over the age of 65 in state and federal prisons increased at 94 times the rate of the overall sentenced population between 2007 and 2010 (Fellner 2012). The dramatic increase in the number of elderly inmates in correctional facilities over the past decade represents a humanitarian crisis. The causes include increasing life expectancy, harsher sentencing practices (long sentences, including life without parole), and, paradoxically, better health care in correctional facilities.

The National Institute of Corrections suggests that it may be useful to consider

inmates over the age of 50 as more likely to have common problems of aging even though the standard in the community is usually 65. This relatively young definition for the geriatric inmate population is supported by the relatively high "biological age" of inmates due to substance abuse, poor nutrition, lack of prior medical care, lower socioeconomic life in the community, and other factors.

Older inmates have special medical needs that sometimes present with psychiatric symptoms or sequelae and affect psychiatric intervention, medications, relevance of counseling, structure of programming time, and housing. The problems are often chronic, persistent, progressive, related to the possibility of dying in custody, and expensive. Older inmates may also have environmental needs such as cells retrofitted with grab bars, handicap toilets, and facilities that accommodate wheelchairs.

Special psycho-social concerns that older inmates face may include:

- Lack of connection to other inmates in the general population;
- Physical vulnerability to serious consequences of assault;
- Difficult and prolonged adjustment to a new environment;
- Higher rate of suicide;
- Greater likelihood of dying during incarceration.
- Higher incidence of loss of external supports (e.g., spouse, parents, and friends)

Isolation may exacerbate or create mental illness or psychiatric crisis for older inmates. Some of them may benefit from mental health intervention, including group or peer counseling.

Clinical staff need training and competence in the special needs and care required by older inmates, and they can help educate custody staff to recognize and deal with cognitively impaired inmates who might not respond appropriately to a direct order.

Lesbian, gay, bisexual, and transgender

Trauma and stigma experienced by lesbian, gay, bisexual, or transgender (LGBT) individuals can increase their psychological distress and decrease their willingness to seek mental health services. When incarcerated, they risk additional discrimination and abuse. Compared to heterosexual inmates, studies have reported that they have ten times the rate of sexual victimization by other inmates and up to three times the rate of sexual victimization by staff (Beck et al. 2013). This risk needs consideration on arrival at any correctional facility.

LGBT individuals differ in degree of comfort with their sexual orientation or gender identity and whether they are "out" or "closeted." Their choice about disclosure can change when moving from the community to jail or prison and between institutions. A respectful and non-judgmental approach by the correctional psychiatrist can help LGBT inmates explore their choices and cope with their concerns. Transgendered inmates, for example, may feel distress when housed in settings that do not allow them to express their gender identity or when they elect to stay closeted due to safety concerns. A therapeutic relationship in which they feel known by someone safe can improve emotional well-being.

Differences in issues and experiences exist among and within LGBT groups. For example, lesbians may encounter sexism, gay men have especially high rates of sexually transmitted infections and illicit drug use, and bisexuals sometimes find incomplete acceptance within either LGBT or heterosexual communities. In contrast to sexual orientation terminology (lesbian, gay, and bisexual), transgender refers to individuals who experience themselves differently from their natal gender. They may express a preference to be addressed by a name and a gender-defining pronoun that represents their desired gender. They may also want interventions such as hormones or sex reassignment surgery.

When assessing LGBT inmates psychiatrists should avoid assumptions about how their patients view their sexual orientation or gender identity. Individuals vary widely in their experience of these issues, their degree of comfort and self-acceptance, and their mental health needs. Some use drugs to allay anxiety, improve self-comfort, or enhance sexuality, and a sensitive inquiry about drug use can convey knowledge and concern about their feelings. Although homophobia and discrimination may exacerbate symptoms of anxiety or depression, LGBT individuals should receive standard treatments for psychiatric disorders when present. Individuals who begin to accept and express repressed sexual orientation or gender identity may have emotional lability and heightened sexuality that can mimic a manic state.

Correctional facilities need to assess and address the safety needs of LGBT inmates. Housing units based solely on sexual orientation or gender identity, however, can lead to labeling and demoralization and do not substitute for other protective interventions. Isolation or segregation for safety may be appropriate only as an urgent and interim measure pending other safeguards.

Correctional systems do not have uniform policies about permissible treatment for transgender inmates. They differ on whether they allow access to gender-preferred clothing and toiletries or continuation or initiation of hormones. None have provided sex reassignment surgery, but this may change in response to ongoing litigation by transgender inmates. Consistent with the prevailing position of professional medical organizations, including the American Psychiatric Association, courts and society in general are increasingly recognizing gender dysphoria as a medical condition appropriate for treatment.

Correctional psychiatrists can help foster awareness among custody and medical colleagues of the challenges faced by LGBT inmates, their mental health needs, and prevailing standards for their care.

Veterans

Another population that warrants focused attention is military veterans. The term veteran can have different meaning for different individuals, and correctional facilities need to screen individuals for a “history of military service.” The experience of veterans can vary significantly, ranging from no deployment to multiple tours of duty and combat exposure, especially for individuals who have served in recent military conflicts such as Operation Iraqi Freedom (Iraq) and Operation Enduring Freedom (Afghanistan). According to a Bureau of Justice Statistics Report, 10% of prisoners in 2004 reported prior service in the U.S. Armed Forces (Noonan and Mumola 2007). Most of these individuals had served during wartime, and a quarter had seen combat duty. Almost all

who reported military service were male inmates. Offenses included crimes of violence, non-violence, and sexual offenses.

Many studies have highlighted the "invisible wounds of war" that include mental illness, substance use, post-traumatic stress disorder, and traumatic brain injury. Each of these disorders may affect behavior and functioning and can go unrecognized without appropriate screening. Incarcerated veterans also have a heightened risk for suicide. Irritability, hypervigilence, and disinhibition from traumatic brain injuries can increase the risk of physical aggression. Clinical assessment can help in determining the appropriateness of disciplinary action in correctional environments.

Incarcerated settings need mechanisms for identifying individuals who have a history of military service. Self-reports may be inaccurate. Some individuals do not want their military history known because of shame or potential loss of benefits for themselves or their families, and others may misunderstand the wording in screening questions about military status. For example, some persons who do not receive Veterans Administration (VA) benefits or had not faced combat or deployment may not consider themselves "veterans" and would answer "no" to the question of whether they are veterans. Some correctional facilities work with the VA or other government entities to try to identify these individuals through a data match.

Veteran status is important to identify for programming within the institution and for re-entry planning. Careful assessment of military experience helps with treatment selection. Studies examining justice-involved veterans have begun to identify a significant portion with pre-military trauma in addition to trauma from their military experience. Military Sexual Trauma (MST) is increasingly recognized as an important factor that can influence the development of adjustment difficulties. Although originally identified as an issue about females in the military, it has also emerged as a critical issue for males who have served in the military. Individuals with a history of MST may be particularly vulnerable to further sexual trauma in correctional environments. Facilities need trauma-informed services that recognize the unique aspects of military trauma.

Military history and veteran status has important reentry implications for veteran-focused community supports and benefits. Service members, veterans, and their families may each be affected by an individual's re-adjustment to civilian life. Further, incarceration may reduce crucial financial supports available to immediate family members. Thus re-entry planning should include inquiry into benefits and potential entitlements. Individuals who were not honorably discharged may have reduced or no military benefits. In some cases, the military discharge status may have resulted from mental illness or substance use disorders and may be revisited. Inmates can get a copy of their DD 214 from the National Archives of Military Service to examine their military records and records of separation. Appeals of negative separations may be made.

Some programs allow for diversion and re-entry supports for justice-involved veterans. For example, the VA Health Care for Re-entry Veterans (HCRV) Program assists incarcerated veterans with community reentry planning and provides linkages to treatment services, employment, housing, short-term case management, and other supports. Reentry coordinators in correctional facilities need to know about such programs.

Intellectual and Developmental Disabilities

Offenders with co-occurring mental illness and intellectual or developmental disability encounter unique difficulties in the criminal justice system and have special treatment needs (Hayes et al. 2007).

Intellectual disability involves significantly sub-average intellectual functioning and impairments in adaptive functioning with onset prior to age 18. Individuals with intellectual disability have diagnosable psychiatric disorders at rates three to four times greater than the general population (APA 2013, p40). Estimates vary widely because of the inherent difficulty in assessing behavioral manifestations of symptoms in persons with deficits in receptive and expressive language skills. Self-injurious behavior may occur because of a depressive disorder, diminished ability to tolerate stress, anxiety, impulsivity, or a learned behavior to increase attention from others. Deficits in communication skills contribute to the difficulty in assessing the patient. Often, medications are prescribed to target behavioral manifestations or symptoms instead of an underlying psychiatric disorder.

Inmates with intellectual or developmental disability and co-occurring mental disorders are unfortunately the most likely to be preyed upon and ridiculed by other inmates. Their inability to process information rapidly or to comprehend instructions, their low frustration tolerance, and their impulsivity may have severe disciplinary consequences. Custody and treatment staff need additional training and education on intellectual and developmental disabilities to lessen the likelihood that they misperceive behaviors as intentional rule infractions or attribute them solely to intellectual disability while a serious mental illness goes untreated. In addition, administrative, treatment, and custody staff need to know that the Americans with Disabilities Act (1990) applies to this population and requires “reasonable accommodation” to their needs.

Screening must include assessment of intellectual and adaptive functioning, review of participation in special education programs in school, and history of head injury and seizure disorder. Facility staff or outside consultants may need to further evaluate the nature and severity of limitations, administer individual intelligence tests, assess daily living skills, and obtain educational records or disability agency service records.

Each inmate’s needs must be assessed individually. An inmate with intellectual or developmental disability may be capable of, or even prefer, being housed in the general population with minimal support because of the limited choices available to inmates and the predictability of inmate schedules. Others, however, require additional support, protection, or scrutiny by mental health and custody staff. Such support may involve employing a specialized correctional case worker with additional training or expertise and a smaller caseload or placing the offender in specialized housing or programs, including continuing special education programs. Depending on the size of the population, correctional facilities or systems may develop designated housing units for inmate protection, but they must ensure that offenders with intellectual or developmental disability and mental illness receive and participate in services or programs available to other inmates.

Hospice

A terminal illness is defined as an illness that, despite treatment, will likely result

in death within a year. Dying with dignity and in compassionate surroundings may be more difficult to achieve in custody than in community settings. Caring for inmates with terminal illnesses may involve a defined hospice, either inside the prison (less likely needed in jail) or in an external contract facility, or consideration of compassionate release. Training and written policies need to address use of these options where available.

Larger correctional systems may find it useful to house individuals who have a likelihood of dying while in custody from an identifiable illness in a hospice that provides palliative care (Yampolskaya and Winston 2003). The hospice patient may become more incapacitated, less oriented, and behave more inappropriately as the disease and deterioration progress. Use of inmate volunteers (hospice workers) who are trained in basic health issues, universal precautions, and mobility management (Hoffman and Dickinson 2010) may provide valuable assistance and reduce the dying patient's (or his or her family's) perception that "the prison isn't doing enough." Group therapy, end of life planning, and suicide prevention are interventions that psychiatrists can provide directly or assist other mental health professionals to provide.

Compassionate release in some cases may have advantages, including potential cost savings for the prison health care system and opportunities for patients and families to achieve closure. Perception of problems with public safety may decrease the viability of this option for individual patients.

Professional organizations, including the APA, can advise policy makers on reforms that assure up-to-date, evidence-based, and humane care for this population.

Mental Illness and Segregation

The widespread use of prolonged segregation in correctional systems in the United States creates unnecessary and avoidable risks to the health of individual inmates and to the public when those inmates return to the community. Segregation in this document refers to isolation of an inmate in a cell for an average of 23 hours per day with limited direct human interaction. The term prolonged as used here refers to stays in such settings exceeding thirty days. Under current practices, many inmates with a serious mental illness spend months, years, or decades in segregation with little to no programming, which often results in substantial distress and harm.

Zinger and Wichmann (1999) provide a useful literature review on the psychological effects of 60 days in segregation. They point out that the early literature in this area is conflicting, filled with speculations, and often based on far-fetched extrapolations and generalizations. Methodological shortcomings apparent from reviewing more recent literature include reliance on anecdotal evidence, response bias, non-existent or poor comparison groups, wide variation regarding the conditions of confinement in different prisons, cross sectional instead of longitudinal design, and an over-reliance on field and laboratory experiments pertinent to sensory deprivation (Perrien and O'Keefe in press; Gendreau and Labrecque in press). Mental health clinicians, however, frequently report that inmates without preexisting serious mental disorders can develop irritability, anxiety, and other dysphoric symptoms when housed in segregation units for long periods (Metzner 2002). Kaba, Lewis, Glowa-Kollisch, et al. (2014) found at least one period of solitary confinement to have a significant association with self-harm.

Zubek, Bayer, and Shephard (1969) conceptualized segregation units as having three main characteristics: social isolation, sensory deprivation, and confinement. Each of these elements can vary significantly, as will the responses by different inmates to the segregation experience. In general, decreased and altered social interactions appear to cause more mental health problems than does sensory deprivation. In fact, many segregation units impose sensory overstimulation (e.g., inmates yelling for communication purposes or for other reasons). Radios and television sets, which may be available in these housing units, can decrease or eliminate sensory deprivation, although the severe disruption in normal social interactions remains a problem (Metzner 2002). When sanctions exclude access to even these minimal diversions, however, inmates in segregation can experience adverse psychological effects from unrelenting inactivity and boredom. Most segregation units also severely limit access to exercise, sunlight, and fresh air, which can have additional detrimental effects on mental and physical health.

Gendreau and Labrecque (in press) describe the two dominant schools of thought regarding the impact of segregation housing on an inmate's mental health. One school equates the segregation environment with torture since it is perceived to be psychologically very harmful to inmates (Jackson, 1983; Haney, 2012). Another school's position is that in prisons that meet basic standards of humane care, segregation results in only some inmates experiencing negative effects, and those are generally few (Clements *et al.* 2007; Gendreau and Goggin 2013). The severity of conditions and differences in individual resiliency can influence the degree of effect that segregation has on inmates.

There is a growing movement by health care staff and national organizations within the United States to exclude inmates from long-term segregation housing (NYCLU, 2012). These efforts at exclusion have been much more successful for inmates with serious mental illness. Clinicians generally agree that placement of inmates with serious mental illnesses in settings with extreme isolation (e.g., lack of congregate time out of cell and no access to reading materials, television, radio, educational programming, or work assignments) is contraindicated because many of these inmates' psychiatric conditions will clinically deteriorate or not improve (American Psychiatric Association, 1997). In other words, many inmates with serious mental illnesses are harmed when placed in such settings because they lack access to adequate structured psychosocial programming/activities. In addition to potential litigation, this is the main reason that an increasing number of so-called supermax facilities have been excluding these inmates from long-term segregation housing, often by providing them with specialized mental health programming housing units (Haddad, 1999; Metzner, 1998; Metzner and Dvoskin, 2006).

In addition to the potentially harmful effects on inmates themselves, excessive use of segregation can also compromise public health and safety. Almost all inmates eventually get released from jail or prison. When this occurs directly from segregation settings or after periods of incarceration that included significant time spent in segregation, those inmates may be poorly prepared for adjustment outside the institution. Exposure to extended periods of social isolation, limited or absent programming, and often ineffective or detrimental punishment in an attempt to modify behavior can lessen an inmate's readiness to function successfully in society.

The American Psychiatric Association developed a position statement (American Psychiatric Association 2012) that included the following:

> Prolonged segregation of adult inmates with serious mental illness, with rare exceptions, should be avoided due to the potential for harm to such inmates. If an inmate with serious mental illness is placed in segregation, out-of-cell structured therapeutic activities (i.e., mental health/ psychiatric treatment) in appropriate programming space and adequate unstructured out-of-cell time should be permitted. Correctional mental health authorities should work closely with administrative custody staff to maximize access to clinically indicated programming and recreation for these individuals.

The Society for Correctional Physicians published a similar position statement (Society for Correctional Physicians 2013).

Improvement in the conditions of confinement of long-term segregation however, should be extended to all inmates in segregation settings. Critical barriers to access for clinically indicated mental health care, monitoring, and treatment often exist when an inmate is housed in a segregation environment. When an inmate is segregated—for any reason—from the general population, the correctional facility staff's responsibility to address serious mental health needs remains in effect. Indeed, because of the stressful nature of segregation housing, facilities should make special efforts to assess and address mental health treatment needs in these settings.

Mental health staff should routinely do regular rounds in all segregation housing units that impose isolation (e.g., supermax settings, disciplinary segregation) as an additional mental health screening procedure. These rounds help to identify inmates who have adverse reactions during their confinements in extreme isolation. Use of a mental health liaison model with the correctional and health care staffs, along with the rounds process, can facilitate the timely identification of inmates with acute symptoms of mental illness and the provision of appropriate clinical interventions.

While important for screening and triage, mental health rounds at the cell front do not substitute for clinically indicated assessment or treatment sessions. Such clinical interventions should occur out-of-cell in a safe setting that allows for adequate sound privacy.

In sum, prolonged segregation exposes individuals to potential psychological, physiological, and medical risks. Those with serious mental illness have special vulnerability to the adverse effects of social isolation. Psychiatrists should assist correctional systems with the development of evidence-based behavioral interventions that avoid the potential harm of social isolation.

The following principles address essential mental health services for inmates in segregation housing:

- No inmate should be placed in segregation housing solely because of symptoms of mental illness, unless there is an immediate and serious danger for which there is no other reasonable temporary alternative (American Psychiatric Association 1997). Segregation in this context does not refer to medical or psychiatric seclusion, which should follow state mental health law and

professional practice. Inmates with a serious mental illness who are a high suicide risk or have active psychotic symptoms should not be placed in segregation housing. Instead, they should be transferred to an acute psychiatric setting for stabilization and treatment. If placed in segregation housing solely due to symptoms of a mental illness because there is no other reasonable alternative, the placement should be very short in duration, with adequate monitoring and treatment, until an appropriate clinical setting is available.

- When an inmate is placed in segregated housing for appropriate correctional reasons, the facility remains responsible for meeting all of the serious medical and psychiatric needs of that inmate. Thus, such inmates must receive any mental health services that are deemed clinically indicated, their segregation status notwithstanding, including psychiatric and counseling services. For inmates who need ongoing intensive security, ensure that the conditions of confinement allow safe but meaningful social contact, interactions, and programming.
- Inmates in segregation who decompensate and experience a psychiatric crisis, including but not limited to acute psychosis and significant depression with suicidal ideation, should be removed from segregation and transferred to an acute psychiatric treatment setting (e.g., a hospital or an infirmary). If returned to segregation it should be in a unit that provides adequate structured and unstructured activities as described below.
- When housed in segregation settings that provide clinically appropriate programming and psychiatric treatment, inmates who are known to have mental health needs (especially those with a known history of serious mental illness) must be assessed at least weekly by qualified mental health practitioners. Such assessment is intended to identify and appropriately respond to changing clinical needs of the inmate.
- If an inmate with serious mental illness is placed in segregation, adequate unstructured out-of-cell time should be scheduled (at least 10 hours per week), as must adequate out-of-cell structured therapeutic activities (i.e., mental health/psychiatric treatment) (Metzner and Dvoskin 2006). Such treatment should be responsive to the level of care clinically required, occur in appropriate programming space, and correctional mental health authorities should work closely with administrative custody staff to maximize access to clinically indicated programming and recreation for these individuals.
- Institutions must provide for regular rounds by a qualified mental health clinician in all segregation housing areas. During these rounds, each inmate, regardless of mental health history, should be visited briefly so that any emerging problem can be assessed. The clinician should also communicate with segregation security staff in order to identify any inmates showing signs of mental deterioration or psychological problems. Provision of adequate mental health services to inmates in segregation housing is a critical reflection of and a crucial component of a facility's overall quality of care.
- A policy and procedure should be developed and implemented in order to provide mental health input into the disciplinary process. The mental health assessment should identify any potential mitigating factors related to an inmate's

mental illness that contributed to the alleged disciplinary infraction. Although treating clinicians may provide information about an inmate's symptoms and functioning at the time of the infraction, they should not do formal assessments or provide testimony on culpability for the infraction because doing so could compromise their clinical relationships with the inmate.

- Correctional systems need to develop alternatives to prolonged segregation for inmates. Further studies are needed to examine the efficacy of different behavioral programs and activities to help identify which inmates respond best to which interventions.

Seclusion and Restraint

The principles and guidelines in this report are intended to supplement the standards published by NCCHC. (National Commission on Correctional Health Care, 2014a, b), which require implementation of healthcare-related seclusion or restraint in a manner consistent with current community practice. Such community practice incorporates substantial efforts to train staff in de-escalation skills and in efforts to use less restrictive alternatives to restraint or seclusion. As an APA resource document has stated, little guidance exists on use of current community practice standards, especially regarding timeframes or housing settings, for inmates in seclusion or restraint (Metzner et al. 2007; see Appendix). Regulations established by the Center for Medicare and Medicaid Services (CMS) govern the use of restraints and seclusion in community hospitals.

The APA resource document includes the following:

> Since few correctional facilities are participants in the Medicare or Medicaid systems, the rules established by CMS concerning the use of restraint and seclusion had little impact on use for mental health care purposes in correctional systems. As a result, many correctional health care systems have not developed policies, procedures, or practices that are consistent with the current community practice. In addition, the frequent lack of meaningful external review or oversight in many correctional facilities regarding their mental health care practices has contributed to correctional facilities' not keeping pace with prevailing community standards. When correctional health care systems use seclusion or restraint for health care purposes, they should be held to a similar standard of care as community health facilities, just as correctional facilities are not permitted to perform intrusive medical interventions unless they are done in a manner consistent with the community standard in appropriate health care settings.

Correctional policies, procedures, and practices need to address the following issues:

- Location: Specify where inmates are secluded or restrained for mental health purposes. We recommend that this occur on a health unit.

- Property: In the absence of rare clinical contraindications, inmates secluded or restrained for mental health purposes should have a mattress, blanket, and clothing.
- Timeframes: Specify time frames for obtaining initial orders from appropriate licensed independent practitioners conducting initial face-to-face assessments by the ordering clinician, trained registered nurse, or physician assistant; duration of orders; frequency of nursing checks and range of motion exercises; and documentation intervals.

Other issues to address in policies and procedures include, but are not limited to, the following:

- Timeframes for monitoring by health and custody staff.
- Provisions for regular documented review by a qualified mental health professional and a physician or independently licensed medical provider. The former provides education and instruction to the inmate about the behavioral requirements for removal from seclusion or restraint. The latter reviews inmate health status, intake and output, and daily medication administration.
- Monitoring at least every 8 hours with documented well-being checks by register nursing staff for inmates on clinical seclusion.
- Constant observation by custody or health staff with fifteen minute documented checks by nursing staff to monitor circulation, bathroom breaks, change in mental or health status, and intake of fluids and nourishment for inmates in restraints.
- Inmates have at least underwear, and preferably full clothing.
- Restraints used as a last resort in managing acutely agitated or suicidal inmates.
- Secluded inmates have access to structured therapeutic programming whenever possible without compromising the security and safety of the institution.

Since the publication of the APA resource document, CMS has revised the regulations in the 1999 Interim Rule (Department of Health and Human Services, 1999, 2006; Substance Abuse and Mental Health Services Administration, 2007). For purposes of this section, the most significant change was an expansion of the rule to include trained registered nurses (RN) or physician assistants (PA) among the clinicians allowed to perform the required 1 hour face-to-face evaluation (if followed by a timely consultation with an appropriate LIP). Consistent with this change, the APA resource document has been modified as follows:

> This resource document recommends that the initial face-to-face assessment by a licensed independent professional, appropriately trained/credentialed registered nurse or physician assistant, occurs within four hours of the actual seclusion or restraint. All physicians and other licensed independent professionals (LIPs) should be appropriately trained in

the use of seclusion and restraint. If the face-to –face initial assessment is not performed by a physician, consultation should be obtained by the examining clinician with a physician appropriately trained in the use of seclusion or restraints, within the same four-hour timeframe.

Telepsychiatry

Telepsychiatry here refers to the use of live video conferencing to provide psychiatric services in correctional settings. Telepsychiatry supplements on-site psychiatry services in many correctional settings. Many state medical boards endorse the use of telemedicine and have promulgated rules on the practice of telemedicine and telepsychiatry and grant limited telemedicine licenses. State legislatures have passed laws governing the use of telemedicine and reimbursement for these services. The American Telemedicine Association (ATA) and several mental health professional groups have developed practice guidelines for telepsychiatry (American Telemedicine Association 2013).

Correctional settings lend themselves well to telepsychiatry use. Often these facilities are in rural communities where access to psychiatric services is limited or absent. Studies have shown that patients who receive psychiatric services via videoconferencing have had no negative consequences and quickly adapt to the technology. The patient and psychiatrist are talking to each other in real-time as if they were in the room with each other. Also, not having to transport the inmate to an offsite psychiatrist's office enhances community safety by avoiding inmate transportation. Another use of telepsychiatry is observation of a patient during after-hours crises or for suspected medication side effects. Using remote visualization may avoid the costs associated with emergency transportation.

Psychiatrists and other mental health staff need selection criteria to ensure the appropriateness of patients for videoconference services. Patients who are acutely psychotic or paranoid may have difficulty being seen remotely and may be unable to give consent to participate in this treatment modality. Video quality has to allow the clinician to assess signs such as involuntary movements. An advantage to this technique is that the clinician can video record abnormal involuntary movement exams to more accurately assess any progression in movement disorders.

Telepsychiatry sessions are scheduled like other sessions with mental health professionals. The equipment may be used for other purposes in the clinic so scheduling should be coordinated. If the facility uses stationary videoconferencing equipment, placement near the medical or psychiatric clinic areas in an office that provides sound privacy facilitates clinical access. Few correctional systems have wireless services and even if they do, the equipment may need to be plugged into a hardwired Internet connection.

Institutions need policies and procedures on the use of telepsychiatry, and physicians have to understand the state laws and medical board rules governing the practice where patients reside. No federal guidelines exist on telepsychiatry. The general rule for community and non-federal correctional settings is that psychiatrists may physically be in another state but must hold a license in the state in which the patients reside (ATA 2013).

It is preferable to see patients in a room in the clinic area in the presence of a

professional, often a social worker or nurse, who knows the patient and is a member of their treatment team. Whenever possible, psychiatrists obtain medical records by fax, email, or other means prior to the session and patients provide documented consent to engage in telepsychiatry. At the end of the session, psychiatrists may complete and electronically submit forms, prescriptions, and orders as if they were at the site. In facilities that use electronic health records, the telepsychiatrist needs remote record access for documentation and orders.

Video transmission needs encryption that meets HIPAA guidelines. This is usually accomplished with HIPAA compliant software that ensures secure transmission and records the session.

Telepsychiatry is becoming a more accepted practice in correctional settings and in the community as the shortage of psychiatrists increases. Greater comfort by correctional mental health professionals with this technology increases accessibility of expeditious services for patients.

Spiritual Lives of Inmates

Early notions of the opportunity for spiritual development during incarceration include the rehabilitation movement, which considered imprisonment as a method of reformation based on a religious framework that equated criminal behavior with sin. In this view, prisons were seen as institutions for moral reform. In the United States during the late 1700s, a growing interest in shifting from a paradigm of strict punishment to one of moral reform led a group in Pennsylvania to design a facility that would, theoretically, instill a sense of penitence in each prisoner's conscience and consciousness. This method centered on the belief that reflection on criminal behavior in a forced monastic environment would lead to the development of penitence and thus the term "penitentiary" was born. While the penitentiary concept was initially appealing, well received by the public, and served as the model for prison design and construction around the world, this method of reform through solitary confinement was ultimately abandoned at Eastern State Penitentiary in the 1930s.

Inmates draw on many resources to assist their adaptation to incarceration including family contact, peer support, work, education, and spiritual pursuits including the practices of faith-based traditions. The spiritual experience is a process of personal transformation, which often occurs in relation to and expressed within a religious tradition and practice. This transformation can provide a source of inner liberation that transcends the physical barriers of concrete and bars.

Spiritual endeavors and religious practice may be infused in an inmate's daily life. While not a formal component of the diagnostic system, inmates' spiritual orientation and its place in their worldview are key components of the psychological and emotional constitution and a source for developing resiliency. Psychiatrists and other clinicians should routinely inquire about the importance of spirituality and religious practice when conducting clinical assessments and providing treatment to inmates. Awareness of and support for this potential source of strength and meaning is an important part of assisting in successful adaptation to the correctional environment.

Correctional chaplains are key sources of support for inmates' spiritual growth and religious practice. Chaplains are members of the employed or volunteer staff of correctional facilities and provide pastoral care to inmates and in some cases, their

families. Although chaplains represent their religious communities, pastoral care may be delivered to inmates of all faith traditions if requested. Pastoral care is the ministry of providing care and counseling to members of a congregation or to anyone in an institutional setting. Many correctional chaplains are licensed counselors and can provide formal counseling services. Commonly delivered services include pastoral counseling, grief counseling, and relationship counseling. As they plan treatments for their patients, secular mental health professionals and psychiatrists in particular should know that pastoral counseling is available and applicable across a spectrum of overt religiosity (Young and Griffith 1989)

Staff correctional chaplains often act as religious program managers in facilities and coordinate the activities of different faith groups and religious volunteers. In this capacity, they advise on and implement religious program policy including approved religious articles, diets, and practices. In doing so, chaplains contribute to the coordinated operation of correctional facilities and are valuable members of the larger team. Chaplains and other staff (often volunteers) typically provide faith-based programming that addresses social, emotional, spiritual, recreational, or life skill issues from a faith/spiritual prospective. Mental health staff and psychiatrists should understand the benefits of such programs and make referrals for inmates' participation. Many religious services have demonstrable psychological benefits (Griffith et al. 1986; Anderson and Young 1988).

Frequently, the facility chaplain coordinates programs such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) that potentially benefit all detainees and inmates. Chaplains are also likely to be qualified for and interested in such roles as co-therapists for group therapy. The other group leader might be a psychiatrist, psychologist, nurse, or social worker. Creative combinations for therapy can address problems that might otherwise be neglected. Finally, when turning attention to the world outside the correctional environment and designing re-entry plans, psychiatrists need awareness of the skills, experience, and willingness for collaboration that exist among clergy in the community (Young et al 2003).

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COUNCIL ON PSYCHIATRY AND LAW

EXECUTIVE SUMMARY:
The Council on Psychiatry and Law met during the September Components Meeting in Arlington, VA. The Council heard updates from a range of its committees and workgroups including the Workgroup on Persons with Mental Illness in the Criminal Justice System, the Mandatory Outpatient Treatment Workgroup and the Sex Predator Commitment Laws Workgroup. The draft minutes from the meeting are attached. (Attachment #1)

The Council on Psychiatry and Law had a joint meeting with the Committee on Judicial Action on "The Civil Rights of Institutionalized Persons Act, Americans with Disabilities Act and the Department of Justice Investigations as Tools to Reform State Mental Health Services". Dr. Robert Bernstein from the Bazelon Center for Mental Health Law and Dr. Ezra Griffith, APA Member both gave presentations. The Council had a lively discussion which involved how they could get involved with CRIPA/Olmstead Litigation cases along with discussing how the APA overall can focus on care delivery and treatment.

1. **ACTION: PROPOSED POSITION PAPER ON INQUIRIES ABOUT DIAGNOSIS AND TREATMENT OF MENTAL DISORDERS IN CONNECTION WITH PROFESSIONAL CREDENTIALING AND LICENSING**
   The Council on Psychiatry and Law has developed a position statement on inquiries about diagnosis and treatment of mental disorders in connection with professional credentialing and licensing. (Attachment #2)

   Will the Joint Reference Committee approve the request of the Council to approve the proposed position statement "Inquiries about Diagnosis and Treatment of Mental Disorders in Connection with Professional Credentialing and Licensing"?

2. **ACTION: PROPOSED POSITION STATEMENT ON PATIENT ACCESS TO ELECTRONIC MENTAL HEALTH RECORDS** – The Council on Psychiatry and Law along with the APA Ethics Committee, Committee on Mental Health Technology and the Veterans Caucus developed a proposed position paper on patient access to electronic mental health records. (Attachment #3)

   Will the Joint Reference Committee approve the proposed position paper "Patient Access to Electronic Mental Health Records"?

3. **ACTION: PROPOSED POSITION STATEMENT ON SEGREGATION OF JUVENILES WITH SERIOUS MENTAL ILLNESS IN JUVENILE DETENTION AND REHABILITATION FACILITIES -** The Council on Psychiatry and Law with help from their workgroup led by Dr. Charles Scott developed a position statement on segregation of juveniles with serious mental illness in juvenile detention and rehabilitation facilities. (Attachment #4)

   Will the Joint Reference Committee approve the request of the Council to approve the proposed position statement "Segregation of Juveniles with Serious Mental Illness in Juvenile Detention and Rehabilitation Facilities"?

4. **ACTION: APA GUIDELINES ON PSYCHIATRIC SERVICES IN CORRECTIONAL FACILITIES, 3RD EDITION -** The Council on Psychiatry and Law with help from their Workgroup on Persons with Mental Illness in the Criminal Justice System have updated the "APA Guidelines Psychiatric Services in Correctional Facilities". Special thanks goes to the following members for their hard work on this project: Robert L. Trestman, Ph.D., M.D., Chair, Michael K. Champion, M.D., Elizabeth Ford, M.D., Jeffrey L. Metzner, M.D., Cassandra F. NewKirk, M.D., Joseph V. Penn, M.D., Debra Pinals, M.D., Charles Scott, M.D., Roberta Stellman, M.D., Henry C. Weinstein, M.D., Robert Weinstock, M.D., Kenneth L. Appelbaum, M.D., Consultant, and John L. Young, M.D., M.Th., Consultant. (Attachment #5)

   Will the Joint Reference Committee approve the 3rd edition of the "APA Guidelines on Psychiatric Services in Correctional Facilities"?

Informational Item:

1. **JRC REFERRAL: MAINTAINING COMMUNITY TREATMENT STANDARDS IN FEDERAL CORRECTIONAL FACILITIES**

The Council on Psychiatry and Law discussed the JRC referral. The 3rd edition of the APA Guidelines on Psychiatric Services addresses this issue. The Workgroup on Persons with Mental Illness in the Criminal Justice System will review the issues raised, including staffing and salary concerns, and recommend an appropriate response, in the form of a position statement or resource document.

2. **JRC REFERRAL: REINSTATEMENT OF THE COMMITTEE ON PERSONS WITH MENTAL ILLNESS IN THE CRIMINAL JUSTICE SYSTEM**

The Council discussed the referral and believes that the current structure and composition of the Council is conducive to accomplish the work of the criminal justice area. The Council would like to know from the JCR who the APA Representative to the National Commission on Correction Health Care (NCCHC) and request that the Representative provide a report to the Council on a regular basis.

3. **Review of Position Statements:**

   The Council discussed the referred review of position statements and reports the following:

   1. **2001 (retained in 2008) Position Paper on Juvenile Death Sentences** – The position statement is no longer relevant in light of recent case law and the Council recommends that it be ***sunset***.
   2. **1991 (retained 2007) Peer Review of Expert Testimony** - The Council recommends to ***retain*** as written.
   3. **1985 (retained 2007) Joint Resolution Against Torture** - The Council recommends to ***retain*** as written.
   4. **2000 (retained 2007) Moratorium on Capital Punishment in the United States** - The Council recommends to ***retain*** as written.
   5. **1997 (retained 2007) Discrimination Against Persons with Previous Psychiatric Treatment**- The Council recommends to ***retain*** as written.
   6. **2007 Insanity Defense** - The Council recommends to ***retain*** as written.

7. **2006 Psychiatric Participation in Interrogation of Detainees** - The Council recommends to ***retain*** as written.
8. **2005 Adjudication of Youths as Adults in the Criminal Justice System** - The Council will ***revise*** to reflect current language.
9. **2005 Death Sentence for Persons with Dementia or Traumatic Brain Injury**
10. **2005 Mentally Ill Prisoners and Death Row**
11. **2004 Diminished Responsibility in Capital Sentencing**

Position Papers 9, 10, & 11 were reviewed by the Council in May 2012 and voted to ***retain*** *all three documents. This went forward to the JRC in the CPL report June 2012.*

12. **2001 Doctors Against Handgun Injury** – The position statement will ***sunset*** once the Council's new position statement on gun control is approved by the Board of Trustees.
13. **1995 Ethical Use of Telemedicine** - The Council recommended that the position statement be *retained*. It was suggested that the JRC refer the issue to the appropriate component on technology to consider development of a resource document to accompany it given new technology and use of telemedicine.
14. **1973 (retained in 2009) Antisubstitution Laws and Regulations** – The Council would like to know the originating body and feels this is not in the Council's protocol.

4. JRC Referral: HIPAA and State Restrictions on Duty to Warn

The Council discussed the action paper and reported that there appears to be some confusion regarding psychiatrists' duties to protect third parties. The Council recommended the following actions:

A. That psychiatrists continue to be educated about the provisions of HIPAA. The Privacy Rule, Section 164.512(j) allows for the disclosure of information if the covered entity (psychiatrist) believes, in good faith, that disclosure is necessary to prevent or lessen a serious, imminent threat to the health of a person or the public.

B. The Council developed a Resource Document and model legislation on this issue in 1987. The Council recommends that this document be made available on the APA website.

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.

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.

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.

Position Statement on Moratorium on Capital Punishment in the United States

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

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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

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

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

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

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

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

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

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

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

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

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

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

Position Statement on the Insanity Defense

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

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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.

[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.

Position Statement on Psychiatric Participation in Interrogation* of Detainees

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

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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.

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

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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.**"

Position Statement on Mentally Ill Prisoners on Death Row

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

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(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.

Position Statement on Diminished Responsibility in Capital Sentencing

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

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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.

Position Statement on the Ethical Use of Telemedicine

Approved by the Board of Trustees, December 1995

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The American Psychiatric Association supports the use of telemedicine as a legitimate component of a mental health delivery system to the extent that its use is in the best interest of the patient and is in compliance with the APA policies on medical ethics and confidentiality.

Executive Summary

The Council on Psychosomatic Medicine focuses on psychiatric care of persons who are medically ill and thus stands at the interface of psychiatry with other medical specialties. It recognizes that integration of biopsychosocial care is vital to the well-being of patients and that full membership in the house of medicine is essential to the wellbeing of our profession.

The Council is mission-driven and prioritizes activities around the charge set forth by the APA Board of trustees in late 2012. Since the May meeting, Council members have built on working relationships with the Council on Healthcare Systems and Financing and its' Workgroup on Integrated Care; the Council on Medical Education and Lifelong Learning; the Board of Trustees Work Group on Healthcare Reform; the Academy of Psychosomatic Medicine; and other medical specialties including AAN and AHA. The Council continues to submit abstracts for psychiatric and primary medical meetings for sessions designed to address the educational needs of psychiatrists who treat patients with complex comorbidities, and is currently looking at developing online educational content. And finally, the Council continues to advocate for the enhancement of training in psychosomatic medicine and recruitment of residents into fellowship.

- Action Items: The Council has no action items at this time.

Referral Updates

- No actions have been referred to the Council.

Attachments: (for Joint Reference Committee Reports)

- **Minutes of Meetings of the Council (in-person & conference calls)**

MINUTES: Council on Psychosomatic Medicine APA September Component Meeting 2014
Friday, September 12, 9:00 am – 3:00 pm Hilton Crystal City, Blue Ridge Room, First Floor

Members Attending: Dave Gitlin, MD (chair); Linda Worley, MD (vice-chair); Philip Bialer, MD; Robert Boland, MD; Catherine Crone, MD; Joel Dimsdale, MD (via conference call); Sara Nash, MD; Lorenzo Norris, MD; Melanie Schwartz, MD; Peter Shapiro, MD; Erik Vanderlip, MD; Thomas Wise, MD; **RFM Members:** Yadira Alonso, MD (APA/SAMHSA Fellow); Carrie Cunningham, MD (Public Psychiatry Fellow); Danielle Hairston, MD (APA/SAMHSA Fellow); Vanessa Torres-Llenza, MD (APA/SAMHSA Fellow); Rubiahna Vaughn, MD (APA/SAMHSA Fellow); **Members Excused**: Michelle Riba, MD; Brittany Strawn, MD (Public Psychiatry Fellow); **Guests**: Paul Summergrad, MD; Renee Binder, MD; Karen Sanders, MA (APA staff); **APA Staff Liaison**: Diane Pennessi

Welcome

- Dr. Gitlin opened the meeting with introductions, conflict of interest disclosures, and an overview of meeting objectives. No conflicts of interest were reported.
- Dr. Gitlin briefed the group on a breakfast meeting of Council Chairs convened by Drs. Summergrad and Binder. Emphasis of the meeting was to encourage collaboration between and among councils. Council chairs in attendance provided a brief summary of current activity and priority areas.

Approval of May Minutes

- May minutes were approved without changes.

Visits by President/President Elect

- Paul Summergrad, MD, APA President talked about changes affecting the Association. He highlighted the fiscal health of APA, change and revitalization brought by the hiring of a new CEO, the formation of a workgroup to explore real estate opportunities, negotiations around liability insurance carriers, and strategic planning. He also highlighted the public interest in mental health and the challenges and opportunities that presents. He pointed out how difficult it is to talk about mental health in a public forum. Public perception that people who have mental illness are somehow responsible for that illness, coupled with the idea that the face of mental illness is associated with the most severely ill. It's also difficult to discuss the costs of untreated illness which are both visible and not visible. The historical separation of costs means that it's difficult to quantify patients with psychiatric disorders who are seeing a primary care provider that may not note their psychiatric illness. He continued that Psychosomatic Medicine can be particularly helpful in 1) providing content expertise, 2) providing leadership to healthcare reform efforts because PSM physicians understand and speak both the language of medicine and psychiatry, and 3) helping the public understand mental illness through plain language. Council members subsequently discussed outreach to Communications and Government Relations to offer speakers.

- Renee Binder, MD, APA President-Elect spoke about her desire to increase the diversity of the organization and to train new leadership. She conveyed her concern about the stigma against both patients and psychiatrists and her intention to take steps to positively impact the problem. And finally, she exhorted the APA to set the agenda around what psychiatrists roles and responsibilities will be in the future.

Council Work Plan Initiatives

Healthcare Reform

- Karen Sanders, Director of Delivery Systems Initiatives & Integrated Care described the charge and membership of the new BOT Ad Hoc Work Group on Healthcare Reform and provided an overview of the Report of the Workgroup on the Role of Psychiatry in Healthcare Reform. She went on to update the Council on:
    - PQRS, part of Medicare's new system of quality reporting, includes measures in 8 domains to report, those that relate directly to psychiatrists include medication reconciliation and depression. When Medicare providers do not report then there are penalties. This system is being phased in through the next few years with the penalties progressing to 11% at full implementation.
    - Links to Medicare and Medicaid Policy documents. Ms Sanders reviewed the AAFP's revision to their policy document Joint Principles of Integrating Behavioral Health in the Patient Centered Medical Home and APA's published response "The American Psychiatric Association Response to the "Joint Principles: Integrating Behavioral Health Care Into the Patient-Centered Medical Home" by Lori Raney, MD, David Pollack, MD, Joe Parks, MD, and Wayne Katon, MD.
    - New Medicare Code for CCM – chronic care management, as directed by the MDC Fee Schedule, Ms Sanders reported the issue is complicated. APA likes that it covers non-face-to-face care which is essential, but there are some issues. (e.g. the reimbursement rate is low ($45), any physician can submit for it – the first one who submits gets the money which some practices/specialties may be doing more care management than others,there are gaps in what is included) OHSF is working on this and would like feedback.
    - "Incident to" rules change – CMS made changes in this; Old – direct supervision by MD progressed to general supervision during normal office hours; New – work can be done outside of normal office hours, by a non-employee whose external to practice as designated by care plan, i.e. contractor.
    - CMS part D use of antipsychotics in dementia – CMS identified that 24% of nursing home patients are prescribed antipsychotics and set a goal to decrease use to 15%. CMS wants to develop quality measures around antipsychotic use but getting them to understand the clinical complexities of patients with dementia is difficult and their attention seems to be on decreasing the cost. They also limit the measure to be developed from claims data.
- In response to a request from APA leadership, Council provided feedback on the *BOT Ad Hoc Work Group on Healthcare Reform*, indicating areas of high importance to the Council. Drs. Gitlin, Worley, and Boland had met the evening before with Rick Summers, MD, chair of the Council on Education and Lifelong Learning and worked to complete the section on "Workforce, Work Environment, Medical Education and Training."
- Council reviewed the Position Statement on the Role of Psychiatrists in Reducing Physical Health Disparities in Patients with Mental Illness. The statement has been reviewed and endorsed by APM, AMP, and AACP and will be sent to the JRC in October.

Relationships with Allied Organizations

Dr. Gitlin introduced a discussion of building relationships with non-psychiatric physician organizations. The group discussed strategies to "shepherd" projects which might lead to opportunities to build closer relationships. To date, the Council has provided recommendations of clinical experts to Clinical Endocrinologists in the development of a consensus document on obesity; AAN on the development of measures for multiple sclerosis; and most currently, an author to work with neurologists on and article on post-stroke depression. Dr. Gitlin also urged members to think about leveraging the partnership between APA and APM.

- Academy of Psychosomatic Medicine (APM). Dr. Worley updated the group on APM initiatives. She reviewed a Thursday night meeting between APM leadership, APA Council leadership, and lead staff from both organizations. Discussions around bidirectional collaboration between the Associations carried through both meetings.
- AAN. Multiple Sclerosis quality measure development project- Dr. Schwartz reported that the group met just once last June in Minnesota. She described how important it was to have a psychiatrist at the table, and that the occurrence of comorbid depression would not have likely been addressed by the group at all if not for her presence at the table. The Council discussed how to promote the release of the guidelines including a piece in *Psychiatric News* and development of a brief education module for psychiatrists around it.
- The Stroke Council of the American Heart Association sent a request to APA Deputy Medical Director, Annelle Primm, MD, soliciting the participation of a psychiatrist in a writing group preparing a review paper on post-stroke depression for the journal *STROKE.* The Council identified an author through Robert Robinson, MD. In addition to working on the writing group, Ricardo Jorge, MD has agreed to mentor new SAMHSA fellow Rubi Vaughan, MD through the project.

Provider Education in Psychosomatic Medicine

- Council on Medical Education and Lifelong Learning (CMELL) - Dr. Gitlin briefed the group on a Thursday meeting with CMELL Chair, Rick Summers, MD. Drs. Gitlin, Worley, and Boland met specifically to discuss overlapping activity on the Workforce, Work Environment, Medical Education and Training portion of the BOT Work Group on Healthcare Reform Recommendations. The meeting was productive and it was determined that future collaboration would be beneficial. CMELL will be convening a second meeting of Education Directors from Specialty Societies and CPM members indicated a high level of interest in participating.
- ACGME Milestones- Dr. Boland briefed the Council on implementation of the psychosomatic milestones which are scheduled for release in October, with implementation to begin in July 2015. The Council offered the idea of a joint APA/APM webinar to familiarize fellowship directors with the milestones, and offer a venue for sharing ideas on implementation.
- APA 2015 Annual Meeting Activity- Drs. Crone again was invited to submit the Council's popular "Medical mimics…" program. She also reported that abstract submissions were due September 18. She and Dr. Worley also have encouraged presenters to submit abstracts to APA based on popular sessions offered at APM.
- APA Online Education Opportunities - APA offers a new format for online CME that provides 1-hour of credit. The case-based modules provide 3-4 multiple choice questions, rationale for correct answers, links to peer-reviewed articles, and feedback on how participants scored among their peers. Modules could be linked to products developed in partnership with Allied Organizations. Mentoring members and Council fellows may choose to develop cases together.

Fellow Recruitment and Retention

- SAMHSA and Public Psychiatry Fellows- New fellows were warmly welcomed to the Council and urged to fully participate in the day's discussions. The Fellows spoke about their diverse areas of interests including mortality gaps in patients with SPMI, psychiatric aspects of medical issues, novel CHF markers, immigrant access to healthcare, post-disaster community resources, and spirituality and mental health. Council members were subsequently paired with residents to act as mentors, staying in touch throughout the year. Council chairs met with Fellows after conclusion of the business meeting to answer any questions.
- Recruitment into Psychosomatic Fellowship- Dr. Bialer said that 1 new program has joined the Match in psychosomatic medicine. Registration is open now. Last year 105 slots were filled in the Match of the 112 total slots.

- Post-fellowship Survey- Dr. Norris has completed Council edits and the survey will be sent to APA's practice research network for their feedback before being sent to the field.

Research in Psychosomatic Medicine

- Dr. Shapiro discussed the status of research in the field of psychosomatic medicine. There was a consensus within the Council that although psychosomatic medicine is primarily a clinical field, there is an ongoing need for new knowledge, and therefore new research, to keep the field intellectually alive and growing. He added that this was a challenge as the opportunities for research training and funding are limited in current training and funding environments. The Council voted to request that APM and its Research Committee survey psychosomatic medicine training programs about the research training and activity of faculty and current and recent fellows. The goal of the survey is to provide a baseline "snapshot" of the state of research activity and training and the field's relationship to major research funders such as NIMH and SAMHSA, and to identify opportunities for improvement.

Endorsement of the Patient-Physician Covenant

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

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

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

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

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

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

Ralph Crawshaw, M.D.
David E. Rogers, M.D.
Edmund D. Pellegrino, M.D.
Roger J. Bulger, M.D.
George D. Lundberg, M.D.
Lonnie R. Bristow, M.D.
Christine K. Cassel, M.D.
Jeremiah A. Barondess, M.D.

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

Position Statement on Provision of Psychotherapy for Psychiatric Residents

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

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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.

Position Statement
Need to Train Psychiatrists in Provision of Care and Support to Individuals with Disorders of Sex Development and Their Families

Issue:

Disorders of sex development (DSDs) are congenital conditions (including but not limited to those formerly referred to as intersex disorders, hermaphroditism, and pseudohermaphroditism) which entail atypical development of chromosomal, gonadal and/or genital sex. The gender that should be assigned to infants may not be obvious at birth, and in many cases the process of decision making regarding gender assignment is complex and laden with uncertainties. Individuals with DSDs may experience gender dysphoria in the initially assigned gender and require gender reassignment. Gender reassignment may be rendered more complicated if early genitoplasty was employed to align the appearance of the external genitalia with the initially assigned gender. The proportion of individuals with DSDs who request gender reassignment varies as a function of both the particular DSD syndrome and the initial gender assignment. Besides initial gender assignment, and sometimes reassignment, other complex decisions are often required in areas were consensus for optimal management is lacking, particularly those involving irreversible elective surgical procedures performed on minors who lack capacity to participate in these decisions.

DSDs and the decision making they entail have the potential to cause great distress for both parents who struggle to make the best decisions for their children, and for the affected individuals themselves many of whom report feelings of stigmatization and shame. Accordingly, DSD advocacy groups, several existing treatment guidelines for DSDs, many individuals with DSDs, and the APA Task Force on Treatment of Gender Identity Disorder have called for an increased role of mental-health professionals in the care of individuals with DSDs and their parents or primary caregivers.

APA Position:

1) **Because of the multiplicity of DSDs, the complex differences among them, and their implications for medical, surgical and mental healthcare, provision of care to individuals with DSDs and their families is best accomplished by integrated interdisciplinary teams; because of the psychological distress associated with such decisions and the complex developmental processes involving body, brain, and mind that must be considered, these teams should include mental-health professionals.**

2) **Because of their medical training, and because of the complex biological and medical considerations that come to play in decision making and psychoeducation regarding DSDs, with limited additional training psychiatrists can become well prepared to participate in these interdisciplinary teams.**

3) **In light of the existing dearth of psychiatrists with the necessary training and expertise to contribute to such interdisciplinary teams, opportunities should be increased in residency and fellowship programs, including child and adolescent psychiatry and consultation-liaison psychiatry, for psychiatric training in the provision of care to individuals with DSDs and their families.**

4) **Given the deficiencies in the evidence base upon which many management decisions must currently be made, APA encourages increased support for longitudinal outcome studies in collaboration with other disciplines**

Authors:
Workgroup on Gender Dysphoria of the APA Council on Research and Quality Care: William Byne M.D., Ph.D.; Eli Coleman, Ph.D.; A. Evan Eyler, M.D., MPH; Richard Green, M.D., JD; Edgardo J. Menvielle, M.D., M.S.H.S.; Heino F. L. Meyer-Bahlburg, Dr. rer. nat.; Richard R. Pleak, M.D.

Background

As employed here, the term, *disorders of sex development (DSD)* refers to congenital conditions (formerly called intersex disorders, hermaphroditism, and pseudohermaphroditism) which entail atypical development of chromosomal, gonadal and/or genital sex. The gender that should be assigned may not be obvious at birth, and in many cases the process of decision making with respect to gender assignment is complex and fraught with uncertainties. Although gender reassignment can be made without genital surgery, genitoplasty is often employed to bring the appearance of the external genitalia in line with the assigned gender; in most cases, its outcome is essentially irreversible. Additionally, gonadectomy may be considered in a variety of DSD syndromes in which there is an increased risk of gonadal malignancy. Various viewpoints have been expressed on these controversial interdisciplinary issues (1;3;5;6;12-14).

The presence of a genital anomaly complicating gender assignment at birth can engender a sense of "psychosocial emergency" for parents and healthcare providers (3;4;11). Parents sometimes report feeling that their consent for surgical procedures was not fully informed or was given at a time of emotional duress (4). Such situations call for dispelling the sense of urgency, and advising against making irreversible decisions in an atmosphere of crisis. Informed consent requires knowledge of the limitations of the evidence base, even in this emotionally laden area. Various DSD advocates and ethicists have argued for postponing any elective genital surgery until the age of consent of the patient with a DSD. On the other hand, 4 surveys of clinical samples of individuals with DSDs have been conducted, and in these the majority of individuals, but not all, retrospectively endorsed a childhood age for genital surgery rather than adolescence or later (7;9;10;15). This controversy remains unresolved.

Some individuals with DSDs, in a proportion that varies greatly with syndrome and assigned gender, become dysphoric in the initially assigned gender and may choose to live in a different gender role. They may request or require endocrinological, surgical or mental-health services to facilitate gender transition. The clinical options and decision making processes that bear on gender transition and reassignment in individuals with a DSD overlap with those for transgender patients without a DSD. When a DSD is present, however, there are fewer barriers to legal gender reassignment, and the barriers to hormonal and surgical treatments in conjunction with gender reassignment are lower, particularly in

individuals for whom gonadectomy has already been performed or is indicated due to their particular DSD (2;8).

Because of the multiplicity of DSDs, the complex differences among them, and their implications for medical, surgical and mental healthcare, provision of care to individuals with DSDs and their families is best accomplished by integrated interdisciplinary teams. These teams should include mental-health professionals because DSDs and the decision making they entail have the potential to cause great distress for both parents who struggle to make the best decisions for their children, and for the affected individuals, themselves, many of whom report feelings of stigmatization and shame, and some of whom report dissatisfaction with the treatment decisions made on their behalf. The role of mental-health professionals in caring for individuals with DSDs and their families has been detailed elsewhere (2;3;11).

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2014 Revision of 2010 Revision to 1997 APA Position Statement

New Title: Position Statement on Confidentiality of Electronic Health Information
[Old Title: Position Statement on Confidentiality of Computerized Records]

Issue:

Computerization of medical records can bring clear-cut benefits to the delivery and quality of health care, including psychiatric treatment. Electronic health records (EHRs), as well as the sharing of information via health information exchanges (HIEs), can raise significant security challenges and potential threats to patients' confidentiality. Government intelligence agencies, such as the NSA, are reported to be able to access the personal health information of patients by bypassing built-in security and encryption features of EHRs and HIEs. Psychiatrists have an obligation to advocate for EHR and HIE policies, features, and implementations that allow the sharing of medically necessary information to enhance care, as well as to support a culture of confidentiality and respect for patients' privacy and their preferences in the electronic storage, access, and sharing of health information.

Position:

Patients should be able to benefit from the potential improvements in the delivery and quality of care with electronic health records (EHRs), without being forced to relinquish the privacy and confidentiality of their personal health-related information. Patients should also be able to enjoy the care coordination benefits provided by EHRs and health information exchanges (HIEs) without having to share all or none of their information, i.e., they should be able to identify classes of data for more restricted access. Approaches to accessing health information via EHR and HIE should consider the diverse settings in which electronic health information will be used, including its use in emergency and other acute settings where rapid access to medically necessary information is essential. Such approaches should also consider that patients have a broad range of needs, preferences and abilities to provide informed consent about the implications of electronic record access. At the very least, computerized records should give patients as much control over their information as they have with paper-based records. Electronic health record design and implementation should leverage technology to give more flexible approaches to access for sensitive information. Government organizations or other third parties should not be able to access electronic health information by bypassing built-in security and encryption features of EHRs and HIEs. As health information technology continues to

advance and evolve, the complexities and potential consequences of electronic health information make it essential for psychiatrists to be aware of the implications for their patients and advocate for a culture of confidentiality and respect for patients' privacy preferences.

Submitted by the Committee on Mental Health Information Technology, in consultation with the Council on Psychiatry and the Law and the Council on Healthcare Systems and Financing. All have approved.

Action Item

Will the Joint Reference Committee approve the recommendation by the Workgroup on Gender Dysphoria for the psychiatric training in the provision of care for those with Gender Dysphoria?

- Revised Gender Dysphoria Position Statement, Attachment 1
- Recommendation for the psychiatric training in the provision care for those with Gender Dysphoria, Attachment 2

Action Item

Will the Joint Reference Committee recommend that the Assembly vote to approve the new Position Statement on Management of Sensitive Health Information within Health Information Exchanges?

- Explanation for new position statement (ASMNOV1212.B), Attachment 3
- New position statement on Management of Sensitive Health Information within Health Information Exchanges, Attachment 4

Action Item

Will the Joint Reference Committee recommend that the Assembly vote to approve the revised Position Statement on *Confidentiality of Electronic Health Information*?

- Revised position statement (ASMNOV1312.D), Attachment 5

Referral Updates

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.

Meeting Minutes

See following pages for the minutes of the joint meeting of the Council on Quality Care.

Council on Quality Care

September 11, 9AM-5PM

Richmond, Lobby Level

Hilton Crystal City, Virginia

I. Opening/Introductions: Joel Yager, M.D., Chair

A. Conflict of Interest/Disclosure Statements, *Attachment #1*

Attendees: Chair: Dr. Yager
Members (CQC): Drs. Dalack, Daviss, Norquist, Smith, Wilner, Zima
Guests: Drs. Binder, Plakun, Levin, Iles-Shih, Summergrad, Young,
Administration: Hong, Keller, Kroeger, Kuhl, Moscicki, Narrow, Shugarman

Meeting participants introduced themselves, summarized their background in Quality Care, and identified any potential conflicts of interest. Dr. Zima (PCORI. UCLA CTSI. and Illinois Child Healthcare Foundation), Dr. Smith (NY Community Trust and the NYS Department of Health)

B. Appointment Recommendations—
Council is accepting names and recommendations of future participants with knowledge of performance measurement and Practice Guidelines

C. May 8, 2014 Annual Meeting, *Attachment #1A*
Minutes approved

II. Remarks

A. Dr. Levin:
Thanked administration and identified the important focus of the council and how their decisions and leadership form psychiatric practice and clinician payment. He identified the need to press forward in the changes within the quality space (e.g. registries and measure development) and emphasized members staying current and practicing at the state of the art in the field.

B. Dr. Summergrad and Dr. Binder

Dr. Summergrad addressed the group by explaining that the APA is in a period of important transition with the successful launch of the DSM having passed, the organization's focus will turn to healthcare reform and integration of care. Dr. Summergrad noted that the BOT is looking at the next 3-5 years in reform, quality indicators, registries and how this will influence APA's diverse membership. He informed the group that the strategic plan is expected to be finalized in March 2015.

Dr. Binder addressed the group and highlighted what her efforts will focus on in the next two years. She informed Council members that a group of residents have worked together on a proposal of an APA software application (resident Dr. Lara Cox leading the group). Dr. Yager noted this is good timing as a reporting component to the Council on Quality Care is the Workgroup on Mental Health Apps led by Dr. John Luo. There could be some synergy on these efforts. Dr. Binder continued to explain that this year's strategic planning process will focus on some of her priorities for the organization; including the reduction of stigma against psychiatry (she identified two forms of stigma 1. against psychiatric consumers and 2. against psychiatric clinicians). She continued by explaining that the focus of the Annual Meeting 2016 be on the emerging roles and responsibilities of psychiatrists (and to remove the stigma of the role as "pill pushers").

III. Reporting Component Updates.

A. Steering Committee on Practice Guidelines, *Attachment #2*
Ms. Keller provided the update to the group.

- *Guideline on Psychiatric Evaluation:*
  - *The revised guideline is being reviewed by the Assembly, as well as District Branch's (DBs) Presidents and Executives*
  - *Next steps:*
    - *Sept. 21 – comments from the Assembly and DBs are due*
    - *Mid. Oct. – Submit a final version of the guidelines to APA Governance*
    - *Nov. – Assembly meeting - up or down vote, then to BOT*
- *Guideline on Antipsychotics in Patients with Dementia:*
  - *A summary of expert opinion survey results and a summary of an evidence review are being finalized.*
  - *Next steps:*
    - *Start drafting the guideline (Sept. and Oct., 2014)*
    - *The Guideline Writing Group (chaired by Dr. Victor Reus) is adding 3 members from other disciplines to the group*
    - *Hope to finish around March 2015, with Assembly approval in May, 2015*
- *Guidelines on Bipolar Disorder:*

- *The Guideline Writing Group is adding a few bipolar experts to the group as consultants.*
- *Next step:*
  - *Waiting for an AHRQ systematic review on the topic (a draft review is expected to be available between late October and early November)*

- *Guideline Watch –Alzheimer's Disease and other Dementias:*
  - *Authors are currently reviewing the draft.*
  - *Next steps:*
    - *Incorporating comments from authors*
    - *Approval of Steering Committee on Practice Guidelines by Sept. 9, 2014*
    - *Publication on Psychiatryonline.org*

- *Future Topics*
  - *The Executive Committee on Practice Guidelines is considering topics for future guidelines*
  - *AHRQ evidence summary on bipolar disorder will be finished by the end of this year (2014)*
  - *An AHRQ review on Binge Eating Disorders is expected in spring, 2015*

Discussion by the group included the recognition of the cost and need for meaningful systematic reviews by AHRQ and the value of practice guidelines as they dictate the development of performance measures. Several Council members identified that as the field evolves and new practice guidelines are developed, the way for APA to maintain its voice over how psychiatrists are measured and eventually paid is to include measure statements (and eventually measure development) within the guidelines.

Dr. Norquist identified the cumbersome process involved with practice guideline development within the APA and asked if there is a way to streamline the effort. Ms. Keller agreed that it is a long process and that the SCPG is looking at the current process and trying to determine ways to streamline.

B. Committee on Mental Health Information Technology , *Attachment #3*
Report provided by Dr. Daviss, highlights can be viewed in the designated attachment

C. Workgroup Mental Health and Psychiatric Apps, *Attachment* #4
Dr. John Luo chairing, highlights can be viewed in the designated attachment
The group inquired as to what is the APA doing because attaching an "endorsement" by the APA could raise legal issues. Dr. Yager explained that this group is not developing an "endorsement" process, but working to create a rating system from people who have

used the Apps. It was recommended that the workgroup or those participating in the ratings comprise of a wide range of diversity (specifically when it applied to age of members).

D. Workgroup on Patient Safety, *Attachment #5*
Work being completed by the group can be seen in the related attachment provided by the group's chairperson, Geetha Jayaram, MD.

Dr. Yager relayed that the focus of transition of care will occur in the first 30-days out of the hospital as those tend to be the most sensitive time period for those discharged.

Both Dr. Young and Dr. Norquist will reach out to Dr. Jayaram to discuss how the group's work and PCORI efforts might align.

E. Workgroup on Standards and Survey Procedures, *update not available*

F. Workgroup on Gender Dysphoria, *Attachment #7*
Work being completed by the group can be seen in the related attachment provided by the group's chairperson, William Byne, MD.

G. Workgroup on Registries, *Attachment #8*
Dr. Dalack, chair of the APA Registry Workgroup provided an update to the group's activities. Dr. Dalack explained that the group has met five times by conference call and that an in-person meeting will take place later today. The major focus is for the APA to pay attention to this valuable activity. Registry efforts have existed for some societies for some time and it is important that the APA produce registry processes and products on behavioral health before another organization does. Dr. Dalack explained some of the hot button issues that have been and continued to be addressed by the workgroup: how do we get members to buy in? Do we include other mental health groups as partners in this effort? The group plans to finalize their recommendations to the Council by December 2014.

Dr. Narrow offered the perspective of the Council on Research (COR) on this effort and expressed that there is a disconnect between what the CQC wants to see come out of an APA registry and what the COR would like to see as a result of an APA registry (e.g. COR might want blood samples).

Dr. Zima suggested that the final document of this work group look like a multiple choice matrix that identifies different aims and allows the BOT to see the pros, cons, costs, and future implications of various choices.

H. Psychotherapy Caucus, *Attachment #9*

Dr. Plakun attended the meeting to provide the Caucus's update. He informed the group that there are 150 APA members currently participating in the Caucus. The focus is on the utilization of psychotherapy and psychosocial treatment, but not to the exclusion of pharmacotherapeutic interventions. Dr. Plakun also provided the group with a written report that outlines their ongoing efforts.

IV. Discussion: Current Status of Quality Improvement and Quality Measurement

A. Update: NQF Activities

a. Moving forward with 3rd stage of Behavioral Health Measure Endorsement
Ms. Shugarman highlighted the successful efforts of the three APA supported nominations of Pincus, Zima, and Shea, all having been successfully appointed to the standing committee.

Dr. Zima explained to the group that NQF is changing their endorsement process to a more open ended survey that allows the co-chairs of the committee to take the "temperature" of the group. The new Standing committees will allow continuity to endorsement periods. Dr. Zima and Ms. Shugarman explained their experience with the NQF endorsement process that by history, measures up for endorsement tend to fall flat on validity. This raises questions about companies (e.g. NCQA) that develop measures which haven't been adequately validated, but which push the measures forward anyway.

b. Discuss strategies to address pitfalls found in measuring quality care of SMI, *Attachment # 10*
The AHRQ draft technical report was used as a springboard to address the pitfalls around measuring quality care of the SMI. The group agreed that it would be wise to use the many identified faults as springboards to improve quality of care, to make a case for more funding. Dr. Norquist reinforced that PCORI is in the position to fund studies to find evidence. While CMS is most concerned about the substantial public costs of SMI, it is a good idea to also look at potential cost savings in improving the quality of care for mild/moderate mental illnesses which are accompanied by significant medical co-morbidities. Improving quality for these conditions might result in significant savings in overall medical costs.

The group agreed that doing research in this area is a data access problem. The data exists at the state level (via Medicaid), but is not easily shared. Large states have the biggest influence when tackling CMS. NAMD (mentioned by Dr. Smith) SAMHSA can work with RWJ, NASHBD. Council suggested that suitable groups within the APA encourage mechanisms to facilitate collaborative research based on shared access to large systems databases.

B. Update: Current APA Activities
   a. Partners with AAN in management of Dementia Measure Set
   b. Partners with AACAP in management of Childhood Major Depressive Disorders Measures
   c. Potential partners with substance use specialty groups in Substance Use Measures
   Ms. Shugarman informed the group that efforts are underway to develop a formal relationship with organizations that have content expertise in this space (e.g. ASAM, AAAP)

V. Discussion: Examination of the original BOT Workgroup on the Role of Psychiatry in Health Reform
   A. Game plan on responding to the request of the JRC of how our Council addresses the identified areas, *Attachment #11*

Ms. Kroeger explained that the third ad hoc work group will look at areas that each council identifies as priorities. This effort is intended to be a longitudinal exercise and has the capacity to change over time. The group then addressed the attached spreadsheet and discussed each assigned subject.

In his address to the group, Dr. Summergrad mentioned that the Ad Hoc Workgroup is in its third iteration and rather than phase the efforts out the goal is to work their findings into normal business structure.

VI. Discussion: Five year review of position statements, *Attachment #12*
The group agreed that the papers assigned to the CQC that involve the subject of HIV are better suited to be reviewed by the COR.
   - ***Endorsement of the Patient-Physician Covenant****: The group agreed to endorse until a "better one comes along."*
   - ***Position Statement on Provision of Psychotherapy for Psychiatric Residents:*** *The group agreed to endorse, but recommend the statement be broadened to all training programs, not just psychiatry.*

VII. Update: Choosing Wisely Campaign
Ms. Shugarman informed the group that statement number five that is focused on children and adolescents and the prescription of antipsychotics was approved by the BOT in July 2014 and the updated list is available on the APA and ABIM Foundation website.

She also explained that the APA Council on Geriatrics has expressed interest in updating their statement as it applies to the prescription of antipsychotics to patients with Dementia. They are concerned that the way it currently reads is too categorical.

The CQC discussed the matter of updating the list again. CQC strongly believes that unless new evidence strongly supportsa change in the last year, the statement should remain. Ms. Shugarman will communicate this to the Council on Geriatrics.

VIII. Update: Council on Research

Dr. Narrow updated the group to the efforts of the COR as it applies to the CQC.

- *The group voted to approve signing on to the AllTrials Registry (www.alltrials.net), an international registry for all intervention and diagnostic trials.*
- *The Health Services Research awards were announced. Dr. Jurgen Unutzer is the senior awardee, and Dr. Joseph Ceremele is the junior awardee. Awards will be presented at the IPS in October/November 2014.*
- *The Diagnostic and Treatment Markers Work Group is working with the Caucus on Complementary and Alternative Medicine, who is developing a review paper on CAM treatments. They are still working to define their topic, which likely will be the efficacy of SAM-E for depression.*
- *The Council was asked by the JRC to provide comments in support and in opposition of removal of the black box warning on antidepressants. The Council is in favor of removal but before taking a formal position want to enlist the consultation of Robert Gibbons, Ph.D., who has conducted research on prescribing implications of the black box warning.*
- *The Council discussed the report from the Research Workgroup and expressed concern at the report's suggestion to appoint a Research Advisory Group. The COR believes such a group would be redundant with their group. Currently there are no health services researchers on the group. Dr. Yager mentioned that not many people have had government experience and it would be beneficial to include people from outside to round out the expertise. Drs. Summergrad and Levin reassured the COR that an advisory group would not be appointed and they would consult with the COR on an as-needed basis.*
- *In her remarks to the group, Dr. Binder mentioned that the COR doesn't have any consulting or reporting members.*
- *Recruitment of the Division of Research Director: efforts are moving forward to identify appropriate candidates. Dr. Levin indicated the position description would be developed by the end of the month and circulated to the COR for their review and input.*

IX. Update: Recruitment of QIPS Director

Ms. Kroeger updated the group on the effort to hire a permanent QIPS Director.

X. New Business

A. Potential Action item asking us to take on guidelines for telepsychiatry practice—

Ms. Kroeger explained that it would be to the SCPG to determine if it is in their purview. She relayed the message that Dr. Levin thinks there should be a committee responsible for this growing area of medicine. The BOT and Dr. Levin's office is communicating with the AMA about this and the policies and intricacies of psychiatry under telemedicine.

Dr. Yager acknowledged the need for a new workgroup to manage this effort. He suggested that with tele-health guidelines already developed it would be beneficial to have our own group to review what exists and further evaluate if this is a practice recommendation.

The discussion led to whether this workgroup should be attached to the CQC or the Council on Health Systems and Finance. It was agreed that it should be developed under both groups (the Telepsychiatry Workgroup will report to CQC). Dr. Daviss provided feedback (as the chairman of the Committee of Health Information Technology) that the APA ensure our efforts to integrate with the American Telemedicine Association and the American Psychological Association.

Position Statement on Confidentiality of ~~Computerized Records~~ Electronic Health Information

Approved by the Board of Trustees, December 2010 Approved by the Assembly, November 2010

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

Issue: Computerization of medical records can bring clear-cut benefits to the delivery and quality of health care, including psychiatric treatment. Electronic health records (EHRs), as well as the sharing of information via health information exchanges (HIEs), can raise significant security challenges and potential threats to patients' confidentiality. Government intelligence agencies, such as the NSA, are reported to be able to access the personal health information of patients by bypassing built-in security and encryption features of EHRs and HIEs. Psychiatrists have an obligation to advocate for HER and HIE policies, features, and implementations that allow the sharing of medically necessary information to enhance care, as well as to support a culture of confidentiality and respect for patients' privacy and their preferences in the electronic storage, access, and sharing of health information.

Patients should be able to benefit from the potential improvements in the delivery and quality of care with electronic health records (EHRs), without being forced to relinquish the privacy and confidentiality of their personal health-related information. Patients should also be able to enjoy the care coordination benefits provided by EHRs and health information exchanges (HIEs) without having to share all or none of their information, i.e., they should be able to identify classes of data for more restricted access. Approaches to accessing ~~electronic~~ health information via HER and HIE ~~record access~~ should consider the diverse settings in which electronic health information ~~records~~ will be used, including ~~their~~ its use in emergency and other acute settings where rapid access to medically necessary information is essential. Such approaches should also consider that patients have a broad range of needs, preferences and abilities to provide informed consent about the implications of electronic record access. At the very least, computerized records should give patients as much control over their information as they have with paper-based records. ~~In addition, computerized records should not force patients to choose between either making all or none of their information available~~. Electronic health record design and implementation should leverage technology to give more flexible approaches to access for sensitive information. Government organizations or other third parties should not be able to inappropriately access electronic health information by bypassing built-in security and encryption features of EHRs and HIEs. As health information technology continues to advance and evolve, the complexities and potential consequences of computerized records make it essential for psychiatrists to be aware of the implications for their patients and advocate for a culture of confidentiality and respect for patients' privacy preferences.

This revision of the 1997 position statement was developed by the Council on Research and Quality Care

Revision to Position Statement

Title: *Psychiatric Implications of HIV/HCV Co-infection*

Issue

People with HIV infection are disproportionally affected by viral hepatitis. [i] In addition, about 80% of people with HIV who inject drugs also have hepatitis C virus (HCV). [i] HIV/HCV co-morbidity presents more complex medical and psychiatric management issues than the presence of either infection alone.

APA Position

The APA strongly supports the important role psychiatrists should play in the diagnosis and treatment of co-morbid HIV/HCV infection. Psychiatrists are uniquely positioned to contribute to the management of these patients, but to be effective they need to stay abreast of the rapid changes taking place in the treatment of people with comorbid HIV and HCV infection. Both of these infections are over-represented among people with mental illness. Both of these infections, and their treatments, are associated with psychiatric complications. New treatments for HCV infection now produce high rates of cure, potentially extending the lives of these co-infected patients.

The Role of the Psychiatrist

1. Psychiatrists should stay current in their medical knowledge of the psychiatric and neuropsychiatric manifestations of HIV and HCV disease and the complications of their treatments.
2. Psychiatrists should consider, encourage, facilitate and in certain instances (such as inpatient psychiatric care) provide both HIV and HCV testing.
3. Patients should be treated for current mood disorders prior to initiating HCV treatment. When interferon is part of the HCV regimen, patients with a past history of mood or other psychiatric disorders may benefit from prophylaxis with antidepressant medications. It is also desirable to ensure that the patient is as stable as possible with regard to psychiatric symptoms, substance use, psychosocial support and housing, as these factors are associated with adherence to treatment.
4. Psychiatrists have a responsibility to advocate for necessary access to HCV treatment for their infected patients. In addition, psychiatrists should be involved in closely monitoring changes in neuropsychiatric functioning, such as mood, behavior and cognition.
5. Psychiatrists are encouraged to collaborate with hepatologists, infectious disease physicians and other primary care providers for the HIV/HCV infected.
6. Because of the increased hepatotoxicity in the HCV co-infected patient, psychiatrists should collaborate with the HCV treatment team and other clinical specialists to actively monitor the potential for drug-drug interactions and overlapping toxicities of treatments for HCV, HIV and psychiatric disorders. In addition, attention should be paid to the potential for the interaction of substances of abuse with HIV/HCV antiretroviral treatment and psychiatric medications.
7. ~~Patients infected with HIV should be screened for Hepatitis A, B, and C and vaccinated against A & B where immunity is not present to these infections.~~

Authors

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Background Information/Resource Document

Approximately one quarter of people with HIV in the U.S. are also infected with Hepatitis C (HCV). In high risk groups the rate of co-infection rises and HCV is found in 50 to 70 percent of HIV-infected intravenous drug users. [ii] HIV/HCV co-morbidity presents more complex medical and psychiatric management issues than the presence of either infection alone. Psychiatrists have much to contribute to the management of these patients, but to be effective they need to stay abreast of rapidly changing treatment advances.

Patients at risk for or infected with HIV are also at risk for infection with Hepatitis B, and/or C, and sometimes Hepatitis A depending on high risk behaviors. HIV and HCV co-infection rates are particularly high as the viruses share similar routes of transmission. [iii] Though there are more public awareness campaigns to encourage people to learn about their HCV status, psychiatric patients, in particular, may not have had adequate assessment of their hepatitis exposure status. Studies show that people with severe mental illness have higher rates of Hepatitis C virus (HCV) compared to the general population. [iv]

The most common route of HCV infection is injection drug use. Sexual transmission is less common but also occurs. For unclear reasons the cohort of "baby-boomers" born between 1945 and1965 has an elevated rate of HCV infection independent of their reporting risk factors. The CDC therefore recommends HCV testing in those with risk factors and at least once for those born between 1945 and1965 regardless of reported risk factors. CDC guidelines for Hepatitis C testing can be found at www.cdc.gov/hepatitis/hcv/GuidelinesC.htm

Independent of HIV, HCV becomes chronic in 80-85% of infected individuals. Of those, 20-25% will develop serious chronic liver disease. In fact, HCV is the most common reason for liver transplants in the U.S. Most chronically infected people, however, usually remain asymptomatic for many years before being diagnosed with HCV, [v] and the majority of people with HCV infection are unaware of their infection.

HIV complicates the course of HCV by increasing the prevalence and hastening the development of liver disease and failure and increasing the risk of developing hepatocellular carcinoma. There appears to be enhancement of HCV replication in the context of HIV. The effects of HCV co-infection on HIV disease progression are less certain and studies have had conflicting results. Some studies have suggested that HCV infection is associated with more rapid progression to AIDS or death. However, while the subject remains controversial, it is possible that HCV has detrimental effects on the liver's ability to process medications used to treat HIV and its associated medical consequences. Among the problems that follow is the potentially increased toxicity of the antiretroviral medications.

Like HIV, HCV is also a neurotropic virus, which may invade the CNS much as HIV does via infected monocyte/macrophages, a process known as the "Trojan Horse" mechanism. HCV replicates in the brain, its viral load can be measured in the cerebrospinal fluid, and there is cognitive impairment independent of HIV infection. Patients with HCV mono-infection have been shown to have cognitive impairments including difficulties with concentration and working memory. However, unlike HIV, HCV alone does not lead to frank dementia. There is emerging evidence that HCV and HIV co-infected patients demonstrate more cognitive impairment than patients with HIV mono-infection. Thus, there may be an increased likelihood of HIV Associated Neurocognitive Disorders (HAND) in the setting of HCV co-infection (see statement on the

Recognition and Management of HIV-Related Neuropsychiatric Findings and Associated Impairments). In advanced HCV disease, metabolic complications due to liver failure can lead to CNS impairment, potentially affecting treatment adherence, and making the diagnosis of cognitive impairment due to HIV more problematic.

Unlike HIV treatment, the goal of HCV treatment is eradication of the virus and cure. The criterion for cure is sustained virologic response (SVR) that continues after HCV treatment has been discontinued. Treatment is not recommended, or necessary, for all people with HCV infection. However, all HIV/HCV co-infected patients should undergo readiness evaluation for HCV treatment. ~~When possible, it is often advisable to treat HCV before initiating treatment for HIV to avoid the issues of drug interactions between HCV and HIV medications and to reduce the risk of ARV-related hepatotoxicity. In patients with CD4 counts <200 cells/mul and/or plasma HIV RNA counts above 100,000 copies/ml, it may be better to consider anti-HIV treatment before HCV treatment regimens.~~

Rapid and dramatic changes are occurring in assessing the degree of liver disease present in people with HCV infection and in the treatment of HCV infection. Non-invasive techniques have largely replaced liver biopsy when assessing liver fibrosis. ~~Two new medications, both protease inhibitors, are on the market and many other new HCV medications are in the pipeline. These new medications are anticipated to reduce the toxicity of HCV treatment, allow HCV treatment to be completed in shorter periods of time, and achieve cure rates approaching 100%.~~

<u>The treatment of HCV infection has also changed dramatically with the introduction of new medications that reduce the toxicity of HCV treatment, allow HCV treatment to be completed in shorter periods of time, and achieve cure rates approaching 100%. There are also some treatment regimens that no longer require the use of interferon. HCV treatment will continue to evolve as new medications in the pipeline become FDA approved. Guidelines for HCV treatment can be found at www.hcvguidelines.org</u>

<u>In regimens for which interferon is still required, it's important to bear in mind that</u> interferon (IFN) has significant neuropsychiatric side effects, most importantly severe depression and suicidal thinking and behaviors. In addition, fatigue, insomnia, anxiety, and impaired neurocognitive function have also been observed. Essentially any psychiatric symptom has the potential to worsen on IFN treatment. [vi] Ribavirin, another older medication that is still used in many HCV treatment regimens, also has problems associated with toxicity, predominantly anemia (which may also increase fatigue), depression, and cognitive dysfunction. Hepatologists and other medical providers, recognizing these potential effects, may be concerned about initiating treatment for HCV in people with significant histories of depression and other mental illnesses. However, based on clinical experience, and published research, the high incidence of depressive symptoms with IFN treatment suggests prophylaxis with antidepressants may prove to be beneficial in most patients. ~~It is anticipated that as HCV treatment regimens that do not require IFN and/or ribavirin become available, patients will experience less severe toxicities during treatment.~~

~~The two currently available HCV protease inhibitors, telapravir and boceprevir, have numerous drug-drug interactions due to metabolism via CYP450 3A4. These medications are both inducers and inhibitors of the enzymes and pose potential interactions with many classes of medications, including antiretrovirals (protease inhibitors, NNRTI's, and tenofovir) and numerous psychotropics (anticonvulsants, antidepressants, sedative hypnotics and~~

~~antipsychotics).~~ Keeping track of drug-drug interactions is best achieved through the use of online drug interaction websites, keeping in mind that most interactions are listed as between two medications and less is known about drug interactions when multiple medications are prescribed. Two useful drug interaction websites are www.hiv-druginteractions.org<http://www.hiv-druginteractions.org and www.hcv-druginteractions.org.

~~Common side effects of telapravir and boceprevir include rash (including potential for Stevens Johnson Syndrome), pruritis, anemia, fatigue, and headache~~.

~~Pre-morbid psychiatric disorders, including severe depression, other mood disorders, and substance abuse, are not necessarily reasons to withhold HCV treatment. However,~~ Every effort should be made to stabilize psychiatric issues prior to HCV treatment. Patients who are stable on psychotropics should be maintained on the effective therapy. Psychiatrists can support HCV treatment initiation by enhancing treatment readiness, including obtaining baseline and follow-up depression inventories, and enlisting other supportive resources (e.g., family support, psychotherapy, support groups). Psychiatrists can also participate after treatment initiation in supporting adherence and treatment response monitoring. When INF is part of the regimen, SSRIs remain the most extensively studied medications for both prophylactic treatment in patients with a history of depression, and for the treatment of depression during IFN therapy. Suicidal ideation and behaviors are potential clinical manifestations of interferon treatment and should be assessed at every visit. [viii]

Co-morbid substance use disorders and behaviors that put patients at risk of becoming re-infected with HCV need to be addressed aggressively if treatment rates for HCV are to be improved in the HIV-HCV co-infected populations. Integrated patient-centered care involving an interdisciplinary team of mental health professionals and substance abuse counselors can promote better outcomes.

New HCV medications are very expensive and the team of providers treating the patient may need to assist patients with obtaining insurance coverage and advocate for them. This availability of insurance coverage for new HCV treatments will vary from state to state.

[i] CDC HIV and Viral Hepatitis [fact sheet] May 2014

[ii] Rockstroh JK, Spengler U: HIV and hepatitis C virus co-infection. Lancet Infect Dis 2004; 4:437-444

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COUNCIL ON RESEARCH
REPORT TO THE JOINT REFERENCE COMMITTEE

Executive Summary

The following general issues were discussed at the meeting: 1) the report from the BOT-appointed Workgroup on Research; 2) the status of the APA Patient Registries Work Group; 3) recommendations for the BOT Ad Hoc Workgroup on Healthcare Reform report; 4) removal of the black box warning from antidepressants; and 5) recommendations on expired APA position statements under the Council's jurisdiction. The meeting included reports/discussions from the Council components as well as discussions with Drs. Levin, Summergrad, and Binder regarding the role of research at the APA.

The Council brings the following Action Items:

Action Item 1: Will the Joint Reference Committee recommend that the Board of Trustees vote to approve the Council on Research's revised charge?

- See Attachment 1 for previous and revised charges.

Action Item 2: Will the Joint Reference Committee recommend that the Assembly vote to approve the revised Position Statement on the Psychiatric Implication of HIV/HCV Co-Infection?

- See Attachment 2 for revised position statement.

Action Item 3: Will the Joint Reference Committee recommend that the Board of Trustees vote to approve the APA signing on to the AllTrials registry?

- See Attachment 3 (pg. 13) for details.

The Council brings the following Information Item:

The Council wishes to inform the Joint Reference Committee that it is continuing work on reviewing and revising the expired APA policy statements subject to its jurisdiction.

Referral Updates

The Council wishes to provide updates on the following Joint Reference Committee referrals:

Action Item Number: JRCJAN148.L.1
Title: Revised Charge to the Council on Research
Action: See Action Item 1 above. The Joint Reference Committee previously reviewed the Council's revised charge and had some additional language for the group to consider. At their September meeting, the Council reviewed the additional language suggested by the Joint Reference Committee and respectfully decided the revisions were not necessary. A motion was raised to approve the former revised charge (minus the recent revisions from the Joint Reference Committee), which was unanimously approved. (See Attachment 1.)

Action Item Number: JRCJAN148.L.3; ASMMAY144.B.3
Title: Position Statement on the Psychiatric Implication of HIV/HCV Co-Infection
Action: See Action Item 2 above. The Assembly and Joint Reference Committee asked the Council and the Office on HIV Psychiatry to make several revisions to the statement. These changes have been implemented as requested (see Attachment 2).

Action Item Number: ASMMAY1312.R
Title: APA Should Sign the AllTrials Campaign Petition
Action: See Action Item 3 above. The Council was provided additional information about the AllTrials campaign, including the purpose of the campaign, the organizations that have already signed on, and what the APA signing on would mean. The Council agreed that there was benefit to the APA signing on and unanimously approved the motion to recommend the APA do so. (See Attachment 3.)

Action Item Number: ASMMAY1412.K
Title: Remove Black Box Warning from Antidepressants
Action: 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. (See Attachment 3.)

Title: Recommendations of the BOT Ad Hoc Workgroup on the Role of Psychiatry in Healthcare Reform
Action: The Council was asked to review and provide feedback on indicated sections of the workgroup report. The Council was not able to address the spreadsheet at its meeting because of time constraints, and despite agreement to do so after the meeting (with reminders from administration), did not send the APA any responses. However, the research knowledge pertinent to this report resides in the section assigned to the Council on Quality Care. Division of Research administration reviewed their responses and found them to be sufficient. Those were turned into the MDO as requested.

Attachments
Attachment 1: Council on Research Current and Revised Charge

Attachment 2: Revised Position Statement on the Psychiatric Implication of HIV/HCV Co-Infection

Attachment 3: Minutes from the Council on Research's September Components Meeting

Attachment 1

Charge to the former 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 psychiatric knowledge through the conduct of research by physician scientists across a broad range of research fields and issues: basic science, clinical diagnosis and assessment, treatment research, research training, health services, and prevention research. These areas are represented by the Committees and Task Forces under the Council's jurisdiction.

Draft Revised Charge to newly constituted Council on Research:
(Approved by 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 to APA's mission and in the forefront of the national health agenda. The Council embodies the Association's commitment to advance evidence-based psychiatric knowledge 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, prevention research, and research ethics, and through the recognition of psychiatrist researchers who have made significant contributions to psychiatric knowledge and practice. These areas 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.

Proposed Revisions to the Charge to the Council on Research from Dr. Jeffrey Akaka
(Not approved by 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 to the APA's mission and in the forefront of the national health agenda.

The Council embodies the Association's commitment to advance evidence based psychiatric knowledge 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) HEALTHCARE INTEGRATION, THE NEEDS OF OUR MEMBERS AND HOW TO MEET THEM, and research ethics. (and through the recognition of research psychiatrists who have made significant contributions to psychiatric knowledge and practice. These areas may be represented by the Committees and Task Forces under the Councils jurisdiction and others may be established relevant to the Council's areas of interest.)

IT MAY ESTABLISH OR SUNSET COMMITTEES AND TASK FORCES UNDER THE COUNCILS JURISDICTION IN RESPONSE TO EMERGING NEEDS OF PSYCHIATRISTS RELEVANT TO AREAS ABOVE.

THE COUNCIL WILL PROMOTE RECOGNITION OF RESEARCH PSYCHIATRISTS WHO HAVE MADE SIGNIFICANT CONTRIBUTIONS TO THIS KNOWLEDGE, AND IDENTIFY APPROPRIATE

SOURCES OF FUNDING FOR NEEDED RESEARCH TO BE SUPPORTED, INCLUDING GOVERNMENT GRANTS, PRIVATE FOUNDATIONS AND OTHERS.

Attachment 2

Title

Psychiatric Implications of HIV/HCV Co-infection

Issue

People with HIV infection are disproportionally affected by viral hepatitis. [i] In addition, about 80% of people with HIV who inject drugs also have hepatitis C virus (HCV). [i] HIV/HCV co-morbidity presents more complex medical and psychiatric management issues than the presence of either infection alone.

APA Position

The APA strongly supports the important role psychiatrists should play in the diagnosis and treatment of co-morbid HIV/HCV infection. Psychiatrists are uniquely positioned to contribute to the management of these patients, but to be effective they need to stay abreast of the rapid changes taking place in the treatment of people with comorbid HIV and HCV infection. Both of these infections are over-represented among people with mental illness. Both of these infections, and their treatments, are associated with psychiatric complications. New treatments for HCV infection now produce high rates of cure, potentially extending the lives of these co-infected patients.

The Role of the Psychiatrist

1. Psychiatrists should stay current in their medical knowledge of the psychiatric and neuropsychiatric manifestations of HIV and HCV disease and the complications of their treatments.
2. Psychiatrists should consider, encourage, facilitate and in certain instances (such as inpatient psychiatric care) provide both HIV and HCV testing.
3. Patients should be treated for current mood disorders prior to initiating HCV treatment. When interferon is part of the HCV regimen, patients with a past history of mood or other psychiatric disorders may benefit from prophylaxis with antidepressant medications. It is also desirable to ensure that the patient is as stable as possible with regard to psychiatric symptoms, substance use, psychosocial support and housing, as these factors are associated with adherence to treatment.
4. Psychiatrists have a responsibility to advocate for necessary access to HCV treatment for their infected patients. In addition, psychiatrists should be involved in closely monitoring changes in neuropsychiatric functioning, such as mood, behavior and cognition.
5. Psychiatrists are encouraged to collaborate with hepatologists, infectious disease physicians and other primary care providers for the HIV/HCV infected.

6. Because of the increased hepatotoxicity in the HCV co-infected patient, psychiatrists should collaborate with the HCV treatment team and other clinical specialists to actively monitor the potential for drug-drug interactions and overlapping toxicities of treatments for HCV, HIV and

psychiatric disorders. In addition, attention should be paid to the potential for the interaction of substances of abuse with HIV/HCV antiretroviral treatment and psychiatric medications.

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Steering Committee on HIV Psychiatry and the Council on Research

Resource Document

Approximately one-quarter of people with HIV in the U.S. are also infected with Hepatitis C (HCV). In high risk groups the rate of co-infection rises and HCV is found in 50 to 70 percent of HIV-infected intravenous drug users. [ii] HIV/HCV co-morbidity presents more complex medical and psychiatric management issues than the presence of either infection alone. Psychiatrists have much to contribute to the management of these patients, but to be effective they need to stay abreast of rapidly changing treatment advances.

Patients at risk for or infected with HIV are also at risk for infection with Hepatitis B, and/or C, and sometimes Hepatitis A depending on high risk behaviors. HIV and HCV co-infection rates are particularly high as the viruses share similar routes of transmission. [iii] Though there are more public awareness campaigns to encourage people to learn about their HCV status, psychiatric patients, in particular, may not have had adequate assessment of their hepatitis exposure status. Studies show that people with severe mental illness have higher rates of Hepatitis C virus (HCV) compared to the general population. [iv]

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Further Recommended Reading

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Attachment 3

Draft Minutes
Council on Research
September Components Meeting
September 10, 2014

In attendance:
Dwight Evans, M.D., Chair
Linda Carpenter, M.D
Michael First, M.D.
John Krystal, M.D
Glenn Martin, M.D.
William McDonald, M.D.
Brent Nelson, M.D. (resident fellow)
Charles Nemeroff, M.D., Ph.D.
Daniel Pine, M.D.
James Potash, M.D., M.P.H.
Carolyn Rodriguez, M.D., Ph.D.
Anup Sharma, M.D., Ph.D. (resident fellow)
Crystal Watkins, M.D., Ph.D.

Not present:
Daniel DeLuca, M.D. (resident fellow)
Robert Golden, M.D.
David Henderson, M.D.
Matthew Iles-Shih, M.D., M.P.H. (resident fellow)
Mauricio Tohen, M.D., Dr.P.H.

APA leadership and administration:
Saul Levin, M.D. (partial attendance)
Paul Summergrad, M.D. (partial attendance)
Renee Binder, M.D. (partial attendance)
Kristin Kroeger (partial attendance)
Rodger Currie (partial attendance)
Ian Hedges (partial attendance)

William Narrow, M.D., M.P.H.
Emily Kuhl, Ph.D.
Eve Moscicki, Sc.D., M.P.H.
Carol Svoboda (partial attendance)
Alison Bondurant (partial attendance)
Annelle Primm, M.D. (partial attendance)

1. Opening Session

The meeting was opened by Dwight Evans, M.D., Council chair, with introductions of attendees and conflict of interest disclosures. The minutes from the APA Annual Meeting were presented to the full Council and formally approved.

Following the introductions, William Narrow, M.D., MPH, Acting Director of the Division of Research, discussed the report from the Board of Trustees-appointed Research Workgroup, who was charged with determining the appropriate scope and priority areas for research at the APA. The Council expressed concern about the Workgroup's recommendation for formation of a Research Advisory Group to work with APA leadership on research needs. They felt such a group would be redundant with their Council and was thus unnecessary. Dr. Evans reminded the Council that Saul Levin, M.D., APA Medical Director and CEO, and Paul Summergrad, APA President, were scheduled to partially attend the meeting; further discussion was tabled until they arrived.

Meeting with Drs. Saul Levin, Paul Summergrad, and Renee Binder
(These meetings took place throughout different portions of the Council's agenda. This information is presented here together for continuity).

Dr. Binder, APA President-Elect, thanked the Council for their service, noting that the Council does not currently have any consultants or corresponding members but could benefit from their use. She then outlined her priorities while President, which included addressing public stigma against psychiatrists and psychiatric patients; clarifying the role of psychiatrists for the general public; and increasing interest and participation in psychiatry by young physicians, particularly from a diversity perspective.

Dr. Summergrad joined shortly thereafter and discussed current priorities for the APA under his leadership as they pertain to research. Specifically, he noted the importance of identifying funding opportunities for research; utilizing the APA's Division of Research and the Council to identify relevant policy issues; and enhancing physician-scientist training in residency programs. The Council then raised their concerns about the Research Workgroup's suggestion to form a Research Advisory Group. Dr. Summergrad agreed that such a group would not be necessary, given the role of the Council, and therefore would not be formed. The Council inquired about the degree to which the formation of patient registries was a priority for the APA, and Dr. Summergrad concurred that it was important but noted critical questions remain and require clarification, such as defining the purpose and utility of a patient registry and determining how best to handle data input. The Council thanked Dr. Summergrad for providing context and clarification on the Research Workgroup report and on the APA's research plans in general.

The Council was later visited by Dr. Levin, along with Kristin Kroeger, Rodger Currie, and Ian Hedges. Dr. Levin also thanked the Council for their service and hard work and provided an update on recent staffing changes to the Division of Research. He noted that the position description for the Director of the Division of Research was being finalized and would be distributed to the Council for review by the end of the month. He also discussed recent efforts to enhance Federal government support for research, such as meeting with House Energy and Commerce Committee Chairman Fred Upton (R-MI) on the 21st Century Cures initiative to accelerate the development of medical cures and breakthroughs. He indicated that the APA's Division of Government Relations will be in touch with the Council with more specific information on APA's involvement in this initiative. Kristin Kroeger

mentioned a neuroscience briefing on depression taking place on Capitol Hill in November and encouraged Council members to attend and recruit others to attend as well.

Dr. Levin agreed with Dr. Summergrad that a Research Advisory Group would not be appointed and that he would continually seek consultation from the Council on an ad hoc basis. Dr. Levin described the importance of reaching out to other mental health organizations to ensure the needs of psychiatric patients and the field at large are being addressed. For example, the APA recently provided comments and suggestions to SAMHSA regarding their FY 2015 – 2018 Strategic Plan, entitled "Leading Change 2.0: Advancing the Behavioral Health of the Nation." Dr. Levin informed the Council that he would send them a copy of his letter to SAMSHA.

Dr. Levin concluded by introducing Rodger Currie as the newly hired APA Chief of Government Affairs.

2. Informational Updates

- At the APA Annual Meeting, the Council reviewed their revised charge and was informed that the JRC recommended some additional edits. These edits were reviewed at the current gathering. Although the Council appreciated the JRC's input, they felt the additions did not add any significantly critical information to the original revision. They agreed that the original revision, without the suggested edits from the JRC, should be sent back to the JRC for approval.

3. Council Updates

- APA Patient Registry

  Dr. Potash reported on the status of the APA patient registry. He noted that the Council on Quality Care, Council on Research, and Council on Healthcare Systems and Financing have named a workgroup on patient registry development, which has now met five times. The charge for the group includes such items as establishing a working definition of a registry; laying out the potential nature, scope, and purposes of psychiatric registries and key questions that such registries might answer; advising on which types of psychiatric registries might be most suitable and appropriate for APA involvement; identifying key stakeholders for such APA registries; assessing the current environment of active and developing registries among medical specialty societies and other healthcare organizations; and determining an initial process and timeline for developing a new registry, including key personnel needs, the possibility of a small-scale pilot study, etc.

  Among the questions and topics the workgroup has prioritized are clarifying the purpose of the registries, particularly in terms of research activity; determining how registries could help APA members without electronic health records gathering data for administrative purposes; and assessing how ambitious a project this should be in terms of its scope (e.g., collection of data on all psychiatric diagnoses or focused on one particular diagnosis). The workgroup also has discussed the challenges of data entry, especially given that busy clinicians will be unlikely and/or unable to enter data themselves. The Council emphasized the need to consider what patient registries can accomplish for the research community and how that informs the type of data that should be collected.

- AllTrials Registry

  Dr. Martin presented the Council with additional information about the purpose and possible implications of APA signing the AllTrials registry. He noted than more 500 organizations—largely non-academic—have already signed on. Although the Council discussed some potential barriers to psychiatrists' participation (e.g., lack of clear and consistent definition of what a clinical trial is), they could not identify any true downsides to the APA signing on. A motion was raised to support APA signing the registry and was unanimously approved.

- Deep Brain Stimulation Article for Huffington Post

  Dr. Rodriguez circulated to the Council her draft article on the use and evidence base for deep brain stimulation (DBS), developed for the Huffington Post. The purpose of the article is to increase public awareness and decrease stigma about DBS, while also advocating for further research of DBS as a possible therapy. The Council discussed the extent to which the piece should address DBS for depression, especially in light of recently published results from two sham-controlled DBS depression studies that failed to find any efficacy. After discussion, the Council agreed that the article should mainly concentrate on discussion of DBS for Parkinson's disease and obsessive-compulsive disorder and should not describe in-depth the evidence base for depression—although it should mention the two recently failed trials. Dr. Rodriguez agreed to make some revisions and recirculate to the Council for review.

- Committee on Research Training

  Dr. Nemeroff and Alison Bondurant, Associate Director of the APA's Division of Diversity and Health Equity, reported on the status of application announcements for the APA's research training opportunities. Ms. Bondurant noted that the Division of Diversity and Health Equity has taken over several of the diversity training awards and has been actively circulating applications.

- Committees on Research Awards and Health Services Research

  Dr. Kuhl briefly reported on the activities of these two research award committees. The Research Awards Committee only recently appointed their chair (Carol Tamminga, M.D.) and has not yet had any conference calls. These are in the process of being scheduled.

  The Health Services Committee award recipients who will receive awards at the 2014 IPS meeting include Joseph Ceremele, M.D. (Health Services Early Career Research Award) and Jurgen Unützer, M.D., M.P.H. (APF Health Services Research Senior Scholar Award). The committee is organizing a health services research track at IPS, which to-date includes lectures on healthcare reform, treatment of depression in community populations, and bipolar disorder in primary care.

- Task Force to Revise the Practice of Electroconvulsive Therapy

  Dr. McDonald reported that the Task Force has made considerable progress on the development of a book on the practice of ECT, with initial drafts anticipated by January. At that time, chapters will need to be distributed to authors for review and revisions compiled. He asked whether or not the APA could provide support for those activities, and Dr. Narrow

indicated that staff in American Psychiatric Publishing should be able to assist. Dr. Narrow indicated he would contact John McDuffie, Editorial Director of American Psychiatric Publishing Books, for further details.

Dr. McDonald also provided an update on the development of a clinical information guide on the use and application of Transcranial Magnetic Stimulation (TMS). He reported that he would work with Council members to develop the draft and will circulate amongst the entire group once complete. Although this will not be developed as an official APA clinical practice guidelines document, the Council suggested it may be appropriate to submit to the *American Journal of Psychiatry* as an article on the efficacy, side effects, and practice of TMS.

- HIV

  Carol Svoboda, Director of the APA Office on Psychiatry, reported that outside funding from SAMHSA for APA's current HIV training contract (280-14-0428) will end on September 30. In June, APA submitted a new proposal in partnership with the Education Development Center, Inc. (EDC), the American Psychological Association, and the National Association of Social Workers. While EDC would assume the primary contractor role, the intent of the partnership agreement is to enhance collaboration among all subcontracting partners, expand audiences served, support the ongoing work of each organization, and advance training of all mental health professionals. The anticipated period of performance for this contract is a base period of 12-months, plus four 12-month option periods. The proposed total budget for APA is approximately $130,000 (current funding is approximately $240,000).

  Update: Funding was approved after the closure of the meeting. The new contract begins September 15.

- Committee on Psychiatric Dimensions of Disaster

  Dr. Kuhl reported that the Committee has nominated two individuals for the Bruno Lima Award: Charles P. Ciolino, M.D., and Jagannathan Srinivasaraghavan, M.D. The Council unanimously voted to approve the nominees.

- Diagnostic and Treatment Markers Workgroup

  Dr. Nemeroff reported that he and Jeffrey Newport, M.D., are close to finalization of their drafts of A Critical Review of the Ketamine Literature, and that he plans to circulate to the rest of the workgroup within the next 30 days. He then will send to the entire Council for their input as well. The plans are to submit the review to the *American Journal of Psychiatry*. Dr. Potash has begun drafting a review paper on biomarkers of antidepressant response and anticipates having a draft prepared within the next 30 days. The manuscript on Diagnostic Tests for Mood Disorders also is still in preparation.

- Caucus on Complementary and Alternative Medicine

  Lila Massoumi, M.D., Chair of the CAM Caucus, previously asked the Council about their interest in the Caucus developing a literature review on the evidence for CAM interventions in

psychiatric disorders. As Chair of the Diagnostic and Treatment Markers Workgroup, Dr. Nemeroff suggested to her that the Caucus narrowly focus on a specific CAM intervention or biomarker, such as omega-3 fatty acids or methylfolate, rather than attempt to review CAM therapies as a whole. In reply to his suggestion, Dr. Massoumi indicated by email that the Caucus would like to develop a paper on S-adenosylmethionine (SAMe) for depression. She noted that significant findings have emerged since the last review of SAMe for depression was published in 2012. The Council emphasized the importance of having the opportunity to review the completed manuscript but noted that they would not have time to be significantly involved in any drafting or analysis. Drs. Carpenter and Sharma agreed to help with the review.

4. Additional Discussion Issues

- The APA Board of Trustees Ad Hoc Workgroup on Healthcare Reform recently completed a report on the role of psychiatry and integrated care in healthcare reform. The Council on Research—along with other APA Components—was asked to review certain portions of the report to provide feedback on the workgroup's research recommendations, relevant research questions, and proposed projects. The report and response grid was distributed to the Council, who will conduct their reviews and provide responses to Dr. Kuhl via email.

- At the previous Joint Reference Committee (JRC) meeting, the JRC referred to the Council the action paper on the removal of the black box warning on antidepressants. Specifically, they asked the Council to provide a listing of pros and cons to removing the black box warning. Dr. Nemeroff noted that Robert Gibbons, Ph.D., University of Chicago, has previously been involved with research on the topic, particularly how the presence of the black box warning has impacted prescribing habits. The Council felt that before a formal recommendation could be made to the JRC, including a description of benefits and detriments to removing the warning, it would be helpful to receive input from Dr. Gibbons and his colleagues (e.g., J. John Mann, M.D.) who have studied the issue extensively. As a next step, Dr. Nemeroff indicated that he would speak with Dr. Gibbons to ascertain his interest level and availability in assisting.

- Finally, the Council was assigned 12 expired APA Position Statements to review for revisions, retention, or retirement. Although these were distributed before the meeting and Council members had already reviewed them, there was not sufficient time left in the meeting to discuss each statement in detail. Rather, each statement was briefly discussed in terms of whether it needed revisions, retirement, or could be retained as-is, and Council members were asked to provide their specific edits and rationales to Dr. Kuhl via email, as needed.

The Council, having completed its deliberations, adjourned, with its next meeting scheduled during the 2015 APA Annual Meeting in Toronto, Canada.