Joint Reference Committee

American Psychiatric Association

Orlando, FL

Materials included in this document

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Joint Reference Committee

American Psychiatric Association

Orlando, FL

DRAFT AGENDA

January 20, 2015

Sunday, January 25th, 2015

Location: **Wyndham Grand Orlando Resort Bonnet Creek**
Voyage Room, Ground Level
Lunch: **12:00 noon – 1:00 pm**
Meeting: **1:00 pm – 5:00 pm**

1:00 pm – 1:20 pm

1 Welcome, Introductions and Verbal Disclosures of Interests & Affiliations – Renée Binder, MD

cc 2.A Review and approval of draft Summary of Actions from the October 2014 Joint Reference Committee Meeting – Renée Binder, MD

Will the Joint Reference Committee approve the draft summary of actions from the October 2014 meeting?
(Please see item 2.A)

2.B Approval of the Consent Calendar

Will the Joint Reference Committee approve the Consent Calendar?
(Please see item 2.B)

1:20 pm – 1:40 pm

4 Report of the CEO and Medical Director – Saul Levin, MD, MPA

REFERRAL UPDATES

4.A JRCOCT138.F.1 – Council Communications to Members
Action is ongoing

While not all work of councils is appropriate for public dissemination (as it may need to go to the BOT and other groups per the approval process), in those cases where communication is desired, we will:

- Help councils create a "one pager" to promote their papers and projects;
- Ensure that the Office of Member Communication/Psychiatric News is aware of the forthcoming product, which can work to inform members and DB/SAs;
- Ensure that the Office of Corporate Communications and Public Affairs is aware, which can inform key external audiences, including news media as appropriate; and
- Alert the Council on Communications for additional ideas (social media, blogs, etc.).

Other ideas will be considered once APA's infrastructure is ready. APA's Chief Communications Officer has engaged the Assembly's Work Group on Communications, as well.

4.B JRCOCT148.G.17 – Position Statement: Bill of Rights: Principles for the Provision of Mental and Substance Abuse Treatment Services

Action is ongoing

The position statement remains important when advocating on behalf of mental and substance use treatment services. The principles are applicable to implementation as they were to the enactment of passage. The Division of Government Relations is working with the Council on Advocacy and Government Relations to revise the statement.

4.C JRCOCT148.G.22 – Current Health Services Literature on Integrated Care Models

Action is ongoing

Division of Research Administration met with Healthcare Systems and Financing Administration to discuss and clarify the areas of focus that would be most helpful for this literature review. From these discussions, an outline was developed to guide the literature searches, which will now commence.

4.D JRCOCT148.I.3 – Revise Position Statement: Sexual Harassment

This action is referred to JRC and Board of Trustees for reaffirmation

It is important to maintain a position statement addressing the organization's opposition to sexual harassment in the workplace. The Division of Government Relations recommends retaining as written. (Please see item 4, attachment #1)

Will the Joint Reference Committee recommend that the Assembly approve the revised Position Statement [Title Revised] on Sexual Harassment and if approved, forward it the Board of Trustees for consideration?

4.E JRCOCT148.I.4 – Position Statement: Right to Privacy

This action is referred to the JRC for assignment to appropriate Council (e.g., Council on Psychiatry and Law and Council on Quality Care as the suggested group leads).

The statement remains relevant to our organization's position on an individual's right to privacy. The Division of Government Relations recommends that the JRC assign the task to the appropriate council as noted

Will the Joint Reference Committee refer the Position Statement: Right to Privacy to the appropriate Council for review?

1:40 pm – 2:00 pm

5 Items for Joint Reference Committee Discussion

A. Maintaining consistency within JRC functioning

B. Expectations of JRC members

8 Reports from Councils

2:00 pm – 2:15 pm

Sandra Walker, MD – via speakerphone

8.I **Council on Minority Mental Health and Health Disparities**

Please see item 8.I for the Council's report, summary of current activities and information items.

8.I.1 Revised Position Statement: Bias-Related Incidents (2007)

Will the Joint Reference Committee recommend that the Assembly approve the revised the 2007 Position Statement on Bias-Related Incidents and if approved, forward it to the Board of Trustees for consideration?

Please see item 8.I, page 2

Please note that if the revision to the Position Statement is approved, the 2008 version of the statement will automatically be retired.

Rationale:

1. Issues section, first sentence: The 2007 Position Statement mixed specific biases such as "racism," "sexism," and "antigay and antilesbian prejudice" with a more generic "intolerance based on religion, ethnicity, and national/tribal origin." In contrast, the revision uses the generic "intolerance based on…" and then cites the cultural identity variables "race/ethnicity, gender, age, religion/spirituality, places of birth and growing up, migrant status, socioeconomic status, sexual orientation, gender identity, and disabilities" which both includes the ones from the 2007 Position Statement and adds new ones that are significant. Instead of "national/tribal origins," the more generic term "places of birth and growing up" is used consistent with the DSM-5 Outline for Cultural Formulation Section A. Cultural Identity. In addition, this section also includes "socioeconomic background" and "migrant status," which are included in the revision. Both intolerance to "gender identity" and "disabilities" have been sources of bias. Finally, since this list is not exclusive, the phrase "among other characteristics" was added.

2. Issues section, second sentence: "Biases" are described more clearly in this revision as "explicit/conscious and implicit/unconscious"; see http://med.stanford.edu/diversity/FAQ_REDE.html and https://implicit.harvard.edu/implicit/takeatest.html
Furthermore, bias and prejudice were cited as reasons for health care disparities in the 2002 "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care" by the Institute of Medicine; see https://www.iom.edu/~/media/Files/Report%20Files/2003/Unequal-Treatment-Confronting-Racial-and-Ethnic-Disparities-in-Health-Care/DisparitiesAdmin8pg.pdf

3. Issues section, third sentence: This sentence combines several ideas from the 2007 Position Statement into one sentence: "These incidents are ubiquitous and occur in both urban and rural areas. Such hate-based incidents consist of acts of violence on harassment. These incidents result in emotional and physical trauma for individuals, as well as stigmatization of affected groups." becomes "These bias-related incidents, occurring in both urban and rural areas, consist of acts of violence and harassment based on stereotypes that devalue the human dignity of stigmatized individuals, families, and communities."

4. Issues section, fourth sentence: This sentence re-states a sentence in the 2007 Position Statement: "Ethnic and cultural biases, vividly manifest in bias-related incidents, serve to frustrate the basic human need for dignity, resulting in despair and hopelessness among the victims that ultimately affect the whole nation." becomes "These bias-related incidents result in despair and hopelessness that undermine the mental health and well-being of affected individuals that ultimately affects the whole nation."

5. APA Position section: This expands on the 2007 Position Statement last paragraph:
"The American Psychiatric Association (APA) deplores such bias-related incidents. Moreover, APA encourages its own members and components to take appropriate actions in helping to prevent such events, as well as to respond actively in the aftermath when such bias related incidents occur locally."

The first sentence is the same. The second and third sentences bring additional specificity to the where bias related incidents occur. The fourth sentence re-states the last sentence in the 2007 Position Statement without the qualifier "locally" since that is unduly confining.

6. Specific actions to be taken section: These are four specific action steps for APA to implement the new Position Statement.

2:20 pm – 2:35 pm
Dilip Jeste, MD – via speakerphone

8.F **Council on International Psychiatry**
Please see item 8.F for the Council's report, summary of current activities and information items.

The Council does not have action items.

2:40 pm – 2:55 pm
Francis Levin, MD – via speakerphone

8.A **Council on Addiction Psychiatry**
Please see item 8.A for the Council's report, summary of current activities and information items.

The Council does not have action items.

3:00 pm – 3:15 pm
Debra Pinals, MD – via speakerphone

8.J **Council on Psychiatry and Law**
Please see item 8.J for the Council's report, summary of activities and information items.

cc 8.J.1 Retire Position Statement: Employment Related Psychiatric Examinations (2009)

Will the Joint Reference Committee recommend that the Assembly retire the 2009 Position Statement: *Employment Related Psychiatric Examinations* and if retired, forward it to the Board of Trustees for consideration?
(Please see item 8.J, attachment #1)

Rationale: The Joint Reference Committee referred the revised position paper on Employment Related Psychiatric Examinations to the Council on Psychiatry and Law for feedback. The Council on Psychiatry and Law reviewed both position papers (proposed and current) and recommends that the 2009 position statement be sunset. The Council felt that there is not a current need for a position paper on this subject at this time, as the issue of informed consent is addressed in other documents.

3:20 pm – 3:35 pm
Ray DePaulo, MD – via speakerphone

8.D **Council on Communications**
Please see item 8.D for the Council's report, summary of current activities and information items.

The Council does not have action items.

7.A **Assessment of the Council**
Please see two attachments
7.A – Communications Work Plan Jan 2015
7.A – Communications Criteria for Evaluation Jan 2015

3:40 pm – 3:50 pm

8.K **Council on Psychosomatic Medicine**
Please see item 8.K for the Council's report, summary of current activities and information items.

cc 8.K.1 Revised Charge to the Council on Psychosomatic Medicine

Will the Joint Reference Committee recommend that the Board of Trustees approve the revised charge to the Council on Psychosomatic Medicine which adds HIV psychiatry?
(Please see item 8.K, attachment #1)

Referral Updates – no action required

8.K.2
Referral Update JRCOCT148.G.23 – Identify the Roles and Responsibilities of Psychiatrists

This item was referred to the Council on Psychosomatic Medicine after the Council informed the Council on Healthcare Systems and Financing that the Council on Psychosomatic Medicine was creating a joint APA Council on Psychosomatic Medicine and Academy of Psychosomatic Medicine workgroup to meet the objective of this action item. This workgroup will be tasked with performing an environmental scan of high quality, cost-effective integrated care models in which psychiatrists play a predominant role in the practice setting. The Council will provide regular updates on this action item as the workgroup progresses with its work.

3:50 pm – 4:30 pm

6 **Report of the Assembly** – Glenn Martin, MD

Please see the Assembly's Report for information items.

6.1 Direct to Consumer Advertising [ASMNOV1412.A]
(Please see item 6, attachment 1)

The action paper asks that

1. APA shall sunset: Position Statement on Direct-to-Consumer (DTC) Advertising of Prescription Drugs and Implantable Devices Adoption of AMA Policy H-105.988, approved 2010.
2. APA shall adopt the Position Statement on Direct to Consumer Advertising, 2014.

Will the Joint Reference Committee refer the Assembly action paper ASMNOV1412.A *Direct to Consumer Advertising* to the appropriate Component(s) for input or follow-up?

6.2 E-prescribing of Controlled Substances [ASMNOV1412.B]
(Please see item 6, attachment 2)

The action paper asks

1. That the APA refer this issue to our delegation to the AMA to support the option for electronically prescribed controlled substances as aligned with federal regulations and express the importance of adopting such standards to allow for this to the relevant components of the e-prescribing chain.
2. The APA will develop a position statement supporting the options of electronic prescribing of controlled substances.

Will the Joint Reference Committee refer the Assembly passed action paper ASMNOV1412.B: *E-prescribing of Controlled Substances* to the appropriate Component(s) for input or follow-up?

6.3 Telepsychiatry [ASMNOV1412.C]
(Please see item 6, attachment 3)

The action paper asks that the Council on Quality Care be charged to develop and recommend a plan to the Board of Trustees facilitating the defining of, adoption and use of telepsychiatry, including but not limited to research priorities, standardization of regulation, training, development of evidence based treatment guidelines, resolution of impediments, and addressing incentives/disincentives to its adoption.
That the Board of Trustees of the American Psychiatric Association act to review, revise, approve and implement said plan.

Will the Joint Reference Committee refer the Assembly action paper ASMNOV1412.C: *Telepsychiatry* to the appropriate Component(s) for input or follow-up?

6.4 Critical Psychiatrist Shortages at Federal Medical Centers [ASMNOV1412.D]
(Please see item 6, attachment 4)

The action paper asks that the American Psychiatric Association's Council on Advocacy and Government Relations design and implement a plan to best address the compensation and benefits of Bureau of Prisons psychiatrists that is substantially below community levels including other federally employed physicians as it prevents recruitment and retention of medical providers.

Will the Joint Reference Committee refer the Assembly action paper ASMNOV1412.D: *Critical Psychiatrist Shortages at Federal Medical Centers* to the appropriate Component(s) for input or follow-up?

6.5 EHR for Psychiatrists [ASMNOV1412.E)
(Please see item 6, attachment 5)

The action paper asks

1. That the APA Administration assist the Committee on Mental Health Information Technology to explore the feasibility of sending out a Request for Proposal to EHR vendors for psychiatry friendly EHRs with the goal of identifying and/or fostering development of one or more products for consideration by members.
2. That the APA Administration report their progress to the Assembly via the Assembly listserv by March 1, 2015.

Will the Joint Reference Committee refer the Assembly action paper ASMNOV1412.E: *EHR for Psychiatrists* to the appropriate Component(s) for input or follow-up?

6.6 Integrating Buprenorphine Maintenance Therapy with Mental Health [ASMNOV1412.G]
(Please see item 6, attachment 6)

The action paper asks that APA create a task force composed of appropriate council membership to focus on issues salient to integrated Substance Use Disorders and MI treatment including buprenorphine therapy.

Will the Joint Reference Committee refer the Assembly action paper ASMNOV1412.G: *Integrating Buprenorphine Maintenance Therapy with Mental Health* to the appropriate Component(s) for input or follow-up?

6.7 Exploration: Whether to Add Some Symptoms to the Next DSM [ASMNOV1412.N]
(Please see item 6, attachment 7)

The action paper asks that the DSM Steering Committee explore adding some mental health symptoms and codes, available to rest of medicine, to the next update of DSM-5.

Will the Joint Reference Committee refer the Assembly action paper NOVASM1412.N: *Exploration: Whether to Add Some Symptoms to the Next DSM* to the appropriate Component(s) for input or follow-up?

6.8 Neurodevelopmental [ASMNOV1412.P]
(Please see item 6, attachment 8)

The action paper asks that future printings of DSM use "Neurodevelopmental Disorder associated with Prenatal Alcohol Exposure" throughout DSM-5.

Will the Joint Reference Committee refer the Assembly action paper ASMNOV1412.P: *Neurodevelopmental* to the appropriate Component(s) for input or follow-up?

6.9 Position Statement: Active Treatment [JRCOCT148.G.14; ASMNOV144.B.14]
(Please see item 6, attachment 9)

The Assembly voted to retain the Position Statement: *Active Treatment* and refer it back to the Council on Healthcare Systems and Financing. The recommendation from the Joint Reference Committee was to retire the position statement however the Assembly felt a position statement on this topic was needed and did not want to retire it until a replacement has been drafted.

Will the Joint Reference Committee refer the Position Statement: *Active Treatment* to the appropriate Component(s) for input or follow-up?

Monday, January 26th, 2015
Location: Wyndham Grand Orlando Resort Bonnet Creek
Explorer Room, Ground Level
Breakfast: 8:00 am
Meeting: 9:00 am – 12:00 noon

8 Reports from Councils

9:00 am – 9:15 am
Louis Kraus, MD – via speakerphone

8.C **Council on Children, Adolescents and Their Families**
Please see item 8.C for the Council's report, a summary of current activities, and information items.

8.C.1 Revision to Position Statement: Psychiatric Hospitalization of Children and Adolescents (2008)

Will the Joint Reference Committee recommend that the Assembly approve the revision to the 2008 Position Statement on Psychiatric Hospitalization of Children and Adolescents and if approved, forward it to the Board of Trustees for consideration?
(Please see item 8.C, attachment A)

Please note that if the revision to the Position Statement is approved, the 2008 version of the statement will automatically be retired.

Rationale: The Council noted that the Position Statements were revised because they were antiquated.

8.C.2 Revision to Position Statement: Reactive Attachment Disorder (2008)

Will the Joint Reference Committee recommend that the Assembly approve the revision to the 2008 Position Statement on Reactive Attachment Disorder and if approved, forward it to the Board of Trustees for consideration?
(Please see item 8.C, attachment B)

Please note that if the revision to the Position Statement is approved, the 2008 version of the statement will automatically be retired.

Rationale: The Council noted that the Position Statements were revised because they were antiquated.

Referral Updates – no action required

8.C.3
Referral Update JRCOCT148.C.1 – Position Statement on Child Abuse and Neglect
Rather than rewrite the Position Statement on Child Abuse and Neglect by Adults per JRC's request, the Council has opted to create an entirely new and more germane position statement on the issue, that of reporting of suspected child abuse. A first draft of this document has been completed and will be passed on to the Council on Psychiatry and Law for comment, then on to JRC in June. A recommendation will be made to retire the existing policy document on Child Abuse and Neglect by Adults at that time.

8.C.4
Referral Update JRCOCT148.C.2 – Position Statement on College Mental Health
The Council has drafted an improved version of the Position Statement on College Mental Health per JRC's directive to thoroughly edit it and add information about FERPA. The draft was sent to the College Mental Health Caucus for comment. Feedback from the Council on Psychiatry and Law will be sought as well, before submitting the final draft to JRC in June.

8.C.5
Referral Update JRCOCT148.C.3 – Funding for the APA Child and Adolescent Psychiatry Fellowship
The Council's withdraws its request for APA funding for the APA Child and Adolescent Psychiatry Fellowship. The program has been subsequently approved for APF funding.

9:20 am – 9:35 am
Barry Perlman, MD – via speakerphone

8.B Council on Advocacy and Government Relations

Please see item 8.B for the Council's report, a summary of current activities and informational items.

The Council does not have action items.

9:40 am – 9:55 am
Robert Roca, MD – via speakerphone

8.E Council on Geriatric Psychiatry

Please see item 8.E for the Council's report, summary of current activities and information items.

8.E.1 Revision of Position Statement: Principles of End-of-Life Care for Psychiatry (2001)

Will the Joint Reference Committee recommend that the Assembly approve the revised 2001 Position Statement Principles of End-of-Life Care for Psychiatry and if approved, forward it to the Board of Trustees for consideration?
(Please see item 8.E, attachment #1)

Please note that if the revision to the Position Statement is approved, the 2001 version of the statement will automatically be retired.

Rationale: The Council revised the current position statement because it was out of date.

8.E.2 Revision of Position Statement: Role of Psychiatrists in Assessing Driving Ability (2007)

Will the Joint Reference Committee recommend that the Assembly approve the revised 2007 Position Statement on the Role of Psychiatrists in Assessing Driving Ability and if approved, forward it to the Board of Trustees for consideration?
(Please see item 8.E, attachment #2)

Please note that if the revision to the Position Statement is approved, the 2007 version of the statement will automatically be retired.

Rationale: The Council revised the current position statement because it was out of date.

8.E.3 Resource Document: Establishing Guidelines for Interacting with Caregivers

Will the Joint Reference Committee approve the resource document *Establishing Guidelines for Interacting with Caregivers?*
(Please see item 8.E, attachment #3)

7.B Assessment of the Council
Please see two attachments
7.B – Geriatric Psychiatry Work Plan Jan 2015
7.B – Geriatric Psychiatry Criteria for Evaluation Jan 2015

10:00 am – 10:15 am
Harsh Trivedi, MD – via speakerphone

8.G **Council on Healthcare Systems and Financing**
Please see item 8.G for the Council's report, summary of current activities and information items.

cc 8.G.1 Retire Position Statement: Psychiatric Disability Evaluation by Psychiatrists (2007)

Will the Joint Reference Committee recommend that the Assembly retire the 2007 Position Statement Psychiatric Disability Evaluation by Psychiatrists and if retired, forward it to the Board of Trustees for consideration?
(Please see item 8.G, attachment 1)

Rationale: Members of the CHSF had reviewed and recommended retaining the 2007 position statement "Psychiatric Disability Evaluation by Psychiatrists". The JRC discussed this recommendation at their October meeting and decided to refer the position statement back to the Council on Healthcare Systems and Financing for further review and possible revision. "The JRC questioned whether there was additional information or background that would support retaining the position statement, especially the part about disability evaluations being done "most effectively and efficiently by psychiatric physicians". In the JRC's view, the information regarding reimbursement was the most relevant portion of the statement, but it is unclear whether this continues to be an issue for our field. It was suggested that input be sought from those with expertise in disability evaluation." The Council sent the position statement as currently written to Andrea Stolar, MD, past-chair of the former Corresponding Committee on Psychiatry and the Workplace for review and comment. Dr. Stolar recommended retiring the

position statement, noting that the issues it was written to address have been resolved. The CHSF therefore recommends that the JRC retire the position statement "Psychiatric Disability Evaluation by Psychiatrists."

8.G.2 Identification of APA Entity to Review/Develop Medical Necessity or Level of Care Criteria [ASMMAY1412.F; JRCMAY146.6; JRCOCT148.G.19]

Will the Joint Reference Committee identify the appropriate APA entity to review and or develop medical necessity or level of care criteria?

Background: The Joint Reference Committee referred the action paper "Psychiatrists Patient Relationship and Adverse External Influences in Resolving Danger" (Attachment 2) to the CHSF to review and provide feedback. The CHSF discussed the item at their September meeting and again on a recent conference call. Members of the Council agreed that dangerousness cannot be predicted; that dangerousness is just one component/factor in assessing a patient's status. The CHSF believes the appropriate next step is a review of and/or development of medical necessity/clinical acuity levels of care. It was agreed that OHSF would survey a sample of major payers to inquire as to what their policies are in this regard. However, members of the CHSF do not believe they have expertise in this area (clinical best practices) and recommend that the JRC identify the appropriate APA body that has the expertise to weigh in on this process in a more formalized way, similar to that of the APA's Practice Guidelines.

10:20 am – 10:35 am
Dwight Evans, MD – via speakerphone

8.M **Council on Research**
Please see item 8.M for the Council's report, summary of current activities and information items.

8.M.1 Revised Position Statement: College and University Mental Health (2005)

Will the Joint Reference Committee recommend that the Assembly approve the revised 2005 Position Statement on *College and University Mental Health* and if approved, forward it to the Board of Trustees for consideration?
(Please see item 8.M, attachment #1)

Please note that if the revision to the Position Statement is approved, the 2005 version of the statement will automatically be retired.

Rationale: The Council states that the statement is still relevant, but the Council is recommending that this statement be revised for language and clarity.

8.M.2 Revised Position Statement: Publication of Clinical Trial Findings (2005)

Will the Joint Reference Committee recommend that the Assembly approve the revised 2005 Position Statement on the Publication of Clinical Trial Findings and if approved, forward it to the Board of Trustees for consideration?
(Please see item 8.M, attachment #2)

Please note that if the revision to the Position Statement is approved, the 2005 version of the statement will automatically be retired.

Rationale: The Council states that the statement is still relevant, but the Council is recommending that this statement be revised for language and clarity.

8.M.3 Revised Position Statement: Hypnosis (2009)

Will the Joint Reference Committee recommend that the Assembly approve the revised 2009 Position Statement on Hypnosis, and if approved, forward it to the Board of Trustees for consideration?
(Please see item 8.M, attachment #3)

Please note that if the revision to the Position Statement is approved, the 2009 version of the statement will automatically be retired.

Rationale: The Council notes that the statement is still relevant, but the Council is recommending that this statement be revised for language and clarity. Revisions also were made to reflect advances in clinical research on hypnosis.

cc 8.M.4 Retain Position Statement: Use of the Concept of Recovery (2005)

Will the Joint Reference Committee recommend that the Board of Trustees retain the 2005 Position Statement on Use of the Concept of Recovery?
(Please see item 8.M, attachment #4)

Rationale: The Council is recommending that this statement be retained as-is because it is still relevant and worded appropriately.

8.M.5 Revised Position Statement: Use of Animals in Research (2009)

Will the Joint Reference Committee recommend that the Assembly approve the revised 2009 Position Statement on the Use of Animals in Research and if approved, forward it to the Board of Trustees for consideration?
(Please see item 8.M, attachment #5)

Please note that if the revision to the Position Statement is approved, the 2009 version of the statement will automatically be retired.

Rationale: The Council notes that the statement is still relevant, but the Council is recommending that this statement be revised for language and clarity.

8.M.6 Retain Position Statement: Interference with Scientific Research and Medical Care (2009)

Will the Joint Reference Committee recommend that the Board of Trustees retain the 2009 Position Statement on Interference with Scientific Research and Medical Care?
(Please see item 8.M, attachment #6)

Rationale: The Council is recommending that this statement be retained as-is because it is still relevant and worded appropriately.

8.M.7 Retain Position Statement: Medication Substitutions (2009)

Will the Joint Reference Committee recommend that the Board of Trustees retain the 2009 Position Statement on Medication Substitutions?
(Please see item 8.M, attachment #7)

Rationale: The Council is recommending that this statement be retained as-is because it is still relevant and worded appropriately.

cc 8.M.8 Retain Position Statement: Electroconvulsive Therapy (ECT) (2007)

Will the Joint Reference Committee recommend that the Board of Trustees retain the 2007 Position Statement on Electroconvulsive Therapy (ECT)?
(Please see item 8.M, attachment #8)

Rationale: The Council is recommending that this statement be retained as-is because it is still relevant and worded appropriately.

8.M.9 Referral of Position Statement: Death Sentences for Persons with Dementia or Traumatic Brain Injury (2014)

Will the Joint Reference Committee refer the 2014 Position Statement on Death Sentences for Persons with Dementia or Traumatic Brain Injury to the Council on Psychiatry and the Law?

Rationale: The Council on Research feels this statement more appropriately falls under the purview of the Council on Psychiatry and the Law. The Council on Research is happy to review any of their suggested revisions but believes that the Council on Psychiatry and the Law should take primary ownership of this position statement.

Referral Updates – no action required

8.M.10
Referral Update ASMMAY1412.K – Remove Black Box Warning from Antidepressants
The Council was asked by the Joint Reference Committee to provide a list of pros and cons to removing the FDA black box warning from antidepressants. Their findings are summarized in a brief report located in attachment #10.

8.M.11
Referral Update JRCOCT148.L.4 – Referral of Position Statements to the Council on Research
The Joint Reference Committee referred the following position statements to the Council on Research for evaluation and encouraged them to consolidate into a single statement:

- 2009 Position Statement on HIV and Adolescents;
- 2009 Position Statement on HIV Antibody Testing;
- 2009 Position Statement on HIV and Inpatient Psychiatric Services;
- 2009 Position Statement on HIV and Outpatient Psychiatric Services; and
- Position Statement on Recognition and Management of HIV-Related Neuropsychiatric Findings and Associated Impairments.

The Council on Research made some minor revisions to these statements and forwarded them to the Steering Committee on HIV Psychiatry for their review. The Committee is still reviewing the statements.

8.M.12
Referral Update JRCOCT148.A.2 – Position Statement on Recognition and Management of Substance Use Disorders Comorbid with HIV
The Joint Reference Committee referred the position statement back to the Council on Addiction Psychiatry and the Council on Research to determine which version of the position statement, the 2014 or the 2012, is the most current and should be retained. The Council on Addiction Psychiatry confirmed that the statement from 2012, currently on the APA website, is the one that should be retained.

10:40 am – 10:55 am
Joel Yager, MD – via speakerphone

8.L Council on Quality Care

Please see item 8.L for the Council's report, summary of current activities and information items.

8.L.1 Updates to the Choosing Wisely List: Care of Patients with Dementia

Will the Joint Reference Committee recommend that the Council on Geriatric Psychiatry and the Council on Quality Care update the Choosing Wisely List item number three on the care of patients with dementia?
(Please see item 8.L, #1 and #2)

8.L.2 Position Statement Title Revision – Ethical Use of Telemedicine (1995)

Will the Joint Reference Committee recommend updating the title of the 1995 Position Statement originally entitled "Position Statement on the Ethical Use of Telemedicine?"
(Please see item 8.L, attachment #3)

Rationale: The Committee on Mental Health Information Technology reviewed this statement during their November 12, 2014 and December 10, 2014 monthly teleconferences. The Committee requests that the word "Ethical" be deleted from this statement title. The rest of the statement is requested to remain the same.

cc 8.L.3 Revision of Charge to Council on Quality Care

Will the Joint Reference Committee recommend that the Board of Trustees approve the revised charge to the Council on Quality Care which omits HIV psychiatry?
(Please see item 8.L, attachment #4)

Referral Updates – no action required

8.M.10
Referral Update JRCOCT148.G.21 – Performance Measures on Integrated Care

An integrated care measure environmental scan was completed and put into an Excel spreadsheet for the Report to BOT AHWG on Healthcare Reform.

11:00 am – 11:15 am
Richard Summers, MD – via speakerphone

8.H **Council on Medical Education and Lifelong Learning**
Please see item 8.H for the Council's report, summary of current activities and information items.

cc 8.H.1 Retain Position Statement: Consistent Treatment of all Applicants for State Medical Licensure (2008)

Will the Joint Reference Committee recommend that the Board of Trustees retain the 2008 Position Statement Consistent Treatment of all Applicants for State Medical Licensure?

Rationale: The Council on Medical Education believes that this position statement is still relevant because disparity in licensing requirements still exist. Examples of disparities may be found in the Council's report.

NEXT JOINT REFERENCE COMMITTEE MEETING
JUNE 11, 2015
Sausalito, CA

Joint Reference Committee
October 11, 2014
DRAFT SUMMARY OF ACTIONS

As of October 28, 2014

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

JRC Members Present:

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

Daniel Anzia, MD: 100% employed at Advocate Health and Hospitals/Advocate Lutheran Hospitals; Spouse and father of Advanced Practice Nurses.

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

Saul Levin, MD, MPA: CEO/Medical Director; receives income from the APA [*via Conference Call*]

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

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

Jeffrey A Lieberman, MD: Excused

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

APA Administration:
Annelle Primm, MD, MPH – Deputy Medical Director
Rodger Currie, Esq. – Chief of Government Affairs
Yoshie Davison, MSW – Chief of Staff
Jon Fanning – Chief RFM and ECP Officer
Kristin Kroeger – Chief, Allied and External Partnerships
Shaun Snyder, Esq. – Chief Operating Officer
Jason Young – Chief of Communications

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
2.A	Review and Approval of the Summary of Actions from the May 2014 Joint Reference Committee Meeting **Will the Joint Reference Committee approve the draft summary of actions from the May 2014 meeting?**	The Joint Reference Committee approved the draft summary of actions from the May 2014 meeting.	Shaun Snyder, Esq. Margaret Dewar Laurie McQueen, MSSW	Association Governance
2.B	Approval of the Consent Calendar **Will the Joint Reference Committee approve the Consent Calendar?**	The Joint Reference Committee approved the consent calendar with the following items removed: 8.A.2; 8.E.1; 8.E.3; 8.G.3; 8.I.3; 8.I.4; 8.J.15; 8.L.4	Shaun Snyder, Esq. Margaret Dewar Laurie McQueen, MSSW	Association Governance

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
3.1	<u>Subspecialty Ex-officio Member of the Councils</u> **Will the Joint Reference Committee recommend that the Board of Trustees approve the creation of an ex-officio, non-voting position on each council for a subspecialty representative on the appropriate related organization [The 5 ABPN defined subspecialties]**? Council on Geriatric Psychiatry (AAGP) Council on Children, Adolescents & Their Families (AACAP) Council on Psychiatry and Law (AAPL) Council on Psychosomatic Medicine (APM) Council on Addiction Psychiatry (AAAP) The JRC recommends that this be done on a pilot basis for the ABPN approved subspecialties with subspecialty organizations that have a medical director or equivalent position. [Some of the subspecialty groups do not have medical directors or equivalent positions and they won't need to participate if not appropriate.] The cost of a representative [travel to the September Components Meetings and conference calls] would be shared between the APA and the subspecialty. The estimated total cost per person per year is $1,043 (2014 dollars) per Council. The APA total = $2,607.50 [5 subspecialty reps/2]	The Joint Reference Committee recommended that the Board of Trustees approve, as a pilot program, that each ABPN subspecialty identify one individual to hold an ex-officio, non-voting position on its corresponding APA council. The cost of this position will be shared between the APA and the subspecialty. The individual chosen must be an APA member. There is no requirement that the council have such a position filled each year. Council on Geriatric Psychiatry (AAGP) Council on Children, Adolescents & Their Families (AACAP) Council on Psychiatry and Law (AAPL) Council on Psychosomatic Medicine (APM) Council on Addiction Psychiatry (AAAP)	Shaun Snyder, Esq. Margaret Dewar Ardell Lockerman	Board of Trustees December 2014 [BOT Deadline 11/19/2014]

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
3.2	Task Force Report – Ethics Annotations **Will the Joint Reference Committee vote to recommend that the Board of Trustees form a work group to revise and update the 2008 Task Force Report to Update the Ethics Annotations**? The work group will also recommend to the BOT whether the report should replace the current ethics annotations or be published as a separate resource document.	The Joint Reference Committee recommended the Board of Trustees form a work group to review and revise the 2008 Task Force Report to Update the Ethics Annotations. The work group would bring recommendations to the Board of Trustees with regard to whether a revised document might replace the current ethics annotations or be approved as a separate resource document of the APA. The JRC recommended that the work group have representatives from the BOT, Assembly, Ethics Committee, Council on Psychiatry and Law, and also include the APA General Counsel. In addition, the JRC recommended that Drs. Paul Appelbaum and Laura Roberts be appointed as consultants. Names of members recommended by the JRC can be given to Dr. Summergrad who will appoint the workgroup.	Shaun Snyder, Esq. Margaret Dewar Ardell Lockerman Ethics Committee (for information) Colleen Coyle, JD Jon Fanning Mia Smith	Board of Trustees December 2014 [BOT Deadline 11/19/2014]
4	CEO/Medical Director's Office Report **Updates on Referrals & Other Information**	Dr. Levin updated the JRC on the hiring of a DHHE Director. After interviewing rank order candidates, discussions are underway with a potential new director. It is hoped that the new director will have a December 2014 start date. A second round of interviews will commence for the Director of Education. There have been no final decisions regarding the final candidates. Meetings regarding the use of the DSM copyright occurred between ADMSEP and the APA. ADMSEP had access to the DSM via their library accounts. An agreement has been made with regard to the use of the DSM for ADMSEP's on-line Clinical Simulation Educational Modules for teaching medical students using DSM 5.		

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
4.A	Referral Update on the Recommendations of the BOT Ad Hoc Work Group on the Role of Psychiatry in Healthcare Reform [JRCMAY148.G.1] The CEO and Medical Director's Office asked staff liaisons, Councils, and the Administration to review the recommendations of the Ad Hoc Work Group on the Role of Psychiatry in Health Reform per the JRC's May request (item 8.G.1). A working document was created in an effort to collect an inventory of the work already underway at the APA.	The Joint Reference Committee thanked the CEO's office for the update and referred this information to the BOT AHWG on Healthcare Reform. It is anticipated that the AHWG will develop recommendations for the Board of Trustees' consideration.	Sam Muszynski, Esq. Becky Yowell	BOT AHWG on Healthcare Reform
4.B	Referral Update: Resident Fellow Position on Council [JRCMAY148.E.1] The JRC was asked to recommend that one member position on a council be designated for a Resident Fellow. The action was referred to the Office of the Chief Executive Officer and Medical Director and a report on the financial implications of this action, were it to be implemented across all the Councils was requested. Please see attachment #4 for financial information related to this request.	The Joint Reference Committee thanked the CEO's office for the detailed information regarding the options for an RFM position on APA Councils. The Joint Reference Committee considered the options and the current assignments of RFM's to the Council's via the fellowship programs. The JRC did not feel that additional RFM positions needed to be created at the present time. Council chairpersons and staff liaisons will be reminded of the existing procedures regarding the participation of RFMs on councils as per the Operations Manual. The Operations Manual state that ***Fellowship Program Participants on Councils:*** *(1) One Fellow assigned to the Council will have voting privileges on the Council for the tenure of his/her assignment as a Fellow to the Council; (2) This individual will be chosen from amongst those fellows assigned to the council, by the fellows themselves.*	Shaun Snyder, Esq. Margaret Dewar Laurie McQueen, MSSW	Council Chairperson and Staff Liaisons Information transmitted not later than 10/31/2014

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
5	<u>Issues for Joint Reference Committee Discussion</u> • Mechanisms to Improve Communication between Assembly and Council Chairperson o Council chairpersons make themselves available for phone calls from Reference Committee chairpersons during the Assembly meetings o Action paper authors confer with APA Staff and Council chairpersons regarding their potential action papers and incorporate their suggestions prior to submitting their action papers. o The Joint Reference Committee reviews action papers and sends them to Councils with recommendations for prioritization (i.e. how important is the issue) o Council Chairs are responsible for prioritizing action papers based on the work that they are currently doing and the subject matter and APA priorities/strategic goals. They should include these comments with their feedback to the JRC and possibly to the authors of the action papers. • JRC Liaisons (JRC Members) to Councils to Attend September Components Meetings (Budget request)	The JRC discussed methods to improve the efficiency and efficacy of the action paper process, most especially from the component aspect. The sharing of information between the action paper authors and the councils needs to bi-directional. Often action paper authors draft their papers without full knowledge of the ongoing work of the components and where their idea would fit into that work and the priorities for the APA and the component. For November, the Assembly is considering having the Chairpersons from the Council on Healthcare Systems and Financing, Council on Advocacy and Government Relations and Council on Psychiatry and Law available to the Assembly's Reference Committee chairpersons should questions about the action papers arise. Other ideas were suggested such as adjusting the action paper deadline so keyed to the SCM; creating a Super Reference Committee that all action papers go to for review and editing, communication with author and component prior to going to the Assembly; and creating a flowchart or template cover sheet for an action paper to be completed by the action paper author and submitted with the final action paper. **Action Papers** 1) Goes to ASM leadership 2) ASM Leadership has 3 week process a. Refer to staff – Questions to be answered i. Is APA already doing X? ii. Is there a policy? 1. Yes – is the action paper consistent with policy or inconsistent with policy? a. If wanting to change issue/policy need rationale for change 2. No - iii. Discuss with council chairperson 1. Does the Council support? why? 2. Does the Council not support? why? *Cont'd next column*	JRC asks that the AEC to consider a process to ensure that all action papers have information about whether 1) the APA is currently doing what the action paper asks of APA; and 2) confirmation that the issue/idea has been discussed with the relevant council (chairperson/staff liaison) and feedback has been provided. The JRC will work to prioritize the action papers that come from the Assembly within the workload of the Councils and the APA. It was noted that the AEC had begun prioritizing approved action papers after the Assembly meeting, with the understanding that there was no wish to overload either council or administration resources.	

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
6	**Assembly Report**	The Assembly continues to improve communication between the action paper authors and the councils. The Assembly will be considering many of the position statements from the JRC on the consent calendar in November and will consider the revised statements in May 2015. At their meeting in November, the Assembly will also consider and work to approve the Practice Guidelines and the Position Statement on Firearms Access.		
7	Awards			
7.A	2015 Jacob Javits Award **Will the Joint Reference Committee recommend that the Board of Trustees approve the 2015 nominee for the Jacob Javits Award, Dave Jones (California State Insurance Commissioner)**?	The Joint Reference Committee recommended that the Board of Trustees approve the 2015 nominee for the Jacob Javits Award (Dave Jones, California State Insurance Commissioner).	Shaun Snyder, Esq. Margaret Dewar Ardell Lockerman	Board of Trustees December 2014 [BOT Deadline 11/19/2014]
7.B	2015 Human Rights Award **Will the Joint Reference Committee recommend that the Board of Trustees approve the 2015 nominee for the Human Rights Award, Chester Pierce, MD?**	The Joint Reference Committee recommended that the Board of Trustees approve the 2015 nominee for the Human Rights Award (Chester Pierce, MD).	Shaun Snyder, Esq. Margaret Dewar Ardell Lockerman	Board of Trustees December 2014 [BOT Deadline 11/19/2014]
7.C	2014 Jack Weinberg Memorial Award in Geriatric Psychiatry **Will the Joint Reference Committee recommend that the Board of Trustees approve the 2014 nominee for the Jack Weinberg Memorial Award in Geriatric Psychiatry, Robert G. Robinson, MD**?	The Joint Reference Committee recommended that the Board of Trustees approve the 2014 nominee for the Jack Weinberg Memorial Award in Geriatric Psychiatry (Robert G. Robinson, MD).	Shaun Snyder, Esq. Margaret Dewar Ardell Lockerman	Board of Trustees December 2014 [BOT Deadline 11/19/2014]

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
7.D	2014 Member Communications Award **Will the Joint Reference Committee recommend that the Board of Trustees approve bestowing the 2014 Member Communications Award, "Certificate of Continued Excellence in Member Communication," to the Ohio Psychiatric Association, North Carolina Psychiatric Association and Pennsylvania Psychiatric Society**?	The Joint Reference Committee recommended that the Board of Trustees approve the 2014 nominees for the Member Communications Award, the "Certificate of Continued Excellence in Member Communication" for the following recipients, the Ohio Psychiatric Association, North Carolina Psychiatric Association and Pennsylvania Psychiatric Society.	Shaun Snyder, Esq. Margaret Dewar Ardell Lockerman	Board of Trustees December 2014 [BOT Deadline 11/19/2014]
7.E	2015 Adolf Meyer Award **Will the Joint Reference Committee recommend that the Board of Trustees approve the 2015 nominee for the Adolf Meyer Award, Dr. Karl Deisseroth**?	The Joint Reference Committee recommended that the Board of Trustees approve the 2015 nominee for the Adolf Meyer Award recipient, Dr. Karl Deisseroth.	Shaun Snyder, Esq. Margaret Dewar Ardell Lockerman	Board of Trustees December 2014 [BOT Deadline 11/19/2014]
7.F	2015 Patient Advocacy Award Lecture **Will the Joint Reference Committee recommend that the Board of Trustees approve the 2015 nominee for the Patient Advocacy Award, Patrick J. Kennedy**?	The Joint Reference Committee recommended that the Board of Trustees approve the 2015 nominee for the Patient Advocacy Award recipient, Patrick J. Kennedy.	Shaun Snyder, Esq. Margaret Dewar Ardell Lockerman	Board of Trustees December 2014 [BOT Deadline 11/19/2014]

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
7.G	<u>2014 Psychiatric Services Achievement Awards</u> **Will the Joint Reference Committee recommend that the Board of Trustees approve the 2014 nominees for the Psychiatric Services Achievement Awards?** **Gold Award for Academically or Institutional Sponsored Programs:** Alliance Health Project Department of Psychiatry, University of California, San Francisco, San Francisco, CA **Gold Award for Community-based Programs:** Bridge for Resilient Youth in Transition Program (BRYT), Brookline Community Mental Health Center, Brookline, MA **Silver:** Children's Community Pediatrics Behavioral Health Services in the Pediatric Medical Home (CCPBHS), Pittsburgh, PA **Bronze:** Shared Psychiatric Services, LifeWorks, Austin, TX **Certificate of Significant Achievement:** • The Mental Health Crisis Alliance, St. Paul MN • GATE-Utah (Giving Access to Everyone) Salt Lake City UT • Behavioral Health Integration Program, University of Washington, Seattle WA	The Joint Reference Committee recommended that the Board of Trustees approve the 2014 nominees for the Psychiatric Services Achievement Award recipients as presented.	Shaun Snyder, Esq. Margaret Dewar Ardell Lockerman	Board of Trustees December 2014 [BOT Deadline 11/19/2014]
7.H	<u>2015 John Fryer Award</u> **Will the Joint Reference Committee recommend that the Board of Trustees approve the 2015 John Fryer Award nominee, Laverne Cox**?	The Joint Reference Committee recommended that the Board of Trustees approve the 2015 John Fryer Award recipient, Laverne Cox.	Shaun Snyder, Esq. Margaret Dewar Ardell Lockerman	Board of Trustees December 2014 [BOT Deadline 11/19/2014]

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
7.I	2014 Bruno Lima Award **Will the Joint Reference Committee recommend that the Board of Trustees approve the 2014 Bruno Lima Award nominees, Charles P. Ciolino, MD and Jagannathan Srinivasaraghavan, MD**?	The Joint Reference Committee recommended that the Board of Trustees approve the 2014 Bruno Lima Award recipients, Charles P. Ciolino, MD and Jagannathan Srinivasaraghavan, MD.	Shaun Snyder, Esq. Margaret Dewar Ardell Lockerman	Board of Trustees December 2014 [BOT Deadline 11/19/2014]
8.A	**Council on Addiction Psychiatry**	The Joint Reference Committee thanked Dr. Levin and the Council for their report and updates.		
8.A.1 CC	Retain Position Statement: Relationship Between Treatment and Self-Help **Will the Joint Reference Committee recommend that the Assembly retain the Position Statement *Relationship between Treatment and Self Help* and if retained, forward it to the Board of Trustees for consideration**?	The Joint Reference Committee recommended that the Assembly retain the Position Statement *Relationship between Treatment and Self Help.* Rationale: The Council on Addiction Psychiatry states that the statement is current, relevant and should be retained.	Shaun Snyder, Esq. Margaret Dewar Allison Moraske	Assembly November 2014
8.A.2	Retain Position Statement: Recognition and Management of Substance Use Disorders Comorbid with HIV **Will the Joint Reference Committee recommend that the Assembly retain the Position Statement *Recognition and Management of Substance Use Disorders Comorbid with HIV* and if retained, forward it to the Board of Trustees for consideration**?	The Joint Reference Committee referred the position statement back to the Council on Addiction Psychiatry and the Council on Research to determine which version of the position statement, the 2014 or the 2012, is the most current and should be retained.	Bea Eld William Narrow, MD Emily Kuhl, PhD	Council on Addition Psychiatry (LEAD) Council on Research Report to JRC [JRC Deadline 1/9/2015]
8.A.3 CC	Retire Position Statement: Mental Health & Substance Abuse and Aging: Three Resolutions **Will the Joint Reference Committee recommend that the Assembly retire the Position Statement *Mental Health & Substance Abuse and Aging: Three Resolutions* and if retired, forward it to the Board of Trustees for consideration**?	The Joint Reference Committee recommended that the Assembly retire the Position Statement *Mental Health & Substance Abuse and Aging: Three Resolutions.* Rationale: The Council on Addiction Psychiatry states that the statement was not authored by the APA, and it is not known if updates to resolutions authored by another organization can be made.	Shaun Snyder, Esq. Margaret Dewar Allison Moraske	Assembly November 2014

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
8.A.4	Referral Update: Increasing Buprenorphine Prescribing Limits [ASMMAY1412.G] Representatives of the Council developed a series of recommendations to expand access to buprenorphine treatment, including increases in the patient limits reflected in the Drug Addiction Treatment Act of 2000. The recommendations were endorsed by the American Academy of Addiction Psychiatry and the American Osteopathic Academy of Addiction Medicine (Attachment #1). At the request of government officials, the joint recommendations were forwarded to ONDCP, SAMHSA, and NIDA to inform their current deliberations regarding the issues.	The Joint Reference Committee thanked the Council for the update.		n/a
8.A.5	Substance Abuse in the Elderly	The Joint Reference Committee requested that the Council on Addiction Psychiatry and the Council on Geriatric Psychiatry jointly develop a position statement on Substance Use and Abuse in the Elderly.	Kristin Kroeger Sejal Patel Kristin Kroeger Bea Eld	Council on Geriatric Psychiatry [LEAD] Council on Addiction Psychiatry Report to Joint Reference Committee – January [JRC Deadline 1/9/2015]
8.B	**Council on Advocacy and Government Relations**	The Joint Reference Committee thanked Dr. Bailey and the Council for their report and updates.		

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
8.B.1	Referral Update: Multiple Co-payments Charged for Single Prescriptions [ASMMAY1412.A; JRCMAY146.1] The Council on Advocacy and Government Relations discussed the JRC referral of the action paper, "Multiple Co-payments Charged for Single Prescription." The Council requires more data collection before drafting a comprehensive policy. To date, the Council has shared their recommendations to the Council on Healthcare Systems and Financing (LEAD). DGR staff will work with the Office of Health Care Systems and Financing to compile data to share with the Council.	The Joint Reference Committee thanked the Council for the update on this item. (Please also see 8.G.18)		n/a
8.B.2	Referral Update: Remove Black Box Warning from Antidepressants [ASMMAY1412.K; JRCMAY146.10] The Council on Advocacy and Government Relations discussed the JRC referral of the action paper, "Remove Black Box Warning from Antidepressants." As there is currently no mechanism, for patient or provider advocacy groups, to alter or remove black box warning, the Council suggests to advocate for revising the word content. In consideration of the political and legislative ramifications, the Council suggests bringing a resolution to the APA AMA Delegation, hopefully opening a dialogue with the FDA, AMA, APA, and other medical specialties to consider how to reform the black box warning. The Council has shared their recommendations to the Council on Research (LEAD) and will await feedback from further investigation by the Council.	The Joint Reference Committee thanked the Council for the update. It was noted that the Council on Research will provide a list of the pros and cons of the black box warnings to CAGR. (Please see also 8.M.4) Please note that the Council on Research is the LEAD component on this item.	William Narrow, MD Kristin Kroeger (for Information)	n/a

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
8.B.3	Referral Update: Patient Safety and Veterans Affairs Medical Center (VAMC) Participation in State Prescription Monitoring Programs (PMP) [[ASMMAY1412.X; JRCMAY146.18] The Council on Advocacy and Government Relations discussed the JRC referral of the action paper, "Patient Safety and Veterans Affair Medical Center (VAMC) Participation in State Prescription Monitoring Programs (PMP)." The Council is in support of the action paper's resolve to explore federal legislative and regulatory opportunities to advocate for the creation of a program to allow licensed prescribers universal access to state prescription monitoring programs. With current policy movement within the Veterans Health Administration, the Council agrees this is an ideal focus for advocacy efforts by APA.	The Joint Reference Committee thanked the Council for this update.		n/a
8.B.4	Referral Update: Maintaining Community Treatment Standards in Federal Correctional Facilities [ASMMAY1412.C; JRCMAY146.3] The Council on Advocacy and Government Relations discussed the JRC referral of the action paper, "Maintaining Community Treatment Standards in Federal Correctional Facilities." The Council has requested a four week time span to gather more information about the issue and regroup for a conference call to discuss further. APA staff will work Council members and the author of the action paper.	The Joint Reference Committee thanked the Council for this update and noted that the Task Force Report/Resource Document , "APA Guidelines on Psychiatric Services in Correctional Facilities, 3rd Edition," just approved by the JRC, includes information about Treatment Standards in Federal Correctional Facilities.		n/a

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
8.B.5	Referral Update: No Punishment for Choosing Not to Adopt Electronic Medical Records [ASMMAY1412.H; JRCMAY146.8] The Council on Advocacy and Government Relations discussed the JRC referral of the action paper, "No Punishment for Choosing Not to Adopt Electronic Medical Records." The Council favors a proposal for incentives; however, supports the recommendation for a "no penalty for non-adoption" position. APA should move forward advocating for an extension, a delay or the complete removal of penalties.	The Joint Reference Committee thanked the Council for this update.		
8.C	**Council on Children, Adolescents and Their Families**	The Joint Reference Committee thanked Dr. Kraus and the Council for their report and updates.		
8.C.1	Revision to Position Statement: Child Abuse and Neglect by Adults **Will the Joint Reference Committee recommend that the Assembly approve the revised Position Statement *Child Abuse and Neglect by Adults*, and if approved, forward it to the Board of Trustees for consideration?**	The Joint Reference Committee referred the position statement back to the Council on Children, Adolescents and Their Families requesting that the revision be rewritten. Specifically, the JRC requested the inclusion of more recent data to support the statement, clarity that there are mandatory child abuse reporting laws in all states, and information regarding to whom one should report suspicions. Additionally, the JRC requested that the Council on Psychiatry and Law review the rewritten position statement.	Kristin Kroeger Alison Bondurant Lori Klinedinst Whitaker	Council on Children, Adolescents and Their Families Report to Joint Reference Committee – January [JRC Deadline 1/9/2015]

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
8.C.2	Revision to Position Statement: College Mental Health **Will the Joint Reference Committee recommend that the Assembly approve the revised Position Statement *College Mental Health*, and if approved, forward it to the Board of Trustees for consideration**?	The Joint Reference Committee referred the position statement back to the Council on Children, Adolescents and Their Families requesting a rewrite of the revision. The statement needs a thorough editing for clarity and tightening of language. The addition of information about FERPA would be helpful. The 3rd bullet needs to be completed. Once the statement has been rewritten, the JRC requested that it be reviewed by the Council on Psychiatry and Law.	Kristin Kroeger Alison Bondurant	Council on Children, Adolescents and Their Families Report to Joint Reference Committee – January [JRC Deadline 1/9/2015]
8.C.3	Funding of the APA Child and Adolescent Psychiatry Fellowship **Will the Joint Reference Committee recommend to the Board of Trustee that APA Fund, on an ongoing basis, the APA Child and Adolescent Psychiatry Fellowship**?	The Joint Reference Committee did not recommend approval of this action item. Prior to making a recommendation, the JRC requested information regarding whether these fellows go into child psychiatry and how many remain APA members. Additionally, the JRC requested data on the number of child psychiatry residency training positions filled and whether they are filled during the match or after the match.	Kristen Kroeger Alison Bondurant	Report to Joint Reference Committee – January [JRC Deadline 1/9/2015]
8.D	**Council on Communications**	The Joint Reference Committee thanked Dr. Luo and the Council for their report and updates.		
8.D.1	Revision of Charge to the Council on Communications **Will the Joint Reference Committee recommend that the Board of Trustees approve amending the charge of the Council on Communications to include the entirety of the APA Communications Division (the Office of Corporate Communications & Public Affairs, the Office of Member Communication and the Office of Integrated Marketing), as well as internal and external communications strategies**?	The Joint Reference Committee recommended that the Board of Trustees approve the revised charge to the Council on Communications.	Shaun Snyder, Esq. Margaret Dewar Ardell Lockerman	Board of Trustees December 2014 [BOT Deadline 11/19/2014]

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
8.D.2	APA Branding Initiative **Will the Joint Reference Committee recommend that the Board of Trustees vote to approve the Council on Communications recommendation and support the APA's branding initiative to help brand the APA consistently and demonstrate its value**?	The Joint Reference Committee recommended that the Board of Trustees approve and support branding the APA consistently to demonstrate its value.	Shaun Snyder, Esq. Margaret Dewar Ardell Lockerman	Board of Trustees December 2014 [BOT Deadline 11/19/2014]
8.D.3	Referral Update: Council Communications to Members [JRCOCT138.F.1] The council discussed in great detail the JRCOCT 138.F.1 action titled: Council Communications to Members. The action recommends that APA councils provide a brief summary of useful information relevant to members that's published on a timely basis in appropriate venues. Policy positions instituted by councils are easily accessible but there are different ways to cluster council information. The council wanted to know if they're responsible for considering or identifying what activities of a particular council are good ideas. In response to the action the council offered the following suggestions; • Create a one page document to promote council's papers and projects; • Establish a bulletin board on APA's homepage providing access to an executive summary – recent work of each council (member only access); • The COC could offer advice to councils on the most efficient way to promote key issues; • Offer council chairs a venue or place to discuss their issues; and • APA should survey members to find out specifically what they want to know.	The Joint Reference Committee referred this update to the CEO's office and the Division of Communications to develop a list of tools and tips that councils can utilize when communicating both internally and externally. The JRC requested that this information be sent to the Assembly's Work Group on Communications.	Saul Levin, MD, MPA Jason Young Margaret Dewar Allison Moraske	Report to Joint Reference Committee – January [JRC Deadline 1/9/2015]

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
8.E	**Council on Geriatric Psychiatry**	The Joint Reference Committee thanked Dr. Roca and the Council for their report and updates.		
8.E.1	Retain Position Statement Precepts of Palliative Care ***Will the Joint Reference Committee recommend that the Assembly retain the Position Statement Precepts of Palliative Care and if retained, forward it to the Board of Trustees for consideration****?*	The Joint Reference Committee is considering this action item via email. Rationale: The Council on Geriatric Psychiatry states that this position statement is still relevant with current practice.		
8.E.2 CC	Retain Position Statement Elder Abuse, Neglect and Exploitation Will the Joint Reference Committee recommend that the Assembly retain the Position Statement *Elder Abuse, Neglect and Exploitation* and if retained, forward it to the Board of Trustees for consideration?	The Joint Reference Committee recommended that the Assembly retain the Position Statement *Elder Abuse, Neglect and Exploitation.* Rationale: The Council on Geriatric Psychiatry states that this position statement is still relevant with current practice.	Shaun Snyder, Esq. Margaret Dewar Allison Moraske	Assembly November 2014
8.E.3	Retain Position Statement Ensuring Access to Appropriate Utilization of Psychiatric Service of the Elderly Will the Joint Reference Committee recommend that the Assembly retire the Position Statement *Ensuring Access to Appropriate Utilization of Psychiatric Service of the Elderly* and if retired, forward it to the Board of Trustees for consideration?	The Joint Reference Committee is considering this action item via email. Rationale: The Council on Geriatric Psychiatry believes that this statement is still relevant with current practice..	Shaun Snyder, Esq. Margaret Dewar Laurie McQueen	

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
8.E.4	Referral Update: Establishing Guidelines for Interacting with Caregivers [ASMHNOV1312.C; JRCJAN146.1] The Joint Reference Committee referred the action paper *Establishing Guidelines for Interacting with Caregivers* to the Council on Geriatric Psychiatry, Council on Children, Adolescents and Their Families, and the Council on Psychiatry and Law. The Council on Geriatric Psychiatry was designated as the lead Council and has put a workgroup together comprising of members from all three councils. The Workgroup has created a draft document and circulated it to members of the Councils for feedback.	The Joint Reference Committee thanked the Council for the update and requested that the draft document be sent to the action paper author, Dr. Joshua Sonkiss for information.	Sejal Patel	Council on Geriatric Psychiatry
8.F	**Council on International Psychiatry**	The Joint Reference Committee thanked Dr. Jeste and the Council for their report and updates on progress to date. The JRC looks forward to receiving actionable items from the Council based on all their ideas and recommendations.		
8.G	**Council on Healthcare Systems and Financing**	The Joint Reference Committee thanked Dr. Trivedi and the Council for their report and updates.		
8.G.1	Proposed Joint Position Statement: Role of Psychiatrists in Reducing Physical Health Disparities in Patients with Mental Illness Will the Joint Reference Committee recommend that the Assembly approve (in an up or down vote) the Joint Position Statement *Role of Psychiatrists in Reducing Physical Health Disparities in Patients with Mental Illness* and if approved, forward it to the Board of Trustees for approval in an up or down vote?	The Joint Reference Committee recommended that that Assembly approve the Joint Position Statement *Role of Psychiatrists in Reducing Physical Health Disparities in Patients with Mental Illness.*	Shaun Snyder, Esq. Margaret Dewar Allison Moraske	Assembly May 2015

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
8.G.2 CC	Retain Position Statement: Discriminatory Disability Insurance Coverage Will the Joint Reference Committee recommend that the Assembly retain the Position Statement *Discriminatory Disability Insurance Coverage* and if retained, forward it to the Board of Trustees for consideration?	The Joint Reference Committee recommended that the Assembly retain the Position Statement *Discriminatory Disability Insurance Coverage.* [CC] Rationale: The Council on Healthcare Systems and Financing recommend retaining this position statement as it remains relevant for current practice.	Shaun Snyder, Esq. Margaret Dewar Allison Moraske	Assembly November 2014
8.G.3	Retain Position Statement: Psychiatric Disability Evaluation by Psychiatrists Will the Joint Reference Committee recommend that the Assembly retain the Position Statement *Psychiatric Disability Evaluation by Psychiatrists* and if retained, forward it to the Board of Trustees for consideration?	The Joint Reference Committee referred the position statement back to the Council on Healthcare Systems and Financing for another review and revision. The JRC questioned whether there was additional information or background that would support retaining the position statement, especially the part about disability evaluations being done "most effectively and efficiently by psychiatric physicians". In the JRC's view, the information regarding reimbursement was the most relevant portion of the statement, but it is unclear whether this continues to be an issue for our field. It was suggested that input be sought from those with expertise in disability evaluation.	Sam Muszynski, Esq. Becky Yowell	Council on Healthcare Systems and Financing Report to Joint Reference Committee – January [JRC Deadline 1/9/2015]
8.G.4 CC	Retain Position Statement: Psychiatrists Practicing in Managed Care: Rights and Regulations Will the Joint Reference Committee recommend that the Assembly retain the Position Statement *Psychiatrists Practicing in Managed Care: Rights and Regulations* and if retained, forward it to the Board of Trustees for consideration?	The Joint Reference Committee recommended that the Assembly retain the Position Statement *Psychiatrists Practicing in Managed Care: Rights and Regulations.* [CC] Rationale: The Council on Healthcare Systems and Financing recommend retaining this position statement as it remains relevant for current practice.	Shaun Snyder, Esq. Margaret Dewar Allison Moraske	Assembly November 2014

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
8.G.5 CC	Retain Position Statement: State Mental Health Services Will the Joint Reference Committee recommend that the Assembly retain the Position Statement *State Mental Health Services* and if retained, forward it to the Board of Trustees for consideration?	The Joint Reference Committee recommended that the Assembly retain the Position Statement *State Mental Health Services.* [CC] Rationale: The Council on Healthcare Systems and Financing recommend retaining this position statement as it remains relevant for current practice.	Shaun Snyder, Esq. Margaret Dewar Allison Moraske	Assembly November 2014
8.G.6 CC	Retain Position Statement: Universal Access Will the Joint Reference Committee recommend that the Assembly retain the Position Statement *Universal Access* and if retained, forward it to the Board of Trustees for consideration?	The Joint Reference Committee recommended that the Assembly retain the Position Statement *Universal Access.* [CC] Rationale: The Council on Healthcare Systems and Financing recommend retaining this position statement as it remains relevant for current practice.	Shaun Snyder, Esq. Margaret Dewar Allison Moraske	Assembly November 2014
8.G.7 CC	Retain Position Statement: Federal Exemption from the IMD Exclusion Will the Joint Reference Committee recommend that the Assembly retain the Position Statement *Federal Exemption from the Institution for Mental Disease (IMD) Exclusion* and if retained, forward it to the Board of Trustees for consideration?	The Joint Reference Committee recommended that the Assembly retain the Position Statement *Federal Exemption from the Institution for Mental Disease (IMD) Exclusion.* [CC] The JRC requested that the Council spell out all the acronyms within the Position Statement. Rationale: The Council on Healthcare Systems and Financing recommend retaining this position statement as it remains relevant for current practice.	Shaun Snyder, Esq. Margaret Dewar Allison Moraske	Assembly November 2014

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
8.G.8	Revise Position Statement: Employment Related Psychiatric Examinations Will the Joint Reference Committee recommend that the Assembly approve the revised Position Statement *Employment Related Psychiatric Examinations*, and if approved, forward it to the Board of Trustees for consideration?	The Joint Reference Committee referred the revised Position Statement *Employment Related Psychiatric Examinations* to the Council on Psychiatry and Law and requested their input, feedback and potential revisions for the January JRC meeting, including whether there is a current need for such a position statement **N.B.** If the revised position statement is approved, it will supersede and retire the 2009 version of the position statement.	Lori Klinedinst Whitaker	Council on Psychiatry and Law Report to Joint Reference Committee – January [JRC Deadline 1/9/2015]
8.G.9	Revise Position Statement: Patient Access to Treatments Prescribed by Their Physicians Will the Joint Reference Committee recommend that the Assembly approve the revised Position Statement *Patient Access to Treatments Prescribed by Their Physicians* and if approved, forward to the Board of Trustees for consideration?	The Joint Reference Committee referred the revised position statement back to the Council on Healthcare Systems and Financing for additional work. It was felt that the title of the position statement should reflect the key message and that the statement itself be succinct and on point.	Sam Muszynski, Esq. Becky Yowell	Council on Healthcare Systems and Financing Report to Joint Reference Committee – January [JRC Deadline 1/9/2015]
8.G.10	Revise Position Statement: Medical Necessity Definition (Endorsed AMA Policy) Will the Joint Reference Committee recommend that the Assembly approve the revised Position Statement *Medical Necessity Definition (Endorsed AMA Policy)* and if approved, forward it to the Board of Trustees for consideration	The Joint Reference Committee recommended that the Assembly approved the revised Position Statement *Medical Necessity Definition (Endorsed AMA Policy).* **N.B.** If the revised position statement is approved, it will supersede and retire the 2008 version of the position statement. Rationale: The Council on Healthcare Systems and Financing recommends revising this position statement to ensure that it is in line with current practice.	Shaun Snyder, Esq. Margaret Dewar Allison Moraske	Assembly May 2015

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
8.G.11 CC	Retire Position Statement: 2002 Access to Comprehensive Psychiatric Assessment and Integrated Treatment Will the Joint Reference Committee recommend that the Assembly retire the Position Statement 2002 *Access to Comprehensive Psychiatric Assessment and Integrated Treatment* and if retired, forward it to the Board of Trustees for consideration?	The Joint Reference Committee recommended that the Assembly retire the 2002 Position Statement *Access to Comprehensive Psychiatric Assessment and Integrated Treatment.* [CC] Rationale: The Council on Healthcare Systems and Financing recommends retiring this position statement as it is an earlier iteration of the 2009 position statement "Access to Comprehensive Psychiatric Assessment and Integrated Treatment."	Shaun Snyder, Esq. Margaret Dewar Allison Moraske	Assembly November 2014
8.G.12 CC	Retire Position Statement: Psychotherapy and Managed Care Will the Joint Reference Committee recommend that the Assembly retire the Position Statement *Psychotherapy and Managed Care* and if retired, forward to the Board of Trustees for consideration?	The Joint Reference Committee recommended that the Assembly retire the Position Statement *Psychotherapy and Managed Care.* [CC] Rationale: The Council on Healthcare Systems and Financing recommends retiring this position statement. The key elements of this statement are captured in the 2009 position statement "Access to Comprehensive Psychiatric Assessment and Integrated Treatment."	Shaun Snyder, Esq. Margaret Dewar Allison Moraske	Assembly November 2014
8.G.13 CC	Retire Position Statement: Guidelines for Handling the Transfer of Provider Networks Will the Joint Reference Committee recommend that the Assembly retire the Position Statement *Guidelines for Handling the Transfer of Provider Networks* and if retired, forward to the Board of Trustees for consideration?	The Joint Reference Committee recommended that the Assembly retire the Position Statement *Guidelines for Handling the Transfer of Provider Networks.* [CC] Rationale: The Council on Healthcare Systems and Financing recommends retiring this position statement. There have been changes in healthcare delivery methods or in the healthcare system which make the current position no longer relevant. Elements of this are covered in the 2009 position statement "Access to Comprehensive Psychiatric Assessment and Integrated Treatment."	Shaun Snyder, Esq. Margaret Dewar Allison Moraske	Assembly November 2014

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
8.G.14 CC	Retire Position Statement: Active Treatment Will the Joint Reference Committee recommend that the Assembly retire the Position Statement *Active Treatment* and if retired, forward it to the Board of Trustees for consideration?	The Joint Reference Committee recommended that the Assembly retire the Position Statement *Active Treatment.* [CC] Rationale: The Council on Healthcare Systems and Financing recommends retiring this position. The points made in this position statement are covered in other, more current, statements.	Shaun Snyder, Esq. Margaret Dewar Allison Moraske	Assembly November 2014
8.G.15 CC	Retire Position Statement: Endorsement of Medical Professionalism in the New Millennium: A Physician Charter Will the Joint Reference Committee recommend that the Assembly retire Position Statement *Endorsement of Medical Professionalism in the New Millennium: A Physician Charter* and if retired, forward it to the Board of Trustees for consideration?	The Joint Reference Committee recommended that the Assembly retire the Position Statement *Endorsement of Medical Professionalism in the New Millennium: A Physician Charter.* [CC] Rationale: The Council on Healthcare Systems and Financing recommends retiring this position statement. This charter was originally developed by leaders in the ABIM Foundation, ACP-ASIM Foundation and the European Federation of Internal Medicine. The key points made in this position statement are covered in other, more current, statements.	Shaun Snyder, Esq. Margaret Dewar Allison Moraske	Assembly November 2014
8.G.16 CC	Retire Position Statement: Desegregation of Hospitals for the Mentally Ill and Retarded Will the Joint Reference Committee recommend that the Assembly retire Position Statement *Desegregation of Hospitals for the Mentally Ill and Retarded* and if retired, forward it to the Board of Trustees for consideration?	The Joint Reference Committee recommended that the Assembly retire the Position Statement *Desegregation of Hospitals for the Mentally Ill and Retarded.* [CC] Rationale: The Council on Healthcare Systems and Financing recommends retiring this position. There have been changes in healthcare delivery methods or in the healthcare system which make the subject and current position no longer relevant.	Shaun Snyder, Esq. Margaret Dewar Allison Moraske	Assembly November 2014

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
8.G.17	Refer Position Statement: Bill of Rights: Principles for the Provision of Mental and Substance Abuse Treatment Services Will the Joint Reference Committee refer the Position Statement *Bill of Rights: Principles for the Provision of Mental and Substance Abuse Treatment Services* to the Council on Advocacy and Government Relations for review and to determine if a position on this issue is necessary? If a need to retain the position remains, the CHSF recommends CAGR revise the statement to ensure it is current; otherwise the position should be retired.	The Joint Reference Committee referred the action to the Office of the Chief Executive Officer and the Division of Government Affairs to determine if the APA still needs a position statement on this topic for APA advocacy reasons. If there is not a need, than the JRC would entertain an action to retire the position statement.	Saul Levin, MD, MPA Rodger Currie, Esq.	Report to Joint Reference Committee – January [JRC Deadline 1/9/2015]
8.G.18	Referral Update: Multiple Co-payments Charged for Single Prescriptions [ASMMAY1412.A; JRCMAY146.1] Action referred to APA's General Counsel to determine legality of the practice. It would be helpful to have specific examples as to where this is happening (geographic location and retail outlet). Need to develop a coherent way of handling the range of issues that relate to prescription copays. A suggestion was made to consider sending a letter to the Attorneys General to cease and desist. The Council on Healthcare Systems and Financing will gather additional details/specific examples while the legal issue is explored.	The Joint Reference Committee thanked the Council for the update. (Please also see item 8.B.1)		n/a

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
8.G.19	Referral Update: Psychiatrist Patient Relationship and Adverse External Influences in Resolving Danger [ASMMAY1412.F; JRCMAY146.6] The CHSF discussed a number of options including the development of standards of care, level of care criteria or a practice guideline for risk assessment. It was mentioned that APA has something assessing risk and perhaps a starting point would be to review that document (2011 Resource Document Psychiatric Violence Risk Assessment). The point was made that the standard of care should be followed whether or not the service is covered/paid for. There was discussion that perhaps a task force should be created to define criteria as to when continued care is required.	The Joint Reference Committee thanked the Council for the update		n/a
8.G.20	Referral Update: Ad Hoc Group to Assist with APA Response to the Excellence in Mental Health Act/Demonstration Project [JRCMAY148.G.3] A small workgroup was convened and developed a written response to concerns about the implementation of the Excellence in Mental Health Act. That group will continue to monitor the situation through the rule writing phase.	The Joint Reference Committee thanked the Council for the update.		n/a
8.G.21	Performance Measures on Integrated Care Will the Joint Reference Committee refer the request from the Council on Healthcare Systems and Financing to the Council on Quality Care to review the performance measures currently in place on integrated care to determine what measures are needed?	The Joint Reference Committee tasked the Council on Quality Care to review performance measures currently in place on integrated care to determine what measures are needed and report that information back to the BOT AHWG on Healthcare Reform	Samantha Shugarman, MS	Council on Quality Care Report to BOT AHWG on Healthcare Reform not later than December 15, 2014

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
8.G.22	Current Health Services Literature on Integrated Care Models Will the Joint Reference Committee refer the request from the Council on Healthcare Systems and Financing to the Council on Research to review the current health services literature on integrated care models, including physician-led and non-physician-led models, and summarize and organize this review in such a way that it can be used by APA administrative staff and members for integrated care education and advocacy?	The Joint Reference Committee referred the action to the CEO's Office for referral to the Office of Research for review as requested.	Saul Levin, MD, MPA William Narrow, MD	Office of Research Report to Joint Reference Committee – January [JRC Deadline 1/9/2015]
8.G.23	Identify the Roles and Responsibilities of Psychiatrists Will the Joint Reference Committee refer the request from the Council on Healthcare Systems and Financing to the Council on Psychosomatic Medicine to work together to identify the roles and responsibilities of psychiatrists across the spectrum of models and settings for medical care delivery?	The Joint Reference Committee referred the action to the Council on Psychosomatic Medicine.	William Narrow, MD Diane Pennessi	Council on Psychosomatic Medicine Report to Joint Reference Committee – January [JRC Deadline 1/9/2015]
8.H	**Council on Medical Education and Lifelong Learning**	The Joint Reference Committee thanked Dr. Summers and the Council for their report and updates.		

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
8.H.1	Referral Update: Psychiatric Education with Respect to Patients at Risk of Violent Behavior [ASMMAY1412.E] The Council discussed the issue of violent patients in 2011 in the context of resident safety. AADPRT has developed de-escalation guidelines along with training director and resident protocols to respond to a traumatic event in residency. An outline of a 10-hour course of essential components of violence management is available from the AADPRT website and is intended to be taught in the first year of residency training. The SPC added a topic "*Aggressive Behaviors: Etiology, Assessment & Treatment"* in the online abstract submissions system. The topic will be available to 2015 Annual Meeting abstract submitters. This action will allow interested parties to prepare submissions on the topic and permit attendees at the annual meeting to quickly locate sessions on that topic either in the *Program Guide* topic index or by using the Annual Meeting mobile/tablet app. In addition, the SPC will solicit a session from the practice guideline group working on the assessment of risk for aggressive behaviors for the 2015 meeting. At the 2014 Annual Meeting there were two Seminars and one Symposium directly related to this topic. Seminars are submitted using the same criteria required for a 4 hour course but do not require the attendee to pay an additional fee to attend them. Seminar packets are available online for anyone wishing to attend the session. The course committee chair has been made aware of the interest in providing this information for annual meeting attendees. The seminars presented last year were reviewed at the July repeat course/seminar meeting of the Course/Seminar subcommittee. The need has also been met by new educational resources in the field, including a curriculum written by Robert Feinstein entitled "Violence Prevention Education Program for Psychiatric Outpatient Departments" (Academic Psychiatry, July-August 2014).	The Joint Reference Committee thanked the Council for this update and noted that all of this information was a good response to the action paper. The JRC considered this action paper closed.		n/a

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
8.H.2	Referral Update: Addressing the Shortage of Psychiatrists with Sources of Funding [ASMMAY1412.M] Federally-funded programs already exist that address the AP author's request (psychiatry practice in an underserved area of a specific number of years.) • National Health Service Corps http://www.psychiatry.org/practice/professional-interests/underserved-communities/national-health-service-corps • NIH Loan Repayment Program for clinical research http://www.lrp.nih.gov/about_the_programs/intramural/Introduction.aspx • State loan repayment and/or forgiveness scholarship programs (maintained by the AAMC) https://services.aamc.org/fed_loan_pub/index.cfm?fuseaction=public.welcome&CFID=7563505	The Joint Reference Committee thanked the Council for the update noting that all of this information is available on the APA website. The JRC requested that this information be sent to the Assembly for their knowledge. The JRC considered this action paper closed.	Shaun Snyder, Esq. Margaret Dewar Allison Moraske	n/a
8.I	**Council on Minority Mental Health and Health Disparities**	The Joint Reference Committee thanked Dr. Walker and the Council for their report and updates.		
8.I.1 CC	Retain Position Statement: Abortion & Women's Reproductive Health Care Rights Will the Joint Reference Committee recommend that the Assembly retain the Position Statement *Abortion & Women's Reproductive Health Care Rights* and if retained, forward it to the Board of Trustees for consideration?	The Joint Reference Committee recommended that the Assembly retain the Position Statement *Abortion & Women's Reproductive Health Care Rights.* [CC] Rationale: The Council on Minority Mental Health and Health Disparities believed that the statement sufficiently made the point and given that the statement was fairly new, recommends that it be retained.	Shaun Snyder, Esq. Margaret Dewar Allison Moraske	Assembly November 2014

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
8.I.2 CC	Retain Position Statement: Xenophobia, Immigration and Mental Health Will the Joint Reference Committee recommend that the Assembly retain the Position Statement *Xenophobia, Immigration and Mental Health* and if retained, forward it to the Board of Trustees for consideration?	The Joint Reference Committee recommended that the Assembly retain the Position Statement *Xenophobia, Immigration and Mental Health.* [CC] Rationale: The Council on Minority Mental Health and Health Disparities believed that the statement sufficiently made the point and given that the statement was fairly new, recommends that it be retained.	Shaun Snyder, Esq. Margaret Dewar Allison Moraske	Assembly November 2014
8.I.3	Retain Position Statement: Sexual Harassment Will the Joint Reference Committee recommend that the Assembly retain the Position Statement *Sexual Harassment* and if retained, forward it to the Board of Trustees for consideration?	The Joint Reference Committee referred this position statement to the CEO's Office to determine if there is an advocacy/political need to have a position statement on the various types of harassment. The APA opposes all forms of harassment in the workplace. The JRC thought it best to revise the position statement to include all forms of harassment.	CEO and Medical Director Rodger Currie, Esq.	Report to Joint Reference Committee – January [JRC Deadline 1/9/2015]
8.I.4	Retain Position Statement: Right to Privacy Will the Joint Reference Committee recommend that the Assembly retain the Position Statement *Right to Privacy* and if retained, forward it to the Board of Trustees for consideration?	The Joint Reference Committee referred the position statement to the CEO's office and the Division of Government Affairs to determine if there is a need for such a position statement. If it is determined that the APA needs a position statement on such an issue, the Joint Reference Committee will assign the task to the appropriate council.	CEO and Medical Director Rodger Currie, Esq.	Report to Joint Reference Committee – January [JRC Deadline 1/9/2015]
8.J	**Council on Psychiatry and Law**	The Joint Reference Committee thanked Dr. Hoge and the Council for their report and updates.		

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
8.J.1	Proposed Position Statement: Inquiries about Diagnosis and Treatment of Mental Disorders in Connection with Professional Credentialing and Licensing Will the Joint Reference Committee recommend that the Assembly approve the proposed Position Statement *Inquiries about Diagnosis and Treatment of Mental Disorders in Connection with Professional Credentialing and Licensing* and if approved, forward it to the Board of Trustees for consideration?	The Joint Reference Committee recommended that the Assembly approve the proposed position statement *Inquiries about Diagnosis and Treatment of Mental Disorders in Connection with Professional Credentialing and Licensing.*	Shaun Snyder, Esq. Margaret Dewar Allison Moraske	Assembly May 2015
8.J.2	Proposed Position Statement: Patient Access to Electronic Mental Health Records Will the Joint Reference Committee recommend that the Assembly approve the proposed Position Statement *Patient Access to Electronic Mental Health Records* and if approved, forward it to the Board of Trustees for consideration?	The Joint Reference Committee recommended that the Assembly approve the proposed Position Statement *Patient Access to Electronic Mental Health Records*.	Shaun Snyder, Esq. Margaret Dewar Allison Moraske	Assembly May 2015
8.J.3	Proposed Position Statement: Segregation of Juveniles with Serious Mental Illness in Juvenile Detention and Rehabilitation Facilities Will the Joint Reference Committee recommend that the Assembly approve the proposed Position Statement *Segregation of Juveniles with Serious Mental Illness in Juvenile Detention and Rehabilitation Facilities* and if approved, forward it to the Board of Trustees for consideration?	The Joint Reference Committee recommended that the Assembly approve the proposed Position Statement *Segregation of Juveniles with Serious Mental Illness in Juvenile Detention and Rehabilitation Facilities.*	Shaun Snyder, Esq. Margaret Dewar Allison Moraske	Assembly May 2015
8.J.4	APA Guidelines on Psychiatric Services in Correctional Facilities, 3rd Edition Will the Joint Reference Committee approve as a resource document the *APA Guidelines on Psychiatric Services in Correctional Facilities, 3rd Edition*?	The Joint Reference Committee approved the document *APA Guidelines on Psychiatric Services in Correctional Facilities, 3rd Edition* as a resource document of the APA.	Shaun Snyder, Esq. Margaret Dewar Laurie McQueen	

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
8.J.5 CC	Retire Position Statement: Juvenile Death Sentences Will the Joint Reference Committee recommend that the Assembly retire the Position Statement on *Juvenile Death Sentences* and if retired, forward it to the Board of Trustees for consideration?	The Joint Reference Committee recommended that the Assembly retire the Position Statement *on Juvenile Death Sentences.* [CC] Rationale: The Council on Psychiatry and Law recommends that the position statement be retired as written as it is no longer relevant in light of recent case law.	Shaun Snyder, Esq. Margaret Dewar Allison Moraske	Assembly November 2014
8.J.6 CC	Retain Position Statement: Peer Review of Expert Testimony Will the Joint Reference Committee recommend that the Assembly retain the Position Statement *Peer Review of Expert Testimony* and if retained, forward it to the Board of Trustees for consideration?	The Joint Reference Committee recommended that the Assembly retain the Position Statement *Peer Review of Expert Testimony.* [CC] Rationale: The Council on Psychiatry and Law recommends that the position statement be retained as it is still relevant for current practice.	Shaun Snyder, Esq. Margaret Dewar Allison Moraske	Assembly November 2014
8.J.7 CC	Retain Position Statement: Joint Resolution Against Torture Will the Joint Reference Committee recommend that the Assembly retain the Position Statement *Joint Resolution Against Torture* and if retained, forward it to the Board of Trustees for consideration?	The Joint Reference Committee recommended that the Assembly retain the Position Statement *Joint Resolution Against Torture.* [CC] Rationale: The Council on Psychiatry and Law recommends that the position statement be retained as written as it is still relevant for current practice.	Shaun Snyder, Esq. Margaret Dewar Allison Moraske	Assembly November 2014
8.J.8 CC	Retain Position Statement: Moratorium on Capital Punishment in the United States Will the Joint Reference Committee recommend that the Assembly retain the Position Statement *Moratorium on Capital Punishment in the United States* and if retained, forward it to the Board of Trustees for consideration?	The Joint Reference Committee recommended that the Assembly retain the Position Statement *Moratorium on Capital Punishment in the United States.* [CC] Rationale: The Council on Psychiatry and Law recommends that the position statement be retained as written as it is still relevant for current practice.	Shaun Snyder, Esq. Margaret Dewar Allison Moraske	Assembly November 2014

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
8.J.9 CC	Retain Position Statement: Discrimination Against Persons with Previous Psychiatric Treatment Will the Joint Reference Committee recommend that the Assembly retain the Position Statement *Discrimination against Persons with Previous Psychiatry Treatment* and if retained, forward it to the Board of Trustees for consideration?	The Joint Reference Committee recommended that the Assembly retain the Position Statement *Discrimination against Persons with Previous Psychiatry Treatment.* [CC] Rationale: The Council on Psychiatry and Law recommends that the position statement be retained as written as it is still relevant for current practice	Shaun Snyder, Esq. Margaret Dewar Allison Moraske	Assembly November 2014
8.J.10 CC	Retain Position Statement: Insanity Defense Will the Joint Reference Committee recommend that the Assembly retain the Position Statement *Insanity Defense* and if retained, forward it to the Board of Trustees for consideration?	The Joint Reference Committee recommended that the Assembly retain the Position Statement *Insanity Defense.* [CC] Rationale: The Council on Psychiatry and Law recommends that the position statement be retained as written as it is still relevant for current practice.	Shaun Snyder, Esq. Margaret Dewar Allison Moraske	Assembly November 2014
8.J.11 CC	Retain Position Statement: Psychiatric Participation in Interrogation of Detainees Will the Joint Reference Committee recommend that the Assembly retain the Position Statement *Psychiatric Participation in Interrogation of Detainees* and if retained, forward it to the Board of Trustees for consideration?	The Joint Reference Committee recommended that the Assembly retain the Position Statement *Psychiatric Participation in Interrogation of Detainees.* [CC] Rationale: The Council on Psychiatry and Law recommends that the position statement be retained as written as it is still relevant for current practice.	Shaun Snyder, Esq. Margaret Dewar Allison Moraske	Assembly November 2014
8.J.12 CC	Retain Position Statement: Death Sentences for Persons with Dementia or Traumatic Brain Injury Will the Joint Reference Committee recommend that the Assembly retain the Position Statement *Death Sentences for Persons with Dementia or Traumatic Brain Injury* and if retained, forward it to the Board of Trustees for consideration?	The Joint Reference Committee recommended that the Assembly retain the Position Statement *Death Sentences for Persons with Dementia or Traumatic Brain Injury.* [CC] Rationale: The Council on Psychiatry and Law recommends that the position statement be retained as written as it is still relevant for current practice.	Shaun Snyder, Esq. Margaret Dewar Allison Moraske	Assembly November 2014

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
8.J.13 CC	Retain Position Statement: Mentally Ill Prisoners and Death Row Will the Joint Reference Committee recommend that the Assembly retain the Position Statement *Mentally Ill Prisoners and Death Row* and if retained, forward to it to the Board of Trustees for consideration?	The Joint Reference Committee recommended that the Assembly retain Position Statement *Mentally Ill Prisoners and Death Row.* [CC] Rationale: The Council on Psychiatry and Law recommends that the position statement be retained as written as it is still relevant for current practice.	Shaun Snyder, Esq. Margaret Dewar Allison Moraske	Assembly November 2014
8.J.14 CC	Retain Position Statement: Diminished Responsibility in Capital Sentencing Will the Joint Reference Committee recommend that the Assembly retain the Position Statement *Diminished Responsibility in Capital Sentencing*?	The Joint Reference Committee recommended that the Assembly retain Position Statement *Diminished Responsibility in Capital Sentencing*. [CC] Rationale: The Council on Psychiatry and Law recommends that the position statement be retained as written as it is still relevant for current practice.	Shaun Snyder, Esq. Margaret Dewar Allison Moraske	Assembly November 2014
8.J.15	Retain Position Statement: Ethical Use of Telemedicine Will the Joint Reference Committee recommend that the Assembly retain the Position Statement *Ethical Use of Telemedicine* and if retained, forward it to the Board of Trustees for consideration?	The Joint Reference Committee referred the Position Statement to the Committee on Mental Health Information Technology for their review and feedback and for the Committee to consider development of a resource document. Rationale: The Council on Psychiatry and Law recommends that the position statement be retained. It is suggested that the statement be referred to the appropriate component on technology to consider development of a resource document to accompany it given new technology and use of telemedicine.	William Narrow, MD Lisa Greiner, MSSA	Committee on Mental Health Information Technology Report to Joint Reference Committee – January [JRC Deadline – 1/9/2015]
8.J.16	Human Rights /Isaac Ray Award Committee The Joint Reference Committee discussed separating the Human Rights Award from the Isaac Ray Award Committee. The Council on International Psychiatry is directed to administer the Human Rights Award. If the Board of Trustees approves, the name of the Human Rights/Isaac Ray Award Committee will be revised to the Isaac Ray Award Committee.	The Joint Reference Committee recommended that the Board of Trustees transfer the administration of the Human Rights Award from the Council on Psychiatry and Law to the Council on International Psychiatry. If approved, the name of the Human Rights/Isaac Ray Award Committee will be revised to the Isaac Ray Award Committee.	Shaun Snyder, Esq. Margaret Dewar Ardell Lockerman	Board of Trustees December 2014 [BOT Deadline 11/19/2014]

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
8.K	**Council on Psychosomatic Medicine** (Consultation-Liaison Psychiatry)	The Joint Reference Committee thanked Dr. Gitlin and the Council for their report and updates.		
8.L	**Council on Quality Care**	The Joint Reference Committee thanked Dr. Dalack and the Council for their report and updates.		
8.L.1	Proposed Position Statement: Need to Train Psychiatrists in Provision of Care and Support to Individuals with Disorders of Sex Development and Their Families Will the Joint Reference Committee recommend that the Assembly approve the proposed Position Statement *Need to Train Psychiatrists in Provision of Care and Support to Individuals with Disorders of Sex Development and Their Families* and if approved, forward it to the Board of Trustees for consideration?	The Joint Reference Committee recommended that the Assembly approve the proposed Position Statement *Need to Train Psychiatrists in Provision of Care and Support to Individuals with Disorders of Sex Development and Their Families*. The JRC also referred the position statement to the Council on Medical Education and Lifelong Learning for their review and requested their recommendations for any changes be sent to the JRC for their meeting in January.	Kristin Kroeger Nancy Delanoche Shaun Snyder, Esq. Margaret Dewar Allison Moraske	Council on Medical Education and Lifelong Learning Report to Joint Reference Committee – January [Deadline 1/9/2015] Assembly May 2015
8.L.2	Proposed Position Statement on Management of Sensitive Health Information within Health Information Exchanges [ASMNOV1212.B] **Will the Joint Reference Committee recommend that the Assembly approve the proposed Position Statement *Management of Sensitive Health Information within Health Information Exchanges* and if approved, forward to the Board of Trustees for consideration?** Explanation for proposed position statement The Committee on Mental Health Information Technology (CMHIT) developed a Position Statement on the *Management of Sensitive Health Information within Health Information Exchanges*. This area has been evolving quickly over the past 18 months, so the committee waited for some new technical capabilities to be piloted and shown to be acceptable. CMHIT believes that now that this technology for improving the confidentiality of sensitive information has been proven, a useful Position Statement can be crafted.	The Joint Reference Committee recommended that the Assembly approved the proposed Position Statement *Management of Sensitive Health Information within Health Information Exchanges.*	Shaun Snyder, Esq. Margaret Dewar Allison Moraske	Assembly November 2014

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
8.L.3	Revised Position Statement: Confidentiality of Electronic Health Information **Will the Joint Reference Committee recommend that the Assembly approve the revised Position Statement on *Confidentiality of Electronic Health Information* and if approved, forward it to the Board of Trustees for consideration?** **N.B.** If the revised position statement is approved it will supersede and retire the former version of the position statement. **N.B.** This action is a referral update on ASMNOV1312.D Confidentiality of Electronic Health Information What has been done or not done on the referral? • Members of the CMHIT reviewed this statement and suggested minor changes in wording of the position statement would be appropriate in terms of the security of the record. Steve Daviss, M.D. (CMHIT Chair) prepared a revised Position Statement for review and comment by the Committee on Mental Health Information Technology (CMHIT), the Council on Healthcare Systems and Financing and the Council on Psychiatry and Law. The title of the Statement was revised (from *Confidentiality of Computerized Records* to *Confidentiality of Electronic Health Information)* to reflect current terminology. Members of the CMHIT and the two councils reviewed and discussed the revised Position Statement during a joint teleconference on July 22, 2014. The final Position Statement was reviewed and approved by the Committee on Mental Health Information Technology during their September 10, 2014 teleconference. The Council on Healthcare Systems and Financing approved the statement as written on September 17, 2014. • The Council on Psychiatry and Law discussed the proposed position paper and discussed data segmentation allowing a higher degree of protection for sensitive information and the technology surrounding the issue. It was suggested that the APA could have a statement to encourage development of programs and prototypes where this type of segmentation can occur.	The Joint Reference Committee recommended that the Assembly approve the revised Position Statement on *Confidentiality of Electronic Health Information.* **N.B.** If the revised position statement is approved, it will supersede and retire the 2010 version of the position statement.	Shaun Snyder, Esq. Margaret Dewar Allison Moraske	Assembly May 2015

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
8.L.4 CC	Referral of Position Statements to the Council on Research **Will the Joint Reference Committee refer the five year review of the following position statements to the Council on Research?** a) 2009 Position Statement on HIV and Adolescents b) 2009 Position Statement on HIV Antibody Testing c) 2009 Position Statement on HIV/AIDS and Confidentiality, Disclosure, and Protection of Others d) 2009 Position Statement on HIV and Inpatient Psychiatric Services e) 2009 Position Statement on HIV and Outpatient Psychiatric Services f) 2012 Position Statement on Recognition and Management of HIV-Related Neuropsychiatric Findings and Associated Impairments	The Joint Reference Committee referred the position statements to the Council on Research for evaluation. The JRC encouraged the Council to consolidate the HIV related position statements into a single statement. a) 2009 Position Statement on HIV and Adolescents b) 2009 Position Statement on HIV Antibody Testing d) 2009 Position Statement on HIV and Inpatient Psychiatric Services e) 2009 Position Statement on HIV and Outpatient Psychiatric Services f) 2012 Position Statement on Recognition and Management of HIV-Related Neuropsychiatric Findings and Associated Impairments The JRC referred the following position statement to the Council on Psychiatry and Law for review and update c) 2009 Position Statement on HIV/AIDS and Confidentiality, Disclosure, and Protection of Others	William Narrow, MD Emily Kuhl, PhD	Council on Research Report to Joint Reference Committee – January [Deadline 1/9/2015]
8.L.5 CC	Retain Position Statement: Endorsement of the Patient-Physician Covenant **Will the Joint Reference Committee recommend that the Assembly retain the 2007 Position Statement *Endorsement of the Patient-Physician Covenant* and if retained, forward it to the Board of Trustees for consideration?**	The Joint Reference Committee recommended that the Assembly retain the 2007 Position Statement *Endorsement of the Patient-Physician Covenant.* [CC] Rational: The Council on Quality Care agreed to retain the statement until a better one came along or until they choose to revise the statement.	Shaun Snyder, Esq. Margaret Dewar Allison Moraske	Assembly November 2014

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
8.L.6 CC	Retain Position Statement: Provision of Psychotherapy for Psychiatric Residents **Will the Joint Reference Committee recommend that the Assembly retain the 2009 Position Statement *Provision of Psychotherapy for Psychiatric Residents* and if retained, forward it to the Board of Trustees for consideration?**	The Joint Reference Committee recommended that the Assembly retain the 2009 Position Statement *Provision of Psychotherapy for Psychiatric Residents.* [CC] Rational: The Council on Quality Care agreed to retain the statement but thought that the statement should be broadened to all training programs, not just psychiatry.	Shaun Snyder, Esq. Margaret Dewar Allison Moraske	Assembly November 2014
8.M	**Council on Research**	The Joint Reference Committee thanked Dr. Evans and the Council for their report and updates.		
8.M.1	Revision of Charge to Council on Research **Will the Joint Reference Committee recommend that the Board of Trustees approve the revision of the charge to the Council on Research?**	The Joint Reference Committee recommended that the Board of Trustees approved the revision to the charge of the Council on Research.	Shaun Snyder, Esq. Margaret Dewar Ardell Lockerman	Board of Trustees December 2014 [BOT Deadline 11/19/2014]
8.M.2	Revised Position Statement: Psychiatric Implications of HIV/HCV Co-Infection **Will the Joint Reference Committee recommend that the Assembly approve the revised Position Statement *Psychiatric Implication of HIV/HCV Co-Infection* and if approved, forward it to the Board of Trustees for consideration?**	The Joint Reference Committee recommended that the Assembly approved the revised Position Statement *Psychiatric Implication of HIV/HCV Co-Infection.* **N.B.** if the revised position statement is approved it will supersede and retire the former version of the position statement.	Shaun Snyder, Esq. Margaret Dewar Allison Moraske	Assembly May 2015
8.M.3	APA Signing onto the AllTrials Registry **Will the Joint Reference Committee recommend that the Board of Trustees approve the APA signing onto the AllTrials registry?**	The Joint Reference Committee recommended that the Board of Trustees sign the APA onto the AllTrials registry.	Shaun Snyder, Esq. Margaret Dewar Ardell Lockerman	Board of Trustees December 2014 [BOT Deadline 11/19/2014]

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
8.M.4	Referral Update: Remove Black Box Warnings from Antidepressants [ASMMAY1412.K; JRCMAY146.10] The Council was asked by the Joint Reference Committee to provide a list of pros and cons to removing the black box warning from antidepressants. Before providing a formal recommendation to the Joint Reference Committee, the Council wishes to first seek input from Robert Gibbons, Ph.D., University of Chicago, who has studied this issue extensively—particularly data reflecting how the presence of the black box warning has impacted prescribing habits. The Council felt like this could help them provide the Joint Reference Committee a more informed and empirically based response. The next step is for the Council to contact Dr. Gibbons to ascertain his interest and availability in assisting with this matter.	The Joint Reference Committee thanked the Council for the information and looks forward to receiving their recommendations in January.	William Narrow, MD Emily Kuhl, PhD	Council on Research Report to Joint Reference Committee – January [Deadline 1/9/2015]

Joint Reference Committee

American Psychiatric Association
January 25-26, 2015
Orlando, Florida

CONSENT CALENDAR

as of 1/20/2015

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cc 2.A Review and approval of draft Summary of Actions from the October 2014 Joint Reference Committee Meeting – Renée Binder, MD

Will the Joint Reference Committee approve the draft summary of actions from the October 2014 meeting?
(Please see item 2.A)

cc 8.G.1 Retire Position Statement: Psychiatric Disability Evaluation by Psychiatrists (2007)

Will the Joint Reference Committee recommend that the Assembly retire the 2007 Position Statement Psychiatric Disability Evaluation by Psychiatrists and if retired, forward it to the Board of Trustees for consideration?
(Please see item 8.G, attachment 1)

Rationale: Members of the CHSF had reviewed and recommended retaining the 2007 position statement "Psychiatric Disability Evaluation by Psychiatrists". The JRC discussed this recommendation at their October meeting and decided to refer the position statement back to the Council on Healthcare Systems and Financing for further review and possible revision. "The JRC questioned whether there was additional information or background that would support retaining the position statement, especially the part about disability evaluations being done "most effectively and efficiently by psychiatric physicians". In the JRC's view, the information regarding reimbursement was the most relevant portion of the statement, but it is unclear whether this continues to be an issue for our field. It was suggested that input be sought from those with expertise in disability evaluation." The Council sent the position statement as currently written to Andrea Stolar, MD, past-chair of the former Corresponding Committee on Psychiatry and the Workplace for review and comment. Dr. Stolar recommended retiring the position statement, noting that the issues it was written to address have been resolved. The CHSF therefore recommends that the JRC retire the position statement "Psychiatric Disability Evaluation by Psychiatrists."

cc 8.H.1 Retain Position Statement: Consistent Treatment of all Applicants for State Medical Licensure (2008)

Will the Joint Reference Committee recommend that the Board of Trustees retain the 2008 Position Statement Consistent Treatment of all Applicants for State Medical Licensure?

Rationale: The Council on Medical Education believes that this position statement is still relevant because disparity in licensing requirements still exist. Examples of disparities may be found in the Council's report.

cc 8.J.1 Retire Position Statement: Employment Related Psychiatric Examinations (2009)

Will the Joint Reference Committee recommend that the Assembly retire the 2009 Position Statement: *Employment Related Psychiatric Examinations* and if retired, forward it to the Board of Trustees for consideration?
(Please see item 8.J, attachment #1)

Rationale: The Joint Reference Committee referred the revised position paper on Employment Related Psychiatric Examinations to the Council on Psychiatry and Law for feedback. The Council on Psychiatry and Law reviewed both position papers (proposed and current) and recommends that the 2009 position statement be sunset. The Council felt that there is not a current need for a position paper on this subject at this time, as the issue of informed consent is addressed in other documents.

cc 8.K.1 Revised Charge to the Council on Psychosomatic Medicine

Will the Joint Reference Committee recommend that the Board of Trustees approve the revised charge to the Council on Psychosomatic Medicine adding HIV psychiatry?
(Please see item 8.K, attachment #1)

cc 8.M.4 Retain Position Statement: Use of the Concept of Recovery (2005)

Will the Joint Reference Committee recommend that the Board of Trustees retain the 2005 Position Statement on Use of the Concept of Recovery?
(Please see item 8.M, attachment #4)

Rationale: The Council is recommending that this statement be retained as-is because it is still relevant and worded appropriately.

cc 8.M.8 Retain Position Statement: Electroconvulsive Therapy (ECT) (2007)

Will the Joint Reference Committee recommend that the Board of Trustees retain the 2007 Position Statement on Electroconvulsive Therapy (ECT)?
(Please see item 8.M, attachment #8)

Rationale: The Council is recommending that this statement be retained as-is because it is still relevant and worded appropriately.

cc 8.L.3 Revision of Charge to Council on Quality Care

Will the Joint Reference Committee recommend that the Board of Trustees approve the revised charge to the Council on Quality Care which omits HIV psychiatry?
(Please see item 8.L, attachment #4)

CEO Report to the JRC, January 2015

Agenda Item #	Action	CEO/MDO Response	Staff/Component Responsible	Status
8.D.3	Referral Update: Council Communications to Members [JRCOCT138.F.1] The council discussed in great detail the JRCOCT 138.F.1 action titled: Council Communications to Members. The action recommends that APA councils provide a brief summary of useful information relevant to members that's published on a timely basis in appropriate venues. Policy positions instituted by councils are easily accessible but there are different ways to cluster council information. The council wanted to know if they're responsible for considering or identifying what activities of a particular council are good ideas. In response to the action the council offered the following suggestions; • Create a one page document to promote council's papers and projects; • Establish a bulletin board on APA's homepage providing access to an executive summary – recent work of each council (member only access); • The COC could offer advice to councils on the most efficient way to promote key issues; • Offer council chairs a venue or place to discuss their issues; and • APA should survey members to find out specifically what they want to know. The Joint Reference Committee referred this update to the CEO's office and the Division of Communications to develop a list of tools and tips that councils can utilize when communicating both internally and externally. The JRC requested that this information be sent to the Assembly's Work Group on Communications.	While not all work of councils is appropriate for public dissemination (as it may need to go to the BOT and other groups per the approval process), in those cases where communication is desired, we will: • Help councils create a "one pager" to promote their papers and projects; • Ensure that the Office of Member Communication/Psychiatric News is aware of the forthcoming product, which can work to inform members and DB/SAs; • Ensure that the Office of Corporate Communications and Public Affairs is aware, which can inform key external audiences, including news media as appropriate; and • Submit the Council on Communications for additional ideas (social media, blogs, etc.). Other ideas will be considered once APA's infrastructure is ready. APA's Chief Communications Officer has engaged the Assembly's Work Group on Communications, as well.	Saul Levin, MD, MPA Jason Young Margaret Dewar Allison Moraske Division of Communications Association Governance	This action is ongoing.

CEO Report to the JRC, January 2015

Agenda Item #	Action	CEO/MDO Response	Staff/Component Responsible	Status
8.G.17	Refer Position Statement: Bill of Rights: Principles for the Provision of Mental and Substance Abuse Treatment Services Will the Joint Reference Committee refer the Position Statement *Bill of Rights: Principles for the Provision of Mental and Substance Abuse Treatment Services* to the Council on Advocacy and Government Relations for review and to determine if a position on this issue is necessary? If a need to retain the position remains, the CHSF recommends CAGR revise the statement to ensure it is current; otherwise the position should be retired. The Joint Reference Committee referred the action to the Office of the Chief Executive Officer and the Division of Government Relations to determine if the APA still needs a position statement on this topic for APA advocacy reasons. If there is not a need, than the JRC would entertain an action to retire the position statement.	The position statement remains important when advocating on behalf of mental and substance use treatment services. The principles are applicable to implementation as they were to the enactment of passage. The Division of Government Relations is working with the Council on Advocacy and Government Relations to revise the statement.	Saul Levin, MD, MPA Rodger Currie, Esq. Deana McRae Council on Advocacy and Government Relations	To be completed by June JRC 2015.

CEO Report to the JRC, January 2015

Agenda Item #	Action	CEO/MDO Response	Staff/Component Responsible	Status
8.G.22	Current Health Services Literature on Integrated Care Models Will the Joint Reference Committee refer the request from the Council on Healthcare Systems and Financing to the Council on Research to review the current health services literature on integrated care models, including physician-led and non-physician-led models, and summarize and organize this review in such a way that it can be used by APA administrative staff and members for integrated care education and advocacy? The Joint Reference Committee referred the action to the CEO's Office for referral to the Division of Research for review as requested.	Division of Research Administration met with Healthcare Systems and Financing Administration to discuss and clarify the areas of focus that would be most helpful for this literature review. From these discussions, an outline was developed to guide the literature searches, which will now commence. 1. Inventory of Models: What is the full range of models that have been evaluated in the literature? There have been more than 80 randomized controlled trials on the Collaborate Care Models (CCM), but what are the other available models that may be less robustly supported by evidence? For example, what models are available for community behavioral health and primary care (e.g., physician-led versus non-physician-led CCMs; co-location, health homes)? 2. Outcomes of various models a. Financial Outcomes: What is the cost-effectiveness and the return-on-investment of integrated care? b. Clinical Outcomes: The possibilities include measurement of symptoms, disability, quality of life, response to treatment, remission and recovery, adherence to treatment, and satisfaction with care. c. Practice Behaviors: Does integrated care improve practice behaviors of clinicians, such as level of guideline-concordant care? 3. Measurement of fidelity to the integration model: both short- and long-term, including barriers and facilitators to fidelity. 4. Associated Factors a. Payment source/payer: Private/commercial insurance, public funds (Medicare, Medicaid, other government); b. Setting: (public/private) Outpatient (solo, group, clinic), inpatient/partial, ACO, VA/military, Health Home; and c. Reimbursement mechanisms: Private and public managed care mechanisms including capitated and other risk/bonus mechanisms, traditional fee for service.	Saul Levin, MD, MPA Kristin Ptakowski William Narrow, MD Division of Research Healthcare Systems & Financing	Share information with Council on Healthcare Systems and Financing and Council on Research by May 2015.

CEO Report to the JRC, January 2015

Agenda Item #	Action	CEO/MDO Response	Staff/Component Responsible	Status
8.I.3	Retain Position Statement: Sexual Harassment Will the Joint Reference Committee recommend that the Assembly retain the Position Statement *Sexual Harassment* and if retained, forward it to the Board of Trustees for consideration? The Joint Reference Committee referred this position statement to the CEO's Office to determine if there is an advocacy/political need to have a position statement on the various types of harassment. The APA opposes all forms of harassment in the workplace. The JRC thought it best to revise the position statement to include all forms of harassment.	It is important to maintain a position statement addressing the organization's opposition to harassment in the workplace. The Division of Government Relations recommends retaining as written and changing the title to "Position Statement on Harassment."	Saul Levin, MD, MPA Rodger Currie, Esq. Deana McRae	This action is referred to Board of Trustees March 2015 for reaffirmation.
8.I.4	Retain Position Statement: Right to Privacy Will the Joint Reference Committee recommend that the Assembly retain the Position Statement *Right to Privacy* and if retained, forward it to the Board of Trustees for consideration? The Joint Reference Committee referred the position statement to the CEO's office and the Division of Government Relations to determine if there is a need for such a position statement. If it is determined that the APA needs a position statement on such an issue, the Joint Reference Committee will assign the task to the appropriate council.	The statement remains relevant to our organization's position on an individual's right to privacy. The Division of Government Relations recommends that the JRC assign the task to the appropriate council as noted.	Saul Levin, MD, MPA Rodger Currie, Esq. Deana McRae	This action is referred to the JRC for assignment to appropriate Council (e.g., Council on Psychiatry and Law and Council on Quality Care as the suggested group leads).

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.

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

Will JRC recommend that the Board of Trustees vote to approve the revised *Position Statement on Bias-Related Incidents*? Page 2

Information

- Council members recently contributed to APA's upcoming feedback to NIDA regarding the agency's five-year strategic plan as many of NIDA's strategic priorities particularly impact diverse populations.
- Council continues its review of diversity-related position statements to ensure timeliness and relevance. These include position statements on diversity, affirmative action, and MURs in leadership positions. Drafts of the anticipated revised documents will be finalized at the Council's meeting in May.

Proposed revisions to

Position Statement on Bias-Related Incidents

This statement is based on the 1992 position statement that was reaffirmed in 2007 and revised in 2014 by the Council on Minority Mental Health and Health Disparities.

Issue: Bias-related incidents~~, arising~~ arise from ~~racism, from sexism, from~~ intolerance based on religion/ethnicity, gender, age, religion/spirituality, places of birth and growing up, migrant status, socioeconomic status, sexual orientation, gender identity, and disabilities, among other characteristics. Biases, both explicit/conscious and implicit/unconscious, underlie these incidents that are widespread in society and continue to be a source of social disruption, individual suffering, trauma, and health inequities. These bias-related incidents, occurring in both urban and rural areas, consist of acts of violence and harassment based on stereotypes that devalue the human dignity of stigmatized individuals, families, and communities. These bias-related incidents result in ~~and national/tribal origin, and from antigay and antilesbian prejudice, are widespread in society and continue to be a source of social disruption, individual suffering, and trauma. These incidents are ubiquitous and occur in both urban and rural areas. Such hate-based incidents consist of acts of violence on harassment. These incidents result in emotional and physical trauma for individuals, as well as stigmatization of affected groups. Ethnic and cultural biases, vividly manifest in bias-related incidents, serve to frustrate the basic human need for dignity, resulting in~~ despair and hopelessness that undermine the mental health and well-being of affected individuals that ultimately affects ~~among the victims that ultimately affect~~ the whole nation.

APA Position: The American Psychiatric Association (APA) deplores ~~such~~ bias-related incidents. We acknowledge that since our membership is diverse, many of our members have experienced bias-related incidents, both personally and professionally. We recognize that these incidents occur in our nation's families, communities, institutions, organizations and throughout all levels of society. The APA encourages its members to take appropriate actions to prevent such incidents, as well as actively respond when such bias-related incidents occur.

~~Moreover, APA encourages its own members and components to take appropriate actions in helping to prevent such events, as well as to respond actively in the aftermath when such bias-related incidents occur locally.~~

Specific actions to be taken include:

1. APA Leadership must acknowledge that a basic principle of our organization is the importance of valuing human dignity as the basis for optimal mental health and well-being. APA leadership must demonstrate consistent modeling of respect for others and willingness to remain open and curious when assessing for and addressing individual and institutional/organizational biases.

2. APA Leadership must educate themselves about biases, both explicit/conscious and implicit/unconscious, and promote this skill as relevant to all members as necessary for optimum mental health and human dignity. This should include specific training by all in the leadership on cultural competency and diversity management.

3. APA Leadership must develop valuing messages and images to challenge stereotypes and broaden our viewpoints to be inclusive of diverse individuals, families, and communities.

4. APA Leadership must understand that dissemination of evidence-based research that demonstrates effective paths to decrease or eliminate bias-related incidents is critical to addressing these issues in society, our organization and in our work with patients.

Authors:
Daena L. Petersen, MD, MPH, MA
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Altha J. Stewart, MD
Francis G. Lu, MD

Council on International Psychiatry

The Council on International Psychiatry is focused on international membership growth by reviewing and enhancing strategies in Education, Training and Membership.

Education/Training

In order to support international education and training at the 2015 APA Annual Meeting in Toronto, the Council reviewed several submissions accepted by the Scientific Programs Committee, listed under the new topic **"Global Mental Health & International Psychiatry"**, to determine which would be available and appropriate for Council support. Upon review of the submitted abstracts, the following Symposiums were approved for Council support and will be indicated as such in the Program Guide:

- **Addictions: Epidemiology and Treatment in France and in the US** – Chair: J. Talbott
- **Challenges and Opportunities for Global Mental Health** – Chair: D. Ostrow
- **Global Mental Health** – Chair: D. Jeste
- **Implementing Mental Health Interventions in Low-Income Contexts** – Chair. S. Kidd

The Council also recognized the accepted Workshop, **"US and Low and Middle Income Countries Models of Education and Training on Global Mental Health"**, from the newly established Caucus on Global Mental Health and Psychiatry. This Workshop will be listed as supported by the Caucus which now reports to the Council. Additionally, several Council members initiated the development of a session for submission for the 2016 Annual Meeting in Atlanta which will address training American psychiatrists as global mental health investigators, implementers, and collaborators.

The Council established a **Work Group on Scientific Programs** that will facilitate the submission of quality abstracts for future Annual Meetings, beginning with Atlanta, that incorporate international issues and perspectives on psychiatry and global mental health. Additionally, the Council is recommending to the Scientific Programs Committee the addition of an **"International Track"** for the Annual Meeting, beginning with Atlanta.

The Council also established a **Cross-Component Work Group** that will coordinate communications with components with overlapping goals and projects to maintain awareness of opportunities for possible collaboration and cooperation as appropriate.

Membership

In support of the Membership Committee's successful initiative recognizing new International Members and Fellows at the Annual Meeting, the Council will support the **"New International Member/Fellow Welcome Reception"** in Toronto. Council members will attend and network with participants, including presidents of international psychiatric organizations. The Council is communicating and coordinating with the Membership Committee through the Cross-Component Work Group on various International Membership initiatives in consideration.

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: November 3, 2014
Time: 2:00 PM – 3:00 PM
Location: Conference Call

Council Members Present: B. Acharya, D. Baron, A. Becker, K. Busch, J. Griffith, D. Jeste, J. McIntyre, S. Okpaku, E. Pi, E. Sorel, A. Tasman

Council Members with Excused Absences: N. Juthani, S. Okpaku, U.K. Quang Dang, M. Riba, P. Ruiz, M. Soliman, S. Rataemane, V. Vahia, M. Agbonyitor, S. Jani, M. Morse, L. Smith, C. White, R. Winer

Council Members with Unexcused Absences: None

Guests in Attendance: None

Staff in Attendance: R. Juarez

Summary

The Council on International Psychiatry discussed international scientific sessions and events at the Annual Meeting, potential new international membership categories, and managing international components. For the 2015 Annual Meeting (Toronto), the Council will review abstracts for accepted sessions for Council support, co-host the New International Member Networking Event, and connect the International Discussion Groups to the Caucus on Global Mental Health and Psychiatry. The Council also discussed international membership categories for RFMs and ECPs using information from the Membership Committee and formed two Work Groups – (1) Work Group on Scientific Programs; (2) Cross-Component Work Group.

Minutes

The Council approved the minutes from the September 11 meeting during the 2014 September Components in Arlington, VA.

Annual Meeting (Toronto)

International Sessions: The Council discussed scientific sessions scheduled to be presented at the 2015 APA Annual Meeting in Toronto on the topics of global mental health and international psychiatry. The Council was presented with a list of sessions approved by the Scientific Programs Committee for Toronto to review in order to consider supporting.

- Symposium: ***Global Mental Health*** – Chair: D. Jeste
- Symposium: ***Challenges and Opportunities for Global Mental Health*** – Chair: D. Ostrow
- Symposium: ***Implementing Mental Health Interventions in Low-Income Contexts*** – Chair. S. Kidd
- Symposium: ***Addictions: Epidemiology and Treatment in France and in the US*** – Chair: J. Talbott

- Symposium: ***Terrorism in Pakistan-A Behavioral Sciences Perspective*** – Chair: J. Malat

Staff will request the submitted abstracts and forward to the Council for review. Council supported sessions will be indicated as such in the Program Guide distributed to Annual Meeting attendees.

Dr. Jeste briefly discussed the Symposium ***Global Mental Health*** submitted by him and Dr. Becker at the request of Dr. Summergrad which will address issues and perspectives of global mental health. It was noted that the Caucus on Global Mental Health and Psychiatry submitted a Workshop ***US and Low and Middle Income Countries Models of Education and Training on Global Mental Health*** which was accepted for presentation in Toronto.

The Council briefly discussed the importance of presenting an International Track to attendees of APA Annual Meetings and passed a motion to recommend that an International Track be explored by the Scientific Programs Committee for implementation beginning with the 2016 Annual Meeting (Atlanta). As a member of the Scientific Programs Committee, Dr. Pi mentioned that he would share the Council's discussion with the Committee.

Dr. Tasman mentioned that he is the Chair of the WPA Section on Education in Psychiatry and would be available to facilitate any connections.

New International Member Networking Event: The Council discussed co-hosting the New International Member Welcome Networking Event held during the APA Annual Meeting. The event will include invitations to International Presidents attending the Annual Meeting.

Council on International Psychiatry Meeting: The Council discussed announcing the Council's in-person meeting during the Annual Meeting (Toronto) for anyone to attend, though there was concern that managing a Council meeting with a large number of participants may be challenging.

International Discussion Groups: The Council discussed the status of the APA's International Discussion Groups which used to report to the International Council previously sunset in 2009, but continue to meet each year at Annual Meetings. The three current active International Discussion Groups include the African Discussion Group, the European Discussion Group, and the South-East Asia Discussion Group. The Council recommended that the International Discussion Groups report to the APA Caucus on Global Mental Health and Psychiatry which reports to the Council and meet prior to the Caucus meeting during Annual Meetings.

International Membership

Dr. Busch reported on the Membership Committee's meeting in October. It was reported that the APA's presence at the WPA World Congress of Psychiatry in Madrid, Spain in September netted the recruitment of 18 new members. Dr. Busch also reported the Committee's consideration of International RFM and International Medical Student membership categories. The Membership Committee approved recommending to the December BOT the International

RFM membership category and decided to put the International Medical Student membership category on hold for the time being.

The Council briefly discussed recruitment strategies should the International RFM membership category be approved. This included reaching out to international residency training directors to become APA members prior to reaching out to potential international psychiatrists in training. This strategy would incorporate directors into the process in order to have them assist with recruitment efforts for International RFMs. Should the International RFM membership category be approved by the BOT, the Council discussed forming a Work Group to focus on recruitment strategies for the new international membership category.

The Council passed a motion to recommend to the Membership Committee that an International ECP membership category be explored by the Membership Committee that follows the current International Member dues structure based on World Bank income categories. Dr. Busch mentioned that he would share the Council's discussion with the Committee.

International Meetings

Dr. Sorel discussed the WPA International Congress scheduled for June 24-27, 2015 in Bucharest, Romania and invited the Council members to submit abstracts by the December 1 deadline. The theme is ***Primary Care Mental Health: Innovation and Transdisciplinarity*** and Dr. Summergrad is scheduled to be one of six speakers.

Council Components

Work Group on Scientific Programs: In order to facilitate international submissions with international perspectives on international issues, the Council passed a motion to have a Work Group dedicated to facilitating the submission of quality Symposiums and Workshops for APA Annual Meetings focused on global mental health and international psychiatry. The Work Group will focus on recruiting and organizing submissions, in tandem with the Caucus on Global Mental Health and Psychiatry, for the 2016 Annual Meeting (Atlanta). Several Council members stated their interest in being part of the Work Group and are listed below.

Work Group on Scientific Programs

- **Ann Becker**
- **Sam Okpaku**
- **Edmond Pi**

Council members, including Dr. Becker, Dr. Griffith, and Dr. Acharya, connected at the 2014 September Components meeting and worked to pull together a submission for the 2015 Annual Meeting which unfortunately was past the submission deadline. However, these efforts will be rebooted in 2015 to meet the 2016 Annual Meeting submission deadline.

Cross-Component Work Group: The Council discussed forming a Cross-Component Work Group that will focus on communications between the Council and relevant components including Council, Committees, Work Groups, etc. Specifically, the Work Group will liaise with the work of the Council on Medical Education and Life-Long Learning and the Council on Minority and Mental Health Disparities on international graduate medical education initiatives and with the Assembly Caucus of International Medical Graduate Psychiatrists on IMG initiatives. Several Council members stated their interest in being part of the Work Group and are listed below.

Cross-Component Work Group

- **Ken Busch**
- **Jack McIntyre**

Human Rights Award Work Group (pending): The JRC met in October and approved moving the management of the Human Rights Award from the Council on Psychiatry and Law to the Council on International Psychiatry. This action will go to the December BOT for approval. Pending the approval of this action by the BOT, the Council will form the Human Rights Award Work Group to manage the solicitation, nomination and vetting of candidates for the award.

Work Group on International RFMs (pending): Pending the approval of a membership category for International RFMs by the BOT, the Council will form a Work Group to discuss strategies for International RFM recruitment.

Item JRC #8.A
Joint Reference Committee
January 2015

Summary
Council on Addiction Psychiatry

The Council has been actively engaged in a number of activities.

1. Tobacco Use Disorder

A funding proposal was submitted to and approved by the Smoking Cessation Leadership Center, a program of the Robert Wood Johnson Foundation. It will support the Council and its Workgroup on Tobacco Use Disorder efforts to develop a comprehensive plan to influence and lead cultural change within APA's membership and beyond to help reduce tobacco use among individuals with mental illness and/or addiction. In the coming months, up to five conference calls and one in-person meeting will be convened with invited clinical experts. The goals of the effort include:

- Create a strategic plan to a) address psychiatrists' educational needs regarding tobacco use disorders and b) improve psychiatric practice by integrating evidence-based approaches for assessment and treatment of tobacco use disorder;
- Establish a resource page on www.psychiatry.org devoted to Tobacco Use Disorder;
- Update existing APA policy on Tobacco Use Disorder;
- Present an educational session at APA's 2015 Annual Meeting and plan a webinar or other online training module(s) to be conducted in 2015;
- Develop and pilot test a survey of APA members to examine psychiatrists' current tobacco use assessment and management practice patterns.

2. Development of SUD Curriculum for General Psychiatry Training Programs

A small workgroup comprised of Council members and NIDA leaders continues to meet frequently by conference call to discuss the design of a project to develop SUD curriculum for general psychiatry programs. Undertaken at the request of the National Institute on Drug Abuse, the project aims to provide open-source curriculum for use by any psychiatry training program, but particularly for those programs that do not have addiction psychiatry faculty. Council has invited representatives of the Council on Medical Education and Life Long Learning and the American Association of Directors of Psychiatry Residency Training to participate in the project.

The workgroup submitted a proposal for a workshop to be presented at the upcoming AADPRT meeting. Though it was not approved, members will continue to outreach to AADPRT leadership and pursue other opportunities to engage their interest, support, and participation in developing the curriculum . Additionally, the group solicited the input of a few addiction psychiatrists who currently serve as directors of general psychiatry programs.

Under current consideration is development of a survey of APA's Resident Fellows Members and early career psychiatrists to obtain information about their training experiences. An additional survey of

directors of psychiatry residency training to be done in collaboration with AADPRT is also being considered.

3. Providers' Clinical Support Systems for Medication Assisted Treatment and Opioid Therapies

As a partner organization in the SAMSA-funded Providers Clinical Support System-Medication Assisted Treatment (PCSS-MAT), APA conducts a monthly webinar series for the benefit of physicians and other interested clinicians. Sixteen webinars were presented in 2014 and a like number will be presented in 2015. CME is offered without charge to the participant. The sessions are well attended and highly evaluated. Additional webinars plus on-line clinical case vignettes will be offered as part of the Providers Clinical Support System for Opioid Therapies (PCSS-O).

4. **AMA Opioid Abuse Task Force**

Drs. Frances Levin and John Renner and the Council's administration liaison participated in a meeting of the newly created AMA Task Force on Opioid Abuse. The forum was attended by approximately 40 specialty and state medical association leaders and focused on development of strategies to engage the medical and dental communities in reducing opioid abuse. The Task Force, chaired by APA Member Patrice Harris, MD, will continue meet by conference call.

5. Status of APA Position Statements Related to Substance Use Disorders

A number of APA position statements are in the revision process. They include:

- Adolescent Substance Abuse
- Inclusion of Substance-Related Disorders as Psychiatric Disorders in Any Program Designed to Assure Access and Quality of Care for Persons with Mental Illness
- Care of Pregnant and Newly Delivered Women Addicts
- Treatment of Substance Use Disorders in the Criminal Justice System
- Tobacco Dependence

The Council will work with the Council on Geriatric Psychiatry to develop a new statement on Substance Use Disorders in the Elderly.

Executive Summary
Council on Psychiatry and Law

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

Action Item:

ACTION: EMPLOYMENT RELATED PSYCHIATRIC EXAMINATIONS
The Joint Reference Committee referred the revised position paper on *Employment Related Psychiatric Examinations* to the Council on Psychiatry and Law for feedback. The Council on Psychiatry and Law reviewed both position papers (proposed and current) and recommends that the 2009 position statement be sunset. The Council felt that there is not a current need for a position paper on this subject at this time, as the issue of informed consent is addressed in other documents.

> **Will the Joint Reference Committee approve the recommendation of the Council on Psychiatry and Law to sunset the 2009 position statement on Employment Related Psychiatric Examinations? (See attachment 1)**

Information Items:

Clinical Guidelines for Interacting with Caregivers
The Council on Psychiatry and Law worked closely with the Council on Geriatric Psychiatry on the *Clinical Guidelines for Interacting with Caregivers*. The document will be submitted under the Council on Geriatric Psychiatry's written report.

Confidentiality/Privacy Relating to Psychiatric Disorders
The Council on Psychiatry and Law and the Committee on Judicial Action recently reviewed an amicus brief that involved confidentiality/privacy relating to psychiatric disorders of those on parole or probation. The groups declined to participate in the case due to the complex issues which are not currently addressed in APA policies and timing. The Council on Psychiatry and Law is currently discussing the development of further policies/documents on this subject.

Position Statement on 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. 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).

Item #8.D
Joint Reference Committee
January 2015

EXECUTIVE SUMMARY:

Council on Communications

The Council on Communications (COC), chaired by J. Raymond DePaulo, MD had a conference call on December 11, 2014. The items mentioned herein were discussed.

Staff of Corporate Communications & Public Affairs presented updates to the Council on a variety of communication issues & current projects to include APA's branding initiative, the marketing plans for Mental Health Parity and Addiction Equity Act of 2008, and the Joint Reference Committee Review of COC work plan. Personnel updates were highlighted to include new hires to come, the introduction of the new Director of Corporate Communications Glenn O'Neal and Cathy Brown's promotion as Director of Member Communication & Executive Editor, Psychiatric News.

The Council on Communications brings forth one Information item to the JRC.

Information Item: The Council thought highly of the mental health Marquee Event tentatively scheduled in March 2016. The event will be planned by APA & APF. The council looks forward to learning more about how they can help.

Council on Communications
Conference Call Minutes
December 11, 2014

Present
J Raymond DePaulo, MD
Carol Ann Bernstein, MD
Jeffrey Borenstein, MD
Lawrence Malak, MD
Gail M Saltz, MD
Lloyd I Sederer, MD
David Spiegel, MD
Arshya Barati Namin Vahabzadeh, MD
Marie Claire Bourque, MD
Dimas Javier Tirado-Morales, MD
Chuan Mei Lee, MD
Ayana Jordan, MD PhD

APA Staff
Jason Young, Chief Communications Officer
Cathy Brown, Director of Member Communication & Executive Editor, *Psychiatric News*
Glenn O'Neal, Director, Corporate Communications & Public Affairs
Debbie Cohen, Senior Writer
Erin Connors, Senior Media Relations Specialist

Not Present:
John Luo, MD
Serina Deen, MD MPH
Richard Friedman, MD
Sarah Johnson, MD, MSC
Peter David Kramer, MD
Steven Richard Chan, MD MBA
Olanrewaju Dokun, MD
Ahmed Khan, MD
Stefani La Frenierre, MD

I. Introductions

Council Chair Raymond DePaulo, MD, opened the call by asking APA Chief Communications Officer Jason Young to make introductions. Jason offered personnel updates and introduced the new Director of Corporate Communications Glenn O'Neal. He talked about Glenn's background with USA Today as a writer, manager and editor. Glenn shared his excitement about taking on this job and the changes he hopes to accomplish in the coming months. He said he looks forward to working with everyone and he's available to answer any question or concerns of the council.

Jason shared with the Council Cathy Brown's promotion to Director of Member Communication & Executive Editor, Psychiatric News. Jason also mentioned new hires to come: Associate Editor of Psych News, Social Media Manager, as well as Director of Integrated Marketing. Resumes are coming in for the integrated marketing job posting and that person will be in charge of the APA brand; membership, meeting and product marketing; and social action – a much enhanced role compared to the previous marketing function.

II. Joint Reference Committee Review of COC work plan

Jason and Dr. Bernstein shared with the Council the function of the Joint Reference Committee (JRC) chaired by President-Elect Renee Binder, MD, and Dr. Bernstein added the JRC is a clearing house for components and the Assembly. When an action item or position statement is introduced by a council or the Assembly, it is reviewed by the JRC first.

The JRC reviews the work plan of councils every three years and the Council has been asked to submit a work plan this January that includes a summary of accomplishments, as well as current and future activities. Prior to the call, the Council received the criteria used by the JRC in evaluating the Council. The content of the report is imperative to the Council's future and it will be submitted by, or before the January 9th JRC deadline.

III. APA Branding Initiative

Jason updated the Council on the branding initiative proposal. He reminded them about their unanimous vote to rebrand the APA at its meeting in September 2014. Since then, the action was presented, reviewed and unanimously approved by the JRC in October. The same action will go before the Board of Trustees (BOT) the weekend of December 13th. The cost for branding is part of the 2015 APA budget.

A formal RFP was sent to eight firms who work in this space, and six responses were received to the RFP Jason said. After review of the six proposals, three finalists were selected. An APA staff committee met in person with each. Each firm offered a different approach to how they would tackle rebranding; it was a good series of meetings.

Dr. DePaulo asked how to determine what success looks like with this sort of project. APA needs a strong clear voice in our work for our members, for patients and on Capitol Hill, Jason explained. A new brand will express APA's value to society.

Jason concluded by asking the Council if anyone was interested in being part of the rebranding initiative to let staff know. He wants to ensure member input is reflected in rebranding.

IV. Marquee Event in March 2016

Jason told the Council about a proposed event in partnership with the American Psychiatric Foundation. He mentioned that D.C. lacks a signature mental health event of this sort—one that seeks to capture the attention of lawmakers and elite media. The event should put a human face to the cause. There's a real conversation right now about, for example, inmates suffering from mental illness particularly at Rikers Island, a correctional facility in New York. This event could help change national conversation/dialogue by highlighting the problem. Members of the Council wanted to know about event funding and who would be invited. They also offered suggestions about other targeted patient groups such as battered women, child abuse or PTSD.

Dr. Bourque talked about a gala she attended that was organized for rich men and poor men. One out of seven attendees got a wealthy person's meal, and the others received a poor person's meal. The event captured how many people are living below the poverty line. Attendees, rich and poor, sat at the same table.

The Council thought highly of the mental health event that's being planned by the APA & APF and they look forward to learning more about how they can help.

V. APA's Parity Poster

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) has been on the books for five years. A new parity poster by APA outlines patient rights' for fair mental health coverage under federal law and how to report problems. The poster clearly explains the law and the steps to take when a violation is suspected.

Jason shared with the Council the marketing plans to include the release in the December 5th edition of Psychiatric News and a full page pull-out was inserted. APA's District Branch and State Associations received an email correspondence asking them to print the poster and to share the poster with members of their DB/SA. The poster was placed on APA's website www.psychiatry.org/parity and messaging was pushed out on social media.

Members praised the idea but they also thought sharing personal stories via social media should be a good next step. Dr. Vahabzadeh mentioned that the poster had too many words for social media and it should point directly to Mental Health. Jason told the Council that the poster will be simplified so that key points can be teased. Dr. Bernstein stressed the importance of getting the word out.

VI. COC meeting in Toronto: Saturday, May 16, 2015, 9am-3pm

Jason told the Council that it's tentatively scheduled to meet at the annual meeting on Saturday, May 16, 2015, from 9am to 3pm, Fairmont Royal York, Imperial room, main floor. He also reminded members about Toronto's travel requirements and stressed the importance of planning ahead by obtaining passports.

Item #8.D
Joint Reference Committee
January 2015

COUNCIL ON COMMUNICATIONS
WORK PLAN TEMPLATE

	TASK/ACTION	Priority #	Start Date	Completion Date	Responsible Person/Entity
I	**TASK:**				
	The council will assist in the APA branding initiative to ensure input from APA members.	**1**	**Sept 2014**	**May 2015**	**J. Raymond DePaulo, MD**
II	**TASK:**				
	Once the APA develops an integrated care and health care reform vision/mission statement, the council will create specific communications strategies to promote the value of integrated care.	**2**	**Pending**		**Council on Communications**
III	**TASK:**				
	Educate our younger member audience on how Health Reform affects them in the future	**2**	**Pending**		**Council on Communications**
IV	**TASK:**				
	The council will work with Corporate Communications & Public Affairs in organizing the Marquee Event in March 2016	**1**	**Dec 2014**	**Mar 2016**	**Arshya Vahabzadeh, MD**
V	**TASK:**				
	Help review/revise the resources available on the Patient/Families Section (formerly the Mental Health section) of psychiatry.org.	**1**	**Jan 2015**	**Jul 2015**	**Council on Communications**
VI	**TASK:**				

Council on Communications
Criteria for Evaluating Councils

1) How many times did the Council meet?
   The council met face-to-face twice in the past year: APA's Annual Meeting (2 days) and the September Component Meeting (2 days). Conference calls were held at least three times, with the most recent one on Dec. 11, 2014.

    a. Virtually all Council members were present for the entirety of the face-to-face meetings, though some late arrivals and early departures occur, and the Annual Meeting is understandably the tougher environment. Conference calls are usually attended by about half of the Council. On the December call, for example, 57% of the Council was present. We would note that some members who could not attend that call are also otherwise those most active participants, so in our view, this participation rate is only one important measure. Other forms of engagement including writing blog posts, engaging in social media, reviewing patient education materials and speaking to news media, for example.

2) Education
    a. What workshops/symposia, etc. have been submitted for presentation at APA Annual Meetings.

IPS 2015, NY (Planned):
1. Even Doctors Can Learn to Write

Annual Meeting 2015, Toronto (Planned):
1. Social Media: the Good, the Bad, and the Ugly
2. Are You a Sitting Duck Online? What You Can (and Can't, or Shouldn't) Do About Negative Reviews Your Patients Post About You
3. Exploring Technologies in Psychiatry

Annual Meeting 2014, NY:
1. The American Journal of Psychiatry Residents' Journal: How to Participate
2. Are You a Sitting Duck Online? What you Can (and Can't or Shouldn't) do about Negative Reviews that your Patients Post About You
3. Exploring Technologies in Psychiatry

Annual Meeting 2013, SF:
1. The American Journal of Psychiatry Residents' Journal: How to be Involved"
2. E-Psychiatry: How Innovative Websites Reach Diverse Populations
3. Mentoring 101: Secrets for Success
4. Exploring Technologies in Psychiatry
5. What are People Saying About you Online? Your E-Reputation and What You Can Do About It

Annual Meeting 2012, Philadelphia:
1. Exploring Technologies in Psychiatry

Annual Meeting 2011, Honolulu:

1. Exploring Technologies in Psychiatry

Annual Meeting 2010, New Orleans:

1. The Explosion of Social Media: Why, Where, When and How Can Psychiatrists Catch up With the Trend?

b. What was the attendance at these events and what was the feedback on these events?

APA member attendees, uneven in their attendance, but often popular are always enthusiastic about learning how to use, and write for social media and other digital communication formats to connect with patients and the public in a way that is immediate and appealing.

3) What are the council's current activities and what activities are planned for the coming years? [please use the work plan template]

4) Has work product been sent to the Assembly and the Board of Trustees?
The Council on Communications has brought the following actions to the Assembly and Board of Trustees since 2011.

2014

- **Amend 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.**
- **Approve the Council on Communications recommendation and support the APA's branding initiative to help brand the APA consistently and demonstrate its value.**

- **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.**

2013

- **Approve bestowing the 2013 Member Communications Award, "Certificate of Continued Excellence in Member Communication," to the Arizona Psychiatric Society, Washington Psychiatric Society, and North Carolina Psychiatric Association.**

2012

- **Approve bestowing the 2012 Member Communications Award, "Certificate of Continued Excellence in Member Communication," to the Maine Association of Psychiatric Physicians, Michigan Psychiatric Society, and Maryland Psychiatric Society, Inc.**

2011

- **Support the move of Psychiatric News toward a robust digital presence to complement the print version.**
- **Integrate the various newsletters produced across the Association (such as APA Member Update, Headlines, RushNotes, Psychiatric Research Report, Spectrum, and PRN Update) and include their articles under tabbed sections in the new, expanded online version of Psychiatric News.**

- **Add 10,000 psychiatrists to the circulation of Psychiatric News.**
- **Appoint a search committee for a new editor-in-chief of Psychiatric News.**
- **Approve funds for a redesign of the print version of Psychiatric News and adapt that design for its digital products (website, e-newsletter) to improve readability and strengthen brand identification.**

5) What is the Council doing for MIT and ECP members?
Members of the Council on Communications have been extremely generous with their time and energy in helping to facilitate and improve communications among early-career psychiatrists (ECPs) and resident fellow members (RFMs):

- **At the Council's meeting in September, ECP and RFM COC members aligned their communication interest with members of the Council in order to facilitate outreach and communication with each other.**
- **Once the APA develops an integrated care and health care reform vision/mission statement, the Council has pledged to create specific communications strategies to promote the value of integrated care and educate younger members on how health reform affects them in the future.**
- **The COC developed a "Brief Guide for New Resident-Fellow Members."**
- **COC and staff have made a first effort toward a LinkedIn subgroup for ECPs & RFMs.**
- **Staff continuously engages former and current COC ECPs and RFMs to serve as bloggers on Healthy Minds Healthy Lives (public education blog) and solicit their participation in all APA's social media communities.**
- **When new ECPs and RFMs are appointed to the Council, a welcome letter is sent to each expressing how the APA and the COC values their expertise and participation in APA's communication outreach efforts. A list (including hyperlinks) to all APA's social media outlets is provided.**
- **COC worked with IT on the development of an ECP & RFM Communities website portal which was a communal venue to promote the work of the APA councils that many of the ECPs and RFMs serve on.**

Evaluate the staff support to the Council and its components
(N.B. the staff will be asked to evaluate what the Council does and the work of the participants)
Staff provides consistent and valuable support to the Council. The Administration has increased the number of staff providing reports and insight to the Council as the new, integrated Communications Division has taken shape and the COC's charge has been amended to reflect this expanded scope of work, which now includes marketing and member communication, as well.

Outcome:

- ☐ Continue the component in its current form
- ☐ Recommend changes to the component
- ☐ Discontinue the component

COUNCIL ON PSYCHOSOMATIC MEDICINE
REPORT TO THE JOINT REFERENCE COMMITTEE

Executive Summary

The Council on Psychosomatic Medicine last met at the September Component Meetings where the Council discussed the following:

- Building relationships with allied organizations, including the Academy of Psychosomatic Medicine and the American Academy of Neurology;
- Importance of education psychosomatic medicine as early career physicians enter a new era of practicing medicine with healthcare reform;
- Individual opportunities for provider education in psychosomatic medicine;
- Recruiting and retaining psychosomatic fellows into psychosomatic medicine; and
- Current research occurring in psychosomatic medicine

The meeting also included visits and reports from Drs. Summergrad and Binder, who discussed current APA initiatives, ways that the Council could become further involved with healthcare reform efforts, and assisting the APA in setting the agenda around what psychiatrists' roles and responsibilities will be in the future.

Additionally, Ian Hedges became the new Associate Director of HIV Psychiatry, and will serve as the Staff Liaison for the Council on Psychosomatic Medicine. Since the changes from the Office of HIV Psychiatry occurred, the Council on Psychosomatic Medicine discussed the possibility of including HIV-related topics to its charge.

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 Psychosomatic's revised charge?
>
> - See Attachment 1 for previous and revised charges

Referral Updates

Action Item Number: JRCOCT148.G.23
Title: Identify the Roles and Responsibilities of Psychiatrists
Action: This item was referred to the Council on Psychosomatic Medicine after the Council informed the Council on Healthcare Systems and Financing that the Council on Psychosomatic Medicine was creating a joint APA Council on Psychosomatic Medicine and Academy of Psychosomatic Medicine workgroup to meet the objective of this action item. This workgroup will be tasked with performing an environmental scan of high quality, cost-effective integrated care models in which psychiatrists play a predominant role in the practice setting. The Council will provide regular updates on this action item as the workgroup progresses with its work.

Attachments: (for Joint Reference Committee Reports)

- **Attachment 1: Council on Psychosomatic Current and Revised Charge**

- **Attachment 2: Minutes from the Council on Psychosomatic Medicine's September Components Meeting**

Attachment 1

Council on Psychosomatic Medicine (Consultation-Liaison Psychiatry) Charge

The Council on Psychosomatic Medicine (Consultation-Liaison Psychiatry) is charged with the following: The Council 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 bio-psychosocial care is vital to the well-being of patients and that full membership in the house of medicine is essential to the well-being of our profession. It accomplishes its goals by initiatives related to research, clinical care, education, and health care policy. The Council is charged to:

- Provide leadership at the interface of psychiatry with other medical specialties.
- Provide training and education to psychiatrists and other physicians, residents (including psychiatric residents), and medical students at scientific meetings and in other settings about the special needs of those with psychiatric illness in medically ill and complex medically ill populations.
- Advocate for the enhancement of training in Psychosomatic Medicine (Consultation-Liaison Psychiatry) in medical schools and residency training programs.
- Create educational materials about the needs of those with psychiatric illness in medically ill and complex medically ill populations and the role of psychiatry/psychiatrists in meeting those needs–for medical and non-medical audiences
- Work with other components and/or organizations on health care policy initiatives: the evaluation and design of delivery systems, models of care, and payment mechanisms aimed at promoting high degrees of quality and cost-effectiveness in those with significant medical-psychiatric co-morbidity.
- Support APA's advocacy efforts to increase the funding of research in these areas
- Support and/or lead ongoing efforts to improve the recruitment of psychiatrists into Psychosomatic (Consultation-Liaison Psychiatry) fellowship programs.

Composition:	Standard council composition
Components:	None
Awards:	None
History:	The Council on Psychosomatic Medicine was first established in March 2004. In 2009 it was restructured as part of the Council on Adult Psychiatry, a consolidation of the former councils on aging, psychosomatic medicine and addiction psychiatry. In September 2010, The Council on Adult Psychiatry was sunset and the Council on Psychosomatic Medicine and Geriatric Psychiatry and Council on Addiction Psychiatry were formed. In December 2011, the Council on Psychosomatic Medicine (Consultation-Liaison Psychiatry) was established.

Council on Psychosomatic Medicine (Consultation-Liaison Psychiatry) Charge (Revised)

The Council on Psychosomatic Medicine (Consultation-Liaison Psychiatry) is charged with the following: The Council 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 bio-psychosocial care is vital to the well-being of patients and that full membership in the house of medicine is essential to the well-being of our profession. It accomplishes its goals by initiatives related to research, clinical care, education, and health care policy. The Council is charged to:

- Provide leadership at the interface of psychiatry with other medical specialties.
- Provide training and education to psychiatrists and other physicians, residents (including psychiatric residents), and medical students at scientific meetings and in other settings about the special needs of those with psychiatric illness in medically ill and complex medically ill populations.
- Provide scientific and clinical expertise on issues surrounding co-morbidities such as, but not limited to HIV Psychiatry and Integrated Care
- Advocate for the enhancement of training in Psychosomatic Medicine (Consultation-Liaison Psychiatry) in medical schools and residency training programs.
- Create educational materials about the needs of those with psychiatric illness in medically ill and complex medically ill populations and the role of psychiatry/psychiatrists in meeting those needs–for medical and non-medical audiences
- Work with other components and/or organizations on health care policy initiatives: the evaluation and design of delivery systems, models of care, and payment mechanisms aimed at promoting high degrees of quality and cost-effectiveness in those with significant medical-psychiatric co-morbidity.
- Support APA's advocacy efforts to increase the funding of research in these areas
- Support and/or lead ongoing efforts to improve the recruitment of psychiatrists into Psychosomatic (Consultation-Liaison Psychiatry) fellowship programs.

Composition:	Standard council composition
Components:	None
Awards:	None
History:	The Council on Psychosomatic Medicine was first established in March 2004. In 2009 it was restructured as part of the Council on Adult Psychiatry, a consolidation of the former councils on aging, psychosomatic medicine and addiction psychiatry. In September 2010, The Council on Adult Psychiatry was sunset and the Council on Psychosomatic Medicine and Geriatric Psychiatry and Council on Addiction Psychiatry were formed. In December 2011, the Council on Psychosomatic Medicine (Consultation-Liaison Psychiatry) was established.

Attachment 2

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.

EXECUTIVE SUMMARY
Assembly

The Assembly met in Washington, DC, November 7-9, 2014, and passed several actions that are referred to the Joint Reference Committee (JRC), below. The draft summary of actions from the meeting is provided as attachment 10.

The Assembly brings the following action items:

1. **Direct to Consumer Advertising (ASM Item #2014A2 12.A) [attachment 1]**

   Action paper 2014A2 12.A asks that:

   1. The American Psychiatric Association shall sunset: Position Statement on Direct-to-Consumer (DTC) Advertising of Prescription Drugs and Implantable Devices Adoption of AMA Policy H-105.988, approved 2010.

   2. The American Psychiatric Association shall adopt the Position Statement on Direct to Consumer Advertising, 2014.

   Action: Will the JRC refer the Assembly passed action paper *2014A2 12.A: Direct to Consumer Advertising* to the appropriate Component(s) for input or follow-up?

2. **E-prescribing of Controlled Substances (ASM Item #2014A2 12.B) [attachment 2]**

   Action paper 2014A2 12.B asks that:

   1. That the APA refer this issue to our delegation to the AMA to support the option for electronically prescribed controlled substances as aligned with federal regulations and express the importance of adopting such standards to allow for this to the relevant components of the e-prescribing chain.

   2. The APA will develop a position statement supporting the options of electronic prescribing of controlled substances.

   Action: Will the JRC refer the Assembly passed action paper *2014A2 12.B: E-prescribing of Controlled Substances* to the appropriate Component(s) for input or follow-up?

3. **Telepsychiatry (ASM Item #2014A2 12.C) [attachment 3]**

   Action paper 2014A2 12.C asks:

   That the Council on Quality Care be charged to develop and recommend a plan to the Board of Trustees facilitating the defining of, adoption and use of telepsychiatry, including but not limited to research priorities, standardization of regulation, training, development of evidence based treatment guidelines, resolution of impediments, and addressing incentives/disincentives to its adoption.

   That the Board of Trustees of the American Psychiatric Association act to review, revise, approve and implement said plan.

   Action: Will the JRC refer the Assembly passed action paper *2014A2 12.C: Telepsychiatry* to the appropriate Component(s) for input or follow-up?

4. <u>Critical Psychiatrist Shortages at Federal Medical Centers</u> (ASM Item # 2014A2 12.D) [attachment 4]

Action paper 2014A2 12.D asks that the American Psychiatric Association's Council on Advocacy and Government Relations design and implement a plan to best address the compensation and benefits of Bureau of Prisons psychiatrists that is substantially below community levels including other federally employed physicians as it prevents recruitment and retention of medical providers.

Action: Will the JRC refer the Assembly passed action paper *2014A2 12.D: Critical Psychiatrist Shortages at Federal Medical Centers* to the appropriate Component(s) for input or follow-up?

5. <u>EHR for Psychiatrists</u> (ASM Item # 2014A2 12.E) [attachment 5]

Action paper 2014A2 12.E asks

1. That the APA Administration assist the Committee on Mental Health Information Technology to explore the feasibility of sending out a Request for Proposal to EHR vendors for psychiatry friendly EHRs with the goal of identifying and/or fostering development of one or more products for consideration by members.

2. That the APA Administration report their progress to the Assembly via the Assembly listserv by March 1, 2015.

Action: Will the JRC refer the Assembly passed action paper *2014A2 12.E: EHR for Psychiatrists* to the appropriate Component(s) for input or follow-up?

6. <u>Integrating Buprenorphine Maintenance Therapy with Mental Health</u> (ASM Item # 2014A2 12.G) [attachment 6]

Action paper 2014A2 12.G asks that APA create a task force composed of appropriate council membership to focus on issues salient to integrated Substance Use Disorders and MI treatment including buprenorphine therapy.

Action: Will the JRC refer the Assembly passed action paper *2014A2 12.G: Integrating Buprenorphine Maintenance Therapy with Mental Health* to the appropriate Component(s) for input or follow-up?

7. <u>Exploration: Whether to Add Some Symptoms to the Next DSM</u> (ASM Item #2014A2 12.N) [attachment 7]

Action paper 2014A2 12.N asks that the DSM Steering Committee explores adding some mental health symptoms and codes, available to rest of medicine, to the next update of DSM-5.

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

8. <u>Neurodevelopmental</u> (ASM Item #2014A2 12.P) [attachment 8]

Action paper 2014A2 12.P asks that future printings of DSM use "Neurodevelopmental Disorder associated with Prenatal Alcohol Exposure" throughout DSM-5.

Action: Will the JRC refer the Assembly passed action paper 2014A2 12.P: *Neurodevelopmental* to the appropriate Component(s) for input or follow-up?

9. Position Statement: Active Treatment (JRCOCT148.G.14; ASMNOV144.B.14) [attachment 9]

The Assembly voted to retain the Position Statement: *Active Treatment* and refer it back to the Council on Healthcare Systems and Financing. The recommendation from the Joint Reference Committee was to retire the position statement however the Assembly felt a position statement on this topic was needed and did not want to retire it until a replacement has been drafted.

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

The Assembly brings the following informational items:

1. Assembly Nominating Committee Report

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

Speaker-Elect:	Daniel Anzia, M.D., Area 4 Robert Roca, M.D., Area 3
Recorder:	Ludmila De Faria, M.D., Area 5 Theresa Miskimen, M.D., Area 3

2. **Position Statement on Residency Training Needs in Addiction Psychiatry for the General Psychiatrist (JRCOCT128.A.1; ASMMAY134.B.1; ASMNOV144.B.1)**

The Assembly voted, to approve the Position Statement on *Residency Training Needs in Addiction Psychiatry for the General Psychiatrist*. This was forwarded to the Board of Trustees for consideration in December 2014. The Board of Trustees approved the position statement.

3. **Proposed Position Statement on Firearm Access, Acts of Violence and Relationship to Mental Illness and Mental Health Services (JRCMAY148.J.1; ASMNOV144.B.2)**

The Assembly voted to approve the Proposed Position Statement on *Firearm Access, Acts of Violence and Relationship to Mental Illness and Mental Health Services*. This was forwarded to the Board of Trustees for consideration in December 2014. The Board of Trustees approved the position statement.

4. **Retain Position Statement: Relationship between Treatment and Self Help (JRCOCT148.A.1; ASMNOV144.B.3)**

The Assembly, on its consent calendar, voted to retain the Position Statement: *Relationship between Treatment and Self Help.* This was forwarded to the Board of Trustees for consideration in December 2014. The Board of Trustees approved retaining the position statement.

5. **Retire Position Statement: Mental Health & Substance Abuse and Aging: Three Resolutions (JRCOCT148.A.3; ASMNOV144.B.4)**

The Assembly, on its consent calendar, voted to retire the Position Statement: *Mental Health & Substance Abuse and Aging: Three Resolutions*. This was forwarded to the Board of Trustees for consideration in December 2014. The Board of Trustees approved retiring the position statement.

6. **Retain Position Statement: Elder Abuse, Neglect and Exploitation (JRCOCT148.E.2; ASMNOV144.B.5)**

The Assembly voted, on its consent calendar, to retain the Position Statement: *Elder Abuse, Neglect and Exploitation*. This was forwarded to the Board of Trustees for consideration in December 2014. The Board of Trustees approved retaining the position statement.

7. **Retain Position Statement: Discriminatory Disability Insurance Coverage (JRCOCT148.G.2; ASMNOV144.B.6)**

The Assembly voted, on its consent calendar, to retain the Position Statement: *Discriminatory Disability Insurance Coverage*. This was forwarded to the Board of Trustees for consideration in December 2014. The Board of Trustees approved retaining the position statement.

8. **Retain Position Statement: Psychiatrists Practicing in Managed Care: Rights and Regulations (JRCOCT148.G.4; ASMNOV144.B.7)**

The Assembly voted, on its consent calendar, to retain the Position Statement: *Psychiatrists Practicing in Managed Care: Rights and Regulations*. This was forwarded to the Board of Trustees for consideration in December 2014. The Board of Trustees approved retaining the position statement.

9. **Retain Position Statement: State Mental Health Services (JRCOCT148.G.5; ASMNOV144.B.8)**

The Assembly voted to retain the Position Statement: *State Mental Health Services* and refer the Position Statement to the Assembly Committee on Public and Community Psychiatry. This was forwarded to the Board of Trustees for consideration in December 2014. The Board of Trustees approved the retention of the Position Statement: State Mental Health Services with revised title: **Leadership of State Mental Health Services**.

10. **Retain Position Statement: Universal Access to Healthcare (JRCOCT148.G.6; ASMNOV144.B.9)**

The Assembly voted, on its consent calendar, to retain the Position Statement: *Universal Access to Healthcare*. This was forwarded to the Board of Trustees for consideration in December 2014. The Board of Trustees approved retaining the position statement.

11. **Retain Position Statement: Federal Exemption from the Institutions for Mental Diseases (IMD) Exclusion (JRCOCT148.G.7; ASMNOV144.B.10)**

The Assembly voted, on its consent calendar, to retain the Position Statement: *Federal Exemption from the Institutions for Mental Diseases (IMD) Exclusion*. This was forwarded to the Board of Trustees for consideration in December 2014. The Board of Trustees approved retaining the position statement.

12. **Retire Position Statement: 2002 Access to Comprehensive Psychiatric Assessment and Integrated Treatment (JRCOCT148.G.11; ASMNOV144.B.11)**

The Assembly voted, on its consent calendar, to retire the Position Statement: *2002 Access to Comprehensive Psychiatric Assessment and Integrated Treatment*. This was forwarded to the Board of Trustees for consideration in December 2014. The Board of Trustees approved retiring the position statement.

12. **Retire Position Statement: Psychotherapy and Managed Care (JRCOCT148.G.12; ASMNOV144.B.12)**

The Assembly voted, on its consent calendar, to retire the Position Statement: *Psychotherapy and Managed Care*. This was forwarded to the Board of Trustees for consideration in December 2014. The Board of Trustees approved retiring the position statement.

13. **Retire Position Statement: Proposed Guidelines for Handling the Transfer of Provider Networks (JRCOCT148.G.13; ASMNOV144.B.13)**

The Assembly voted, on its consent calendar, to retire the Position Statement: *Proposed Guidelines for Handling the Transfer of Provider Networks*. This was forwarded to the Board of Trustees for consideration in December 2014. The Board of Trustees approved retiring the position statement.

14. **Retire Position Statement: Endorsement of Medical Professionalism in the New Millennium: A Physician Charter (JRCOCT148.G.15; ASMNOV144.B.15)**

The Assembly voted, on its consent calendar, to retire the Position Statement: *Endorsement of Medical Professionalism in the New Millennium: A Physician Charter*. This was forwarded to the Board of Trustees for consideration in December 2014. The Board of Trustees approved retiring the position statement.

15. **Retire Position Statement: Desegregation of Hospitals for the Mentally Ill and Retarded (JRCOCT148.G.16; ASMNOV144.B.16)**

The Assembly voted, on its consent calendar, to retire the Position Statement: *Desegregation of Hospitals for the Mentally Ill and Retarded*. This was forwarded to the Board of Trustees for consideration in December 2014. The Board of Trustees approved retiring the position statement.

16. **Retain Position Statement: Abortion and Women's Reproductive Health Rights (JRCOCT148.I.1; ASMNOV144.B.17)**

The Assembly voted, on its consent calendar, to retain the Position Statement: *Abortion and Women's Reproductive Health Rights*. This was forwarded to the Board of Trustees for consideration in December 2014. The Board of Trustees approved retaining the position statement.

17. **Retain Position Statement: Xenophobia, Immigration and Mental Health (JRCOCT148.I.2; ASMNOV144.B.18)**

The Assembly voted, on its consent calendar, to retain the Position Statement: *Xenophobia, Immigration and Mental Health*. This was forwarded to the Board of Trustees for consideration in December 2014. The Board of Trustees approved retaining the position statement.

18. **Retire Position Statement: Juvenile Death Sentences (JRCOCT148.J.5; ASMNOV144.B.19)**

The Assembly voted, on its consent calendar, to retire the Position Statement: *Juvenile Death Sentences*. This was forwarded to the Board of Trustees for consideration in December 2014. The Board of Trustees approved retiring the position statement.

19. **Retain Position Statement: Peer Review of Expert Testimony (JRCOCT148.J.6; ASMNOV144.B.20)**

The Assembly voted, on its consent calendar, to retain the Position Statement: *Peer Review of Expert Testimony*. This was forwarded to the Board of Trustees for consideration in December 2014. The Board of Trustees approved retaining the position statement.

20. **Retain Position Statement: Joint Resolution against Torture (JRCOCT148.J.7; ASMNOV144.B.21)**

The Assembly voted, on its consent calendar, to retain the Position Statement: *Joint Resolution against Torture*. This was forwarded to the Board of Trustees for consideration in December 2014. The Board of Trustees approved retaining the position statement.

21. **Retain Position Statement: Moratorium on Capital Punishment in the United States (JRCOCT148.J.8; ASMNOV144.B.22)**

The Assembly voted, on its consent calendar, to retain the Position Statement: *Moratorium on Capital Punishment in the United States*. This was forwarded to the Board of Trustees for consideration in December 2014. The Board of Trustees approved retaining the position statement.

22. **Retain Position Statement: Discrimination against Persons with Previous Psychiatric Treatment (JRCOCT148.J.9; ASMNOV144.B.23)**

The Assembly voted, on its consent calendar, to retain the Position Statement: *Discrimination against Persons with Previous Psychiatric Treatment*. This was forwarded to the Board of Trustees for consideration in December 2014. The Board of Trustees approved retaining the position statement.

23. **Retain Position Statement: Insanity Defense (JRCOCT148.J.910; ASMNOV144.B.24)**

The Assembly voted, on its consent calendar, to retain the Position Statement: *Insanity Defense*. This was forwarded to the Board of Trustees for consideration in December 2014. The Board of Trustees approved retaining the position statement.

24. **Retain Position Statement: Psychiatric Participation in the Interrogation of Detainees (JRCOCT148.J.11; ASMNOV144.B.25)**

The Assembly voted, on its consent calendar, to retain the Position Statement: *Psychiatric Participation in the Interrogation of Detainees*. This was forwarded to the Board of Trustees for consideration in December 2014. The Board of Trustees approved retaining the position statement.

25. **Retain Position Statement: Death Sentences for Persons with Dementia or Traumatic Brain Injury (JRCOCT148.J.12; ASMNOV144.B.26)**

The Assembly voted, on its consent calendar, to retain the Position Statement: *Death Sentences for Persons with Dementia or Traumatic Brain Injury*. This was forwarded to the Board of Trustees for consideration in December 2014. The Board of Trustees approved retaining the position statement.

26. **Retain Position Statement: Mentally Ill Prisoners on Death Row (JRCOCT148.J.13; ASMNOV144.B.27)**

The Assembly voted, on its consent calendar, to retain the Position Statement: *Death Sentences for Persons with Dementia or Traumatic Brain Injury*. This was forwarded to the Board of Trustees for consideration in December 2014. The Board of Trustees approved retaining the position statement.

27. **Retain Position Statement: Diminished Responsibility in Capital Sentencing (JRCOCT148.J.14; ASMNOV144.B.28)**

The Assembly voted, on its consent calendar, to retain the Position Statement: *Diminished Responsibility in Capital Sentencing*. This was forwarded to the Board of Trustees for consideration in December 2014. The Board of Trustees approved retaining the position statement.

28. **Retain Position Statement: Endorsement of the Patient-Physician Covenant (JRCOCT148.L.5; ASMNOV144.B.29)**

The Assembly voted, on its consent calendar, to retain the Position Statement: *Endorsement of the Patient-Physician Covenant*. This was forwarded to the Board of Trustees for consideration in December 2014. The Board of Trustees approved retaining the position statement.

29. **Retain Position Statement: Provision of Psychotherapy for Psychiatric Residents (JRCOCT148.L.6; ASMNOV144.B.30)**

The Assembly voted, on its consent calendar, to retain the Position Statement: *Provision of Psychotherapy for Psychiatric Residents*. This was forwarded to the Board of Trustees for consideration in December 2014. The Board of Trustees approved retaining the position statement.

Attachment #1
Item 2014A2 12.A
Assembly
November 7-9, 2014

ACTION PAPER
FINAL

TITLE: Direct to Consumer Advertising

WHEREAS:

Direct to consumer advertising of medications for the treatment of psychiatric disorders (in fact all prescription medication) is legal in the United States and New Zealand, but illegal in the rest of the world;

Direct to consumer advertising of medications for the treatment of psychiatric disorders is expanding from print and television to online marketing;

There is considerable evidence that direct to consumer advertising of psychotropic medication harms more individuals than it benefits;

There is substantial evidence that direct to consumer advertising of psychotropic medication benefits pharmaceutical companies through greater sales of medications without medical indications;

There is little evidence that direct to consumer advertisements of medications used to treat psychiatric disorders provides information in a fashion that increases informed decision making by patients;

There is considerable evidence that direct to consumer advertising impacts physicians prescribing of psychotropic medication through patients' requests for specific medications by brand name;

There is some evidence that direct to consumer advertising of psychotropic medication biases individuals against non-pharmacologic treatment, such as psychotherapies and psychosocial treatments;

It is well known that non-psychiatric medications can negatively impact an individual's mental status so medications that are not medically indicated should be avoided;

It is well known that drug-drug interactions of a psychiatric medication and a non-psychiatric medication can increase the blood levels of either, decrease the effectiveness of either, have side effects neither medication would have alone so medications that are not medically indicated should be avoided;

The current position statement of the APA on Direct to Consumer advertising, an adoption of AMA policy (see attachment A), is neither meaningful nor effective:

- The structure and actions the position paper calls for have either never been created or never been implemented (see Attachment B)
- The research called for has never been done (see Attachment B)
- The safeguards, particularly physician involvement, have never been put in place
- What actions the FDA has taken has very rarely applied to psychotropic medication (see Attachment C)

BE IT RESOLVED:

1. The American Psychiatric Association shall sunset: Position Statement on Direct-to-Consumer (DTC) Advertising of Prescription Drugs and Implantable Devices Adoption of AMA Policy H-105.988, approved 2010.
2. The American Psychiatric Association shall adopt the Position Statement on Direct to Consumer Advertising, 2014.

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Miriam Tepper, M.D., APA Member
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ESTIMATED COST:
Author: $0
APA: $700

ESTIMATED SAVINGS: None

ESTIMATED REVENUE GENERATED: $5,000
ENDORSED BY: Area 1

KEY WORDS: Direct to consumer advertising

APA STRATEGIC GOAL: Advocating for Patients, Advocating for the Profession, Defining and Supporting Professional Values

REVIEWED BY RELEVANT APA COMPONENT:

References

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Steven S. Sharfstein**. Big Pharma and American Psychiatry**. Journal of Nervous & Mental Disease 2008:196(4):265-266.doi:10.1097/NMD.0b013e31816a4380

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Julian De Freitas, Brian A. Falls, Omar S. Haque et.al. **Recognizing misleading pharmaceutical marketing online**. Journal of the American Academy of Psychiatry and the Law 2014: 42(2): 219-225,

[Position Statement is on the next page]

g) The advertisement should not make comparative claims for the product versus other prescription drug or implantable medical device products; however, the advertisement should include information about the availability of alternative non-drug or non-operative management options such as diet and lifestyle changes, where appropriate, for the disease, disorder, or condition.

h) In general, product-specific DTC advertisements should not use an actor to portray a health care professional who promotes the drug or implantable medical device product, because this portrayal may be misleading and deceptive. If actors portray health care professionals in DTC advertisements, a disclaimer should be prominently displayed.

i) The use of actual health care professionals, either practicing or retired, in DTC to endorse a specific drug or implantable medical device product is discouraged but if utilized, the advertisement must include a clearly visible disclaimer that the health care professional is compensated for the endorsement.

j) The advertisement should be targeted for placement in print, broadcast, or other electronic media so as to avoid audiences that are not age appropriate for the messages involved.

k) In addition to the above, the advertisement must comply with all other applicable Food and Drug Administration (FDA) regulations, policies and guidelines.

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

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

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

5. DTC advertisements for newly approved prescription drug or implantable medical device products not be run until physicians have been appropriately educated about the drug or implantable medical device.

   The time interval for this moratorium on DTC for newly approved drugs or implantable medical devices should be determined by the FDA, in negotiations with the drug or medical device product's sponsor, at the time of drug or implantable medical device approval. The length of the moratorium may vary from drug to drug and device to device depending on various factors, such as: the innovative nature of the drug or implantable medical device; the severity of the disease that the drug or implantable medical device is intended to treat; the availability of alternative therapies; and the intensity and timeliness of the education about the drug or implant-able medical device for physicians who are most likely to prescribe it.

Position Statement

American Psychiatric Association

DIRECT TO CONSUMER ADVERTISING

The American Psychiatric Association opposes any direct to consumer advertising of medications for the purpose of treating psychiatric disorders. The American Psychiatric Association does not support direct to consumer advertising of any prescription medications.

Attachment A

Position Statement on Direct-to-Consumer (DTC) Advertising of Prescription Drugs and Implantable Devices
Adoption of AMA Policy H-105.988
Approved by the Board, December 2010
Approved by the Assembly, November 2010

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

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

It is the policy of our AMA:

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

a) The advertisement should be indication-specific and enhance consumer education about both the drug or implantable medical device, and the disease, disorder, or condition for which the drug or device is used.

b) In addition to creating awareness about a drug or implantable medical device for the treatment or prevention of a disease, disorder, or condition, the advertisement should convey a clear, accurate and responsible health education message by providing objective information about the benefits and risks of the drug or implantable medical device for a given indication. Information about benefits should reflect the true efficacy of the drug or implantable medical device as determined by clinical trials that resulted in the drug's or device's approval for marketing.

c) The advertisement should clearly indicate that the product is a prescription drug or implantable medical to distinguish such advertising from other advertising for nonprescription products.

d) The advertisement should not encourage self-diagnosis and self-treatment, but should refer patients to their physicians for more information. A statement, such as "Your physician may recommend other appropriate treatments," is recommended.

e) The advertisement should exhibit fair balance between benefit and risk information when discussing the use of the drug or implantable medical device product for the disease, disorder, or condition. The amount of time or space devoted to benefit and risk information, as well as its cognitive accessibility, should be comparable.

f) The advertisement should present information about warnings, precautions, and potential adverse reactions associated with the drug or implantable medical device product in a manner (e.g., at a reading grade level) such that it will be understood by a majority of consumers, without distraction of content, and will help facilitate communication between physician and patient.

6. That our AMA opposes any manufacturer (drug or device sponsor) incentive programs for physician prescribing and pharmacist dispensing that are run concurrently with DTC advertisements.

7. That our AMA encourages the FDA, other appropriate federal agencies, and the pharmaceutical and medical device industries to conduct or fund research on the effect of DTC, focusing on its impact on the patient-physician relationship as well as overall health outcomes and cost benefit analyses; research results should be available to the public.

8. That our AMA supports the concept that when companies engage in DTC, they assume an increased for the informational content and an increased duty to warn consumers, and they may lose an element of protection normally accorded under the learned intermediary doctrine.

9. That our AMA encourages physicians to be familiar with the above AMA guidelines for product-specific DTC and with the Council on Ethical and Judicial Affairs (CEJA) Ethical Opinion E-5.015 and to adhere to the ethical guidance provided in that Opinion.

10. That the Congress should request the Agency for Healthcare Research and Quality (AHRQ) to perform periodic evidence-based reviews of DTC in the United States to determine the impact of DTC on health outcomes and the public health. If DTC is found to have a negative impact on health outcomes and is detrimental to the public health, the Congress should consider enacting legislation to increase DTC regulation or, if necessary, to prohibit DTC in some or all media. In such legislation, every effort should be made to not violate protections on commercial speech, as provided by the First Amendment to the U.S. Constitution.

11. That our AMA continues to monitor DTC, including new research findings, and work with the FDA and the pharmaceutical and medical device industries to make policy changes regarding DTC, as necessary.

12. That our AMA supports "help-seeking" or "disease awareness" advertisements (i.e., advertisements that discuss a disease, disorder, or condition and advise consumers to see their physicians, but do not mention a drug or implantable medical device or other medical and are not regulated by the FDA).

(BOT Rep. 38 and Sub. Res. 513, A-99; Reaffirmed: CMS Rep. 9, Amended: Res. 509, and Reaffirmation 1-99; Appended & Reaffirmed: Sub. Res. 503, A-O I; Reaffirmed: Res. 522, A-02; Reaffirmed: Res. 914, 1-02; Reaffirmed: Sub. Res. 504, A-03; Reaffirmation A-04; Reaffirmation A-05; Modified: BOT Rep. 9, A-06; Reaffirmed in lieu of Res. 514, A-07)

Attachment B

Power and Scope of the FDA

The current APA Position Paper depends heavily on the functioning of the FDA in the area of Direct to Consumer advertising. But the FDA actually has limited authority and is not performing adequately in the areas within its scope. From the FDA:

Does the FDA review and approve all advertisements for drugs before their release? **NO**

Does Federal law ban ads for drugs that have serious risks? **NO**

Can the FDA limit the amount of money spent on prescription drug ads? **NO**

Does the FDA work with drug companies to create prescription drug ads? **NO**

Does the FDA approve ads for prescription drugs before they are seen by the public? **NO.**
"*This means that the public may see ads that violate the law before we can stop the ad from appearing or seek corrections to the ad. Consumers should know that they may not necessarily be able to tell whether any specific DTC ad includes false or misleading information.****"***

What are ads not required by the FDA to tell you?

- Cost
- If there is a generic version of the drug
- If there is a similar drug with fewer or different risks that can treat the condition
- If changes in your behavior could help your condition (such as diet and exercise)
- How many people have the condition the drug treats
- How the drug works (its "mechanism of action")
- How quickly the drug works
- How many people who take the drug will be helped by it

Has FDA done research on DTC advertising? **Yes, but**

in the last 10 years, the FDA has not done one controlled study of the effects of Direct to Consumer ads. Their work has been almost exclusively surveys and literature reviews.

Attachment C

FDA Office of Prescription Drug Promotion

	No. Warning Letters	No. Psychotropic Meds
2014	6	0
2013	24	1
2012	28	2
2011	31	1
2010	40	2
4.75 years	129	6

American Psychiatric Association
Action Paper Worksheet
2014 Budget Estimate - AUTHOR/MEMBER PREPARED

Title: 12.A: Direct to Consumer Advertising
Action Paper Author(s): Jeffrey Geller, M.D., MPH, Liaison, American Association of Community Psychiatrists
Contact Information:

2014 Budget Request: ***$*** ***-***

Budget Summary

Number of Component Members:	**0**
Number of Staff:	**0**
Number of Non-Staff:	**0**
Total:	**0**

Travel Expense	**$ -**
Non-Staff Costs	**$ -**
Staff Costs	**$ -**
Conference Calls	**$ -**
Postage	**$ -**
Total Budget Estimate	**$ -**

Travel Budget

	No. of Attendees	No. of Nights	Airfare	Hotel/PD	Meals	Ground Transportation	Total
Meeting 1	-	-	-	-	-	-	-
Meeting 2	-	-	-	-	-	-	-
Meeting 3	-	-	-	-	-	-	-
Meeting 4	-	-	-	-	-	-	-
Meeting 5	-	-	-	-	-	-	-
Total Travel Budget		**-**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**

Other Non-staff Budget Items

	Description		Cost
1		-	$ -
2		-	$ -
3		-	$ -
4		-	$ -
5		-	$ -
	Total Other Non-Staff Budget Items:		**$ -**

Staff Costs

						Total
Existing:	Salary	$ -	Fringe	$ -	$	-
New / PT:	Salary	$ -	Fringe	$ -	$	-
Space:	If each new/PT staff >.5 FTE, add $40K each				$	-
				Total Staff Cost	**$**	**-**

Conference Calls and Postage Budget

Conference Calls:

No. of Calls	0
Average Cost	$ 170.00
Total Conference Calls	**$ -**

Mailing and Postage:

Overnight/ 2nd Day Packages:	
No. of Mailings	0
Quantity Mailed	0
Cost Per Package	$ 30.00
Sub total of Overnight/2nd Day Packages:	$ -
Other Regular Postage:	$ -
Total Mailing and Postage	**$ -**

American Psychiatric Association
Action Paper Worksheet
2014 Budget Estimate - STAFF PREPARED

Title: 12.A: Direct to Consumer Advertising
Action Paper Author(s): Jeffrey Geller, M.D., MPH, Liaison, American Association of Community Psychiatrists
Staff: Deana McRae
Contact Information: 703-907-8643

2014 Budget Request: $ 700.00

Budget Summary

Number of Component Members:	**0**
Number of Staff:	**0**
Number of Non-Staff:	**0**
Total:	**0**

Travel Expense	**$**	**-**
Non-Staff Costs	**$**	**-**
Staff Costs	**$**	**700.00**
Conference Calls	**$**	**-**
Postage	**$**	**-**
Total Budget Estimate	**$**	**700.00**

Travel Budget

	No. of Attendees	No. of Nights	Airfare	Hotel/PD	Meals	Ground Transportation	Total
Meeting 1	-	-	-	-	-	-	-
Meeting 2	-	-	-	-	-	-	-
Meeting 3	-	-	-	-	-	-	-
Meeting 4	-	-	-	-	-	-	-
Meeting 5	-	-	-	-	-	-	-
Total Travel Budget		**-**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**

Other Non-staff Budget Items

	Description		Cost
1		-	$ -
2		-	$ -
3		-	$ -
4		-	$ -
5		-	$ -
	Total Other Non-Staff Budget Items:		**$ -**

Staff Costs

						Total
Existing:	Salary	$ 538.46	Fringe	$ 161.54	$	700.00
New / PT:	Salary	$ -	Fringe	$ -	$	-
Space:	If each new/PT staff >.5 FTE, add $40K each				$	-
				Total Staff Cost	**$**	**700.00**

Conference Calls and Postage Budget

Conference Calls:

No. of Calls	0
Average Cost	$ 170.00
Total Conference Calls	**$ -**

Mailing and Postage:

Overnight/ 2nd Day Packages:		
No. of Mailings		0
Quantity Mailed		0
Cost Per Package		$ 30.00
Sub total of Overnight/2nd Day Packages:		$ -
Other Regular Postage:		$ -
Total Mailing and Postage		**$ -**

12.A Staff Comments:

As the author indicated, the action paper would require minimum cost for the APA. The addition to the estimated cost consists of staff labor for approximately 15 hours. APA staff would provide the labor associated with researching background information and recent AMA activity; in addition to the administrative labor for sunsetting, adopting, and governance logistics

Attachment #2
Item 2014A2 12.B
Assembly
November 7-9, 2014

ACTION PAPER
FINAL

TITLE: E-prescribing of Controlled Substances

WHEREAS:
Providing the appropriate standard of care to our patients may include the prescribing of controlled substances;

As with all other prescribed medications, there are certain advantages for patients, providers, and pharmacies that come with electronic prescriptions and this practice is currently the most popular means of prescribing in this country.

On June 1, 2010, the DEA's Interim Final Rule titled "Electronic Prescriptions for Controlled Substances" became effective and revised DEA regulations to provide practitioners with the option of writing prescriptions for controlled substances electronically.

As of 9/1/14, 49 states have adopted regulatory status to allow for the e-prescribing of controlled substances (stats unclear in MT, CIII-V in KS and VT, CII-V in all other states).

The process of e-prescribing controlled substances requires a higher level of authentication and security on both the sending side (e-prescribing module often bundled with EHR) and the receiving side (pharmacy). This technology currently exists and is in place with certain e-prescribing vendors and pharmacies including many of the larger national pharmacy chains.

The inability for most patients, pharmacists, and physicians to have the option for the advantages of e-prescribed controlled substances is neither a legal nor an undue technologic matter.

BE IT RESOLVED:
1. That the APA refer this issue to our delegation to the AMA to support the option for electronically prescribed controlled substances as aligned with federal regulations and express the importance of adopting such standards to allow for this to the relevant components of the e-prescribing chain.
2. The APA will develop a position statement supporting the options of electronic prescribing of controlled substances.

AUTHOR:
Jacob Behrens, M.D., ECP Deputy Representative, Area 4

ESTIMATED COST:
Author: $8,000
APA: $2,080

ESTIMATED SAVINGS: None

ESTIMATED REVENUE GENERATED: None

ENDORSED BY: Assembly Committee of Early Career Psychiatrists

KEY WORDS: e-prescribing, controlled substances

APA STRATEGIC GOAL: Advocating for the Patient, Advocating for the Profession

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

American Psychiatric Association
Action Paper Worksheet
2014 Budget Estimate - AUTHOR/MEMBER PREPARED

Title: 12.B: E-prescribing of Controlled Substances
Action Paper Author(s): Jacob Behrens, M.D., ECP Deputy Representative, Area 4
Contact Information: behrens.jake@gmail.com 920.450.4947

2014 Budget Request: $ 8,000.00

Budget Summary

Number of Component Members:	**0**
Number of Staff:	**0**
Number of Non-Staff:	**0**
Total:	**0**

Travel Expense	**$ -**
Non-Staff Costs	**$ 8,000.00**
Staff Costs	**$ -**
Conference Calls	**$ -**
Postage	**$ -**
Total Budget Estimate	**$ 8,000.00**

Travel Budget

	No. of Attendees	No. of Nights	Airfare	Hotel/PD	Meals	Ground Transportation	Total
Meeting 1	-	-	-	-	-	-	-
Meeting 2	-	-	-	-	-	-	-
Meeting 3	-	-	-	-	-	-	-
Meeting 4	-	-	-	-	-	-	-
Meeting 5	-	-	-	-	-	-	-
Total Travel Budget			**-**	**$ -**	**$ -**	**$ -**	**$ -**

Other Non-staff Budget Items

	Description		Cost
1	staff time to draft policy and expressing to outside groups		$ 8,000.00
2		-	$ -
3		-	$ -
4		-	$ -
5		-	$ -
	Total Other Non-Staff Budget Items:		**$ 8,000.00**

Staff Costs

						Total
Existing:	Salary	$ -	Fringe	$ -	$	-
New / PT:	Salary	$ -	Fringe	$ -	$	-
Space:	If each new/PT staff >.5 FTE, add $40K each				$	-
				Total Staff Cost	**$**	**-**

Conference Calls and Postage Budget

Conference Calls:

No. of Calls	0
Average Cost	$ 170.00
Total Conference Calls	**$ -**

Mailing and Postage:

Overnight/ 2nd Day Packages:	
No. of Mailings	0
Quantity Mailed	0
Cost Per Package	$ 30.00
Sub total of Overnight/2nd Day Packages:	$ -
Other Regular Postage:	$ -
Total Mailing and Postage	**$ -**

American Psychiatric Association
Action Paper Worksheet
2014 Budget Estimate - STAFF PREPARED

Title: 12.B: E-prescribing of Controlled Substances
Action Paper Author(s): Jacob Behrens, M.D., ECP Deputy Representative, Area 4
Staff: Beatice Eld
Contact Information: 703-907-8598/beld@psych.org

2014 Budget Request: $ 2,080.00

Budget Summary

Number of Component Members:	**0**
Number of Staff:	**0**
Number of Non-Staff:	**0**
Total:	**0**

Travel Expense	**$**	**-**
Non-Staff Costs	**$**	**-**
Staff Costs	**$**	**1,400.00**
Conference Calls	**$**	**680.00**
Postage	**$**	**-**
Total Budget Estimate	**$**	**2,080.00**

Travel Budget

	No. of Attendees	No. of Nights	Airfare	Hotel/PD	Meals	Ground Transportation	Total
Meeting 1	-	-	-	-	-	-	-
Meeting 2	-	-	-	-	-	-	-
Meeting 3	-	-	-	-	-	-	-
Meeting 4	-	-	-	-	-	-	-
Meeting 5	-	-	-	-	-	-	-
Total Travel Budget		**-**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**

Other Non-staff Budget Items

	Description		Cost
1		-	$ -
2		-	$ -
3		-	$ -
4		-	$ -
5		-	$ -
	Total Other Non-Staff Budget Items:		**$ -**

Staff Costs

						Total
Existing:	Salary	$ 1,076.92	Fringe	$ 323.08	$	1,400.00
New / PT:	Salary	$ -	Fringe	$ -	$	-
Space:	If each new/PT staff >.5 FTE, add $40K each				$	-
				Total Staff Cost	**$**	**1,400.00**

Conference Calls and Postage Budget

Conference Calls:

No. of Calls	4
Average Cost	$ 170.00
Total Conference Calls	**$ 680.00**

Mailing and Postage:

Overnight/ 2nd Day Packages:	
No. of Mailings	0
Quantity Mailed	0
Cost Per Package	$ 30.00
Sub total of Overnight/2nd Day Packages:	$ -
Other Regular Postage:	$ -
Total Mailing and Postage	**$ -**

12.B Staff Comments:

The staff cost estimate assumes that several members of the Council on Addiction Psychiatry will meet by conference call up to 4 times to draft an APA position statement on E-prescribing of controlled substances. The input of other appropriate Councils will be invited.

Staff will schedule the meetings, prepare and circulate drafts, and facilitate the approval of the full Council.

Attachment #3
Item 2014A2 12.C
Assembly
November 7-9, 2014

ACTION PAPER
FINAL

TITLE: Telepsychiatry

WHEREAS:
Technology has evolved to the point where secure and confidential psychiatric care can effectively and efficiently be delivered through computerized interactive video connections;

There exist restrictions, limitations and impediments to the full deployment and use of this technology;

There exist problems with access to general and specialty psychiatric care as well as regional distribution issues;

Telepsychiatry has the potential to deliver psychiatric care to underserved areas and populations;

The American Medical Association House of Delegates has recently approved guiding principles on telemedicine which may not be appropriate to telepsychiatry;

Numerous states are in the process of drafting legislation regarding telepsychiatry and their efforts would benefit from standardization;

BE IT RESOLVED:
That the Council on Quality Care be charged to develop and recommend a plan to the Board of Trustees facilitating the defining of, adoption and use of telepsychiatry, including but not limited to research priorities, standardization of regulation, training, development of evidence based treatment guidelines, resolution of impediments, and addressing incentives/disincentives to its adoption.

That the Board of Trustees of the American Psychiatric Association act to review, revise, approve and implement said plan.

AUTHOR:
Ronald M. Burd, M.D., DFAPA, Representative, North Dakota Psychiatric Society

ESTIMATED COST:
Author: $1,953.34
APA: $3,380

ESTIMATED SAVINGS: APA minimal

ESTIMATED REVENUE GENERATED: APA: Minimal. Membership value: Positive. Members: Potentially substantial.

ENDORSED BY: Area 4 Council (in principle)

KEY WORDS: telepsychiatry, telemedicine, access to care

APA STRATEGIC GOAL: Advocating for the Profession, Advocating for the Patient
REVIEWED BY RELEVANT APA COMPONENT:
Council on Quality Care, Committee on Mental Health Information Technology: Their comments are below, noting that developing the plan is a relatively low cost item, but that implementation is likely to require substantially higher resources including possibly full-time staff and consultants.

Comments of Steve Daviss, M.D., Chair of Committee on Mental Health Information Technology (CMHIT): Great to see a desire to standardize around telepsychiatry. This will be a huge lift, of course, impacting standards of care, regulations (state, national), health IT (EHRs, HIEs, documentation, technology), government relations, billing, etc. My concern would be for having the bandwidth to develop this in a reasonable timeframe using our current committee structure, whether if falls to CMHIT or to the Council on Quality Care. It is certainly an endeavour that is needed, but we'd need a full-time APA staff person, preferably a psychiatrist with relevant experience, to pull it all together and keep us on track, in my opinion, with another FT support person. So, BOT would need to commit resources to make it happen.
More thoughts...

- AATP (American Association for Technology in Psychiatry), John Luo's (et al) group, has an overlapping interest here.

- Marlene Maheu (from the other APA) has a parallel effort to unite the various mental health orgs around "telemental health." Our committee (i.e., me) is having preliminary discussions with her group. Having different "standards" for telepsychiatry, telemedicine, telemental health, teletherapy ... is where we are heading, though not sure if it's where we want to be. The guild issues combine with healthcare policy, regulatory practicality, payer policies, and clinical and service needs of patients, to make a potentially big mess. First mover advantages are potentially huge, but require a lot of effort.

- This area is of higher interest to younger members, so getting it right, and involving them in the process, should have a positive impact on recruitment and retention of younger members.

- A standards body that involves certification of some sort seems likely to grow out of the regulatory need for bodies that can keep pace with the rapidly changing quality and technical standards in this area. Might be an opportunity to plant a flag AND a revenue center, if not for us then maybe another org.

So, the short version of my comments, after reading through Ron's AP again, is that I would personally fully support the action paper's Resolved, except I point out that the "implementation" part will require more than the Council can manage on its own, so maybe change from "develop and implement a plan" to "develop and recommend a plan to the BOT".

Comments of Joel Yager, M.D., Chair of Council on Quality Care: Suggested refer to Council on Quality Care, rather than the Committee on Mental Health Information Technology and specify that this effort might require additional resources allocated to the Council.

American Psychiatric Association
Action Paper Worksheet
2014 Budget Estimate - AUTHOR/MEMBER PREPARED

Title: 12.C: Telepsychiatry
Action Paper Author(s): Ronald M Burd, M.D., DFAPA, Representative, North Dakota Psychiatric Society
Contact Information: (701) 367-2843/ronald.burd@sanfordhealth.org

2014 Budget Request: $ 1,953.34

Budget Summary

Number of Component Members:	**8**
Number of Staff:	**1**
Number of Non-Staff:	
Total:	**9**

Travel Expense	**$ -**
Non-Staff Costs	**$ -**
Staff Costs	**$ 933.34**
Conference Calls	**$ 1,020.00**
Postage	**$ -**
Total Budget Estimate	**$ 1,953.34**

Travel Budget

	No. of Attendees	No. of Nights	Airfare	Hotel/PD	Meals	Ground Transportation	Total
Meeting 1	-	-	-	-	-	-	-
Meeting 2	-	-	-	-	-	-	-
Meeting 3	-	-	-	-	-	-	-
Meeting 4	-	-	-	-	-	-	-
Meeting 5	-	-	-	-	-	-	-
Total Travel Budget		**-**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**

Other Non-staff Budget Items

	Description		Cost
1		-	$ -
2		-	$ -
3		-	$ -
4		-	$ -
5		-	$ -
	Total Other Non-Staff Budget Items:		**$ -**

Staff Costs

						Total
Existing:	Salary	$718	Fringe	$ 215.39	$	933.34
New / PT:	Salary	$ -	Fringe	$ -	$	-
Space:	If each new/PT staff >.5 FTE, add $40K each				$	-
				Total Staff Cost	**$**	**933.34**

Conference Calls and Postage Budget

Conference Calls:

No. of Calls	6
Average Cost	$ 170.00
Total Conference Calls	**$ 1,020.00**

Mailing and Postage:

Overnight/ 2nd Day Packages:	
No. of Mailings	0
Quantity Mailed	9
Cost Per Package	$ 30.00
Sub total of Overnight/2nd Day Packages:	$ -
Other Regular Postage:	$ -
Total Mailing and Postage	**$ -**

American Psychiatric Association
Action Paper Worksheet
2014 Budget Estimate - STAFF PREPARED

Title: 12.C: Telepsychiatry
Action Paper Author(s): Ronald M Burd, M.D., DFAPA, Representative, North Dakota Psychiatric Society
Staff: Samantha Shugarman
Contact Information: sshugarman@psych.org

2014 Budget Request: $ 3,380.00

Budget Summary

Number of Component Members:	**0**
Number of Staff:	**3**
Number of Non-Staff:	**0**
Total:	**3**

Travel Expense	**$**	**-**
Non-Staff Costs	**$**	**-**
Staff Costs	**$**	**1,680.00**
Conference Calls	**$**	**1,700.00**
Postage	**$**	**-**
Total Budget Estimate	**$**	**3,380.00**

Travel Budget

	No. of Attendees	No. of Nights	Airfare	Hotel/PD	Meals	Ground Transportation	Total
Meeting 1	-	-	-	-	-	-	-
Meeting 2	-	-	-	-	-	-	-
Meeting 3	-	-	-	-	-	-	-
Meeting 4	-	-	-	-	-	-	-
Meeting 5	-	-	-	-	-	-	-
Total Travel Budget		**-**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**

Other Non-staff Budget Items

	Description		Cost
1		-	$ -
2		-	$ -
3		-	$ -
4		-	$ -
5		-	$ -
	Total Other Non-Staff Budget Items:		**$ -**

Staff Costs

						Total
Existing:	Salary	$ 1,292.31	Fringe	$ 387.69	$	1,680.00
New / PT:	Salary	$ -	Fringe	$ -	$	-
Space:	If each new/PT staff >.5 FTE, add $40K each				$	-
				Total Staff Cost	**$**	**1,680.00**

Conference Calls and Postage Budget

Conference Calls:

No. of Calls	10
Average Cost	$ 170.00
Total Conference Calls	**$ 1,700.00**

Mailing and Postage:

Overnight/ 2nd Day Packages:	
No. of Mailings	0
Quantity Mailed	3
Cost Per Package	$ 30.00
Sub total of Overnight/2nd Day Packages:	$ -
Other Regular Postage:	$ -
Total Mailing and Postage	**$ -**

Attachment #4
Item 2014A2 12.D
Assembly
November 7-9, 2014

ACTION PAPER
FINAL

TITLE: Critical Psychiatrist Shortages at Federal Medical Centers

WHEREAS:
Whereas Estelle v Gamble guarantees inmates timely access to treatment by physician without deliberate indifference and

Whereas the Subcommittee on Intellectual Property and Judicial Administration Committee on the Judiciary House of Representative requested an evaluation of the adequacy of the Federal Bureau of Prison's (BOP) medical services and the effectiveness of its medical service's quality assurance program and that report was published on February 10, 1994 and

Whereas the report concluded the BOP does not have the capacity to provide appropriate medical and psychiatric care because it has been unable to recruit and retain qualified health care staff; staffing shortages at the medical centers are chronic and show no sign of improving; and patients are and will continue to be at risk of receiving poor care and

Whereas staffing levels have significantly declined in the 20 years since that report was published and

Whereas 61% of females and 44% of males have mental health problems and

Whereas United States Medical Center for Federal Prisons Springfield has three of seven psychiatry positions filled, Federal Medical Center (FMC) Butner has three of six psychiatry positions filled, FMC Carwell has three of six psychiatry positions filled, FMC Rochester has three of six psychiatry positions filled, and FMC Devens has two of five positions filled to fulfill their mental health missions and

Whereas efforts to recruit new psychiatrists have failed due to the Office of Personnel Management (OPM) failure to respond to the pay differential between community compensation and benefits compared to the federal bureau of prisons and

Whereas current psychiatrists are currently on call for one week periods every three weeks without compensation and

Whereas at one-third of the thirty-five current full-time psychiatrists are mandated to retired within the next five years and

Whereas there are active lawsuits related to the inadequate staff levels within the BOP and the physical and mental harm suffered by inmates who were denied mental health care and

Whereas current lawsuits are challenging the treatment of individuals with mental illness at Administrative Maximum Facility (ADX) Florence, where media coverage uncovered evidence of

psychotic patients who engaged in serious self-injurious behaviors or ate their own feces, along with at least one suicide and

Whereas the leadership of the Bureau of Prisons has failed to address the shortage of psychiatrists and its potential impact upon the safety of the patient within the BOP and

BE IT RESOLVED:

Be It Resolved that the American Psychiatric Association's Council on Advocacy and Government Relations design and implement a plan to best address the compensation and benefits of Bureau of Prisons psychiatrists that is substantially below community levels including other federally employed physicians as it prevents recruitment and retention of medical providers.

AUTHOR:
Dionne Hart, M.D., Representative, Minnesota Psychiatric Society

ESTIMATED COST:
Author: $2,174
APA: $11,040.67

ESTIMATED SAVINGS: $0

ESTIMATED REVENUE GENERATED: $0

ENDORSED BY: Area 4

KEY WORDS: Correctional psychiatry, psychiatry shortage, CME restrictions

APA STRATEGIC GOAL: Advocating for the Profession, Supporting Education, Training and Career Development

REVIEWED BY RELEVANT APA COMPONENT
Council on Psychiatry and Law: Chair was ok with the paper.

American Psychiatric Association
Action Paper Worksheet
2014 Budget Estimate - AUTHOR/MEMBER PREPARED

Title: 12.D: Critical Psychiatrist Shortages at Federal Medical Centers
Action Paper Author(s): Dionne Hart, M.D., Representative, Minnesota Psychiatric Society
Contact Information: dionnehart@charter.net

2014 Budget Request: $ 2,174.00

Budget Summary

Number of Component Members:	**1**
Number of Staff:	**1**
Number of Non-Staff:	**0**
Total:	**2**

Travel Expense	**$**	**1,834.00**
Non-Staff Costs	**$**	**-**
Staff Costs	**$**	**-**
Conference Calls	**$**	**340.00**
Postage	**$**	**-**
Total Budget Estimate	**$**	**2,174.00**

Travel Budget

	No. of Attendees	No. of Nights	Airfare	Hotel/PD	Meals	Ground Transportation	Total
Meeting 1	2	1	850.00	500.00	284.00	200.00	1,834.00
Meeting 2	-	-	-	-	-	-	-
Meeting 3	-	-	-	-	-	-	-
Meeting 4	-	-	-	-	-	-	-
Meeting 5	-	-	-	-	-	-	-
Total Travel Budget			**850.00**	**$ 500.00**	**$ 284.00**	**$ 200.00**	**$ 1,834.00**

Other Non-staff Budget Items

	Description		Cost
1		-	$ -
2		-	$ -
3		-	$ -
4		-	$ -
5		-	$ -
	Total Other Non-Staff Budget Items:		**$ -**

Staff Costs

						Total
Existing:	Salary	$ -	Fringe	$ -		$ -
New / PT:	Salary	$ -	Fringe	$ -		$ -
Space:	If each new/PT staff >.5 FTE, add $40K each					$ -
					Total Staff Cost	**$ -**

Conference Calls and Postage Budget

Conference Calls:

No. of Calls	2
Average Cost	$ 170.00
Total Conference Calls	**$ 340.00**

Mailing and Postage:

Overnight/ 2nd Day Packages:		
No. of Mailings		0
Quantity Mailed		2
Cost Per Package	$	30.00
Sub total of Overnight/2nd Day Packages:	$	-
Other Regular Postage:	$	-
Total Mailing and Postage	**$**	**-**

American Psychiatric Association
Action Paper Worksheet
2014 Budget Estimate - STAFF PREPARED

Title: 12.D: Critical Psychiatrist Shortages at Federal Medical Centers
Action Paper Author(s): Dionne Hart, M.D., Representative, Minnesota Psychiatric Society
Staff: Deana McRae
Contact Information: 703-907-8643

2014 Budget Request: $ 11,040.67

Budget Summary

Number of Component Members:	**0**
Number of Staff:	**0**
Number of Non-Staff:	**0**
Total:	**0**

Travel Expense	**$ 1,834.00**
Non-Staff Costs	**$ -**
Staff Costs	**$ 8,866.67**
Conference Calls	**$ 340.00**
Postage	**$ -**
Total Budget Estimate	**$ 11,040.67**

Travel Budget

	No. of Attendees	No. of Nights	Airfare	Hotel/PD	Meals	Ground Transportation	Total
Meeting 1	2	1	850.00	500.00	284.00	200.00	1,834.00
Meeting 2	-	-	-	-	-	-	-
Meeting 3	-	-	-	-	-	-	-
Meeting 4	-	-	-	-	-	-	-
Meeting 5	-	-	-	-	-	-	-
Total Travel Budget			**850.00**	**$ 500.00**	**$ 284.00**	**$ 200.00**	**$ 1,834.00**

Other Non-staff Budget Items

	Description		Cost
1		-	$ -
2		-	$ -
3		-	$ -
4		-	$ -
5		-	$ -
	Total Other Non-Staff Budget Items:		**$ -**

Staff Costs

						Total
Existing:	Salary	$ 6,820.51	Fringe	$ 2,046.15	$	8,866.67
New / PT:	Salary	$ -	Fringe	$ -	$	-
Space:	If each new/PT staff >.5 FTE, add $40K each				$	-
				Total Staff Cost	**$**	**8,866.67**

Conference Calls and Postage Budget

Conference Calls:

No. of Calls	2
Average Cost	$ 170.00
Total Conference Calls	**$ 340.00**

Mailing and Postage:

Overnight/ 2nd Day Packages:		
No. of Mailings		0
Quantity Mailed		0
Cost Per Package		$ 30.00
Sub total of Overnight/2nd Day Packages:		$ -
Other Regular Postage:		$ -
Total Mailing and Postage		**$ -**

12.D Staff Comments:

The author specified an estimated cost for the actions, including two conference calls and expenses for two APA members to participate in a Hill fly-in. The staff estimate is a fair greater amount due to cost of staff labor required to accomplish the task of the action paper. The action paper requests for APA to lobby the issue to both chambers of Congress and three federal agencies. The staff labor estimated will consist of staff lobbying hours, briefing material development, membership preparation, and an overall APA grassroots campaign.

Attachment #5
Item 2014A2 12.E
Assembly
November 7-9, 2014

ACTION PAPER
FINAL

TITLE: EHR for Psychiatrists

WHEREAS:

Whereas, APA Members and non-members are interested in concrete benefits of APA Membership,

Whereas, APA Members are under pressure from several sectors to adopt EHR,

Whereas, the APA Staff, in comments to the original Action Paper 12E eloquently described the complexities of choosing an EHR,

Whereas, most members of the APA lack Internet Technology and Business expertise, and are unable to properly evaluate the multiple products available,

Whereas, most EHR's are not "psychiatry friendly,"

Whereas, EHR vendors do not have long term business stability,

Whereas, EHR vendors with larger psychiatry clienteles would be more capable of maintaining and supporting their product,

Whereas, the APA has vetted and sponsored other programs beneficial to members such as malpractice insurance,

Whereas, the Texas Medical Association has successfully undergone a similar process of endorsing vendors for their members which include four companies,

Whereas, similar activities involving medical association in North Carolina are also successful in the general medical community,

BE IT RESOLVED:

1. That the APA Administration assist the Committee on Mental Health Information Technology to explore the feasibility of sending out a Request for Proposal to EHR vendors for psychiatry friendly EHRs with the goal of identifying and/or fostering development of one or more products for consideration by members.
2. That the APA Administration report their progress to the Assembly via the Assembly listserv by March 1, 2015.

AUTHORS:
Elias H. Sarkis, MD, DFAPA, Representative, Florida Psychiatric Society
John T. Bailey, DO, DFAPA, Representative, Florida Psychiatric Society

ESTIMATED COST:
Author: $ 92,280
APA: Cost Prohibitive

ESTIMATED SAVINGS:

ESTIMATED REVENUE GENERATED: $150,000.00

ENDORSED BY:

KEY WORDS: Electronic Health Records

APA STRATEGIC GOAL: Advocating for Patients, Advocating for the Profession
Defining and Supporting Professional Values

REVIEWED BY RELEVANT APA COMPONENT:

American Psychiatric Association
Action Paper Worksheet
2014 Budget Estimate - AUTHOR/MEMBER PREPARED

Title: 12.E: EHR for Psychiatrists
Action Paper Author(s): Elias H. Sarkis, M.D., Representative, Florida Psychiatric Society
Contact Information: (352) 514-2800; eliassarkis@gmail.com AND jtbaileydo@gmail.com

2014 Budget Request: ***$*** ***-***

Budget Summary

Number of Component Members:	
Number of Staff:	
Number of Non-Staff:	**0**
Total:	**0**

Travel Expense	**$ -**
Non-Staff Costs	**$ -**
Staff Costs	
Conference Calls	**$ -**
Postage	**$ -**
Total Budget Estimate	**$ -**

Travel Budget

	No. of Attendees	No. of Nights	Airfare	Hotel/PD	Meals	Ground Transportation	Total
Meeting 1	-	-	-	-	-	-	-
Meeting 2	-	-	-	-	-	-	-
Meeting 3	-	-	-	-	-	-	-
Meeting 4	-	-	-	-	-	-	-
Meeting 5	-	-	-	-	-	-	-
Total Travel Budget		**-**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**

Other Non-staff Budget Items

	Description		Cost
1		-	$ -
2		-	$ -
3		-	$ -
4		-	$ -
5		-	$ -
	Total Other Non-Staff Budget Items:		**$ -**

Staff Costs

						Total
Existing:	Salary	$ 70,000.00	Fringe	$ 21,000.00	$	91,000.00
New / PT:	Salary	$ -	Fringe	$ -	$	-
Space:	If each new/PT staff >.5 FTE, add $40K each				$	-
				Total Staff Cost	**$**	**91,000.00**

Conference Calls and Postage Budget

Conference Calls:
No. of Calls
Average Cost
Total Conference Calls **$ -**

Mailing and Postage:
Overnight/ 2nd Day Packages:
No. of Mailings
Quantity Mailed
Cost Per Package
Sub total of Overnight/2nd Day Packages: $ -

Other Regular Postage: $ -
Total Mailing and Postage **$ -**

American Psychiatric Association
Action Paper Worksheet
2014 Budget Estimate - STAFF PREPARED

Title: 12.E: EHR for Psychiatrists
Action Paper Author(s): Elias H. Sarkis, M.D., Representative, Florida Psychiatric Society
Staff: William Narrow, MD, MPH; Lisa Greiner
Contact Information: X8628 wnarrow@psych.org; X8624 lgreiner@psych.org

2014 Budget Request: ***$ -***

Budget Summary

Number of Component Members:	**0**
Number of Staff:	**0**
Number of Non-Staff:	**0**
Total:	**0**

Travel Expense	**$ -**
Non-Staff Costs	**$ -**
Staff Costs	
Conference Calls	**$ -**
Postage	**$ -**
Total Budget Estimate	**$ -**

Travel Budget

	No. of Attendees	No. of Nights	Airfare	Hotel/PD	Meals	Ground Transportation	Total
Meeting 1	-	-	-	-	-	-	-
Meeting 2	-	-	-	-	-	-	-
Meeting 3	-	-	-	-	-	-	-
Meeting 4	-	-	-	-	-	-	-
Meeting 5	-	-	-	-	-	-	-
Total Travel Budget		**-**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**

Other Non-staff Budget Items

	Description		Cost
1	Note: further costs may be associated with this paper if implemented.		$ -
2		-	$ -
3		-	$ -
4		-	$ -
5		-	$ -
	Total Other Non-Staff Budget Items:		**$ -**

Staff Costs

					Total
Existing:	Salary		Fringe	$ -	$ -
New / PT:	Salary	$ -	Fringe	$ -	$ -
Space:	If each new/PT staff >.5 FTE, add $40K each				$ -
				Total Staff Cost	**$ -**

Conference Calls and Postage Budget

Conference Calls:

No. of Calls	0
Average Cost	$ 170.00
Total Conference Calls	**$ -**

Mailing and Postage:

Overnight/ 2nd Day Packages:		
No. of Mailings		0
Quantity Mailed		0
Cost Per Package		$ 30.00
Sub total of Overnight/2nd Day Packages:		$ -
Other Regular Postage:		$ -
Total Mailing and Postage		**$ -**

12.E Staff Comments:

1. Note on Costs: No staff budget estimate has been prepared. The cost of developing and maintaining an EHR includes the following components:

a) Determine the requirements and laws that need to be satisfied by the EHR.
b) Determine the hardware platforms that would be supported.
c) Determine which e-prescribing software to integrate into the EHR.
d) Develop high level and detailed designs, including database structures.
e) Write software code.
f) **Extensively** test the code.
g) Determine how the software is going to be distributed and develop a mechanism to do so.
h) Implement the data servers and other hardware that would be needed.
i) Maintain a staff to maintain the code as problems arise and need to be fixed, as well as incorporating additional requirements into the software as they are identified.
j) Maintain a robust technical support and customer service staff.

At this point, it would be impossible to provide even a close estimate of the total cost of the components listed above without a much more extensive investigation involving the expertise of organizations and individuals beyond APA staff.

2. Staff would like to point out that two of the "Whereas" statements are of questionable accuracy:

"None are specific to psychiatry and none have enough of a market presence to ensure market stability"

"Most available systems are prohibitively expensive for small practices"

To use one prominent example, Valant Medical Solutions has been in existence since 2005 and its website reports 5,000 users as of July 2014 which includes psychiatrists, psychologists, nurse practitioners, and mental health billers. During that month, they also reported receiving 11 million dollars in private equity funding. Valant Medical Solutions is very stable and their long term viability does not appear to be a concern. Valant is one example and information about other EHRs is available to psychiatrists on the AmericanEHR website. APA contributed 20 specialty questions to this survey concerning the needs of psychiatrists. While some EHRs are expensive for small practices, there are several free or low cost EHRs (including ICANotes, Valant, Practice Fusion, DocuTrac, RxNT, and TheraManager) that address the needs of psychiatry.

3. There are several potential problems with the APA directly supporting the development of and endorsing a psychiatry-specific EHR:

a) It would stifle competition which is important in terms of maximizing functionality and maintaining a reasonable cost for psychiatrists.
b) It would garner much animosity toward APA from other vendors who already have EHRs which support psychiatry to some degree. It would also be "reinventing the wheel" to some extent.
c) There is a lot more involved in developing an EHR than creating the software. For example, EHRs need to support interoperability with other software applications,

especially. e-prescribing software, and keep up with the ongoing need to support additional functionality as it is identified and possibly required by new federal laws. In addition, individual states can have their own requirements which often differ from state to state.

d) The provision of EHR software also includes having staffing for robust customer service and technical support which is absolutely essential. In addition, patient data would need to be stored somewhere which is now typically in the "cloud" on remote servers.

4. More optimal solutions to increase the availability of EHRs which support psychiatry: It is apparent from the above that the APA would need to contract with a vendor not only to develop the EHR, but to distribute, maintain, and support the members who buy it which is problematic for the reasons mentioned. However, there are other activities that can be undertaken with the support of the APA which can substantially assist the membership in gaining access to EHRs which better satisfy their needs at a reasonable cost.

a) Closer Interaction with Vendors. The Committee on Mental Health Information Technology (CMHIT) hosted a webinar in June for vendors with two main purposes: 1) Identify the potential market for EHRs which support the mental health field, and 2) Acquaint them with various computer-related activities which could potentially help them better support mental health. Representatives from various organizations were involved, including SAMHSA and HL7. In the near future, the Committee is planning on hosting additional webinars for small groups of vendors to have a more open-ended discussion on how they can optimally support mental health applications, the impediments that are preventing them from doing so, and how the APA and other professional organizations can best help them achieve that goal. This will also be an opportunity for the APA to convey to the vendors the problems that their membership has been having with existing EHRs and begin the work to resolve them.

b) Consolidate Existing Psychiatry/Mental Health EHR Requirements. There are currently three sets of such requirements created by the CMHIT, the Certification Commission for Healthcare Information Technology (CCHIT), and Health Level 7 (HL7). Work will shortly begin within HL7 to consolidate these requirements, upgrade HL7's Behavioral Health Functional Profile to support the latest release of their EHR Functional Model on which it is based, and develop a structure for expanding support for requirements from additional mental health settings. This work will be done, in part, by representatives from SAMHSA and the CMHIT who are also members of HL7. The ultimate goal is to develop a database which vendors can use to identify which requirements their software needs to support and then indicate which of those requirements they have, in fact, incorporated into their products, as well as for mental health providers to identify which vendors have products which support the requirements they need.

c) Develop Closer Ties with Other Mental Health Professional Organizations: The CMHIT and SAMHSA have had preliminary discussions on convening representatives from various mental health professional organizations to discuss how best to work with vendors to have the vendors support all segments of the mental health field. Mental health, more so than most other areas of health care, involves

many different types of professionals. Optimal patient care by psychiatrists often requires their interaction with not only other mental health professionals, but primary care practitioners as well. It would be very short-sighted of the APA if, with regard to EHRs, it only considered the needs of psychiatrists.

Attachment #6
Item 2014A2 12.G
Assembly
November 7-9, 2014

ACTION PAPER

TITLE: Integrating Buprenorphine Maintenance Therapy with Mental Health

WHEREAS:

1. Opioid use disorders are reaching epidemic proportions in many areas of the United States, resulting in significant mortality and morbidity.
2. Buprenorphine is an effective maintenance treatment for opioid use disorders that has many advantages over methadone treatment. Patients are not required to attend a clinic every day, thus increasing their occupational potential, reducing stigma, and reducing contact with other opioid users. Buprenorphine does not produce opioid intoxication symptoms to the same degree that methadone does, and buprenorphine alone or in combination with other opioids is much less likely to lead to fatal overdoses than methadone. As such, increasing numbers of opioids users are seeking buprenorphine treatment.
3. The number of buprenorphine providers in many areas falls below patient demand for such services. This results in many patients continuing to use street opioids rather than buprenorphine to avoid withdrawals, with significant ongoing mortality and morbidity.
4. The majority of buprenorphine prescriptions currently being written are by non-psychiatrists, many of whom will only accept patients that are able to pay out of pocket. Furthermore, the treatment for co-morbid psychiatric disorders is deferred to the patient's outpatient psychiatrist, translating into additional costs for an already vulnerable patient population. As such, patients may be forced to choose between treatment for their primary mental health disorders or their opioid dependence.
5. Such separation of mental health care from substance use treatment may reflect psychiatrists' own biases, personal discomfort with the treatment of substance use disorders or an attempt to profit from this desperate and treatment seeking patient population.

BE IT RESOLVED:

That APA create a task force composed of appropriate council membership to focus on issues salient to integrated Substance Use Disorders and MI treatment including buprenorphine therapy.

AUTHORS:
Elie G. Aoun M.D., RFM Representative, Area 1
Loreen Pirnie M.D., RFM Deputy Representative, Area 1
Anish Dube M.D., APA Member

ESTIMATED COST:
Author: $340
APA: $2,610

ESTIMATED SAVINGS:

ESTIMATED REVENUE GENERATED:

ENDORSED BY: ACORF, Council on Addiction Psychiatry, Area 1

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

APA STRATEGIC GOAL: Advocating for Patients, Advocating for the Profession, Supporting Education, Training and Career Development

REVIEWED BY RELEVANT APA COMPONENT: Council on Addiction Psychiatry

American Psychiatric Association
Action Paper Worksheet
2014 Budget Estimate - AUTHOR/MEMBER PREPARED

Title: 12.G: Integrating Buprenorphine Maintenance Therapy With Primary Mental Health
Action Paper Author(s): Elie Aoun, M.D., RFM Representative, Area 1
Contact Information: aoun.elie.g@gmail.com

2014 Budget Request: $ 340.00

Budget Summary

Number of Component Members:	**4**
Number of Staff:	**1**
Number of Non-Staff:	**0**
Total:	**5**

Travel Expense	**$**	**-**
Non-Staff Costs	**$**	**-**
Staff Costs	**$**	**-**
Conference Calls	**$**	**340.00**
Postage	**$**	**-**
Total Budget Estimate	**$**	**340.00**

Travel Budget

	No. of Attendees	No. of Nights	Airfare	Hotel/PD	Meals	Ground Transportation	Total
Meeting 1	-	-	-	-	-	-	-
Meeting 2	-	-	-	-	-	-	-
Meeting 3	-	-	-	-	-	-	-
Meeting 4	-	-	-	-	-	-	-
Meeting 5	-	-	-	-	-	-	-
Total Travel Budget		**-**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**

Other Non-staff Budget Items

	Description		Cost
1		-	$ -
2		-	$ -
3		-	$ -
4		-	$ -
5		-	$ -
	Total Other Non-Staff Budget Items:		**$ -**

Staff Costs

						Total
Existing:	Salary	$ -	Fringe	$ -	$	-
New / PT:	Salary	$ -	Fringe	$ -	$	-
Space:	If each new/PT staff >.5 FTE, add $40K each				$	-
				Total Staff Cost	**$**	**-**

Conference Calls and Postage Budget

Conference Calls:

No. of Calls	2
Average Cost	$ 170.00
Total Conference Calls	**$ 340.00**

Mailing and Postage:

Overnight/ 2nd Day Packages:	
No. of Mailings	0
Quantity Mailed	5
Cost Per Package	$ 30.00
Sub total of Overnight/2nd Day Packages:	$ -
Other Regular Postage:	$ -
Total Mailing and Postage	**$ -**

American Psychiatric Association
Action Paper Worksheet
2014 Budget Estimate - STAFF PREPARED

Title: 12.G: Integrating Buprenorphine Maintenance Therapy With Primary Mental Health
Action Paper Author(s): Elie Aoun, M.D., RFM Representative, Area 1
Staff: Beatrice Eld
Contact Information: 703-907-8598/beld@psych.org

2014 Budget Request: $ 2,610.00

Budget Summary

Number of Component Members:	**4**
Number of Staff:	**1**
Number of Non-Staff:	**0**
Total:	**5**

Travel Expense	**$**	**-**
Non-Staff Costs	**$**	**-**
Staff Costs	**$**	**2,100.00**
Conference Calls	**$**	**510.00**
Postage	**$**	**-**
Total Budget Estimate	**$**	**2,610.00**

Travel Budget

	No. of Attendees	No. of Nights	Airfare	Hotel/PD	Meals	Ground Transportation	Total
Meeting 1	-	-	-	-	-	-	-
Meeting 2	-	-	-	-	-	-	-
Meeting 3	-	-	-	-	-	-	-
Meeting 4	-	-	-	-	-	-	-
Meeting 5	-	-	-	-	-	-	-
Total Travel Budget		**-**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**

Other Non-staff Budget Items

	Description		Cost
1		-	$ -
2		-	$ -
3		-	$ -
4		-	$ -
5		-	$ -
	Total Other Non-Staff Budget Items:		**$ -**

Staff Costs

						Total
Existing:	Salary	$ 1,615.38	Fringe	$ 484.62	$	2,100.00
New / PT:	Salary	$ -	Fringe	$ -	$	-
Space:	If each new/PT staff >.5 FTE, add $40K each				$	-
				Total Staff Cost	**$**	**2,100.00**

Conference Calls and Postage Budget

Conference Calls:

No. of Calls		3
Average Cost	$	170.00
Total Conference Calls	**$**	**510.00**

Mailing and Postage:

Overnight/ 2nd Day Packages:		
No. of Mailings		0
Quantity Mailed		5
Cost Per Package	$	30.00
Sub total of Overnight/2nd Day Packages:	$	-
Other Regular Postage:	$	-
Total Mailing and Postage	**$**	**-**

12.G Staff Comments:

Recommendation #1 - APA waives online course fee for members

Background: The APA offers waiver-eligible buprenorphine training via (1) an online training module, (2) an 8-hour course presented at the APA Annual Meeting, and (3) an 8-hour course presented at the Institute on Psychiatric Services. The courses are identical but the cost of each option varies.

1. **Online Buprenorphine Course: Reporting Period - August 2013 to August 2014**

	Course Fee	Revenue
Resident-Fellow Members	$ 0	-
Member Registration Fee	$100	$13,700
Non-Member Registration Fee	$200	$26,400
TOTAL Revenue		**$40,100**

2. **Buprenorphine Training Offered at APA Annual Meeting**

Comparison of Course Fees: 2013 - 2015

	2013*	2014*	2015
Early Bird – Member	$210	$255	$260
Early Bird – Non Member	N/A*	N/A*	$360
Advance – Member	$300	$305	$310
Advance – Non Member	N/A*	N/A*	$410
Onsite – Member	$340	$345	$330
Onsite – Non Member	N/A*	N/A*	$430
Total Revenue	**$8,850**	**$17,010**	**-**

* Rate structure did not include separate categories for non-members in 2013 and 2014

3. **Buprenorphine Training Offered at Institute on Psychiatric Services**

- Course is included in the general registration fee with no additional charge

Recommendation #4: Develop position statement on integration of SUD treatment with primary mental health.

- A position statement can be developed by the Council on Addiction Psychiatry. The staff cost estimate includes 3 conference calls of a few Council members plus staff time to compile materials, prepare position statement drafts, solicit input, and facilitate Council and JRC approval.

Attachment #7
Item 2014A2 12.N
Assembly
November 7-9, 2014

ACTION PAPER
FINAL

TITLE: Exploration: Whether to Add some Symptoms to the Next DSM

WHEREAS:
1] DSM-5 conditions with a known etiology are not usually syndromes. [Two of thirteen, one of seven, and so forth is not a syndrome.]

2] DSM-5 conditions where the etiology is not stated, are presented as syndromes.

3] When further etiologies are uncovered, there is no reason to believe they will be syndromes like those in DSM-5.

4] Patients often present with an assortment of symptoms that poorly fit DSM-5's syndromes.

5] With almost no exceptions, DSM-5 does not inform the reader of mental symptoms that are used in the rest of medicine.

6] Psychiatrists and other mental health clinicians should not be discouraged from using the symptom designations available in the rest of medicine.

7] Using the symptoms available in the rest of medicine may sometimes better capture the patient's condition than a DSM-5 syndrome.

8] Where data collection is important, useful to have a recognized code for the conditions of interest, which may be a symptom, not a syndrome.

9] The National Center for Health Statistics makes the decisions as to ICD-CM codes.

10] There are already more than two dozen mental symptoms used in the rest of medicine, ICD-9-CM, as listed below alphabetically – but not yet available in DSM-5 as a coded option:

Altered mental status, 780.97
Apathy, 799.25
Attention deficit, 799.51
Cachexia, 799.4
Cognitive deficit, 799.52
Decreased libido, 799.81
Delayed milestones, 783.42
Demoralization 799.25
Emotional lability, 799.24
Excessive crying of adolescent, 780.95
Excessive crying of adult, 780.95
Excessive crying of infant, 780.92
Failure to thrive, adult, 783.7

Failure to thrive, child, 783.41
Fussy infant, 780.91
Hallucinations
    Auditory, 780.1
    Gustatory, 780.1
    Olfactory, 780.1
    Tactile, 780.1
    Visual, 368.16
Impulsivity, 799.23
Irritability, 799.22
Lethargy, 780.79
Memory loss, 780.93
Nervousness, 799.21
Polyphagia, 783.6
Psychomotor deficit, 799.54

BE IT RESOLVED:
1] That the DSM Steering Committee explores adding some mental health symptoms and codes, available to rest of medicine, to the next update of DSM-5

AUTHOR:
Roger Peele, M.D., DLFAPA, Representative, Washington Psychiatric Society

ESTIMATED COST:
Author: $0
APA: $0

ESTIMATED SAVINGS: None

ESTIMATED REVENUE GENERATED: None

ENDORSED BY: Washington Psychiatric Society

KEY WORDS: DSM, Symptoms

APA STRATEGIC GOAL: Enhancing the Scientific Basis of Psychiatric Care

REVIEWED BY RELEVANT APA COMPONENT:

American Psychiatric Association
Action Paper Worksheet
2014 Budget Estimate - AUTHOR/MEMBER PREPARED

Title: 12.N: Exploration: Whether to Add some Symptoms to the Next DSM
Action Paper Author(s): Roger Peele, M.D., DLFAPA, Representative, Washington Psychiatric Society
Contact Information:

2014 Budget Request: ***$*** ***-***

Budget Summary

Number of Component Members:	**0**
Number of Staff:	**0**
Number of Non-Staff:	**0**
Total:	**0**

Travel Expense	**$ -**
Non-Staff Costs	**$ -**
Staff Costs	**$ -**
Conference Calls	**$ -**
Postage	**$ -**
Total Budget Estimate	**$ -**

Travel Budget

	No. of Attendees	No. of Nights	Airfare	Hotel/PD	Meals	Ground Transportation	Total
Meeting 1	-	-	-	-	-	-	-
Meeting 2	-	-	-	-	-	-	-
Meeting 3	-	-	-	-	-	-	-
Meeting 4	-	-	-	-	-	-	-
Meeting 5	-	-	-	-	-	-	-
Total Travel Budget		**-**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**

Other Non-staff Budget Items

	Description		Cost
1		-	$ -
2		-	$ -
3		-	$ -
4		-	$ -
5		-	$ -
	Total Other Non-Staff Budget Items:		**$ -**

Staff Costs

					Total	
Existing:	Salary	$ -	Fringe	$ -	$	-
New / PT:	Salary	$ -	Fringe	$ -	$	-
Space:	If each new/PT staff >.5 FTE, add $40K each				$	-
				Total Staff Cost	**$**	**-**

Conference Calls and Postage Budget

Conference Calls:

No. of Calls	0
Average Cost	$ 170.00
Total Conference Calls	**$ -**

Mailing and Postage:

Overnight/ 2nd Day Packages:	
No. of Mailings	0
Quantity Mailed	0
Cost Per Package	$ 30.00
Sub total of Overnight/2nd Day Packages:	$ -
Other Regular Postage:	$ -
Total Mailing and Postage	**$ -**

American Psychiatric Association
Action Paper Worksheet
2014 Budget Estimate - STAFF PREPARED

Title: 12.N: Exploration: Whether to Add some Symptoms to the Next DSM
Action Paper Author(s): Roger Peele, M.D., DLFAPA, Representative, Washington Psychiatric Society
Staff: William Narrow, MD, MPH; Jennifer Shupinka
Contact Information: wnarrow@psych.org

2014 Budget Request: ***$ -***

Budget Summary

Number of Component Members:	**0**
Number of Staff:	**0**
Number of Non-Staff:	**0**
Total:	**0**

Travel Expense	**$ -**
Non-Staff Costs	**$ -**
Staff Costs	**$ -**
Conference Calls	**$ -**
Postage	**$ -**
Total Budget Estimate	**$ -**

Travel Budget

	No. of Attendees	No. of Nights	Airfare	Hotel/PD	Meals	Ground Transportation	Total
Meeting 1	-	-	-	-	-	-	-
Meeting 2	-	-	-	-	-	-	-
Meeting 3	-	-	-	-	-	-	-
Meeting 4	-	-	-	-	-	-	-
Meeting 5	-	-	-	-	-	-	-
Total Travel Budget		**-**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**

Other Non-staff Budget Items

	Description		Cost
1		-	$ -
2		-	$ -
3		-	$ -
4		-	$ -
5		-	$ -
	Total Other Non-Staff Budget Items:		**$ -**

Staff Costs

					Total
Existing:	Salary $ -		Fringe $ -		$ -
New / PT:	Salary $ -		Fringe $ -		$ -
Space:	If each new/PT staff >.5 FTE, add $40K each				$ -
				Total Staff Cost	**$ -**

Conference Calls and Postage Budget

Conference Calls:

No. of Calls	0
Average Cost	$ 170.00
Total Conference Calls	**$ -**

Mailing and Postage:

Overnight/ 2nd Day Packages:	
No. of Mailings	0
Quantity Mailed	0
Cost Per Package	$ 30.00
Sub total of Overnight/2nd Day Packages:	$ -
Other Regular Postage:	$ -
Total Mailing and Postage	**$ -**

12.N Staff Comments:

APA administration has major concerns about listing conditions from this chapter in the DSM-5. The conditions listed in this action paper are included in the ICD-9-CM chapter entitled, “Symptoms, signs, and ill-defined conditions.” By including these terms, it would appear that APA is endorsing their use. In actuality the use of these terms should be strongly discouraged in favor of providing a DSM-5 diagnosis, even an “unspecified” diagnosis. The addition of these terms to DSM-5 may also bolster the lingering criticisms that DSM is continuously adding new conditions, to the point of pathologizing everyday experiences. These conditions are attached to valid ICD codes and psychiatrists are, of course, free to use them when absolutely necessary, and there may be very rare occasions when they must be used. However, in such rare cases, it does not seem unreasonable to ask psychiatrists to look up the corresponding codes in ICD-9-CM, just as physicians in the rest of medicine.

Attachment #8
Item 2014A2 12.P
Assembly
November 7-9, 2014

ACTION PAPER
FINAL

TITLE: Neurodevelopmental

WHEREAS:

The entity "Neurodevelopmental Disorder associated with Prenatal Alcohol Exposure" is the term used in DSM-5, page 86.

"Neurodevelopmental Disorder associated with Prenatal Alcohol Exposure" is part of the chapter on Neurodevelopment Disorders and its 29 Disorders.

The location of "Neurodevelopmental Disorder associated with Prenatal Alcohol Exposure" in the ICD-9-CM is in section pertaining to developmental disorders.

Inexplicable, the term "Neurobehavioral Disorder associated with Prenatal Alcohol Exposure" is used in DSM-5 on page 798 in DSM-5.

"Neurobehavioral" is an idiosyncratic term not otherwise used in DSM-5.

Unlike "neurodevelopmental," there is no chapter in DSM-5 to place "neurobehavioral."

Unlike "neurodevelopmental," there is no location in ICD-9-CM to place "neurobehavioral."

These patients are broadly impacted by their condition, which is a brain-based phenomenon caused by the effects of alcohol on neural development. It is not accurate to narrow their signs and symptoms to "behavior," a more pejorative choice. We do not need a term that suggests the behavior is bad.,

The medical literature finds greater use of "neurodevelopmental" than "neurobehavioral" and more use of Neurodevelopmental disorder associated with prenatal alcohol exposure" than Neurobehavioral disorder associated with prenatal alcohol exposure" as indicated by a PubMed searches on June 29, 2014:
a] "Neurobehavioral," 449
b] "Neurodevelopmental," 12,891
c] "Neurobehavioral disorder associated with prenatal alcohol exposure," 16
d] "Neurodevelopmental disorder associated with prenatal alcohol exposure," 30.

BE IT RESOLVED:
That future printings of DSM use "Neurodevelopmental Disorder associated with Prenatal Alcohol Exposure" throughout DSM-5.

AUTHORS:
Roger Peele, M.D., DLFAPA, Representative, Washington Psychiatric Society
Susan D. Rich, M.D., MPH, APA Member
Miguel Magsaysay Alampay, M.D., APA Member
Richard Ratner, M.D., Liaison, American Society for Adolescent Psychiatrists
Gustavo Goldstein, M.D., APA Member
Guillermo Olivos, M.D., APA Member
Marilou Tablang-Jimenez, M.D., APA Member
David Zwerdling, M.D., APA Member
Gustave Weiland, M.D., APA Member

ESTIMATED COST:
Authors: Unknown
APA: $340

ESTIMATED SAVINGS: None

ESTIMATED REVENUE GENERATED: Unknown

ENDORSED BY: Washington Psychiatric Society

KEY WORDS: DSM

APA STRATEGIC GOAL: Enhancing the Scientific Basis of Psychiatric Care

REVIEWED BY RELEVANT APA COMPONENT: Sent to Chair, DSM component

American Psychiatric Association
Action Paper Worksheet
2014 Budget Estimate - AUTHOR/MEMBER PREPARED

Title: 12.P: Neurodevelopmental
Action Paper Author(s): Roger Peele, M.D., DLFAPA, Representative, Washington Psychiatric Society
Contact Information: -

2014 Budget Request: $ -

Budget Summary

Number of Component Members:	**0**
Number of Staff:	**0**
Number of Non-Staff:	**0**
Total:	**0**

Travel Expense	**$ -**
Non-Staff Costs	**$ -**
Staff Costs	**$ -**
Conference Calls	**$ -**
Postage	**$ -**
Total Budget Estimate	**$ -**

Travel Budget

	No. of Attendees	No. of Nights	Airfare	Hotel/PD	Meals	Ground Transportation	Total
Meeting 1	-	-	-	-	-	-	-
Meeting 2	-	-	-	-	-	-	-
Meeting 3	-	-	-	-	-	-	-
Meeting 4	-	-	-	-	-	-	-
Meeting 5	-	-	-	-	-	-	-
Total Travel Budget		**-**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**

Other Non-staff Budget Items

	Description		Cost
1		-	$ -
2		-	$ -
3		-	$ -
4		-	$ -
5		-	$ -
	Total Other Non-Staff Budget Items:		**$ -**

Staff Costs

					Total	
Existing:	Salary	$ -	Fringe	$ -	$	-
New / PT:	Salary	$ -	Fringe	$ -	$	-
Space:	If each new/PT staff >.5 FTE, add $40K each				$	-
				Total Staff Cost	**$**	**-**

Conference Calls and Postage Budget

Conference Calls:

No. of Calls	0
Average Cost	$ 170.00
Total Conference Calls	**$ -**

Mailing and Postage:

Overnight/ 2nd Day Packages:	
No. of Mailings	0
Quantity Mailed	0
Cost Per Package	$ 30.00
Sub total of Overnight/2nd Day Packages:	$ -
Other Regular Postage:	$ -
Total Mailing and Postage	**$ -**

American Psychiatric Association
Action Paper Worksheet
2014 Budget Estimate - STAFF PREPARED

Title: 12.P: Neurodevelopmental
Action Paper Author(s): Roger Peele, M.D., DLFAPA, Representative, Washington Psychiatric Society
Staff: William Narrow, MD, MPH; Jennifer Shupinka
Contact Information: wnarrow@psych.org

2014 Budget Request: $ 340.00

Budget Summary

Number of Component Members:	**0**
Number of Staff:	**0**
Number of Non-Staff:	**0**
Total:	**0**

Travel Expense	**$**	**-**
Non-Staff Costs	**$**	**-**
Staff Costs	**$**	**-**
Conference Calls	**$**	**340.00**
Postage	**$**	**-**
Total Budget Estimate	**$**	**340.00**

Travel Budget

	No. of Attendees	No. of Nights	Airfare	Hotel/PD	Meals	Ground Transportation	Total
Meeting 1	-	-	-	-	-	-	-
Meeting 2	-	-	-	-	-	-	-
Meeting 3	-	-	-	-	-	-	-
Meeting 4	-	-	-	-	-	-	-
Meeting 5	-	-	-	-	-	-	-
Total Travel Budget			**-**	**$ -**	**$ -**	**$ -**	**$ -**

Other Non-staff Budget Items

	Description		Cost
1		-	$ -
2		-	$ -
3		-	$ -
4		-	$ -
5		-	$ -
	Total Other Non-Staff Budget Items:		**$ -**

Staff Costs

						Total
Existing:	Salary	$ -	Fringe	$ -	$	-
New / PT:	Salary	$ -	Fringe	$ -	$	-
Space:	If each new/PT staff >.5 FTE, add $40K each				$	-
				Total Staff Cost	**$**	**-**

Conference Calls and Postage Budget

Conference Calls:

No. of Calls		2
Average Cost	$	170.00
Total Conference Calls	**$**	**340.00**

Mailing and Postage:

Overnight/ 2nd Day Packages:		
No. of Mailings		0
Quantity Mailed		0
Cost Per Package	$	30.00
Sub total of Overnight/2nd Day Packages:	$	-
Other Regular Postage:	$	-
Total Mailing and Postage	**$**	**-**

12.P Staff Comments:

The term “Neurobehavioral Disorder Associated with Prenatal Alcohol Exposure” was the term intended for use by the DSM-5 Substance Use Disorders work group. Consideration for a change in the name of this condition should be referred to the DSM-5 Steering Committee.

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.

Attachment #10

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

DRAFT SUMMARY OF ACTIONS

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

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

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

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2014A2 4.B.26	Retain Position Statement: Death Sentences for Persons with Dementia or Traumatic Brain Injury	The Assembly voted, on its Consent Calendar, to retain the Position Statement: *Death Sentences for Persons with Dementia or Traumatic Brain Injury*.	Board of Trustees, December, 2014 FYI- Joint Reference Committee, January 2015 FYI – Melvin Sabshin Library and Archives
2014A2 4.B.27	Retain Position Statement: Mentally Ill Prisoners on Death Row	The Assembly voted, on its Consent Calendar, to retain the Position Statement: *Mentally Ill Prisoners on Death Row*.	Board of Trustees, December, 2014 FYI- Joint Reference Committee, January 2015 FYI – Melvin Sabshin Library and Archives
2014A2 4.B.28	Retain Position Statement: Diminished Responsibility in Capital Sentencing	The Assembly voted, on its Consent Calendar, to retain the Position Statement: *Diminished Responsibility in Capital Sentencing*.	Board of Trustees, December, 2014 FYI- Joint Reference Committee, January 2015 FYI – Melvin Sabshin Library and Archives
2014A2 4.B.29	Retain Position Statement: Endorsement of the Patient-Physician Covenant	The Assembly voted, on its Consent Calendar, to retain the Position Statement: *Endorsement of the Patient-Physician Covenant*.	Board of Trustees, December, 2014 FYI- Joint Reference Committee, January 2015 FYI – Melvin Sabshin Library and Archives
2014A2 4.B.30	Retain Position Statement: Provision of Psychotherapy for Psychiatric Residents	The Assembly voted, on its Consent Calendar, to retain the Position Statement: *Provision of Psychotherapy for Psychiatric Residents*.	Board of Trustees, December, 2014 FYI- Joint Reference Committee, January 2015 FYI – Melvin Sabshin Library and Archives
2014 A2 5.A	Will the Assembly vote to approve the minutes of the May 2-4, 2014, meeting?	The Assembly voted to approve the Minutes & Summary of Actions from the May 2-4, 2014 meeting.	Chief Operating Officer • Association Governance
2014 A2 6.B	Will the Assembly vote to approve the Consent Calendar?	Items 2014A2, 4.B.8, 4.B.14, and 12.L were removed from the consent calendar. The Assembly approved the consent calendar as amended.	Chief Operating Officer • Association Governance
2014 A2 6.C	Will the Assembly vote to approve the Special Rules of the Assembly?	The Assembly voted to approve the Special Rules of the Assembly.	Chief Operating Officer • Association Governance
2014 A2 7.A	The Assembly voted to accept the report of the Nominating Committee.	The Assembly voted to accept the report of the Nominating Committee. The slate of candidates for the May 2015 Assembly election is as follows: Speaker-Elect: Daniel Anzia, M.D., Area 4 Robert Roca, M.D., Area 3 Recorder: Ludmila De Faria, M.D., Area 5 Theresa Miskimen, M.D., Area 3	Chief Operating Officer • Association Governance

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

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

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

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

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

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

EXECUTIVE SUMMARY
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.

JRC Referrals

- [JRC October 11, 2014, 8.C.1]. Rather than rewrite the *Position Statement on Child Abuse and Neglect by Adults* per JRC's request, the Council has opted to create an entirely new and more germane position statement on the issue, that of reporting of suspected child abuse. A first draft of this document has been completed and will be passed on to the Council on Psychiatry and Law for comment, then on to JRC in June. A recommendation will be made to retire the existing policy document on Child Abuse and Neglect by Adults at that time.
- [JRC October 11, 2014, 8.C.2]. The Council has drafted an improved version of the *Position Statement on College Mental Health* per JRC's directive to thoroughly edit it and add information about FERPA. The draft was sent to the College Mental Health Caucus for comment. Feedback from the Council on Psychiatry and Law will be sought as well, before submitting the final draft to JRC in June.
- [JRC October 11, 2014, 8.C.3]. The Council's withdraws its request for APA funding for the APA Child and Adolescent Psychiatry Fellowship. The program has been subsequently approved for APF funding.

Action Items

1. **Will the Joint Reference Committee recommend that the Board of Trustees vote to approve the revision to the Position Statement on Psychiatric Hospitalization of Children and Adolescents?** See Attachment A.
2. **Will the Joint Reference Committee recommend that the Board of Trustees vote to approve the revision to the Position Statement on Reactive Attachment Disorder?** See Attachment B.

Information Items

- Dr. Kraus is representing APA on a work group to develop a parents' medication guide on autism spectrum disorder. Members of the work group include representatives from the American Academy of Child and Adolescent Psychiatry (AACAP), American Academy of Pediatrics, and Autism Speaks, among other organizations and advocates. The group is currently fine-tuning the outline of the publication. Parents' medication guides are a collaboration by APA and AACAP.
- The Council convened by conference call on January 7. The call primarily focused on drafts of position statements on reactive attachment disorder, psychiatric hospitalization of youth, college mental health, and reporting of suspected child abuse. The position statement on corporal punishment in schools was critiqued, with Dr. Sharon Hirsch promising to draft an improved version. The group also commented on NIDA's draft strategic plan which is to be integrated into APA's overall feedback to NIDA per the agency's Request for Information. Dr. Ranna Parekh, the newly appointed Director of the APA Division of Diversity and Health Equity, introduced herself. Another conference call will be held in early April.
- The Council provided input to the Council on Psychiatry and Law's proposed *Position Statement on Segregation of Juveniles with SMI in Correctional Facilities*. Some of the Council on Children's feedback included removing SMI from the title and inserting as part of the background section of the paper an excerpt from AACAP's policy statement on Solitary Confinement of Juvenile Offenders.

ATTACHMENT A

DRAFT REVISION

Position Statement on Psychiatric Hospitalization of Children and Adolescents

~~*This statement is supported in principle by the American Academy of Child and Adolescent Psychiatry, the American Hospital Association, the Federation of American Health Systems, and the National Association of Private Psychiatric Hospitals. Other organizations are being invited to support the statement.*~~

Admitting children and adolescents to a hospital for psychiatric evaluation and treatment involves careful clinical judgment as well as collaboration with patients, providers, and families. ~~diagnosis and treatment of psychiatric disorders is a serious step for both youngsters and parents. As with any hospitalization, t~~The decision to admit a child or adolescent should be based on medical necessity and the best interest of the patient (and where appropriate, his or her family). Inpatient psychiatric care may be warranted in severe psychiatric circumstances which may include impairments in a patient's functioning and/or safety concerns. Psychiatric hospitalization may be helpful to evaluate, acutely stabilize, treat, and transition patients to outpatient care. Other less restricted options such as residential treatment, day treatment, or intensive outpatient care should be considered and deemed unavailable, ineffective, or insufficient prior to recommending locked inpatient treatment. It is important to recognize there may be risks, in addition to benefits, when hospitalizing a patient, therefore careful consideration is recommended. The treatment proposed should be appropriate and clearly indicated. Financial interests of either the doctor or the hospital must never dominate these decisions.

The American Psychiatric Association believes that the vast majority of psychiatrists and hospitals act appropriately and ethically in the admission of children and adolescents for inpatient psychiatric care. We deplore any instance when a child or adolescent has been inappropriately hospitalized, especially when there are appropriate, equally effective, and less restrictive and more affordable treatment settings available in the community ~~and affordable to the patient~~.

Optimally, a psychiatrist—and where available a child and/or adolescent psychiatrist—should be responsible for the decision to admit a child or adolescent to the hospital, and also ~~then~~ be responsible for evaluation, diagnosis, treatment planning, and discharge. Such decisions often involve the cooperation of other physicians and other mental health colleagues. The American Psychiatric Association encourages patient and guardian involvement in each individualized care plan.

Background

In America today, many people with mental disorders, including children and adolescents, are not receiving the care they need. Approximately 1 in 5 children are experiencing or have experienced a seriously debilitating mental illness. The National Institute of Mental Health also estimates that 12 million children ~~only one in five persons with a mental disorder is receiving appropriate treatment, if any at all. The NIMH also estimates that 12 million children~~ under the age of 18 suffer from mental illness including ~~diagnosable psychiatric disorders including~~ depression, anxiety, mood disturbance, suicidal ~~behavior~~ thinking, substance use, psychosis, and eating disorders. Unfortunately, 1 in 4 parents find it difficult to obtain appropriate mental health care for their child and wait times up to 1 year pose a huge barrier to care. In addition, there may be significant delays, ranging from 8-10 years, between onset of symptoms and intervention. In the US, up to 80% of youth with mental illness do not receive necessary specialty services. Of specific concern, minority youth are less likely to seek out and receive care which calls for attention and action. ~~combinations of psychiatric disorders and alcohol and drug abuse, multiple drug addictions, schizophrenia, and life-threatening compulsions, such as eating disorders.~~ There is a nationwide shortage of inpatient health services for children and adolescents. From the 1960s to the early 2000s, there has been an overall decrease in psychiatric hospitals and available beds despite increasing need. Ninety-five percent of the public psychiatry beds available in 1955 were no longer available in 2005. The decrease in inpatient services has also affected private psychiatric hospitals and general hospitals given low reimbursement rates, workforce shortages, and increasing costs. The majority of states in the America have less than half the minimum number of public psychiatry beds needed to serve community needs. As a result, children and adolescents are often kept for long periods of time in Emergency Departments awaiting placements. These youth may be sent to distant hospitals making it extremely difficult for parents and families to visit and participate in family therapy. Even though patients may eventually be hospitalized psychiatrically, they often experience shortened lengths of stays, highlighting the need for adequate and accessible mental health aftercare systems to support patients and their families after acute stabilization.

Despite this clear need for care, there is a shortage of both inpatient and outpatient treatment facilities, ~~and~~ insufficient numbers of trained staff, and long wait times even in the case of emergencies. As a result, large numbers of children and adolescents with diagnosable disorders are not receiving the inpatient, day hospital, residential treatment and outpatient treatment they require. ~~that could help them.~~ Collaborating with the psychiatrist, patient, and family may be helpful when deciding on placement and treatment planning.

Even in communities where such a spectrum of services exists, the treatment may not be paid for by employer-sponsored health insurance and managed care systems, which often favor hospitalization in place of less restrictive alternatives ~~frequently are skewed toward hospitalization~~. Consequently, the choice may be between inpatient hospital care and either no care at all or inadequate care.

The unmet need for ~~mental illness~~ psychiatric care, the shortage of an accessible range of services, and the increase in awareness of the severity of psychiatric illness among children and adolescents ~~recent phenomena of a general lessening of stigma,~~ have led to an increased demand for services at a time when many communities have a shortage of psychiatric hospital beds. ~~a substantial increase in general hospital psychiatric beds and new psychiatric specialty hospitals. Hospitals have launched marketing~~

~~campaigns to let the public know of the availability of these new or expanded facilities and services. All these factors have led to an increase in public demand for services.~~

Recommendations

It would be unconscionable to waste scarce health care dollars on inappropriate services of any kind, when many thousands are not getting the care they need. Wise clinical decisions based on admission and treatment criteria developed by physicians are essential. To this end, the American Psychiatric Association offers the following recommendations:

1. The American Psychiatric Association believes that the health of children and adolescents will be served best if psychiatrists—preferably child and/or adolescent psychiatrists—are responsible for all psychiatric admission decisions, treatment planning and discharge decisions. The Association urges psychiatrists to accept this responsibility. It reminds psychiatrists that in exercising this responsibility they must use not only their professional judgment but the code of ethics which requires that decisions to use medical intervention, including hospitalization, be based on the medical needs of the patient with careful consideration of treatment outcome and discharge planning. Readmission of patients within 30 days should be evaluated given potential concerns and any treatment barriers or issues. In addition, adequate mental health follow-up, including appropriate psychopharmacological monitoring, is essential.

2. The American Psychiatric Association recommends that psychiatric and general hospitals, whenever possible, assign to psychiatrists the responsibility for admitting, treatment planning and discharge decisions, and that they respect the medical judgment of these psychiatrists. ~~their medical judgment~~. The Association recognizes that law in some states may allow otherwise. It further acknowledges that child and/or adolescent psychiatrists or other psychiatrists may not be available at all times for acute emergencies.

3. The American Psychiatric Association will continue to press for development of a full spectrum of adequate, financially available facilities and services for the diagnosis and treatment of all children and adolescents in need of psychiatric care, and it urges other professionals, hospitals, and other psychiatric facilities to do the same. The American Psychiatric Association supports and encourages efforts to address the shortage of psychiatric beds for children and adolescents across the country. Adequate number of beds in each community is imperative in ensuring the mental health and safety of children and adolescents in psychiatric crises.

4. In addition to supporting an increase in availability of and access to inpatient psychiatric services, the American Psychiatric Association recommends less restrictive systems of care to serve the mental health needs of youth in their local communities. Decisions to transition patients from varying levels of care should be discussed and determined collaboratively with the patient, family, and psychiatrist, whenever possible.

Resources *updated by replacing organization's street address with website URL*

There are numerous resources available to help parents obtain information about psychiatric hospitalization and treatment:

American Psychiatric Association
www.psychiatry.org

American Academy of Child and Adolescent Psychiatry
www.aacap.org

Adults and Children with Learning and Developmental Disabilities Inc.
www.acld.org

National Alliance for the Mentally Ill
www.nami.org

Substance Abuse and Mental Health Services Administration
www.samhsa.gov

National Institute of Mental Health
www.nimh.nih.gov

Mental Health America
www.mentalhealthamerica.net

ATTACHMENT B

Position Statement on Reactive Attachment Disorder and Disinhibited Social Engagement Disorder

Reactive Attachment Disorder (RAD) and Disinhibited Social Engagement Disorder (DSED) ~~is~~ are ~~a~~ complex psychiatric conditions that affects a small number of children. Both disorders are the result of pathogenic care such as social neglect or other situations that limit a young child's opportunity to form emotional attachments to others that are present before the age 5.~~It is characterized by problems with the formation of emotional attachments to others that are present before age 5.~~ A parent or a physician may first notice problems in attachment with the caregiver that ordinarily forms in the latter part of the first year of the child's life. There may be concerns for how a child approaches and interacts with unfamiliar adults early in their life as well. The child with RAD may appear detached, unresponsive, inhibited or reluctant to engage in age-appropriate social interactions. Alternatively, ~~some children with RAD~~ a child with DSED may be overly and inappropriately social or familiar, even with strangers. The social and emotional problems associated with RAD and DSED may persist as the child grows older.

Children with RAD or DSED have had problems or severe disruptions in their early relationships. Many have been physically, emotionally or sexually abused. Others have experienced episodes of prolonged isolation or neglect. Some have had multiple or traumatic losses or changes in their primary caregiver.

Children who exhibit signs of RAD or DSED need a comprehensive psychiatric assessment ideally conducted by a multidisciplinary team. If the child continues to be placed with a family who is thought to have been abusive in the past, the assessment must include careful collaboration with the child welfare agency. Particular care must also be taken to distinguish RAD from one of the Pervasive Development Disorders, such as Autistic Disorder. These conditions are known to be neurodevelopmental in origin and are not caused by problems in early parenting. Children with RAD will benefit most from an individualized treatment plan that will usually include work with the child's family to help them foster an attachment to their child. Except when complicating factors arise, hospitalization is generally contraindicated since the treatment goal is fostering an attachment between child and parent. Similarly, DSED must be distinguished from the impulsivity associated with Attention Deficit Hyperactivity Disorder.

While some therapists have advocated the use of so-called coercive holding therapies and/or "re-birthing techniques", there is no scientific evidence to support the effectiveness of such interventions. In fact, there is a strong clinical consensus that coercive therapies are contraindicated in this disorder. And unfortunately, as ~~recent events attest~~ history has shown, such unproven and unconventional therapies can also have tragic consequences.

Parents and caregivers of children who show signs or symptoms of RAD or DSED should:

☐ Seek a comprehensive psychiatric assessment ideally as part of a multidisciplinary evaluation ~~by an appropriately trained, qualified and experienced mental health professional~~ prior to the initiation of any treatment plan,

☐ Ask questions about the results of the evaluation,

☐ Make sure they understand in detail the risks as well as the potential benefits of any intervention, and feel free to seek a second opinion if they have questions or concerns.

Evaluating and treating children with complex child psychiatric conditions such as Reactive Attachment Disorder and Disinhibited Social Engagement Disorder is challenging. There are no simple solutions or magic answers. However, close and ongoing collaboration between the child's family and the treatment team will increase the likelihood of a successful outcome.

Zeanah, C.H. & Gleason, M.M. (2010) Reactive attachment disorder: a review for DSM-V. Report presented to the American Psychiatric Association.

Gleason, M. M. , Fox, N.A., Drury, S., Smyke, A Egger, H.L., Nelson III, C.A., …& Zeanah, C.H. (2011). Validity of evidence-derived criteria for reactive attachment disorder: indiscriminately social/disinhibition and emotionally withdrawn/inhibited types. Journal of the American Academy of Child & Adolescent Psychiatry, 50(3), 216-231.

COUNCIL ON ADVOCACY AND GOVERNMENT RELATIONS

EXECUTIVE SUMMARY:

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

INFORMATIONAL ITEM(S):

The Council brings the following Informational Items to the Joint Reference Committee:

1. JRC REFERRAL: Multiple Co-Payments Charged for Single Prescriptions

The action paper (ASMMAY1212.A; JRC MAY126.1) was referred to the Council requesting for participation in the development of APA policy. As the lead component, the Council on Healthcare Systems and Financing referred the issue to APA's General Counsel to determine legality of the practice. The General Counsel reported that this would not be a MHPAEA issue, if this occurred for all drugs in short supply. The Council on Healthcare Systems and Financing and APA staff continue discussions on the impact of this issue in current industry practice. A position statement is currently pending.

2. APA Supports Comprehensive Mental Health Reform Legislation

The Council has been active in providing policy feedback and strategic advice to the Department of Government Relations on comprehensive mental health reform. In December of 2013, Representative Tim Murphy, PhD (R-PA), who serves as Chairman of the House Energy and Commerce Subcommittee on Oversight and Investigations, introduced H.R. 3717, *Helping Families in Mental Health Crisis Act*, which addressed a number of APA priority issues. Although comprehensive mental health reform was not passed in the 113th Congress, several APA-supported H.R. 3717 provisions were enacted as part of the March 2014 temporary Medicare Sustainable Growth Rate patch. Two examples include the voluntary AOT implementation grant program and the 8 state demonstration programs through the Excellence in Mental Health Act. Expecting an early reintroduction of Helping Families in Mental Health Crisis Act in the 114th Congress, the Board of Trustees recently voted to renew support for the efforts of Chairman Murphy and his bipartisan lead cosponsor Representative Eddie Bernice Johnson (D-TX). APA will continue to utilize all aspects of its advocacy apparatus to push comprehensive mental health reform forward (e.g. DGR staff, APAPAC, grassroots, communications and partnership activities). Enactment of comprehensive mental health reform will be a major priority for CAGR and DGR in 2015.

3. IOM Report and Council on Medical Education and Lifelong Learning

The Council was asked to participate in a CMELL conference call to discuss the Institute of Medicine report on graduate medical education. Council members provided insight regarding the significant role the report could offer in the development of federal legislation. The discussion focused specifically on the future of governance and financing of the graduate medical education program.

4. Update on Federal Advocacy Leadership Conference 2015

The Council informs the Joint Reference Committee that the federal Advocacy Leadership Conference planned for March 2015 has been canceled. Due to the scheduled ALC timeline coinciding with Congressional spring recess, the Finance & Budget Committee recommended and the Board of Trustees approved the 2015 APA Operating Budget included specific language cancelling the Advocacy Leadership Conference.

5. Update on State Advocacy Leadership Meeting 2015

The Council on Advocacy and Government Relations is working with APA staff in developing a State Advocacy Leadership Meeting. The goal of the meeting will be to mobilize state leadership to address top legislative and regulatory priorities related to mental health policies, providers and medical practice. APA members in attendance will be encouraged to participate and learn from the experts on ways to improve their advocacy capabilities. The meeting will be conducted in conjunction with APA's Office of Communications and Public Relations and APA's Office of Health Care Systems & Financing.

Council on Geriatric Psychiatry

The Council provides leadership in the field of geriatric psychiatry and undertakes this task by initiatives related to geriatric psychiatry education, research, and clinical care. The Council also strives to work collaboratively with other professional and advocacy groups to develop best practices in geriatric psychiatry while providing education and training to other physicians (including but not limited to psychiatrists), residents, and medical students, as well as to other allied mental health professionals (including but not limited to nurses and social workers) at scientific meetings and in other settings focused on the special needs of geriatric populations with mental illness.

Action Item:

- Will the JRC approve following two position statements that were revised by the Council on Geriatric Psychiatry?
    1. Position Statement on Principles of End-of-Life Care for Psychiatry
    2. Position Statement on the Role of Psychiatrists in Assessing Driving Ability

The Council reviewed five position statements that came due for review between 2012 and 2014 and made necessary recommendations. The current version of the statement on precepts of palliative care and the statement on ensuring access to appropriate utilization of psychiatric services to the elderly should be retained in their original form. The statements on end-of-life care and on the role of the psychiatrist in assessing driving abilities need revision. The Council is submitting those revised statement with this report.

The Council has proposed minor revisions to the "Choosing Wisely" item related to the use of antipsychotics. The current document makes a categorical statement that antipsychotics should never be used as first-line treatments for treatment of behavioral and psychological symptoms of dementia. While the members agree that they should rarely be used first, there are situations in which this is necessary. The council expects the document to allow for these circumstances. The statement as it currently stands is the same as the American Geriatrics Society (AGS) statement on dementia care. Our proposed revisions have been sent to AGS for their comments; we are hopeful that the AGS will consider altering their statement.

In response to an Assembly action paper "Guideline for Caregivers", the Council worked closely with the Council on Psychiatry and Law to develop a resource document to guide members on how to interact with caregivers of the persons with mental illness. The Council submitted the final product to the JRC in the second week of December 2014.

The Joint Reference Committee has requested that the Council on Addiction Psychiatry and the Council on Geriatric Psychiatry jointly develop a position statement on Substance Use and Abuse in the Elderly. The Council has started discussing the task with the Council on Addiction Psychiatry and plans to form a workgroup to initiate discussions this winter.

As requested by the APA's Government Relations department, the Council provided input for the National Institute on Drug Abuse (NIDA) regarding their strategic plan for research funding over the next five years. The current NIDA Strategic Plan was published in 2010 and, since that time, there have been major advances in the science of drug abuse and addiction. Therefore the Institute has begun a planning process to develop a revitalized Strategic Plan for 2016-2020. The Council suggested emphasizing the

importance of studying substance use disorders in aging populations, with particular focus on treatment, prevention, and effects on cognition.

Attachment: 1

Position Statement on Principles of End-of-Life Care for Psychiatry

1. Respect the dignity of both patient and caregivers;
2. Explore, identify and be sensitive to and respectful of the wishes of the patient, family, loved one and/or surrogate decision-maker;
3. Use the most appropriate measures that are consistent with the patient's and/or surrogate's choices;
4. Ensure the alleviation of pain, suffering and other physical and mental symptoms;
5. Assess and manage psychological, social, cultural, spiritual and religious concerns and problems;
6. Ensure appropriate continuity of care by the patient's primary and/or specialist physician to preserve long-standing patient-caregiver relationships when consistent with the patient's or surrogate's wishes;
7. Provide access to any therapy which may realistically be expected to improve the patient's quality of life, including alternative or nontraditional treatment. Patients who choose alternative or treatment should not be abandoned;
8. Provide timely access to palliative and hospice care;
9. Respect the right of the patient (or his/her authorized surrogate) to refuse treatment;
10. Respect the physician's professional responsibility to discontinue some treatments when futile or otherwise inappropriate, with consideration for the preferences of the patient, family, loved one and/or surrogate decision-maker;
11. Promote clinical and evidence-based research on providing care at the end of life;
12. Educate physicians, caregivers, and the public about good end-of-life care.

Attachment 2

Position Statement on the Role of Psychiatrists in Assessing Driving Ability

The presence of a mental disorder per se does not imply impaired driving capacity. Nonetheless, persons suffering from mental disorders may experience symptoms that can interfere with their ability to operate motor vehicles safely. Accurate assessment of the impact of symptoms on functional abilities usually is not possible in an office or hospital setting because such an assessment typically requires specialized equipment or observation of actual driving, which goes well beyond the scope of ordinary

psychiatric care. Moreover, psychiatrists have no special expertise in assessing the ability of their patients to drive. Thus, psychiatrists should not be expected to make such assessments in the usual course of clinical practice.

Psychiatrists do, however, have a role to play in advising patients about the potential impact of their illnesses and treatments on driving ability:

1. When appropriate, psychiatrists should discuss with their patients symptoms of their mental disorders that may be serious enough to substantially impair their driving ability.
2. Psychiatrists should warn their patients about the possible effects of prescribed psychotropic medications on alertness and coordination and about the possibility that such medications could potentiate the effects of alcohol.
3. When clinically appropriate, medication with a low potential to impair driving ability should be chosen preferentially, depending on the patient's driving requirements and habits.

While maintaining confidentiality in psychiatrist-patient relationships is important, psychiatrists should make themselves aware of laws in their state regarding reporting information on their patients' driving ability to the appropriate authority. A statute that allows, but does not require, reporting when there is clear-cut evidence of substantial driving impairment (e.g. family's statement that a moderately demented patient has had several recent minor accidents) is socially desirable. However, the responsibility for assessing a patient's driving ability ultimately lies with the DMV's. Reports made in good faith should be accompanied by immunity for psychiatrists from subsequent liability.

Clinical Guidelines for
Interacting with Caregivers

APA Draft Document—Not for Dissemination
December 19, 2014

Introduction

Family members and other caregivers play a vital role in the care of their loved ones. A recent position paper of the American College of Physicians (ACP) summarized the importance of relatives, partners, friends and neighbors in medical care

> Family caregivers play a major role in maximizing the health and quality of life of more than 30 million individuals with acute and chronic illness. Patients depend on family caregivers for assistance with daily activities, managing complex care, navigating the health care system, and communicating with health care professionals.[1]

In no other field of medicine is the importance of caregivers greater than in psychiatry. And in no other field is the management of professionals' interactions with patients and caregivers as complex:

- The need for caregiver involvement in psychiatric care is a consequence of the nature of mental disorders and their associated functional impairments. Psychiatrists treat patients with a range of disorders that may affect cognition, including psychotic, mood, substance use and addiction, neurocognitive (e.g., dementias and traumatic brain injuries), and neurodevelopmental disorders. These mental disorders often impair cognitive abilities and, as a result, patients may have impaired ability to understand treatment options, to make treatment decisions, to recognize worsening symptoms or problems in life, and to direct the flow of information related to their care.

- Some patients have a need for significant and ongoing support from caregivers. A substantial proportion of those with serious mental disorders will face lifelong disability, will have an inability to compete for employment, and will rely on entitlement programs for subsistence. On their own, some may not find even this minimal level of support. Caregivers play an important role by providing financial assistance, housing, and other material support necessary not only to facilitate care for their loved ones, but also to provide for food and housing.

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[1]Mitnick S, Leffler C, and Hood VL, for the American College of Physicians Ethics, Professionalism and Human Rights Committee. Family caregivers, patients, and physicians: ethical guidance to optimize relationships. J Gen Intern Med, 25(3): 255-60, 2010.

Caregivers also play an important role in providing emotional support to patients.

- Caregivers are particularly important in psychiatric care because the onset of the disabling effects of mental illness may occur early in life. In such cases, a large proportion of the lifespan is affected and the need for assistance is great. For those with early onset of illness, such as schizophrenia, caregiver involvement may span several decades.

- Managing psychiatrist-patient-caregiver relationships is complicated by the episodic nature of most mental disorders. During symptomatic periods, patients may have a range of needs that could be met by caregivers, including assistance in making treatment decisions. When these episodes resolve, generally many of the associated functional impairments resolve and, with them, the need for caregiver support. [2]

- For individuals with early life onset of mental illness, such as schizophrenia, the caregivers are likely to be parents, who will inevitably face problems associated with aging. Psychiatrists may be called upon to facilitate the transfer of caregiving from elderly parents to a patient's siblings, friends, or others.[3]

- For individuals with late onset conditions, such as Major Neurocognitive Disorder due to Alzheimer's disease, caregivers are likely to be spouses or children. Psychiatrists may be called upon to monitor the effect of caregiving on the aging spouse or overwhelmed children to ensure that they remain capable of meeting the substantial demands of this very challenging role.

- Each patient requires an individualized assessment of the need for caregiver assistance. Psychiatric diagnoses vary widely in associated symptoms, impairments, and disabilities. Even within a given diagnosis, there is substantial heterogeneity of symptoms and impairments. Many patients will not need caregiver involvement; others will need substantial support.

- Individualized assessment is also necessary to address the many complexities arising from psychiatrist-patient-caregiver relationships. Some patients will welcome the involvement of caregivers, but others will not. In some instances, patients will not recognize their illness or need for treatment. This lack of

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[2] Of course, other patients have chronic impairments and, as a result, may have an ongoing need for caregivers' assistance. Those with progressive neurocognitive disorders may face a predictable increase in the need for caregivers' assistance.

[3] In this document, we do not specifically address the needs of caregivers or the family system, although we acknowledge that these must be addressed for optimal patient functioning.

awareness may afflict a high proportion of individuals with schizophrenia and bipolar disorder. As a result, some patients may have longstanding conflicts with their natural caregivers. These conflicts may be exacerbated by cognitive impairments and may have become the focus of delusional beliefs. Psychiatrists may have great difficulty repairing these schisms and negotiating more therapeutic relationships.

In this document, we address ethical and legal issues related to involving caregivers in the treatment of patients and provide a comprehensive approach to clinical management of caregivers in the treatment process. This approach revolves around the development and implementation of a caregiver plan (CGP). **It is important to note that the development of a formal CGP does not reflect current practice in the field.** The discussion of a CGP in this document is for education: to describe a potential best practice. Given the complexity of managing caregivers' involvement, practitioners may find it useful to create formal CGPs.

Ethical Considerations

Psychiatrists have an ethical duty to attempt to provide effective care to their patients. Providing effective care requires acquiring the information needed for developing an accurate formulation and making a correct diagnosis. It also often requires psychiatrists to engage persons close to the patient in the implementation of the treatment plan (e.g., in the supervision of medication use and in the making of appointments for follow-up). The adequate engagement of family caregivers is a necessary skill for all psychiatrists. Caregivers may need specific education and support to be able to fulfill their caregiving role. For this reason among others, communicating with caregivers and involving them in treatment may be essential components of good care and ethical practice.

Psychiatrists also have a duty to respect the autonomy of patients. Respect for autonomy requires psychiatrists to give great weight to the wishes of their patients regarding the sharing of clinical information with anyone, including caregivers. Psychiatrists recognize the fundamental importance of protecting patients' confidentiality. Without the expectation of privacy, patients may not share essential information or engage in treatment at all. For this reason among others, respecting the wishes of patients regarding the sharing of information with caregivers is an essential component of good care and ethical practice.

It is clear that the question of sharing information with caregivers may present the treating psychiatrist with an ethical dilemma, i.e., a situation in which two important moral duties appear to be in conflict. Resolving ethical dilemmas usually involves delving deeply into the details of the case at hand for facts that identify the correct path. But in the cases involving the sharing of clinical information over patients' objections, psychiatrists also must take into account state and federal law and regulations.

Legal Considerations

Psychiatrists' interactions with caregivers generally implicate issues related to patient privacy and decision-making autonomy. When impaired, many patients may not be able to make decisions related to disclosing details of their psychiatric care (or other care), and may not be able to make treatment decisions. Caregivers play a critical role in assisting their loved ones to seek help and to find and authorize appropriate treatment. As will be discussed below, caregiver assistance may extend to providing legally recognized consent to psychiatric treatment and to receiving otherwise confidential information.

Privacy

Historically, the appropriate management of medical information has been addressed as a component of the physician-patient relationship. On the foundation of a general expectation of confidentiality, physicians elaborated professional standards for the disclosure of information. As with other professional standards, those concerning disclosure of information to caregivers and others were not reduced to written form; they were flexible, context-specific, and governed by the goal of acting in patients' best interests.

Today, in the United States, the privacy of healthcare records is protected by a complex set of federal regulations and state laws that complement and, in some cases trump, the professional standard of care.

HIPAA is a set of federal regulations that govern many, but not all, health care providers. The rules governing disclosures of information are elaborated in detail. The most straightforward approach to facilitating communication between psychiatrists and caregivers is to obtain written authorization from the patient. When this is not possible—for example, when the patient presents to an emergency room or inpatient unit for the first time, with no prior relationship established—HIPAA does provide for some flexibility. Recent guidance from the U.S. Department of Health and Human Services addressed some of the problematic issues concerning communications with caregivers.[4]

> In recognition of the integral role that family and friends play in a patient's health care, the HIPAA Privacy Rule allows these routine – and often critical – communications between health care providers and these persons. Where a patient is present and has the capacity to make health care decisions, health care providers may communicate with a patient's family members, friends, or other persons the patient has involved in his or her health care or payment for care, so long as the patient does not object. See 45 CFR 164.510(b). The provider may ask the patient's permission to share relevant information with family members or others, may tell

[4] HIPAA Privacy Rule and Sharing Information Related to Mental Health, available at http://www.hhs.gov/ocr/privacy/hipaa/understanding/special/mhguidance.html

> the patient he or she plans to discuss the information and give them an opportunity to agree or object, or may infer from the circumstances, using professional judgment, that the patient does not object. A common example of the latter would be situations in which a family member or friend is invited by the patient and present in the treatment room with the patient and the provider when a disclosure is made.
>
> Where a patient is not present or is incapacitated, a health care provider may share the patient's information with family, friends, or others involved in the patient's care or payment for care, as long as the health care provider determines, based on professional judgment, that doing so is in the best interests of the patient. Note that, when someone other than a friend or family member is involved, the health care provider must be reasonably sure that the patient asked the person to be involved in his or her care or payment for care.
>
> In all cases, disclosures to family members, friends, or other persons involved in the patient's care or payment for care are to be limited to only the protected health information directly relevant to the person's involvement in the patient's care or payment for care.

The HIPAA Privacy Rule permits the disclosure of information to avert a serious threat to health or safety.[5] Under this provision of HIPAA, a psychiatrist, acting in good faith, may use or disclose information when it is "necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public." Disclosures under this provision may be to persons "reasonably able to prevent or lessen the threat" and may include the "target of the threat." Caregivers may be in a position to intervene; they may also be targets of threats.

State laws may provide additional protections of patient privacy and, in some states, may provide further definition of psychiatrists' duty to avert harm to others.[6] Psychiatrists are advised to be conversant with state laws as well as policies and procedures in their specific practice settings.

Consent

Consent to treatment is governed by the doctrine of informed consent. In order to provide informed consent, a patient must be competent. In emergency circumstances, generally when there is imminent risk of harm to self or others, treatment may be provided without consent.

With respect to psychiatric inpatients, state laws vary. In many states, a patient who refuses treatment may be treated involuntarily only with judicial approval and oversight. This is often based on a judicial determination of incompetence. In other

[5]HIPAA Privacy Rule, Section 164.512(j).
[6] For further information regarding psychiatrists' duties to protect third parties, see APA Resource Document, Confidentiality: Guidelines on Physician's Duty to Take Precautions Against Patient Violence, 1987.

states, confirmation of the need for treatment may suffice as the basis for treating an objecting patient, and administrative or clinical procedures may suffice. Generally, more stringent legal proceedings govern the provision of electroconvulsive therapy over a patient's objection.

In some states, the law governing outpatient treatment of incompetent or objecting patients is the same as that for inpatients. In other states, a legal guardian or a caregiver recognized by state law may be able to authorize treatment.

Once again, psychiatrists should become familiar with the law and policies governing their local practice setting.

Advance directives (ADs), including psychiatric advance directive (PADs), are used to facilitate the treatment of individuals afflicted with serious mental disorders.[7] ADs include instructional directives regarding treatment (sometimes called living wills) and proxy directives (also called durable powers of attorney) that designate caregivers to make decisions. ADs may be useful in a number of ways:

1. To facilitate treatment of patients before hospitalization is necessary.
2. To provide advance authorization for hospitalization when patients lack capacity to consent.
3. To facilitate the provision of treatment to refusing patients during hospitalization.
4. To provide evidence of valid consent for patients who accept medication while symptomatic.

ADs may be used to provide explicit authorization to specified caregivers to have access to confidential information and to make treatment decisions. ADs may reduce reliance on formal legal procedures, such as civil commitment and guardianship, which may lead to adversarial relationships. These legal mechanisms are expensive, often lead to delayed treatment, and may alienate patients.

Clinical Guidelines

Beginning Treatment: Obtaining a History of Caregiver Participation

The treating psychiatrist should assess the role of caregivers in their patient's life at the outset of treatment.[8]

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[7] See Psychiatric Advance Directives, Resource Document, approved May 2009, American Psychiatric Association. Available at http://psych.org/learn/library--archives/resource-documents. Additional resources are available at the National Resource Center on Psychiatric Advance Directives, http://www.nrc-org

[8] The treating psychiatrist may be acting as the head of team and may delegate various functions to team members.

- At the time of evaluation, psychiatrists should consider the past and current role of caregivers in the patient's life.

- Obtaining information about caregivers will flow from the routine evaluation process. In gathering information about the presenting problems, history of present illness, and past psychiatric history, the psychiatrist will learn about significant impairments and disabilities. Patients who have had past impairments will likely have a history of support and intervention by family and loved ones. Important information about past and potential caregivers will be obtained in the process of obtaining family and social histories.

- When caregivers have been involved in the past, or are involved currently, the treating psychiatrist will gain useful information by inquiring about the nature of the caregiver participation. It may be useful to review each caregiver one-by-one. How did the caregiver participate in the past? How are caregivers currently participating? Was the patient satisfied with the caregiver and the way in which support was provided? What worked well? If there were problems, what could be done differently in the future?

- With the patient's authorization, the treating psychiatrist will often find it useful to gather information directly from caregivers past and current. The history gathered from the patient and the caregivers will provide the psychiatrist with insight into the nature of the patient's past and current impairments. This will often aid the psychiatrist in the formulation of a treatment plan to address symptomatology contributing to impairments, to arrange for needed rehabilitative and support services, and to involve caregivers in the patient's care.

<u>Planning for Caregiver Participation</u>

The treating psychiatrist should develop a plan for caregiver involvement when appropriate. The psychiatrist should strive to develop a plan that clarifies the roles of caregivers, facilitates optimal communication, and results in effective treatment. The process of developing the plan should draw all parties together and lead to a shared understanding regarding respective roles in the care plan and caregivers' access to information. The development of the plan should strengthen caregivers' commitment to the therapeutic process.

- The psychiatrist's judgment about future a patient's need for caregiver assistance may be based on past patterns of illness, current functioning, and prognosis. The treating psychiatrist may determine that some patients have an immediate or inevitable need for caregivers. In other cases, the need for caregiver planning may be less obvious, but may be prudent nonetheless.

- In some cases, the psychiatrist may conclude that the history and likely clinical course do not indicate a need for formal planning regarding caregiving.

- In some cases, the treating psychiatrist will find it useful to discuss caregivers' participation with the patient and to create a caregiver plan (CGP). The treating psychiatrist should initiate a discussion with the patient regarding their caregiver preferences and the likely future need for caregiver involvement in care.

- The treating psychiatrist should document the CGP in the progress notes or elsewhere in the patient's chart. The psychiatrist should briefly describe the essential elements of the plan agreed to by the psychiatrist, patient and caregiver.

- The psychiatrist, patient, and identified caregivers should work together to formulate the caregiver plan. A CGP would identify individuals who will be involved in the patient's care and the nature of their involvement. Based on the patient's diagnosis, history, and prognosis, the psychiatrist will be able to estimate likely future impairments and areas in which caregivers' participation may be useful.

- A CGP should identify a caregiver or, in some cases, a set of caregivers, and specify their participation.

- What if there are no obvious caregivers? It may be necessary for the treating psychiatrist to assist the patient in identifying caregivers, particularly if there is an immediate or likely need. In some instances, patients will have become alienated from parents and other family members, perhaps as a result of their illness. The treating psychiatrist may be able to facilitate a rapprochement. Local religious and other charitable organizations may provide resources and caregivers.

- A CGP may cover a range of issues including housing, income support, transportation, care of family members, as well as clinical issues. Attention to the emotional and practical needs of the caregiver is also important.

- Caregivers may provide assistance in identifying onset of illness, initiating treatment (emergent, urgent, or routine), accompanying the patient to treatment sessions, and assistance in complying with treatment (obtaining medication, organizing administration at prescribed intervals, etc.). They are frequently excellent sources of information about the status and progress of patients and essential partners in the implementation of the treatment plan.

- Caregivers may be able to identify triggers to the onset of illness that the patient does not recognize or accept.

- A CGP will usually include an understanding about information sharing with one or more caregivers. It may include a formal authorization of information disclosure by the patient. Formalizing may be essential when other systems are likely to come into play; for example, when an outpatient may be hospitalized.

- Regular communication with caregivers may be useful. This may be done in a variety of ways: in person, by phone, by email. In some cases, it will be advantageous for the caregiver to accompany the patient to some, if not all, psychiatric visits. Caregivers often have observations about the patient's level of functioning, symptoms, and adaptation. These observations may serve to provide early warning regarding the onset of significant illness or the emergence of side effects to medications. For some patients, communication with caregivers may be an essential element of the CGP. For example, some patients with Bipolar Disorder will not recognize the onset of symptoms or related problematic behaviors. Caregivers' observations may be useful adjuncts to the psychiatrist's mental status examination and office-based assessment of functioning. In some cases, they may be essential.

- The CGP may also provide a plan for how decisions about care are to be made in the event that the patient becomes impaired. In some cases, a CGP may include an Advance Directive (AD) (e.g., proxy directive or durable power of attorney) that facilitates decision-making by a designated caregiver. ADs may also be used to authorize the release of confidential information.

- When possible, the caregivers should be involved in the development of the plan. Caregivers' involvement serves to establish lines of communication to the psychiatrist and to provide a foundation for the development of a relationship between caregiver and psychiatrist. The development of the plan as a shared project will serve to facilitate communication among the parties, to ensure that everyone has the same expectations, and to settle logistical issues related to communication and response in the event of emergent clinical or other issues. Discussing and anticipating potential problems may be therapeutic and facilitate commitment to treatment goals.

- Caregiver participation in a patient's care need not be driven entirely by current impairments or the prospect of future impairments. Some patients simply prefer to have loved ones involved and knowledgeable about their care.

When a Crisis Occurs: Implementing the Caregiver Plan

Implementing a plan at the time of a crisis poses a challenge to the therapeutic relationship. The treating psychiatrist should strive to maintain the therapeutic relationship, even when the patient disagrees about the necessary course of action. Following a crisis, the treating psychiatrist, patient, and caregivers should revisit the caregiver plan.

- Crises may arise in numerous ways, often with the onset or exacerbation of symptoms. Patients may fail to make office visits, or to respond to phone calls or other efforts to communicate. In some cases, a patient may disagree about the presence of symptoms and the urgent need for treatment.

- A clinical crisis may lead to a number of interactions between the treating psychiatrist and caregivers. Caregivers may provide information to the treating psychiatrist regarding the patient's behavior and symptoms. The psychiatrist may enlist caregivers to support clinical interventions for the patient's welfare, such as to add medications, change dosages, or meet more frequently.

- Based on the emergence of cognitive impairments, the treating psychiatrist may judge the patient to have doubtful competence. Generally, the treating psychiatrist will try to resolve the therapeutic impasse (non-compliance with medication, refusal to enter the hospital) without resorting to legal interventions (court orders, involuntary civil commitment). Caregivers may play an important role in these clinical interventions.

- At times, however, it may be necessary for the psychiatrist to invoke formal interventions, which may include applying the directives from PADs or invoking legal procedures (involuntary civil commitment, court ordered medication). Caregivers should be involved in the decision-making process when possible.

- The treating psychiatrist should continue to pay close attention to the therapeutic relationship. In some cases, it may be useful for the treating psychiatrist and caregivers to make reference to the caregiver plan in their discussions with the patient.

- The treating psychiatrist should continue to discuss therapeutic decisions with the patient, even when caregivers have assumed the role of legal decision maker. The treating psychiatrist should strive to involve the patient in planning to the greatest possible extent, anticipating the patient's recovery of functional decision making capacity.

- After the resolution of the crisis, when the patient has resolved acute symptoms and impairments, it may be useful for the psychiatrist to review the episode. A discussion of the actions taken by the psychiatrist and caregivers in accordance with the CGP may facilitate greater insight.

- Also, it will be useful for the psychiatrist, patient, and caregivers to revisit the CGP plan. What worked? What did not work? What additions and changes should be made?

When a Crisis Occurs in the Absence of a Plan

The treating psychiatrist may receive information from caregivers. They may also convey information to caregivers with some limitations. The treating psychiatrist should strive to involve caregivers and note the need for a future caregiver plan. Legal mechanisms may need to be invoked in order to provide care.

- A crisis may develop in the absence of a caregiver plan. There may be no signed authorizations to disclose information, and no prior relationships with caregivers or the patient.

- Caregivers who are family and friends (not health care providers) are free to communicate information to the treating psychiatrist.

- If the patient is regarded as having capacity to make health care decisions and is present, the treating psychiatrist may communicate with caregivers as long as the patient does not object, according to HHS guidance regarding HIPAA (see above).

- When a patient is not regarded as having capacity, or is not present to register an objection, the treating psychiatrist may share information with caregivers if it is in the patient's best interests.

- In some cases, the treating psychiatrist may need to seek out alienated family members in an attempt to engage them in the patient's care.

- Regarding treatment, it may be necessary for the treating psychiatrist to employ legal procedures to hospitalize the patient. And, if the patient refuses necessary treatment, the treating psychiatrist may have to invoke involuntary treatment processes.

- Prior to discharge, it may not be possible to develop a caregiver plan for future episodes. It would be useful to suggest development of a caregiver plan to the outpatient psychiatrist accepting responsibility for the patient's care.

Other Caregiver Issues

The treating psychiatrist should be alert for emerging problems in caregivers.

- The treating psychiatrist may find that a designated caregiver is not able to fulfill their planned role. This may occur as occur as a result of competing obligations or commitments to work, family, or other interests. Caregivers may also develop psychiatric or medical problems that affect their ability to function as planned. Being a caregiver is stressful and may precipitate or contribute to emotional distress. The treating psychiatrist should be alert for emerging emotional problems in caregivers and make appropriate referrals as necessary. Regardless of the reason for the caregiver's inability to act in their planned role, the treating psychiatrist should have the patient designate another caregiver or decision maker.

- Caregivers may have goals or interests related to the patient's care and management that are not compatible with those of the patient. These conflicts may not be evident at the outset of treatment. One example is when children serving as caregivers and surrogate decision-makers are also heirs and may experience a conflict of interest in decisions about how to use the patient's financial assets. The treating psychiatrist should discuss conflicts with the patient. Many conflicts may be resolved through open discussion with the patient and caregiver. In other cases, it may be necessary to change or eliminate the caregiver's participation in the patient's care and management.

- Some patients may have multiple caregivers. This is often the case when caregiving for an elderly parent with Alzheimer's disease is shared by several children. At times, caregivers will disagree about the appropriate course of action. The potential for conflicts may be kept to a minimum when the patient makes their preferences clear in advance of a crisis. In some instances, for example when there are several family members involved, it may be useful to have a primary caregiver designated to interact with the treating psychiatrist.

Council on Geriatric Psychiatry-- Established in May 2012

1. **How many times did the council meet?**

The Council on Geriatric Psychiatry was formed in 2012 when the Council on Psychosomatic Medicine and Geriatric Psychiatry was divided into two separate councils to meet distinct goals. In 2012 May, the members of the newly formed council met unofficially for one hour directly after the last gathering of the Council on Psychosomatic Medicine and Geriatric Psychiatry. Since then, the Council has had 5 in-person meetings. In addition, the group has met several times per year by conference call and has communicated regularly by email to keep projects moving.

- **Please provide the attendance (including those not present) at each meeting.**

May 2012 members attending: Brent Forester, MD (Chairperson), Bruce Saltz, MD, Keith Stowell, MD, Ipsit Vahia, MD, Robert Roca, MD, Helen Kyomen, MD, Istvan Boksay, MD, Charles Nemeroff, MD, Allan Anderson, MD, Blaine Greenwald, MD, Alex Threlfall, MD, Staff: Alison Bondurant, Annelle Primm, MD

September 2012 members attending: Brent Forester, MD, Maria Llorente, MD, Mohit Chopra, MD, Ipsit Vahia, MD, Helen Kyomen, MD, Alex Threlfall, MD, Bruce Saltz, MD, Keith Stowell, MD, Robert Roca, MD

September 2013 members attending: Robert Paul Roca, MD (Chair), Mohit Chopra, MD, Brent Forester, MD, Blain Stuart Greenwald, MD, Maria D Llorente, MD, Bret R Rutherford, MD, Bruce L Saltz, MD, Susan K Schultz, MD, Keith R Stowell, MD, Alexander W Threlfall, MD, Ipsit Vihang Vahia, MD, Helen Lavretsky, MD, Uyen-Khanh Quang-Dang, MD MS, Sejal Patel (Staff), APA

May 2014 members attending: Robert Paul Roca, MD (Chair), Brent Forester, MD, Blaine Stuart Greenwald, MD, Bret R Rutherford, MD, Bruce L Saltz, MD, Keith R Stowell, MD, Ipsit Vihang Vahia, MD, Helen Lavretsky, MD, Anand Kumar, MD, Uyen-KhanhQuang-Dang, MD MS (UK)
Staff in Attendance, Sejal Patel (Staff), APA/members not attending: Susan Schultz, MD (absent with excused absence), Council Members Absent with unexcused absence: Maria Llorente, MD, Mohit Chopra, MD, Olivia I Okereke, MD, Alexander Threlfall, MD

September 2014 members attending: Robert Roca, MD (Chair), Anand Kumar, MD (Vice Chair) (Joined via conference call), Brent Forester, MD, Bruce Saltz, MD, Bret Rutherford, MD, Sherrie Godbolt, MD, Keith Stowell, MD, Alex Threlfall, MD, Maria Llorente, MD, 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

2. **Education:**

a. **What workshops/symposia, etc. have been submitted for presentation at APA Annual Meeting**

- **2013 Annual Meeting submission:**

a. Brent Forester, MD: The Evaluation and Management of Bipolar Disorder in Older Adults: New Findings From Clinical Research/Mood Disorders in Later Life/Brain Health and Alzheimer's Prevention
b. Ipsit Vahia, MD: Successful Aging

c. Alexander Threlfall, MD: Psychotherapy in Late-Life Adults
d. Mohit Chopra, MD and Maria Llorente, MD: Differential Diagnosis in Dementia and What's New in DSM-5
e. Olivia Okereke, MD: Preventing Depression: Life-Cycle Perspectives

- **2014 Annual Meeting submission:**

  a. Helen Lavretsky, M.D.,M.S. : Prevention and Treatment of Mood and Cognitive Symptoms in Late Life./Emerging Neuroscience of Mind-Body Interventions for Stress-Related Neuropsychiatric Disorders Across the Life Cycle
  b. Bret Rutherford, MD: Antidepressant Clinical Management: One Size Fits All or Patient-based?
  c. IpsitV. Vahia, MD: Can't Go Home Again: Issues in Long Term Care of Geriatric Asian Americans
  d. Bruce L. Saltz, MD: Drug Induced Movement Disorders in the Elderly: Teaching the teachers to employ videotapes on recognizing dyskinesia, dystonia, akathisia and parkinsonism.
  e. Robert Roca, MD: Management of the non-cognitive signs and symptoms of dementias/major neurocognitive disorders: a systems view of individualized treatments (with Helen Kyomen, Soo Borson, and Anne Ellett).

- **2015 Annual Meeting Submissions:**

  a. Helen Lavretsky, MD: Advances in Therapeutic Interventions in Geriatric Psychiatry
  b. Brent Forester, MD: Late Life Mood Disorders: Achieving Accurate Diagnosis and Effective Treatment
  c. Susan Schultz, MD: Geriatric Psychiatry: Treatment Updates and New Perspectives

b. What was the attendance at these events and what was the feedback on these events?

a. Attendance was good and the feedback positive.

3. What are the Council's current activities and what activities are planned for the coming years? (Please use the work plan template).

Work plan attached.

From May 2013 - December 2014, members of the Council on Geriatric Psychiatry:

- Produced a position paper and a resource document on Use of Antipsychotics in Patients with Dementia
- Developed a resource document on Clinical Guidelines for Interacting with Caregivers in collaboration with the Council on Psychiatry and Law
- Reviewed five positions statements that were due for evaluation and revised two of the five statements.
- Advocated for a minor revision to the "Choosing Wisely" item related to the use of antipsychotics. The current document makes a categorical statement that antipsychotics

should never be used as first-line treatments for treatment of behavioral and psychological symptoms of dementia. While the members agree that they should rarely be used first, there are situations in which this is necessary. The council expects the document to allow for these circumstances.

- Solicited, evaluated, and nominated the 2012, 2013 and 2014 Jack Weinberg Memorial Award winners.
- Solicited, evaluated and nominated the winners of the 2013 and 2014 Hartford-Jeste Award for Future Leaders in Geriatric Psychiatry
- Advocated for having a permanent spot for a RFM on the Council in the same way that we have a permanent position for an ECP.
- Participated in a conference call in response to a request from the Government Accountability Office for input from the APA regarding antipsychotic drug use in elderly persons, specifically the extent of and rationale for antipsychotic drug prescribing to elderly persons with dementia living in nursing homes and in the community.
- Provided input in the meeting called by CMS to seek assistance from the APA in their work to develop regulations and metrics associated with their initiative to reduce antipsychotic use in nursing home by 15%
- Reviewed the document summarizing the recommendations of the Health Care Reform Working Group and provided detailed responses to the questions addressed to the Council.

4. Has the product been sent to the Assembly and the Board of Trustees?

The Council has submitted following products in last 2 years:

1. A resource document on the Use of Antipsychotics in Patients with Dementia.
2. A position statement on the Use of Antipsychotics in Patients with Dementia
3. A resource document on Clinical Guidelines for Interacting with Caregivers

JRC asked the Council to review five position statements that were due for the evaluation. The Council recommended retaining three of those statements. Two of the statements needed revision. The Council worked on those statements and submitted the revised version to the JRC.

4. Position statement on the Role of Psychiatrists in Assessing Driving Ability
5. Position statement on Principles of End-of-Life Care for Psychiatry

5. What is the Council doing for MIT and ECP members?

A number of Council members attended the PsychSIGN meeting in New York on May 3 to give medical students attending the 2014 Annual Meeting an opportunity to interact with geriatric psychiatrists.

A Council member also attended the Brown Bag Lunch session at the 2014 Annual Meeting for subspecialty groups and residents at the Resident Resource Center. The program included Curriculum Vitae (CV) Boot Camp where the students and residents had an opportunity to have their CV read by experts and get their input.

The Council has observed how valuable it is to have a Resident Fellow Member at the table, particularly in discussions of how to develop educational programs and membership recruitment strategies and how to relate to AAGP, which focuses special attention on trainees. So the Council has advocated for having a

permanent spot for a RFM on the Council in the same way that we have a permanent position for an ECP. The Council has requested the JRC to consider asking the Board to create such a position.

6. **Evaluate the staff support to the Council and its components.**

From Robert Roca, MD (Chair)-

The Council in its various iterations has had the advantage of excellent support from a succession of APA staff members over the past three years. We are very pleased with the assignment of Ms. Sejal Patel to our Council. She is very conscientious, well organized, and extremely pleasant to work with. I hope to have her with us for a long time.

From Sejal Patel (Staff Liaison)-

I have staffed the Council since July 2013 when I joined APA. Although, the Council on Geriatric Psychiatry came in existence in May 2012 after its split from the Council on Psychosomatic Medicine, it has been very productive from the very beginning. After the Council was formed in 2012, the staff support has been uneven, at least for the first year, but the Council didn't lose the focus.The current Council is comprised of accomplished geriatric psychiatrists who are hard-working, enthusiastic and insightful. Dr. Roca always encourages the participation from the members and remains committed to the matters that are important to the subspecialty and the APA membership. The Council is very supportive of the initiatives that address the current issues related to recruitment, health reforms and collaborative care to name a few. I have learned a lot from each of them and have witnessed their continuous attention and commitment to the issues they face in caring for their patients.

COUNCIL ON GERIATRIC PSYCHIATRY:
2015 WORK PLAN

	TASK/ACTION	Priority #	Start Date	Completion Date	Responsible Person/Entity
I	***TASK: Assist APA staff and leadership in their effort to influence legislation and regulation governing the use of antipsychotic medications in persons with major neurocognitive disorders, and to provide guidance to members who encounter this controversy in their practice.***				
	This has been a major focus of in-person meetings (2 annually) and conference calls (several per year) over the past 3 years. Activities to date include (1) development of a Position Statement (submitted to JRC in the winter of 2014) and Resource Document on this topic; the Resource Document, entitled "The Use of Antipsychotic Medications to Treat Behavioral Disturbances in Persons with Dementia", is now on the APA website. These materials were developed in collaboration with the APA Clinical Guidelines Writing Group and with the American Association of Geriatric Psychiatry (2) participation in a face-to-face meeting (conducted with staff of the Office of Healthcare Systems and Financing) with the Medical Director of the Medicare program at CMS to discuss the metrics that CMS will use in its initiative to reduce antipsychotic use in long-term care; (3) participation in a teleconference (conducted in collaboration with the Office of Government Relations) with staff from the General Accountability Office who were charged with investigating the extent of and rationale for the use of antipsychotics in persons with dementia; (4) work with Samantha Shugarman to propose wording changes in the "Choosing Wisely" language on using antipsychotic medications in persons with dementia.		*This has been an area of focus over the last several years, as the Council has transitioned from the Council on Aging, to the Council on Adult Psychiatry, to the Council on Psychosomatics and Geriatric Psychiatry, and finally to the Council on Geriatric Psychiatry*	*A number of work products have been generated, as noted in the narrative, but the work is ongoing.*	*Dr. Robert Roca and members of the Council*

COUNCIL ON GERIATRIC PSYCHIATRY:
2015 WORK PLAN

	TASK/ACTION	Priority #	Start Date	Completion Date	Responsible Person/Entity
II	***TASK: In collaboration with the Council on Psychiatry and the Law, develop a Resource Document on interacting with caregivers of persons with psychiatric disorders***				
	Working closely with Dr. Ken Hoge, we developed a draft document and submitted this to the JRC in December 2014 for their consideration. In the creation of this draft we solicited input from the Assembly member who authored the action paper requesting this document as well as outside experts (e.g., Dr. Alison Heru) who are published in this area. This work was done mainly by teleconference and email, with one in-person meeting. The draft was helpful in a meeting in which APA leaders and staff (Annelle Primm, Rodger Currie, Matt Sturm) met, in response to a request from Congressman Murphy's office, with the caregiver of a patient who committed suicide.		*Winter 2014*	*Draft was submitted to the JRC in December 2014*	*Drs. Robert Roca and Ken Hoge, and members of the Council on Geriatric Psychiatry and the Council on Psychiatry and the Law*
III	***TASK: In collaboration with the Council on Addictions, develop a position statement on substance use disorders in older adults***				
	The Council on Addictions recommended retiring the current statement on this issue. The JRC charged the Council on Geriatric Psychiatry (lead) and the Council on Addictions with drafting a new statement.		*January 2015*	*May 2015*	*Drs. Robert Roca and Frances Levin*
IV	***TASK: Work with APA governance to ensure that AAGP has access to Assembly representation***				

COUNCIL ON GERIATRIC PSYCHIATRY:
2015 WORK PLAN

	TASK/ACTION	Priority #	Start Date	Completion Date	Responsible Person/Entity
	In December 2013 it was clarified that the AAGP is entitled to send a representative to the Assembly, but this has not been occurring. As it happens, the Council Chair is a member of AAGP and of the Assembly, so there are in fact AAGP members in the Assembly. But there is an opportunity to bring the AAGP into the Assembly more formally, and this will continue to be a focus of effort. The Council meetings always include AAGP staff and the AAGP President-elect, and Council meetings can serve as a forum for discussions about AAGP representation in the Assembly as well as about APA-AAGP alignment in general.		*November 2013*	*December 2013, and ongoing*	*Dr. Robert Roca*
V	***TASK: Reach out to medical students and RFMs to promote interest in the mental healthcare of older adults***				
	Council members have attended PsychSIGN gatherings and other activities aimed at trainees at all levels. The Council also recommended to the JRC that RFMs have standing positions on all Councils		*November 2013*	*Ongoing*	*Dr. Robert Roca, and members of Council*
VI	***TASK: Develop workshops and symposia for the Annual Meeting as well as for meetings of the AAGP***				
	Every year the Council produces numerous programs for both annual meetings. Topics in recent years include (1) Prevention and treatment of mood and cognitive symptoms in late life; (2) Emerging Neuroscience of Mind-Body Interventions for Stress-related Neuropsychiatric Disorders Across the Life		*Ongoing*	*Ongoing*	*Members of Council*

COUNCIL ON GERIATRIC PSYCHIATRY:
2015 WORK PLAN

	TASK/ACTION	Priority #	Start Date	Completion Date	Responsible Person/Entity
	Cycle; (3) Antidepressant clinical management: one size fits all, or patient-based? (4) Can't Go Home Again: Issues in long-term care of geriatric Asian-Americans; (5) Drug-induced Movement Disorders in the Elderly; (6) Management of the non-cognitive signs and symptoms of dementia/major neurocognitive disorders: a systems view of individualized treatments				
VII	***TASK: Nominate honorees for the Jack Weinberg Award and the Hartford-Jeste Award;***				
	This work is conducted by email and conference call and concluded in one face-to-face meeting		*Annual*	*Ongoing*	*Nominations sub-committee of Council*
VIII	***TASK: Identify source of ongoing funding for the Jack Weinberg Award***				
	The fund supporting the Jack Weinberg Award is nearly exhausted and a source of new dollars must be identified if the APA is to continue recognizing outstanding geriatric psychiatrists. This is a very prestigious award and it should be preserved.		*Jan 2014*	*May 2014*	*Dr. Robert Roca*

American Psychiatric Association
Council on Healthcare Systems & Financing
Harsh K. Trivedi, MD, MBA, Chair

The CHSF is offering the following action and information items:

Action Item 1

Background: Members of the CHSF had reviewed and recommended retaining the 2007 position statement "Psychiatric Disability Evaluation by Psychiatrists" (Attachment 1). The Joint Reference Committee (JRC) discussed this recommendation at their October meeting and decided to refer the position statement back to the Council on Healthcare Systems and Financing for further review and possible revision. "The JRC questioned whether there was additional information or background that would support retaining the position statement, especially the part about disability evaluations being done "most effectively and efficiently by psychiatric physicians". In the JRC's view, the information regarding reimbursement was the most relevant portion of the statement, but it is unclear whether this continues to be an issue for our field. It was suggested that input be sought from those with expertise in disability evaluation." The Council sent the position statement as currently written to Andrea Stolar, MD, past-chair of the former Corresponding Committee on Psychiatry and the Workplace for review and comment. Dr. Stolar recommended retiring the position statement, noting that the issues it was written to address have been resolved. The CHSF therefore recommends that the JRC retire the position statement "Psychiatric Disability Evaluation by Psychiatrists."

Will the Joint Reference Committee (JRC) recommend to the Assembly to vote to retire the position statement "Psychiatric Disability Evaluation by Psychiatrists"? (Attachment 1)

Action Item 2

Background: The Joint Reference Committee referred the action paper "Psychiatrists Patient Relationship and Adverse External Influences in Resolving Danger" (Attachment 2) to the CHSF to review and provide feedback. The CHSF discussed the item at their September meeting and again on a recent conference call. Members of the Council agreed that dangerousness cannot be predicted; that dangerousness is just one component/factor in assessing a patient's status. The CHSF believes the appropriate next step is a review of and/or development of medical necessity/clinical acuity levels of care. It was agreed that OHSF would survey a sample of major payers to inquire as to what their policies are in this regard. However, members of the CHSF do not believe they have expertise in this area (clinical best practices) and recommend that the JRC identify the appropriate APA body that has the expertise to weigh in on this process in a more formalized way, similar to that of the APA's Practice Guidelines.

Will the Joint Reference Committee identify the appropriate APA entity to review and or develop medical necessity or level of care criteria?

Information Item 1

Background: Members of the CHSF had reviewed and recommended retaining a revised/updated version of the position statement "Patient Access to Treatments Prescribed by Their Physicians" (Attachment 3), which is based on existing AMA policy on this issue. The JRC referred the revised position statement back to the CHSF for additional work. The JRC "felt that the title of the position statement should reflect the key message and that the statement itself be succinct and on point." Members of the CHSF reviewed the document on a recent call and decided to recommend separating the existing position statement into at least two position statements:

1. One statement that supports a physicians' ability to prescribe off-label when clinically appropriate and based on sound scientific evidence; and
2. One statement that speaks to the dissemination of information about off-label uses, and the process by which supplemental indications can be added to the labeling, and continued encouragement of clinical research to identify investigational drugs that have pediatric indications.

Below is the language the CHSF has developed for the statement on the ability to prescribe off-label. We will be working on the other statement(s) and will forward the complete set to the JRC for review once they are complete.

Position Statement on Off-Label Treatments [Draft]

> The APA affirms strong support for the autonomous clinical decision-making authority of a physician and for a physician's lawful use of an FDA-approved drug product or medical device for an off-label [i] indication when such use is based upon sound scientific evidence in conjunction with sound medical judgment; APA encourages the use of the current drug compendia recognized by the Centers for Medicare and Medicaid Services (*American Hospital Formulary Service-Drug Information, Gold Standard Inc. Clinical Pharmacology Compendium, NCCN Drugs and Biologics Compendium, Thomson Micromedex DrugDex® Compendium, Tomson Healthcare DrugPoints® Compendium*) in conjunction with the peer-reviewed literature for determining the medical acceptability of unlabeled uses; APA further affirms that when the prescription of a drug or use of a device represents safe and effective therapy, third-party payers, including Medicare, should consider the intervention as reasonable and necessary medical care, should fulfill their obligation to their beneficiaries by covering such

therapy, and should be required to cover appropriate off-label uses of drugs on their formularies.

_____

[i] The FDA describes off-label use of approved drugs as "when a drug is used in a way that is different from that described in the FDA-approved drug label…New uses for these drugs may have been found, and often medical evidence supports the new use. But the makers of the drugs have not put them through the formal, lengthy, and often costly studies required by FDA to officially approve the drug for new uses."

For example, the drug is:

- Used for a different disease or medical condition.
- Given in a different way (such as by a different route).
- Given in a different dose.
- Given for a different patient population (e.g., age, gender)
- Given to patients with conditions for which the drug is contraindicated (e.g. specific medical conditions, pregnancy)
- Given in combination with another drug or drugs that are contraindicated in the label

Information Item 2

Background: The action paper titled "Multiple Co-payments Charged for Single Prescriptions" was referred to APA's General Counsel to determine the legality of the practice and to the CHSF for any additional follow-up. Ms. Coyle, APA General Counsel, reported back that the issues raised in the paper would not be a MHPAEA issue if this occurred for all drugs in short supply.

Generally speaking, the potential for being charged multiple co-payments for a single prescription falls into the following categories:

1. A partially-filled prescription, generally due to drug shortages
2. Controlled dispensing of Schedule II drugs

Partial-Fill Prescription

A partial-fill claim occurs when a pharmacy attempts to fill a prescription but finds there is not enough of the drug in stock to provide the entire prescribed quantity. There were a number of lawsuits and subsequent settlements in the late 1990s and early 2000s against pharmacy chains (e.g., Eckerd, Walgreens, CVS, Rite Aid) for fraudulently billing patients or insurers for the full cost of the prescription when only part of the prescription was filled. In January 2003, the

Maryland Attorney General's office announced a settlement with CVS pharmacies over this issue. Under the agreement, CVS pharmacies are required to clearly inform the customer of the following when dispensing a partially-filled prescription:

- That this is a partially-filled prescription, including the amount of medication that has been dispensed;
- The reason for providing only a partial-fill;
- That the consumer is not required to pay for the partial-fill prescription in whole, in part, or through any payment of a co-pay or deductible at the time the partial-fill is received; and
- Instructions on the need to return to the pharmacy to obtain the remaining medication.

The following is from a 2003 from Express Scripts (the largest pharmacy benefit management company in the US) directive http://www.express-scripts.com/pharmacist/notifications/docs/fax_partial_fill.pdf providing instructions on how to handle payment of a partially-filled prescription:

> How will the claim be priced and the member copay be determined?
>
> 1) The claim will be priced and a copay assigned based on the Intended Days Supply and Quantity
> 2) The claim will be priced based on the final cost calculation of the Intended Quantity
> 3) The Partial and Completed Claim will be prorated based on the Actual Days Supply and Quantity dispensed on each claim
> 4) The member will pay a prorated copay based on the actual quantity dispensed
> 5) The pharmacy will receive a prorated dispensing fee based on the actual quantity dispensed for both the partial and completed claim. This was necessary in order to accurately balance the payable amount to the pharmacy and the member copay between the two claims

There appears to be some variability in terms of how partial-fills are handled. However, the patient should pay no more than a prorated copay based on the actual quantity dispensed.

Controlled dispensing of Schedule II drugs

Schedule II drugs are defined by the DEA as "drugs with a high potential for abuse, less abuse potential than Schedule I drugs, with use potentially leading to severe psychological or physical dependence. These drugs are also considered dangerous. Examples of Schedule II drugs are: cocaine, methamphetamine, methadone, hydromorphone (Dilaudid), meperidine (Demerol), oxycodone (OxyContin), fentanyl, Dexedrine, Adderall, and Ritalin."

There are specific prescribing requirements. The following is from the DEA website:

Schedule II Substances

Schedule II controlled substances require a written prescription which must be signed by the practitioner. There is no federal time limit within which a Schedule II prescription must be filled after being signed by the practitioner.

While some states and many insurance carriers limit the quantity of controlled substance dispensed to a 30-day supply, there are no specific federal limits to quantities of drugs dispensed via a prescription. For Schedule II controlled substances, an oral order is only permitted in an emergency situation.

Refills

The refilling of a prescription for a controlled substance listed in Schedule II is prohibited (**Title 21 U.S. Code § 829**(a)).

Issuance of Multiple Prescriptions for Schedule II Substances

DEA has revised its regulations regarding the issuance of multiple prescriptions for schedule II controlled substances. Under the new regulation, which became effective December 19, 2007, an individual practitioner may issue multiple prescriptions authorizing the patient to receive a total of up to a 90-day supply of a schedule II controlled substance provided the following conditions are met:

1. Each separate prescription is issued for a legitimate medical purpose by an individual practitioner acting in the usual course of professional practice.
2. The individual practitioner provides written instructions on each prescription (other than the first prescription, if the prescribing practitioner intends for that prescription to be filled immediately) indicating the earliest date on which a pharmacy may fill each prescription.
3. The individual practitioner concludes that providing the patient with multiple prescriptions in this manner does not create an undue risk of diversion or abuse.
4. The issuance of multiple prescriptions is permissible under applicable state laws.
5. The individual practitioner complies fully with all other applicable requirements under the Controlled Substances Act and Code of Federal Regulations, as well as any additional requirements under state law.

It should be noted that the implementation of this change in the regulation should not be construed as encouraging individual practitioners to issue multiple

prescriptions or to see their patients only once every 90 days when prescribing Schedule II controlled substances. Rather, individual practitioners must determine on their own, based on sound medical judgment, and in accordance with established medical standards, whether it is appropriate to issue multiple prescriptions and how often to see their patients when doing so.

CONTROLLED SUBSTANCES LISTED IN SCHEDULE II

§1306.13 Partial filling of prescriptions.

(a) The partial filling of a prescription for a controlled substance listed in Schedule II is permissible if the pharmacist is unable to supply the full quantity called for in a written or emergency oral prescription and he makes a notation of the quantity supplied on the face of the written prescription, written record of the emergency oral prescription, or in the electronic prescription record. The remaining portion of the prescription may be filled within 72 hours of the first partial filling; however, if the remaining portion is not or cannot be filled within the 72-hour period, the pharmacist shall notify the prescribing individual practitioner. No further quantity may be supplied beyond 72 hours without a new prescription.

As noted above, quantity limits vary from state to state and payer to payer although it appears that many dispense in 30-day increments. What is less clear is the rules on patient co-pays. Feedback from the California State Board of Pharmacy is that co-pays could be applied for Schedule II prescriptions if there are changes to the dosage during the same prescription period.

Other

There are other practices such as the process of **synchronizing the patients medications so that the patients prescriptions may all be refilled at the same time (usually once per month),** that could impact the frequency or amount with which a copay is applied. No information on that aspect of the process was available at this time.

Next Steps

The OHSF is in the process of gathering additional information on issues related to pharmacy benefit management (PBM) and contacting the appropriate trade associations (e.g. Pharmaceutical Care Management Association). A survey will be sent in the next few weeks to APA members requesting feedback on PBM practices. Additionally, the OHSF will seek specific data from APA members via the APA Practice Management Helpline on instances where it is thought that multiple co-pays have been charged inappropriately.

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.

Item 2014A112.F
Assembly
May 2-4, 2014

ACTION PAPER

FINAL

TITLE: Psychiatrist Patient Relationship and Adverse External Influences in Resolving Danger

WHEREAS:

Whereas insurance policies and payments of hospital stay and outpatient psychiatric treatment can adversely affect the achievement of successful outcomes, and increase risk to the community, and

Whereas there are payment restrictions that prevent a therapy visit on the same day as a psychiatric visit, which reduce the possibility of successful outcome,

BE IT RESOLVED:
The APA promotes expansion of length of stay for inpatient treatment, when necessary to determine if a patient is or remains at risk or to initiate or continue treatment to reduce potential for violence; and promotes expansion of coverage for outpatient treatment for patients at risk of harm to self or others.

AUTHORS:
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ESTIMATED COST:
Author: $0
APA: $21,066.67

ESTIMATED SAVINGS:$0

ESTIMATED REVENUE GENERATED: $0

ENDORSED BY: Washington Psychiatric Society

KEY WORDS: Insurance influence on treatment; legislative intrusion
APA STRATEGIC GOAL: Advocating for Patients, Advocating for the Profession, Defining and Supporting Professional Values

REVIEWED BY RELEVANT APA COMPONENT: Sent to Council on Psychiatry and Law

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 represents safe and effective therapy, third party payers, including Medicare, should consider the intervention as reasonable and necessary medical care, should fulfill their obligation to their beneficiaries by covering such therapy, and should be required to cover appropriate "off-label" uses of drugs on their formularies. The APA recommends the following:

Prescribing and Reimbursement for FDA-Approved Drugs and Devices for Unlabeled Uses

1. APA reaffirms the following policies:

a. A physician may lawfully use an FDA-approved drug product or medical device for an unlabeled indication when such use is based upon sound scientific evidence and sound medical opinion;

b. When the prescription of a drug or use of a device represents safe and effective therapy, third party payers, including Medicare, should consider the intervention as reasonable and necessary medical care, irrespective of labeling, and should fulfill their obligation to their beneficiaries by covering such therapy; and

c. APA encourages the use of three compendia (AMA's *Drug Evaluations**; *United States Pharmacopeia-Drug Information*, Volume I*; and *American Hospital Formulary Service-Drug Information*) in conjunction with the peer-reviewed literature for determining the medical acceptability of unlabeled uses. (*These two compendia currently are being merged as the result of an alliance between the American Medical Association and the United States Pharmacopeia.)

Dissemination of Information about Unlabeled Uses of Drugs and Devices by Manufacturers

2. APA strongly supports the need for physicians to have access to accurate and unbiased information about unlabeled uses of drugs and devices, while ensuring that manufacturer-sponsored promotions remain under FDA regulation.

3. APA supports the dissemination of independently derived scientific information about unlabeled uses by manufacturers to physicians, if the independent information is provided in its entirety [including comprehensive results of relevant clinical trials], is not edited or altered by the manufacturer, and is clearly distinguished from manufacturer-sponsored materials. Dissemination of information by manufacturers to physicians about unlabeled uses can be supported under the following conditions:

a. **For Reprints** of independently derived articles from reputable, peer-reviewed journals, the following criteria must be met:

   i. The article should be peer reviewed and published in accordance with the regular peer review procedure of the journal in which it is published;

   ii. The reprint should be from a peer-reviewed journal that both has an editorial board and utilizes experts to review and objectively select, reject, or provide comments about proposed articles; such experts should have demonstrated expertise in the subject of the article under review, and be independent from the journal;

   iii. The journal should be recognized to be of national scope and reputation, as defined by an advisory panel to the FDA; among its members, this advisory panel should have representatives from national psychiatric societies;

   iv. The journal must be indexed in the *Index Medicus* of the National Library of Medicine;

   v. The journal must have and adhere to a publicly stated policy of full disclosure of any conflicts of interest or biases for all authors or contributors;

   vi. When the subject of the article is an unlabeled use, or the article contains information that differs from approved labeling, the industry sponsor disseminating the reprint must disclose that the reprint includes information that has not been approved by the FDA and attach a copy of the FDA-approved professional labeling with the reprint;

   vii. If financial support for the study and/or the author(s) was provided by the industry sponsor disseminating the reprint, and this is not already stated in the article, then this information should be clearly disclosed with the reprint.

b. **For Reprints of monographs or chapters from the three compendia** (AMA's *Drug Evaluations*; *United States Pharmacopeia-Drug Information*, Volume I; and *American Hospital Formulary Service-Drug Information*) named in federal statutes for determining the medical acceptability of unlabeled uses, the following criteria must be met:

i. The monograph or chapter should be reprinted in entirety by the publisher of the compendia, and the reprints then sent to the requesting industry sponsor;
ii. The reprints of the monographs or chapters should not be altered in any way by the industry sponsor;
iii. The industry sponsor disseminating the reprint of the monograph or chapters should disclose that the reprint includes information that has not been approved by the FDA and should attach a copy of the FDA-approved professional labeling with the reprint.

c. **For Complete Textbooks** the following criteria must be met:

i. The reference text should not have been written, edited, excerpted, or published specifically for, or at the request of, a drug, device, or biologic firm; when financial support is provided by a drug, device, or biologic firm, it should be disclosed clearly in the textbook;
ii. The content of the reference text should not have been edited or significantly influenced by a drug, device, or biologic firm, or agent thereof;
iii. The reference text should be generally available for sale in bookstores or other distribution channels where similar texts are normally available and should not be distributed only or primarily through drug, device, or biologic firms;
iv. The reference text should not focus primarily on any particular drug(s), device(s), or biologic(s) of the disseminating company, nor should it have a significant focus on unapproved uses of drug(s), device(s), or biologic(s) marketed or under investigation by the firm supporting the dissemination of the text;
v. Specific product information (other than the approved package insert) should not be physically appended to the reference text.

d. **For Proprietary Information** indicating that a drug is ineffective or unsafe when used for a specific unlabeled indication, manufacturers should report to the FDA and share with all physicians all of the proprietary information.

e. **For Continuing Medical Education (CME) activities and information:**

i. The FDA should continue to support principles in the FDA Draft Policy Statement on Industry-Supported Scientific and Educational Activities (Fed. Reg. 1992; 57:56412-56414); the FDA Draft Policy Statement acknowledges the importance of relying on professional health-care communities, rather than the FDA, to monitor independent provider activities;
ii. The FDA should continue a policy of regulatory deference for industry-supported CME activities conducted by organizations accredited by the Accred-itation Council for Continuing Medical Education (ACCME), state medical societies, and specialty societies such as the American Psychiatric Association (APA), that follow the Essentials and Standards of the ACCME and that may be certified for AMA PRA credit under the auspices of the American Medical Association Physician's Recognition Award program.

4. APA strongly supports the responsibility of physicians to interpret and put into context evidence received from all sources [including pharmaceutical manufacturers], before making clinical decisions (i.e.., prescribing a drug for an unlabeled use).

Improving the Supplemental New Drug Application (SNDA) Process

5. APA strongly supports the addition to FDA-approved labeling those uses of drugs for which safety and efficacy have been demonstrated.

6. APA strongly encourages the US Congress, the FDA, pharmaceutical manufacturers, the United States Pharmacopeia, patient organizations, APA and other medical specialty societies to work together to ensure that Supplemental New Drug Applications (SNDAs) for new indications (efficacy supplements), including those for uses in populations with mental disorders , are submitted and acted upon in a timely manner. Specific recommendations include:

a. **User fee legislation should be re-authorized** to ensure that the FDA has the necessary resources to act on all efficacy supplements within six months of submission;
b. **The SNDA process should be streamlined** as much as possible without compromising the requirements for substantial evidence of efficacy and safety;
c. **Legislation should be enacted** that provides extensions of marketing exclusivity for a product to manufacturers who conduct supplemental research [i.e., Phase IV studies] and submit efficacy supplements gaining FDA approval for additional indications; the legislation should place a limit on total length of extended marketing exclusivity;
d. **For drugs no longer under patent and for which generic versions are available**, the FDA, other governmental agencies (e.g., the National Insti-tutes of Health), the pharmaceutical industry, the United States Pharmacopeia, patient organiza-tions, the APA and other medical specialty societies should discuss and mutually agree on alternative mechanisms to ensure that efficacy supplements based on relevant research findings will be submitted to and acted upon by the FDA in a timely manner.

Encouraging Clinical Research in Child and Adolescent Psychiatry

7. APA urges pharmaceutical manufacturers and the FDA to work with the American Psychiatric Association, the American Academy of Child and Adolescent Psychiatry, and the American College of Neuropsychopharmacology and other experts in pediatric medicine to identify those investigational drugs that should have pediatric indications and set up a mechanism to ensure that necessary pediatric clinical studies are completed prior to submission of NDAs for approval of these drug products.

COUNCIL ON RESEARCH
REPORT TO THE JOINT REFERENCE COMMITTEE

Executive Summary

Since the Council's face-to-face gathering at the 2014 September Components Meeting, the group has been primarily working on the following two issues: 1) reviewing the remaining expired APA position statements under their purview, and 2) responding to the JRC's request to develop a list of pros and cons to removal of the FDA's black box warning on antidepressants. The Council has scheduled their next in-person meeting at the 2015 APA Annual Meeting for Tuesday, May 19, 2015, from 9 a.m. to noon.

The Council brings the following Action Items:

Action Item 1: Will the Joint Reference Committee recommend that the Assembly vote to approve the revised Position Statement on College and University Mental Health?

- See Attachment 1 for revised position statement.
- The statement is still relevant, but the Council is recommending that this statement be revised for language and clarity.

Action Item 2: Will the Joint Reference Committee recommend that the Assembly vote to approve the revised Position Statement on the Publication of Clinical Trial Findings?

- See Attachment 2 for position statement.
- The statement is still relevant, but the Council is recommending that this statement be revised for language and clarity.

Action Item 3: Will the Joint Reference Committee recommend that the Assembly vote to approve the revised Position Statement on Hypnosis?

- See Attachment 3 for revised position statement.
- The statement is still relevant, but the Council is recommending that this statement be revised for language and clarity. Revisions also were made to reflect advances in clinical research on hypnosis.

Action Item 4: Will the Joint Reference Committee recommend that the Assembly vote to retain the Position Statement on Use of the Concept of Recovery?

- See Attachment 4 for position statement.
- The Council is recommending that this statement be retained as-is because it is still relevant and worded appropriately.

Action Item 5: Will the Joint Reference Committee recommend that the Assembly vote to approve the revised Position Statement on the Use of Animals in Research?

- See Attachment 5 for revised position statement.
- The statement is still relevant, but the Council is recommending that this statement be revised for language and clarity.

Action Item 6: Will the Joint Reference Committee recommend that the Assembly vote to retain the Position Statement on Interference with Scientific Research and Medical Care?

- See Attachment 6 for position statement.
- The Council is recommending that this statement be retained as-is because it is still relevant and worded appropriately.

Action Item 7: Will the Joint Reference Committee recommend that the Assembly vote to retain the Position Statement on Medication Substitutions?

- See Attachment 7 for position statement.
- The Council is recommending that this statement be retained as-is because it is still relevant and worded appropriately.

Action Item 8: Will the Joint Reference Committee recommend that the Assembly vote to retain the Position Statement on Electroconvulsive Therapy (ECT)?

- See Attachment 8 for position statement.
- The Council is recommending that this statement be retained as-is because it is still relevant and worded appropriately.

Action Item 9: Will the Joint Reference Committee refer the Position Statement on Death Sentences for Persons with Dementia or Traumatic Brain Injury to the Council on Psychiatry and the Law?

- See Attachment 9 for position statement.
- The Council on Research feels this statement more appropriately falls under the purview of the Council on Psychiatry and the Law. The Council on Research is happy to review any of their suggested revisions but believes that the Council on Psychiatry and the Law should take primary ownership of this position statement.

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 Position Statement on Atypical Antipsychotic Medications.

Referral Updates

The Council wishes to provide updates on the following Joint Reference Committee referrals:

Referral 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 FDA black box warning from antidepressants. Their findings are summarized in a brief report (Attachment 10).

Referral Item Number: JRCOCT148.L.4
Title: Referral of Position Statements to the Council on Research
Action: The Joint Reference Committee referred the following position statements to the Council on Research for evaluation and encouraged them to consolidate into a single statement: 2009 Position Statement on HIV and Adolescents; 2009 Position Statement on HIV Antibody Testing; 2009 Position Statement on HIV and Inpatient Psychiatric Services; 2009 Position Statement on HIV and Outpatient Psychiatric Services; and Position Statement on Recognition and Management of HIV-Related Neuropsychiatric Findings and Associated Impairments.

The Council on Research made some minor revisions to these statements and forwarded them to the Steering Committee on HIV Psychiatry for their review. The Committee is still reviewing the statements.

Referral Item Number: JRCOCT148.A.2
Title: Position Statement on Recognition and Management of Substance Use Disorders Comorbid with HIV
Action: The Joint Reference Committee referred the position statement back to the Council on Addiction Psychiatry and the Council on Research to determine which version of the position statement, the 2014 or the 2012, is the most current and should be retained. The Council on Addiction Psychiatry confirmed that the statement from 2012, currently on the APA website, is the one that should be retained.

Attachments
Attachment 1: Revised Position Statement on College and University Mental Health

Attachment 2: Revised Position Statement on the Publication of Clinical Trial Findings

Attachment 3: Revised Position Statement on Hypnosis

Attachment 4: Position Statement on Use of the Concept of Recovery

Attachment 5: Revised Position Statement on the Use of Animals in Research

Attachment 6: Position Statement on Interference with Scientific Research and Medical Care

Attachment 7: Position Statement on Medication Substitutions

Attachment 8: Position Statement on Electroconvulsive Therapy (ECT)

Attachment 9: Position Statement on Death Sentences for Persons with Dementia or Traumatic Brain Injury

Attachment 10: Report from the Council on Research on the Removal of the Black Box Warning for Antidepressants

Attachment 1

Revised 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~~ student health and counseling centers. 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~~ young adults, especially when faced with ~~more~~ intensive ~~grade~~ academic pressure to perform. Stressors can also develop following separation from parents ~~and friends, and the continuing and~~ and from the ongoing formation of ~~one's~~ personal identity. In addition, several psychiatric disorders begin during late adolescence and early treatment is often necessary during this time. Data shows that treatment for mental health problems results in higher rates of student retention and graduation.

~~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 psychiatrists 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.~~ 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 that of treating the student, psychiatrists should serve in a consultative capacity in academic decisions, but the final decisions should rest with those not involved in the direct health care of students.
4. ~~offer~~ ensure that health insurance coverage ~~programs~~ to students ~~that~~ provides 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~~ implement programs that focus on wellness and prevention on a larger scale, including those offering strategies for stress management 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; and revised by the Council on Research, November 2014.

Attachment 2

Revised Position Statement on Publication of Findings from Clinical Trials

This document states the position of the American Psychiatric Association (APA) on the publication rights of researchers participating in clinical trials and on the broader issue of participation in a national, comprehensive, clinical trials registry as a condition for publication in peer-reviewed scientific journals.

The APA ~~believes that all~~ encourages researchers ~~should have the freedom to contribute to the design of clinical trials~~ , whenever possible, to critically evaluate the design of an established trial when they consider participation, and to publish all findings from the trials in which they participate regardless of outcome. APA ~~thus~~ discourages investigators and their institutions ~~who~~ participat~~e~~ing in clinical trials research from entering into agreements with trial sponsors that place restrictions of any kind on the right to publish.

~~Simultaneously,~~ The APA urges Institutional Review Boards (IRBs) and journal editors to require researcher assurances of unfettered access to methodology, findings and results as a condition of approval and of publication, respectively. Public accessibility to all methods and findings related to clinical trials has direct implications for improved patient care and treatment, while the suppression of negative findings has the potential of exposing patients to ineffective and potentially harmful treatments.

With regard to the overarching issue of research integrity in the conduct of clinical trials, APA ~~believes that a comprehensive~~ endorses participation in, and values the function of, clinicaltrials.gov and believes a public registry of all clinical trials initiated in the United States, whether publicly—or privately funded, promotes transparency ~~will go a long way toward alleviating the mistrust and doubt currently surrounding published data on the~~ of information relevant to efficacy and safety of ~~medications~~ treatments for children and for adults diagnosed with mental disorders.

~~The APA supports and advocates for legislation mandating and funding a national registry initiative to be implemented by the National Institutes of Health in accordance with principles and procedures already established and successfully implemented in other comprehensive national and international databases. As part of the legislation on this subject, the APA strongly encourages inclusion of provisions—directed toward IRBs and scientific journals—that require registration and assignment of unique trial identifiers as conditions of IRB approval and of journal publication.~~

~~Additionally, in the interest of improved ethical standards and public safety, the APA encourages legislative provisions that require registration as a necessary condition for clinician referral and for patient participation in clinical trials.~~

Attachment 3

Revised Position Statement on Hypnosis

Hypnosis is a state of aroused, attentive, focal concentration accompanied by a relative reduction in peripheral awareness (dissociation), and heightened response to social cues (suggestibility). It can be utilized to facilitate a variety of psychotherapeutic interventions, including psychodynamic, cognitive-behavioral, and exposure-based treatments. ~~Hypnosis is a specialized psychiatric procedure and as such is an aspect of the doctor-patient relationship. Hypnosis is not in itself a therapy, but rather is a state of aroused, attentive, focal concentration with a relative reduction in peripheral awareness that can be utilized to facilitate a variety of psychotherapeutic interventions.~~ The capacity to experience hypnosis can be spontaneous or it can be activated by a formal induction procedure which taps the inherent ~~neural~~ hypnotic capacity of the individual. This capacity varies widely but is a stable trait that can be reliably measured in clinical and research settings. Hypnosis provides an adjunct to research, to diagnosis and to treatment in psychiatric and other medical practice. Because of its intensity and adaptability to training patients in the use of self-hypnosis for symptom management, it ~~It~~ often shortens the clinical time required for a psychotherapeutic effect.

Randomized clinical trials have shown that interventions employing hypnosis are effective in the treatment of pain, anxiety, stress, cancer surgery, phobias, psychosomatic disorders, nausea and vomiting, irritable bowel syndrome, and habit control problems such as smoking and weight control. It is also helpful in the management of patients with dissociative and posttraumatic stress disorders. Clinical trials have demonstrated comparable outcomes to exposure-based and psychodynamic treatment for PTSD, smoking cessation rates that compare favorably with pharmacological approaches, and superior analgesia and anti-anxiety effects to standard medication during medical procedures.

Since hypnosis is a psychotherapeutic facilitator of a primary treatment strategy, it should be employed by psychiatrists, other physicians, psychologists, or other health care professionals with appropriate licensure and training, and utilized within the scope of their professional expertise. Hypnosis or hypnotic treatment, as in any other ~~psychiatric~~ medical procedure, calls for all examinations necessary to ~~a~~ properly diagnose ~~diagnosis~~ and ~~to the formulation of~~ adequately formulate the immediate therapeutic needs of the patient. The technique of induction and termination of the trance state should be clearly structured and usually can be brief. ~~Long induction ceremonies using a sleep paradigm are misleading.~~

Because of the heightened responsiveness to suggestion in hypnosis, it is especially important that therapeutic strategies and language be formulated carefully. ~~Although similar dangers attend the improper or inept use of all other aspects of the doctor-patient relationship, the nature of hypnosis renders its inappropriate use particularly hazardous. For hypnosis to be used safely, even for the relief of pain or for sedation, more than a superficial knowledge of the dynamics of human motivation is essential.~~

Since hypnosis has definite application in the various fields of medicine and allied health care disciplines, appropriate training is important. Courses conducted~~, physicians have recently shown increasing interest in hypnosis and have turned to psychiatrists for training in hypnosis.~~

~~To be adequate for medical purposes, all courses in hypnosis should be given~~ in conjunction with recognized medical teaching institutions or teaching hospitals, or appropriate professional organizations in medicine, psychology, and related disciplines provide a basis for practice. ~~under the~~

~~auspices of the department of psychiatry and in collaboration with those other departments which are similarly interested.~~ Although lectures, demonstrations, seminars, conferences and discussions are helpful, the basic learning experience ~~must~~ should also derive from closely supervised clinical contact with patients. ~~Since such psychiatrically centered courses are virtually non-existent, many physicians have enrolled in the inadequate brief courses available, which are taught often by individuals without medical or psychiatric training. These courses have concentrated on prolonged redundant induction ceremonies and have neglected or covered psychodynamics and psychopathology in a superficial or stereotyped fashion.~~

Originally developed by the APA Committee on Therapy and adopted by the APA Council in 1961. This revision was prepared by David Spiegel, M.D., Michael First, Ph.D., and John Krystal, M.D. ~~and Herbert Spiegel, M.D.~~

Attachment 4

Position Statement on Use of the Concept of Recovery
Approved by the Board of Trustees, July 2005
Approved by the Assembly, May 2005

The American Psychiatric Association endorses and strongly affirms the application of the concept of recovery to the comprehensive care of chronically and persistently mentally ill adults, including the concept of resilience in seriously emotionally disturbed children. The concept of recovery emphasizes a person's capacity to have hope and lead a meaningful life, and suggests that treatment can be guided by attention to life goals and ambitions. It recognizes that patients often feel powerless or disenfranchised, that these feelings can interfere with initiation and maintenance of mental health and medical care, and that the best results come when patients feel that treatment decisions are made in ways that suit their cultural, spiritual, and personal ideals. It focuses on wellness and resilience and encourages patients to participate actively in their care, particularly by enabling them to help define the goals of psychopharmacologic and psychosocial treatments.

The concept of recovery has a long history in medicine and its principles are important in the management of all chronic disorders. The concept of recovery enriches and supports medical and rehabilitation models. By applying the concept of recovery as well as rehabilitation techniques and by encouraging other mental health professionals to adopt the concept of recovery, psychiatrists can enhance the care of all clinical populations served within the community based and other public sector mental health and behavioral health systems.

The concept of recovery values include maximization of 1) each patient's autonomy based on that patient's desires and capabilities, 2) patient's dignity and self-respect, 3) patient's acceptance and integration into full community life, and 4) resumption of normal development. The concept of recovery focuses on increasing the patient's ability to successfully cope with life's challenges, and to successfully manage their symptoms. The application of the concept of recovery requires a commitment to a broad range of necessary services and should not be used to justify a retraction of resources.

The concept of recovery is predicated on a partnership between psychiatrist, other practitioners, and patient in the construction and direction of all services aimed at maximizing hope and quality of life.

Attachment 5

Revised Position Statement on Use of Animals in Research

In recognition of the need for the appropriate and humane use of animals in research, and in response to the growing pressure from other organizations that would deny Americans the health benefits evolving from research using animals, the APA joins with other scientific and medical organizations in support of the following policy statement:

1. Psychiatric medicine is at a crucial point. The past few ~~years~~ decades have seen tremendous advances in neuroscience, in our capacity to diagnose and treat patients effectively. The advances depend in large part on studies of living systems, requiring the use of laboratory animals. Building on these advances also will require animal studies.

2. The study of living systems is essential, either directly or indirectly, to virtually all forms of biological, behavioral and medical research. The absence of laboratory animals would paralyze basic research in the life sciences as well as bring an end to the overwhelming majority of research programs aimed at relieving human disease and suffering. Behavior is the cornerstone of psychiatric diagnosis and it cannot be studied in vitro. This necessitates the use of animals or humans to better understand behavior.

3. Today, the psychiatric and neuroscience community is on the threshold of even greater progress through expanded research in genetics, neuroimaging, immunology, epidemiology and in understanding the complex functioning of neurotransmitters. Because of the complexity of these interrelated areas, further research cannot depend upon the use of human volunteers, computer models or epidemiological studies. Further advances against mental illnesses must continue to depend on the use of living systems, mandating the careful and humane use of animals, and respect for them as living beings.

4. In recognition of this necessity, society at large supports the humane treatment of animals in research. It has conferred upon psychiatric researchers who use animals a high level of responsibility for the health and well-being of these living creatures entrusted to their care. Psychiatric researchers must make every effort to ensure that their research is conducted in a humane manner. They should permit no unnecessary pain or discomfort. They should design experiments using the minimum number of animals necessary to ensure scientific validity.

5. All research with animals must be conducted with strict adherence to the standards promulgated by appropriate scientific and professional organizations, as well as in compliance with applicable federal, state or local statutes.

~~Because the major psychiatric disorders are now known to arise from dysfunction of the brain, it is necessary to better understand brain function in order to understand the pathophysiology of psychiatric disorders.~~

This revision of the 1989 statement was developed by the Council on Research and Quality Care.

Attachment 6

Position Statement on Interference with Scientific Research and Medical Care
Approved by the Board of Trustees, September 2009
Approved by the Assembly, May 2009

The American Psychiatric Association deplores any and all acts of intimidation, physical interference, terrorism, and violence that impede the progress of scientific research or the provision of legal medical care.

Patients in need of medical psychotherapy should have the same respect and access to care as any other persons needing medical treatment. APA strongly objects to stereotyping or caricaturing patients who utilize medical psychotherapy, especially in ways that minimize the seriousness of their illness.

The position statement originally was approved by the Assembly in May 1995 and by the Board of Trustees in March 1995.This position statement was proposed by the Council on National Affairs. The members of the council are Terry Stein, M.D. (chairperson), Nada L. Stotland, M.D. (vice chairperson and Assembly liaison), Leah J. Dickstein, M.D., Clifford K. Moy, M.D., Lourdes M Dominguez, M.D., Fred Gottlieb, M.D. (Board liaison), Mary Kay Smith, M.D. (Board liaison), Billy Jones, M.D. (observer-consultant), and Andrew J. Elliott, M.D. (APA/BurroughsWellcome Fellow).

Attachment 7

Position Statement on Medication Substitutions
Approved by the Board of Trustees, December 1995
Reaffirmed, September 2009

The American Psychiatric Association opposes the practice of therapeutic interchange of psychoactive medication, including the interchangeability of generic and brand medications, without the express consent of the prescribing psychiatrist.

The above statement if considered a supplement to the Joint Statement on Anti-substitution Laws and Regulations, which was adopted by the American Psychiatric Association in February 1973, and is endorsed by a number of other medical societies.

Attachment 8

Position Statement on Electroconvulsive Therapy (ECT)
Approved by the Board of Trustees, December 2007
Approved by the Assembly, November 2007

Electroconvulsive Therapy (ECT) is a safe and effective evidence-based medical treatment. ECT is endorsed by the APA when administered by properly qualified psychiatrists for appropriately selected patients.

Attachment 9

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

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."

Attachment 10

Report from the Council on Research on the Removal of the Black Box Warning for Antidepressants

The charge to the Council on Research from the Joint Reference Committee (JRC) was to articulate the pros and cons of removing the black box warning from antidepressants for children and adolescents in an effort to inform a decision as to whether or not the APA should take action in recommending the FDA rescind the warning.

A subcommittee of the Council was formed, consisting of Drs. James Potash (chair), Daniel Pine, and William McDonald, with APA Administration support from Drs. William Narrow and Emily Kuhl, and the group held four conference calls to discuss relevant points to be considered. They sought input from outside experts who have extensive research experience on the impact of the black box warning on antidepressant use, including Drs. J. John Mann, Robert Gibbons, Mark Olfson, and John Walkup. The subcommittee also sought perspectives from the APA Division of Government Relations, including Mr. Rodger Currie and Ms. Lizbet Boroughs, both of whom have previous experience with the FDA and black box warning hearings.

In accordance with the request from the JRC, and based on their discussions with the experts, the Council reports the following pros and cons to removing the warning.

Pros to Removing the Warning

Data clearly indicate a reduction in antidepressant prescribing and depression diagnoses for children and adolescents following the placement of the black box warning in 2004 (Lu et al., 2014; Friedman 2014; Libby et al., 2009; Libby et al., 2007). This was associated with an increase in suicide attempts and completed suicides among adolescents and young adults from 2005-10 (Lu et al.). Anecdotally, because of the black box warning, some experts cited that patients and families are questioning recommendations for antidepressant treatment and refusing medications recommended by their psychiatrist. Thus, a potential upside to removing the warning would be that a larger proportion of children and adolescents would benefit from appropriate antidepressant treatment of their depressive illness.

A corollary to the above is that our experts reported an increase in the off-label prescribing of antipsychotic medications to treat depression and anxiety due to a concern amongst prescribers of the legal implications of prescribing antidepressants with this black box warning. This is consistent with documented trends of the increased off-label use of antipsychotics in children by both psychiatrists and non-psychiatrists (Ronsley et al., 2013) and the data indicating a surge in the use of antipsychotics among children and adolescents over the past decade (Olfson et al., 2012; Matone et al., 2012). The use of antipsychotics in children and adolescents brings with it a host of serious side effects, such as weight gain, cardiac risks, and other aspects of metabolic syndrome.

Cons to Removing the Warning

Suicidal ideation or behaviors can occur in the setting of child and adolescent antidepressant use, and the FDA has a recommendation from their panel of experts that the black box warning is justified by data. More recent analyses by the FDA have supported the black box warning (Stone 2014). Thus, to the extent that removing the warning would increase prescription rates, it is conceivable that suicidal ideation or behaviors could increase too. This would support maintaining the warning.

From the perspective of the pharmaceutical industry, a downside to removing the warning includes the potential for increased liability in the setting of bad outcomes for children and adolescents taking antidepressants. In fact, in order for the FDA to evaluate changing the black box warning, a pharmaceutical company that was marketing the drug would have to file a petition with the FDA. The APA or other interested parties cannot file such a petition. Mr. Currie noted that pharmaceutical

companies would be very hesitant to partner with the APA given the appearance of collusion with doctors in an effort to expand pharmaceutical prescriptions.

An additional drawback is that, given the intense feelings that some patients and families have about psychiatric medications, if the APA is viewed as being a partner in removing the black box warning then the APA could be inappropriately accused of "pushing dangerous medications" on vulnerable patients. Ms. Boroughs described the situation when the black box warning was originally being discussed and the public outcry from families of patients who had committed suicide on antidepressants expressed toward the APA for its opposition to the black box warning. In the view of many patients and advocacy groups, the APA has a conflict of interest when it comes to prescribing antidepressants.

Conclusions

One key issue evolved from the Council's discussions on this topic. Nearly all of the experts agreed that the weight of the data published since 2004 would not be strong enough to persuade the FDA to overturn the label, nor would it be compelling enough to convince the FDA to reconvene a panel to discuss the *possibility* of overturning the label. Dr. Marc Stone of the FDA has gone on record stating that data refuting the evidence that antidepressants increase suicidal risk in children and adolescents are flawed (Stone, 2014). Based on feedback from those with prior experience with the FDA and black box warning hearings, it became clear that the FDA's interest in re-analyzing data or revisiting their decision would be extremely low. This is further complicated by the fact that pharmaceutical companies would have very little incentive (financial or otherwise) to encourage the FDA toward such a move, especially since most antidepressants have now gone off patent. Thus, scientifically, politically, and practically, the evidence does not support the APA taking direct action in asking the FDA to remove the warning.

One potential action that garnered support was that of the APA advocating for an organization, particularly the Patient-Centered Outcomes Research Institute, to fund a large-scale study to generate the type of gold-standard data the FDA would require for them to reconsider the warning (e.g., data gathered from prospective, randomized, placebo-controlled studies using the FDA-supported Columbia Suicide Severity Rating Scale). The Council is therefore recommending that the APA advocate for research to prospectively evaluate the risk/benefit ratio of antidepressants in children and adolescents with major depression. The APA should partner with other interested parties, such as the American Academy of Child and Adolescent Psychiatry (AACAP), to support research in this area.

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Action Item 1

Will the Joint Reference Committee approve the recommendation by the Council on Geriatric Psychiatry and the Council on Quality Care to update the Choosing Wisely List item number three on the care of patients with dementia?

- Revised Choosing Wisely item number three, Attachment 1
- Article to support the recommended change, Attachment 2

Action Item 2

Will the Joint Reference Committee approve the recommendation by the Committee on Mental Health Information Technology to update the title of the Position Statement originally entitled "Position Statement on the Ethical Use of Telemedicine?"

- The CMHIT reviewed this statement during their November 12, 2014 and December 10, 2014 monthly teleconferences. The Committee requests that the word "Ethical" be deleted from this statement title. The rest of the statement is requested to remain the same.
- Original position statement with red-lined version, Attachment 3

Action Item 3

Will the Joint Reference Committee recommend that the Board of Trustees vote to approve the Council on Quality Care's revised charge to omit HIV psychiatry?

- See Attachment 4 for the most current charge

Referral Updates

In response to the request "Will the Joint Reference Committee refer the request from the Council on Healthcare Systems and Financing to the Council on Quality Care to review the performance measures currently in place on integrated care to determine what measures are needed?" (Agenda item 8.G.21)

- An integrated care measure environmental scan was completed and put into an Excel spreadsheet for the Report to BOT AHWG on Healthcare Reform.

The Registry Workgroup is in the process of finalizing the recommendation report and will be shared with the JRC upon completion.

Attachment # 1

Don't routinely use antipsychotics as first choice to treat behavioral and psychological symptoms of dementia.

Behavioral and psychological symptoms of dementia are defined as the non-cognitive symptoms and behaviors, including agitation or aggression, anxiety, irritability, depression, apathy and psychosis. Evidence shows that risks (e.g., cerebrovascular effects, mortality, parkinsonism or extrapyramidal signs, sedation, confusion and other cognitive disturbances, and increased body weight) tend to outweigh the potential benefits of antipsychotic medications in this population. Clinicians should **generally** limit the use of antipsychotic medications to cases where non-pharmacologic measures have failed and the patients' symptoms may create a threat to themselves or others. This item is also included in the American Geriatric Society's list of recommendations for "*Choosing Wisely*."

The Long-Term Effects of Conventional and Atypical Antipsychotics in Patients With Probable Alzheimer's Disease

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Objective: The authors sought to determine the effects of conventional and atypical antipsychotic use on time to nursing home admission and time to death in a group of outpatients with mild to moderate probable Alzheimer's disease.

Method: The authors examined time to nursing home admission and time to death in 957 patients with the diagnosis of probable Alzheimer's disease who had at least one follow-up evaluation (mean follow-up time, 4.3 years [SD=2.7]; range, 0.78–18.0 years) using Cox proportional hazard models adjusted for age, gender, education level, dementia severity, hypertension, diabetes mellitus, heart disease, extrapyramidal signs, depression, psychosis, aggression, agitation, and dementia medication use.

Results: A total of 241 patients (25%) were exposed to antipsychotics at some time during follow-up (conventional, N=138; atypical, N=95; both, N=8). Nursing home admission (63% compared with 23%) and death (69% compared with 34%) were more frequent in individuals taking conventional than atypical antipsychotics. In a model that included demographic and cognitive variables, hypertension, diabetes mellitus, heart disease, incident strokes, and extrapyramidal signs, only conventional antipsychotic use was associated with time to nursing home admission. However, the association was no longer significant after adjustment for psychiatric symptoms. Psychosis was strongly associated with nursing home admission and time to death, but neither conventional nor atypical antipsychotics were associated with time to death.

Conclusions: The use of antipsychotic medications, both conventional and atypical, was not associated with either time to nursing home admission or time to death after adjustment for relevant covariates. Rather, it was the presence of psychiatric symptoms, including psychosis and agitation, that was linked to increased risk of institutionalization and death after adjustment for exposure to antipsychotics.

(Am J Psychiatry 2013; 170:1051–1058)

Antipsychotics are widely used to treat symptoms of psychosis and disruptive behaviors in patients with Alzheimer's disease (1). Although both conventional and atypical antipsychotics are used to treat patients with dementia, the use of atypical antipsychotics has significantly increased over the past 2 decades. These have similar efficacy and fewer side effects than conventional antipsychotics, especially in terms of sedation, extrapyramidal signs, orthostatic hypotension, and ECG abnormalities (2, 3). Short-term trials have shown a mixed behavioral response to conventional and atypical antipsychotics in patients with Alzheimer's disease (4–6).

There is significant concern among physicians and public health authorities about the reported increased mortality in elderly demented patients exposed to either conventional or atypical antipsychotics (7–10), although increased mortality is not a universal finding (11–13). A meta-analysis of randomized controlled trials with atypical antipsychotics found that these agents were associated with a small increase in risk for death in patients with Alzheimer's disease (8), leading the Food and Drug Administration to issue a black box warning (April 2005). In addition, studies in nonselected populations found an increase in heart disease and stroke among antipsychotic users (14, 15), and a similar trend has been noted in placebo-controlled studies (16). However, this result has not been found by others (11, 17), and it has been hypothesized that previous exposure to antipsychotics or the presence of other comorbid conditions (e.g., metabolic syndrome) may have predisposed some patients to develop vascular events (18).

We know very little about the effects of antipsychotics on the natural history of Alzheimer's disease. The majority of trials with atypical antipsychotics have been conducted in institutionalized patients in the later stages of the disease and tended to be of short duration. Of the 15 trials examined by the Cochrane Review (19), 13 used samples of institutionalized patients and two used samples of mixed dementia populations. Mean scores on the Mini-Mental State Examination

This article is featured in this month's AJP Audio, is an article that provides Clinical Guidance (p. 1058), is the subject of a CME course (p. 1075), and is discussed in an Editorial by Dr. Devanand (p. 957)

(MMSE) ranged from 2.8 to 14.4 (severe impairment), and the trials lasted only 10–12 weeks (19). Only one study (9) continued follow-up for more than a ear, and this was in a group of dementia patients residing in care facilities in the United Kingdom. That study found an increased risk for death in those treated mainly with conventional antipsychotics. However, only 13 of the 128 patients entered in the study completed the 48 months of follow-up.

The study of the long-term effects of antipsychotics in Alzheimer's disease is extremely complex. The same symptoms (e.g., agitation and psychosis) for which antipsychotics are used can themselves accelerate the clinical progression of the dementia syndrome (i.e., confounding by indication) (20–23). In addition, these medications are used at different stages of dementia (including early), and in some cases they are used in combination with other psychotropic treatments (e.g., antidepressants). A study of patients with Alzheimer's disease with moderate dementia taking mainly conventional antipsychotics (22) found that psychosis, agitation, aggression, and antipsychotic use independently increased the risk of functional decline, and psychosis was associated with nursing home admission. Thus, while there may be a link between the use of antipsychotics and death in patients with Alzheimer's disease, the data supporting this conclusion are complicated by the fact that studies used samples of institutionalized patients who had severe cognitive deficits and exhibited symptoms that were themselves linked to cognitive or behavioral morbidity.

We report here an analysis of the long-term effects of antipsychotics in a large cohort of patients with probable Alzheimer's disease who were followed between 1983 and 2005. This observation period is unique and fortuitous because it occurred during the time of transition from the use of conventional to atypical antipsychotics. This allowed us to examine the long-term effects of these two types of compounds on time to nursing home admission and time to death in the context of multiple clinical comorbidities.

Method

All of the patients were participants in the Alzheimer's Research Program (1983–1988) and the Alzheimer's Disease Research Center of Pittsburgh (1985–2005). A total of 1,886 Alzheimer's patients were enrolled between April 1983 and December 2005, of whom 1,587 had a diagnosis of probable Alzheimer's disease (24). The sensitivity for Alzheimer's disease was 98% and the specificity was 88% in this cohort (25). All patients received an extensive neuropsychiatric evaluation that included medical history and physical examination, neurological history and examination, semistructured psychiatric interview, neuroimaging, and neuropsychological assessment (25). At the conclusion of these examinations, each individual set of results was reviewed by the study team (neurologists, neuropsychologists, and psychiatrists) at a consensus conference. Clinical evaluations were repeated on an annual basis. When patients stopped coming to the clinic, a telephone interview was conducted to obtain their clinical status, living arrangements, and medication use. The present study was conducted with 957 of the 1,587 patients with probable Alzheimer's disease who had at least one annual follow-up evaluation. The demographic and clinical characteristics of participants with and without follow-up evaluations are presented in Tables S1 and S2 in the data supplement that accompanies the online edition of this article.

The inclusion and exclusion criteria have been published previously (25). Briefly, we excluded patients with a lifetime history of schizophrenia, bipolar disorder, or schizoaffective disorder, a history of ECT, alcohol or drug abuse or dependence within 2 years of the onset of the cognitive symptoms, a history of cancer within the previous 5 years, or any significant disease or unstable medical condition that could affect the cognitive assessment (e.g., chronic renal failure, chronic hepatic disease, and severe pulmonary disease).

Psychiatric Examination

The psychiatric evaluations were conducted by academic geriatric psychiatrists using a semistructured interview (the Initial Evaluation Form) and the Consortium to Establish a Registry for Alzheimer's Disease (CERAD) Behavioral Rating Scale (26). In addition, the Hamilton Depression Rating Scale (HAM-D) (27) was completed by the psychiatrist on the basis of interviews with each patient and primary caregiver. The Initial Evaluation Form has been used at the Western Psychiatric Institute and Clinic of Pittsburgh since the early 1980s, and it was used to support the creation of diagnostic categories for DSM-IV (28). For a diagnosis of major depression in patients with Alzheimer's disease, the Initial Evaluation Form has been validated relative to depressive symptoms identified with the CERAD Behavioral Rating Scale and the HAM-D (29). The reliability of psychosis-related items of the CERAD Behavioral Rating Scale ranged from substantial to excellent agreement (kappa values, 0.60–0.85) among the psychiatrists (30).

Each patient and caregiver was evaluated annually by psychiatrists, and any psychiatric diagnosis was made by consensus among Alzheimer's Disease Research Center psychiatrists. In addition, a social worker interviewed the caregiver by telephone every 6 months between visits to determine the patient's status and medication use; an annual contact was done for those who stopped coming to the clinic. Psychiatric symptoms were diagnosed according to DSM-IV criteria, and symptom contribution to the dementia syndrome was discussed among psychiatrists, neurologists, and neuropsychologists at the weekly consensus conference. For the present study, symptoms were recorded as either present or absent. If the initial presentation was ambiguous, symptoms were recorded as absent; that is, we used a high threshold for adjudicating a symptom as present. All patients meeting DSM-IV criteria for major depression (in remission, in partial remission, active, recurrent, or single episode) were classified as having depression. Agitation required the presence of signs of emotional distress, with or without increased motor activity. Aggression required the display of verbal or physical aggressive behavior. Delusions were defined according to DSM-IV criteria and were distinguished from confabulations, disorientation, and amnesia by requiring that the false beliefs persisted in spite of evidence of the contrary. Hallucinations were adjudged as present if the patient spontaneously reported a sensory perception with no concomitant external stimulus.

Neurological Examination

The neurological examination included a semistructured interview with the caregivers to assess the effects of cognitive loss on the most relevant instrumental activities of daily living (e.g., job performance) and performance in activities of daily living (e.g., hygiene and continence). The examination also assessed cranial nerve function, motor tone, abnormal movements, strength, deep tendon reflexes, release signs, plantar response

and clonus, cerebellar testing, primary sensory testing (including graphesthesia and stereognosis), gait (including heel, toe, and tandem walking), and postural stability. The examiner also completed the New York University Scale for Parkinsonism (31), the CERAD scale for extrapyramidal signs, the Hachinski Ischemic Scale (32), and the Clinical Dementia Rating scale (33). For extrapyramidal signs, the New York University scale was used from 1983 to 2003 and the CERAD scale from 2004 to 2005; extrapyramidal signs were considered present with scores of >4 on the New York University scale and >5 on the CERAD scale.

Statistical Analysis

We used two-factor analyses of variance (ANOVAs), t tests, and chi-square tests to analyze demographic and clinical characteristics of patients exposed or unexposed to antipsychotic medications. We used Cox regression models with time-varying covariates to determine whether there were differences in time to nursing home admission or time to death in Alzheimer's patients with or without antipsychotic treatment. Cox models were also used to assess individually the effects of each psychiatric symptom and other psychiatric medications on these same outcomes. Because psychiatric symptoms and psychotropic medication use are more frequent as the disease progresses, the effects of individual symptoms and treatments were assessed as time-dependent covariates, which allowed us to examine the effect of medications and symptoms if they were present after baseline.

Three Cox regression models were used to determine whether exposure to antipsychotic medication was associated with time to nursing home admission or time to death. Model 1 included antipsychotic exposure, age, education level, gender, and MMSE scores. Model 2 included the items in model 1 with the addition of present baseline extrapyramidal signs, incident stroke/transient ischemic attack, hypertension, diabetes mellitus, and heart disease. Model 3 included the items in models 1 and 2 with the addition of aggression, agitation, psychosis, major depression, and dementia medication (e.g., cholinesterase inhibitors).

Results

Patients with Alzheimer's disease who were exposed to antipsychotics had a longer duration of illness before the baseline clinic evaluation and longer follow-up time relative to those who had never taken antipsychotics. In addition, antipsychotic-exposed patients were younger; had less education; had worse scores on the MMSE, the Clinical Dementia Rating scale, and the HAM-D; had less hypertension; and were more likely to die or be admitted to a nursing home during follow-up than those who had never taken antipsychotics (Table 1). Patients taking conventional antipsychotics had longer follow-up after the initial visit, were younger and less educated, had worse scores on the MMSE and the HAM-D, had better scores on the Hachinski Ischemic Scale, and were more likely to die or be admitted to a nursing home during follow-up than those treated with atypical antipsychotics or those who had never taken antipsychotics.

We found higher rates of psychosis, aggression, agitation, and antidepressant use and a lower rate of dementia medication use among those who used antipsychotics (Table 2). Patients who had been treated with conventional and atypical antipsychotics had more psychosis and aggression than those who had never taken antipsychotics, and more patients with agitation had taken atypical than conventional antipsychotics. Patients exposed to atypical antipsychotics had more extrapyramidal signs compared with those taking conventional antipsychotics. More patients were taking antidepressants and dementia medication with atypical than with conventional antipsychotics. For informational purposes, a Kaplan-Meier plot depicts the time to death in patients with and without antipsychotic treatment at any time during follow-up (Figure 1).

As a group, patients exposed to antipsychotics had a greater risk of going to a nursing home in models 1 and 2 but not in model 3 (see Table S3 in the online data supplement). The risk of death was not increased in patients exposed to antipsychotics (see Table S4 in the online data supplement). Table 3 shows that patients taking conventional antipsychotics had an increased risk of nursing home admission in models 1 and 2 but not in model 3. Education level, lower MMSE scores, extrapyramidal signs, heart disease, agitation, and psychosis were associated with nursing home admission. Neither conventional nor atypical antipsychotic use increased the risk of death (Table 4), but age, education level, male gender, MMSE scores, extrapyramidal signs, and psychosis were associated with risk of death.

Discussion

This large longitudinal observational study revealed that a higher proportion of patients exposed to antipsychotic medications, especially conventional antipsychotics, were admitted to a nursing home or died compared with those who never took these medications. However, in time-dependent statistical models, these associations were no longer present after we adjusted for the symptoms for which the antipsychotic treatments were usually used (hazard ratio=2.2 compared with 1.3). This suggests that the primary correlate of negative outcomes was the psychiatric symptomatology and not the drugs used to treat these symptoms.

This observational study does not support the association between mortality and antipsychotic use that has been reported in institutionalized elderly patients (34). The discrepancy may be a result of the fact that nursing home patients are more clinically heterogeneous and tend to be more cognitively and physically impaired than individuals commonly seen in outpatient clinics. Furthermore, interactions among multiple factors (including psychiatric symptoms) that have yet to be identified may be associated with antipsychotic-associated death in nursing home patients. For example, in a study conducted in Finnish institutionalized patients with dementia, while neither conventional nor atypical antipsychotics were associated with death, the use of restraints doubled the risk of mortality (13).

Similarly, outcome studies from large databases should be interpreted with caution, as they include not only institutionalized and noninstitutionalized patients, but also patients with a lifetime history of psychiatric disorders

TABLE 1. Demographic and Clinical Characteristics of Patients With Probable Alzheimer's Disease Taking Conventional or Atypical Antipsychotics

Characteristic	Patient Sample						Patient Sample[a]					
	Unexposed to Antipsychotics (N=716)		Any Type of Antipsychotic (N=241)		Analysis		Conventional Antipsychotics (N=138)		Atypical Antipsychotics (N=95)		Analysis	
	Mean	**SD**	**Mean**	**SD**	**t**	**p**	**Mean**	**SD**	**Mean**	**SD**	**t or F**	**p**
Duration of the cognitive symptoms[b]	3.7	2.2	4.1	2.4	–1.94		4.0	2.6	4.3	2.1	2.61	
Age at study entry	73. 5	8.7	72.0	8.6	2.27	0.02	71.2	8.0	73. 1	9.5	3.78	0.02
Education level (years)	12.5	2.9	12.0	2.9	2.32	0.02	11.8	3.0	12.2	2.6	4.08	0.01
Baseline Mini-Mental State Examination (MMSE) score	18.9	5.2	16.1	5.2	7.12	<0.001	15.8	5.6	16.2	4.7	26.4	<0.0001
Clinical dementia rating	1.17	0.56	1.38	0.67	–4.64	<0.0001	1.37	0.66	1.42	0.71	11.5	<0.0001
Hamilton Depression Rating Scale score	5.9	4.4	7.0	4.5	–3.32	0.0001	7.1	4.1	6.9	5.7	5.61	0.004
Hachinski Ischemia Scale score	2.47	1.7	2.23	1.6	1.85		2.0	1.4	2.4	1.7	4.13	0.01
	N	**%**	**N**	**%**	**t or χ^2**	**p**	**N**	**%**	**N**	**%**	**t or F**	**p**
Female	482	67	163	68	0.008		91	66	65	68	0.15	
White	675	675	225	93	0.26		129	93.5	88	93	0.47	
Severity of dementia by MMSE scores												
Mild (≥20)	377	53	66	27.5			36	26	*25*	*26*		
Moderate (19–10)	297	41	146	61			83	60	60	63		
Severe (≤9)	42	6	29	12			19	14	10	10.5		
APOE-4 allele (N=734)	316	57	115	62	1.48		62	61	66	64.5	2.38	
Hypertension[c]	305	42.5	82	34	5.50	0.01	30	22	48	50.5	25.3	<0.0001
Diabetes mellitus[d]	48	7	15	6	0.070		7	5	8	8	1.03	
Heart disease[e]	108	15	25	10	3.36		14	10	11	12	2.88	
Deceased	267	37	137	57	28.6	<0.0001	97	70	36	38	52.7	<0.0001
Nursing home admission	198	28	110	46	26.7	<0.0001	83	60	24	25	58.1	<0.0001

[a] Eight patients were taking conventional and atypical antipsychotics during follow-up and were excluded from the analysis.
[b] From the onset of the symptoms to initial visit.
[c] Told by doctor.
[d] Told by doctor and taking hypoglycemic agents.
[e] History of congestive heart failure, angina, or coronary bypass grafting/coronary angioplasty.

and exposure to antipsychotics or with neurodegenerative processes that are themselves associated with increased mortality (e.g., Parkinson's disease) (35, 36). This may explain the lack of association found in some studies conducted in elderly individuals that did not include these types of patients (11, 13). In addition, it seems that the highest reported risk of death occurs with conventional antipsychotics (e.g., haloperidol) and with some atypical antipsychotics (e.g., risperidone), but not with others (e.g., quetiapine) (34, 37). Although our study had enough participants to examine the effects of antipsychotics on mortality and nursing home admission, we lacked statistical power to compare the effects among individual antipsychotic agents.

The results of this study suggest that it is the symptoms and not the medications that predict nursing home admission and death. The study of long-term effects of antipsychotics in patients with Alzheimer's disease has strengths and limitations. It is difficult in observational studies to determine the duration of exposure to these medications as well as dosages. In addition, brief exposure to medications may be missed, especially if these occur between clinic visits or in the late stages of the disease. Thus, in the present study, if medication initiation and death occurred in the last 6 months between contacts, we may not have detected the use of antipsychotics. While studies based on claims data provide better information about dosages and date of therapy onset, they do not have information about whether the medication was actually used or about previous exposure to antipsychotics (34). Similarly, while randomized controlled trials provide useful short-term information, they would have to last many years in order to capture time to nursing home admission or death. Furthermore, if a patient in a placebo group had increasingly severe symptoms, he or she would have to be placed on medication (i.e., breaking the blind) and then continued in long-term observation. If the medications are effective at treating the symptoms (in the medicated group), any decision to stop the medication incurs the risk that the symptoms will immediately return in some patients, who may then require long-term maintenance therapy. Indeed, in a recent study of risperidone treatment for patients with Alzheimer's disease with psychosis and agitation, symptom relapse occurred when the antipsychotic was discontinued in a randomly assigned, double-blind fashion (38).

TABLE 2. Clinical Characteristics of Patients With Probable Alzheimer's Disease Taking Conventional or Atypical Antipsychotics

	Patient Sample						Patient Sample[a]					
	Unexposed to Antipsychotics (N=716)		Any Type of Antipsychotic (N=241)		Analysis		Conventional Antipsychotics (N=138)		Atypical Antipsychotics (N=95)		Analysis	
Characteristic	N	%	N	%	t or χ^2	p	N	%	N	%	t or F	p
Psychiatric symptoms (baseline or incident)												
Major depression	152	21	60	25	1.40		20	14.5	24	25	5.10	
Psychosis	361	50	200	83	78.80	<0.0001	108	78.0	84	88	76.60	<0.0001
Aggression	141	20	111	46	64.20	<0.0001	53	38.0	54	57	72.10	<0.0001
Agitation	513	72	203	84	14.90	<0.001	105	76.0	90	95	23.60	<0.0001
Neurological syndromes												
Baseline extrapyramidal signs[b]	297	42	99	41	0.009		62	45.0	35	37	1.63	
Baseline or incident extrapyramidal signs[b]	457	64	170	71	3.71	0.05	113	82.5	52	55	23.10	<0.001
Incident stroke/transient ischemic attack	37	5	16	7	0.73		10	7.0	5	5	0.98	
Medications (baseline or incident)												
Antidepressants	257	36	116	48	11.30	0.001	49	35.5	61	64	29.20	<0.0001
Dementia medication	441	62	99	41	30.80	<0.0001	10	7.0	85	90	185.50	<0.0001

[a] Eight patients were taking conventional and atypical antipsychotics during follow-up and were excluded from the analysis.
[b] Presence of bradykinesia, tremors, increased motor tone, abnormal gait, or dyskinesias.

TABLE 3. Results of the Cox Regression Model Examining Risks Associated With Nursing Home Admission in Patients With Probable Alzheimer's Disease Taking Conventional or Atypical Antipsychotics[a]

	Model 1			Model 2			Model 3		
Variable	Hazard Ratio	95% CI	p	Hazard Ratio	95% CI	p	Hazard Ratio	95% CI	p
Conventional antipsychotics	2.21	1.68–2.90	<0.0001	2.27	1.71–3.01	<0.0001	1.30	0.95–1.79	0.10
Atypical antipsychotics	1.01	0.62–1.65	0.97	1.05	0.64–1.72	0.84	1.02	0.61–1.71	0.94
Age	1.00	0.99–1.01	0.93	0.99	0.98–1.01	0.30	1.00	0.98–1.01	0.59
Education	1.05	1.01–1.09	0.01	1.05	1.01–1.10	0.01	1.07	1.03–1.11	0.001
Gender	0.92	0.71–1.18	0.50	0.88	0.68–1.13	0.30	0.83	0.64–1.08	0.17
MMSE score	0.94	0.92–0.97	<0.0001	0.94	0.92–0.97	<0.0001	0.95	0.93–0.97	<0.0001
Extrapyramidal signs				1.28	1.00–1.64	0.05	1.29	1.00–1.65	0.04
Incident stroke				1.01	0.68–1.52	0.94	0.87	0.58–1.33	0.52
Hypertension				1.07	0.83–1.39	0.58	1.16	0.90–1.51	0.25
Diabetes mellitus				1.21	0.77–1.90	0.41	1.22	0.77–1.93	0.40
Heart disease				1.52	1.09–2.12	0.01	1.57	1.12–2.20	0.009
Aggression							1.26	0.95–1.69	0.11
Agitation							1.35	1.01–1.79	0.04
Depression							1.06	0.75–1.49	0.75
Psychosis							1.56	1.19–2.04	0.001
Dementia medication							0.38	0.28–0.52	<0.0001

[a] Model 1 controlled for age, education level, gender, and baseline Mini-Mental State Examination (MMSE) score. Model 2 included items from model 1 plus extrapyramidal signs, incident stroke, heart disease, diabetes mellitus, and hypertension. Model 3 included items from models 1 and 2 plus psychosis, depression, aggression, agitation, and dementia medication.

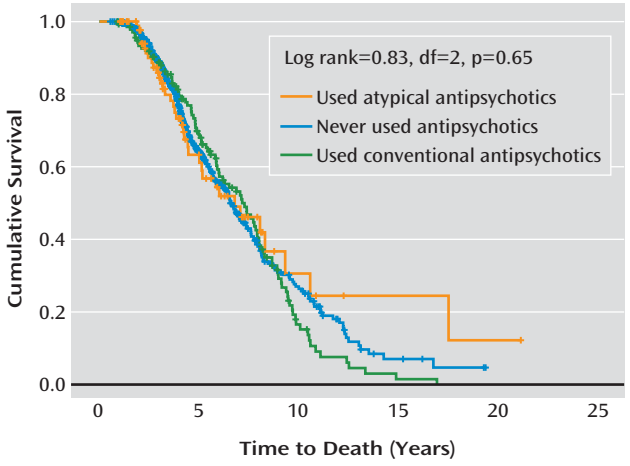
Psychosis was a significant predictor of death, even after adjustment for antipsychotic use. This finding is consistent with a previous observation of a faster cognitive decline (21) and increased mortality (23) in patients with Alzheimer's disease with psychotic features. This suggests that these patients live with a more aggressive Alzheimer's disease phenotype, but the study of psychiatric symptoms and mortality in Alzheimer's disease is complex. The psychotic phenomenon in Alzheimer's patients does not occur in isolation and tends to develop in a constellation of symptoms that include agitation, aggression, sundowning, and inappropriate behavior across the spectrum of disease severity (29). Thus, the psychotic symptoms may co-occur with other disturbing behavioral symptoms that can lead to death (39). For example, agitation and aggression can lead to falls, which can cause head trauma or fractures, in turn leading to physical immobilization and subsequent increased risk of death. Aggression was also a risk factor for death when we examined the relationship between antipsychotic exposure and mortality (hazard ratio=1.30

TABLE 4. Results of the Cox Regression Model Examining Risks Associated With Death in Patients With Probable Alzheimer's Disease Taking Conventional or Atypical Antipsychotics[a]

	Model 1			Model 2			Model 3		
Variable	Hazard Ratio	95% CI	p	Hazard Ratio	95% CI	p	Hazard Ratio	95% CI	p
Conventional antipsychotics	0.94	0.73–1.20	0.60	0.92	0.71–1.19	0.52	0.83	0.63–1.09	0.17
Atypical antipsychotics	1.10	0.77–1.59	0.60	1.20	0.83–1.74	0.32	1.02	0.69–1.50	0.93
Age	1.03	1.02–1.05	<0.0001	1.03	1.02–1.04	<0.0001	1.03	1.01–1.04	<0.0001
Education	1.05	1.01–1.09	0.007	1.06	1.02–1.10	0.002	1.06	1.02–1.10	0.002
Gender	1.53	1.23–1.89	<0.0001	1.50	1.21–1.88	<0.0001	1.48	1.19–1.85	0.001
MMSE score	0.93	0.92–0.95	<0.0001	0.94	0.92–0.96	<0.0001	0.94	0.92–0.96	<0.0001
Extrapyramidal signs				1.55	1.26–1.92	<0.0001	1.61	1.30–2.00	<0.0001
Incident stroke				1.32	0.95–1.84	0.10	1.22	0.87–1.72	0.24
Hypertension				1.16	0.93–1.43	0.18	1.15	0.92–1.42	0.21
Diabetes mellitus				1.45	0.99–2.13	0.05	1.39	0.94–2.06	0.10
Heart disease				0.90	0.67–1.21	0.48	0.90	0.67–1.22	0.50
Aggression							1.25	0.97–1.61	0.08
Agitation							0.99	0.77–1.26	0.91
Depression							1.26	0.95–1.67	0.11
Psychosis							1.26	1.00–1.59	0.04
Dementia medication							1.00	0.77–1.29	0.97

[a] Model 1 controlled for age, education level, gender, and baseline Mini-Mental State Examination (MMSE) score. Model 2 included items from model 1 plus extrapyramidal signs, incident stroke, heart disease, diabetes mellitus, and hypertension. Model 3 included items from models 1 and 2 plus psychosis, depression, aggression, agitation, and dementia medication.

FIGURE 1. Kaplan-Meier Survival Analysis of Time to Death in Patients With Probable Alzheimer's Disease and Antipsychotic Use



(95% CI=1.01–1.67; see Table S4 in the online data supplement).

Extrapyramidal signs were an independent predictor of nursing home admission and death, consistent with previous studies (40, 41). Notably, extrapyramidal signs are frequent in patients with Alzheimer's disease, and practically all will develop an extrapyramidal sign during the course of the disease (41). The presence of extrapyramidal signs can predispose patients to reduce their mobility, consequently increasing the risk of infections (e.g., pneumonia). The increased need for personal care in patients with extrapyramidal signs may also lead to nursing home admission. In this study, extrapyramidal signs were more frequent in patients taking conventional than atypical antipsychotics, but we did not examine the effect of the severity of the extrapyramidal signs (as distinct from their presence or absence) on mortality.

The study of factors related to mortality in patients with Alzheimer's disease is complex, with multiple factors converging to increase the risks of nursing home admission and death. In this outpatient-based population with mild to moderate dementia, exposure to antipsychotics was not associated with an increased risk of nursing home admission after the presence of disruptive behaviors was taken into account. Rather, it was the psychotic/agitated phenotype that emerged as a critical factor influencing the natural and treated history of Alzheimer's disease.

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Clinical Guidance: Antipsychotics and Alzheimer's Disease

Long-term observations of 957 outpatients with probable Alzheimer's disease indicate that neither conventional nor atypical antipsychotics increase the likelihood of nursing home admission or death. Instead, these adverse outcomes are related to psychosis and agitation, the conditions for which antipsychotics are prescribed in Alzheimer's disease patients. The study by Lopez et al. included patients who were not institutionalized when the study began. Devanand cautions in an editorial (p. 957) that if antipsychotics are needed for patients with dementia, the dose should start low and should be increased slowly.

Attachment # 3

Will the Joint Reference Committee recommend that the Assembly retain the APA Position Statement on the Ethical Use of Telemedicine, including a revision to the title of the statement?

Position Statement on the ~~Ethical~~ Use of Telemedicine

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.

The CMHIT reviewed this statement during their November 12, 2014 and December 10, 2014 monthly teleconferences. The Committee requests that the word “Ethical” be deleted from this statement title. The rest of the statement is requested to remain the same.

COUNCIL ON MEDICAL EDUCATION AND LIFELONG LEARNING
Report to the Joint Reference Committee

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

ACTION ITEM:

Will the JRC recommend to the Assembly that the Assembly retain the Position Statement *Consistent Treatment of all Applicants for State Medical Licensure* and, if retained, forward it to the Board of Trustees for consideration?

The Council on Medical Education believes that this position statement is still relevant because disparity in licensing requirements still exist. Here are examples of states that impose greater requirements based on source of medical school training.

From the North Carolina Medical Board:
The Board collects and verifies the credentials of physicians applying for licenses in North Carolina. … [A]pplicants must have graduated from a medical school accredited by the Liaison Committee on Medical Education (LCME) or the American Osteopathic Association (AOA) and have successfully completed at least one year of accredited graduate training. … Physicians who are graduates of schools that are not accredited by the LCME or the AOA (foreign medical schools) must have been individually certified by the Educational Commission for Foreign Medical Graduates, have successfully completed at least three years of accredited graduate medical training, and have passed the USMLE or its equivalent.

From New York State:
If you graduated from a NYS- registered or LCME- or AOA-accredited medical program or are pursuing the 5th Pathway route to licensure, you must complete at least one year of postgraduate hospital training in an accredited residency program approved by the Accreditation Council for Graduate Medical Education, the American Osteopathic Association, or the Royal College of Physicians and Surgeons of Canada.

If you did not graduate from a NYS-registered or LCME- or AOA-accredited medical program, you must complete at least three years of postgraduate hospital training in an accredited residency program approved by the Accreditation Council for Graduate Medical Education, the American Osteopathic Association, or the Royal College of Physicians and Surgeons of Canada.

INFORMATION ITEMS:

Training Psychiatrists for Integrated Behavioral Health Care
The Council thanks the JRC for approving the white paper on integrated care education entitled "Training Psychiatrists for Integrated Behavioral Health Care" as a Resource Document. The APA Board has given approval to the Council to submit a summary of the report for publication

in Academic Psychiatry. If published, the final version of the resource document should have the recommendations removed.

IOM Report on GME Financing
The Council had a conference call in November with representatives of the Council on Advocacy and Government Relations to discuss the IOM report on GME financing entitled "Graduate Medical Education That Meets the Nation's Health Needs."

Council members expressed the following views:

1. Expand training in psychiatry with greatest expansion in CAP and geriatrics.
2. Tying funds to Medicare and patient days needs to be reconsidered.
3. Funding should not be tied to current training sites only, but also to places where innovation and new models of care are being implemented. Funding method should not be a barrier to innovation. Transparency of funds, with funds for residents used for residents and funds for hospitals used for hospitals' bottom line makes more sense; there should be no more Indirect GME payment.
4. Whatever model comes through, the APA should have a meaningful place in the discussion and psychiatry's interests are protected.

Related to this issue, the House Energy and Commerce Committee is seeking comments from relevant stakeholders concerning the IOM's GME report and the future of GME in general. The Council and the Ad Hoc Work Group on Education and Training will provide input for the APA response to this request.

Further Clarification of Use of DSM-5 (Intellectual Property)
The Council formed a Work Group to further explore the DSM5 licensing criteria for use by educators and what is considered proper paraphrasing for the purposes of APP. The Work Group invited Becky Rinehart and her staff to discuss a clear definition of paraphrasing.

According to APP, use of materials in printed handouts and/or PowerPoint slides for one-time, non-commercial seminars, trainings, or presentations for up to 40 participants, is gratis. The APP views medical schools as commercial because they charge students for tuition; people at medical schools should contact their librarians about the appropriate use of DSM-5. Use of DSM-5 criteria in teaching residents could be considered non-commercial educational use, but this also depends on how exactly the criteria are used, how much of the presentation includes the criteria, etc. Grand Rounds may constitute non-commercial educational use, depending on exact circumstances and depending on whether money is being made. APP encourages people to contact them to see if their use would constitute non-commercial educational use.

Position Statement on Consistent Treatment of All Applicants for State Medical Licensure

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 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.

Revision of the 1997 position statement.