Joint Reference Committee
American Psychiatric Association

AGENDA

Location: Omni Amelia Island Plantation Resort, Florida
Amelia Island Racket Park - Ibis Room
(NB – there is a shuttle service to meeting location if you prefer not to walk)

February 11, 2018 - Sunday
Plated Lunch: Noon – 1:00 pm – Ibis Room
Meeting: 1:00 pm – 5:00 pm – Ibis Room

1 Welcome, Introductions, and Verbal Disclosures of Interests & Affiliations – Altha Stewart, MD

2 Review and approval of draft Summary of Actions from the October 2017 Joint Reference Committee Meeting – Altha Stewart, MD

Will the Joint Reference Committee approve the draft summary of actions from the October 2017 meeting? (See item 2)

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

Referral Update – no action required
3.1 ACGME Standard for Common Program Requirement for Psychiatry Residency Programs (JRCOCT178.I.3)

The Joint Reference Committee referred to the Council on Medical Education and Lifelong Learning for review, the Council on Minority Mental Health and Health Disparities' support for an ACGME accreditation standard for psychiatry residency programs on diversity programs and partnerships to achieve health care equity and eliminate health disparities.

On November 21, 2017, the Executive Committee of the APA Board of Trustees held a conference call during which it supported sending comments drafted by the Council on Medical Education and Lifelong Learning regarding the importance of diversity training to the ACGME.

The comments were submitted by APA Administration on Wednesday, November 22, 2017, and ACGME confirmed receipt the following week.

Specifically, the comments submitted to ACGME contained the following language: "The American Psychiatric Association wishes to communicate to the ACGME its support of the establishment of an ACGME accreditation standard III. C. in the section "The Learning and Working Environment" in the Institutional Requirements on diversity programs and partnerships to achieve health care equity and eliminate health care disparities… In a

medical education program, the facts that having medical students and faculty members from a variety of socioeconomic backgrounds, racial and ethnic groups, and other life experiences can 1) enhance the quality and content of interactions and discussions for all students throughout the preclinical and clinical curricula and 2) result in the preparation of a physician workforce that is more culturally aware and competent and better prepared to improve access to healthcare and address current and future health care disparities."

5 Referral from the Board of Trustees

5.A Proposed Position Statement on Human Trafficking

The Board of Trustees voted to refer the Proposed Position Statement on Human Trafficking to the Joint Reference Committee.

Will the Joint Reference Committee refer the proposed Position Statement back to the Council on Minority Mental Health and Health Disparities for additional review and revision?

1:50 pm – 2:00 pm

Ezra Griffith, MD – *via speakerphone*

4 Update from the Ethics Committee (please see item 4)

In November 2017, the Assembly approved action paper 2017A2 12.K, which asks that the APA will direct the authors of the *APA Commentary on Ethics in Practice* to bring its language into congruence with that of the *AMA Principles of Medical Ethics 10.1.1*, including a thoughtful exploration of the complexities involved. This would apply to any psychiatrist making any benefit and/or policy determinations. Please see the memo from the Ethics Committee which responds to the action paper's request.

From the Assembly Report to the JRC:

6.10 Achieving Congruence between the APA Commentary on Ethics in Practice and the AMA Principles of Medical Ethics Concerning Ethical Obligations of Psychiatrists Making Benefit Determination Decisions (ASM2017A2 12.K)

(Attachment 10 - Action paper, cost estimate, administration comments)

The action paper asks that the APA will direct the authors of the *APA Commentary on Ethics in Practice* to bring its language into congruence with that of the *AMA Principles of Medical Ethics 10.1.1*, including a thoughtful exploration of the complexities involved. This would apply to any psychiatrist making any benefit and/or policy determinations.

Will the Joint Reference Committee refer the action paper 2017A2 12.K: *Achieving Congruence between the APA Commentary on Ethics in Practice and the AMA Principles of Medical Ethics Concerning Ethical Obligations of Psychiatrists Making Benefit Determination Decisions* to the appropriate Component(s) for input or follow-up?

APA Administration recommends referral to: **The Administration refers the JRC to the Ethics Update (see item 4) and notes that the Ethics Committee's response completes the ask of this action paper.**

2:00 pm – 2:20 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 current activities, and information items.

8.J.1 Revised Proposed Position Statement: Weapons Use in Hospitals and Patient Safety (see attachment 1 of the council's report)

Will the Joint Reference Committee recommend that the Assembly approve the revised proposed *Position Statement on Weapons Use in Hospitals and Patient Safety* and if approved, forward it to the Board of Trustees for consideration?

The Council on Psychiatry and Law has developed a Position Statement on Weapons Use in Hospitals and Patient Safety. The draft Position Statement was revised by the Council in response to feedback from the Joint Reference Committee after considering the draft document during its October meeting. Specifically, revisions were made to clarify that the document focuses on appropriate clinical responses to patient violence, and that the usual clinical response from clinical personnel should never include weapons use.

2:20 pm – 2:40 pm
Joseph Penn, MD – *via speakerphone*

8.C **Council on Children, Adolescents, and Their Families**

Please see item 8.C for the Council's report, summary of current activities, and information items. The council has no action items.

Information Items

1. The Council reviewed and supported a letter addressed to the Netflix Executive Producers of "13 Reasons Why". The letter was in response to Season 1 and the upcoming Season 2. In addition, the Council on Communications also reviewed the letter and supported the document as written.
2. The Council is in the process of reviewing and providing feedback on AACAP's Parent Medication Guide on anxiety and obsessive related disorders.
3. In collaboration with the APA Committee on Telepsychiatry, the Council is in the process of reviewing the Higher Education Mental Health Alliance (HEMHA) Guide, College Counseling from a Distance: Deciding Whether and When to Engage in Telemental Health Services.
4. As a request from the Council on Quality Care, the Council reviewed and provided feedback for a letter to the editor of the Journal of the American Academy of Child and Adolescent Psychiatry regarding the paper "Specific Components on Pediatricians' Medication-Related Care Predict Attention-Deficit/Hyperactivity Disorder Symptom Improvement" (Epstein, JN, et. al).
5. The following interest groups were created: Integrated Care, Juvenile Justice/Corrections, Social Media, TAY/Adult Psychiatrists, Gender Dysphoria/Transgender Mental Health, Immigrant and Refugees, First Break Psychosis.

2:40 pm – 3:00 pm
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. The council has no action items.

Information Items:

- The Council is revising two position statements: "Elder Abuse, Neglect and Exploitation" and "HIV Infection in People over 50."
- The Council is also developing a new position statement on Disaster Response for older adults.
- The Council collaborated with the Council on Quality Care and AAGP to advocate for issues pertaining to CMS's stand on creating a "ligature-resistant" psychiatric hospital environment.

7.B 3-year Assessment of the Council on Geriatric Psychiatry (please see attachment 7.B)
Will the Joint Reference Committee review and provide feedback to the Council on Geriatric Psychiatry based on the materials submitted for its 3-year assessment?

3:00 pm – 3:20 pm
Sanjeev Sockalingam, MD for David Gitlin, MD – *via speakerphone*

8.K **Council on Psychosomatic Medicine**

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

8.K.1 Request to Change the Name of the Council
Will the Joint Reference Committee recommend that the Board of Trustees approve changing the name of the Council on Psychosomatic Medicine to the Council on Consultation-Liaison Psychiatry to conform with the official name change of the subspecialty?

8.K.2 Resource Document: The Assessment of Capacity for Medical Decision Making (see attachment 1 of the council's report)
Will the Joint Reference Committee approve the Resource Document *on the Assessment of Capacity for Medical Decision Making?*

The authors of the resource document reviewed the classic and emerging literature on decisional capacity, including literature on clinical approaches to determination of decisional capacity, specific psychiatric and neurologic illness affecting decisional capacity, use of standardized rating instruments, and modification of clinical examination techniques specific to decisional capacity determinations. The authors cover nine topic areas pertinent to decisional capacity determinations, with review of the relevant literature for each topic, and offer a proposed clinical methodology for decisional capacity determinations in the context of comprehensive psychiatric evaluations.

3:20 pm – 3:40 pm
Christina Mangurian, 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 on Abortion (see linked document in the council's report)
Will the Joint Reference Committee recommend that the Assembly approve the *revised Position Statement on Abortion* and if approved, forward it to the Board of Trustees for consideration?

NB: If the revised position statement is approved by both the Assembly and the Board of Trustees, the 1978 Position Statement on Abortion will be retired.

8.I.2 Revised Position Statement: Resolution Against Racism and Racial Discrimination and Their Adverse Impacts on Mental Health (see linked document in the council's report)
Will the Joint Reference Committee recommend that the Assembly approve the *revised Position Statement: Resolution Against Racism and Racial Discrimination and Their Adverse Impacts on Mental Health* and if approved, forward it to the Board of Trustees for consideration?

NB: If the revised position statement is approved by both the Assembly and the Board of Trustees, the 2006 *Position Statement: Resolution Against Racism and Racial Discrimination and Their Adverse Impacts on Mental Health* will be retired.

8.I.3 Revised Position Statement on Religious Persecution and Genocide (see linked document in the council's report)
Will the Joint Reference Committee recommend that the Assembly approve the *revised Position Statement on Religious Persecution and Genocide* and if approved, forward it to the Board of Trustees for consideration?

NB: If the revised position statement is approved by both the Assembly and the Board of Trustees, the 1977 *Position Statement on Religious Persecution and Genocide* will be retired.

8.I.4 Proposed Position Statement on Mental Health Needs of Undocumented Immigrants, including Childhood Arrivals, Asylum Seekers, and Detainees (see linked document in the council's report)
Will the Joint Reference Committee recommend that the Assembly approve the *proposed Position Statement on Mental Health Needs of Undocumented Immigrants, including Childhood Arrivals, Asylum Seekers, and Detainees* and if approved, forward it to the Board of Trustees for consideration?

8.I.5 Proposed Position Statement on Equitable Treatment of Substance Use Disorders Across Racial Lines (see linked document in the council's report)
Will the Joint Reference Committee recommend that the Assembly approve the *proposed Position Statement on Equitable Treatment of Substance Use Disorders Across Racial Lines* and if approved, forward it to the Board of Trustees for consideration?

8.I.6 Proposed Position Statement on Mental Health Equity and the Social and Structural Determinants of Mental Health (see linked document in the council's report)
Will the Joint Reference Committee recommend that the Assembly approve the *proposed Position Statement on Mental Health Equity and the Social and Structural Determinants of Mental Health* and if approved, forward it to the Board of Trustees for consideration?

8.I.7 Proposed Position Statement on Police Brutality and Black Men (see linked document in the council's report)
Will the Joint Reference Committee recommend that the Assembly approve the *proposed Position Statement on Police Brutality and Black Men* and if approved, forward it to the Board of Trustees for consideration?

8.I.8 Proposed Position Statement on Discrimination of Religious Minorities (see linked document in the council's report)
Will the Joint Reference Committee recommend that the Assembly approve the *proposed Position Statement on Discrimination of Religious Minorities* and if approved, forward it to the Board of Trustees for consideration?

8.I.9 Retire 2013 Position Statement on Detained Immigrants with Mental Illness
Will the Joint Reference Committee recommend that the Assembly retire the 2013 *Position Statement on Detained Immigrants with Mental Illness* and if retired, forward it to the Board of Trustees for consideration?

Rationale: A newly drafted Position Statement — *Mental Health Needs of Undocumented Immigrants, including Childhood Arrivals, Asylum-Seekers, and Detainees* — incorporates content from *Detained Immigrants with Mental Illness* and includes additional resources that address the current political and social climate. To eliminate duplicative publications, CMMH/HD recommends the Position Statement be retired.

3:40 pm – 4:00 pm
Bernardo Ng, MD – *via speakerphone*

8.G **Council on International Psychiatry**
Please see item 8.G for the Council's report, summary of current activities, and information items. The council has no action items.

Information Item: Update on the status of the proposed Caucus on Mental Health and Climate Change

4:00 pm – 4:20 pm
Drew Ramsey, MD – *via speakerphone*

8.D **Council on Communications**

Please see item 8.D for the Council's report, a summary of current activities, and information items. The council has no action items.

7.A 3-year Assessment of the Council on Communications (please see attachment 7.A)
Will the Joint Reference Committee review and provide feedback to the Council on Communications based on the materials submitted for its 3-year assessment?

4:20 pm – 4:40 pm
Mark Rapaport, 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. The council has no action items.

Information Item: Comment on ACGME Institutional Requirements – The Council weighed in on submission of a comment to revise the Institutional Requirements for residency and fellowship programs accredited by the Accreditation Council for Graduate Medical Education (ACGME). The comment from the APA supported the establishment of an ACGME accreditation standard III. C. in the section "The Learning and Working Environment".

4:40 pm – 5:00 pm
Grayson Norquist, MD – *via speakerphone*

8.L **Council on Quality Care**

Please see item 8.L for the Council's report, a summary of current activities, and information items. The council has no action items.

Referral Update – no action required

8.L.1 Providing Education and Guidance for the Use and Limitations of Pharmacogenomics in Clinical Practice (JRCJUNE176.5, ASM2017A1 12.G).

LEAD: Council on Quality Care

As originally requested by the JRC in June 2017, the Council on Quality Care continued to work with several APA component groups to address the varying resolves found within the Action Paper:

• The APA Staff Liaison to the Council on Research shared the Council on Research-charged Work Group on Biomarkers draft paper on the use of pharmacogenomics and the treatment of depression (recently approved by the Board of Trustees for submission to the American Journal of Psychiatry) with the Council on Quality Care.

• After reviewing the paper, the Council discussed and agreed there is insufficient evidence to draft a resource document describing the use and limitations of pharmacogenomics in psychiatric clinical practice. The Council agreed they would charge the Committee on Practice Guidelines with including pharmacogenomics considerations as part of systematic literature reviews, when appropriate to the practice guidelines topic under development.

• They also suggested the APA Staff Liaison to the Council on Research speak with AJP staff about the possibility of linking this paper to practice guidelines, when appropriate recommendations are made on the subject of pharmacogenomics.

February 12, 2018 - Monday
Amelia Island Racket Park - Egret Room
Meeting: 9:00 pm – 12:00 noon – Egret Room
Breakfast: 8:00 am – 9:00 am – Egret Room

8:40 am – 9:00 am
Patrick Runnels, 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.

8.B.1 Revised Position Statement on Psychologists and Other Mental Health Professionals and Hospital Privileges (see attachments #3 and #4 of the council's report)
Will the Joint Reference Committee recommend that the Assembly approve the revises *Position Statement Psychologists and Other Mental Health Professionals and Hospital Privileges* and if approved, forward it to the Board of Trustees for consideration?

Through JRC directive, the Council on Advocacy and Government Relations established a joint Council work group with the Council on Psychosomatic Medicine to broaden the 2007 position statement to encompass perspective of those psychiatrists working in general medical and hospital setting in addition to those in psychiatric hospitals. Taking into consideration the work group's recommended modifications, the Council voted to support advancing the revised position statement as written.

Referral Update

8.B.2 Revision of Position Statement on Principles for Health Care Reform for Psychiatry (JRCOCT178.B5; JRCJUNE178.B.2)
LEAD: Council on Advocacy and Government Relations
The Council is working closely with the Council on Healthcare Systems and Financing to revise the 2008 position statement. Given that it is a decade old, the Councils' are tasked with address outdated language. The Council is awaiting feedback from the Council on Healthcare Systems and Financing provided their review of a draft position statement. The Council will present a revised statement to the June 2018 JRC.

Referral Update

8.B.3 Requesting a Position Statement on Prescription Drug Monitoring Programs (PDMPs) (JRCOCT178.B.3; JRCJUNE176.10; ASMMAY1712.L)
LEAD: Council on Advocacy and Government Relations
The Council reviewed a draft position statement developed by the Council on Healthcare Systems and Financing and the Council on Addiction Psychiatry. The Council provided concrete feedback on specific issues to be addressed within the document. The Council will continue to work with both councils to finalize a position statement.

9:00 am – 9:20 am
Harsh Trivedi, MD – *via speakerphone*

8.F **Council on Healthcare Systems and Financing**

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

8.F.1 Proposed Position Statement on Peer Support Services (see attachment A of the council's report)

Will the Joint Reference Committee recommend that the Assembly approve the *proposed Position Statement on Peer Support Services* and if approved, forward it to the Board of Trustees for consideration?

N.B. If the revised position statement is approved by both the Assembly and the Board of Trustees, the *2012 Position Statement Support for Peer Support Services* will be retired.

8.F.2 Proposed Position Statement on the Need to Maintain Intermediate and Long Term Hospital Care for Certain Individuals with Serious Mental Illness (see attachment B of the council's report)

Will the Joint Reference Committee recommend that the Assembly approve the *proposed Position Statement on the Need to Maintain Intermediate and Long Term Hospital Care for Certain Individuals with Serious Mental Illness* and if approved, forward it to the Board of Trustees for consideration?

N.B. If the revised position statement is approved by both the Assembly and the Board of Trustees, the *1974 Position Statement on the Need to Maintain Long-Term Inpatient Psychiatric Hospitals and the 2014 Position Statement on the Federal Exemption from Medicaid Institutions for Mental Disease*, will be retired.

8.F.3 Revised Position Statement on Telemedicine in Psychiatry (see attachment C of the council's report)

Will the Joint Reference Committee recommend that the Assembly approve the *revised Position Statement on Telemedicine in Psychiatry* and if approved, forward it to the Board of Trustees for consideration?

N.B. If the revised position statement is approved by both the Assembly and the Board of Trustees, the *2015 Position Statement on Telemedicine in Psychiatry* will be retired.

8.F.4 Resource Document: Best Practices in Videoconferencing-Based Telemental Health (see attachment D of the council's report)

Will the Joint Reference Committee approve the Resource Document *Best Practices in Videoconferencing-Based Telemental Health*, developed in concert with the American Telemedicine Association?

Note: Over the past six months, the APA's Committee on Telepsychiatry has worked jointly with the American Telemedicine Association (ATA) to develop this guidance document. The document is currently moving through the approval process at both the APA and the ATA and it is hoped that the document will be approved by both associations by their May Annual Meetings. Once approved, the document would reside concurrently on the APA's Telepsychiatry toolkit and the website of the American Telemedicine Association.

8.F.5 Request for Work Group - Level of Service Intensity Instrument

Will the Joint Reference Committee support the creation of a joint workgroup, under the Council on Healthcare Systems and Financing, the Council on Quality Care, and the Council on Research, to develop a budget for a proposed APA-owned Level of Service Intensity Instrument?

The council supports the APA developing a levels of care assessment tool, but only if APA will commit the funding and resources to achieve the gold standard. For reference, 15 years ago, AACAP's tool is estimated to have cost $200,000 over a 3-4 period for research alone.

From the Assembly Report to the JRC:

6.11 Adopting an APA Position Statement Supporting Implementation of the Mental Health Parity and Addiction Equity Act (MHPAEA or parity law) (ASM2017A2 12.L)
(Attachment 11 - Action paper, cost estimate, administration comments)
Action paper asks:

A. That the Assembly recommend adoption of an APA position statement, appropriately formatted, as follows:

It is the position of the APA that:

1. Insurance and/or other third party MHSUD utilization management and medical necessity criteria should be developed by individuals who are trained as psychiatrists or by work groups that include psychiatrists.
2. Insurance and/or other third party MHSUD utilization management and medical necessity criteria should be in full compliance with requirements of applicable state and federal parity laws, including with MHPAEA requirements that quantitative limits (QTLs) and non-quantitative limits (NQTLs) for MHSUD care should be comparable to and no more stringent than medical necessity criteria for medical and surgical care, except as allowed by the law.
3. Insurance companies and/or other third parties offering coverage for both medical/surgical and MHSUD treatment—including those that do so through MHSUD "carve outs"—have an obligation to provide to their medical directors, psychiatrist reviewers, other clinicians who make benefit determinations, and to treating clinicians and to covered individuals, current and accurate information about whether and how their MHSUD utilization review and medical necessity criteria comply with MHPAEA QTL and NQTL requirements.

B. The Assembly will directly refer this action paper outlining specific elements of a position statement to the Board of Trustees for adoption at their next meeting, including holding a separate vote to this effect, if required by Assembly rules.

Will the Joint Reference Committee refer the Assembly passed action paper 2017A2 12.L: *Adopting an APA Position Statement Supporting Implementation of the Mental Health Parity and Addiction Equity Act (MHPAEA or parity law)* to the appropriate Component(s) for input or follow-up?

APA Administration recommends referral to: **Council on Healthcare Systems and Financing (LEAD) and Council on Advocacy and Government Relations**

9:20 am – 9:40 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 Proposed Position Statement: Mental Health Screening, Diagnosis, and Treatment During Pregnancy and Postpartum (see attachment 1 of the council's report)

Will the Joint Reference Committee recommend that the Assembly vote to approve the proposed *Position Statement on Mental Health Screening, Diagnosis, and Treatment During Pregnancy and Postpartum* and if approved, forward it to the Board of Trustees for consideration?

10:00 am – 10:20 am
Andrew Saxon, 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 has no action items.

6 **Assembly Report** – James (Bob) Batterson, MD

6.1 Designation of Psychiatry as Primary Care for Any Medical School Scholarships Requiring Primary Care Service (ASM2017A2 12.A)
(Attachment 1 - Action paper, cost estimate, administration comments)
The action paper asks that APA advocate for state and federal legislation labeling psychiatry as primary care for any medical school scholarships requiring primary care residencies and service to a community.

Will the Joint Reference Committee refer the action paper *2017A2 12.A: Designation of Psychiatry as Primary Care for Any Medical School Scholarships Requiring Primary Care Service* to the appropriate Component(s) for input or follow-up?

APA Administration recommends referral to: **Council on Advocacy and Government Relations (LEAD) and Council on Medical Education and Lifelong Learning**

6.2 Medical School Loan Repayment Subsidies for Psychiatrists Practicing in Community Mental Health Centers and State Psychiatric Facilities (ASM2017A2 12.B)
(Attachment 2 - Action paper, cost estimate, administration comments)
The action paper asks that the APA advocate for state and federal legislation to provide funds to help repay loans for psychiatrists in community mental health centers and state psychiatric hospitals.

Will the Joint Reference Committee refer the action paper *2017A2 12.B: Medical School Loan Repayment Subsidies for Psychiatrists Practicing in Community Mental Health Centers and State Psychiatric Facilities* to the appropriate Component(s) for input or follow-up?

APA Administration recommends referral to: **Council on Advocacy and Government Relations (LEAD) and Council on Medical Education and Lifelong Learning**

6.3 **Transitional Care Services Post-Psychiatric Hospitalization (ASM2017A2 12.C)**
(Attachment 3 - Action paper, cost estimate, administration comments)
Action paper asks:

That the American Psychiatric Association advocate to national policymakers to increase federal funding for psychiatric access-to-care/transition-based clinics aimed at readily available short-term coverage in psychiatric care for uninsured, low-income, and serious mental illness populations.

That the American Psychiatric Association promotes the concept of a transitional care based clinic model, aimed at bridging the gap between hospitalization and outpatient follow-up, to ACGME/GME leadership, in an effort to grow interest in implementation of such clinics in GME based settings.

Will the Joint Reference Committee refer the action paper *2017A2 12.C: Transitional Care Services Post-Psychiatric Hospitalization* to the appropriate Component(s) for input or follow-up?

APA Administration recommends referral to: **Council on Advocacy and Government Relations (LEAD) and Council on Quality Care**

6.4 Enacting APA Positions: State Medical Board Licensure Queries (ASM2017A2 12.D)
(Attachment 4 - Action paper, cost estimate, administration comments)
Action paper asks that:

1. The American Psychiatric Association query the licensing boards (M.D., D.O) and, in each state, territory or licensure jurisdiction query their compliance with APA policy and with the ADA act allowing questions only about current mental and physical impairment affecting current ability to practice medicine.
2. The American Psychiatric Association notify each Board of Medicine in writing whether or not their medical licensure application(s) reflect current APA position regarding queries about their applicants' mental health history. The APA will notify each District Branch of the APA of the status of the Board of Medicine or Board of Osteopathic Medicine in its jurisdiction and will publish on the APA website a list of jurisdictions and whether or not their policies on queries are congruent with the Position of the APA.
3. The American Psychiatric Association notify the Federation of State Medical Boards Work Group of its Position Statement entitled Position Statement on Inquiries about Diagnosis and

Treatment of Mental Disorders in Connection with Professional Credentialing and Licensing, adopted in 2015, in advance of the January 2018 meeting of the FSMB Work Group.

Will the Joint Reference Committee refer the action paper *2017A2 12.D: Enacting APA Positions: State Medical Board Licensure Queries* to the appropriate Component(s) for input or follow-up?

APA Administration recommends referral to: **CEO/Medical Director's Office – General Counsel**

6.5 Recognition of Psychiatric Expertise: Efficiency and Sufficiency (ASM2017A2 12.E)
(Attachment 5 - Action paper, cost estimate, administration comments)
Action paper asks that:

1. APA encourages the AMA to adopt a policy that the MOC should not be a requirement for maintenance of licensure, hospital privileges, insurance credentialing or employment
2. The APA should support a SA-CME learning option in lieu of the 10-year exam and encourage the ABPN to accelerate the timeline for reform of the MOC process.
3. The MOC should not be part of the licensure requirements for interstate compacts.

Will the Joint Reference Committee refer the action paper *2017A2 12.E: Recognition of Psychiatric Expertise: Efficiency and Sufficiency* to the appropriate Component(s) for input or follow-up?

APA Administration recommends referral to: **Council on Medical Education and Lifelong Learning (LEAD) and the APA AMA Delegation**

6.6 Conflicts of Interest Not Limited to Pharmaceutical Companies (ASM2017A2 12.G)
(Attachment 6 - Action paper, cost estimate, administration comments)
The action paper asks that the American Psychiatric Association, through its Annual Meeting Scientific Program Committee, review the current mechanism for reporting conflicts of interest, which mainly are limited to pharmaceutical companies, with an eye toward encouraging the reporting of conflicts which extend beyond pharmaceutical companies.

Will the Joint Reference Committee refer the action paper *2017A2 12.G: Conflicts of Interest Not Limited to Pharmaceutical Companies* to the appropriate Component(s) for input or follow-up?

APA Administration recommends referral to: **Conflict of Interests Committee and Scientific Program Committee**

6.7 Non-Physician Registration Fee for Annual Meetings (ASM2017A2 12.H)
(Attachment 7 - Action paper, cost estimate, administration comments)
The action paper asks that allied health professionals pay the same registration fee as non-member physicians at the Annual Meeting.

Will the Joint Reference Committee refer the action paper 2017A2 12.H: *Non-Physician Registration Fee for Annual Meeting* to the appropriate Component(s) for input or follow-up?

APA Administration recommends referral to: **Finance and Budget Committee, Department of Meetings and Conventions**

6.8 APA Position Statement Strongly Recommending Twelve Weeks of Paid Parental Leave (ASM2017A2 12.I)
(Attachment 8 - Action paper, cost estimate, administration comments)
The action paper asks that the APA approve and adopt the attached position statement recommending 12 weeks of paid parental leave. [Note: The Assembly voted to approve the action paper as a position statement.]

Will the Joint Reference Committee refer the position statement 2017A2 12.I: *APA Position Statement Strongly Recommending Twelve Weeks of Paid Parental Leave* to the appropriate Component(s) for input or follow-up?

APA Administration recommends referral to: **Council on Healthcare Systems and Financing (LEAD) and the Financing and Budget Committee**

6.9 Helping Members Join Caucuses (ASM2017A2 12.J)
(Attachment 9 - Action paper, cost estimate, administration comments)
The action paper asks that the APA new member and membership renewal emails have a direct link to joining a caucus.

Will the Joint Reference Committee refer the Assembly passed action paper 2017A2 12.J: *Helping Members Join Caucuses* to the appropriate Component(s) for input or follow-up?

APA Administration recommends referral to: **Membership Committee (LEAD), Council on Minority Mental Health and Health Disparities**

6.12 Joint Meeting of the Council on Minority Mental Health and Health Disparities and the Assembly Committee of Representatives of Minority/Underrepresented Groups (ASM2017A2 12.M)
(Attachment 12 - Action paper, cost estimate, administration comments)
The action paper asks that:

1) That the American Psychiatric Association will support another Joint Meeting of the Council on Minority Mental Health and Health Disparities and the Assembly Committee of Representatives of Minority/Underrepresented Groups, in alignment with the APA's fourth strategic initiative addressing diversity.
2) That such meeting will take place during the Annual September Components Meeting of the American Psychiatric Association in September 2018.

[N.B.: At its meeting in October, the Joint Reference Committee recommended that the Board of Trustees approve the request for the seven M/UR Caucus Assembly Representatives (or their designees) to meet with the Council at the 2018 September Components Meeting at the same level of funding as this year at approximately $9,000 from the Assembly Budget and additional costs for members of the Council on Minority Mental Health and Health Disparities from the component's budget. This action was approved by Board of Trustees at its December 2017 meeting.]

Will the Joint Reference Committee refer the action paper 2017A2 12.M: *Joint Meeting of the Council on Minority Mental Health and Health Disparities and the Assembly Committee of Representatives of Minority/Underrepresented Groups* to the appropriate Component(s) for input or follow-up?

APA Administration recommends referral to: **The Administration notes that this request was approved by the Board of Trustees at their October 2017 meeting.**

6.13 Civil Liability Coverage for District Branch Ethics Investigations (ASM2017A2 12.N)
(Attachment 13 - Action paper, cost estimate, administration comments)
The action paper asks that:

1. The American Psychiatric Association shall make a copy of the APA Director & Officer Liability policy available upon request by District Branch.
2. The American Psychiatric Association shall amend the APA Operations manual to include information regarding indemnification of district branches for liability related to ethics investigations.
3. The American Psychiatric Association shall develop a written policy and protocol to provide expenditures to district branches specifically to support ethics investigations.

Will the Joint Reference Committee refer the action paper 2017A2 12.N: *Civil Liability Coverage for District Branch Ethics Investigations* to the appropriate Component(s) for input or follow-up?

APA Administration recommends referral to: **Board of Trustees – March 2018**

6.14 Council on Women's Mental Health (ASM2017A2 12.O)
(Attachment 14 - Action paper, cost estimate, administration comments)
The action paper asks that the American Psychiatric Association develop a Council on Women's Mental Health to address mental health conditions and health related disorders pertaining to mental health that affect women

Will the Joint Reference Committee refer the action paper 2017A2 12.O: *Council on Women's Mental Health* to the appropriate Component(s) for input or follow-up?

APA Administration recommends referral to: **Council on Minority Mental Health and Health Disparities (LEAD), Council on Research and Finance and Budget Committee.**

6.15 Addressing the Negative Impact of the Rule of 95 on Dues Revenue (ASM2017A2 12.P)
(Attachment 15 - Action paper, cost estimate, administration comments)
The action papers asks that the Board of Trustees (BOT) establish a Task Force charged with reviewing the Rule of 95 and making recommendations to be presented to the BOT in time for possible action by the BOT and the Assembly at the November 2018 Assembly Meeting. Membership on this Task Force could be drawn from the BOT, APA management, the Assembly leadership, the Membership Committee, and DB and State Association leadership and staff and shall include representation from the Senior Psychiatrists, RFMs, and ECPs.

Wil the Joint Reference Committee refer the action paper 2017A2 12.P: *Addressing the Negative Impact of the Rule of 95 on Dues Revenue* to the appropriate Component(s) for input or follow up?

APA Administration recommends referral to: **The Administration notes that the Board of Trustees formed a Work Group on the Rule of 95. The action paper will be forwarded to the Work Group**.

6.16 Revised Position Statement: Need to Maintain Long-Term Care Facilities for Certain Individuals with Serious Mental Illness (JRCJUNE178.F.1/ASMNOV174.B.2
(Attachment 16 - Action paper, cost estimate, administration comments)
The Assembly did not approve the Revised Position Statement: *Need to Maintain Long-Term Care Facilities for Certain Individuals with Serious Mental Illness* as the Assembly had concerns about the title and felt some revisions are needed to clarify the intent of the position statement.

Will the Joint Reference Committee refer the Revised Position Statement: *Need to Maintain Long-Term Care Facilities for Certain Individuals with Serious Mental Illness* to the appropriate Component(s) for input or follow-up?

APA Administration recommends referral to: **Please see item 8.F.2 of this agenda (page 9). The Council on Healthcare Systems and Financing has submitted a position statement on this topic for the Joint Reference Committee's consideration.**

9 Other Business

9.A Proposed Resource Document: Psychiatric Impact of Environmental Toxicants (see attachments #9, #9.1, and #9.2)
Will the Joint Reference Committee approve the proposed Resource Document *Psychiatric Impact of Environmental Toxicants*?

NEXT JOINT REFERENCE COMMITTEE MEETING

June 2, 2018
APA Headquarters
Washington, DC
Report Deadline: May 23, 2018 @ Noon (Wednesday)

Joint Reference Committee
October 14, 2017
DRAFT SUMMARY OF ACTIONS

As of October 22, 2017

JRC Members Present:

Altha Stewart, MD: President-elect; Full time faculty from University of Tennessee Health Science Center; Small consulting contract with WNBA; Honoraria from the APA as President-elect

James Batterson, MD: Full time faculty Children's Mercy Hospital; receives funding from Pfizer (sertraline) and Psyadon Pharmaceuticals through the hospital; Small family real estate business

Daniel J Anzia, MD: Immediate Past Speaker; salary as independent contractor for Advocate Healthcare (part-time)

Lama Bazzi, MD: receives income from Maimonides Medical Center; forensic private practice

Glenn Martin, MD: Assembly Representative; income from Mt. Sinai Medical Center; head of IRB for the NFL; part-time private practice; board member of small health informatics company

Philip R Muskin, MD: APA Secretary; Income from Columbia University – part-time; volunteer at New York Psychiatric Institute; Private practice, expert testimony, and honoraria from APP

Saul Levin, MD, MPA: CEO/Medical Director; APA salary; Chair of the APAF Board of Directors; clinical professor George Washington; Veteran's Administration Secretary's Advisory Group (unpaid Federal Employee)

Linda Drozdowicz, MD: APAF Leadership Fellow: Resident Physician at Mount Sinai (full-time); additional income from Metropolitan Center for Mental Health, Silver Hill Hospital, St. Joseph's Hospital, and Lenox Hill Hospital. ABPN reimbursing portion of salary.

JRC Administration:

Margaret Cawley Dewar – Director, Association Governance

Laurie McQueen, MSSW – Associate Director, Association Governance

APA Administration:

Tanya J Bradsher	Chief of Communications
Colleen Coyle, JD	General Counsel
Yoshie Davison, MSW	Chief of Staff
Kristin Kroeger	Chief, Policy, Programs, & Partnerships
Ashley Mild	Interim Chief – Government Relations
Judson Woods, JD	Special Assistant to the CEO/Medical Director

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*.

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
2	Review and approval of the Summary of Actions from the June 2017 Joint Reference Committee Meeting *Will the Joint Reference Committee approve the draft summary of actions from the June 2017 meeting?*	The Joint Reference Committee approved the draft summary of actions from the June 2017 meeting. Dr. Martin abstained.	Yoshie Davison, MSW Margaret Cawley Dewar Laurie McQueen	Association Governance
3	**Report of the CEO Medical Director**			
3.1	Referral Update Making Access to the Voting Page a Default Action During Elections (JRCJUNE1712.P; ASMMAY1712.P) During future elections the APA webpage, www.psychiatry.org, will prominently feature a red call out button for members to vote during elections. Additionally, elections will be advertised in *Psychiatric News*, Headlines, *Psychiatric News* Update, APA Twitter, Facebook, and LinkedIn, as well as sending postcards and member emails. For those members who prefer paper ballots, we will continue current practice and send him/her a paper ballot upon request	The Joint Reference Committee thanked the CEO/Medical Director for this update and for addressing the issue brought forth in the action paper.		N/A
4	**APA Awards**			
4.A	2017 Irma Bland Award for Excellence in Teaching Residents **Will the Joint Reference Committee recommend that the Board of Trustees approve the nomination of the educators identified in attachment 4.A, as recipients of the 2017 Irma Bland Award for Excellence in Teaching Residents?**	The Joint Reference Committee recommended that the Board of Trustees approve the nomination of the educators identified in attachment 4.A, as recipients of the 2017 Irma Bland Award for Excellence in Teaching Residents**.**	Yoshie Davison, MSW Margaret Cawley Dewar Ardell Lockerman	Board of Trustees December 2017 Deadline: 11/15/17
4.B	2017 Nancy C.A. Roeske Certificate of Recognition for Excellence in Medical Student Education **Will the Joint Reference Committee recommend that the Board of Trustees approve the nomination of the educators identified in attachment 4.B, as recipients of the 2017 Nancy C.A. Roeske Certificate of Recognition for Excellence in Medical Student Education?**	The Joint Reference Committee recommended that the Board of Trustees approve the nomination of the educators identified in attachment 4.B, as recipients of the 2017 Nancy C.A. Roeske Certificate of Recognition for Excellence in Medical Student Education.	Yoshie Davison, MSW Margaret Cawley Dewar Ardell Lockerman	Board of Trustees December 2017 Deadline: 11/15/17

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
4.C	2017 Vestermark Psychiatry Educator Award **Will the Joint Reference Committee recommend that the Board of Trustees approve the nomination of Nyapati R Rao, MD as the recipient of the 2017 Vestermark Psychiatry Educator Award?**	The Joint Reference Committee recommended that the Board of Trustees approve the nomination of Nyapati R Rao, MD as the recipient of the 2017 Vestermark Psychiatry Educator Award.	Yoshie Davison, MSW Margaret Cawley Dewar Ardell Lockerman	Board of Trustees December 2017 Deadline: 11/15/17
4.D	2017 Benjamin Rush Award/Lectureship **Will the Joint Reference Committee recommend that the Board of Trustees approve the nomination of Steven S. Sharfstein, MD, MPA as the recipient of the 2017 Benjamin Rush Award?**	The Joint Reference Committee recommended that the Board of Trustees approve the nomination of Steven S. Sharfstein, MD, MPA as the recipient of the 2017 Benjamin Rush Award.	Yoshie Davison, MSW Margaret Cawley Dewar Ardell Lockerman	Board of Trustees December 2017 Deadline: 11/15/17
4.E	2018 Jacob Javits Public Service Award **Will the Joint Reference Committee recommend that the Board of Trustees approve the nomination of Senator Chris Murphy (D-CT) and Senator Bill Cassidy (R-LA) as the recipients of the 2018 Jacob Javits Public Service Award?**	The Joint Reference Committee referred the request back to the Council on Advocacy and Government Relations for further discussion and consideration of the award nominations.	Ashley Mild Deana McRae	Council on Advocacy and Government Relations Report to JRC – February 2018 Deadline: 1/25/18
4.F	2018 Jack Weinberg Award in Geriatric Psychiatry **Will the Joint Reference Committee recommend that the Board of Trustees approve the nomination of Paul Kirwin, MD as the recipient of the 2018 Jack Weinberg Award in Geriatric Psychiatry?**	The Joint Reference Committee recommended that the Board of Trustees approve the nomination of Paul Kirwin, MD as the recipient of the 2018 Jack Weinberg Award in Geriatric Psychiatry.	Yoshie Davison, MSW Margaret Cawley Dewar Ardell Lockerman	Board of Trustees December 2017 Deadline: 11/15/17
4.G	2017 Psychiatric Services Achievement Award **Will the Joint Reference Committee recommend that the Board of Trustees approve the nomination of *Meeting the Challenges of Domestic Violence: A Partnership for Research and Treatment* (Academic Gold); *Chesapeake Connections* (Community Gold); *Reciprocal Peer Support* (Silver) as the recipients of the 2017 Psychiatric Services Achievement Award?**	The Joint Reference Committee recommended that the Board of Trustees approve the nomination of *Meeting the Challenges of Domestic Violence: A Partnership for Research and Treatment* (Academic Gold); *Chesapeake Connections* (Community Gold); *Reciprocal Peer Support* (Silver) as the recipients of the 2017 Psychiatric Services Achievement Award.	Yoshie Davison, MSW Margaret Cawley Dewar Ardell Lockerman	Board of Trustees December 2017 Deadline: 11/15/17

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
5	Resource Document: Ethical Considerations Regarding Internet Searches for Patient Information **Will the Joint Reference Committee approve the Resource Document: *Ethical Considerations Regarding Internet Searches for Patient Information?***	The Joint Reference Committee approved the Resource Document: *Ethical Considerations Regarding Internet Searches for Patient Information.*	Yoshie Davison, MSW Margaret Cawley Dewar Ardell Lockerman Laurie McQueen	FYI - Board of Trustees December 2017 Deadline: 11/15/17
6	**Report of the Assembly**	Dr. Batterson noted that the Assembly will meet at the Omni Shoreham November 3-5, 2017. There will be a special election for the position of Recorder. The slate of nominees is Harold Ginzburg, MD; Paul O'Leary, MD; and James Polo, MD.		
8.A	**Council on Addiction Psychiatry** Please see item 8.A for the Council's report, summary of current activities and information items.			
8.A.1	Proposed Position Statement: Physician Health Services in the Treatment of Substance Use Disorders/Addictions in Physicians **Will the Joint Reference Committee recommend that the Assembly approve the proposed Position Statement: Physician Health Programs 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 Addiction Psychiatry (LEAD) to be reformatted and rewritten in a more concise manner. The JRC noted that the position statement needs to be shortened and also to look into the possibility of using the existing material for a resource document to supplement the position statement. Please also have the Council on Psychiatry and Law review the document and provide any additional feedback.	Kristin Kroeger Michelle Dirst Colleen Coyle, JD Alison Crane, JD	Council on Addiction Psychiatry (LEAD) Council on Psychiatry and Law Report to JRC – February 2018 Deadline: 1/25/18
7.A	Council Assessment – Council on Addiction Psychiatry – Work Plan **Will the Joint Reference Committee accept the Council on Addiction Psychiatry's three-year work plan?**	The Joint Reference Committee thanked the Council for the development of its work plan and accepted the Council's three-year work plan.		N/A
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.			

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
8.B.1	Smart Guns as a Gun Safety Response to Gun Violence, a Public Health Hazard (JRCFEB176.9; ASMNOV1612.M) **Will the Joint Reference Committee accept the Council's recommendation not to advance the action paper *Smart Guns as a Gun Safety Response to Gun Violence, a Public Health Hazard?*** The council discussed the action paper as referred by the JRC. A Council work group was established to assess the language, review existing APA policy documents (2014 position statement on Firearm Access and 2014 Resource Document on Access to Firearms by People with Mental Disorders) for similarities, and advise the Council on next steps. The work group concluded the 2014 position statement encompasses the vision of the action paper, thus does not feel it is necessary to promote specific language related to smart guns. Taking into consideration the work group's recommendation, the Council voted to not support advancing the action paper as written.	The Joint Reference Committee did not accept the council's recommendation and recognizes that the language of the APA's 2014 Position Statement: *Firearms Access, Acts of Violence and the Relationship to Mental Illness and Mental Health Services* subsumed the issue smart gun technology. The Joint Reference Committee referred the action paper to the APA AMA Delegation to consider development of a resolution on smart gun technology in consultation with the AMA and other Delegations.	Kristin Kroger Becky Yowell	APA AMA Delegation
8.B.2	Referral Update Providing Education and Guidance for the Use and Limitations of Pharmacogenomics in Clinical Practice (JRCJUNE176.5; ASMMAY1712.G) **LEAD**: Council on Quality Care The Council on Addiction Psychiatry discussed the action paper and indicated they require more information to make an informed recommendation. The Council agreed to postpone further discussion until they hear back from the Council on Quality Care with a draft document to guide the discussion.	The Joint Reference Committee thanked the Council for the update on this referral.		N/A

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
8.B.3	Referral Update Requesting the APA Draft a Position Statement on Prescription Drug Monitoring Programs (PDMPs) (JRCJUNE176.10; ASMMAY1712.L) **LEAD**: Council on Addiction Psychiatry The Council discussed the action paper and through unanimous consent, selected to establish a small work group to research the topic further, review the proposed documents drafted by the Council on Addiction Psychiatry, and recommend next steps to the Council. The Council will forward their recommendations to the Council on Addiction Psychiatry before the February 2018 JRC meeting.	The Joint Reference Committee thanked the Council for the update on this referral.	Ashley Mild Deana McRae Kristen Kroeger Michelle Dirst	Council on Advocacy and Government Relations Council on Addiction Psychiatry (LEAD) Report to JRC – February 2018 Deadline: 1/25/18
8.B.4	Referral Update Position Statement on Hospital Privileges for Psychologists (JRCJUNE178.B.1) The Council reviewed and discussed at length the position statement as revised by the Council's work group. Through JRC directive, the Council will establish a joint Council work group with the Council on Psychosomatic Medicine to broaden the 2007 position statement to encompass perspective of those psychiatrists working in general medical and hospital setting in addition to those in psychiatric hospitals. The work group will present a revised statement to the JRC before the February 2018 JRC meeting.	The Joint Reference Committee thanked the Council for the update on this referral and asked that the Administration provide the Council with a summary of the role of psychologists in mental health care within each branch of the military. The Joint Reference Committee noted that the development of this position statement is a joint effort between the Council on Advocacy and Government Relations and the Council on Psychosomatic Medicine.	Ashley Mild Deana McRae Kristen Kroeger Michelle Dirst	Council on Advocacy and Government Relations Council on Psychosomatic Medicine Report to JRC – February 2018 Deadline: 1/25/18
8.B.5	Referral Update Position Statement on Principles for Health Care Reform for Psychiatry (JRCJUNE178.B.2) The Council discussed at length the latest draft of the 2008 position statement, drafted by the Council's work group. The statement was amended to include relevant data and revised language. The Council will continue to work with the Council on Healthcare Systems and Financing to amend the position statement. The revised statement will be presented to the February 2018 JRC.	The Joint Reference Committee thanked the Council for the update on this referral.	Ashley Mild Deana McRae Kristin Kroeger Kathy Orellana	Council on Advocacy and Government Relations (LEAD) Council on Healthcare Systems and Financing Report to JRC – February 2018 Deadline: 1/25/18

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
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	Proposed Position Statement: Risks of Adolescents' Online Behavior **Will the Joint Reference Committee recommend that the Assembly approve the proposed Position Statement: *Risks of Adolescents' Online Behavior* and if approved, forward it to the Board of Trustees for consideration?** NB: The position statement was approved by the JRC in January 2017 and the Assembly in May 2017. In July 2017, the Board of Trustees requested that the position statement be reorganized into the proper format for an APA position statement.	**The Joint Reference Committee recommended that the Assembly approve the proposed Position Statement: *Risks of Adolescents' Online Activity* and if approved, forward it to the Board of Trustees for consideration.** Please note that the Joint Reference Committee revised the title of the statement from *Risks of Adolescents' Online Behavior* to *Risks of Adolescents' Online Activity* and where grammatically and contextually practical throughout the document changed the term 'online behavior' to 'online activity.'	Yoshie Davison, MSW Margaret Cawley Dewar Allison Moraske	Assembly – May 2018 Deadline: 3/15/18
8.D	**Council on Communications** Please see item 8.D for the Council's report, a summary of current activities, and information items.			
8.D.1	Revised Charge to the Council on Communications **Will the Joint Reference Committee recommend that the Board of Trustees approve the revised charge to the Council on Communications?**	The Joint Reference Committee recommended that the Board of Trustees approve the revised charge to the Council on Communications.	Yoshie Davison, MSW Margaret Cawley Dewar Ardell Lockerman	Board of Trustees December 2017 Deadline: 11/15/17

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
8.D.2	Referral Update Educational Strategies to Improve Mental Illness Perceptions of Medical Students (JRCJUNE176.7; ASMMAY1712.I) **LEAD**: Council on Medical Education and Lifelong Learning Consensus among many Council members was that many of the actions listed in the action paper were already being performed by various APA departments and by medical training directors at programs across the country. The Council questioned the assertion that there may not be sufficient interest among medical training directors to develop or implement training strategies around patients with mental illness and/or substance use disorders. Members of the Council concluded that many of the APA's Department of Education's own programs satisfy the requests of the action paper to work with outside bodies in developing and implementing education strategies involving patients with mental illness and/or substance use disorders.	The Joint Reference Committee thanked the council for this update and requested that a detailed response from the Divisions of Communications and Education be developed specifying what programs and activities are currently implemented at the APA to address the issues raised in the action paper.	Tanya Bradsher Tristan Gorrindo, MD	Division of Communications Division of Education Report to Assembly – May 2018 Deadline: 3/15/18

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
8.D.3	Referral Update Educational Strategies to Improve Mental Illness Perceptions of Non-Mental Health Medical Professionals (JRCJUNE176.8; ASMMAY1712.J) **LEAD**: Council on Medical Education and Lifelong Learning The consensus among members of the Council was that the strategies and curriculum requested by the action paper are redundant with many of the day-to-day functions of the APA, particularly APA's Department of Education. One of the main missions of the APA is to work with outside groups to improve the perception of those with mental illness and/or substance use disorders, and to promote the use of collaborative care models. The Council concluded that while many of the programs or actions requested by the paper currently exist in some form or another, perhaps they could be better publicized. The Council resolved to do its part to promote broader awareness of APA programs by members and non-members alike.	The Joint Reference Committee thanked the council for this update and requested that a detailed response from the Divisions of Communications and Education be developed specifying what programs and activities are currently implemented at the APA to address the issues raised in the action paper.	Tanya Bradsher Tristan Gorrindo, MD	Division of Communications Division of Education Report to Assembly – May 2018 Deadline: 3/15/18
8.D.4	Referral Update Making Access to the Voting Page a Default Action During Elections (JRCJUNE176.14; ASMMAY1712.P) See also item 3.1. **LEAD**: Office of the CEO/Medical Director The Council took information from APA staff on website traffic sources into account when formulating their feedback. According to APA staff, only 10% of traffic on psychiatry.org comes from APA Members. APA staff has worked with members of the Elections work group convened by the Board of Trustees. APA will advertise the Election and voting procedures in *Psychiatric News*, Headlines, *Psychiatric News* Update, on the APA twitter account, APA Facebook account, APA LinkedIn account, through mail post cards, and will send out member emails reminding them to vote.	The Joint Reference Committee thanked the Council for the update on this referral and referred to item 3.1 of this summary.		N/A

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
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	Proposed Position Statement: The Role of the Psychiatrist in Palliative Care **Will the Joint Reference Committee recommend that the Assembly approve the Proposed Position Statement: *The Role of the Psychiatrist in Palliative Care* and if approved, forward it to the Board of Trustees for consideration?**	The Joint Reference Committee referred the proposed position statement back to the Council for revision. It was noted that a position statement should be clear and concise. The JRC recommended that the internal looking recommendations portion of the statement become part of the background statement and that the 7th recommendation should be listed last. The language used in the background document was more clear and direct than that used in the position statement.	Ranna Parekh, MD, MPH Sejal Patel	Council on Geriatric Psychiatry Report to JRC – February 2018 Deadline: 1/25/18
8.F	**Council on Healthcare Systems and Financing** Please see item 8.F for the Council's report, summary of current activities and information items.			
8.F.1	Proposed Position Statement: Telemedicine: Synchronous Video-conferencing in Psychiatry **Will the Joint Reference Committee recommend that the Assembly approve the proposed Position Statement: *Telemedicine: Synchronous Video-conferencing in Psychiatry* and if approved, forward it to the Board of Trustees for consideration?**	The Joint Reference Committee referred the proposed Position Statement to the Council on Healthcare Systems and Financing to be reformatted and for potential integration with the APA's current position statement *Telemedicine in Psychiatry*.	Kristin Kroeger Kathy Orellana Nate Tatro	Council on Healthcare Systems and Financing Report to JRC – February 2018 Deadline: 1/25/18
8.F.2	Resource Document: Telemedicine: Synchronous Video-conferencing in Psychiatry **Will the Joint Reference Committee approve the Resource Document: *Telemedicine: Synchronous Video-conferencing in Psychiatry*?**	The Joint Reference Committee approved the Resource Document: *Telemedicine: Synchronous Video-conferencing in Psychiatry*.	Yoshie Davison, MSW Margaret Cawley Dewar Ardell Lockerman Laurie McQueen	FYI – Board of Trustees December 2017 Deadline: 11/15/17

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
8.F.3	Referral Update Level of Service Intensity Instrument (JRCJULY156.5; ASMMAY1512.F) **LEAD**: The action paper asked the APA Administration research level of care/intensity of service tools available and used by insurance companies and other organizations for determination of appropriate psychiatric and substance abuse care for adults. APA staff will review the identified level of service/core criteria and develop next steps for the Council's consideration.	The Joint Reference Committee thanked the Council for the update on this referral.		N/A
8.F.4	Referral Update Revising the Nomenclature, Definition, and Clinical Criteria for Partial Hospitalization Program (JRCJUNE176.4; ASMMAY1712.E) **LEAD**: Transferred to Council on Healthcare Systems and Financing The Council on Healthcare Systems and Financing has taken over as LEAD on this action paper and will roll this task into the discussions regarding level or service/core criteria.	The Joint Reference Committee thanked the Council for the update on this referral.		N/A
8.F.5	Referral Update Continuity of Care (JRCFEB17XX; ASMNOV1612.C) The Council on Quality Care discussed this action paper and noted that quality measures exist regarding transitions in care. Members of the Council have agreed to draft a position statement on the issue. The statement can utilize the NQF measures on the topic.	The Joint Reference Committee thanked the Council for the update on this referral.		N/A
8.G	**Council on International Psychiatry** Please see item 8.G for the Council's report, summary of current activities and information items.			

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
8.G.1	Revised Charge to the Council on International Psychiatry **Will the Joint Reference Committee recommend to the Board of Trustees to approve the recommendation to add "including with international presenters through a poster engagement program" to the charge to the Council on International Psychiatry?**	The Joint Reference Committee recommended to the Board of Trustees to approve the recommendation to add "including with international presenters through a poster engagement program" to the charge to the Council on International Psychiatry.	Yoshie Davison, MSW Margaret Cawley Dewar Ardell Lockerman	Board of Trustees December 2017 Deadline: 11/15/17
8.G.2	2018 Chester M Pierce Human Rights Award **Will the Joint Reference Committee recommend that the Board of Trustees approve the nomination of the Mental Disability Advocacy Center as the recipient of the 2018 Chester M. Pierce Human Rights Award?**	The Joint Reference Committee recommend that the Board of Trustees approve the nomination of the Mental Disability Advocacy Center as the recipient of the 2018 Chester M. Pierce Human Rights Award.	Yoshie Davison, MSW Margaret Cawley Dewar Ardell Lockerman	Board of Trustees December 2017 Deadline: 11/15/17
7.B	Council Assessments – Council on International Psychiatry – Work Plan **Will the Joint Reference Committee accept the three – year Work Plan submitted by the Council on International Psychiatry?**	The Joint Reference Committee thanked the council for the development of their work plan and accepted the Council's three-year work plan.	Jon Fanning, CAE Ricardo Juarez	Council on International Psychiatry
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.			

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
8.H.1	Referral Update Expanding Access to Psychiatric Subspecialty Fellowships (JRCJUNE176.6; ASMMAY1712.H) **LEAD**: Council on Medical Education and Lifelong Learning Current policies of ABPN and ACGME have addressed some of the concerns of this action paper (see the attachment) However, the changes may not go far enough. The Council supports a statement of intent for encouraging ABPN and ACGME to find a pathway for evaluating the AOA graduates – especially those who have already graduated – so that they can find pathways into subspecialty training. The Council on Medical Education and Lifelong Learning is in favor of "encouraging actions." The Council is considering whether this can be done through direct advocacy (letter of representation) of if a formal position should be drafted.	The Joint Reference Committee thanked the Council for the update on this referral.		N/A
8.H.2	Referral Update Fostering Medical Student Interest and Training in Psychiatry: The Importance of Medical Student Clerkships (JRCJUNE176.9; ASMMAY1712.K) **LEAD**: Council on Medical Education and Lifelong Learning The Liaison Committee on Medical Education (LCME) does not specify minimum lengths for clerkships that may not suit a minimum requirement. The LCME website posts data about clerkship length (5.2 weeks in 2016) https://www.aamc.org/initiatives/cir/426810/05d.html ADMSEP and AAP have a position statement on clerkship length (2006) which supports a 6-week clerkship. http://www.admsep.org/pdf/Position_Clerksh_Length.pdf The Council also notes that if data arrives which support minimum length or if LCME adopts new standards this should be revisited.	The Joint Reference Committee thanked the Council for the update on this referral.		N/A

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
8.H.3	Referral Update Educational Strategies to Improve Mental Illness Perceptions of Medical Students (JRCJUNE176.7; ASMMAY1712.I) **LEAD**: Council on Medical Education and Lifelong Learning The Council see the value in a diversity of experiences to patient narratives throughout medical school but doesn't endorse the idea of creating a series of products on MH recovery. The component around student wellness, and medical student coming forward, is something the wellness group is looking at now.	The Joint Reference Committee thanked the Council for the update on this referral.		N/A
8.H.4	Referral Update Educational Strategies to Improve Mental Illness Perceptions of Non-Mental Health Medical Professionals (JRCJUNE176.8; ASMMAY1712.J) **LEAD**: Council on Medical Education and Lifelong Learning The work of the SAN grant is already doing much of this in terms of building bridges. The Council notes that before any initiative be undertaken a needs assessment should be completed which would determine what the current opinions are before we seek to change perceptions. It's not clear to the Council that this type of intervention would be effective in changing perceptions of physicians in other specialties.	The Joint Reference Committee thanked the Council for the update on this referral.		N/A

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
8.H.5	Referral Update Addressing Physician Burnout, Depression, and Suicide – Within Psychiatry and Beyond (JRCJUNE17XX; ASMMAY1712.N) **LEAD**: Council on Medical Education and Lifelong Learning The Council on Medical Education and Lifelong Learning discussed this issue; they want to make sure there is long-term institutionalization of the wellness efforts of this year. They would be willing, for example, to be a home to an ongoing physician wellbeing committee in the same way that they are to the two scientific program committees. The Council would want input from others related to government (FSMB) and systems level issues.	The Joint Reference Committee thanked the Council for the update on this referral.		N/A
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	<u>Request for Funding: Assembly M/UR Caucus Representatives to the Council Meeting at the 2018 September Components Meeting</u> **Will the Joint Reference Committee recommend that the Board of Trustees approve the request, and identify a funding source, for the seven M/UR Caucus Assembly Representatives (or their designees) to meet with the Council at the 2018 September Components Meeting?** The estimated cost is $6,636.00	The Joint Reference Committee recommended that the Board of Trustees approve the request for the seven M/UR Caucus Assembly Representatives (or their designees) to meet with the Council at the 2018 September Components Meeting at the same level of funding as this year at approximately $9,000 from the Assembly Budget and additional costs for members of the Council on Minority Mental Health and Health Disparities from the component's budget.	Yoshie Davison, MSW Margaret Cawley Dewar Ardell Lockerman	Board of Trustees December 2017 Deadline: 11/15/17

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
8.I.2	ACGME Standard for Common Program Requirement for Psychiatry Residency Programs **Will the Joint Reference Committee refer to the Council on Medical Education and Lifelong Learning for review, the Council on Minority Mental Health and Health Disparities' support for an ACGME accreditation standard for psychiatry residency programs on diversity programs and partnerships to achieve health care equity and eliminate health disparities?** If the Council on Medical Education and Lifelong Learning concurs, the APA will send a letter of support of this Common Program Requirement to the ACGME	The Joint Reference Committee referred to the CEO/Medical Director's Office and the Division of Education, the Council on Minority Mental Health and Health Disparities' support for an ACGME accreditation standard for psychiatry residency programs on diversity programs and partnerships to achieve health care equity and eliminate health disparities. The Joint Reference Committee noted that the comments and review from the APA are to be completed in a timely manner to meet the ACGME deadline for a letter of support.	Saul Levin, MD, MPA Tristan Gorrindo, MD	CEO/Medical Director's Office Division of Education
8.I.3	Revised Position Statement Access to Care for Transgender and Gender Diverse Individuals **Will the Joint Reference Committee recommend that the Assembly approve the revised position statement *Access to Care for Transgender and Gender Diverse Individuals* and if approved, forward it to the Board of Trustees for consideration?**	The Joint Reference Committee recommended that the Assembly approve the revised position statement *Access to Care for Transgender and Gender Diverse Individuals* and if approved, forward it to the Board of Trustees for consideration. The JRC made a minor revision to the position statement.	Yoshie Davison, MSW Margaret Cawley Dewar Allison Moraske	Assembly – May 2018 Deadline: 3/15/18
8.I.4	Revised Position Statement Discrimination Against Transgender and Gender Diverse Individuals **Will the Joint Reference Committee recommend that the Assembly approve the revised position statement *Discrimination Against Transgender and Gender Diverse Individuals* and if approved, forward it to the Board of Trustees for consideration?**	The Joint Reference Committee recommended that the Assembly approve the revised position statement *Discrimination Against Transgender and Gender Diverse Individuals* and if approved, forward it to the Board of Trustees for consideration.	Yoshie Davison, MSW Margaret Cawley Dewar Allison Moraske	Assembly – May 2018 Deadline: 3/15/18

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
8.I.5	Revised Position Statement on the Resolution Against Racism and Racial Discrimination and Their Adverse Impacts on Mental Health **Will the Joint Reference Committee recommend that the Assembly approve revised position statement *Resolution Against Racism and Racial Discrimination and Their Adverse Impacts on Mental Health* and if approved, forward it to the Board of Trustees for consideration?**	The Joint Reference Committee referred the revised position statement back to the Council with minor suggestions from Dr. Anzia. Additional revisions to the document were requested based on the data supporting the position statement.	Ranna Parekh, MD, MPH Vabren Watts Omar Davis	Council on Minority Mental Health and Health Disparities Report to JRC – February 2018 Deadline: 1/25/18
8.J	**Council on Psychiatry and Law** Please see item 8.J for the Council's report, summary of current activities and information items.			
8.J.1	Revision to Composition of Council on Psychiatry and Law **Will the Joint Reference Committee recommend that the Board of Trustees approve revising the composition of the Council on Psychiatry and Law to reserve a corresponding member position exclusively for the chairperson of the Committee on Judicial Action, a subcomponent of the Council, with such position not subject to the term limits typically applicable to corresponding members?**	The Joint Reference Committee recommended that the Board of Trustees approve the revision of the composition of the Council on Psychiatry and Law to *reserve* one of the corresponding member positions exclusively for the chairperson of the Committee on Judicial Action, a subcomponent of the Council, with such position not subject to the term limits typically applicable to corresponding members.	Yoshie Davison, MSW Margaret Cawley Dewar Ardell Lockerman	Board of Trustees December 2017 Deadline: 11/15/17

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
8.J.2	<u>Proposed Position Statement: Solitary Confinement (Restricted Housing) of Juveniles</u> **Will the Joint Reference Committee recommend that the Assembly approve the proposed Position Statement: *Solitary Confinement (Restricted Housing) of Juveniles* and if approved, forward it to the Board of Trustees for consideration?** **NB**: the proposed position statement was developed by a work group comprised of members from the Council on Psychiatry and Law, Council on Children, Adolescents, and Their Families, and the Council on Minority Mental Health and Health Disparities. All three councils have unanimously approved the proposed position statement.	The Joint Reference Committee recommended that the Assembly approve the proposed Position Statement: *Solitary Confinement (Restricted Housing) of Juveniles* and if approved, forward it to the Board of Trustees for consideration. For the future, the JRC asked that the Council and its work group consider terms other than "juvenile" to describe youth who are involved with the criminal justice system.	Yoshie Davison, MSW Margaret Cawley Dewar Allison Moraske	Assembly – May 2018 Deadline: 3/15/18
8.J.3	<u>Proposed Position Statement: Psychiatric Services in Adult Correctional Facilities</u> **Will the Joint Reference Committee recommend that the Assembly approve the proposed Position Statement: *Psychiatric Services in Adult Correctional 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: *Psychiatric Services in Adult Correctional Facilities* and if approved, forward it to the Board of Trustees for consideration.	Yoshie Davison, MSW Margaret Cawley Dewar Allison Moraske	Assembly – May 2018 Deadline: 3/15/18

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
8.J.4	<u>Proposed Position Statement: Weapons Use in Hospitals and Patient Safety</u> **Will the Joint Reference Committee recommend that the Assembly approve the proposed Position Statement: *Weapons Use in Hospitals and Patient Safety* 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 Psychiatry and Law and requested that the document be rewritten based on the feedback below: The position statement seems to conflate the issue of a clinical situation in which a patient possesses a weapon with the intent to harm and a possession of a weapon by hospital personnel. There also seemed to be confusion between patients who become perpetrators and a non-patient who enters an ED with a weapon. It was noted that a hospital's active shooter protocol would supersede most other actions.	Colleen Coyle, JD Alison Crane, JD	Council on Psychiatry and Law Report to JRC – February 2018 Deadline: 1/25/18
8.J.5	<u>Proposed Position Statement: Research with Involuntary Psychiatric Patients</u> **Will the Joint Reference Committee recommend that the Assembly approve the proposed Position Statement: *Research with Involuntary Psychiatric Patients* 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: *Research with Involuntary Psychiatric Patients* and if approved, forward it to the Board of Trustees for consideration.	Yoshie Davison, MSW Margaret Cawley Dewar Allison Moraske	Assembly – May 2018 Deadline: 3/15/18

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
8.J.6	Revised Position Statement: Inquiries about Diagnosis and Treatment of Mental Disorders in Connection with Professional Credentialing and Licensing (2015) **Will the Joint Reference Committee recommend that the Assembly approve the revised 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?** **NB**: if the revised position statement is approved, the 2015 position statement will be retired.	The Joint Reference Committee recommended that the Assembly approve the revised 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.	Yoshie Davison, MSW Margaret Cawley Dewar Allison Moraske	Assembly – May 2018 Deadline: 3/15/18
8.J.7	Development of a Proposed Position Statement on Health Care, inclusive of mental health care, is a Human Right **Will the Joint Reference Committee approve the development of a proposed Position Statement on Health Care, inclusive of mental health care, is a human right by a workgroup under the auspices of the Council on Psychiatry and Law with input from the Council on Minority Mental Health and Health Disparities and the Ethics Committee?**	The Joint Reference Committee referred the position statement *Health Care, inclusive of mental health care, is a human right to the Board of Trustees* for further review and discussion.	Yoshie Davison, MSW Margaret Cawley Dewar Ardell Lockerman	Board of Trustees December 2017 Deadline: 11/15/17
8.J.8	Proposed Resource Document: Recommended Best Practices for Physician Health Programs **Will the Joint Reference Committee approve the proposed Resource Document: *Recommended Best Practices for Physician Health Program?***	The Joint Reference Committee approved the proposed Resource Document: *Recommended Best Practices for Physician Health Program.*	Yoshie Davison, MSW Margaret Cawley Dewar Ardell Lockerman	FYI – Board of Trustees December 2017 Deadline: 11/15/17

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
8.J.9	<u>Permission to Publish: Resource Document Recommended Best Practices for Physician Health Programs</u> **Will the Joint Reference Committee recommend that the Board of Trustees grant permission to publish the Resource Document *Recommended Best Practices for Physician Health Programs?*** Please note that after the *American Journal of Psychiatry* has the right of first refusal. The following disclaimer must be included in the manuscript. "The findings, opinions, and conclusions of this report do not necessarily represent the views of the officers, trustees, or all members of the American Psychiatric Association. The views expressed are those of the authors."	The Joint Reference Committee recommended that the Board of Trustees grant permission to publish the Resource Document *Recommended Best Practices for Physician Health Programs.*	Yoshie Davison, MSW Margaret Cawley Dewar Ardell Lockerman	Board of Trustees December 2017 Deadline: 11/15/17
8.K	**Council on Psychosomatic Medicine** Please see item 8.L for the Council's report, summary of current activities and information items.			
7.C	Council Assessments – Council on Psychosomatic Medicine – Work Plan **Will the Joint Reference Committee accept the Council on Psychosomatic Medicine's three-year work plan?**	The Joint Reference Committee accepted the Council on Psychosomatic Medicine's three-year work plan.	Kristin Kroeger Michelle Dirst	Council on Psychosomatic Medicine
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	<u>Revised Charge to the Committee on Performance Measurement?</u> **Will the Joint Reference Committee recommend that the Board of Trustees approve the revised charge to the Committee on Performance Measurement?**	The Joint Reference Committee recommended that the Board of Trustees approve the revised charge to the Committee on Performance Measurement.	Yoshie Davison, MSW Margaret Cawley Dewar Ardell Lockerman	Board of Trustees December 2017 Deadline: 11/15/17

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
8.L.2	Revised Position Statement: Use of the Concept of Recovery (2015) (JRCFEB178.M.1; ASMMAY174.B.1) **Will the Joint Reference Committee recommend that the Assembly approve the Revised Position Statement: Use of the Concept of Recovery and if approved, forward it to the Board of Trustees for consideration?** NB: If the revised position statement is approved, the 2015 position statement will be retired.	The Joint Reference Committee postponed consideration of the revised position statement until the February 2018 JRC meeting, pending the review of the statement by mental health consumer groups.	Kristin Kroeger Samantha Shugarman	Council on Quality Care Report to JRC – February 2018 Deadline: 1/25/18

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
8.L.3	<u>Referral Update</u> Providing Education and Guidance for the Use and Limitations of Pharmacogenomics in Clinical Practice (JRCJUNE176.5; ASMMAY1712.G) **LEAD**: Council on Quality Care • The Committee on Practice Guidelines, a reporting component of the Council on Quality Care, will work with each Guideline Writing Group to include pharmaco-genomic testing as appropriate based on the guideline topic. It will be built into any in-house literature searches, and can be done separately (if needed) for outside literature searches. The writing group chairs will work with topic experts to identify the appropriate guideline topics, for potential inclusion. If there is sufficient data to be included in the guideline topic, the group will include a guideline statement on pharmaco-genomic testing addressing implementation, quality measures, the strength of the evidence, and the benefits/harms. If there is insufficient data to make a statement but it is a relevant topic, it will be included in areas for future research. • The APA Staff Liaison to the Council on Research shared that the Council on Research-charged Work Group on Biomarkers will share their draft paper on the use of pharmacogenomics and the treatment of depression with the Council on Quality Care. • Following review of this draft paper, the Council on Quality Care will ascertain the quality of the evidence and determine the appropriateness for the Council on Quality Care to develop a resource document.	The Joint Reference Committee thanked the Council for the update on this referral.		N/A

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
8.L.4 New Item	Request for Funding: Meeting of the Work Group on Performance and Quality Measurement **Will the Joint Reference Committee recommend that the Board of Trustees approve up to $5,000 in funding for an in-person meeting of the Work Group on Performance and Quality Measurement?** The work group will work on a grant application (deadline February 2018) to CMS for up to $6 million to develop, improve, update of expand quality measure for inclusion in the Medicare Merit-Based Incentive Payment System (MIPS) or alternative payment models. The funding will come from the budget of the policy department.	The Joint Reference Committee recommended that the Board of Trustees approve up to $5,000 in funding for an in-person meeting of the Work Group on Performance and Quality Measurement.	Yoshie Davison, MSW Margaret Cawley Dewar Ardell Lockerman	Board of Trustees October 2017
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	Request to Publish: Clinical Implementation of Pharmacogenetic Decision Support Tools for Antidepressant Drug Prescribing **Will the Joint Reference Committee recommend that the Board of Trustees approve the Council's request to publish the manuscript *Clinical Implementation of Pharmacogenetic Decision Support Tools for Antidepressant Drug Prescribing* in the *American Journal of Psychiatry*?** The following disclaimer must be included in the manuscript. "The findings, opinions, and conclusions of this report do not necessarily represent the views of the officers, trustees, or all members of the American Psychiatric Association. The views expressed are those of the authors."	The Joint Reference Committee recommended that the Board of Trustees approve the Council's request to publish the manuscript *Clinical Implementation of Pharmacogenetic Decision Support Tools for Antidepressant Drug Prescribing*?	Yoshie Davison, MSW Margaret Cawley Dewar Ardell Lockerman	Board of Trustees December 2017 Deadline: 11/15/17

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
8.M.2	Proposed Position Statement: Mental Health Screening, Diagnosis, and Treatment During Pregnancy and Postpartum **Will the Joint Reference Committee recommend that the Assembly approve the proposed Position Statement: *Mental Health Screening, Diagnosis, and Treatment During Pregnancy and Postpartum* and if approved, forward it to the Board of Trustees for consideration?**	The Joint Reference Committee thanked the Council for a very well written and comprehensive document. The Joint Reference Committee referred the proposed position statement back to the Council on Research with the suggestion that it be reformatted into a resource document rather than a position statement. Should the Council wish to produce a position statement, the JRC requested a clear and very concise statement.	Philip Wang, MD, Dr.PH Diana Clarke, PhD Keila Barber	Council on Research Report to JRC – February 2018 Deadline: 1/25/18
8.M.3	2018 Bruno Lima Award in Disaster Psychiatry **Will the Joint Reference Committee recommend that the Board of Trustees approve the nomination of Michael Blumenfield, MD, as a recipient of the 2018 Bruno Lima Award in Disaster Psychiatry?**	The Joint Reference Committee recommended that the Board of Trustees approve the nomination of Michael Blumenfield, MD, as a recipient of the 2018 Bruno Lima Award in Disaster Psychiatry.	Yoshie Davison, MSW Margaret Cawley Dewar Ardell Lockerman	Board of Trustees December 2017 Deadline: 11/15/17
8.M.4	2018 Bruno Lima Award in Disaster Psychiatry **Will the Joint Reference Committee recommend that the Board of Trustees approve the nomination of Robert J Ursano, MD, as a recipient of the 2018 Bruno Lima Award in Disaster Psychiatry?**	The Joint Reference Committee recommended that the Board of Trustees approve the nomination of Robert J Ursano, MD, as a recipient of the 2018 Bruno Lima Award in Disaster Psychiatry.	Yoshie Davison, MSW Margaret Cawley Dewar Ardell Lockerman	Board of Trustees December 2017 Deadline: 11/15/17
8.M.5	Proposed Position Statement Neuroscience-based Nomenclature (NbN) for Medications (JRCJUNE176.3; ASMMAY1712.D) **Will the Joint Reference Committee recommend that the Assembly approve the proposed Position Statement *Neuroscience-based Nomenclature (NbN) for Medications* and if approved, forward it to the Board of Trustees for consideration?**	The Joint Reference Committee did not recommend that the Assembly approve the proposed Position Statement *Neuroscience-based Nomenclature (NbN) for Medications*.	Philip Wang, MD, Dr.PH Diana Clarke, PhD Keila Barber	FYI – Council on Research

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
8.M.6	Referral Update Revising the Nomenclature, Definition, and Clinical Criteria for Partial Hospitalization Program (JRCJUNE176.4; ASMMAY1712.E) **LEAD**: Council on Healthcare Systems and Financing The Council on Research transferred the LEAD on this action paper to the Council on Healthcare Systems and Financing. The Council on Research will provide input and guidance when needed.	The Joint Reference Committee thanked the Council for the update on this referral.		N/A
8.M.7	Referral Update Providing Education and Guidance for the Use and Limitations of Pharmacogenomics in Clinical Practice (JRCJUNE176.5; ASMMAY1712.G) **LEAD**: Council on Quality Care The Council on Research submitted a manuscript for the JRC's review entitled *Clinical Implementation of Pharmacogenetic Decision Support Tools for Antidepressant Drug Prescribing.* The council would like to submit this manuscript to the *American Journal of Psychiatry* for publication.	The Joint Reference Committee thanked the Council for the update on this referral.		N/A
9.A	<u>Resource Document: Physician Assisted Death</u> **Will the Joint Reference Committee approve the Resource Document on Physician Assisted Death**?	The Joint Reference Committee approved the Resource Document on Physician Assisted Death.	Yoshie Davison, MSW Margaret Cawley Dewar Ardell Lockerman Laurie McQueen	FYI – Board of Trustees December 2017 Deadline: 11/15/17

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
9.B	<u>Request to Publish: Resource Document: Physician Assisted Death</u> **Will the Joint Reference Committee recommend that the Board of Trustees grant permission to publish the Resource Document: *Physician Assisted Death*?** The following disclaimer must be included in the document. "The findings, opinions, and conclusions of this report do not necessarily represent the views of the officers, trustees, or all members of the American Psychiatric Association. The views expressed are those of the authors."	The Joint Reference Committee recommended that the Board of Trustees grant permission to publish the Resource Document: *Physician Assisted Death*. The following disclaimer must be included in the document. "The findings, opinions, and conclusions of this report do not necessarily represent the views of the officers, trustees, or all members of the American Psychiatric Association. The views expressed are those of the authors."	Yoshie Davison, MSW Margaret Cawley Dewar Ardell Lockerman Laurie McQueen	FYI – Board of Trustees December 2017 Deadline: 11/15/17

Action	CEO/MDO Response	Staff/Component Responsible	Status
8.I.3 ACGME Standard for Common Program Requirement for Psychiatry Residency Programs **Will the Joint Reference Committee refer to the Council on Medical Education and Lifelong Learning for review, the Council on Minority Mental Health and Health Disparities' support for an ACGME accreditation standard for psychiatry residency programs on diversity programs and partnerships to achieve health care equity and eliminate health disparities?** If the Council on Medical Education and Lifelong Learning concurs, the APA will send a letter of support of this Common Program Requirement to the ACGME	On November 21, 2017, the Executive Committee of the APA Board of Trustees held a conference call during which it supported sending comments drafted by the Council on Medical Education and Lifelong Learning regarding the importance of diversity training to the ACGME. The comments were submitted by APA Administration on Wednesday, November 22, 2017, and ACGME confirmed receipt the following week. Specifically, the comments submitted to ACGME contained the following language: "The American Psychiatric Association wishes to communicate to the ACGME its support of the establishment of an ACGME accreditation standard III. C. in the section "The Learning and Working Environment" in the Institutional Requirements on diversity programs and partnerships to achieve health care equity and eliminate health care disparities… In a medical education program, the facts that having medical students and faculty members from a variety of socioeconomic backgrounds, racial and ethnic groups, and other life experiences can 1) enhance the quality and content of interactions and discussions for all students throughout the preclinical and clinical curricula and 2) result in the preparation of a physician workforce that is more culturally aware and competent and better prepared to improve access to healthcare and address current and future health care disparities."	Saul Levin, MD, MPA Tristan Gorrindo, MD	APA Administration has completed the action requested and submitted commentary to ACGME supporting an ACGME accreditation standard for psychiatry residency programs on diversity.

ACGME Requirements
Review and Comment Form

Title of Requirements	Institutional Requirements

Organizations submitting comments should indicate whether the comments represent a consensus opinion of its membership or whether they are a compilation of individual comments.

Select [X] only one	
Organization (consensus opinion of membership)	X
Organization (compilation of individual comments)	
Review Committee	
Designated Institutional Official	
Program Director in the Specialty	
Resident/Fellow	
Other (specify):	

Name	Saul Levin, MD
Title	CEO and Medical Director
Organization	American Psychiatric Association

As part of the ongoing effort to encourage the participation of the graduate medical education community in the process of revising requirements, the ACGME may publish some or all of the comments it receives on the ACGME website. By submitting your comments, the ACGME will consider your consent granted. If you or your organization does not consent to the publication of any comments, please indicate such below.

The ACGME welcomes comments, including support, concerns, or other feedback, regarding the proposed requirements. For focused revisions, only submit comments on those requirements being revised. Comments must be submitted electronically and must reference the requirement(s) by both line number and requirement number. Add rows as necessary.

	Line Number(s)	Requirement Number	Comment(s)/Rationale
1	516	III. The Learning and	Proposal to add III. C. described in "General Comments" below
2		Working Environment	
3			
4			
5			
6			
7			
8			
9			
10			

General Comments:

The American Psychiatric Association wishes to communicate to the ACGME its support of the establishment of an ACGME accreditation standard III. C. in the section "The Learning and Working Environment" in the Institutional Requirements on diversity programs and partnerships to achieve health care equity and eliminate health care disparities.

> **"Diversity Programs and Partnerships**
> The sponsoring institution has effective policies and practices in place, and engages in ongoing, systematic, and focused recruitment and retention activities, to achieve mission-appropriate diversity outcomes among its residents/fellows, faculty, senior administrative staff, and other relevant members of its clinical learning environment. These activities include the use of programs and/or partnerships aimed at achieving diversity among qualified applicants for residency/fellowship training program admission and the evaluation of program and partnership outcomes."

Background: In Feb. 2017, an ACGME document stated "Eliminating health care disparities in the US is a national concern (5,6). Overall, the findings from this first set of CLER [Clinical Learning Environment Review] site visits suggest that there is currently a substantive deficiency in preparing residents and fellows to both identify and address disparities in health care outcomes, as well as ways to minimize or eliminate them." (Ref.1)

One important mechanism to achieve health care equity and eliminate health care disparities at the medical school level has been the LCME accreditation standard 3.3 (Ref. 2), which is missing in the current ACGME institutional, common program, and specialty GME accreditation standards including psychiatry (Ref. 3):

> **"Standard 3: Academic and Learning Environments**
>
> A medical school ensures that its medical education program occurs in professional, respectful, and intellectually stimulating academic and clinical environments, recognizes the benefits of diversity, and promotes students' attainment of competencies required of future physicians.
>
> **3.3 Diversity/Pipeline Programs and Partnerships**
>
> A medical school has effective policies and practices in place, and engages in ongoing, systematic, and focused recruitment and retention activities, to achieve mission-appropriate diversity outcomes among its students, faculty, senior administrative staff, and other relevant members of its academic community. These activities include the use of programs and/or partnerships aimed at achieving diversity among qualified applicants for medical school admission and the evaluation of program and partnership outcomes."

For example, the need to increase diversity in psychiatry's academic workforce and hence in its psychiatry residency programs to reduce mental health disparities has been documented since the American Psychiatric Association Steering Committee to Reduce Disparities in Access to Psychiatric Care Final Report of 2004 (Ref. 4) and in recent articles in Academic Psychiatry (Refs. 5, 6).

Faculty and resident diversity as a key component of excellence for medical education and research has been documented since 2009 (Ref. 7, 8, 9, 10).

References:

1. Wagner, R, Koh, N, Bagian, JP, Weiss, KB, for the CLER Program. CLER 2016 National Report of Findings. Issue Brief #4: Health Care Disparities. Accreditation Council for Graduate Medical Education, Chicago, Illinois USA. ISBN-13: 978-1-945365-07-2

2. LCME Functions and Structure of a Medical School: Standards for Accreditation of Medical Education Programs Leading to the MD Degree, effective July 1, 2017. Accessed 9/1/17 at http://lcme.org/publications/

3. Pierre, J, Mahr, F, Carter, A, Madaan, V. Underrepresented in Medicine Recruitment: Rationale, Challenges, and Strategies for Increasing Diversity in Psychiatry
Residency Programs. Academic Psychiatry (2017) 41:226–232

4. Lu, F, Primm, A. Mental Health Disparities, Diversity, and Cultural Competence in Medical Student Education: How Psychiatry Can Play a Role. Academic Psychiatry (2006); 30:9–15

5. Roberts, L, Maldonado, Y, Coverdale, J, Balon, R, Louie, A, Beresin, E. The Critical Need to Diversify the Clinical and Academic Workforce. Academic Psychiatry (2014) 38:394–397

6. Lokko, H, Chen, J, Parekh, P, Stern, T. Racial and Ethnic Diversity in the US Psychiatric Workforce: A Perspective and Recommendations. Academic Psychiatry (2016) 40:898–904

7. Association of American Medical Colleges. Striving Toward Excellence:
Faculty Diversity in Medical Education (2009). Accessed 9/27/17 at
https://www.aamc.org/download/482376/data/strivingtowardexcellence.pdf

8. Association of American Medical Colleges. Reflections on Diversity and Inclusion in Academic Medicine. Accessed 9/27/17 at
https://www.aamc.org/download/427368/data/nickensinteractivecommemorativebook.pdf

9. Coalition of Urban Serving Universities, Association of Public & Land-Grant Universities, Association of American Medical Colleges.
https://www.aamc.org/external/471258?url=http://urbanuniversitiesforhealth.org/media/documents/Increasing_Diversity_in_the_Biomedical_Research_Workforce.pdfIncreasing Diversity in the Biomedical Research Workforce: Actions for Improving Evidence. Accessed 9/27/17 at
http://urbanuniversitiesforhealth.org/media/documents/Increasing_Diversity_in_the_Biomedical_Research_Workforce.pdf

10. Nivet, M. Diversity 3.0: A Necessary Systems Upgrade. Academic Medicine. (2011) 86:1487–1489

Glossary of Terms for LCME Accreditation Standards and Elements

Benefits of diversity: In a medical education program, the facts that having medical students and faculty members from a variety of socioeconomic backgrounds, racial and ethnic groups, and other life experiences can 1) enhance the quality and content of interactions and discussions for all students throughout the preclinical and clinical curricula and 2) result in the preparation of a physician workforce that is more culturally aware and competent and better prepared to improve access to healthcare and address current and future health care

disparities. (Standard 3)

Health care disparities: Differences between groups of people, based on a variety of factors including, but not limited to, race, ethnicity, residential location, sex, age, and socioeconomic, educational, and disability status, that affect their access to health care, the quality of the health care they receive, and the outcomes of their medical conditions. (Element 7.6)

Mission-appropriate diversity: The inclusion, in a medical education program's student body and among its faculty and staff and based on the program's mission, goals, and policies, of persons from different racial, ethnic, economic, and/or social backgrounds and with differing life experiences to enhance the educational environment for all medical students. (Element 3.3)

Association of American Medical Colleges (AAMC) Group on Diversity and Inclusion (GDI) and Group on Women in Medicine and Science (GWIMS)

https://www.aamc.org/members/gdi/ and https://www.aamc.org/members/gwims/

Diversity

Diversity as a core value embodies inclusiveness, mutual respect, and multiple perspectives and serves as a catalyst for change resulting in health equity. In this context, we are mindful of all aspects of human differences such as socioeconomic status, race, ethnicity, language, nationality, sex, gender identity, sexual orientation, religion, geography, disability and age.

AMERICAN PSYCHIATRIC ASSOCIATION

To: Altha Stewart, MD
Chair, Joint Reference Committee
From: Ezra H. Griffith, MD
Chair, APA Ethics Committee
Date: January 22, 2018
Re: Assembly Action Paper Assignment to Ethics Committee (2017A2 12.K)

The Assembly voted to approve action paper 2017A2 12.K, which asks that the APA will direct the authors of the *APA Commentary on Ethics in Practice* to bring its language into congruence with that of the *AMA Principles of Medical Ethics 10.1.1*, including a thoughtful exploration of the complexities involved. This would apply to any psychiatrist making any benefit and/or policy determinations.

BACKGROUND

The action paper sees a conflict between APA's *Commentary on Ethics in Practice* (*Commentary*) and the AMA's Ethics Opinion 10.1.1 (AMA Opinion) and asks that the *Commentary* be modified to reflect the AMA Opinion. The Ethics Committee does not agree there is a conflict because the two address different issues. The Ethics Committee does not see any need to change the *Commentary*.

For your reference, at issue here is whether, in the case of conflict, the patient's interest should always come first regardless of the role the psychiatrist is in, and regardless of who or what the conflict is about. The *Commentary* and the Ethics Committee opinions on this issue illustrate the preferred approach to resolving conflicting ethics principles. It is in practice not helpful to see ethics rules in black or white and to apply them rigidly. Context matters. The *Commentary* does not set out hard and fast rules, but provides a framework for evaluating ethics dilemmas and seeking their resolution.

The Ethics Committee recommends two resources to help members resolve potential conflicts:

1. McCarthy J. Principlism or narrative ethics: must we choose between them? *Medical Humanities* 2003; 29:65-71.
2. Mol A. The logic of care: health and the problem of patient choice. New York, NY: Routledge; 2008.

McCarthy reminds us that in morally difficult situations, no principle is a priori privileged. And any principle, while obligatory on first impression, may be overridden in certain situations. Thus, it is important to seek "reflective equilibrium," evaluating strengths and weaknesses of competing principles before we decide on a prescriptive action.

Mol uses a simple example to make us reflect on the basic principle of autonomy. She makes clinical rounds on Monday morning and finds a patient asserting his claim of preference. He wishes to stay in bed. Mol honors the patient's choice. At rounds the following week, the patient is claiming choice

again. Now Mol raises questions about clinical sequelae. She asks staff to consider the possibility of maleficent outcomes that attend staying in bed. Suddenly, autonomy, one of the major guiding principles of care, is seen in a new light. The outcome may well be patient neglect and poor care. So even the primary commitment to autonomy is now no longer absolute, assuming the overall care of the patient is your goal. But Mol is not being prescriptive. She wants you to reflect before you decide, weighing the pros and cons, and the possible impact on the patient.

Whether working as a medical director, in a system of care, or in private practice, relying on absolute values without reflective equilibrium is potentially problematic. Yes, it is true that we should be serious about committing to caring for the patient. The patient's welfare should be uppermost in our minds. But no one physician is always in control of all the forces at play in the marketplace. Thus, there may come the occasion when other interests preoccupy us. Reflective equilibrium demands thoughtful assessment of the competing forces, their advantages and disadvantages. Then we make a decision, with the patient's interests always in mind. But we know that there are times when our hands are tied, and the reality of the situation forces a reordering of the usual primary commitment to the patient.

DISCUSSION

The *Commentary* emphasizes the need for such reflective equilibrium.

> By virtue of their activities and roles, psychiatrists may have competing obligations that affect their interactions with patients. The terms "dual agency," "dual roles," "overlapping roles," and "double agency" refer to these competing obligations. Psychiatrists may have competing duties to an institution (e.g., employers, the judicial system, or the military) and to an individual patient, or to two patients or two institutions.
>
> *The treating psychiatrist has a primary, but not absolute, obligation to the patient*. Wherever possible, the treating psychiatrist should strive to eliminate potentially compromising dual roles by attending to the separation of their work as clinicians from their role as institutional or administrative representatives. However, as the medical system becomes increasingly complex, it is critical for psychiatrists to recognize that not all competing obligations may be resolved.
>
> *Psychiatrists should remain committed to prioritizing patient interests as treating physicians, expecting that they will find themselves in the position of having to reconcile these interests against other competing commitments and obligations*. Psychiatrists should inform patients about the potential for competing obligations within the treatment or other non-clinical evaluation, such as a forensic evaluation. At a minimum, the psychiatrist should inform the person being treated as a patient or evaluated for another purpose of the purpose of the clinical encounter or evaluation, the limits on confidentiality of the treatment/examination, and the parameters of the relationship between the physician and the patient or evaluee, (e.g., who requested the examination/evaluation, whether an ongoing relationship will occur, and, if so, the parameters/expectations of that relationship).

Commentary Topic 3.1.3 Dual agency and overlapping roles

While psychiatrists enjoy professional autonomy in their practice, an increasing number of psychiatrists nonetheless work within at least one system of care, such as a hospital, group practice, multispecialty group practice, accountable care organization, government system, military system, or work for third-party payors. These systems have increased in complexity but can create opportunities for improved patient care through innovation, clinical research, integration of health care, collegiality, and peer relationships. *However, they also create potential for conflict between the primacy of the individual patient and the legal, business, and political interests of the care system about which the psychiatrist should be aware and monitor.*

In increasingly complex systems of care, treating psychiatrists will encounter situations in which the primacy of individual patient care competes with other compelling interests and obligations. *Psychiatrists in any system of care, whether or not they are providing clinical care to individual patients, maintain responsibility to patient interests and commitment to promoting organizational ethics supportive of individual patient care and care of patients more generally*. Care systems may employ a variety of cost--containing measures, including prospectively, concurrently, or retrospectively reviewing treatment, emphasizing preventive or primary care services, requiring specific approvals for specialty procedures or referral, promoting the use of treatment guidelines, or creating economies of scale to streamline care within large systems. In these systems, other values often compete with the interests of the individual patient. *The fundamental tension of psychiatrists working in organized settings, then, is that the terms of employment relate to the needs of the venture, but as physicians, psychiatrists working in organized systems of care cannot wholly ignore the needs of patients. Psychiatrists practicing within such systems must be honest about treatment restrictions, maintain the confidentiality of patient information, ensure reasonable access to care within the system, and help identify alternatives available outside of the system when the patient's psychiatric or medical well-being requires it.*

Commentary Topic 3.4.1 Working within organized systems of care

The Ethics Committee, in response to a question regarding the role of a managed care or utilization reviewer, explained:

In our opinion, the questions posed can be distilled into one: does the psychiatrist working as a managed care or utilization reviewer owe primary obligation to the patient or to the plan? To be clear, in this situation, the psychiatrist is a non-treating physician . The Opinions of the APA ethics code are best interpreted as meaning that for a treating psychiatrist in a managed care setting, patient welfare is primary. Similarly, for forensic psychiatrists in most contexts, patient care is not primary, and their primary duties instead are to promote justice and answer questions honestly.

A managed care or utilization reviewer is not a treating psychiatrist. Managed care is designed to cut costs, reduce premiums, and possibly increase profits. The reviewer is hired by the company to assess whether the care meets the criteria the plan has established. The reviewer cannot authorize benefits that are not covered by the plan. The patient who purchased the insurance should have been supplied the coverage by the plan. In our opinion, the psychiatrist managed care or utilization reviewer owes his primary obligation to the managed care company and a secondary one to the patient. In

this context, it is a reasonable expectation that the reviewer will stay within the guidelines established by the company.[1]

All of these comments and opinions deal with a conflict between the interests of a patient and the interests of an organization. The Ethics Committee continues to believe they address the issue thoroughly and provide the tools necessary for members to evaluate ethical dilemmas in this context.

The AMA Opinion at issue states:

10.1.1 Ethical Obligations of Medical Directors

Physicians' core professional obligations include acting in and advocating for patients' best interests. When they take on roles that require them to use their medical knowledge on behalf of third parties, physicians must uphold these core obligations.

When physicians accept the role of medical director and must make benefit coverage determinations on behalf of health plans or other third parties or determinations about individuals' fitness to engage in an activity or need for medical care, they should:

a) Use their professional expertise to help craft plan guidelines to ensure that all enrollees receive fair, equal consideration.
b) Review plan policies and guidelines to ensure that decision-making mechanisms:
    i. are objective, flexible, and consistent;
    ii. rest on appropriate criteria for allocating medical resources in accordance with ethics guidance.
c) Apply plan policies and guidelines evenhandedly to all patients.
d) Encourage third-party payers to provide needed medical services to all plan enrollees and to promote access to services by the community at large.
e) **Put patient interests over personal interests (financial or other) created by the nonclinical role**.

The Action Paper suggests that there is incongruity between the *Commentary* sections noted above and the highlighted sentence above. The Ethics Committee does not read section (e) to mean that the patient always gets the treatment they need from their insurance plan regardless of plan coverage. Rather, it means that the physician reviewing and making the coverage determination must not put **his individual personal interests** (i.e., bonuses for saving money, good personal evaluations for keeping to budget, etc.) over the interest of the patient. In other words, they need to review and evaluate the case honestly using their medical knowledge without letting their *personal interest* and *personal benefit* dictate the patient's care plan.

[1] The Ethics Committee amended the Opinion at the request of the JRC to provide resources members could read if they felt the need for further education on dual agency issues. https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/Ethics/Ethics-Opinion-On-Dual-Agency-Issues-When-Working-Within-Organized-Systems-Of-Care.pdf

There is of course no doubt, that a physician should not effectively be bribed into denying care to a patient when that care is medically necessary and covered by the plan. The concept of honesty in dealings with patients and not exploiting patients financially or otherwise permeates the *Commentary* and is consistent with section (e) of the AMA Opinion, e.g., *Commentary* Topics 3.1.1 The Physician Patient Relationship; 3.2.2 Honest and Integrity; 3.2.3 Non-participation in Fraud. However, that does not mean that the patient's interest always trumps the personal interest of the physician. In response to a different action paper last year, the Ethics Committee opined:

> The ethical issue of conflict between limited resources or allocation of resources in systems of care are similar for psychiatrists in private practice. Psychiatrists in these settings often find their own financial interest at odds with the interest of the patient. For example, psychiatrists who do not participate in insurance limit the ability of certain patients to receive care. Likewise, psychiatrists who elect to do only medication management when both medication management and psychotherapy are the standard of care put their own financial interest before the patient's care. In these situations, both of which is ethical, the psychiatrist meets his or her ethical obligation if he or she explains to the patient why they do not accept insurance in the first instance and in the second the psychiatrist must provide a complete evaluation of the patient and share the doctor's conclusion as to the best course of treatment, explain why the psychiatrist will only provide partial treatment and aid the patient in finding another person who can provide the necessary psychotherapy. While this inconvenience for the patient is financially motivated by the psychiatrist, it is nonetheless permissible as long as the limitations are made known. The same hold true in managed care settings. Allocation of limited resources is ethical where the patient is given honest feedback about what is and is not available and what is and is not necessary treatment.

Response to Action Paper 2016A1 12.Y, May 2016 Assembly.

APA Official Actions

Position Statement on Human Trafficking

Approved by the Board of Trustees, XXXX
Approved by the Assembly, XXXX

"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*

POSITION:

1. The American Psychiatric Association recognizes that human trafficking is a public health issue with profound mental health consequences impacting individuals of all ages and genders both domestically and internationally.
2. Because human trafficking is a complex issue with legal, social, economic, and educational impacts, the American Psychiatric Association encourages psychiatric providers addressing this issue to collaborate across disciplines.
3. The American Psychiatric Association advocates for increased education of psychiatric providers on how to identify victims of trafficking in their clinical practices, how to appropriately refer to resources, and how to provide trauma-informed care for this population with unique needs.
4. As there is minimal evidence about how to provide care to this population, the American Psychiatric Association advocates for increased research into how to address the mental health needs of this population.
5. The American Psychiatric Association advocates for legislation that focuses on prevention of human trafficking, protection of identified victims and increased partnership between civil and government agencies to facilitate access to mental health care for identified victims.

Authors: Council on Psychiatry and Law (Rachel Robitz, M.D.), Council on Minority Mental Health and Health Disparities (Amy Gajaria, M.D., Carine Nzodom, M.D., Mary Roessel, M.D., Samra Sahlu, M.D., and Ludmilla de Faria, M.D. [past member]), Council on International Psychiatry (Michelle Riba, M.D.), Council on Children, Adolescents and Their Families (Carlos Fernandez, M.D.), Board of Trustees (Vivian Pender, M.D.)

EXECUTIVE SUMMARY
Assembly

The Assembly met in Washington, DC, November 3-5, 2017, 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 17.

The Assembly brings the following action items:

1. **Designation of Psychiatry as Primary Care for Any Medical School Scholarships Requiring Primary Care Service (ASM Item #2017A2 12.A) [Attachment 1]**

   Action paper 2017A2 12.A asks that the APA advocate for state and federal legislation labeling psychiatry as primary care for any medical school scholarships requiring primary care residencies and service to a community.

   Action: Will the JRC refer the Assembly passed action paper *2017A2 12.A: Designation of Psychiatry as Primary Care for Any Medical School Scholarships Requiring Primary Care Service* to the appropriate Component(s) for input or follow-up?

2. **Medical School Loan Repayment Subsidies for Psychiatrists Practicing in Community Mental Health Centers and State Psychiatric Facilities (ASM Item #2017A2 12.B) [Attachment 2]**

   Action paper 2017A2 12.B asks that the APA advocate for state and federal legislation to provide funds to help repay loans for psychiatrists in community mental health centers and state psychiatric hospitals.

   Action: Will the JRC refer the Assembly passed action paper *2017A2 12.B: Medical School Loan Repayment Subsidies for Psychiatrists Practicing in Community Mental Health Centers and State Psychiatric Facilities* to the appropriate Component(s) for input or follow-up?

3. **Transitional Care Services Post-Psychiatric Hospitalization (ASM Item #2017A2 12.C) [Attachment 3]**

   Action paper 2017A2 12.C asks:

   That the American Psychiatric Association advocate to national policymakers to increase federal funding for psychiatric access-to-care/transition-based clinics aimed at readily available short-term coverage in psychiatric care for uninsured, low-income, and serious mental illness populations.

   That the American Psychiatric Association promotes the concept of a transitional care based clinic model, aimed at bridging the gap between hospitalization and outpatient follow-up, to ACGME/GME leadership, in an effort to grow interest in implementation of such clinics in GME based settings.

   Action: Will the JRC refer the Assembly passed action paper *2017A2 12.C: Transitional Care Services Post-Psychiatric Hospitalization* to the appropriate Component(s) for input or follow-up?

4. <u>Enacting APA Positions: State Medical Board Licensure Queries</u> (ASM Item # 2017A2 12.D) [Attachment 4]

Action paper 2017A2 12.D asks that:

1. The American Psychiatric Association query the licensing boards (M.D., D.O) and, in each state, territory or licensure jurisdiction query their compliance with APA policy and with the ADA act allowing questions only about current mental and physical impairment affecting current ability to practice medicine.

2. The American Psychiatric Association notify each Board of Medicine in writing whether or not their medical licensure application(s) reflect current APA position regarding queries about their applicants' mental health history. The APA will notify each District Branch of the APA of the status of the Board of Medicine or Board of Osteopathic Medicine in its jurisdiction, and will publish on the APA website a list of jurisdictions and whether or not their policies on queries are congruent with the Position of the APA.

3. The American Psychiatric Association notify the Federation of State Medical Boards Work Group of its Position Statement entitled Position Statement on Inquiries about Diagnosis and Treatment of Mental Disorders in Connection with Professional Credentialing and Licensing, adopted in 2015, in advance of the January 2018 meeting of the FSMB Work Group.

Action: Will the JRC refer the Assembly passed action paper *2017A2 12.D: Enacting APA Positions: State Medical Board Licensure Queries* to the appropriate Component(s) for input or follow-up?

5. <u>Recognition of Psychiatric Expertise: Efficiency and Sufficiency</u> (ASM Item # 2017A2 12.E) [Attachment 5]

Action paper 2017A2 12.E asks that:

1. APA encourages the AMA to adopt a policy that the MOC should not be a requirement for maintenance of licensure, hospital privileges, insurance credentialing or employment

2. The APA should support a SA-CME learning option in lieu of the 10-year exam and encourage the ABPN to accelerate the timeline for reform of the MOC process.

3. The MOC should not be part of the licensure requirements for interstate compacts.

Action: Will the JRC refer the Assembly passed action paper *2017A2 12.E: Recognition of Psychiatric Expertise: Efficiency and Sufficiency* to the appropriate Component(s) for input or follow-up?

6. <u>Conflicts of Interest Not Limited to Pharmaceutical Companies</u> (ASM Item # 2017A2 12.G) [Attachment 6]

Action paper 2017A2 12.G asks that the American Psychiatric Association, through its Annual Meeting Scientific Program Committee, review the current mechanism for reporting conflicts of interest, which mainly are limited to pharmaceutical companies, with an eye toward encouraging the reporting of conflicts which extend beyond pharmaceutical companies.

Action: Will the JRC refer the Assembly passed action paper *2017A2 12.G: Conflicts of Interest Not Limited to Pharmaceutical Companies* to the appropriate Component(s) for input or follow-up?

7. **Non-Physician Registration Fee for Annual Meetings (ASM Item #2017A2 12.H) [Attachment 7]**

Action paper 2017A2 12.H asks that allied health professionals pay the same registration fee as non-member physicians at the Annual Meeting.

Action: Will the JRC refer the Assembly passed action paper 2017A2 12.H: *Non-Physician Registration Fee for Annual Meeting* to the appropriate Component(s) for input or follow-up?

8. **APA Position Statement Strongly Recommending Twelve Weeks of Paid Parental Leave (ASM Item #2017A2 12.I) [Attachment 8]**

Action paper 2017A2 12.I asks that the APA approve and adopt the attached position statement recommending 12 weeks of paid parental leave. [Note: The Assembly voted to approve the action paper as a position statement.]

Action: Will the JRC refer the Assembly passed position statement 2017A2 12.I: *APA Position Statement Strongly Recommending Twelve Weeks of Paid Paternal Leave* to the appropriate Component(s) for input or follow-up?

9. **Helping Members Join Caucuses (ASM Item #2017A2 12.J) [Attachment 9]**

Action paper 2017A2 12.J asks that the APA new member and membership renewal emails have a direct link to joining a caucus.

Action: Will the JRC refer the Assembly passed action paper 2017A2 12.J: *Helping Members Join Caucuses* to the appropriate Component(s) for input or follow-up?

10. **Achieving Congruence between the APA Commentary on Ethics in Practice and the AMA Principles of Medical Ethics Concerning Ethical Obligations of Psychiatrists Making Benefit Determination Decisions (ASM Item #2017A2 12.K) [Attachment 10]**

Action paper 2017A2 12.K asks that the APA will direct the authors of the *APA Commentary on Ethics in Practice* to bring its language into congruence with that of the *AMA Principles of Medical Ethics 10.1.1*, including a thoughtful exploration of the complexities involved. This would apply to any psychiatrist making any benefit and/or policy determinations.

Action: Will the JRC refer the Assembly passed action paper 2017A2 12.K: *Achieving Congruence between the APA Commentary on Ethics in Practice and the AMA Principles of Medical Ethics Concerning Ethical Obligations of Psychiatrists Making Benefit Determination Decisions* to the appropriate Component(s) for input or follow-up?

11. <u>Adopting an APA Position Statement Supporting Implementation of the Mental Health Parity and Addiction Equity Act (MHPAEA or parity law)</u> (ASM Item #2017A2 12.L) [Attachment 11]

Action paper 2017A2 12.L which asks:

A. That the Assembly recommend adoption of an APA position statement, appropriately formatted, as follows:

It is the position of the APA that:

1. Insurance and/or other third party MHSUD utilization management and medical necessity criteria should be developed by individuals who are trained as psychiatrists or by work groups that include psychiatrists.
2. Insurance and/or other third party MHSUD utilization management and medical necessity criteria should be in full compliance with requirements of applicable state and federal parity laws, including with MHPAEA requirements that quantitative limits (QTLs) and non-quantitative limits (NQTLs) for MHSUD care should be comparable to and no more stringent than medical necessity criteria for medical and surgical care, except as allowed by the law.
3. Insurance companies and/or other third parties offering coverage for both medical/surgical and MHSUD treatment—including those that do so through MHSUD "carve outs"—have an obligation to provide to their medical directors, psychiatrist reviewers, other clinicians who make benefit determinations, and to treating clinicians and to covered individuals, current and accurate information about whether and how their MHSUD utilization review and medical necessity criteria comply with MHPAEA QTL and NQTL requirements.

B. The Assembly will directly refer this action paper outlining specific elements of a position statement to the Board of Trustees for adoption at their next meeting, including holding a separate vote to this effect, if required by Assembly rules.

Action: Will the JRC refer the Assembly passed action paper 2017A2 12.L: *Adopting an APA Position Statement Supporting Implementation of the Mental Health Parity and Addiction Equity Act (MHPAEA or parity law)* to the appropriate Component(s) for input or follow-up?

12. <u>Joint Meeting of the Council on Minority Mental Health and Health Disparities and the Assembly Committee of Representatives of Minority/Underrepresented Groups</u> (ASM Item #2017A2 12.M) [Attachment 12]

Action paper 2017A2 12.M asks that:

1) That the American Psychiatric Association will support another Joint Meeting of the Council on Minority Mental Health and Health Disparities and the Assembly Committee of Representatives of Minority/Underrepresented Groups, in alignment with the APA's fourth strategic initiative addressing diversity.

2) That such meeting will take place during the Annual September Components Meeting of the American Psychiatric Association in September 2018.

[N.B.: At its meeting in October, the Joint Reference Committee recommended that the Board of Trustees approve the request for the seven M/UR Caucus Assembly Representatives (or their designees) to meet with the Council at the 2018 September Components Meeting at the same level of funding as this year at approximately $9,000 from the Assembly Budget and additional costs for members of the Council on

Minority Mental Health and Health Disparities from the component's budget. This action was approved by Board of Trustees at its December 2017 meeting.]

Action: Will the JRC refer the Assembly passed action paper 2017A2 12.M: *Joint Meeting of the Council on Minority Mental Health and Health Disparities and the Assembly Committee of Representatives of Minority/Underrepresented Groups* to the appropriate Component(s) for input or follow-up?

13. Civil Liability Coverage for District Branch Ethics Investigations (ASM Item #2017A2 12.N) [Attachment 13]

Action paper 2017A2 12.N asks that:

1. The American Psychiatric Association shall make a copy of the APA Director & Officer Liability policy available upon request by District Branch.

2. The American Psychiatric Association shall amend the APA Operations manual to include information regarding indemnification of district branches for liability related to ethics investigations.

3. The American Psychiatric Association shall develop a written policy and protocol to provide expenditures to district branches specifically to support ethics investigations.

Action: Will the JRC refer the Assembly passed action paper 2017A2 12.N: *Civil Liability Coverage for District Branch Ethics Investigations* to the appropriate Component(s) for input or follow-up?

14. Council on Women's Mental Health (ASM Item #2017A2 12.O) [Attachment 14]

Action paper 2017A2 12.O asks that the American Psychiatric Association develop a Council on Women's Mental Health to address mental health conditions and health related disorders pertaining to mental health that affect women

Action: Will the JRC refer the Assembly passed action paper 2017A2 12.O: *Council on Women's Mental Health* to the appropriate Component(s) for input or follow-up?

15. Addressing the Negative Impact of the Rule of 95 on Dues Revenue (ASM Item #2017A2 12.P) [Attachment 15]

Action paper 2017A2 12.P asks that the Board of Trustees (BOT) establish a Task Force charged with reviewing the Rule of 95 and making recommendations to be presented to the BOT in time for possible action by the BOT and the Assembly at the November 2018 Assembly Meeting. Membership on this Task Force could be drawn from the BOT, APA management, the Assembly leadership, the Membership Committee, and DB and State Association leadership and staff and shall include representation from the Senior Psychiatrists, RFMs, and ECPs.

Action: Wil the JRC refer the Assembly passed action paper 2017A2 12.P: *Addressing the Negative Impact of the Rule of 95 on Dues Revenue* to the appropriate Component(s) for input or follow up?

16. **Revised Position Statement: Need to Maintain Long-Term Care Facilities for Certain Individuals with Serious Mental Illness (JRCJUNE178.F.1/ASMNOV174.B.2) [Attachment 16]**

The Assembly did not approve the Revised Position Statement: *Need to Maintain Long-Term Care Facilities for Certain Individuals with Serious Mental Illness* as the Assembly had concerns about the title and felt some revisions are needed to clarify the intent of the position statement.

Action: Will the JRC refer the Revised Position Statement: *Need to Maintain Long-Term Care Facilities for Certain Individuals with Serious Mental Illness* 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 elect the following candidate as Recorder of the Assembly from November 2017 to May 2018: Paul J. O'Leary, M.D., Area 5.

The Assembly voted to approve the slate of candidates for the May 2018 Assembly election as follows:

Speaker-Elect:
C. Deborah Cross, M.D., Area 2
Paul J. O'Leary, M.D., Area 5

Recorder:
Jacob Behrens, M.D., Area 4
Stephen Brown, M.D., Area 7
Seeth Vivek, M.D., Area 2

2. **Retain Position: Endorsement of United Nations Ratification of the Convention of the Rights of the Child (JRCJUNE178.C.1/ASM Item #2017A2 4.B.1)**

The Assembly voted, on its Consent Calendar, to approve the retention of the position*: Endorsement of United Nations Ratification of the Convention of the Rights of the Child*. This was forwarded to the Board of Trustees for consideration in December 2017. The Board of Trustees approved the retention of the position.

3. **Retire 2010 Position Statement: Psychiatry and Primary Care Integration across the Lifespan (JRCJUNE178.F.3/ASM Item #2017A2 4.B.3)**

The Assembly voted to approve the retirement of the 2010 Position Statement: *Psychiatry and Primary Care Integration across the Lifespan*. This was forwarded to the Board of Trustees for consideration in December 2017. The Board of Trustees approved the retirement of the position statement.

4. **Retain 2011 Position Statement: Remuneration for Psychiatrists' Time Performing Utilization Review (Endorsement of AMA policy H-385.951) (JRCJUNE178.F.4/ASM Item #2017A2 4.B.4)**

The Assembly voted, on its Consent Calendar, to approve the retention of the 2011 Position Statement: *Remuneration for Psychiatrists' Time Performing Utilization Review (Endorsement of AMA policy H-385.951).* This was forwarded to the Board of Trustees for consideration in December 2017. The Board of Trustees approved the retention of the position statement.

5. **Retain 2014 Position Statement: Universal Access to Health Care (JRCJUNE178.F.5/ASM Item #2017A2 4.B.5)**

The Assembly voted, on its Consent Calendar, to approve the retention of the 2014 Position Statement: *Universal Access to Health Care*. This was forwarded to the Board of Trustees for consideration in December 2017. The Board of Trustees approved the retention of the position statement.

6. **Proposed Position Statement on Human Rights (JRCJUNE178.G.1/ ASM Item #2017A2 4.B.6)**

The Assembly voted to approve the Proposed Position Statement on *Human Rights*. It was forwarded to the Board of Trustees for consideration in December 2017. The Board of Trustees approved the proposed position statement.

7. **Proposed Position Statement: Domestic Violence Against Women (JRCJUNE178.I.2/ASM Item #2017A2 4.B.7)**

The Assembly voted to approve the Proposed Position Statement: *Domestic Violence Against Women*. This was forwarded to the Board of Trustees for consideration in December 2017. The Board of Trustees approved the proposed position statement.

8. **Proposed Position Statement: Prevention of Violence (JRCJUNE178.I.3/ASM Item #2017A2 4.B.8)**

The Assembly voted to approve the Proposed Position Statement: *Prevention of Violence*. This was forwarded to the Board of Trustees for consideration in December 2017. The Board of Trustees approved the proposed position statement.

9. **Proposed Position Statement: Human Trafficking (JRCJUNE178.I.5/ASM Item #2017A2 4.B.9)**

The Assembly voted to approve the Proposed Position Statement: *Human Trafficking*. This was forwarded to the Board of Trustees for consideration in December 2017. The Board of Trustees voted to **refer** the position statement to the Joint Reference Committee.

10. **Proposed Position Statement: Police Interactions with Persons with Mental Illness (JRCJUNE178.J.1/ASM Item #2017A2 4.B.10)**

The Assembly voted to approve the Proposed Position Statement: *Police Interactions with Persons with Mental Illness*. This was forwarded to the Board of Trustees for consideration in December 2017. The Board of Trustees approved the proposed position statement.

11. **Proposed Position Statement: Lengthy Sentences Without Parole for Juveniles (JRCJUNE178.J.4/ASM Item #2017A2 4.B.11)**

The Assembly voted to approve the Proposed Position Statement: *Lengthy Sentences Without Parole for Juveniles*. This was forwarded to the Board of Trustees for consideration in December 2017. The Board of Trustees approved the proposed position statement.

12. **Retire 2011 Position Statement: Review of Sentences for Juveniles Serving Lengthy Mandatory Terms of Imprisonment (JRCJUNE178.J.5/ASM Item #2017A2 4.B.12)**

The Assembly voted to approve the retirement of the Position Statement: *Review of Sentences for Juveniles Serving Lengthy Mandatory Terms of Imprisonment*. This was forwarded to the Board of Trustees for consideration in December 2017. The Board of Trustees approved the retirement of the position statement.

13. **Retain 2012 Position Statement: Segregation of Prisoners with Mental Illness (JRCJUNE178.J.6/ASM Item #2017A2 4.B.13)**

The Assembly voted, on its Consent Calendar, to approve the retention of the 2012 Position Statement: *Segregation of Prisoners with Mental Illness*. This was forwarded to the Board of Trustees for consideration in December 2017. The Board of Trustees approved the retention of the position statement.

14. **Retain 2012 Position Statement: Assessing the Risk for Violence (JRCJUNE178.J.7/ASM Item #2017A2 4.B.14)**

The Assembly voted, on its Consent Calendar, to approve the retention of the 2012 Position Statement: *Assessing the Risk for Violence*. This was forwarded to the Board of Trustees for consideration in December 2017. The Board of Trustees approved the retention of the position statement.

15. **Retain 2012 Position Statement: Firearms Access: Inquiries in Clinical Settings (JRCJUNE178.J.8/ASM Item #2017A2 4.B.15)**

The Assembly voted, on its Consent Calendar, to approve the retention of the 2012 Position Statement: Firearms Access: *Inquiries in Clinical Settings*. This was forwarded to the Board of Trustees for consideration in December 2017. The Board of Trustees approved the retention of the position statement.

16. **Retain 2007 Position Statement: Use of Jails to Hold Persons Without Criminal Charges Who are Awaiting Civil Psychiatric Hospital Beds (JRCJUNE178.J.9/ASM Item #2017A2 4.B.16)**

The Assembly voted, on its Consent Calendar, to approve the retention of the 2007 Position Statement: *Use of Jails to Hold Persons Without Criminal Charges Who are Awaiting Civil Psychiatric Hospital Beds*. This was forwarded to the Board of Trustees for consideration in December 2017. The Board of Trustees approved the retention of the position statement.

17. **Retain 2007 Position Statement: Psychiatric Services in Jails and Prisons (JRCJUNE178.J.10/ASM Item #2017A2 4.B.17)**

The Assembly voted, on its Consent Calendar, to approve the retention of the 2007 Position Statement: *Psychiatric Services in Jails and Prisons*. This was forwarded to the Board of Trustees for consideration in December 2017. The Board of Trustees approved the retention of the position statement.

18. **Retain 1993 Position Statement: Homicide Prevention and Gun Control (JRCJUNE178.J.11/ASM Item #2017A2 4.B.18)**

The Assembly voted to approve the retention of the 1993 Position Statement: *Homicide Prevention and Gun Control*. This was forwarded to the Board of Trustees for consideration in December 2017. The Board of Trustees approved the retention of the position statement.

Attachment #1
Item 2017A2 12.A
Assembly
November 3-5, 2017

ACTION PAPER
FINAL

TITLE: Designation of Psychiatry as Primary Care for Any Medical School Scholarships Requiring Primary Care Service

WHEREAS:
The projected need for psychiatrists is outpacing the current supply;

A 2012 report by the AAMC indicated that the average debt for medical students across the country in 2011 was over $160,000 and 86% of graduates have debt;

Over 45% of psychiatrists are over 60;

The Department of Health and Human Services reports about 4000 areas where there are 30,000 or more individuals per psychiatrists;

BE IT RESOLVED:
That the APA advocate for state and federal legislation labeling psychiatry as primary care for any medical school scholarships requiring primary care residencies and service to a community.

AUTHORS:
Mary Jo Fitz-Gerald, M.D., MBA, DLFAPA, Representative, Louisiana Psychiatric Medical Association
Mark Townsend, M.D., DFAPA, Representative, Louisiana Psychiatric Medical Association

SPONSORS:
T.O. Dickey, M.D., Representative, West Virginia Psychiatric Association
Edward Thomas Lewis III, M.D., Representative, South Carolina Psychiatric Association
Debra Atkisson, M.D., Representative, Texas Society of Psychiatric Physicians
Harold Ginzburg, M.D., JD, MPH, Representative, Oklahoma Psychiatric Physicians Association
Sudhakar Madakasira, M.D., Representative, Mississippi Psychiatric Association
Stephen V. Marcoux, M.D., RFM Representative, Area 5
Jack Bonner, M.D., DLFAPA, Representative, Senior Psychiatrists
Michelle P. Durham, M.D., MPH, Representative, Massachusetts Psychiatric Society
Edmond Amyot, M.D., Representative, New York State Capital District Branch
Dionne Hart, M.D., Representative, Minnesota Psychiatric Society
Mary Anne Albaugh M.D., Representative, Pennsylvania Psychiatric Society
Rahn Bailey, M.D., Representative, Black Psychiatrists
Barry Herman, M.D., Representative, American Association of Psychiatric Administrators
Lisa Catapano-Friedman, M.D., Representative, Vermont Psychiatric Association
Isabel Norian, M.D., Representative, New Hampshire Psychiatric Society
Roger Peele, M.D., APA Member
Stephen Marcoux, M.D., RFM Representative, Area 5

ESTIMATED COST:
Author: $7,700
APA: $6,622

ESTIMATED SAVINGS:

ESTIMATED REVENUE GENERATED:

ENDORSED BY: Louisiana Psychiatric Medical Association (LPMA), Women Psychiatrists, Assembly Committee of Resident-Fellow Members

KEY WORDS: Medical Education; Primary Care; Loan Repayment; Workforce Issues; Public Psychiatry

APA STRATEGIC PRIORITIES: Advancing Psychiatry, Education, Diversity

REVIEWED BY RELEVANT APA COMPONENT:

References:

Japsen, B. US Psychiatrist Shortage Intensifies. https://www.forbes.com/sites/brucejapsen/2017/06/06/psychiatrist-shortage-intensifies/#7b77d3ae5d96 , accessed 9/12/17.

AAMC Analysis in Brief. Trends in Cost and Debt at U.S. Medical Schools Using a New Measure of Medical School Cost of Attendance, accessed at https://www.aamc.org/download/296002/data/aibvol12_no2.pdf, 9/12/17

Psychiatry Facing Severe Workforce Crisis - *Medscape* - Jul 30, 2015, http://www.medscape.com/viewarticle/848884, accessed 9/12/17.

Action Paper Worksheet
2017 Action Paper Budget Estimate

Action Paper Title:	12.A: Designation of Psychiatry as Primary Care for Medical Student Scholarship Repayment
Action Paper Author(s):	Mary Jo Fitz-Gerald, M.D., MBA, DLFAPA, Representative, Louisiana Psychiatric Medical Association
Phone/email:	3186756619, mfitzg@lsuhsc.edu
APA Admin. Name:	Ashley Mild, Department of Government Relations
Phone/email	703-907-7800; amild@psych.org

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

Author Estimate:

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

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

Staff Costs:

	Description:		
1	Lobby efforts on behalf of above		7,700
2		-	-
3		-	-
	Total Staff Costs		7,700

Other Costs not included above:	
0	-
Total Author Estimate	**7,700**

APA Administration Estimate:

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

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

Staff Costs:

	Description:	
1	APA ADMINISTRATION: continued federal lobbying/advocacy campaign	1,540
2	APA ADMINISTRATION: working with DB/SA, state lobbying/advocacy campaign	3,850
3	APA ADMINISTRATION: internal meetings, research/material creation, coalition activity	1,232
	Total Staff Costs	**6,622**

Other Costs not included above:	
0	-
Total Administration Estimate	**6,622**

Rvsd. April 2017

Action Paper 12.A: Designation of Psychiatry as Primary Care for Any Medical School Scholarships Requiring Primary Care Service

APA Administration Feedback:

DEPARTMENT: Department of Government Relations/Division of Policy, Programs, and Partnerships: The author has asked for the American Psychiatric Association to direct advocacy efforts towards labeling psychiatry as a primary health care profession when medical school scholarships require primary care residencies for eligibility. There are already federal programs, including the National Health Service Corps, that recognizes psychiatry as an eligible primary care health profession. State sponsored medical school scholarships have varying eligibility criteria. APA will continue their advocacy efforts for psychiatry to be included in the designation of primary care professions when required for medical school scholarships. The Administration will expand their advocacy efforts, working with the House of Medicine and APA district branches/state associations to identify state sponsored medical scholarships with criteria restrictions for eligible primary care practitioners.

EXPLANATION OF COST: The Department of Government Relations projects that an advocacy campaign based on the premise of the action paper may entail 3 hours of APA Administration meetings, 20 hours of Capitol Hill meetings (roughly the interested members of the relevant House and Senate committees) I would remove this unless you think it is necessary, 10 hours of meetings with District Branches/State Associations, 40 hours of meeting with relevant state Administration (APA State Regional Directors), 8 hours of research and material creation, and 5 hours of national partnership activity.

Attachment #2
Item 2017A2 12.B
Assembly
November 3-5, 2017

ACTION PAPER
FINAL

TITLE: Medical School Loan Repayment Subsidies for Psychiatrists Practicing in Community Mental Health Centers and State Psychiatric Facilities

WHEREAS:
The projected need for psychiatrists is outpacing the current supply;

A 2012 report by the AAMC indicated that the average debt for medical students across the country in 2011 was over $160,000 and 86% of graduates have debt;

Over 45% of psychiatrists are over 60;

The Department of Health and Human Services reports about 4000 areas where there are 30,000 or more individuals per psychiatrists;

There is precedence as the Clay Hunt Act provided ways to repay loans for psychiatrists in VA facilities.

BE IT RESOLVED:
That the APA Advocate for state and federal legislation to provide funds to help repay loans for psychiatrists in community mental health centers and state psychiatric hospitals.

AUTHORS:
Mary Jo Fitz-Gerald, M.D., MBA, DLFAPA, Representative, Louisiana Psychiatric Medical Association
Mark Townsend, M.D., DFAPA, Representative, Louisiana Psychiatric Medical Association

SPONSORS:
T.O. Dickey, M.D., Representative, West Virginia Psychiatric Association
Edward Thomas Lewis III, M.D., Representative, South Carolina Psychiatric Association
Debra Atkisson, M.D., Representative, Texas Society of Psychiatric Physicians
Harold Ginzburg, M.D., JD, MPH, Representative, Oklahoma Psychiatric Physicians Association
Sudhakar Madakasira, M.D., Representative, Mississippi Psychiatric Association
Stephen V. Marcoux, M.D., RFM Representative, Area 5
Jack Bonner, M.D., DLFAPA, Representative, Senior Psychiatrists
Michelle P. Durham, M.D., MPH, Representative, Massachusetts Psychiatric Society
Edmond Amyot, M.D., Representative, New York State Capital District Branch
Dionne Hart, M.D., Representative, Minnesota Psychiatric Society
Mary Anne Albaugh M.D., Representative, Pennsylvania Psychiatric Society
Rahn Bailey, M.D., Representative, Black Psychiatrists
Barry Herman, M.D., Representative, American Association of Psychiatric Administrators
Lisa Catapano-Friedman, M.D., Representative, Vermont Psychiatric Association
Isabel Norian, M.D., Representative, New Hampshire Psychiatric Society

Roger Peele, M.D., APA Member
Stephen Marcoux, M.D., RFM Representative, Area 5

ESTIMATED COST:
Author: $7,700
APA: $4,312

ESTIMATED SAVINGS:

ESTIMATED REVENUE GENERATED:

ENDORSED BY: Louisiana Psychiatric Medical Association (LPMA), APA Women's Caucus, Assembly Committee on Public and Community Psychiatry, Assembly Committee of Resident-Fellow Members

KEY WORDS: Medical Education; Primary Care; Loan Repayment; Workforce Issues; Public Psychiatry

APA STRATEGIC PRIORITIES: Advancing Psychiatry, Education, Diversity

REVIEWED BY RELEVANT APA COMPONENT:

References:

Japsen, B. US Psychiatrist Shortage Intensifies. https://www.forbes.com/sites/brucejapsen/2017/06/06/psychiatrist-shortage-intensifies/#7b77d3ae5d96 , accessed 9/12/17.

AAMC Analysis in Brief. Trends in Cost and Debt at U.S. Medical Schools Using a New Measure of Medical School Cost of Attendance, accessed at https://www.aamc.org/download/296002/data/aibvol12_no2.pdf, 9/12/17

Psychiatry Facing Severe Workforce Crisis - *Medscape* - Jul 30, 2015, http://www.medscape.com/viewarticle/848884, accessed 9/12/17.

Action Paper Worksheet
2017 Action Paper Budget Estimate

Action Paper Title:	12.B: Medical School Loan Repayment for Psychiatrists in CMHC and State Hospitals
Action Paper Author(s):	Mary Jo Fitz-Gerald, M.D., MBA, DLFAPA, Representative, Louisiana Psychiatric Medical Association
Phone/email:	3186756619, mfitzg@lsuhsc.edu
APA Admin. Name:	Ashley Mild, Department of Government Relations
Phone/email	703-907-7800; amild@psych.org

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

Author Estimate:

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

Non-Staff Costs:	
LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	**-**
Staff Costs:	
Description:	
1 Lobby efforts on behalf of above	7,700
2	-
3	-
Total Staff Costs	7,700
Other Costs not included above:	
0	-
Total Author Estimate	**7,700**

APA Administration Estimate:

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

Non-Staff Costs:	
LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	**-**
Staff Costs:	
Description:	
1 APA ADMINISTRATION: continued federal lobbying/advocacy campaign	-
2 APA ADMINISTRATION: working with DB/SA, state lobbying/advocacy campaign	3,080
3 APA ADMINISTRATION: internal meetings, research/material creation, coalition activity	1,232
Total Staff Costs	**4,312**
Other Costs not included above:	
0	-
Total Administration Estimate	**4,312**

Rvsd. April 2017

Action Paper 12.B: Medical School Loan Repayment Subsidies for Psychiatrists Practicing in Community Mental Health Centers and State Psychiatric Facilities

APA Administration Feedback:

DEPARTMENT: Department of Government Relations/Division of Policy, Programs, and Partnerships: The author has asked for the American Psychiatric Association to direct advocacy efforts towards labeling psychiatry as a primary health care profession when loan repayment programs specific to community mental health centers and state psychiatric hospitals require primary care residencies. There are already federal programs, including the National Health Service Corps, that recognize psychiatry as an eligible primary care health profession. State loan repayment programs have varying eligibility criteria. APA already advocates on this issue on the federal level and will continue their advocacy efforts for psychiatry to be included in the designation of primary care professions when required for loan repayment programs. The Administration will expand their advocacy efforts, working with the House of Medicine and APA district branches/state associations to identify state funded loan repayment programs with criteria restrictions for eligible primary care practitioners.

EXPLANATION OF COST: The Department of Government Relations projects that an advocacy campaign based on the premise of the action paper may entail 3 hours of APA Administration meetings, 10 hours of meetings with District Branches/State Associations, 30 hours of meeting with relevant state Administration (APA State Regional Directors), 8 hours of research and material creation, and 5 hours of national partnership activity.

Attachment #3
Item 2017A2 12.C
Assembly
November 3-5, 2017

ACTION PAPER
FINAL

TITLE: Transitional Care Services Post-Psychiatric Hospitalization

WHEREAS:
Medically uninsured United States citizens remain at nearly 28 million, with the concurrent imminent threat of a significant loss of mental health and general medical coverage for low-income and uninsured individuals in context of ongoing legislation changes to the ACA (Affordable Care Act) and medical coverage system[1].

Access to psychiatric services, specifically post hospitalization follow-up wait times, remain at averages of 25 days to several months per multiple studies, longer in several geographic regions of the United States, with pediatric psychiatry services with average wait times of 50 days from initial consultation[4,6,8].

In a 2011 study, mood disorders and schizophrenia had the highest all-cause re-hospitalization rates within 30 days among adult Medicaid patients. Average costs of psychiatric hospitalization and re-hospitalization tallies $6,000-$8,500 per studied Medicaid individual; roughly 37% of disabled Medicare beneficiaries had a severe mental illness[5].

To assist in bridging the gap between hospitalization and outpatient follow-up, thus to improve overall recovery and to avoid re-admission, transitional care clinics, urgent psychiatric care centers, and same-day/discharge clinics have begun surfacing around the nation[2]. Funding for such clinics typically involves utilization of government grants, local/state grants, and philanthropic sources.

One such clinic, based out of south Texas, operates on a $2.5million budget, seeing roughly 500 patients a month, with new intake evaluations at roughly 120/month. Nearly 50% of the clinic's patients are uninsured, with 15% on Medicaid. The clinic operates under a team of psychiatrists, therapists, and multiple psychiatric residents and counseling/social work interns. The clinic functions as a roughly 90 day transition clinic, with patients receiving psychiatric and therapy services along with case management, to assist in easier transition to long term community providers. The clinic involves a daily access group of referred patients from multiple psychiatric facilities of which screening for needed 'day of' psychiatric evaluation versus scheduling psychiatric or therapy follow-up within one to two weeks[9,10].

Transitional care clinics based within residency associated health centers allows significant educational opportunities for resident psychiatrists, of who can make an effective impact on underserved populations while gaining valuable educational experience with an attending psychiatrist's oversight[9, 10].

Grant funding for transitional care clinics remains prominently from 1115 Healthcare Transformation Waiver sources. This waiver aims to incentivize hospitals and clinics to improve and transform service delivery[11]. These waivers are time-sensitive and can be extended, but at times are difficult to maintain. Other grant funding utilized in such clinics are research grants or hospital based grants to assist in decreasing re-hospitalization of patients; the Texas based clinic noted above reports a 5.8% reduction in admissions at their associated University Hospital psychiatry unit last year[3,7,10].

BE IT RESOLVED:
That the American Psychiatric Association advocate to national policymakers to increase federal funding for psychiatric access-to-care/transition-based clinics aimed at readily available short-term coverage in psychiatric care for uninsured, low-income, and serious mental illness populations.

That the American Psychiatric Association promotes the concept of a transitional care based clinic model, aimed at bridging the gap between hospitalization and outpatient follow-up, to ACGME/GME leadership, in effort to grow interest in implementation of such clinics in GME based settings.

AUTHOR:
Stephen Marcoux, M.D., RFM Representative, Area 5

SPONSORS:
Mary Jo Fitz-Gerald, M.D., MBA, DLFAPA, FAPM, FACP, Representative, Louisiana Psychiatric Medical Association
Debra Atkisson, M.D., DFAPA, Representative, Texas Association of Psychiatric Physicians
Dionne Hart, M.D., Representative, Minnesota Psychiatric Society
Steven Starks, M.D., FAPA, Deputy Representative, Black Psychiatrists
David Braitman, M.D., RFM Representative, Area 7
Nazanin Silver, M.D., FACOG, RFM Representative, Area 3
Daniella Palermo, M.D., RFM Representative, Area 1
Jessica Isom, M.D., RFM Deputy Representative, Area 1
Isabel Norian, M.D., Representative, New Hampshire Psychiatric Society

ESTIMATED COST:
Author: $17,492
APA: $3,465

ESTIMATED SAVINGS:

ESTIMATED REVENUE GENERATED: Significant decrease in healthcare costs for re-admission to inpatient psychiatric units given inability to obtain psychiatric care in timely matter.

ENDORSED BY: Assembly Committee on Public and Community Psychiatry, Assembly Committee of Area Resident-Fellow Members

KEY WORDS: access to care, federal funding, transitional care clinics, uninsured, GME

APA STRATEGIC PRIORITIES: Advancing Psychiatry, Education

REVIEWED BY RELEVANT APA COMPONENT: Council on Advocacy and Government Relations

Sources:

1. Boronio, Kirsten. Affordable Care Act Expands Mental Health and Substance Use Disorder Benefits and Federal Parity Protection for 62 million Americans. Office of the Assistant Secretary for Planning and Evaluation. U.S. Department of Health and Human Services. https://aspe.hhs.gov/report/affordable-care-act-expands-mental-health-and-substance-use-disorder-benefits-and-federal-parity-protections-62-million-americans
2. Clarke, Robin. Delivering on Accountable Care: Lessons From A Behavioral Health Program To Improve Access and Outcomes. Health Affairs. August 2016. http://content.healthaffairs.org/content/35/8/1487.short
3. Grants.gov, Mental Health. https://www.grants.gov/web/grants/search-grants.html?keywords=mental%20health
4. Herman, Keith. Bridging the Gap in Psychiatric Care for Children with a School-Based Psychiatry Program. School Mental Health, 1-9. Aug 1, 2017. https://link.springer.com/article/10.1007/s12310-017-9222-7.
5. Heslin, Kevin. Hospital Readmissions Involving Psychiatric Disorders, 2012. Statistical Brief #189. Healthcare Cost and Utilization Project, Agency for Healthcare Research and Quality. May 2015. https://www.hcup-us.ahrq.gov/reports/statbriefs/sb189-Hospital-Readmissions-Psychiatric-Disorders-2012.pdf
6. Mozes, Alan. Just Trying to Get an Appointment With a Psychiatrist. HealthDay News. Oct 15, 2014. http://health.usnews.com/health-news/articles/2014/10/15/just-try-getting-an-appointment-with-a-psychiatrist
7. State waivers list. 1115 waiver. Medicaid.gov. <https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/waivers_faceted.html
8. Steinman, KJ. How Long Do Adolescents Wait for Psychiatry Appointments. Community Mental Health. 2015 Oct;51(7):782-9. NCBI 2015. https://www.ncbi.nlm.nih.gov/pubmed/26108305
9. Velligan, Dawn. Engagement-focused care during transitions from inpatient and emergency psychiatric facilities. Patient Preference and Adherence, 11: 919–928, 2017. NCBI, 12May2017online. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5440071/
10. Velligan, Dawn. Following AACP Guidelines for Transitions in Care: The Transitional Care Clinic. Psychiatric Services 67:3, March 2016. Best Practices. Ps.psychiatryonline.org. http://ps.psychiatryonline.org/doi/pdf/10.1176/appi.ps.201500435
11. Waiver Overview and Background Resources. 1115 Waiver. Texas Health and Human Services Commission. <http://legacy-hhsc.hhsc.state.tx.us/1115-Waiver-Overview.shtml

Action Paper Worksheet
2017 Action Paper Budget Estimate

Action Paper Title:	12.C: Transitional Care Services Post-Psychiatric Hospitalization
Action Paper Author(s):	Stephen Marcoux, M.D., RFM Representative, Area 5
Phone/email:	480-229-0159; marcouxblue@gmail.com
APA Admin. Name:	Deana McRae, Department of Government Relations
Phone/email	703-907-8643; dmcrae@psych.org

Attendance Summary:	**Author**	**APA Administration**
Number of Component Members	2	-
Number of Staff	1	-
Number of Non-Staff	1	-
Total	**4**	**-**

Author Estimate:

Travel Budget:	No. of Attendees	Airfare	Hotel/Lodging	Ground Transportation	Per Diem/Meals	Total
Meeting 1	2	$850	$5,200	$200	$1,184	$7,434
Meeting 2	2	850	5,200	200	1,184	7,434
Total Travel Budget		1,700	10,400	400	2,368	$14,868

Non-Staff Costs:	
LCD Projector	1,700
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	**1,700**
Staff Costs:	
Description:	
1 Review current federal funding for transitional care clinics	462
2 Meeting with APA Lobbyists on federal funding for transitional care clinics	231
3 Meeting with ACGME/GME leadership to discuss transitional care model for psychiatry and utilization at residency centers	231
Total Staff Costs	924
Other Costs not included above:	
0	-
Total Author Estimate	**17,492**

APA Administration Estimate:

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

Non-Staff Costs:	
LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	-
Staff Costs:	
Description:	
1 APA Administration: internal meetings, research, creation of materials, conference calls with members	924
2 APA Administration: lobbying and advocacy campaign, coalition meetings	2,156
3 APA Administration: Div of Education research	385
Total Staff Costs	**3,465**
Other Costs not included above:	
0	-
Total Administration Estimate	**3,465**

Rvsd. April 2017

Action Paper 12.C: Transitional Care Services Post-Psychiatric Hospitalization

APA Administration Feedback:

DEPARTMENT: Department of Government Relations
In reviewing the actions requested of the Department of Government Relations, the author has asked for the American Psychiatric Association to direct advocacy efforts towards increasing federal funding for psychiatric access-to-care/transition-based clinics. As identified in the action paper, transitional care clinics is prominently funded through the 1115 Medicaid Demonstration Waivers. The waiver program is not a consistent funding stream, but rather a short-term mechanism typically approved for a five-year period and can be extended up to three years.

EXPLANATION OF COST:
The APA Administration could consider the barriers to consistent funding for care transitions, and identify potential funding streams support new and existing innovations. The Department of Government Relations projects that an advocacy campaign based on the premise of the action paper may entail 6 hours of APA Administration meetings (inclusive of conference calls with membership), 20 hours of Capitol Hill meetings (roughly the interested members of the relevant House and Senate committees), 3 hours of meetings with federal Administration, 6 hours of research and materials creation, and 5 hours of national partnership activity.

DEPARTMENT: Division of Education
The Accreditation Council for Graduate Medical Education (ACGME) places the responsibility of designing clinical experiences to meet training requirements on individual programs/training sites. The Division of Education would identify mechanism to incorporate transitional care services into the narrative for training programs, allowing residents to meet core program requirements.

Attachment #4
Item 2017A2 12.D
Assembly
November 3-5, 2017

ACTION PAPER
FINAL

TITLE: Enacting APA Positions: State Medical Board Licensure Queries

WHERAS:
Whereas, The American Psychiatric Association has an adopted Position Statement on Medical Licensure Board Applicant Questionnaires, promulgated in 2015 by the APA Council on Psychiatry and the Law [see attached], and

Whereas, there are a number of Boards of Medicine and Boards of Osteopathic Medicine which still have not reformed their applicant questionnaire with regarding to questions regarding mental illness, and

Whereas, the Federation of State Medical Boards has formed a Work Group on this issue in order address the issue throughout the United States.

BE IT RESOLVED:
That:

1. The American Psychiatric Association query the licensing boards (M.D., D.O) and in each state, territory or licensure jurisdiction on their compliance with APA policy and with the ADA act allowing questions only about current mental and physical impairment affecting current ability to practice medicine.
2. The American Psychiatric Association notify each Board of Medicine in writing whether or not their medical licensure application(s) reflect current APA position regarding queries about their applicants' mental health history. The APA will notify each District Branch of the APA of the status of the Board of Medicine or Board of Osteopathic Medicine in its jurisdiction, and will publish on the APA website a list of jurisdictions and whether or not their policies on queries are congruent with the Position of the APA.
3. The American Psychiatric Association notify the Federation of State Medical Boards Work Group of its Position Statement entitled Position Statement on Inquiries about Diagnosis and Treatment of Mental Disorders in Connection with Professional Credentialing and Licensing, adopted in 2015, in advance of the January 2018 meeting of the FSMB Work Group.

AUTHOR:
John Bailey, D.O., DFAPA, Representative, Florida Psychiatric Society

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

ESTIMATED SAVINGS: $0

ESTIMATED REVENUE GENERATED: None

ENDORSED BY:

KEY WORDS: Federation of State Medical Boards, Medical Licensure, Applicant Questions

APA STRATEGIC PRIORITIES: Advancing Psychiatry

REVIEWED BY RELEVANT APA COMPONENT:

Action Paper Worksheet
2017 Action Paper Budget Estimate

Action Paper Title:	12.D: Enacting APA Positions: State Medical Board Licensure Queries
Action Paper Author(s):	John Bailey, D.O., DFAPA, Representative, Florida Psychiatric Society
Phone/email:	-
APA Admin. Name:	Alison Crane (Office of General Counsel - Colleen Coyle)
Phone/email	703-907-7306; acrane@psych.org

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

Author Estimate:

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

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

Staff Costs:

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

Other Costs not included above:

0	-
Total Author Estimate	**-**

APA Administration Estimate:

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

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

Staff Costs:

	Description:	
1	For item 1 of Action Paper Resolutions, a state survey of licensing practices is required; APA does not have the manpower resources to perform this task. Hours estimate is based on revised process described in APA Administration Feedback document.	2,310
2	See APA Administration Feedback document.	-
3	See APA Administration Feedback document.	770
	Total Staff Costs	**3,080**

Other Costs not included above:

See APA Administration Feedback document for revised approach upon which estimate is based.	-
Total Administration Estimate	**3,080**

Rvsd. April 2017

Action Paper 12.D: Enacting APA Positions: State Medical Board Licensure Queries

APA Administration Feedback:

DEPARTMENT: Office of General Counsel

EXPLANATION OF COST:
This Action Paper calls for three separate resolutions. The portion of the cost estimate attributable to each is described below.

(1) For item # 1 of the Action Paper Resolutions, APA does not have the staff manpower resources available to perform this task. If the item were adopted in its current form to obtain a state-by-state survey of licensing board practices in every state, APA would retain an outside law firm to do the research at a rate of approximately $400-500 per hour. A 50-state survey of three licensing boards applications (and any opinions on those applications that explain, narrow or expand the scope of the question) would take approximately 150 hours.

A better way to do this would be to have each individual state District Branch collect the information about licensing requirements and application questions from the relevant boards and, to the extent the questions do not conform with APA's policy, a particular application can be sent to APA to analyze how it differs and suggest wording in a letter to the state board. This approach might take an estimate of 20-30 staff hours.

(2) For item #2 of the Action Paper Resolutions, see suggested approach above.

(3) For item #3 of the Action Paper Resolutions, the APA staff could produce such a letter identifying the APA Position Statement to the Federation of State Medical Boards Work Group, but it is unclear whether this Action Paper Resolution item will be able to proceed through the governance process in advance of the January 2018 meeting date for that organization. (For the purposes of this Action Paper cost estimate, an estimate of 30 minutes per state (approximately 20 states) total staff time was used).

Attachment #5
Item 2017A2 12.E
Assembly
November 3-5, 2017

ACTION PAPER
FINAL

TITLE: Recognition of Psychiatric Expertise: Efficiency and Sufficiency

WHEREAS:
Whereas, the American Board of Medical Specialties and American Board of Psychiatrists and Neurologists have undertaken inadequately considered, non-evidence based, and onerous changes in the requirements for holding one's self out as a qualified physician specialist, and

Whereas, the aforesaid changes are onerous in that the changes require Psychiatrists to undergo supererogation not relevant to their actual constructive clinical, academic, and administrative activity, and to pay additional fees to the ABPN for "educational" programs which are not superior to programs which Members otherwise attend and activities which Members otherwise perform, and

Whereas, the aforesaid activities place unreasonable and usurious burdens on diligent, well-qualified Psychiatrists,

Whereas, the American Psychiatric Association, on behalf of its Members, and other professional specialty associations on behalf of their Members have expressed ongoing concern over the effect of the aforesaid changes to Board Certification requirements of the ABPN, and have established joint council with between the APA and ABPN since 2011,

Whereas, the American Psychiatric Association, on behalf of its Members wishes to be an active, relevant participant in the governance of Psychiatrists' activities with regard to patient safety, competent clinical practice, and the integrity of the medical specialty of Psychiatry as a career,

BE IT RESOLVED:
That:

1. APA encourages the AMA to adopt a policy that the MOC should not be a requirement for maintenance of licensure, hospital privileges, insurance credentialing or employment
2. The APA should support a SA-CME learning option in lieu of the 10-year exam and encourage the ABPN to accelerate the timeline for reform of the MOC process.
3. The MOC should not be part of the licensure requirements for interstate compacts.

AUTHORS:
John Bailey, D.O., DFAPA, Representative, Florida Psychiatric Society
Valerie Arnold, M.D., DFAPA, Representative, Tennessee Psychiatric Association

ESTIMATED COST:
Author: $0
APA: $1,540

ESTIMATED SAVINGS: Substantial savings to members

ESTIMATED REVENUE GENERATED: None

ENDORSED BY:

KEY WORDS: MOC, AMA, APA, ABPN, ABMS, Right to Treat, ABPN MOC Pilot Project, employment, credentialing and privileging, medical licensure, SA-CME Interstate Medical Licensure Compact

APA STRATEGIC PRIORITIES: Advancing Psychiatry

REVIWED BY RELEVANT APA COMPONENT

Action Paper Worksheet
2017 Action Paper Budget Estimate

Action Paper Title: 12.E: Recognition of Psychiatric Expertise: Efficiency and Sufficiency
Action Paper Author(s): John Bailey, D.O., DFAPA, Representative, Florida Psychiatric Society
Phone/email:
APA Admin. Name: Becky Yowell, Reimbursement Policy/Tristan Gorrindo, MD, Division of Education
Phone/email 703-907-8593/byowell@psych.org/tgorrindo@psych.org

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

Author Estimate:

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

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

Staff Costs:

	Description:		
1		-	-
2		-	-
3		-	-
Total Staff Costs			-
Other Costs not included above:			
0			-
		Total Author Estimate	**-**

APA Administration Estimate:

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

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

Staff Costs:

	Description:		
1	Staff time to work with APA members to develop letters/resolutions, coordinate materials/communicate with advisory group(s).		1,540
2		-	-
3		-	-
Total Staff Costs			**1,540**
Other Costs not included above:			
0			-
		Total Administration Estimate	**1,540**

Rvsd. April 2017

Action Paper 12.E: Recognition of Psychiatric Expertise: Efficiency and Sufficiency

APA Administration Feedback:

DEPARTMENT: APA AMA Delegation and APA Office of Education:
With regard to resolves 1-2, advocacy has and will continue to occur at the House of Delegates on behalf of psychiatry. Members of the delegation, in collaboration with members of the Council on Education and Lifelong Learning can work collaboratively on resolutions to revise existing or create new AMA policies as appropriate.

With regard to resolve 3, the ABMS announced recently that they will be forming a commission to look at MOC; APA will look for opportunities to participate in the process and provide input.

With regard to resolve 4, the APA currently has two groups focused on MOC reform – the MOC Caucus and the Assembly Standing Committee on MOC. These groups help the APA establish MOC-reform priorities and would be well positioned to evaluate what an ideal structure of MOC might look like. In the past individuals have suggested CME only, other have said self-assessment only, others have said maintenance of licensure only. It would be helpful if these groups could evaluate and put forth a consensus recommendation.

EXPLANATION OF COST:
The primary cost of is attributed to staff time to work with APA members to develop letters/resolutions and coordinate materials/communication with any group/workgroup committee formed to advise on these issues. We estimate it would total approximately 20 hours.

Attachment #6
Item 2017A2 12.G
Assembly
November 3-5, 2017

ACTION PAPER
FINAL

TITLE: Conflicts of Interest Not Limited to Pharmaceutical Companies

WHEREAS:
Whereas, the American Psychiatric Association Annual Meeting Scientific Program Committee rightly requires disclosure of conflicts of interest by those seeking to present, in order to ensure that presentations can be evaluated within the proper context; and whereas

When presenters wish to list their conflicts on the submission website, a drop-down menu appears, listing only pharmaceutical companies; and whereas

Many other entities exist, with employment or consultation or other arrangements, which might present a conflict of interest in a presenter at APA meetings; and whereas

Entities such as insurance companies, academic institutions, healthcare systems, certification boards and others, might properly be noted when considering information presented; and whereas

Expanding the scope of disclosure might pose logistical problems, including how precisely to present such potential conflicts, as well as where to draw the lines for reporting; therefore

BE IT RESOLVED:
That the American Psychiatric Association, through its Annual Meeting Scientific Program Committee, review the current mechanism for reporting conflicts of interest, which mainly are limited to pharmaceutical companies, with an eye toward encouraging the reporting of conflicts which extend beyond pharmaceutical companies.

AUTHOR:
Kenneth Certa M.D., DLFAPA, Representative, Pennsylvania Psychiatric Society

SPONSORS:
Mary Ann Albaugh, M.D., Representative, Pennsylvania Psychiatric Society
Joseph Napoli M.D., Representative, Area 3

ESTIMATED COST:
Author: $770
APA: $770

ESTIMATED SAVINGS: 0

ESTIMATED REVENUE GENERATED: 0

ENDORSED BY:

KEY WORDS: conflict of interest, disclosure

APA STRATEGIC PRIORITIES: Education

REVIEWED BY RELEVANT APA COMPONENT:

Action Paper Worksheet
2017 Action Paper Budget Estimate

Action Paper Title:	12.G: Conflicts of Interest Not Limited to Pharmaceutical Companies
Action Paper Author(s):	Kenneth Certa, M.D., Representative, Pennsylvania Psychiatric Society
Phone/email:	215-955-6655/kenneth.certa@jefferson.edu
APA Admin. Name:	Kristen Moeller, Division of Education
Phone/email	703 907 8637

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

Author Estimate:

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

Non-Staff Costs:		
LCD Projector		-
Laptop		-
Screen		-
Flipchart		-
Microphones		-
Total Non-Staff Costs:		**-**
Staff Costs:		
Description:		
1 Evaluate current state of submission website, review options for expanding choices for disclosure of conflicts, implement		770
2	-	-
3	-	-
Total Staff Costs		770
Other Costs not included above:		
0		-
Total Author Estimate		**770**

APA Administration Estimate:

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

Non-Staff Costs:		
LCD Projector		-
Laptop		-
Screen		-
Flipchart		-
Microphones		-
Total Non-Staff Costs:		**-**
Staff Costs:		
Description:		
1 Evaluate submission website, review options for improvement		770
2	-	-
3	-	-
Total Staff Costs		**770**
Other Costs not included above:		
0		-
Total Administration Estimate		**770**

Rvsd. April 2017

Action Paper 12.G: Conflicts of Interest Not Limited to Pharmaceutical Companies

APA Administration Feedback:

DEPARTMENT: Division of Education

The ACCME's Standards for Commercial Support dictate the scope of reported disclosures in CME activities, including the Annual Meeting. The ACCME requires that presenters/authors disclose relationships with a "commercial interest" as defined by *"any entity producing, marketing, re-selling, or distributing health care goods or services consumed by, or used on, patients."* The APA meeting disclosure form has been designed to be compliant with ACCME requirements. A PDF of the Annual Meeting disclosure form accompanies this response. There is an "Other Financial Disclosures" box (page 2 of the attached PDF) in which presenters/authors can note other types of relationships. Based on the text entered into the box, APA staff make a determination if the financial disclosure is one that would be required under ACCME rules.

The intent of the disclosure process is to ensure identification of all financial relationships which could potentially introduce bias into a presentation and to ensure the separation of promotion from education. While the ACCME has categorically included all pharma companies as one of the groups that must be disclosed, the intent of the "other box" is to allow presenters to self-identify other potential sources of bias.

The drop-down boxes are used to standardize the most common disclosures so that a common terminology is used for the final output, but text from the "other box" is also evaluated.

Language from the disclosure form overview:
"In compliance with the ACCME's Standards for Commercial Support, the American Psychiatric Association, as the CME provider of this activity, has a disclosure process to ensure that anyone who is in a position to control the content of the educational activity has disclosed all relevant financial relationships with any commercial interest within the past 12 months.

The ACCME defines a "commercial interest" as "any entity producing, marketing, re-selling, or distributing health care goods or services consumed by, or used on, patients. The ACCME defines "relevant financial relationships" as "financial relationships in any amount occurring within the past 12 months with commercial interests. ... The ACCME does not consider providers of clinical service directly to patients to be commercial interests."

Financial relationships may include, but are not limited to, receiving a consulting fee, honoraria, ownership interest (e.g., stocks, stock options, excluding diversified mutual funds) or other financial benefit. Financial benefits are usually associated with roles such as employment, independent contractor (including contracted research), consulting, speaking and teaching, membership on advisory committees, and other activities from which remuneration is received or expected. ACCME considers relationships of the person involved in the CME activity to include financial relationships of a spouse or partner."

The existing form for the Annual Meeting contains a box which is defined as "other" and allows 500 characters. We expect that persons will disclose "other" relationships that might create bias such as

patents on devices or a proprietary genetic test or ownership of a technology. Usually the published disclosure does not include relationships outside the ACCME definition.

Should this be referred to the Scientific Program Committee, our guidance would be as noted.

EXPLANATION OF COST:
We agree with the author's cost estimate

DEPARTMENT: Association Governance

It is unclear from the action paper whether the intent for the inclusion of conflicts not limited to pharmaceutical companies is to cover only those individuals participating in the APA Annual Meeting or to include all individuals who participate in all APA activities (components, etc.)

The APA's Conflict of Interest Committee is the entity tasked with overseeing conflict issues within the APA. When the current conflict of policy was developed, much thought was given to requesting participants disclosure potential conflicts that were not financial*. However, consensus on conceptualizing and implementing such issues was not reached. Additionally, it was difficult to find an effective and inclusive, yet not onerous, method for collecting those types of data. The APA requires that oral disclosure of interests of all participants occur before all meetings. This disclosure should occur 'if any new activity presents potential competing interests that might conceivable affect the work to be undertaken by those gathered."

A copy of the APA's Financial Statement, Disclosure of Affiliations and Conflict of Interest Policy is attached.

*The language from the APA Policy is as follows:

> Participants will be required to disclose all forms of **financial support, commercial involvements, or other financial involvements related to the field of psychiatry whether or not the participant thinks that the involvement represents a conflict of interest**. This includes, but is not limited to, primary source of income and/or employment, institutional or corporate affiliations, pharmaceutical or device company support, paid consultancies, stock ownership or other equity interests (including exchange-traded funds geared specifically to pharmaceutical or medical device companies), patent ownership, research support, advisory committee membership, publication or other royalties, speaking or writing honoraria, expert testimony, funds for travel, interest in patents, instruments and measurement scales, technologies (including software companies), and individual or group incorporated or unincorporated private practice sources.

It is not anticipated that there would be any additional cost to the APA for reviewing the current COI policy as this work is already within the purview of the Conflict of Interest Committee and the administrative staff assigned to the Committee.

Disclosure Form

In compliance with the ACCME's Standards for Commercial Support, the American Psychiatric Association, as the CME provider of this activity, has a disclosure process to ensure that anyone who is in a position to control the content of the educational activity has disclosed all relevant financial relationships with **any commercial interest within the past 12 months.**

The ACCME defines a "commercial interest" as "any entity producing, marketing, re-selling, or distributing health care goods or services consumed by, or used on, patients. The ACCME defines "relevant financial relationships" as "financial relationships in any amount occurring within the past 12 months with commercial interests. ... The ACCME does not consider providers of clinical service directly to patients to be commercial interests."

Financial relationships may include, but are not limited to, receiving a consulting fee, honoraria, ownership interest (e.g., stocks, stock options, excluding diversified mutual funds) or other financial benefit. Financial benefits are usually associated with roles such as employment, independent contractor (including contracted research), consulting, speaking and teaching, membership on advisory committees, and other activities from which remuneration is received or expected. ACCME considers relationships of the person involved in the CME activity to include financial relationships of a spouse or partner.

The APA has mechanisms in place to identify and resolve all conflicts of interest prior to an educational activity. The prospective audience must be informed of the presenters' affiliations with relevant commercial organizations by an acknowledgement in the printed program and oral or visual disclosure to participants at the session. Disclosure by slide is required if audiovisual equipment is used for the presentation. If an individual has no relevant relationships, the learner must be informed of that as well. The APA also requires oral disclosure of discussion of unapproved uses of a commercial product or investigational use of product not yet approved for this purpose. This disclosure must take place before the discussion of the product.

Every presenter (including cochairpersons and discussants) must complete this form or the submission will not be considered for inclusion on the scientific program. Coauthors are not required to submit a disclosure form. If you are providing disclosure for a commercial interest that is not included in our drop down list, please contact apaedu@psych.org with the pharmaceutical company name so that it can be added.

By completing the APA disclosure and presenter consent forms online, you are certifying that this information is accurate and complete at the time of this submission.

I DO or I DO NOT have a financial interest in or affiliation with any commercial goods/organizations that may have a direct or indirect interest in the scientific program and neither does my spouse/partner. [REQUIRED]

clear selection

- (●) Yes, I DO have a financial disclosure
- ( ) No, I DO NOT have a financial disclosure

Consultant/Advisory Board

Select "Self", "Spouse/Partner", or both below.

- [ ] Self
- [ ] Spouse/Partner

Employee

- [ ] Self
- [ ] Spouse/Partner

Grant/Research Support

- [ ] Self
- [ ] Spouse/Partner

Speakers Bureau/Speaker Honoraria

- [ ] Self
- [ ] Spouse/Partner

Stock/Other Financial Relationship

- [ ] Self
- [ ] Spouse/Partner

Other Financial Disclosures

Characters remaining:

500 count

APA MEETINGS PRESENTER RELEASE AND CONSENT FORM

APA MEETINGS PRESENTER RELEASE AND CONSENT FORM [REQUIRED]

All presenters, speakers, panelists and other participants at APA meetings must agree to the terms and conditions in this Presenter Release and Consent form for all APA meetings. Please note that if your presentation was prepared, or you are appearing as a speaker, panelist or discussant, within the scope of your employment as an employee of an organization other than APA, we may also request written consent of your employer at a later time. As the presenter, you retain intellectual property as noted in the Underlying Ideas section of the Presenter Release document.

I propose to participate as a speaker/panelist/discussant in a session(s) to be presented at an APA meeting. If my submission is accepted, and in consideration for APA allowing me to participate in this session, I hereby agree as follows:

1. **Grant of Rights.** If selected, I hereby grant APA permission to use and publish my name, credentials, affiliations and abstracts relating to my presentation(s) in connection with APA educational activities or derivative products. This permission is for worldwide, royalty-free use in print and electronic media.
2. **Underlying Ideas.** I understand, and APA acknowledges, that I retain my rights to the original ideas, data and analyses reflected in my presentation and that I may freely discuss and develop them in other contexts. I agree that if I later use or present similar or related materials, including excerpts from the presentation itself, I will not in any way designate them as, or indicate that they are or were, endorsed, sponsored or approved by the APA or "from the meetings" or otherwise associated with APA or the APA meetings.

Attachment #7
Item 2017A2 12.H
Assembly
November 3-5, 2017

ACTION PAPER
FINAL

TITLE: Non-Physician Registration Fee for Annual Meetings

WHEREAS:
The Annual Meeting is meant to help physician psychiatrists and other mental health providers in discovering cutting edge science, new therapies, and learning standard of care to optimize the ability to provide top-notch psychiatric care.

As a benefit to membership, the Annual Meeting is discounted to APA members, residents, and fellows.

The Annual Meeting is also open to all professionals treating patients, including non-physicians (Nurse Practitioners, Social Workers, Physician Assistants).

At a time when nurse practitioner and psychologist independent scope of practice bills are abundant, it is all the more important to ensure that our members serve as leaders of the health care team. Member psychiatrists, therefore, should extract maximal benefits from their own professional organization, the American Psychiatric Association.

Members make great efforts to attend the Annual Meeting. There has been a growing concern and resentment among members who are turned away from lectures. It is further alienating when a large portion of the seating is occupied by non-physicians who have received a deeply discounted price for attendance, much less than what a member psychiatrist pays.

Continued inability to enter lectures due to maximal capacity of the room, largely filled with non-physicians, will frustrate member psychiatrists and divert them to other educational seminars, culminating in cancelled memberships leading to a decline in APA revenue.

The Annual Meeting is hosted by the professional organization for physician psychiatrists. There is already a premium for non-member psychiatrists to attend this meeting. However, no such premium exists for non-physicians.

BE IT RESOLVED:
That allied health professionals pay the same registration fee as non-member physicians at the Annual Meeting.

AUTHORS:
Sarit Hovav, M.D., Deputy Representative, International Medical Graduate Psychiatrists
Mehnaz Hyder, M.D., APA Member

ESTIMATED COST:
Author: $0
APA: $0
ESTIMATED SAVINGS:

ESTIMATED REVENUE GENERATED:

ENDORSED BY:

KEY WORDS: Annual Meeting, Registration, Fees, Member benefits

APA STRATEGIC PRIORITIES: Advancing Psychiatry

REVIEWED BY RELEVANT APA COMPONENT:

Action Paper Worksheet
2017 Action Paper Budget Estimate

Action Paper Title:	12.H: Non-Physician Registration Fee for Annual Meetings
Action Paper Author(s):	Sarit Hovav, M.D., Deputy Representative, International Medical Graduate Psychiatrists
Phone/email:	-
APA Admin. Name:	David Keen, Chief Financial Officer
Phone/email	-

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

Author Estimate:

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

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

APA Administration Estimate:

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

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

Action Paper 12.H: Non-Physician Registration Fee for Annual Meetings

APA Administration Feedback:

DEPARTMENT: Finance

EXPLANATION OF COST:
The goal of the action paper, as discussed with the author, Sarit Hovav, M.D., is to ensure that seats in the educational sessions are available for physicians. The assumption is that seats are currently taken up by non-physicians and that if a higher rate is charged few non-physicians will attend, which would free up seats for physicians.

At the 2017 Annual meeting in San Diego there were 543 non-physicians (including non-member medical students) that paid a registration fee to attend the meeting. In addition, there are many non-psychiatrist presenters and exhibitor staff that may attend educational sessions.

Total registration revenue for the 543 non-physicians was $116,000. The author did not provide a specific premium so we are unable to estimate the potential revenue reduction.

Attachment #8
Item 2017A2 12.I
Assembly
November 3-5, 2017

ACTION PAPER
(Approved by the Assembly as a Position Statement)
FINAL

TITLE: APA Position Statement Strongly Recommending Twelve Weeks of Paid Parental Leave

WHEREAS:
There is a strong body of evidence that supports the health benefits and the mental health benefits of having at least 12 weeks of paid parental leave for all parents after the birth of an infant.

Paid parental leave should be equally available to those who give birth, to their spouses or partners, including same-gender partners, to those who adopt a child at any age, and to those who have a child through surrogacy.

This topic is of particular significance to the American Psychiatric Association and to public health and mental health in general. The presence of paid parental leave has the potential to have a salutary effect on the lives of our patients, on the health of the larger community, and on our own lives.

There is significant evidence that paid parental leave results in a significant decrease in maternal depression and infant mortality.

There is an evidence basis that paid leave results in an increase in the induction and duration of breastfeeding, which confers physical as well as psychological benefits. This paid parental leave would allow more mothers to achieve the American Academy of Pediatrics recommendation of at least 6 months of exclusive breastfeeding.

There is an evidence basis that paid leave results in a significant improvement in parent-child attachment.

There is an evidence basis that paid paternal leave is associated with an increase in paternal involvement, which has been shown to have a positive impact on child development and maternal depression.

The United States and Papua New Guinea are the only two countries out of 170 in a United Nations report that do NOT offer any paid nationally mandated leave for the mother following birth of a baby.

Due to the lack of a mandated universal policy, only 13 percent of US workers have access to paid family leave.

Health disparities exist among different socioeconomic groups associated with the lack of paid parental leave. Many women with a higher family income can afford to take unpaid leave for months and stay home with their infants, but millions of women in lower socioeconomic groups with low-paying or part-time jobs do not take leave because they cannot afford to live without the income they provide for their

families. In almost half of all two-parent households, both parents now work full time; in 40 percent of all families with children, the mother is a primary breadwinner. A paid parental leave would address health disparities, a core principle of the APA.

This action paper/position statement is a statement of principle recognizing that the federal government, federal agencies, state governments, companies in the private sector, and institutions will implement the leave in varying ways compatible with their benefit packages. A number of successful solutions have been designed which have allowed the leave to be paid with minimal additional cost to employers or employees.

BE IT RESOLVED:
That the APA approve and adopt the attached position statement recommending 12 weeks of paid parental leave.

AUTHORS:
Maureen Sayres Van Niel, M.D., Representative, Women Psychiatrists
Amy Alexander, M.D., APA Member
Richa Bhatia, M.D., APA Member
Kristin Budde, M.D., APA Member
Lisa Catapano-Friedman, M.D., Representative, Vermont Psychiatric Association
Ludmila de Faria, M.D., APA Member
Christina Mangurian, M.D., MAS, APA Member
Carine Nzodom, M.D., APA Member
Simha Ravven, M.D., ECP Representative, Area 1
Nada Stotland, M.D., APA Member
Barbara Weissman, M.D., Deputy Representative, Area 6

SPONSORS:
Manuel Pacheco, M.D., Deputy Representative, Area 1
Katherine Wisner, M.D., APA Member
Jennifer Payne, M.D., Deputy Representative, Women Psychiatrists
Samantha Meltzer-Brody, M.D., APA Member
Michelle Durham, M.D., Representative, Massachusetts Psychiatric Society
Joseph Napoli, M.D., Representative, Area 3
Nancy Byatt, M.D., APA Member
Mary Ann Schaepper, M.D., Representative, Southern California Psychiatric Society
Paul Lieberman, M.D., Representative, Rhode Island Psychiatric Society
John de Figeuiredo, M.D., APA Member
Leslie Gise, M.D., Representative, Hawaii Psychiatric Medical Association
Nazanin Silver, M.D., RFM Representative, Area 3
Judy Glass, M.D., Representative, Quebec and Eastern Canada District Branch
Annya Tisher, M.D., Representative, Maine Association of Psychiatric Physicians
Vincenzo Di Nicola, M.D., Representative, Quebec and Eastern Canada District Branch
Renata Villela, M.D., Representative, Ontario District Branch
Rachel Houchins, M.D., Representative, South Carolina Psychiatric Association
Elizabeth Horstman, M.D., APA Member
Mary Fitz-Gerald, M.D., Representative, Louisiana Psychiatric Medical Association
Christina Khan, M.D., APA Member

Sana Quijada, M.D., APA Member
Mary Ann Albaugh, M.D., Representative, Pennsylvania Psychiatric Society
Samina Aziz, M.D., Representative, North Carolina Psychiatric Association
Richard Ratner, M.D., Representative, American Society for Adolescent Psychiatry
Winston Chung, Dep Rep Vermont Psychiatric Society
Jorien Campbell, M.D., RFM Deputy Representative,
Bonnie Fauman, M.D. Rep Assembly
Eliot Sorel, M.D. Representative, Washington Psychiatric Society
Francis Sanchez, M.D., Chair, Assembly Committee of Minority and Underrepresented Groups
Sheila Judge, M.D., APA Member
Iqbal Ahmed, M.D. Representative, Hawaii Psychiatric Medical Association
Gabrielle Shapiro, M.D., Representative, New York County District Branch
John Bradley, M.D. Representative, Massachusetts Psychiatric Society
Thomas Dickey, M.D., Representative, West Virginia Psychiatric Association
Dionne Hart, M.D. Representative, Minnesota Psychiatric Society
Constance Dunlap, M.D., Representative, Washington Psychiatric Society
Rahn Bailey, M.D., Representative, Black Psychiatrists
Gail Robinson, M.D., APA Member
Jessica Isom, M.D., MPH, RFM Deputy Representative, Area 1
Paola Ayora, M.D., APA Member
John Chaves, M.D., APA Member
Luming Li, M.D., APA Member
Madeline Teisberg, D.O., APA Member
Mary Vance, M.D., APA Member
Jessica Bayner, M.D., APA Member
Rebecca Radue, M.D., APA Member
Ann Clegg, M.D. APA Member
Debra Lopez M.D. APA Member
Paul Cotton, M.D. APA Member
Sue Deppe, M.D. APA Member
Jonathan Weker, M.D. APA member
Harris Strokoff, M.D. APA member
Joseph Lasek, M.D. APA member
Alya Reeve, M.D. APA member
Christine A. Barney, M.D. APA Member
Linda Zamvil, M.D. APA Member
William Tobey Horn, M.D. APA Member
Alisson Richards, M.D. APA Member
Suzanne Kennedy, M.D. APA Member
Alice Silverman, M.D. APA Member
Margaret Bolton, M.D. APA Member
Catherine Hickey, M.D., APA Member
Adam Greenlee, M.D. APA Member
Andrew Rosenfeld, M.D. APA Member
Steve Sobel, M.D. APA Member
Gwyn Gattell, M.D. APA Member
Leslie Conroy, M.D. APA Member
John Malloy. M.D. APA Member

Errin Hall, M.D. APA Member
Susan Gerretson M.D. APA Member
D. Scott Allen M.D. APA Member
Linda Addante M.D. APA Member

ESTIMATED COST:
Author: $0
APA: $154

ESTIMATED SAVINGS:

ESTIMATED REVENUE GENERATED:

ENDORSED BY: Area 1 Council, American Association of Social Psychiatry, Louisiana Psychiatric Medical Association, Brooklyn Psychiatric Society, Massachusetts Psychiatric Society, Vermont Psychiatric Association, Maine Association of Psychiatric Physicians, Association of Women Psychiatrists, Black Psychiatrists, International Medical Graduate Psychiatrists, Asian-American Psychiatrists, American Indian, Alaska Native, and Native Hawaiian Psychiatrists, Hispanic Psychiatrists, Women Psychiatrists, LGBTQ Psychiatrists

KEY WORDS: mental health effects of paid parental leave, disparities by socioeconomic status in parental leave taken

APA STRATEGIC PRIORITIES: Advancing Psychiatry, Diversity

REVIEWED BY RELEVANT APA COMPONENT: Council on Minority Mental Health and Health Disparities

Attachment:

APA Official Actions

APA Position Statement on Paid Parental Leave

Issue: After completing a review of evidence-based research of the effects of paid parental leave on the mental health of mothers and their infants, the American Psychiatric Association recommends universal paid parental leave of at least 12 weeks after the birth of a child. Data show that paid maternal leave is associated with significant decreases in infant mortality and maternal depression, a significant increase in the induction and duration of breastfeeding, and an improvement of the attachment between infant and parents. At this time in the United States, there are unequal standards for women of different socioeconomic backgrounds in the amount of parental leave taken: Women with a higher family income can afford to take unpaid leave for months and stay home with their infants, but millions of women in lower socioeconomic groups with low-paying or part-time jobs do not take leave because they cannot afford to live without the income they provide for their families. Paid parental leave can no longer be considered an optional benefit. At the APA, we are advocating for a paid parental leave policy because we are committed to protecting the health and well-being of all parents and children following the birth of an infant. As psychiatrists, we are charged with the task of diagnosing, understanding, treating, and preventing mental health disorders whenever possible, including those that occur during the postpartum period or in the early development of an infant. The absence of paid leave in fact exacerbates psychiatric disorders in both parent and child. This form of support for new parents touches all mothers, fathers and partners, including same-gender partners and their infants at a most critical time in their lives. This position statement is a statement of principle recognizing that the federal government, federal agencies, state governments, companies in the private sector, and educational institutions will implement the leave in varying ways compatible with their benefit packages.

POSITION

There is an evidence basis that at least twelve weeks of parental leave following the birth of an infant confers mental, physical, and public health benefits for parents and children. The American Psychiatric Association strongly recommends 12 weeks of universal paid leave be granted for all parents: to those who give birth, to their spouses or partners including same-gender partners, to those who adopt a child, and to those who have a child by surrogacy.

Authors:

Amy Alexander, MD; Richa Bhatia, MD; Kristin Budde, MD; Lisa Catapano-Friedman, MD; Ludmila de Faria, MD; Christina Mangurian, MD, MAS; Carine Nzodom, MD; Simha Ravven, MD; Maureen Sayres Van Niel, MD; Nada Stotland, MD; Barbara Weissman, MD from the Women's Caucus and the Council on Minority Mental Health and Health Disparities

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Action Paper Worksheet
2017 Action Paper Budget Estimate

Action Paper Title:	12.I: APA Position Statement Strongly Recommending Twelve Weeks Paid Parental Leave
Action Paper Author(s):	Maureen Sayres Van Niel, M.D., Representative, Women Psychiatrists
Phone/email:	maureen.vanniel@gmail.com
APA Admin. Name:	Omar Davis, CAPM, Division of Diversity and Health Equity
Phone/email	703-907-7324/odavis@psych.org

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

Author Estimate:

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

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

Staff Costs:

	Description:		
1	I do not know of any costs associated with this Action Paper/Position Statement because voting members will already be at the meetings.		-
2		-	-
3		-	-
	Total Staff Costs		-
Other Costs not included above:			
0			-
		Total Author Estimate	**-**

APA Administration Estimate:

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

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

Staff Costs:

	Description:		
1	Support may be required if JRC refers Action Paper and/or Postion Statement to CMMH/HD (Minority Council) for further review		154
2		-	-
3		-	-
	Total Staff Costs		**154**
Other Costs not included above:			
0			-
		Total Administration Estimate	**154**

Rvsd. April 2017

Action Paper 12.I: APA Position Statement Strongly Recommending Twelve Weeks of Paid Paternal Leave

APA Administration Feedback:

COMPONENT: Council on Minority Mental Health and Health Disparities

As a note, Dr. Maureen Van Niel Sayres, author of the Action Paper/Position Statement on Parental Leave, asked several members of the M/UR caucuses and the Council on Minority Mental Health and Health Disparities (CMMH/HD) to sign on to this work and in response, many of them provided favorable comments. Given that this work is centered around women's issue, our expectation is that the Joint Reference Committee (JRC) will refer the Position Statement to the Council on Minority Mental Health and Health Disparities for further review and endorsement.

EXPLANATION OF COST: Division of Diversity and Health Equity (DDHE)

DDHE expects that a minimum of 2 hours will be required to steer the Position Statement through CMMH/HD.

Attachment #9
Item 2017A2 12.J
Assembly
November 3-5, 2017

ACTION PAPER
FINAL

TITLE: Helping Members Join Caucuses

WHEREAS:

1 - The APA new member and member ship email has no direct link to join a caucus.
2 - Many APA members do not know about the caucuses.
3 - The link to "leadership and involvement opportunities" in the new member email is vague and requires several clicks to see all the caucuses.
4 - APA would like to better serve members with special interests.
5 - Minority and Underrepresented members' issues have been of special recent concern
6 - APA leadership states that diversity is a priority.

BE IT RESOLVED:
That the APA new member and membership renewal emails have a direct link to joining a caucus.

Minority and Underrepresented (M/UR) Caucuses –
https://www.psychiatry.org/psychiatrists/cultural-competency/mur-caucuses

And other APA Caucuses –
https://www.psychiatry.org/psychiatrists/awards-leadership-opportunities/leadership-opportunities/join-a-caucus

AUTHORS:
Leslie Hartley Gise, M.D., Representative, Hawaii Psychiatric Medical Association, leslieg@maui.net
Judy Glass, M.D., Representative, Quebec & Eastern Canada District Branch

SPONSORS:
Iqbal Ahmed, M.D., Representative, Hawaii Psychiatric Medical Association
Samina Aziz, M.D., Representative, South Carolina Psychiatric Association
Amela Blekic, M.D., Representative, Oregon Psychiatric Association
Naviot Brainch, M.D., RFM Deputy Representative, Area 2
Robert Cabaj, M.D., Representative, Northern California Psychiatric Society
Charles Ciolino, M.D., Representative, New Jersey Psychiatric Association
Maisha Correia, M.D., Representative, Idaho Psychiatric Association
Bhasker Dave, M.D., Representative, Area 4
Anish Dube, M.D., Representative, Asian-American Psychiatrists
Michelle Durham, M.D., Representative, Massachusetts Psychiatric Society
Antony Fernandez, M.D., Representative, IMG Psychiatrists
Mary Fitz-Gerald, M.D., Representative, Louisiana Psychiatric Medical Association
Joan Green, M.D., Representative, Montana Psychiatric Association
William Greenberg, M.D., Deputy Representative, Area 3

Annette Hanson, M.D., Representative, Washington Psychiatric Society
Dionne Hart, M.D., Representative, Minnesota Psychiatric Society
Sarit Hovav, M.D., Deputy Representative, IMG Psychiatrists
Ray Hsiao, M.D., Representative, Washington State Psychiatric Association
Jessica Isom, M.D., RFM Deputy Representative, Area 1
Ubaldo Leli, M.D., Representative, LGBTQ Psychiatrists
Sudhakar Madakasira, M.D., Representative, Mississippi Psychiatric Association
Cassandra Newkirk, M.D., Representative, Florida Psychiatric Society
Isabel Norian, M.D., Representative, New Hampshire Psychiatric Society
Eric Plakun, M.D., Representative, American Academy of Psychoanalysis
James Polo, M.D., Representative, Washington State Psychiatric Association
Anita Rao, M.D., RFM Deputy Representative, Area 4
Francis Sanchez, M.D., Chair, Assembly Committee of Representatives of Minority and Underrepresented Groups
Nazanin Silver, M.D., RFM Representative, Area 3
Jagannathan Srinivasaraghavan, M.D., Representative, Illinois Psychiatric Society
Margie Sved, M.D., Representative, AGLP: The Association of LGBTQ Psychiatrists
David A. Tompkins, M.D., Deputy Representative, LGBTQ Psychiatrists
Maureen Sayres Van Niel, M.D., Representative, Women Psychiatrists
Shreekumar Vinekar, M.D., Representative, Oklahoma Psychiatric Medical Association
Craig Zarling, M.D, Representative, Area 7
Brian Zimnitzky, M.D., Representative, Maryland Psychiatric Society

ESTIMATED COST:
Author: $0
APA: $770

ESTIMATED SAVINGS: None

ESTIMATED REVENUE GENERATED: None

ENDORSED BY: American Indian, Alaska Native, Caucus of American Indian, Alaska Native and Native Hawaiian Psychiatrists; Asian-American Psychiatrists; Black Psychiatrists; International Medical Graduate Psychiatrists; LGBTQ Psychiatrists; Women Psychiatrists; Area 7 Council; Area 1 Council, Assembly Committee of Public & Community Psychiatry

KEY WORDS: Caucuses

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

REVIEWED BY RELEVANT APA COMPONENT: Council on Minority Mental Health and Health Disparities, Membership, Division of Diversity and Health Equity (DDHE)

Action Paper Worksheet
2017 Action Paper Budget Estimate

Action Paper Title: 12.J: Helping Members Join Caucuses
Action Paper Author(s): Leslie Hartley Gise, M.D., Representative, Hawaii Psychiatric Medical Association
Phone/email: (808) 283-9095/leslieg@maui.net
APA Admin. Name: Stephanie Auditore, Membership Department
Phone/email 703-907-7833/sauditore@psych.org

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

Author Estimate:

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

Non-Staff Costs:

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

Staff Costs:

	Description:		
1	Add 2 websites in action paper to new member and renewal emails		-
2		-	-
3		-	-
	Total Staff Costs		-

Other Costs not included above:

None	-
Total Author Estimate	**-**

APA Administration Estimate:

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

Non-Staff Costs:

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

Staff Costs:

	Description:		
1	Create vanity URLs, sdd text to template emails, conduct testing to ensure hyperlink works effectively, disseminate across staff		770
2		-	-
3		-	-
	Total Staff Costs		**770**

Other Costs not included above:

0	-
Total Administration Estimate	**770**

Rvsd. April 2017

Action Paper 12.J: Helping Members Join Caucuses

APA Administration Feedback:

DEPARTMENT: Membership

Included below is a sample email that a new member would receive upon joining the APA. New members are encouraged to "tailor their membership" to their interests by completing their profile at my.psychiatry.org, which is also the most direct way to join all of the APA's caucuses. Welcome e-mails also encourage members to explore involvement/leadership opportunities in the APA, which includes a link to the Leadership webpage where all opportunities are highlighted, including the caucuses. Given the space limitations and the fact we must be brief for our new and renewing members to read the correspondence, we have worked extremely hard to highlight broad, inclusive categories in a visually appealing way and encourage members to explore the increasing number of benefits that APA is providing. In the past, APA has resorted to laundry lists in membership communications based on requests and it has negatively impacted open rates and retention because many members stopped reading the communications (i.e. it is not practical to list the 70 plus awards and leadership opportunities in addition to every advocacy effort and educational course).

Consequently, we use several tactics to highlight specific membership value throughout the year. For example, APA promotes the caucuses on a regular basis throughout the website and in various publications. From 2016 to 2017, the caucuses were referenced in 10 articles throughout *Psychiatric News, Psychiatric Update,* and *APA Daily*. This includes the articles, "Minority, Underrepresented Members Connect Through Caucuses," "Executive Orders Usher in Era of Uncertainty for IMGs, Program Director," and "Guidelines Announced for Women's Preventive Services." Furthermore, members can easily find and join the caucuses from the newly designed member profile page (as mentioned above); by searching caucus on the APA website where this option pops up first; and on several web pages such as the cultural competency page. In addition, invitations to join the seven M/UR caucuses are regularly included by leadership in their presentations to members.

The Membership Committee can explore other ways to include the Caucuses in promotions but the membership welcome emails and hard-copy mailed "kits" need to continue to be carefully crafted at the discretion of the Membership Committee and staff to have the intended impact and continue the successful recruiting and retention efforts that have brought membership to a 14-year high.

SAMPLE WELCOME EMAIL FOR NEW GENERAL MEMBER

Dear Dr. **LASTNAME**,

Welcome to the American Psychiatric Association (APA)! My name is xxx, and I will be your APA Membership Coordinator. I am here to help with any questions you have regarding your APA Membership. Your APA ID number is xxx. Shortly, you will receive your membership card with your APA ID number in the mail. Keep this card handy, as you will use it throughout your career when utilizing your APA benefits.

I encourage you to access your my.psychiatry.org account and complete your profile to ensure your membership experience is tailored to your interests and needs.

Below are a few highlights of the **many benefits** you're entitled to through APA Membership.

Learn online at your own pace on the APA Learning Center with free access to more than 90 courses, including the Members' Course of the Month and Risk Management curriculum

Know the latest in psychiatric research with your free print and online subscriptions to the *American Journal of Psychiatry*, the most widely circulated psychiatric journal in the world.

Advocate for your profession and patients with the Advocacy Action Center, and stay informed on current issues like Comprehensive Mental Health Reform, mental health parity, and Scope of Practice.

Engage with the psychiatric community through APA meetings and events (steep discounts for members), leadership and involvement opportunities, or by becoming a Fellow of the APA.

Thank you for choosing the American Psychiatric Association as your professional home. If you have questions regarding your membership, please feel free to contact me. I look forward to your participation in the APA community!

Sincerely,

Attachment #10
Item 2017A2 12.K
Assembly
November 3-5, 2017

ACTION PAPER
FINAL

TITLE: Achieving Congruence between the APA *Commentary on Ethics in Practice* and the AMA *Principles of Medical Ethics* Concerning Ethical Obligations of Psychiatrists Making Benefit Determination Decisions

WHEREAS:

The 2015 APA *Commentary on Ethics in Practice* (Available at https://www.psychiatry.org/psychiatrists/practice/ethics) states in Topic 3.4.1 on "***Working within organized systems of care***," which explicitly includes **psychiatrists who "*work for third party payors*,"** that *"In these systems, other values often compete with the interests of the individual patient. The fundamental tension of psychiatrists working in organized settings, then, is that the terms of employment relate to the needs of the venture, but as physicians, psychiatrists working in organized systems of care* ***cannot wholly ignore the needs of patients***" (bold text and underlining added).;

The 2016 revision of the *Principles of Medical Ethics* of the American Medical Association (Available at *https://www.ama-assn.org/sites/default/files/media-browser/code-of-medical-ethics-chapter-10.pdf*)

states the following (bold text and underling added):

10.1.1 Ethical Obligations of Medical Directors

Physicians' core professional obligations include acting in and advocating for patients' best interests. When they take on roles that require them to use their medical knowledge on behalf of third parties, physicians must uphold these core obligations.

When physicians accept the role of medical director and must make benefit coverage determinations on behalf of health plans *or other third parties or determinations about individuals' fitness to engage in an activity or need for medical care,* ***they should****:*

> *(a) Use their professional expertise to help craft plan guidelines to ensure that all enrollees receive fair, equal consideration.*
>
> *(b) Review plan policies and guidelines to ensure that decision-making mechanisms:*
>
> > *(i) are objective, flexible, and consistent;*
> >
> > *(ii) rest on appropriate criteria for allocating medical resources in accordance with ethics guidance.*
>
> *(c) Apply plan policies and guidelines evenhandedly to all patients.*

(d) Encourage third-party payers to provide needed medical services to all plan enrollees and to promote access to services by the community at large.

(e) Put patient interests over personal interests (financial or other) created by the nonclinical role.

A psychiatrist seeking ethical guidance from these two documents in making benefit determination decisions for access to mental health care would notice a conflict between the language of the 2015 APA *Commentary on Ethics in Practice* ("***cannot wholly ignore the needs of patients"***) and the language of the AMA *Principles of Medical Ethics* ("***Put patient interests over personal interests (financial or other) created by the nonclinical role"****);*

BE IT RESOLVED:
That the APA will direct the authors of the APA *Commentary on Ethics in Practice* to bring its language into congruence with that of the AMA *Principles of Medical Ethics 10.1.1*, including a thoughtful exploration of the complexities involved. This would apply to any psychiatrist making any benefit and/or policy determinations.

AUTHORS:
Eric M. Plakun, M.D., Representative, Academy of Psychoanalysis and Dynamic Psychiatry,
Robert Feder, M.D., Representative, New Hampshire Psychiatric Society

SPONSORS:
Alexander von Hafften, M.D., Representative, Alaska Psychiatric Association
Prudence Gourguechon, M.D., Representative, American Psychoanalytic Association
Manuel Pacheco, M.D., Deputy Representative, Area 1

ESTIMATED COST:
Author: $385
APA: $1,000

ESTIMATED SAVINGS: None

ESTIMATED REVENUE GENERATED: None

ENDORSED BY: Area 1 Council

KEY WORDS: Managed care, utilization review, medical necessity, ethics

APA STRATEGIC PRIORITIES: Advancing Psychiatry

REVIEWED BY RELEVANT APA COMPONENT: Action paper forwarded to staff of Ethics Committee and Attorney Colleen Coyle, with whom there have been prior discussions of related matters.

Action Paper Worksheet
2017 Action Paper Budget Estimate

Action Paper Title:	12.K: Achieving Congruence Between the APA Commentary on Ethics in Practice and the AMA Principles of
Action Paper Author(s):	Eric M. Plakun, M.D., Representative, Academy of Psychoanalysis and Dynamic Psychiatry
Phone/email:	413-931-5208 / eric.plakun@austenriggs.net
APA Admin. Name:	Zhuoyin Yang (Office of General Counsel - Colleen Coyle)
Phone/email	703-907-8632; zyang@psych.org

Attendance Summary:	**Author**	**APA Administration**
Number of Component Members	6	6
Number of Staff	4	2
Number of Non-Staff	-	-
Total	**10**	**8**

Author Estimate:

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

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

Staff Costs:

	Description:		
1	This would be the work of the ethics committee, and would require reviewing both documents, discussion and making changes		385
2		-	-
3		-	-
	Total Staff Costs		385

Other Costs not included above:	
0	-
Total Author Estimate	**385**

APA Administration Estimate:

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

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

Staff Costs:

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

Other Costs not included above:	
It is the Ethics Committee's view that the APA Commentary on Ethics in Practice and Opinion 10.1.1 of the AMA Principles of Medical Ethics are saying and are intended to say different things. Therefore, it is not appropriate to achieve congruence between the two. To add AMA's Opinion to APA's Commentary, assuming AMA would allow it, likely would cost a licensing fee. Estimate: $1000/year	**1,000**
Total Administration Estimate	**1,000**

Action Paper 12.K: Achieving Congruence between the APA Commentary on Ethics in Practice and the AMA Principles of Medical Ethics Concerning Ethical Obligations of Psychiatrists Making Benefit Determination Decisions

APA Administration Feedback:

COMPONENT: Ethics Committee

The AMA section refers to "medical directors." The APA section is broader. The AMA section is more specific just to medical directors.

The AMA section states that there need to be fair procedures for benefit determinations and that physicians should not put **their own** interests over those of patients. **It does not say that medical directors should put patient interests above benefit determination interests**. Just says they should be fair and consistent and base benefit determinations on medical criteria.

Below the role of medical director is the insurance reviewer, who must follow the procedures and maintains responsibility for fidelity for those procedures. However, the APA section actually goes further as if those procedures do not adequately take patient interests into account, the psychiatrist cannot wholly ignore the patient and just follow the procedures.

Finally, the APA section is less specific because it applies to all systems of care. Privileging the physician's own interests over the patient would violate the commentary, just as the AMA language, based on prior sections on the nature of the fiduciary relationship, which privileges the patient over the psychiatrist.

Restated, here is the flaw:
AMA: in medical director work, patients trump individual physician issues
APA: in system of care work, cannot ignore the patient

In neither case does what the patient wants or what the **individual psychiatrist thinks is best for the patient win**.

Managed care is contractual. You can't ignore the patient. You can advocate for change in the system (also in commentary) when you see problems. You can't rewrite the terms on an individual basis for each patient as there is a contract and a plan. These plans need to be based in medical necessity/ evidence. Can't ignore that and need to take that into account.

The author is also missing the balancing nature of the commentary as a guide. There are very few proscriptions. The idea is that you must take both the contract and the patient interest into account.

EXPLANATION OF COST:

It is the Ethics Committee's view that the APA *Commentary on Ethics in Practice* and Opinion 10.1.1 of the AMA *Principles of Medical Ethics* are saying and are intended to say different things. Therefore, it is

not appropriate to achieve congruence between the two. To add AMA's *Opinion* to APA's *Commentary*, assuming AMA would allow it, likely would cost a licensing fee. Estimate: $1000/year.

Attachment #11
Item 2017A2 12.L
Assembly
November 3-5, 2017

ACTION PAPER
FINAL

TITLE: Adopting an APA Position Statement Supporting Implementation of the Mental Health Parity and Addiction Equity Act (MHPAEA or parity law)

WHEREAS:
The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA or parity law) requires that covered mental health and substance use disorder (MHSUD) benefits not have "predominantly" or "substantially" separate or unequal treatment limitations;

The MHPAEA defines "treatment limitations" as either quantitative (QTL) or non-quantitative (NQTLs);

Implementation of the parity law is incomplete, but case law will eventually establish clarity about which MHSUD utilization management limitations are consistent with the requirements of the parity law;

Some major managed care organizations apply MHSUD or "behavioral health" medical necessity criteria purchased or licensed from for-profit corporations that develop such criteria using editorial boards that do not include psychiatrists or licensed behavioral health clinicians (e.g., MCG Health, part of the Hearst Health network, see MCG Health website at https://www.mcg.com/about/clinical-editors/. Not one of the eight MCG Health editorial staff [5 internists and 3 non-physicians] who constitute the team that writes behavioral health guidelines for MCG is trained as a psychiatrist.);

Psychiatrists serving as utilization reviewers or medical directors for managed care entities often lack access to current and accurate information about whether the medical necessity criteria they use or develop are in compliance with parity law requirements, as is also the case for covered individuals and their treating clinicians;

Whereas the APA has no current position statement on the implications of the parity law for managed care utilization management or benefit determination practices;

And whereas the healthcare landscape has been changing at an accelerated pace giving this issue urgency.

BE IT RESOLVED:
A. That the Assembly recommend adoption of an APA position statement, appropriately formatted, as follows:

It is the position of the APA that:

1. Insurance and/or other third party MHSUD utilization management and medical necessity criteria should be developed by individuals who are trained as psychiatrists or by work groups that include psychiatrists.

2. Insurance and/or other third party MHSUD utilization management and medical necessity criteria should be in full compliance with requirements of applicable state and federal parity laws, including with MHPAEA requirements that quantitative limits (QTLs) and non-quantitative limits (NQTLs) for MHSUD care should be comparable to and no more stringent than medical necessity criteria for medical and surgical care, except as allowed by the law.
3. Insurance companies and/or other third parties offering coverage for both medical/surgical and MHSUD treatment—including those that do so through MHSUD "carve outs"—have an obligation to provide to their medical directors, psychiatrist reviewers, other clinicians who make benefit determinations, and to treating clinicians and to covered individuals, current and accurate information about whether and how their MHSUD utilization review and medical necessity criteria comply with MHPAEA QTL and NQTL requirements.

B. The Assembly will directly refer this action paper outlining specific elements of a position statement to the Board of Trustees for adoption at their next meeting, including holding a separate vote to this effect, if required by Assembly rules.

AUTHORS:
Eric M. Plakun, M.D., Representative, Academy of Psychoanalysis and Dynamic Psychiatry,
Robert Feder, M.D., Representative, New Hampshire Psychiatric Society

SPONSORS:
Alexander von Hafften, M.D., Representative, Alaska Psychiatric Association
Prudence Gourguechon, M.D., Representative, American Psychoanalytic Association
Manuel Pacheco, M.D., Deputy Representative, Area 1

ESTIMATED COST:
Author: $154
APA: $1,540

ESTIMATED SAVINGS: None

ESTIMATED REVENUE GENERATED: None

ENDORSED BY: Area 1 Council

KEY WORDS: Managed care, utilization review, medical necessity

APA STRATEGIC PRIORITIES: Advancing Psychiatry

REVIEWED BY RELEVANT APA COMPONENT: Action paper copied to staff of Council on Healthcare Systems and Financing and Council on Advocacy and Government relations. There have been past discussions about related matters with Council on Healthcare Systems and Financing.

Action Paper Worksheet
2017 Action Paper Budget Estimate

Action Paper Title:	12.L: Adopting an APA Position Statement Supporting Implementation of the Mental Health Parity and
Action Paper Author(s):	Eric M. Plakun, M.D., Representative, Academy of Psychoanalysis and Dynamic Psychiatry
Phone/email:	413 931-5208 / eric.plakun@austenriggs.net
APA Admin. Name:	Sam Muszynski, Parity Enforcement and Implementation
Phone/email	703-907-8592/imus@psych.org

Attendance Summary:	**Author**	**APA Administration**
Number of Component Members	15	-
Number of Staff	6	-
Number of Non-Staff	-	-
Total	**21**	**-**

Author Estimate:

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

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

Staff Costs:

	Description:		
1	Approving this position statement would occur at an ordinary meeting of the Board of Trustees		154
2		-	-
3		-	-
	Total Staff Costs		154

Other Costs not included above:

Staff research related to position statement--perhaps a few hours	-
Total Author Estimate	**154**

APA Administration Estimate:

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

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

Staff Costs:

	Description:		
1	Staff time to review and prepare relevant materials for the appropriate governing bodies as this moves through the process.		1,540
2		-	-
3		-	-
	Total Staff Costs		**1,540**

Other Costs not included above:

0	
	-
Total Administration Estimate	**1,540**

Rvsd. April 2017

Action Paper 12.L: Adopting an APA Position Statement Supporting Implementation of the Mental Health Parity and Addiction Equity Act (MHPAEA or parity law)

APA Administration Feedback:

DEPARTMENT: Department of Parity Enforcement and Implementation

EXPLANATION OF COST:
Staff estimates that it will take approximately 20 hours of staff time to review and prepare relevant materials for the appropriate governing bodies as this moves through the process.

Attachment #12
Item 2017A2 12.M
Assembly
November 3-5, 2017

ACTION PAPER
FINAL

TITLE: Joint Meeting of the Council on Minority Mental Health and Health Disparities and the Assembly Committee of Representatives of Minority/Underrepresented Groups

WHEREAS:
diversity and inclusivity are paramount to the future of the American Psychiatric Association.

psychiatrists, and our patients in turn, benefit from improved knowledge and understanding of the different minority and underrepresented groups they treat.

the current sociopolitical environment in the United States has resulted in a palpable increase in stress and trauma that has disproportionately affected minority and underrepresented populations, including our patients.

"The Council on Minority Mental Health and Health Disparities (CMMH/HD) represents and advocates for both minority and underserved populations and psychiatrists from those groups."[1]

"The council seeks to reduce mental health disparities in clinical services and research, which disproportionately affect women and minority populations."[1]

"The council aims to promote the recruitment and development of psychiatrists from minority and underrepresented groups both within the profession and in APA."[1]

"The identified minority groups to have representation in the Assembly are: American Indian, Alaska Native, and Native Hawaiian; Asian-American; Black; Hispanic; Lesbian, Gay and Bisexual; Women; and International Medical Graduate psychiatrists."[2]

"Underrepresentation of such members exists within APA's governing bodies and committee structures, with such underrepresentation related to their characteristics as a minority."[2]

"Potential patients and other citizens with similar minority characteristics […] have had interests, rights, and needs repeatedly neglected, ignored, or violated within the society, such that their mental health has been adversely affected in a significant way."[2]

the Minority/Underrepresented (M/UR) Caucuses of the APA provide a venue for APA members to express concerns, share information, and seek solutions for issues that directly affect M/UR psychiatrists and the patients they treat.

the Board of Trustees supported a one-time expansion of the CMMH/HD's September 2017 Component Meeting to allow for an Assembly representative of each M/UR Caucus to participate in the first ever Joint Meeting of the CMMH/HD and the Assembly Committee of Representatives of Minority/Underrepresented Groups.

the Joint Meeting, having taken place on September 15, 2017, was a successful collaboration between the CMMH/HD and the Assembly Committee of Representatives of Minority/Underrepresented Groups.

the Joint Meeting resulted in significant progress towards the finalization of the "*APA Toolkit on Stress and Trauma related to the Political and Social Environment*", an educational resource collaboratively developed by the CMMH/HD, the M/UR Assembly Representatives, the Division of Diversity and Health Equity, APA Communications, and the Office of the Medical Director, which is geared towards educating consumers and providers on the impact of the current sociopolitical climate in the United States.

This APA toolkit was conceived as a live document that will require regular updates to reflect the burgeoning impact on vulnerable populations and the progress in scientific evidence.

The Joint Meeting also addressed strategies to increase: (1) APA membership from key allied minority groups and (2) the number of joint abstract submissions by the M/UR Caucuses and the CMMH/HD.

the Joint Meeting led to the long-overdue and essential rapprochement of the CMMH/HD and the Assembly Committee of Representatives of Minority/Underrepresented Groups, whose continued collaboration is of the utmost importance and benefit to the M/UR psychiatrists and patients that both bodies have set out to represent.

The APA fourth strategic initiative is: "Supporting and increasing diversity within APA. Serving the needs of evolving, diverse, underrepresented and underserved patient populations. Working to end disparities in mental health care."

BE IT RESOLVED:

1) That the American Psychiatric Association will support another Joint Meeting of the Council on Minority Mental Health and Health Disparities and the Assembly Committee of Representatives of Minority/Underrepresented Groups, in alignment with the APA's fourth strategic initiative addressing diversity.
2) That such meeting will take place during the Annual September Components Meeting of the American Psychiatric Association in September 2018.

AUTHOR:
Felix Torres, M.D., FAPA, Representative, New York County District Branch

ESTIMATED COST:
Author: $13,789
APA: $11,907

ESTIMATED SAVINGS:

ESTIMATED REVENUE GENERATED:

ENDORSED BY: Caucus of American Indian, Alaska Native, and Native Hawaiian Psychiatrists; Caucus of Asian-American Psychiatrists; Caucus of Black Psychiatrists; Caucus of Hispanic Psychiatrists; Caucus of International Medical Graduate Psychiatrists; Caucus of Lesbian, Gay, Bisexual, Transgender and Questioning/Queer Psychiatrists; Caucus of Women Psychiatrists.

KEY WORDS: diversity, inclusivity, minority, underrepresented, health disparities

APA STRATEGIC GOAL: Diversity, Advancing Psychiatry

REVIEWED BY RELEVANT APA COMPONENT: Council on Minority Mental Health and Health Disparities

RESOURCES:

[1] American Psychiatric Association. (n.d.). *Council on Minority Mental Health and Health Disparities*. Retrieved from https://www.psychiatry.org/about-apa/meet-our-organization/councils/minority-mental-health-and-health-disparities

[2] American Psychiatric Association. (n.d.). *Procedural Code of the Assembly of the American Psychiatric Association*. Retrieved from https://www.psychiatry.org/File%20Library/About-APA/Organization-Documents-Policies/procedural-code.pdf

Action Paper Worksheet
2017 Action Paper Budget Estimate

Action Paper Title:	12.M: Joint Meeting of the Council on Minority Mental Health and Health Disparities and the
Action Paper Author(s):	Felix Torres, M.D., FAPA, Representative, New York County District Branch
Phone/email:	(787) 564-2234 / felixtorresmd@nyfpc.com
APA Admin. Name:	Omar Davis, CAPM, Division of Diversity and Health Equity
Phone/email	(703) 907-7324 / odavis@psych.org

Attendance Summary:	**Author**	**APA Administration**
Number of Component Members	13	-
Number of Staff	-	3
Number of Non-Staff	7	7
Total	**20**	**10**

Author Estimate:

Travel Budget:	No. of Attendees	Airfare	Hotel/Lodging	Ground Transportation	Per Diem/Meals	Total
Meeting 1	7	$2,975	$6,500	$700	$1,480	$11,655
Meeting 2	-	-	-	-	-	-
Total Travel Budget		2,975	6,500	700	1,480	11,655

Non-Staff Costs:	
LCD Projector	850
Laptop	300
Screen	180
Flipchart	75
Microphones	190
Total Non-Staff Costs:	**1,595**
Staff Costs:	
Description:	
1 Staff support for the additional day required for the Joint Meeting to take place during the September Components Meeting.	539
2	-
3	-
Total Staff Costs	539
Other Costs not included above:	
The difference between the number of people in the several expense types arises from the fact that the APA already pays for the transportation and the meals of the 13 Council members attending the September Components Meeting. The APA would have also already paid for one of the two lodging nights required for the extension of the Council meeting by one day in order to	-
Total Author Estimate	**$13,789**

APA Administration Estimate:

Travel Budget	No. of Attendees	Airfare	Hotel/Lodging	Ground Transportation	Per Diem/Meals	Total
Meeting 1	7	$2,550	$2,275	$700	$1,036	$6,561
Meeting 2	-	-	-	-	-	-
Total Travel Budget		**2,550**	**2,275**	**700**	**1,036**	**6,561**

Non-Staff Costs:	
LCD Projector	850
Laptop	300
Screen	180
Flipchart	525
Microphones	-
Total Non-Staff Costs:	**1,855**
Staff Costs:	
Description:	
1 Serve as advisor to Chair of Council on Minority Mental Health and Health Disparities on planning, managing and executing of the meeting	770
2 Prepare and give presentation regarding DDHE's programs and activities. Capture and prepare meeting minutes and prepare supplement material	847
3	-
Total Staff Costs	**1,617**
Other Costs not included above:	
Not mentioned is the potential need for APA to provide dinner and coffee service as members are scheduled to meet from 1pm to 8pm	**1,874**
Total Administration Estimate	**$11,907**

Rvsd. Dec. 2016

Action Paper 12.M: Joint Meeting of the Council on Minority Mental Health and Health Disparities and Assembly Committee of Representatives of Minority and Underrepresented Groups

APA Administration Feedback:

DEPARTMENT: Division of Diversity and Health Equity (DDHE)

EXPLANATION OF COST:

If this request is approved, DDHE estimates that the proposed funding source will incur a charge of $6,561.00 for travel related expenditures as opposed to the author's original estimate of $11,655. In summary, DDHE's cost estimate is approximately $5,094 lower than the original brought forward by the author. The estimate also accounts for funding that is allocated (per APA policy) to all APA Councils for use at September Components, annually.

Attachment #13
Item 2017A2 12.N
Assembly
November 3-5, 2017

ACTION PAPER
FINAL

TITLE: Civil Liability Coverage for District Branch Ethics Investigations

WHEREAS:

1. Section 7.2 (Ethics Complaints) of the American Psychiatric Association Bylaws states: "Complaints charging members of the Association with unethical behavior or practices shall be investigated, processed, and resolved in accordance with procedures approved by the Assembly and the Board."

2. Ethics complaints to the American Psychiatric Association are referred to the respective district branch for review and investigation.

3. Section 12 (Indemnification of Officers and Trustees) of the American Psychiatric Association Bylaws states:
   "The Association will indemnify, defend and hold harmless its Officers and Trustees, paid and unpaid, from any and all liability, including all expenses, legal fees and costs associated with any claim arising out of their position with the Association or damages resulting from their actions on behalf of the Association while serving as an Officer or Trustee. Officers and Trustees of the Association shall have no liability to the corporation or to the members for money damages for actions or failures to act as an officer or director. This provision shall not apply if the liability results from intentional infliction of harm, an intentional violation of criminal law, or receipt of a financial benefit to which the Trustee or Officer is not entitled. This provision is intended to provide the broadest indemnification and reimbursement permitted under the law."

4. The American Psychiatric Association purchases Directors and Officers (D&O) Liability Insurance coverage for actions related to Association governance at a national level

5. There is no formal policy for the American Psychiatric Association to provide expenditures for litigation or other expenses related to a district branch ethics investigation.

6. There is implied liability coverage for district branches through the APA's D&O policy, however the policy deductible is $100,000.

7. Most district branches would be unable to afford the current deductible for a single claim.

8. Many district branches may be uninformed related to liability coverage issues, or may not have access to the policy itself.

9. WHEREAS The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry contains mandatory minimum procedural requirements for an ethics investigations, specifically:

    - Review for jurisdiction and statute of limitations
    - Preliminary review for summary judgment (eg, no violation of Principles even if allegations were true)
    - An initial review of the evidence (from Complainant, not necessarily from accused)
    - Notice to the accused member by certified mail regarding accusation and member's rights related to the proceeding
    - Appointment of a three member hearing panel
    - The hearing may consist of: opening and closing statements, direct and cross-examination of witnesses, questions from hearing panel members, consideration of extrinsic evidence
    - The DB must make a transcript of the hearing available to the accused if requested, at the accused's expense
    - The DB executive council must review the hearing board's decision
    - Notice of appeal rights given to accused, if violation supported

BE IT RESOLVED:

1. The American Psychiatric Association shall make a copy of the APA Director & Officer Liability policy available upon request by District Branch.

2. The American Psychiatric Association shall amend the APA Operations manual to include information regarding indemnification of district branches for liability related to ethics investigations.

3. The American Psychiatric Association shall develop a written policy and protocol to provide expenditures to district branches specifically to support ethics investigations.

AUTHOR:
Annette Hanson, M.D., Representative, Maryland Psychiatric Society

SPONSORS:
Jennifer Palmer, M.D., APA Member
Brian Zimnitzky, M.D., Representative, Maryland Psychiatric Society

ESTIMATED COST:
Author: $0
APA: $385

ESTIIMATED SAVINGS: None

ESTIMATED REVENUE GENERATED: None

ENDORSED BY:

KEY WORDS: ethics, governance, policies and procedures, liability, district branch

APA STRATEGIC PRIORITIES: Advancing Psychiatry, Education

REVIEWED BY RELEVANT APA COMPONENT:

References:
American Psychiatric Association Bylaws. Accessed at: https://www.psychiatry.org/File%20Library/About-APA/Organization-Documents-Policies/operations-manual.pdf on September 14, 2017

Action Paper Worksheet
2017 Action Paper Budget Estimate

Action Paper Title:	12.N: Civil Liability Coverage for District Branch Ethics Investigations
Action Paper Author(s):	Annette Hanson, M.D., Representative, Maryland Psychiatric Society
Phone/email:	annette.hanson@maryland.gov
APA Admin. Name:	Alison Crane (Office of the General Counsel - Colleen Coyle)
Phone/email	703-907-7306; acrane@psych.org

Attendance Summary:	**Author**	**APA Administration**
Number of Component Members	-	-
Number of Staff	1	-
Number of Non-Staff	1	-
Total	**2**	**-**

Author Estimate:

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

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

Staff Costs:

	Description:	
1	Any web site or bylaw modifications can be done during the routine course of governance meetings	-
2	The existing D&O policy can be scanned into a PDF file and uploaded to the website. Policy development shall be per usual protocols.	-
3		-
	Total Staff Costs	-
Other Costs not included above:		
	No extra expenditures should be required for bylaw modification and distribution of information.	-
	Total Author Estimate	**-**

APA Administration Estimate:

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

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

Staff Costs:

	Description:	
1	The policy documents are confidential and it would be inadvisable for them to be made widely available.	77
2	Bylaw amendment not proper avenue; if indemnity policy is desired to be in writing, Board should direct it be placed within the Ops Manual.	231
3	APA paying retention in event of legal proceeding can be assured, but the cost of funding entire ethics process at District Branch level cannot be estimated.	77
	Total Staff Costs	**385**
Other Costs not included above:		
	Resolution 3 askd for both assurance APA will pay retention in even of legal proceeding and for APA to fund ethics process at each District Branch, but the cost of this is not possible for staff to estimate.	-
	Total Administration Estimate	**385**

Action Paper 12.N: Civil Liability Coverage for District Branch Ethics Investigations

APA Administration Feedback:

DEPARTMENT: Office of General Counsel

EXPLANATION OF COST:
This Action Paper calls for three separate resolutions. The rationale behind the cost estimate attributable to each is described below.

(1) For Resolution #1, APA notes that the actual policy documents are confidential and not all portions of APA's policies apply to the District Branches. A summary has already been provided of the coverage relevant to this Action Paper. Every year, APA counsel meets with District Branch executives and again with District Branch executives and new presidents to explain the D&O coverage. APA answers all questions DB's bring to it regarding coverage, but APA's insurance counsel recommends not widely sharing entire policies.

(2) For Resolution #2, amendment of the bylaws would not be the proper avenue to put such information in writing. APA's bylaws are the governance documents for APA. The requested information is a process, not a governance issue. (The indemnification language in the bylaws already only addresses indemnification of APA's governing body). The appropriate place for such language would be the APA Operations Manual. APA has repeatedly and consistently informed district branches in writing and verbally that APA will pay the retention if the District Branch is sued in an ethics case and the District Branch followed APA's procedural rules.

(3) Resolution #3 asks for APA both (i) to fund the entire ethics process at the District Branch level and (ii) to provide assurance that APA would pay the retention in the event of a legal proceeding. With regard to providing assurance that APA would pay the retention in the event of a legal proceeding, see number 2 above. With respect to funding the entire ethics process at the District Branch, it is not possible for staff to estimate the cost of an ethics investigation at the District Branch level as each District Branch handles these differently.

Attachment #14
Item 2017A2 12.O
Assembly
November 3-5, 2017

ACTION PAPER
FINAL

TITLE: Council on Women's Mental Health

WHEREAS:
1. There is no current American Psychiatric Association council on women's mental health

2. There was a component titled "Committee on Women" which was a subcommittee under the Council on Minority Mental Health and Health Disparities

3. This committee was sunset in 2009 when the APA reorganized its components

4. The recommendation and subsequent action was for the committee's charge to be subsumed by the Council on Minority Mental Health and Health Disparities

5. Women comprise approximately half of the US population hence not making them appropriately represented as a minority group

6. Medical illnesses affect women and men differently

7. Gender differences exist between men and women particularly in the rates of common mental health disorders

8. Female reproductive hormones affect the production and transportation of neurotransmitters responsible for mood and are implicated in mood changes in women

9. Reproductive health issues are highly emotionally charged and closely linked to a woman's femininity, sexuality attractiveness, and value resulting in psychological conflict

BE IT RESOLVED:
The American Psychiatric Association develop a Council on Women's Mental Health to address mental health conditions and health related disorders pertaining to mental health that affect women.

AUTHOR:
Nazanin E. Silver, M.D., MPH, FACOG, RFM Representative, Area 3

SPONSORS:
Joseph C. Napoli, M.D., DLFAPA, Representative, Area 3
Annette Hanson, M.D., Representative, Maryland Psychiatric Society
Judy Glass, M.D., FRCP, FAPA, Representative, Quebec and Eastern Canada District Branch
Mary Anne Albaugh, M.D., Representative, Pennsylvania Psychiatric Society

Lisa K. Catapano-Friedman, M.D., DLFAPA, Representative, Vermont Psychiatric Association
Mary Jo Fitz-Gerald, M.D., MBA, DFAPA, Representative, Louisiana Psychiatric Medical Association
Annya Tisher, M.D., Representative, Maine Association of Psychiatric Physicians
Leslie Gise, M.D., Representative, Hawaii Psychiatric Medical Association
Samina Aziz, M.D., Representative, North Carolina Psychiatric Association
Dionne Hart, M.D., Representative, Minnesota Psychiatric Society
Ranga N. Ram, M.D., DFAPA, Representative, Psychiatric Society of Delaware
Manuel Reich, M.D., Representative, Pennsylvania Psychiatric Society
Daniella Palermo, M.D., RFM Representative, Area 1
Stephen V. Marcoux, M.D., RFM Representative, Area 5
David Braitman, M.D., RFM Representative, Area 7

ESTIMATED COST:
Author: $ 15,876
APA: $31,510

ESTIMATED SAVINGS: Addressing mental disorders and health issues relating to mental health in women, medical education and research would result in better quality and access to care. This type of personalized medicine would then reduce the societal cost of women not receiving health care that is specific to them resulting in a reduction in health care cost.

ESTIMATED REVENUE GENERATED: none

ENDORSED BY: Assembly Committee of Resident-Fellow Members, Area 3 Council

KEY WORDS: women, women's mental health, women's mental health issues

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

REVIEWED BY RELEVANT APA COMPONENT:

Action Paper Worksheet
2017 Action Paper Budget Estimate

Action Paper Title:	12.O: Council on Women's Mental Health
Action Paper Author(s):	Nazanin E. Silver, M.D., MPH, FACOG, RFM Representative, Area 3
Phone/email:	646-341-2011/nesilver12@gmail.com
APA Admin. Name:	Laurie McQueen, Association Governance
Phone/email	lmcqueen@psych.org

Attendance Summary:	**Author**	**APA Administration**
Number of Component Members	12	12
Number of Staff	-	-
Number of Non-Staff	-	2
Total	**12**	**14**

Author Estimate:

Travel Budget:	No. of Attendees	Airfare	Hotel/Lodging	Ground Transportation	Per Diem/Meals	Total
Meeting 1	12	$5,100	$7,800	$1,200	$1,776	$15,876
Meeting 2	-	-	-	-	-	-
Total Travel Budget		5,100	7,800	1,200	1,776	$15,876

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

Staff Costs:		
Description:		
1	-	-
2	-	-
3	-	-
Total Staff Costs		-
Other Costs not included above:		
0		-
	Total Author Estimate	**15,876**

APA Administration Estimate:

Travel Budget	No. of Attendees	Airfare	Hotel/Lodging	Ground Transportation	Per Diem/Meals	Total
Meeting 1	14	$5,950	$7,800	$1,200	$1,776	$16,726
Meeting 2	-	-	-	-	-	-
Total Travel Budget		**5,950**	**7,800**	**1,200**	**1,776**	**16,726**

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

Staff Costs:		
Description:		
1 A new council will require additional APA Administrative staff. Approximately 16 hours per month.		14,784
2	-	-
3	-	-
Total Staff Costs		**14,784**
Other Costs not included above:		
0		-
	Total Administration Estimate	**31,510**

Rvsd. April 2017

Action Paper 12.O: Council on Women's Mental Health

APA Administration Feedback:

DEPARTMENT: Association Governance/Division of Diversity and Health Equity (DDHE)

As a note, APA has a Caucus of Women Psychiatrists that addresses similar principles of Women's Mental Health. Most recent products of the Caucus of Women Psychiatrists include best practices for "Working with Women Patients" housed at APA's Cultural Competency Website. In addition, the Caucus sponsors sessions at Annual Meetings on women mental health and career advancement of women psychiatrists.

EXPLANATION OF COST:

The costs provided by the Administration reflect the estimated costs of a council for fiscal year 2018. A standard council has 12 members and may have two consultants, who, if appointed, are funded to attend the September Components Meetings. As this would be a new component, administrative staff would need to be hired. It is estimated that at least 4 hours per week per month of administrative staff time would be incurred for this council.

If the action paper is approved and then approved by the Board of Trustees, it is anticipated that a council could be established as of May 2018.

Attachment #15
Item 2017A2 12.P
Assembly
November 3-5, 2017

ACTION PAPER
FINAL

TITLE: Addressing the Negative Impact of the Rule of 95 on Dues Revenue

WHEREAS:
WHEREAS, in 1992, a ballot initiative was approved by APA membership which modified the dues exemption granted to Life Members. Life Members (now including Life Members, Life Fellows and Distinguished Life Fellows) are those whose years of "active membership" plus their age equal 95. During the first five years of Life Member status, Life Members pay 2/3 of the highest General Member dues. For the second five years, they pay 1/3 of the highest General Member dues and thereafter, Life Members are exempt from dues altogether. These reductions and the exemption went into effect for the 1993 dues year and are binding on both the APA and its DBs.

WHEREAS, as shown on Table 1, over the nine-year period from 2009 through 2017, there has been a decline in the number of members paying the highest dues, i.e., General Members, Fellows and Distinguished Fellows. During this period, APA has experienced a 2.4% decline in total dues paying members, an 11.48% decline in members paying the highest dues (General Members, Fellows and Distinguished Fellows).

WHEREAS, although since 2013 APA has been able to grow total membership in all membership categories and has kept dues revenue relatively flat, starting in 2017 and beyond, APA will not be able to grow fast enough to replace members moving into dues exemption categories with 100% dues paying members. The result will likely be a decline of $250,000 in dues revenue each year moving forward.

WHEREAS, due to the Rule of 95 in 2017 and for the next five years through 2022, an average of 630 members will enter the reduced dues membership category. In addition, over the same six year period an average of 389 members will each year become dues exempt. The total revenue loss in 2017 due to the Rule of 95 will be approximately $256,824. This dues loss will continue through 2022 and beyond. Currently, there are approximately 4,585 members in life status with reduced dues and another 4,991 who are dues exempt.

WHEREAS, Table 2 includes a comparison between 2009 Maximum Dues Yield and 2017 Maximum Dues Yield and includes the percentage of members in each of the four dues payment categories and then dues yield for each category for each year (assuming 100% payment in each category). Although APA GM dues were increased by 6.5%, the maximum dues yield dropped by 2% reflecting the impact of the Rule of 95.

WHEREAS, Hypothetical A on Table 2 assumes: 2009 total membership (i.e., 26,488); 2009 GM dues (i.e., $540); and 2017 membership category distribution. Hypothetical A shows that, even if APA had maintained its number of members, with 2009 dues of $540, the re-distribution of members using 2017 percentages (reflecting the impact of the Rule of 95) would have resulted in a loss of revenue of over $700,000 compared to 2009 Projected Maximum Dues. This $700,000 revenue loss is entirely due to the Rule of 95.

WHEREAS, Hypothetical B assumes: 2017 total membership (i.e., 26,029); 2017 GM dues (i.e., $575); and 2009 member category distribution. Hypothetical B demonstrates that even with the slightly reduced number of members in 2017 and with the increased 2017 dues, if APA had just maintained the same distribution of members as in 2009, dues revenue would have increased by approximately $500,000 over the 2017 Maximum Dues Yield. The fact that APA did not achieve this increase in revenue is entirely due to the Rule of 95.

WHEREAS, members who moved to life member status in 2009 are only the first wave of many years of APA baby boomers who will be eligible for reduced dues status starting in 2009 and for years to come. The data on the impact of the Rule of 95 in the next five years confirms that the loss of revenue from the Rule of 95 is continuing and growing over time.

WHEREAS, there are many options that might be considered to address the Rule of 95 including:

- Eliminating the Rule of 95
- Freezing life member status for those who have achieved it already (at their current dues levels) so that their dues don't increase, but don't decrease further in the future
- Eliminating the Rule of 95 entirely for those who have not yet reached life status
- Increasing the combined age plus membership years from 95 to 105 or more.
- Leaving the Rule of 95 as is, but extending the period of time for each stage from five years to ten years.
- Adding an income requirement to life status that would require that a member's income from practice or medical employment not exceed $25,000 or some other amount.
- Expanding membership categories to create new sources of dues revenue.

WHEREAS, the negative impact of the Rule of 95 is even greater on DBs and state associations because these components derive essentially all of their income (more than 90%) from membership dues while membership dues are only 30% of the APA's income.

WHEREAS, APA members need financially strong state organizations to address local challenges including psychology prescribing, scope of practice encroachment and parity enforcement.

BE IT RESOLVED:
That the Board of Trustees (BOT) establish a Task Force charged with reviewing the Rule of 95 and making recommendations to be presented to the BOT in time for possible action by the BOT and the Assembly at the November 2018 Assembly Meeting. Membership on this Task Force could be drawn from the BOT, APA management, the Assembly leadership, the Membership Committee, and DB and State Association leadership and staff and shall include representation from the Senior Psychiatrists, RFMs, and ECPs.

AUTHORS:
Seeth Vivek, M.D., Representative, Area 2
Jeffrey Borenstein, M.D., Deputy Representative, Area 2

ESTIMATED COST:
Author: $5,005
APA: $14,630

ESTIMATED SAVINGS: $0

ESTIMATED REVENUE GENERATED: If adopted, APA, DBs and state associations would generate substantial additional revenue.

ENDORSED BY:

KEY WORDS: Dues, Revenue, Rule of 95, Life Member, Membership

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

REVIEWED BY RELEVANT APA COMPONENT:

Action Paper Worksheet
2017 Action Paper Budget Estimate

Action Paper Title:	12.P: Addressing the Negative Impact of the Rule of 95 on Dues Revenue
Action Paper Author(s):	Seeth Vivek, M.D., Representative, Area 2
Phone/email:	718-206-7165/seethvivek@gmail.com
APA Admin. Name:	Stephanie Auditore, Membership Department
Phone/email	703-907-7833/sauditore@psych.org

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

Author Estimate:

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

Non-Staff Costs:	
LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	**-**
Staff Costs:	
Description:	
1 Staff cost for arranging and participating in conference calls, reviewing data, updating membership information, etc.	5,005
2	-
3	-
Total Staff Costs	5,005
Other Costs not included above:	
0	-
Total Author Estimate	**5,005**

APA Administration Estimate:

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

Non-Staff Costs:	
LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	**-**
Staff Costs:	
Description:	
1 Facilitating meetings, completing financial analysis and modeling, updating and testing database.	14,630
2	-
3	-
Total Staff Costs	**14,630**
Other Costs not included above:	
0	-
Total Administration Estimate	**14,630**

Rvsd. April 2017

Action Paper 12.P: Addressing the Negative Impact of the Rule of 95 on Dues Revenue

APA Administration Feedback:

DEPARTMENT: Membership Department

EXPLANATION OF COST:

Facilitating the review of the Rule of 95 and implementing any change to it would require extensive staff time. In addition to the items noted by the authors, we anticipate a substantial amount of time would need to be dedicated to the analysis and modeling of the revenue impacts of proposed Rule of 95 changes. In addition, any changes to the Rule of 95 would need to be accompanied by a significant communication strategy to affected members as well as thorough testing within the Membership Database.

APA Official Actions

Position Statement on the Need to Maintain Long-Term ~~Mental Hospital~~ Care Facilities ~~(1974)~~ for Certain Individuals with Serious Mental Illness

Approved by the Board of Trustees, XXXX
Approved by the Assembly, XXXX

"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*

~~This statement was approved by the Executive Committee of the Board of Trustees of the American Psychiatric Association on February 18, 1974, upon recommendation of the Council of Professions and Associations. It was prepared by the Committee on Liaison with the American Hospital Association. The statement was endorsed by the Council on Mental Health Services in January 1974 and by the Executive Committee of the Assembly of District Branches in February 1974.~~

(Adopted from the Position Statement on the Need to Maintain Long-Term Inpatient Psychiatric Hospitals, 1974; Position Statement on Federal Exemption from Medicaid Institutions for Mental Disease, 2014; and US House of Representatives Committee on Energy and Commerce "Where have all the Gone: Examining the Psychiatric Bed Shortage," Jeffery Geller, MD, MPH, 2014).

~~While we applaud the trend toward the growing adequacy of community resources and the concurrent reduction of the patient population in public mental hospitals, we now~~ The American Psychiatric Association views with ~~considerable~~ concern the trend toward the phasing out of the capacity for providing long-term ~~inpatient~~ care and treatment ~~for the~~ to seriously mentally ill[1] (SMI) individuals who have demonstrated an inability to maintain life in the community. We ~~or disabled. The American Hospital Association and the American Psychiatric Association~~ recognize and support the ~~importance of continuing to develop and implement~~ continued development and implementation of new and innovative community programs and treatment modalities for the ~~mentally disabled.~~ SMI population. However, at the same time it is essential that we not lose sight of the continuing need for a full ~~range or~~

[1] Serious mental illness among people ages 18 and older is defined at the federal level as having, at any time during the past year, a diagnosable mental, behavior, or emotional disorder that causes serious functional impairment that substantially interferes with or limits one or more major life activities. (http://www.samhsa.gov/disorders)

spectrum of services which, for a small percentage of patients, includes intermediate and long-term care in a structured hospital-type environment.

~~Our reasons for our concern include:~~

~~1. Dehumanization.~~ Financial pressure to discharge patients from the ~~public mental~~ psychiatric hospital setting too often results in ~~discharging~~ patients ~~without adequate planning, which in turn results in their~~ living in substandard and dehumanizing circumstances ~~be it~~. Patients may end up in correctional facilities, in nursing ~~homes,~~ or boarding homes~~, or~~ that are poorly equipped for SMI tenants, or in the streets ~~of a ghetto~~. They may seek care through high utilization of emergency room and acute care psychiatric inpatient services. A portion of the ~~significantly impaired psychiatric~~ SMI patient population ~~will continue to~~ lacks the capability of maintaining even a marginal adjustment to the community, in spite of vigorous therapeutic efforts.

~~2. Unbalanced programs. If the mental health center or other mental health resource attempts to meet the demands for service for people who have been inappropriately placed in the community, it finds it has neither the funds nor the staff to do so without diverting these resources from other patients who could be helped, or otherwise restricting the other services of a mental health center. The unfortunate end result can be a change in the primary mission of mental health centers.~~

Community mental health centers should be funded and staffed to provide ~~a substantial service to the chronically mentally disabled who~~ full wrap-around services to the segment of the SMI population that can be successfully maintained in the community~~; but.~~ However, there must remain the ~~capability for~~ option of providing intermediate and long-term ~~inpatient~~ treatment in a structured hospital-type environment for those that ~~segment of the patient population which~~ cannot maintain even a marginal adjustment ~~in~~ to the community.

Attachment #17

Assembly
November 3-5, 2017
Washington, D.C.

DRAFT SUMMARY OF ACTIONS

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2017 A2 4.B.1	Retain Position: *Endorsement of United States Ratification of the Convention of the Rights of the Child*	The Assembly voted, on its Consent Calendar, to approve the retention of the position: *Endorsement of United States Ratification of the Convention of the Rights of the Child*.	Board of Trustees, December 2017 FYI- Joint Reference Committee, February 2018
2017 A2 4.B.2	Revised Position Statement: *Need to Maintain Long-Term Care Facilities for Certain Individuals with Serious Mental Illness*	The Assembly **did not** approve the Revised Position Statement: *Need to Maintain Long-Term Care Facilities for Certain Individuals with Serious Mental Illness*.	Joint Reference Committee, February 2018
2017 A2 4.B.3	Retire 2010 Position Statement: *Psychiatry and Primary Care Integration across the Lifespan*	The Assembly voted to approve the retirement of the 2010 Position Statement: *Psychiatry and Primary Care Integration across the Lifespan*.	Board of Trustees, December 2017 FYI- Joint Reference Committee, February 2018
2017 A2 4.B.4	Retain 2011 Position Statement: *Remuneration for Psychiatrists' Time Performing Utilization Review (Endorsement of AMA policy H-385.951)*	The Assembly voted, on its Consent Calendar, to approve the retention of the 2011 Position Statement: *Remuneration for Psychiatrists' Time Performing Utilization Review (Endorsement of AMA policy H-385.951)*.	Board of Trustees, December 2017 FYI- Joint Reference Committee, February 2018
2017 A2 4.B.5	Retain 2014 Position Statement: *Universal Access to Health Care*	The Assembly voted, on its Consent Calendar, to approve the retention of the 2014 Position Statement: *Universal Access to Health Care.*	Board of Trustees, December 2017 FYI- Joint Reference Committee, February 2018

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2017 A2 4.B.6	Proposed Position Statement on *Human Rights*	The Assembly voted to approve the Proposed Position Statement on *Human Rights*.	Board of Trustees, December 2017 FYI- Joint Reference Committee, February 2018
2017 A2 4.B.7	Proposed Position Statement: *Domestic Violence Against Women*	The Assembly voted to approve the Proposed Position Statement: *Domestic Violence Against Women.*	Board of Trustees, December 2017 FYI- Joint Reference Committee, February 2018
2017 A2 4.B.8	Proposed Position Statement: *Prevention of Violence*	The Assembly voted to approve the Proposed Position Statement: *Prevention of Violence*.	Board of Trustees, December 2017 FYI- Joint Reference Committee, February 2018
2017 A2 4.B.9	Proposed Position Statement: *Human Trafficking*	The Assembly voted to approve the Proposed Position Statement: *Human Trafficking*.	Board of Trustees, December 2017 FYI- Joint Reference Committee, February 2018
2017 A2 4.B.10	Proposed Position Statement: *Police Interactions with Persons with Mental Illness*	The Assembly voted to approve the Proposed Position Statement: *Police Interactions with Persons with Mental Illness.*	Board of Trustees, December 2017 FYI- Joint Reference Committee, February 2018
2017 A2 4.B.11	Proposed Position Statement: *Lengthy Sentences Without Parole for Juveniles*	The Assembly voted to approve the Proposed Position Statement: *Lengthy Sentences Without Parole for Juveniles*.	Board of Trustees, December 2017 FYI- Joint Reference Committee, February 2018
2017 A2 4.B.12	Retire 2011 Position Statement: *Review of Sentences for Juveniles Serving Lengthy Mandatory Terms of Imprisonment*	The Assembly voted to approve the retirement of the Position Statement: *Review of Sentences for Juveniles Serving Lengthy Mandatory Terms of Imprisonment*.	Board of Trustees, December 2017 FYI- Joint Reference Committee, February 2018

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2017 A2 4.B.13	Retain 2012 Position Statement: *Segregation of Prisoners with Mental Illness*	The Assembly voted, on its Consent Calendar, to approve the retention of the 2012 Position Statement: *Segregation of Prisoners with Mental Illness*.	Board of Trustees, December 2017 FYI- Joint Reference Committee, February 2018
2017 A2 4.B.14	Retain 2012 Position Statement: *Assessing the Risk for Violence*	The Assembly voted, on its Consent Calendar, to approve the retention of the 2012 Position Statement: *Assessing the Risk for Violence*.	Board of Trustees, December 2017 FYI- Joint Reference Committee, February 2018
2017 A2 4.B.15	Retain 2012 Position Statement: *Firearms Access: Inquiries in Clinical Settings*	The Assembly voted, on its Consent Calendar, to approve the retention of the 2012 Position Statement: *Firearms Access: Inquiries in Clinical Settings*.	Board of Trustees, December 2017 FYI- Joint Reference Committee, February 2018
2017 A2 4.B.16	Retain 2007 Position Statement: *Use of Jails to Hold Persons Without Criminal Charges Who are Awaiting Civil Psychiatric Hospital Beds*	The Assembly voted, on its Consent Calendar, to approve the retention of the 2007 Position Statement: *Use of Jails to Hold Persons Without Criminal Charges Who are Awaiting Civil Psychiatric Hospital Beds*.	Board of Trustees, December 2017 FYI- Joint Reference Committee, February 2018
2017 A2 4.B.17	Retain 2007 Position Statement: *Psychiatric Services in Jails and Prisons*	The Assembly voted, on its Consent Calendar, to approve the retention of the 2007 Position Statement: *Psychiatric Services in Jails and Prisons*.	Board of Trustees, December 2017 FYI- Joint Reference Committee, February 2018
2017 A2 4.B.18	Retain 1993 Position Statement: *Homicide Prevention and Gun Control*	The Assembly voted to approve the retention of the 1993 Position Statement: *Homicide Prevention and Gun Control*.	Board of Trustees, December 2017 FYI- Joint Reference Committee, February 2018
2017 A2 5.A	Will the Assembly vote to approve the minutes of the May 19-21, 2017, meeting?	The Assembly voted to approve the Minutes & Summary of Actions from the May 19-21, 2017 Assembly meeting.	Chief of Staff • Association Governance
2017 A2 6.B	Will the Assembly vote to approve the Consent Calendar?	Item 2017A2 4.B.18 was removed from the consent calendar. The Assembly approved the consent calendar as amended.	Chief of Staff • Association Governance

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2017 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 of Staff • Association Governance
2016 A2 7.A.1	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 2018 Assembly election is as follows: *Speaker-Elect*: C. Deborah Cross, M.D., Area 2 Paul O'Leary, M.D., Area 5 *Recorder*: Jacob Behrens, M.D., Area 4 Stephen Brown, M.D., Area 7 Seeth Vivek, M.D., Area 2	Chief of Staff • Association Governance
2017 A2 7.A.2	Special Election of Assembly Recorder	The Assembly voted to elect the following candidate as Recorder of the Assembly from November 2017 to May 2018: Paul O'Leary, M.D., Area 5	Chief of Staff • Association Governance
2017 A2 12.A	Designation of Psychiatry as Primary Care for Any Medical School Scholarships Requiring Primary Care Service	The Assembly voted to approve action paper 2017A2 12.A, which asks that the APA advocate for state and federal legislation labeling psychiatry as primary care for any medical school scholarships requiring primary care residencies and service to a community.	Joint Reference Committee, February 2018
2017 A2 12.B	Medical School Loan Repayment Subsidies for Psychiatrists Practicing in Community Mental Health Centers and State Psychiatric Facilities	The Assembly voted to approve action paper 2017A2 12.B, which asks that the APA advocate for state and federal legislation to provide funds to help repay loans for psychiatrists in community mental health centers and state psychiatric hospitals.	Joint Reference Committee, February 2018

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2017 A2 12.C	Transitional Care Services Post-Psychiatric Hospitalization	The Assembly voted to approve action paper 2017A2 12.C, which asks: That the American Psychiatric Association advocate to national policymakers to increase federal funding for psychiatric access-to-care/transition-based clinics aimed at readily available short-term coverage in psychiatric care for uninsured, low-income, and serious mental illness populations. That the American Psychiatric Association promotes the concept of a transitional care based clinic model, aimed at bridging the gap between hospitalization and outpatient follow-up, to ACGME/GME leadership, in an effort to grow interest in implementation of such clinics in GME based settings.	Joint Reference Committee, February 2018

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2017 A2 12.D	Enacting APA Positions: State Medical Board Licensure Queries	The Assembly voted to approve action paper 2017A2 12.D, which asks that: 1. The American Psychiatric Association query the licensing boards (M.D., D.O) and, in each state, territory or licensure jurisdiction query their compliance with APA policy and with the ADA act allowing questions only about current mental and physical impairment affecting current ability to practice medicine. 2. The American Psychiatric Association notify each Board of Medicine in writing whether or not their medical licensure application(s) reflect current APA position regarding queries about their applicants' mental health history. The APA will notify each District Branch of the APA of the status of the Board of Medicine or Board of Osteopathic Medicine in its jurisdiction, and will publish on the APA website a list of jurisdictions and whether or not their policies on queries are congruent with the Position of the APA. 3. The American Psychiatric Association notify the Federation of State Medical Boards Work Group of its Position Statement entitled *Position Statement on Inquiries about Diagnosis and Treatment of Mental Disorders in Connection with Professional Credentialing and Licensing*, adopted in 2015, in advance of the January 2018 meeting of the FSMB Work Group.	Joint Reference Committee, February 2018
2017 A2 12.E	Recognition of Psychiatric Expertise: Efficiency and Sufficiency	The Assembly voted to approve action paper 2017A2 12.E, which asks that: 1. APA encourages the AMA to adopt a policy that the MOC should not be a requirement for maintenance of licensure, hospital privileges, insurance credentialing or employment 2. The APA should support a SA-CME learning option in lieu of the 10-year exam and encourage the ABPN to accelerate the timeline for reform of the MOC process. 3. The MOC should not be part of the licensure requirements for interstate compacts.	Joint Reference Committee, February 2018

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2017 A2 12.F	APA Member Survey on Medical Aid in Dying as Option for End-of-Life Care	The Assembly did not approve item 2017A2 12.F.	N/A
2017 A2 12.G	Conflicts of Interest Not Limited to Pharmaceutical Companies	The Assembly voted to approve action paper 2017A2 12.G, which asks that the American Psychiatric Association, through its Annual Meeting Scientific Program Committee, review the current mechanism for reporting conflicts of interest, which mainly are limited to pharmaceutical companies, with an eye toward encouraging the reporting of conflicts which extend beyond pharmaceutical companies.	Joint Reference Committee, February 2018
2017 A2 12.H	Non-Physician Registration Fee for Annual Meetings	The Assembly voted to approve action paper 2017A2 12.H, which asks that allied health professionals pay the same registration fee as non-member physicians at the Annual Meeting.	Joint Reference Committee, February 2018
2017 A2 12.I	APA Position Statement Strongly Recommending Twelve Weeks of Paid Parental Leave	The Assembly voted to approve, **as a position statement**, action paper 2017A2 12.I, which asks that the APA approve and adopt the attached position statement recommending 12 weeks of paid parental leave.	Joint Reference Committee, February 2018
2017 A2 12. J	Helping Members Join Caucuses	The Assembly voted, on its Consent Calendar, to approve action paper 2017A2 12.J, which asks that the APA new member and membership renewal emails have a direct link to joining a caucus.	Joint Reference Committee, February 2018
2017 A2 12.K	Achieving Congruence between the APA Commentary on Ethics in Practice and the AMA Principles of Medical Ethics Concerning Ethical Obligations of Psychiatrists Making Benefit Determination Decisions	The Assembly voted to approve action paper 2017A2 12.K, which asks that the APA will direct the authors of the APA *Commentary on Ethics in Practice* to bring its language into congruence with that of the AMA *Principles of Medical Ethics 10.1.1*, including a thoughtful exploration of the complexities involved. This would apply to any psychiatrist making any benefit and/or policy determinations.	Joint Reference Committee, February 2018

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2017 A2 12.L	Adopting an APA Position Statement Supporting Implementation of the Mental Health Parity and Addiction Equity Act (MHPAEA or parity law)	The Assembly voted to approve action paper 2017A2 12.L, which asks: A. That the Assembly recommend adoption of an APA position statement, appropriately formatted, as follows: It is the position of the APA that: 1. Insurance and/or other third party MHSUD utilization management and medical necessity criteria should be developed by individuals who are trained as psychiatrists or by work groups that include psychiatrists. 2. Insurance and/or other third party MHSUD utilization management and medical necessity criteria should be in full compliance with requirements of applicable state and federal parity laws, including with MHPAEA requirements that quantitative limits (QTLs) and non-quantitative limits (NQTLs) for MHSUD care should be comparable to and no more stringent than medical necessity criteria for medical and surgical care, except as allowed by the law. 3. Insurance companies and/or other third parties offering coverage for both medical/surgical and MHSUD treatment—including those that do so through MHSUD "carve outs"—have an obligation to provide to their medical directors, psychiatrist reviewers, other clinicians who make benefit determinations, and to treating clinicians and to covered individuals, current and accurate information about whether and how their MHSUD utilization review and medical necessity criteria comply with MHPAEA QTL and NQTL requirements. B. The Assembly will directly refer this action paper outlining specific elements of a position statement to the Board of Trustees for adoption at their next meeting, including holding a separate vote to this effect, if required by Assembly rules.	Joint Reference Committee, February 2018

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2017 A2 12.M	Joint Meeting of the Council on Minority Mental Health and Health Disparities and the Assembly Committee of Representatives of Minority/ Underrepresented Groups	The Assembly voted to approve action paper 2017A2 12.M, which asks that 1) That the American Psychiatric Association will support another Joint Meeting of the Council on Minority Mental Health and Health Disparities and the Assembly Committee of Representatives of Minority/Underrepresented Groups, in alignment with the APA's fourth strategic initiative addressing diversity. 2) That such meeting will take place during the Annual September Components Meeting of the American Psychiatric Association in September 2018. [**N.B.:** At its meeting in October, the Joint Reference Committee recommended that the Board of Trustees approve the request for the seven M/UR Caucus Assembly Representatives (or their designees) to meet with the Council at the 2018 September Components Meeting at the same level of funding as this year at approximately $9,000 from the Assembly Budget and additional costs for members of the Council on Minority Mental Health and Health Disparities from the component's budget. This action will be voted on at the December 2017 Board of Trustees meeting.]	Joint Reference Committee, February 2018

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2017 A2 12.N	Civil Liability Coverage for District Branch Ethics Investigations	The Assembly voted to approve action paper 2017A2 12.N, which asks that: 1. The American Psychiatric Association shall make a copy of the APA Director & Officer Liability policy available upon request by District Branch. 2. The American Psychiatric Association shall amend the APA Operations manual to include information regarding indemnification of district branches for liability related to ethics investigations. 3. The American Psychiatric Association shall develop a written policy and protocol to provide expenditures to district branches specifically to support ethics investigations.	Joint Reference Committee, February 2018
2017 A2 12.O	Council on Women's Mental Health	The Assembly voted to approve action paper 2017A2 12.O, which asks that the American Psychiatric Association develop a Council on Women's Mental Health to address mental health conditions and health related disorders pertaining to mental health that affect women.	Joint Reference Committee, February 2018
2017 A2 12.P	Addressing the Negative Impact of the Rule of 95 on Dues Revenue	The Assembly voted to approve action paper 2017A2 12.P, which asks that the Board of Trustees (BOT) establish a Task Force charged with reviewing the Rule of 95 and making recommendations to be presented to the BOT in time for possible action by the BOT and the Assembly at the November 2018 Assembly Meeting. Membership on this Task Force could be drawn from the BOT, APA management, the Assembly leadership, the Membership Committee, and DB and State Association leadership and staff and shall include representation from the Senior Psychiatrists, RFMs, and ECPs.	Joint Reference Committee, February 2018

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2017 A2 14.A	New Business: Addressing the Negative Impact of New Joint Commission and CMS Policies on Ligature Risk on Inpatient Psychiatric Units	The Assembly voted to approve new business item 2017A2 14.A, which asks that the American Psychiatric Association immediately request that CMS and the Joint Commission delay implementation of the new ligature risk standards on inpatient psychiatric units pending completion of the CMS process to assess ligature risk and to request that CMS include representatives from American Hospital Association, AMA, APA and other appropriate stakeholders in its assessment of ligature risks and development of appropriate accreditation standards.	Board of Trustees, December 2017

Executive Summary
Council on Addiction Psychiatry
Andrew J. Saxon, MD, Chair

The Council on Addiction Psychiatry provides psychiatric leadership in the growing field of prevention and treatment of addictive disorders. The council works to develop and clarify the role of the psychiatrist in the prevention and treatment of addictive disorders and formulates policy recommendations related to these disorders. The council cooperates with other APA bodies to enhance the quality of medical education in addictive disorders at all levels.

Members of the Council on Addiction Psychiatry have focused their efforts on reviewing position statements and implementing their newly-approved three-year workplan. Specifically, the Council is moving forward position statements on Physician Health Services, Prescription Drug Monitoring Programs, and Involuntary Commitment for Individuals with Substance Use Disorders.

The Council continues to be active in providing feedback on the Trump administration's major actions on substance use disorders. These include:

- APA's public comments to the President's Commission on Combating Drug Addiction and the Opioid Crisis
- The National Institute on Alcohol Abuse and Alcoholism's new Treatment Navigator Tool
- New state Medicaid guidance to include residential treatment for opioid use disorder and other substance use disorders.
- Final report from the President's Commission on Combating Drug Addiction and the Opioid Crisis
- APA's public comments on the Centers for Medicare and Medicaid Innovation's (CMMI) Request for Input on the future of CMMI and alternative payment models

The Council has also provided input to the Council on Quality by:

- Providing feedback on the National Quality Forum's proposed measure of safe use of concurrent opioid prescribing
- Providing feedback on a CMS measure on continuity of pharmacotherapy for opioid use disorder
- Nominating two members to the Workgroup on Performance and Quality Measurement to work on the measure concept on substance use disorders

The Council's workgroup on tobacco continues to be active, and its opioid workgroup is also being launched. *The status of the workgroups is included in a chart (Attachment A), along with an update of the position statements.*

Item 8.A
Joint Reference Committee
February 2018

Council on Addiction Psychiatry
Andy Saxon, MD, Chair
December 13, 2017, 2:00 PM – 3:00 PM EST

Draft Minutes

Council Members: Andrew Saxon, MD; John Renner, MD; Frances Levin, MD; Robert Feder, MD; Smita Das, MD, PhD, MPH; Oscar Bukstein, MD; Elie Aoun, MD; Jill Williams, MD; Jeff DeVido, MD
Consultants: Hector Colon-Rivera, MD; Ken Stoller, MD
Fellows: Daniella Palermo, MD; Siddarth Puri, MD, MA; Leila Vaez-Azizi, MD; Aldorian Chaney, MD, MPH
Absent: Annette Mathews, MD; Karen Drexler, MD; Shelly Greenfield, MD, MPH
APA Administration: Michelle Dirst; Kathy Orellana; Deana McRae; Roke Iko

DGR legislative update

- On the one-year anniversary of the signing of the 21st Century Cures Act, the Senate HELP Committee has been holding hearings to examine the first year of implementation.
    - The bill included $1 billion in new funding to address the opioid crisis. The first half of this new funding was to be rolled out this year, with the second half coming next year.
    - Senators from the states seeing the harshest impact of the crisis are pushing for additional funding funneled to their home states. Some members are encouraging a new funding formula, similar to the Sustainable Growth Rate (SGR) formula, to ensure the resources are reaching the most needy.
- Some members are also pushing for additional funding through mechanisms like the use of the Stafford Act or through an additional funding inclusion in the spending bill.
- APA is aggressively lobbying that more opioid funding be included in the year end spending bill.

PCSS webinar topics

- The Council offered up many potential topics for PCSS webinars next year including treating patients with both SUD and other disabilities, the management of people on opioid replacement therapy, the impending rise in cocaine use, findings from emergency rooms and police interactions, injectable naltrexone, and new apps and technologies for treating patients with SUD.
- Additional topics should be shared with APA staff.

Opioid Workgroup

- To kick off the workgroup's efforts, members should email Dr. Renner and Kathy Orellana to express interest or suggest potential members.
    - Dr. Renner will lead the workgroup, and we will invite Dr. Greenfield to join, given her expertise on SUD treatment for women.
    - The group will work on developing online resources and provide feedback on the ongoing policy discussion surrounding the opioid crisis.
    - Once we have a group established, we will set up a call in early 2018.
- APA staff appreciates the feedback the Council provided to the Opioid Commission.
    - We will be meeting with our DGR colleagues to integrate you feedback into the planning of our 2018 policy objectives.

- FDA Opioid Steering Committee
    - Under former Sec. Tom Price, HHS outlined a five-point strategy to combat the opioid crisis. The Opioid Policy Steering Committee was created to explore and develop additional tools and strategies for FDA to confront the crisis.
    - FDA is soliciting public comments focused on assessing benefit and risks in the opioid setting, promoting proper prescribing and dispensing, and prescriber education. The comments are due March 16, 2018.
    - FDA will be hosting a public meeting at the end of January and APA staff will attend and provide the Council with an update.
- Update on CMS's work to address the crisis
    - APA staff joined a listening session with senior staff at CMS to discuss what role they can play. They will be conducting a series of listening sessions with providers, pharma, and others to inform their learning and will continue to participate in these meetings and communicate our priorities.

Tobacco Workgroup

- The group's main focus has been to get back on track with the goals set in the original plan.
- Dr. Saxon and Dr. Zeidonis participated in the VA's Great American Smokeout Twitter Town Hall, along with the APA communications team. It's not certain what the impact of that will be, but it positions us well with our VA partners.
- Dr. Das and APA are working on setting up on online resource on TUD, modeled after the telepsychiatry toolkit.
- The group is also working with the National Partnership on Behavioral Health and Tobacco Use to engage district branches into our work.

Position Statement updates

- Prescription Drug Monitoring Programs
    - Following feedback from the Council, the updated version will go back to the Council on Healthcare Systems and Financing and the Council on Advocacy and Government Relations
- Physician Health Services in the Treatment of Substance Use Disorders/Addictions in Physicians
    - Dr. Devido will lead the work to update this position statement in the JRC's preferred format.
    - Dr. Stoller will follow-up with additional feedback.
- Involuntary Psychiatry Commitment for Individuals with Substance Use Disorders
    - Dr. Aoun will be working with the Council on Psych and Law, who are taking the lead on this position statement. Once updated with their members, the Council will get a chance to review the language.

General Council Workplan

- The Council is chipping away at the work in the plan, primarily through both the opioid and tobacco workgroups.
- Members will reconsider the rest of the plan's goals in the new year.
- Dr. Colon-Rivera shared that he has been working with the APA Foundation and Dan Gillison on a program focused on mental health prevention among high school students. Anyone interested in the program should follow up with him.

Position Statement Review (New and Existing) **Attachment A**

Position Statement	Reviewers	Action
Prescription Drug Monitoring Programs (PDMP)	Council on Advocacy and Government Relations Council on Healthcare Systems and Financing	The Council on Advocacy and Government Relations is currently reviewing the latest updates from both the Council on Addiction Psychiatry and the Council on Healthcare Systems and Financing. **The Council will finalize the statement and share with the JRC prior to the May meeting.**
Physician Health Services in the Treatment of Substance Use Disorders/Addictions in Physicians	Council on Psychiatry and Law	The Council has updated the statement to reflect the JRC preferred format. The Council on Psychiatry and Law will review the latest version and provide feedback. **The Council will finalize the statement and share with the JRC prior to the May meeting.**
Involuntary Psychiatry Commitment for Individuals with Substance Use Disorders	From the Council on Psychiatry and Law	The Council on Psychiatry and Law is now the lead on this statement. **The Council will review and provide feedback once CPL shares the latest version.**

JRC Summary of Actions **Attachment A**

Work Plan Implementation

Identified Work Plan Issue	Actions	Notes:
Addressing the Opioid Crisis	• The Council has continually provided feedback on the Trump administration's regulatory policies, as well as the latest report from the President's Commission on Combating Drug Addiction and the Opioid Crisis's final report. • The Council has contributed to the PCSS program by helping to brainstorm webinar topics for the next year. • Dr. Renner will lead the establishment of the opioid work group this year. The group will flesh out a workplace to guide their strategy. • The Council is working with PCSS on an implementation project to increase and improve the treatment of opioid use disorder and psychiatric care at Hanover Hospital which provides care in York and Adams Counties, Pennsylvania.	Additional ongoing activities include: • Buprenorphine training curriculum during the Annual Meeting and IPS as well as trainers • Technical and logistical support for monthly webinars and podcasts for PCSS
Tobacco Work Group	• The tobacco work group been working to create an online toolkit of TUD resources for all members. • The group was engaged in the Great American Smokeout Twitter Town Hall. This was a campaign led by the VA and the Office of Minority Health and Suicide Prevention. Work group members joined the conversation online and linked participants to APA resources on TUD. • The group has been engaged with the National Partnership on Behavioral Health and Tobacco	Of note, the FDA has announced that one of its priority issues will be addressing addiction to nicotine by developing a comprehensive approach. The agency will also work to tackle the marketing of tobacco products to kids. The work group will be a resource to APA staff in responding to the agency's actions.

JRC Summary of Actions **Attachment A**

Identified Work Plan Issue	Actions	Notes:
	Use in implementing their national strategy to reduce smoking prevalence among people with behavioral issues. • Created a series of TUD-focused questions for APA's pulsed learning platform. • The group continues to provide APA staff with feedback on regulatory policy.	

COUNCIL ON ADVOCACY AND GOVERNMENT RELATIONS

EXECUTIVE SUMMARY:

The Council on Advocacy and Government Relations (CAGR) held two conference calls between October and December 2017. The Council continues to serve as APA's principle coordinating component for all legislative and regulatory activities involving the federal and state governments.

Specifically, the Council has provided recommendations and counsel to APA's Department of Government Relations on several key areas:

- Supporting the extension of the Children's Health Insurance Program
- Addressing the opioid crisis
- Repealing and replacing the Affordable Care Act
- State battles related to prescribing privileges
- APA membership Advocacy Training Tools
- APAPAC Congressional Advocacy Network Initiative

The approved minutes from the two conference calls are attached **(Attachment #1 and #2)**

The Council brings the following action items to the Joint Reference Committee:

1. **JRC REFERRAL: Position Statement on Hospital Privileges for Psychologists**
   Through JRC directive, the Council on Advocacy and Government Relations established a joint Council work group with the Council on Psychosomatic Medicine to broaden the 2007 position statement to encompass perspective of those psychiatrists working in general medical and hospital setting in addition to those in psychiatric hospitals. Taking into consideration the work group's recommended modifications, the Council voted to support advancing the revised position statement as written.

   ACTION: Will the Joint Reference Committee accept the Council on Advocacy and Government Relations' recommendation to advance the revised Position Statement titled "Psychologists and Other Mental Health Professionals and Hospital Privileges"? (Attachment #3 and #4)

The Council brings the following Information Item to the Joint Reference Committee:

1. **JRC REFERRAL: Position Statement on Principles for Health Care Reform for Psychiatry**
   The Council is working closely with the Council on Healthcare Systems and Financing to revise the 2008 position statement. Given that it is a decade old, the Councils' are tasked with address outdated language. The Council is awaiting feedback from the Council on Healthcare Systems and Financing provided their review of a draft position statement. The Council will present a revised statement to the June 2018 JRC.

2. **JRC REFERRAL: Action Paper on APA Draft Position Statement on Prescription Drug Monitoring Programs**
   The Council reviewed a draft position statement developed by the Council on Healthcare Systems and Financing and the Council on Addiction Psychiatry. The Council provided concrete feedback on specific issues to be addressed within the document. The Council will continue to work with both councils to finalize a position statement.

3. JACOB JAVITS AWARDEES

The Council selected to table the discussion of the Jacob Javits Award until our next monthly conference call.

Attachment #1

Council on Advocacy and Government Relations
Conference Call
October 16, 2017
Meeting Minutes

Members Present:
Patrick Runnels – *Chair*
David Diaz – *Vice Chair*
Jenny Boyer
Katherine Kennedy
Steve Koh
Debra Koss
David Lowenthal
Cassandra Newkirk
Barry Perlman
Jessica Thackaberry (ECP)
Craig Zarling (ASM)
Wilsa Charles Malveaux
Taiwo Babatope – *Child and Adolescent Psychiatry*
Sabrina Bera – *Spurlock Congressional Fellow*
John Chaves – *Public Psychiatry Fellow*
Rachel Talley – *Public Psychiatry Fellow*
Mary C. Vance – *Public Psychiatry Fellow*

Members Absent:
Charles Price
Larry Gross
Michelle Durham
Matthew Erlich
Napoleon Higgins
Alan Rodriguez Penney – *SAMHSA Fellow*
Adrian Jacques Ambrose – *Leadership Fellow*
Dakota Carter – *SAMHSA Fellow*
Katherine Koh – *SAMHSA Fellow*
Natalie Ramirez – *Diversity Leadership Fellow*
Onyinye Ugorji – *Public Psychiatry Fellow*

WELCOME, ROLL CALL & REVIEW OF CALL AGENDA
Council Chair Patrick Runnels welcomed the Council and provided an overview of the agenda for the conference call. Followed by Council roll call.

UPDATES FROM DEPARTMENT OF GOVERNMENT RELATIONS
Federal Activity
Federal Affairs Director KJ Hertz provided an abbreviated update on the federal legislative activity.

CHIP: APA voiced its support for Congressional reauthorization of Children's Health Insurance Program (CHIP). CHIP funding is set to expire on Sept. 30 and Congress must act now to ensure funding and protect children's health coverage and access to needed health and mental health services. The APA sent a letter to Congressional leadership imploring them to reauthorize this program.

DACA: Following President Trump's announcement to end the Deferred Action for Childhood Arrivals (DACA) affecting 800,000 undocumented immigrants, the APA sent a letter to Congressional leadership urging them to take prompt action to make the program permanent. The letter highlighted the negative impact ending DACA would have on the health care workforce, including physician and other allied health professionals.

Health Reform: APA continued its strong advocacy work in opposition to ACA repeal and replace efforts. Most recently, advocating in opposition to the Graham-Cassidy proposal working in collaboration with

other physician organizations and mental health groups. Meanwhile, the APA worked to encourage bipartisan efforts in the Senate to stabilize the ACA insurance marketplaces and supported the development of legislation. On September 26th, the APA participated in a leadership fly-in day with five other physician groups including the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians, the American Congress of Obstetricians and Gynecologists, and the American Osteopathic Association, raising concerns with Graham-Cassidy and urging Senators to focus instead on market stabilization efforts and reauthorizing the Children's Health Insurance Program for five years without any further delay.

COUNCIL MENTORSHIP INITIATIVE

Dr. Runnels expressed the importance of CAGR members committing to mentoring the fellows on the Council. He asked Members to have regular contact throughout the year and have face meetings—in addition to the September Component Meeting and Annual Meeting. He thanked the Council Members for sharing their bios and reminder the fellows to provide Ms. McRae with their top three choices for mentors. Members are not expected to have more than one fellow to mentor. Dr. Chaves requested that there be a requirement of a minimum of two calls with their mentors, and if local, set up two meetings over the year. Dr. Lowenthal agreed that there should be opportunities continuously touch base with the fellows, especially if there is a topic of interest, if the fellows didn't have the chance to say their interest during the conference call. Dr. Runnels reassured the group, the mentorship would get the fellows involved in some of the work groups, as well.

ADVOCACY PLAN: SCOPE OF ACTIVITIES

Dr. Runnels provided a summary of the CAGR advocacy plan, reading over the set expectations of the three work groups. He requested for each Council member to participate on one of the three work groups. He asked for each member to email two choices to Ms. McRae by Friday. If your selections are not forwarded, you will be assigned to a work group.

Dr. Koss, volunteered to participate with the second work group—adding the objectives of the work groups is important for us at this point in time. This is especially true, in the coming year in which states are facing a number of scope issues. She continued, adding that the work groups will assist in streamlining the communication between the national office and district branches and regional representatives (or DGR RDs). Dr. Koss advised the Council to consider the resources readily available to APA membership, thus not reinventing the wheel each time. As author of the advocacy plan, Dr. Koss elaborated on the expectations of the work groups. Work group 1, would acknowledge that not every member is going to get involved in the same way. Rather develop ideas to find a way to get every member involved, in some form. Work group 3, can be proactive in developing a strategy for APA to be more proactive for improving access to care. Recognizing that every district branch is in a different place for improving access and the district branches can assist in develop their respective advocacy needs and priorities. Dr. Zarling shared with the Council, work group 1 is working in a similar fashion as the APA Foundation in establishing grassroots and advocacy efforts in the states. He added, the heavy lifting in the district branches is inspiring.

Dr. Lowenthal asked, if in developing an advocacy strategy should the Council consider develop strategy to address concerns separate for psychologists prescribing? Dr. Runnels responded, that work group will primarily focus on psychologists prescribing. Dr. Koss added, that states are experiencing multiple threats and we can be thoughtful about issues around psychologists prescribing that can be transferable to other issues of scope, as well.

Dr. Koh suggested, the Assembly and DGR staff may already be developing advocacy strategy, can we assume that we are functioning as a hub of activity—without duplicating efforts? Dr. Runnels advised, the Council's job is not to come up with the issue, but rather to support APA and DGR by setting resources and providing

counsel. Dr. Levin added, the Council members are the experts to give oversight and guidance and edit the toolkits. Dr. Levin asked of the Council, how can we best help the district branches with a mutual collaboration.

Dr. Perlman inserted, this is where the nexus between CAGR and the APA PAC becomes crucial, functioning hand-in-hand with each other in advocacy.

Dr. Runnels thanked Dr. Levin, adding that the current advocacy plan may not captured everything, but is a good starting place.

DEPARTMENT OF DEFENSE PRESCRIBING ACTIVITY

Dr. Koh updated the Council on recent activity within the Department of Defense looking to expand the scope of practice for psychologists. Dr. Koh advised the Council, APA drafted an official letter in response to the DoD's actions. APA forwarded the letter today. Dr. Koh added, only the Navy has sought expanding scope for psychologists, thus far. Dr. Runnels asked, if other branches are considering? Ashley Mild informed, APA is looking at legislative-strategic options at the moment. Dr. Perlman asked, why talk about it, if we don't know which facilities are introducing this program. Dr. Levin thanked Dr. Koh for his recent presentation to the local navy base and for sharing our concern with them.

OTHER BUSINESS / DISCUSSIONS

Dr. Runnels shared with the Council, he is in the process of meeting with other councils significant to CAGR's work, in order to coordinate future cross-functional activity.

Dr. Runnels also shared, he recently participated in a call with the JRC. He anticipates in the near future; the Council will be asked to participate in some action by the AMA on the smart guns.

FOLLOW-UP ACTIVITY

Acknowledging the remaining time to the conference call, Dr. Runnels recommended the Council review and approve the revised position statement entitled *Hospital Privileges for Psychologists*.

Dr. Runnels also asked for the Council to review the document shared by Drs. Vance and Kennedy. Our colleagues are looking for the Council to support submitting the advocacy white paper as a resource document.

Dr. Runnels thanked the conference, concluding the call with informing the Council of the next conference call. Scheduled for December.

Attachment #2

Council on Advocacy and Government Relations
Conference Call
December 4, 2017
Meeting Minutes

Members Present:

Patrick Runnels - Chair
David Diaz – Vice Chair
Jenny Boyer
Katherine Kennedy
Steve Koh
David Lowenthal
Barry Perlman
Jessica Thackaberry (ECP)
Wilsa Charles Malveaux
Adrian Jacques Ambrose – *Leadership Fellow*
Taiwo Babatope – *Child and Adolescent Psychiatry*
Sabrina Bera – *Spurlock Congressional Fellow*
Dakota Carter – *SAMHSA Fellow*
Alan Rodriguez Penney – *SAMHSA Fellow*
Rachel Talley – *Public Psychiatry Fellow*
Mary C. Vance – *Public Psychiatry Fellow*

Members Absent:

Michelle Durham
Matthew Erlich
Napoleon Higgins
Debra Koss
Cassandra Newkirk
Craig Zarling (ASM)
Charles Price
Larry Gross
John Chaves – *Public Psychiatry Fellow*
Katherine Koh – *SAMHSA Fellow*
Natalie Ramirez – *Diversity Leadership Fellow*
Onyinye Ugorji – *Public Psychiatry Fellow*

WELCOME, ROLL CALL & REVIEW OF CALL AGENDA

Council Chair Dr. Patrick Runnels welcomed the Council and provided an overview of the agenda for the conference call. Followed by Council roll call.

UPDATES FROM DEPARTMENT OF GOVERNMENT RELATIONS

Federal Legislative Activity

Federal Affairs Director KJ Hertz provided an abbreviated update on the current federal legislative environment in Washington, DC.

Tax Reform: The tax reform debate in the Senate consumed nearly all of the political oxygen in Washington last week, ultimately culminating in a 51-49 passage of the proposal Saturday morning. Despite many Republican senators expressing reservations, the only "no" vote from the majority came from Sen. Bob Corker (R-TN), who has been adamant that he would not vote for a tax bill that adds to the deficit without measures that could boost revenues in the future. The Senate's approval marks a significant step forward in the tax reform effort and prospects for its enactment look good barring a serious reversal of fortunes. The House returns ahead of schedule today to consider a motion to go to conference on the tax reform bill, allowing for lawmakers to reconcile the differences between the two versions of the legislation. The Senate is also expected to approve its own motion to go to conference early this week. Republicans hope that the conference process will last about a week, giving lawmakers time to get a bill to the president's desk before the Christmas holiday.

Budget: The major legislative work this week will focus on government funding as the continuing resolution (CR) currently funding the government is due to expire on Friday. The most likely outcome is that both chambers will approve a new short-term CR this week that will last until Dec. 22, providing a short window for lawmakers to work out a longer-term agreement.

CHIP: A bicameral agreement to extend CHIP could be announced as early as this week. It remains unclear whether health care provisions including CHIP, the Medicare 'extenders,' and community health centers will receive a stand-alone vote or move as part of a December CR. With states facing the exhaustion of their CHIP funds, lawmakers are determined to extend the program before adjourning for the year.

IOWA PSYCHIATRIC SOCIETY CALF GRANT

The Council recently reviewed a request from Iowa for a CALF grant. Before approving the application, Members of the Council had questions specific to the request. APA Regional Director, State Government Affairs, Amanda Blecha ("RD") and the IPS lobbyist and leadership believe that we will have more options if it goes back to the state legislature. The law defers much of the details of education and training standards and the examination to rulemaking. Our strategy throughout the rulemaking process has been to insist on the highest education and training standards and for an examination created by an independent body rather than the American Psychological Association, which we continue to do. Given the current RxP rulemaking subcommittee composition and the Medical Board's approach, we believe we have an opportunity if the legislature reconsiders it.

CAGR SCOPE/ADVOCACY WORK GROUP REPORT OUT

Prior to the individual work group conference calls, CAGR Chair Dr. Runnels selected a Council member to lead the conversation and strategy for each work group.

Work Group #1: *Engaging our Grassroots in Local Efforts*
The Work Group participants held a conference call led by Dr. Debra Koss to develop a national DB advocacy/legislative survey. It was determined the survey will be sent on behalf of Drs. Levin and Runnels, pushed out by the Office of District Branches/State Associations. Dr. Koss anticipates the survey will be completed by March, with data collected and analyzed in April. Dr. Koss would like to bring the information to the whole Council so that a strategy can be implemented at the Annual Meeting in May.

Work Group #2: *Developing an Action Plan for Utilizing our Scope Toolkit*
Council Vice-Chair Dr. David Diaz provided an update following the work group's conference call last month. The work group decided to begin work following the completion of the Advocacy 101 product, allowing for fluidity between topic areas.

Work Group #3: *Developing an advocacy strategy for promoting evidence–based solutions to improving patient access to care*
The Work Group anticipates holding their first conference call in January.

ADVOCACY EDUCATION INITIATIVES

Dr. Runnels thanked Drs. Vance and Kennedy for drafting a resource document on advocacy training. Dr. Perlman raised concerns about mandatory education. Dr. Koh concurred, suggesting members would push back on making advocacy training part of a mandatory curriculum. Dr. Runnels asked the Council what are recommended next steps for the resource document. The Chair recommended the resource document be shared with the Council on Medical Education and Life-long Learning. He added, would the Council consider

developing a position statement constructed from the resource document. Dr. Kennedy advised, there were other physician disciplines that offer advocacy curriculum. Dr. Runnels recommended Drs. Vance and Kennedy form a small group with DGR staff, CAGR members and CMELL members to address these concerns. Dr. Malveaux clarified that the advocacy training product for residents is worth working on to completion and consensus even before we decide on the mandatory piece. She continued, that making it mandatory would potentially be a barrier to getting it through the governance process. She continued, if the Council were to complete the product and advance the concept as an optional elective or quality improvement project, APA could always push to make it mandatory later down the road –if we so choose, though that may not be necessary.

ADDITIONAL BUSINESS / DISCUSSION POINTS

Dr. Perlman inquired, if the recent CVS merger was on APA's radar? He followed up with a request for APA to analyze the merger and, if any, would there be implications to the physician community? KJ Hertz indicated that DGR would research and provide insight to the Council next month. Dr. Runnels agreed, that there has not been any strategic positioning of psychiatry— especially in the rapidly changing world.

APA ANNUAL MEETING IN NEW YORK, NY

Dr. Runnels noted the Council will be meeting on Tuesday, May 8th 1:00 PM – 5:00 PM during the Annual Meeting. The date and time for component workshop is still pending and will be shared with the Council as soon as it has been made available.

It was moved and seconded to adjourn. The Council's next conference call is scheduled for January.

APA Official Actions

Position Statement on ~~Hospital Privileges for~~ Psychologists and Other Mental Health Professionals and Hospital Privileges

Approved by the Board of Trustees, 1970
Approved by the Assembly, XXXX (reaffirmed 2007)

"This statement was approved by the Board of Trustees of the American Psychiatric Association on December 3-4, 1970, upon recommendation of the Committee on Psychiatry and Psychology. These are . . . position statements that define APA official policy on specific subjects. . ." – *APA Operations Manual*

POSITION:

~~Because of the professional and legal considerations, the ultimate medical responsibility for patients admitted to hospitals should remain with licensed physicians. Psychologists, like other non-medical professionals, should be eligible for some type of hospital appointment.~~

Given that hospital treatment is the highest level of treatment available to manage complex psychiatric conditions and often co-morbid general medical disease, the APA advocates that patients hospitalized in both psychiatric and medical settings are best served when responsibility for their mental health and substance use disorder care resides with psychiatrists leading cross disciplinary teams. Psychologists, as well as other mental health professionals, are critical members of cross disciplinary teams, and should be eligible for hospital appointment to act in roles consistent with their specialization and training.

Authors:

~~The Committee on Psychiatry and Psychology drafted the 1970 original Position Statement, included: Marc H. Hollender, M.D. (chairman), Thomas Thale, M.D., Joseph Schachter, M.D., Robert J. McAllister, M.D., Ben W. Feather, M.D., and Avrohn Jacobson, M.D.~~

Revisions to the Position Statement was drafted by a work group comprised of members from the Council on Advocacy & Government Relations and Council on Psychosomatic Medicine: Madeline Becker, M.D., Katherine Kennedy, M.D., John Chaves, M.D., and Dave Gitlin, M.D.

Position Statement on Psychologists and Other Mental Health Professionals and Hospital Privileges

Approved by the Board of Trustees, 1970
Approved by the Assembly, XXXX (reaffirmed 2007)

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Revisions to the Position Statement were drafted by a work group comprised of members from the Council on Advocacy & Government Relations and Council on Psychosomatic Medicine: Madeline Becker, M.D., Katherine Kennedy, M.D., John Chaves, M.D., and Dave Gitlin, M.D.

Item 8.C
Joint Reference Committee
February 2018

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 APA meetings workshops, position statements, and collaborations with APA Councils and allied children and adolescent's organizations.

The Council met via conference call on Wednesday, November 15, 2017 at 7:00PM EST. No action items stemmed from the meeting. See attachments 1-2 for the agenda and minutes of this meetings. The Council's next conference call is scheduled for Wednesday, January 31, 2018.

Information Items

1. The Council reviewed and supported a letter addressed to the Netflix Executive Producers of "13 Reasons Why". The letter was in response to Season 1 and the upcoming Season 2. In addition, the Council on Communication also reviewed the letter and supported the document as written.
2. The Council is in the process of reviewing and providing feedback on AACAP's Parent Medication Guide on anxiety and obsessive related disorders.
3. In collaboration with the APA Telemental Health Committee, the Council is in the process of reviewing the Higher Education Mental Health Alliance (HEMHA) Guide, *College Counseling from a Distance: Deciding Whether and When to Engage in Telemental Health Services.*
4. As a request from the Council on Quality Care, the Council reviewed and provided feedback for a letter to the editor of the *Journal of the American Academy of Child and Adolescent Psychiatry* regarding the paper "Specific Components on Pediatricians' Medication-Related Care Predict Attention-Deficit/Hyperactivity Disorder Symptom Improvement" (Epstein, JN, et. al).
5. The following interest groups were created: Integrated Care, Juvenile Justice/Corrections, Social Media, TAY/Adult Psychiatrists, Gender Dysphoria/Transgender Mental Health, Immigrant and Refugees, First Break Psychosis

Attachments

1. November 2017 Agenda
2. November 2017 Minutes
3. Letter to the Netflix Executive Producers regarding "13 Reasons Why"

AMERICAN PSYCHIATRIC ASSOCIATION

AGENDA

Council on Children, Adolescents and Their Families
Wednesday, November 15, 2017
7:00 p.m. – 8:00 p.m. EST
Conference Call – Various Locations

Welcome and Approval of September Minutes	J.Penn
JRC Update	J. Penn
Assembly Update	G. Shapiro
Youth with gender dysphoria and transgender issues in correctional settings	J. Penn
Any Other Business	Council
Closing Remarks	J.Penn

MINUTES

Council on Children, Adolescents and Their Families
Wednesday, November 15, 2017
7:00 p.m. – 8:00 p.m. EST
Conference Call – Various Locations

Attendance

Members Present:
Joseph Penn, M.D.
Azeesat Babajide, M.D.
Caitlin Costello, M.D.
Gabrielle Shapiro, M.D.
Tresha Gibbs, M.D.

Fellows Present:
Carlos Fernandez, M.D.
Colby Tyson, M.D.
Ferdnand Osuagwu, M.D.
Qortni Lang, M.D.
David Saunders, M.D.
Hayou Lee, M.D.
Richard Lee, M.D.
Alicia Londono, M.D.
Cindy Vargas-Cruz, MD

Absent:
Kim Gordon, M.D.
Lorena Reyna, M.D.
Mark Chenven, M.D.
Mary Ann Schaepper, M.D.
Michael Houston, M.D.
Michael Morse, M.D.
Ricardo Vela, M.D.
Samina Aziz, M.D.

Excused:
Steven Adelsheim, M.D.
Warren Ng, M.D.

APA Staff:
Tatiana Claridad (Staff Liaison)

Welcome and Approval of September Minutes J.Penn

Joseph Penn, M.D. opened the call with welcome remarks and approval of the September minutes. Tatiana conducted roll call.

JRC Update J. Penn

Dr. Penn gave a recap of the JRC meeting that took place on October 14, 2017. The Council recommended that the JRC recommend to the Board of Trustees vote to retain the Official Action, "Endorsement of United States Ratification of the Convention on the Rights of the Child" as written.

Assembly Update G. Shapiro

Gabrielle Shapiro, M.D. gave a brief update on the events that occurred at the APA Assembly in Washington, DC from November 3-5, 2017. She mentioned that great work was done around fundraising for disaster relief in Puerto Rico.

Youth with gender dysphoria and transgender issues in correctional settings J. Penn

Dr. Penn gave an update on his work and interest in working with youth with gender dysphoria and transgender issues in correctional settings. Tatiana mentioned that DDHE just published a new online resource, "A Guide for Working With Transgender and Gender Nonconforming Patients".

Any Other Business Council

There was interest among the Council in a follow up with the various interest/work groups discussed at the APA September Components Meeting. Tatiana offered to e-connect the groups to foster future collaboration and products.

Closing Remarks J.Penn

Netflix

Dear Executive Producers:

The organizations listed below represent thousands of mental health and suicide experts and professionals with decades of experience who work with youth, parents, schools and communities throughout the United States and around the world. We work daily to help youth and their families lead successful, healthy and happy lives often despite challenging times and circumstances. The Series, "13 Reasons Why," captured the attention of many youth around the world and created countless discussions among teens and between teens and their families. As has been well documented, those of us in the mental health and suicide prevention field are very concerned that the series may have also created risk for vulnerable youth. Going forward, we believe the series can be adjusted to minimize this risk while preserving its resonance with your audience. We offer you our collective organizations' expertise in safe messaging, mental health and suicide prevention to develop the safest messaging possible for Season 2. We believe this will reduce the risk of additional potential harm and still fulfill your stated goal of providing a benefit to the mental health of teens and young adults. We can suggest experts if you are not actively consulting with recognized suicide prevention (and homicide if such content is involved) messaging experts in the development of Season 2.

Research demonstrates that depictions of violence and self-harm can increase the likelihood of copycat behaviors. Adolescents are a vulnerable group and are highly impressionable, frequently copying others' behaviors or reacting in response to things they have watched. Such copycat and harmful behaviors depicted on television and/or in film can lead to harmful outcomes and are what we hope to have minimized or avoided. We hope that the new season conveys a message to Netflix subscribers that encouragement of compassion and help-seeking behaviors are important and healthy ways to be part of society, while maintaining your series' artistic goals.

In response to Season 1, Netflix worked to address the concerns of the suicide prevention community by creating an online landing page with links to external resources, including trigger warnings, and helping to broadly disseminate talking points for educators, parents, schools and communities. Even with these actions, a study published in the *Journal of American Medical Association* found a significant increase in internet searches on suicide following the release of Season 1. It is for these reasons we offer our collaboration and express our concern about Season 2 and strongly urge you to incorporate suicide safe messaging going forward.

Please understand that our goal is not to infringe upon or restrict your creative rights or freedom in producing this or any other series, rather it is to provide the best possible information based on science, research and clinical expertise about how to safely communicate your intended messages. We share your belief that reducing the stigma of mental illness, creating a conversation about mental health and suicide prevention, and promoting help-seeking, can promote healing and save lives.

Thank you for your time and attention.

Respectfully submitted by:

American Academy of Child and Adolescent Psychiatry - PENDING
American Association of School Administrators - PENDING
American Association of Suicidology - YES

American Medical Association - PENDING
American Psychiatric Association – PENDING
British Psychological Society - PENDING
International Association for Suicide Prevention – YES
International Association for Suicide Research - YES
Jason Foundation, Inc. - YES
Jed Foundation - YES
Medical University of Vienna, Ctr for Public Health, Department of Social and Preventive Medicine - YES
National Association of School Psychologists - YES
National Association of Social Workers - PENDING
National Council for Behavioral Health - YES
National Suicide Research Foundation, Ireland - YES
School of Public Health, University College Cork, Ireland - YES
Suicidal Behaviour Research Laboratory, University of Glasgow, Scotland - YES
Suicide Awareness Voices of Education – YES
The Lancet Psychiatry - YES
The Trevor Project – YES

Item 8.D
Joint Reference Committee
1/18/2017

Council on Communications Report to the Joint Reference Committee

Action Items:

The Council on Communications has no action items to be reviewed by the JRC.

Current Council Business:

The Council on Communications has participated in the creation of a letter from APA and other mental health stakeholders offering guidance to Netflix as they produce shows like "13 Reasons Why." The goal of this effort is the creation of an advisory group of mental health professionals to consult on Hollywood productions to ensure they are medically correct and do not stigmatize patients. If successful, this would be an ongoing effort to support and assist in the creation of artistic works that are respectful of people with mental illness and substance use disorders, and that portray mental health care accurately. A meeting between APA Components like the Council on Communications and Council on Child & Adolescent Psychiatry and stakeholders in the entertainment industry is in the early stages of being organized in time for the APA Annual Meeting in New York City this May.

Dr. Levin has requested that the Council on Communications review the APA's current Vision statement and revise it to bring it in line with current psychiatric practice standards and terminology. The Council will review the vision statement, and submit a revised version to the JRC for review and approval at a later date.

The Council on Communications will spearhead APA's move onto the social media platform Instagram. APA staff will curate the channel, with guest curation from Council members and other prominent psychiatrists. Instagram is a vibrant and active social media platform that APA does not currently have a presence on. Joining the channel could have a positive effect on communicating APA's mission and values not just to members, but the public as well. The Council will discuss this effort during an upcoming conference call involving new APA Senior Social Media Specialist Angeliki "Angel" Frangos.

Executive Summary

Council on Geriatric Psychiatry

Description of the Council:

The Council supports APA in its work on behalf of older adults and the psychiatrists who care for them. To this end, the Council develops Position Statements and Resource Documents on important issues in geriatric psychiatry, thereby providing APA with background information essential for advocacy efforts and interactions with the media. The Council also works collaboratively with other professional groups to develop best practices in geriatric psychiatry, to promote research, and to provide education and training to psychiatrists, other physicians, residents, medical students, and allied mental health professionals.

Information Items:

- The Council is revising two position statements: "Elder Abuse, Neglect and Exploitation" and "HIV Infection in People over 50."
- The Council is also developing a new position statement on Disaster Response for older adults.
- The Council collaborated with the Council on Quality Care and AAGP to advocate for issues pertaining to CMS's stand on creating a "ligature-resistant" psychiatric hospital environment.

Reference Items:

- The JRC referred the Position Statement on Palliative Care back to the Council for re-formatting and revision.

Position Statements:

Role of Psychiatrists in Long-term Care Settings (LTC): A workgroup consisting of volunteers from the Council on Geriatric Psychiatry and the Council on Psychosomatic Medicine worked on this statement. The Council on Child and Adolescent Psychiatrists also reviewed the statement. The final draft was submitted to the JRC in June 2017. The BOT sent the statement back to the Council for some clarifications and amplifications. Some of the suggestions included the need to define the LTC settings and ways to address collaboration with non-psychiatric clinical personnel. The BOT also suggested to define the role of psychiatrists in LTC settings of monitoring and speaking up about unethical practices in these predominantly for-profit settings (nursing homes, adult homes). The council is working to include these suggestions in the revised draft.

Role of Psychiatrists in Palliative Care: A workgroup consisting of volunteers from the Council on Geriatric Psychiatry and the Council on Psychosomatic Medicine developed and submitted this Position statement to the JRC in advance of the fall meeting. The JRC requested that the statement be reformatted and revised. This work is underway in collaboration with the Council on Psychosomatic Medicine.

The Council decided to develop the following position statements:

- **Elder Abuse, Neglect, and Exploitation (2008)**: The council reviewed the statement and agreed that it needs to be updated. The Council intends to collaborate with APA Ethics Committee in the development of this statement.
- **HIV Infection in People Over 50 (2008):** The council agreed that the statement needs revision. The new statement will also address other diseases like gonorrhea and syphilis. A workgroup was formed to develop this statement. The Workgroup had its first meeting to decide the outline of the statement.
- **Disaster Response (New position statement):** It was discussed that there would be value in developing a new statement regarding the needs of older adults during and after disasters.

Medical Beds and Ligatures Risks:

In response to pressure from CMS, The Joint Commission is tightening its standards in relation to ligature risk in psychiatric hospitals. As a result, many psychiatric facilities have been compelled to make widespread and expensive renovations very rapidly, disrupting patient care and diverting resources from other critical needs. One especially disruptive element is the identification of medical beds as an important ligature risk. There is agreement that no medical bed is entirely ligature free, even if the electric cord is short or the bed is low to the floor. But it is important that CMS and The Joint Commission recognize that some persons in psychiatric hospitals (e.g., the elderly; persons with eating disorders) may require a medical bed and that it would disadvantage these patients if such beds were not permitted in psychiatric facilities. It is essential that TJC and CMS accept suicide risk assessment and other clinical interventions as adequate measures to mitigate the risk associated with the use of these beds without requiring that all patients in medical beds require 1:1 observation or other similarly onerous and impractical solutions. At the components meeting in September, The Council invited representatives from APA Division of Government Relations and Council on Quality Care at the September Meeting to explore the possibilities of collaboration to advocate for this issue more effectively.

Use of Antipsychotics in Treatment of Elderly: A letter to Centers for Medicare and Medicaid Services (CMS):

Currently nursing homes are under pressure from CMS to reduce antipsychotic prescribing for dementia, and rates of prescribing are a quality measure for these facilities. CMS excludes patients with schizophrenia, Tourette's, and Huntington's from the calculation but includes patients with schizoaffective disorder and bipolar disorder, unreasonably penalizing nursing facilities willing to admit patients with these conditions. Council agreed to work with APA's Policy division to draft a letter to CMS that communicates the support for including bipolar and schizoaffective disorders in the quality measure exclusion.

Culture, Heritage and Diversity in Older Adult Mental Health Care
(Formerly "Cultural Competency Guide for the Treatment of Elderly Adults")

In 2004 the Council on Aging (former name of the Council on Geriatric Psychiatry) developed a cultural competency curriculum to guide clinicians treating elderly patients. Dr. Maria Llorente, who worked on the original curriculum, offered to work with DDHE to lead a project to revise the document. A workgroup consisting the members of the Council and AAGP, and APA/APAF Fellows worked to develop the 11-chapter guide.

In light of the quality and comprehensiveness of the guide, the Council agreed to explore the idea of publishing the Guide in the form of a book. The manuscript was sent to APA Publishing for review. After reviewing the contents, APA Publishing agreed to publish the guide in book form. Dr. Dilip Jeste agreed to write the preface.

Annual Meeting Submissions

Council members submitted numerous proposals for potential presentation at 2018 Annual Meeting:

1) Successes and Challenges in Working with H-PACT (Homeless Patient Aligned Care Team) Workshop
2) Psychiatry and US Veterans Workshop
3) Mission Possible: Successful Integration of Alcohol Use Disorder Pharmacotherapy in Primary Care Symposium
4) The AAGP Presidential Symposium
5) Transforming the Geriatric Workforce: Today is Tomorrow
6) Dementia with Behavior Disturbance Assessment and Management
7) Beyond Clinical Interview: Technology in Psychiatry Assessment
8) Course on Palliative Care
9) Ageism in Medical Students
10) End-of-Life Care
11) Integrated Substance Abuse in Primary Care
12) Homeless and Primary Care
13) Every Psychiatrist Need to Know about Bed Bugs

Minutes of Teleconference Meetings

October 18, 2017

1) Position statement on the role of psychiatrists in nursing facilities: We reviewed revisions prepared by Maureen Nash (thank you Maureen). Marsden McGuire offered to do some additional work on it prior to our next meeting.
2) Position statement on Elder Abuse, Neglect, and Exploitation: Marilyn Price, Ebony Dix, Juliet Glover, and E.J. Santos have volunteered to revise this position statement and will get back to the Council soon with a target date for a first draft.
3) Position statement on HIV infection in people over 50: Ebony Dix, Rebecca Radue, and E.J. Santos have volunteered to revise this position statement and will get back to the Council soon with a target date for a first draft.
4) Position statement on disaster preparedness and response: Ebony Dix, Paul Kirwin, and Maria Llorente have volunteered to develop a position statement on this topic (as it relates to older adults) and will get back to the Council soon with a target date for a first draft.

November 8, 2017

1) The position statement on the role of psychiatrists in palliative care was presented to the JRC in October. The paper was well received in terms of content but the JRC is now asking that position statements be formatted differently. They are looking for a brief "issue statement" followed by a simple narrative position statement. Attached to this can be a more expansive background document. They are inviting us to submit a revised version in time for consideration at the February JRC; this would require that we submit it by the end of January. In the next few days we will confirm our understanding of the formatting expectations with APA staff and JRC leadership. We will then work on the next revision. I think it is very realistic to have it ready for the February meeting
2) As you recall, the Board asked us to revise the PS (already passed by the Assembly) on the role of the psychiatrist in nursing homes. Drs. Nash and McGuire worked on this over the last few weeks. Sejal is going to show the revised draft to JRC leadership and APA staff in the next few days to see if the JRC would accept it in its current format. If not, we will proceed with reformatting it before sending it to the JRC for approval.
3) Groups of Council members have agreed to work together on updating or developing statements on (1) elder abuse and neglect, (2) HIV in persons over 50, and (3) disaster preparedness and response. Sejal will begin right away to arrange conference calls of Council members who volunteered to help with these. In the meantime, we will settle the formatting questions so that the first drafts of these statement are developed along the required lines.
4) Susan Lehmann and Brent Forester have volunteered to help compose a letter from the APA to CMS asking that the nursing home quality measure looking at the percentage of patients on antipsychotics exclude patients with bipolar and schizoaffective disorder as well as patients with schizophrenia. Thanks so much to both of you for volunteering to do this.

5) The book on the culturally competent care of older adults is nearly complete. As you know, American Psychiatric Press will be publishing it. Congratulations to Maria Llorente and her team for this fabulous accomplishment!

Executive Summary
Council on Healthcare Systems and Financing
Harsh Trivedi, MD, MBA, Chair

Members of the Council on Healthcare Systems and Financing have focused their efforts on reviewing position statements and responding to action papers presented to the Committee in the past months. As the new administration began addressing its own legislative and regulatory health policy priorities, the Council continued to provide feedback on health reform, quality and payment reform, parity, and alternative payment methods. Our December meeting focused on drug pricing legislation, levels of care tools, and outstanding position statement edits. We continue to monitor APA activities on parity implementation and regulatory issues, as well as the Trump Administration's efforts to combat the opioid crisis.

The Council brings the following Action Items:

Action Item 1: Will the Joint Reference Committee recommend that the Assembly approve the Position Statement on Peer Support Services?
(Attachment A (proposed statement))

Proposed APA Position on Support for Peer Support Services:
(Adopted from the Position Statement on Support for Peer Support Services, 2012)

The American Psychiatric Association supports the value of peer support services and is committed to their participation in the development and implementation of recovery oriented services within systems of care. APA also advocates for appropriate payment for these services. Peer support personnel should have training appropriate to the level of service they will be providing.

Psychiatrists should be knowledgeable of the value and efficacy of the wide array of peer support services in recovery, and support the integration of these services into the comprehensive continuum of care.

Action Item 2: Will the Joint Reference Committee approve the Position Statement on the Need to Maintain Intermediate and Long Term Hospital Care for Certain Individuals with Serious Mental Illness?
(Attachment B (proposed statement))

Proposed APA Position on the Need to Maintain Intermediate and Long Term Hospital Care for Certain Individuals with Serious Mental Illness
(Adopted from the Position Statement on the Need to Maintain Long-Term Inpatient Psychiatric Hospitals, 1974; Position Statement on Federal Exemption from Medicaid Institutions for Mental Disease, 2014; and US House of Representatives Committee on Energy and Commerce "Where have all the Patients Gone: Examining the Psychiatric Bed Shortage," Jeffery Geller, MD, MPH, 2014)

The American Psychiatric Association views with concern the trend toward the phasing out of the capacity for providing long-term care and treatment to seriously mentally ill[1] (SMI) individuals who have demonstrated an inability to maintain life in the community. We recognize and support the continued development and implementation of new and innovative community programs and treatment modalities for the SMI population. However, at the same time it is essential that we not lose sight of the continuing need for a full spectrum of services which, for a small percentage of patients, includes intermediate and long-term care in a structured hospital-type environment.
Financial pressure to discharge patients from the psychiatric hospital setting too often results in patients living in substandard and dehumanizing circumstances. Patients may end up in correctional facilities, in nursing or boarding homes that are poorly equipped for SMI tenants, or in the streets. They may seek care through high utilization of emergency room and acute care psychiatric inpatient services. A portion of the SMI patient population lacks the capability of maintaining even a marginal adjustment to the community, despite vigorous therapeutic efforts, and may require intermediate or long term hospital care.

Community mental health centers should be funded and staffed to provide full, comprehensive wrap-around services to the segment of the SMI population that can be successfully maintained in the community including intensive residential treatment that is less restrictive than hospital based care. These services should be sufficient to prevent unnecessary and avoidable short, intermediate and long term hospitalizations.

Action Item 3: Will the Joint Reference Committee recommend that the Assembly approve the Position Statement on Telemedicine in Psychiatry
(Attachment C (proposed statement))

Proposed Position Statement on Telemedicine in Psychiatry
(Adopted from the Position Statement on Telemedicine in Psychiatry, 2015)
Telemedicine in psychiatry, using video conferencing, is a validated and effective practice of medicine that increases access to care. 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 for the benefit of the patient, protects patient autonomy, confidentiality, and privacy; and when used consistent with APA policies on medical ethics and applicable governing law.

Action Item 4: Will the Joint Reference Committee approve the Best Practices in Videoconferencing-Based Telemental Health document?
(Attachment D (proposed guidance))

The "Best Practices in Videoconferencing-Based Telemental Health," is a consolidated update of the previous APA and American Telemedicine Association official legacy documents and resources in

[1] Serious mental illness among people ages 18 and older is defined at the federal level as having, at any time during the past year, a diagnosable mental, behavior, or emotional disorder that causes serious functional impairment that substantially interferes with or limits one or more major life activities. (http://www.samhsa.gov/disorders)

telemental health (including telepsychiatry). This document is a brief "best practices" guide around telemental health based on current evidence in the field. The APA's Committee on Telepsychiatry has been working jointly with The American Telemedicine Association to develop this guidance document for the past six months. As this document progresses through APA governance and ultimately to the JRC, a parallel process is occurring at the ATA, with a goal of having both organizations approve it in anticipation of their respective Annual Meetings in May. Upon approval, the document will be concurrently hosted on the APA's Telepsychiatry Toolkit and on the web site of The American Telemedicine Association.

Action Item 5: The Council supports the APA developing a levels of care assessment tool, but only if APA will commit the funding and resources to achieve the gold standard. For reference, AACAP's tool is estimated to have cost $200,000, over 15 years ago for research alone. Will the Joint Reference Committee support the creation of a work group, shared by the Council on Healthcare Systems and Financing, the Council on Quality, and the Council on Research, to propose a budget to develop an APA-owned Level of Service Intensity Instrument?

The JRC asked that APA Administration research level of care/intensity of service tools available and used by insurance companies and other organizations for determination of appropriate psychiatric and substance abuse care for adults. Upon reviewing the research compiled by the APA Administration, the Council was asked to determine whether APA should:

a. Endorse a specific tool or set of criteria, or;
b. Propose development of such a tool by APA

The analysis focused on four of the more commonly known level of care assessment tools – ASAM®, LOCUS®, CALOCUS® (Now CASII), and InterQual®. The Council discussed the advantage and disadvantages of each tool and concluded that the ASAM tool is the gold standard the APA should work towards, should it move forward with the creation of a level of care assessment tool. While our goal would be to create some level of transparency for providers and payers, it could prove to be difficult to create a tool that fulfills every need. APA would need to create a tool that is user-friendly and has buy-in from both purchasers and providers.

The Council supports APA developing our own levels of care tool, but only if the organization is willing to commit to the funding, resources, and time necessary to achieve the gold standard. The Council is recommending the JRC approve funding for a taskforce to begin the development of an APA-owned levels of service intensity instrument. For reference, AACAP's tool is estimated to have cost $200,000.

Information Items

See the attached chart of regarding updates to position statements and JRC referrals (Attachment E).

Item 8.F
Joint Reference Committee
February 2018

Council on Healthcare Systems and Financing
Harsh Trivedi, MD, MBA, Chair
December 4, 2017, 12:00 PM – 1:00 PM EST

Draft Minutes

Council Members: Harsh Trivedi, MD, MBA, Chair; Ann Sullivan, Vice Chair; Mark Bradshaw, MD; Robert Cabaj, MD; Naakeesh Dewan, MD; Vikram Kambampati, MD; Joseph Mawhinney, MD; Eileen McGee, M D; Lori Raney, MD; Ole Thienhaus, MD
Fellows: Alexander G Cole, MD; Matthew Goldman, MD, MS; Kathryn Skimming, MD, MS; Adjoa Smalls-Mantey, MD; Kevin Mauclair Simon, MD
Corresponding Member: Sosunmolu Shoyinka, MD
Consultant: Elias Karim Shaya, MD; Bradley Stein, MD
Excused Absence: Eliot Sorel, MD; Luming Li, MD; Ripal Shah, MPH, MD
Unexcused Absence: Ranota Delores Hall, MD
APA Administration: Michelle Dirst; Becky Yowell; Kathy Orellana; Jen Medicus; KJ Hertz; Andrew Strickland

DGR Legislative Update on drug pricing legislation

- Senator Wyden (D-OR) bill: The Creating Transparency to Have Drug Rebates Unlocked (C-THRU) Act (S. 637)
    - This bill would require pharmacy benefit managers (PBMs) to be more transparent regarding drug pricing data from its contracts with pharmaceutical manufacturers.
    - This information would be available to plan sponsors as well as consumers, encouraging PBMS to pass along savings, although this would not include the Veterans Administration.
    - Currently, the bill is sitting with the Finance Committee.
    - Generally, the Council felt that APA should support this legislation.
- Senator Baldwin (D-WI)-Senator McCain(R-AZ) bill: The FAIR Drug Pricing Act (S. 3335)
    - This bill indicates movement in a bipartisan fashion following constituent outcries on drug prices; it also has a companion bill in the House.
    - The bill would require pharmaceutical companies to disclose more information on price increases by requiring them to submit reports 30 days prior to raising drug prices.
    - The reports would lay out the justification for the increase and would also address how the manufacturer will market the drug to consumers.
    - Generally, the Council supported this bill, citing that if we're pushing for transparency on PBMs, we feel we should be requiring that of the manufacturers as well.

Levels of Care Comparison as requested in action paper

- The Council was charged with looking into the varying levels of care tools and making a recommendation as to whether APA should endorse a specific tool or propose development of an APA-owned tool.
- Jenn Medicus provided an overview of her analysis on levels of care to inform the discussion.

- Generally, the group felt strongly about ASAM's tool being well-regarded as a gold standard, which is something we do not have in the mental health space. They also raised that there are benefits to other tools like InterQual's ability to be tailored for the purchaser.
- Looking at the role each of the tools play, it could prove to be difficult to create a tool that fulfills every need.
- If APA develops a tool it should only do so if it achieves the ASAM's gold standard for SUD.
- In several states, including NY, legislation has been passed to ensure providers use ASAM's model.
- Our goal is to create some level of transparency for providers and payers.
- Questions include:
    - Does APA want to own its own tool and would we be willing to fund this?
    - Could we create something that comes up to the standard of ASAM's tool?
    - Could it be user-friendly?
- The Council's next step will be to communicate to JRC support for APA developing a levels of care tool, but only if the organizations is willing to commit the time and funding to achieve the gold standard.

Position Statement Updates

- Peer Support Services
    - With Ann's edits, the Council approves
- Need to Maintain Intermediate and Long Term Hospital Care for Certain Individuals with Serious Mental Illness
    - With Ann's edits, the Council approves
- Prescription Drug Monitoring Programs
    - #6 will be changed to reflect the discussion.
    - This will now move back to the Council on Addiction Psychiatry.
- Telemedicine
    - APA staff will share when updated.
- Health Reform Principles
    - APA staff will share when updated.

Position Statement on Support for Peer Support Services

The American Psychiatric Association supports the value of peer support services and is committed to their participation in the development and implementation of recovery oriented services within systems of care. APA also advocates for appropriate payment for these services. Peer support personnel should have training appropriate to the level of service they will be providing.

Psychiatrists should be knowledgeable of the value and efficacy of the wide array of peer support services in recovery, and support the integration of these services into the comprehensive continuum of care.

Position Statement on the Need to Maintain Intermediate and Long Term Hospital Care for Certain Individuals with Serious Mental Illness

(Adopted from the Position Statement on the Need to Maintain Long-Term Inpatient Psychiatric Hospitals, 1974; Position Statement on Federal Exemption from Medicaid Institutions for Mental Disease, 2014; and US House of Representatives Committee on Energy and Commerce "Where have all the Gone: Examining the Psychiatric Bed Shortage," Jeffery Geller, MD, MPH, 2014).

The American Psychiatric Association views with concern the trend toward the phasing out of the capacity for providing long-term care and treatment to seriously mentally ill[1] (SMI) individuals who have demonstrated an inability to maintain life in the community. We recognize and support the continued development and implementation of new and innovative community programs and treatment modalities for the SMI population. However, at the same time it is essential that we not lose sight of the continuing need for a full spectrum of services which, for a small percentage of patients, includes intermediate and long-term care in a structured hospital ~~-type~~ environment.

Financial pressure to discharge patients from the psychiatric hospital setting too often results in patients living in substandard and dehumanizing circumstances. Patients may end up in correctional facilities, in nursing or boarding homes that are poorly equipped for SMI tenants, or in the streets. They may seek care through high utilization of emergency room and acute care psychiatric inpatient services. A portion of the SMI patient population lacks the capability of maintaining even a marginal adjustment to the community, despite vigorous therapeutic efforts, and may require intermediate or long term hospital care.

Community mental health centers should be funded and staffed to provide full, comprehensive wrap-around services to the segment of the SMI population that can be successfully maintained in the community including intensive residential treatment that is less restrictive than hospital based care. These services should be sufficient to prevent unnecessary and avoidable short, intermediate and long term hospitalizations.

[1] Serious mental illness among people ages 18 and older is defined at the federal level as having, at any time during the past year, a diagnosable mental, behavior, or emotional disorder that causes serious functional impairment that substantially interferes with or limits one or more major life activities. (http://www.samhsa.gov/disorders)

Position Statement on Telemedicine in Psychiatry

Telemedicine in psychiatry, using video conferencing, is a validated and effective practice of medicine that increases access to care. 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 for the benefit of the patient, protects patient autonomy, confidentiality, and privacy; and when used consistent with APA policies on medical ethics and applicable governing law.

Authors:
Committee on Telepsychiatry
Council on Healthcare Systems and Financing

American Psychiatric Association

AND

American Telemedicine Association

Best Practices in Videoconferencing-Based Telemental Health

Writing Committee:

Jay H. Shore, MD, MPH, Peter Yellowlees MD, MBBS, Robert Caudill, MD, Barbara Johnston MSN, Turvey Carolyn, PhD, Matthew Mishkind, PhD, Elizabeth Krupinski, PhD, Kathleen Myers, MD, MPH, Peter Shore PhD, Edward Kaftarian, MD, Donald Hilty, MD

Staff Support:

Sabrina L. Smith (ATA), DrHA, Harry Mellon (ATA), Nathan Tatro (APA) MA, Michelle Dirst (APA)

Reviewers:

Telemental Health Special Interest Group [ATA], APA Telepsychiatry Committee (APA), ATA Standards and Guidelines Committee Member [SG], ATA Staff [ATAS], APA Staff (APAS)

Introduction

This document represents a collaboration between the American Psychiatric Association (APA) and the American Telemedicine Association (ATA) to create a consolidated update of the previous APA and ATA official documents and resources in telemental health to create a single guide on best practices in clinical videoconferencing in mental health. The APA is the main professional organization of psychiatrists and trainee psychiatrists in the United States, and the largest psychiatric organization in the world. The ATA, with members from throughout the United States and the world, is the principal organization bringing together telemedicine practitioners, healthcare institutions, government agencies, vendors and others involved in providing remote healthcare using telecommunications.

Telemental health in the form of interactive videoconferencing has become a critical tool in the delivery of mental health care. It has demonstrated its ability to increase access and quality of care, and in some settings to do so more effectively than treatment delivered in-person.

The APA and the ATA have recognized the importance of telemental health with each individual association undertaking efforts to educate and provide guidance to their members in the development, implementation, administration and provision of telemental health services. It is recommended that this guide be read in conjunction with the other APA and ATA resources that provide more detail.

OFFICIAL APA AND ATA GUIDELINES, RESOURCES AND TELEMENTAL HEALTH TRAININGS	
APA	**ATA**
1) APA Web-based Telepsychiatry Toolkit (2016) 2) Resource Document on Telepsychiatry and Related Technologies in Clinical Psychiatry, Council on Law and Psychiatry (2014) 3) American Psychiatric Association. Telepsychiatry via Videoconferencing. (1998)	4) Practice Guidelines for Telemental Health with Children and Adolescents (2017) 5) Online Training for Video-Based Online Mental Health Service (2014) 6) A Lexicon of Assessment and Outcome Measures for Telemental health (2013) 7) Practice Guidelines for Video-Based Online Mental Health Service (2013) 8) Practice Guidelines for Videoconferencing-Based Telemental Health (2009) 9) Evidence-Based Practice for Telemental Health (2009)

These guidelines focus on interactive videoconferencing based mental health services (a.k.a., telemental health). The use of other technologies such as virtual reality, electronic mail, electronic

health records, telephony, remote monitoring devices, chat rooms, or social networks are not a focus of this document except where these technologies interface with videoconferencing services.

The document was created by a joint writing committee drawn from the APA Telepsychiatry Committee and the ATA Telemental Health Special Interest Group (TMH SIG). This document draws directly from ATA's three previous guidelines, selecting from key statements/guidelines, consolidating them across documents and then updating them where indicated. Following internal review processes within the APA and the ATA, the respective Boards of Directors of both organizations have given approval to its publication.

The reference list includes several detailed reviews providing justification and documentation of the scientific evidence supporting telemental health. Following ATA guideline writing convention this document contains requirements, recommendations, or actions that are identified by text containing the keywords "**shall**," "**should**," or "**may**." "Shall" indicates that it is required whenever feasible and practical under local conditions. "Should" indicates an optimal recommended action that is particularly suitable, without mentioning or excluding others. "May" indicates additional points that may be considered to further optimize the telemental health care process.

It should be recognized that compliance with the recommendations here will not guarantee accurate diagnoses or successful outcomes. The purpose of this guide is to assist providers in providing effective and safe medical care founded on expert consensus, research evidence, available resources, and patient needs.

This document is not meant to establish a legal standard of care.

Administrative Considerations

A. Program Development

Providers or organizations delivering mental health services ***should*** conduct a telehealth needs assessment prior to initiating services. This needs assessment ***should*** include, at a minimum, program overview statement, services to be delivered, proposed patient population, provider resources, technology needs, staffing needs quality and safety protocols, business and regulatory processes, space requirements, training needs, evaluation plan and sustainability.

B. Legal and Regulatory Issues

1) Licensure and Malpractice

Health care services have been defined as delivered in the state where the patient is located. Providers of telemental health services ***shall*** comply with state licensure laws, which typically entail holding an active professional license issued by the state in which the patient is physically located during a telemental health session, and ***shall*** have appropriate malpractice coverage. Providers ***may*** utilize interstate licensure compacts or special telemedicine licensures offered by certain states provided they comply with all individual state licensure and program requirements. Providers ***shall*** conduct their own

due diligence to determine the type of licensure required, and ensure they are in compliance with state licensing board regulations. If providing care within a federal healthcare system (e.g., Department of Veterans Affairs, Department of Defense, Indian Health Service), providers ***shall*** follow their specific organization guidelines around licensure, which may allow for a single state licensure across multiple jurisdictions. Providers ***may*** utilize the interstate licensure compact or special telemedicine licensures offered by certain states provided they comply with all individual state licensure and program requirements.

2) Scope of Practice

Providers or organizations offering telemental health services ***shall*** ensure that the standard of care delivered via telemedicine is equivalent to in-person care. Persons engaged in telemental health services ***shall*** be aware of their professional organization's positions on telemental health and incorporate the professional association standards and clinical practice guidelines whenever possible. Providers in practice and trainees ***should*** stay current with evolving technologies, telemental health research findings, and policies.

3) Prescribing

Providers ***shall*** be aware of both federal and state guidelines around the prescription of controlled substances including the Ryan Haight Online Pharmacy Consumer Protection Act of 2008. Providers ***shall*** comply with federal and state regulations around the prescription of controlled substances based on the setting, model of care, scope of practice and locations in which they are practicing and where the patient is located at the time of treatment.

4) Informed Consent

Local, state, and national laws regarding verbal or written consent ***shall*** be followed. If written consent is required, then electronic signatures, assuming these are allowed in the relevant jurisdiction, may be used. The provider ***shall*** document the provision of consent in the medical record.

5) Billing and Reimbursement

The patient ***shall*** be made aware of any and all financial charges that may arise from the services to be provided prior to the commencement of initial services. Appropriate documentation and coding ***should*** be undertaken specifying when services are rendered via telemental health.

C. Standard Operating Procedures/Protocols

Prior to initiating telemental health services, any organization or provider ***shall*** have in place a set of Standard Operating Procedures or Protocols that ***should*** include (but are not limited to) the following administrative, clinical, and technical specifications:

- Roles, responsibilities (i.e., daytime and after-hours coverage), communication, and procedures around emergency issues.

- Agreements to assure licensing, credentialing, training, and authentication of practitioners as well as identity authentication of patients according to local, state, and national requirements.
- A systematic quality improvement and performance management process that complies with any organizational, regulatory, or accrediting, requirements for outcomes management.

1) Patient-Provider Identification

All persons at both sites of the videoconference ***shall*** be identified to all participants at the beginning of a telemental health session**.** Permission from the patient ***should*** not be required if safety concerns mandate the presence of another individual or if the patient is being legally detained.

At the beginning of a video-based mental health treatment with a patient, the following information ***shall*** be verified and documented:

- The name and credentials of the provider and the name of the patient
- The location(s) of the patient during the session.
- Immediate contact information for both provider and patient (phone or email), and contact information for other relevant support people, both professional and family.
- Expectations about contact between sessions shall be discussed and verified with the patient including a discussion of emergency management between sessions.

2) Emergencies

i. General Considerations

Professionals ***shall*** maintain both technical and clinical competence in the management of mental health emergencies. Provisions for management of mental health emergencies ***shall*** be included in any telemental health procedure or protocol. Clinicians ***shall*** be familiar with local civil commitment regulations and ***should*** have arrangements to work with local staff to initiate/assist with civil commitments or other emergencies.

ii. Clinically supervised settings

Clinically supervised settings are patient locations where other medical or support staff are available in real-time to support the telemental health sessions. Emergency protocols ***shall*** be created with clear explanation of roles and responsibilities in emergency situations. These include determination of outside clinic hours emergency coverage and guidelines for determining when other staff and resources should be brought in to help manage emergency situations. Clinicians ***shall*** *b*e aware of safety issues with patients displaying strong affective or behavioral states upon conclusion of a session and how patients may then interact with remote site staff.

iii. Clinically un-supervised settings

In instances where the mental health provider is providing services to patients in settings without clinical staff immediately available:

- Providers ***should*** discuss the importance of having consistency in where the patient is located for sessions and knowing a patient's location at the time of care as it impacts emergency management and local available resources.

- As patients change locations, providers ***shall*** be aware of the impact of location on emergency management protocols. These include emergency regulations, resources (e.g., Police, emergency rooms, crisis teams), and contacts. These should be documented and available to providers.

- For treatment occurring in a setting where the patient is seen without access to clinical staff, the provider ***should*** consider the use of a "Patient Support Person" (PSP) as clinically indicated. A PSP is a family, friend or community member selected by the patient who could be called upon for support in the case of an emergency. The provider ***may*** contact the Patient Support Person to request assistance in evaluating the nature of emergency and/or initiating 9-1-1 from the patient's home.

- If a patient and/or a PSP will not cooperate in his or her own emergency management, providers ***shall*** be prepared to work with local emergency personnel in case the patient needs emergency services and/or involuntary hospitalization.

3) Care Coordination

With consent from the patient and in accordance with privacy guidelines, telemental health providers ***should*** arrange for appropriate and regular communication with other professionals and organizations involved in the care of the patient.

Technical Considerations

A. Videoconferencing Platform Requirements

Providers and organizations ***should*** select video conferencing applications that have the appropriate verification, confidentiality, and security parameters necessary to be properly utilized for this purpose. In the event of a technology breakdown, causing a disruption of the session, the professional shall have a backup plan in place (e.g., telephone access). Telemental health ***shall*** provide services at a bandwidth and with sufficient resolutions to ensure the quality of the image and/or audio received is appropriate to the services being delivered.

B. Integration of Videoconferencing into Other Technology and Systems

Organizations ***shall*** ensure the technical readiness of the telehealth equipment and the clinical environment. They ***shall*** have policies and procedures in place to ensure the physical security of telehealth equipment and the electronic security of data. Organizations ***shall*** ensure compliance with all relevant safety laws, regulations, and codes for technology and technical safety. Privacy, Security,

HIPPA.

For telemental health services provided within the United States, the United States Health Insurance Portability & Accountability Act (HIPAA;) and state privacy requirements ***shall*** be followed at all times to protect patient privacy. Privacy requirements in other countries ***shall*** be followed for telemental health services provided in those countries.

Patients receiving mental health and substance use disorder services are afforded a higher degree of patients' rights as well as organizational responsibilities (e.g., need for specific consent from patients to release information around substance use). Telemental health organizations ***shall*** be aware of these additional responsibilities and ensure that they are achieved. Telemental health organizations and providers ***shall*** determine processes for documentation, storage, and retrieval of telemental health records.

C. Physical Location/Room Requirements

During a telemental health session, both locations ***shall*** be considered a patient examination room regardless of a room's intended use. Providers ***shall*** ensure privacy so clinical discussion cannot be overheard by others outside of the room where the service is provided. To the extent possible, the patient and provider cameras ***should*** be placed at the same elevation as the eyes with the face clearly visible to the other person. The features of the physical environment for both ***shall*** be adjusted so the physical space, to the degree possible, maximizes lighting, comfort and ambiance synchronous/ asynchronous issues.

When asynchronous telemental health consultations are occurring, the interviewer ***should*** be appropriately trained and the digital recording of the interview ***shall*** be shared and stored in accordance with HIPAA regulations.

Clinical Considerations

A. Patient and Setting selection

There are no absolute contraindications to patients being assessed or treated using telemental health. The use of telemental health with any individual patient is at the discretion of the provider. For clinically unsupervised settings (e.g., home, office) where support staff is not immediately available providers ***shall*** consider appropriateness of fit for an individual patient. Provision of telemental health services in professionally unsupervised settings requires that the patient take a more active and cooperative role in the treatment process than would be the case for in-person locales. Patients need to be able to set up the videoconferencing system, maintain the appropriate computer/device settings, establish a private space, and cooperate for effective safety management. Factors to consider include:

- Providers ***should*** consider such things as patient's cognitive capacity, history regarding cooperativeness with treatment professionals, current and past difficulties with substance abuse, and history of violence or self-injurious behavior.

- Providers ***shall*** consider geographic distance to the nearest emergency medical facility, efficacy of patient's support system, and current medical status.

- The consent process ***shall*** include discussion of circumstances around session management so that if a patient can no longer be safely managed through distance technology, the patient is aware that services may be discontinued.

- Providers ***should*** consider whether there are any medical aspects of care that would require in-person examination including physical exams. If the provider cannot manage the medical aspects for the patient without being able to conduct initial or recurrent physical exams, this shall be documented in the record, and arrangements ***shall*** be made to perform physical exams onsite as clinically indicated.

B. Management of Hybrid Patient-Provider relationships

Telemental health interviews can be conducted as part of a wider, in-person and online clinical relationship using multiple technologies by providers working individually or in teams. The telemental health interview can be an adjunct to periodic face-to-face in person contact or can be the only contact. It is typically supported by additional communications technologies such as faxed or emailed consultation information, patient portals, telephone, mobile devices, and electronic health records. Providers ***should*** have clear policies pertaining to communications with patients. These ***should*** describe the boundaries around ways in which patients can communicate with a provider, which content is appropriate to share over different technology platforms, anticipated response times, and how and when to contact a provider. Providers **should** identify clearly which platforms are acceptable for communication of an emergency and expected response times. Providers ***should*** be attentive of the impact of different technology platforms on patient rapport and communication.

C. Ethical Considerations

Health professionals ***shall*** be responsible for maintaining the same level of professional and ethical discipline and clinical practice principles and guidelines as in person care in the delivery of care in telemental health, as well as additional telemental health related concerns such as consent processes, patient autonomy, and privacy.

D. Cultural Issues

Telemental health providers ***should*** be culturally competent to deliver services to the populations that they serve. Providers ***should*** familiarize themselves with the cultures and environment where they are working and ***may*** use site visits and cultural facilitators to enhance their local knowledge when appropriate and practical. Providers ***should*** assess a patient's previous exposure, experience, and comfort with technology/video conferencing. They **shall** be aware of how this might impact initial

telemental health interactions. Providers ***should*** conduct ongoing assessment of the patient's level of comfort with technology over the course of treatment.

E. Specific populations and settings

1) Child/Adolescent Populations

Telemental health procedures for the evaluation and treatment of youth ***shall*** follow the same guidelines presented for adults with modifications to consider the developmental status of youth such as motor functioning, speech and language capabilities, relatedness, and relevant regulatory issues. When working with younger children the environment ***should*** facilitate the assessment by providing an adequate room size, furniture arrangement, toys, and activities that allow the youth to engage with the accompanying parent, presenter, and provider and demonstrate age-appropriate skills.

Extended participation of family members or other relevant adults is typical of mental health treatment of children and adolescents. Providers ***should*** adhere to usual in-person practices for including relevant adults with appropriate modifications for delivering service through videoconferencing in the context of resources at the patient site. Extended participation ***may*** include a "presenter" who ***may*** facilitate sessions (e.g., vital signs, assistance with rating scales, managing active children, assisting with any urgent interventions) Providers ***should*** consider how the presenter's involvement can affect service delivery (e.g., social familiarity with the family, perceived confidentiality, sharing information with other team members).

When telemental services are delivered outside of traditional clinic settings (eg. schools) providers ***should*** work with staff to ensure safety, privacy, appropriate setting, and accommodations. This is particularly true if multiple staff participate in sessions. Appropriateness for telemental care ***shall*** consider safety of the youth, the availability of supportive adults, the mental health status of those adults, and ability of the site to respond to any urgent or emergent situations.

2) Forensic and Correctional

Providers ***shall*** be aware of systems issues in working in forensic and correctional settings and follow applicable standard consent around both treatment and evaluation in terms of patient's legal status and rights. Provider ***shall*** have clear site specific protocols about working with patients and staff in forensic and correctional settings.

3) Geriatric

The geriatric patient often has multiple medical problems and the inclusion of family members ***should*** be undertaken as clinically appropriate and with the permission of the patient. Interviewing techniques ***shall*** be adapted for patients who may be cognitively impaired, find it difficult to adapt to the technology, or have visual or auditory impairment. Cognitive testing may be provided via videoconferencing but might need to be modified for use via video. Organizations administrating

cognitive testing via videoconferencing ***shall*** be aware of the properties of the individual test instrument, how it may be impacted by videoconferencing, and any potentially needed modifications.

4) Military, Veteran and other federal populations

Providers ***shall*** be familiar with the federal and specific organizational structures and guidelines for patients related to the location of care. Providers ***should*** familiarize themselves with the culture of the patients (e.g., military cultural competency) and the organizational systems in which they practice.

5) Substance Use Disorder Treatment

Providers ***shall*** be aware of and comply with federal, state and local regulations around prescription of controlled substances involved in Substance Use Disorder treatment. Providers ***shall*** coordinate with onsite staff to provide appropriate standard of care including care coordination and monitoring of physiological parameters for monitoring of ongoing treatment as clinically indicated.

6) Inpatient and Residential Settings

Providers ***should*** work to integrate themselves into inpatient and residential care settings where they practice through virtual participation in administration and organizational meetings including clinical case staffing on a routine/regular basis. Remote providers ***should*** optimize use of patient site staff for help with telemental health consultations and case coordination as clinically indicated. Inpatient units should provide the Telemental Health provider with adequate access to patients, members of the interdisciplinary treatment team, and primary medical providers and nursing support when appropriate.

7) Primary Care Settings

Providers ***should*** be aware of best practice in leveraging telepsychiatry to support integrated care across a continuum of models including direct patient assessment, consultative models, (e.g., asynchronous) and team-based models of care. Providers practicing integrated care telepsychiatry should attend to the impact of virtual interactions on team processes, dynamics, and patient outcomes in the delivery of integrated care.

8) Rural

Providers ***should*** be familiar with the impact of rural environments on treatment including firearm ownership, kinship in small communities, local geographic barriers to care and general availability of healthcare resources.

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Position Statement Review (New and Existing) **Attachment E**

Position Statement	Reviewers	Action
Prescription Drug Monitoring Programs (PDMP)	From Council on Addiction Psychiatry	The Council on Addiction Psychiatry has developed a position statement (and associated resource document) in response to an APA Assembly Action Paper (Improving the Confidentiality of Prescription Drug Monitoring Programs (ASMNOV1612.G)). **The Council has again reviewed and provided feedback to the Council on Addiction Psychiatry.**
Principles for Healthcare Reform for Psychiatry	From Council on Advocacy and Public Policy	The Council is working to overhaul this document, given that it is now a decade old and outdated. The Council will provide comprehensive feedback for the Council on Advocacy and Government Relations to review. As discussed, the drafted Position Statement on Cost Barriers to Care for Patients with Recurrent Disabling Mental Disorders will be rolled into this document. **The Council will work on revisions and share the updated version with CAGR.**
Banning of Pharmacy Benefit Management (PBM) Policies that Require the Provision of Dangerous Quantities of Medications	Eileen McGee	**The Council is reviewing the current statement and considering revisions.**

JRC Summary of Actions **Attachment E**

Status	Action	JRC Comments/Recomm	Referral/Follow-up	Notes:
June 2017 Referral	Revising the Nomenclature, Definition, and Clinical Criteria for Partial Hospitalization Program (ASM2017A1 12.E) The action paper asks that: 1. Refer to the Council on Healthcare Systems and Financing to review and revise nomenclature, definition, and clinical criteria for Partial Hospitalization Program for the purpose of uniform and consistent utility among clinicians, researchers, patients, general public, clinical facilities and health insurance industry, and to reduce stigma and confusion. 2. The Council on Healthcare Systems and Financing reviews, and revises if appropriate, the definition and clinical criteria for Intensive Outpatient Program and residential treatment programs for similar purpose. 3. The Council on Healthcare Systems and Financing, after consultation and input from appropriate APA councils, submit a report to the Assembly by May 2018. 4. The Council on Healthcare Systems and Financing also recommend to Assembly on how to implement and advocate the revisions to all parties concerned.	The Joint Reference Committee referred the action paper to the Council on Research (LEAD), Council on Healthcare Systems and Financing, Council on Medical Education and Lifelong Learning; Council on Quality Care for the Committee on Practice Guidelines, and the DSM Steering Committee for implementation.	Council on Research ~~(LEAD)~~ DSM Steering Committee Council on Healthcare Systems and Financing (LEAD) Council on Quality Care Committee on Practice Guidelines Council on Medical Education and Lifelong Learning Report to the JRC – Oct. 2017 (Deadline 9/28/17)	**CHSF is now the LEAD on this action and will roll it into the discussions regarding level of service/core criteria.**
	FYI ONLY			
Feb 2017	Continuity of Care	The Joint Reference	Council on Healthcare Systems	The Council on Quality discussed this

JRC Summary of Actions **Attachment E**

Status	Action	JRC Comments/Recomm	Referral/Follow-up	Notes:
Referral	(ASMNOV1612.C) The action paper asks that the Council on Quality Care explore options such as a position statement or resource document to encourage timely communication between inpatient and outpatient teams, including both general medical and psychiatric facilities.	Committee referred the action paper to the Council on Healthcare Systems and Financing (LEAD) and then to the Council on Quality Care (Secondary).	and Financing (LEAD) Council on Quality Care (Secondary) Report to the JRC – June 2017 (Deadline June 5, 2017)	paper & noted that quality measures exist regarding transitions in care. Drs. Dewan and Berger have agreed to draft a position statement on the issue. The position statement can utilize the NQF measures on the topic. Status: Not yet completed
Feb 2017 Referral	Mental Health Parity for Individuals with Intellectual and Developmental Disability (IDD) (ASMNOV1612.P) The action paper asks: • That the American Psychiatric Association develop a position statement supporting mental health parity for individuals with IDD. • That the American Psychiatric Association join with other allies and organizations to prioritize the educational, access to care, advocacy, and legislative efforts needed to assure that all individuals with IDD receive appropriate mental healthcare consistent with established mental health parity rights	The Joint Reference Committee referred the action paper to the Council on Healthcare Systems and Financing (LEAD), Council on Children, Adolescents, and Their Families, and the Council on Advocacy and Government Relations. A report to the Joint Reference Committee is requested by the deadline for the June 2017 meeting.	Council on Healthcare Systems and Financing (LEAD) Council on Children, Adolescents, and Their Families Council on Advocacy and Government Relations Report to the JRC – June 2017 (Deadline June 5, 2017)	CAGR discussed the action paper and agreed a position statement is relevant to the current climate and emergency department boarding. The Council requested the APA Administration review the legislative landscape on this issue, before determining next steps. The Council will report its recommendations to the Council on Healthcare Systems and Financing, and consider enlisting the assistance of the Caucus of Psychiatrists Treating Persons with IDD. Status: Not yet completed
June 2017 Referral	Providing Education and Guidance for the Use and Limitations of Pharmacogenomics in Clinical Practice (ASM2017A1 12.G) The action paper asks that: 1. The APA educate its members about the use and limitations of pharmacogenomic testing in clinical	The Joint Reference Committee referred the action paper to the Council on Quality Care (LEAD), Council on Healthcare Systems and Financing, Council on Medical Education and Lifelong Learning, Council on Research, and Council on Advocacy and Government	Council on Quality Care (LEAD) Council on Healthcare Systems and Financing Council on Medical Education and Lifelong Learning	Status: FYI ONLY - Council on Quality to do the initial review.

Status	Action	JRC Comments/Recomm	Referral/Follow-up	Notes:
	psychiatric practice and advance integrated collaborative care by educating non-psychiatrist physicians about the use and limitations of pharmacogenomic testing for psychiatric care. 2. The Council on Medical Education and Lifelong Learning offer education on pharmacogenomics and pharmacogenomic testing via various educational activities (e.g., Member's Course of the Mouth, Annual Meeting and IPS) and other means, e.g., via Psychiatric News articles. 3. The Council on Quality Care: A. evaluate and provide guidance on the use and limitations of pharmaco-genomic testing in pertinent practice guidelines covering rating the strength of research evidence and recommendations, benefits and harms, and quality measurement considerations B. consider producing a resource document on the use and limitations of pharmacogenomic testing in clinical practice 4. The Council on Research promote research on pharmacogenomic testing, especially addressing study questions about informing clinical practice and treatment outcomes using pharmaco- genomic testing. 5. The Council on Advocacy and Government Relations	Relations, and the Office of the CEO/Medical Director.	Council on Research Council on Advocacy and Government Relations Office of the CEO/Medical Director Report to the JRC – Oct. 2017 (Deadline 9/28/17)	

JRC Summary of Actions **Attachment E**

Status	Action	JRC Comments/Recomm	Referral/Follow-up	Notes:
	explore whether the APA should advocate for truth in advertising for pharmacogenomic testing, and thus, promote accurate consumer education. 6. An article on pharmacogenomic testing and its limitations be placed on the APA Website "Patients & Families" section to provide accurate information for consumers			

Council on International Psychiatry

The Council on International Psychiatry is focused on increasing international membership by working cross-collaboratively with individuals and organizations to identify and develop benefits that support the education and training of psychiatrists in the United States and around the world.

International Development and Engagement

- **Chester M. Pierce Human Rights Award Nominating Committee:** Following the approval of the Mental Disability Advocacy Center, now known as Validity, by the APA Board of Trustees to receive the 2018 Chester M. Pierce Human Rights Award, the Committee, under the guidance of Committee Chair, James Griffith, MD, has begun to discuss preparations for the presentation of the award during the 2018 APA Annual Meeting with APA Administration and in consultation with the Council. Several relevant sessions accepted by the Scientific Programs Committee as well as relevant meetings are being taken into consideration and APA staff has been in contact with the Interim Executive Director of Validity, Mr. Steven Allen, to begin preliminary coordination of the presentation of the award during the 2018 APA Annual Meeting. The Committee is in the process of scheduling a conference call for March 2018 to discuss the nominations process, which includes a call for nominations to APA members, in preparation for their in-person meeting in May. The Committee welcomes any recommendations from APA members for 2019.

  The Chester M. Pierce Human Rights Award recognizes the extraordinary efforts of individuals and organizations to promote the human rights of populations with mental health needs by bringing attention to their work. Originally established in 1990 to raise awareness of human rights abuses, the award was renamed in 2017 to honor Chester M. Pierce, M.D. (1927-2016) and recognize his dedication as an innovative researcher on humans in extreme environments, an advocate against disparities, stigma, and discrimination, and as a pioneer and visionary in global mental health.

  Validity, formerly known as the Mental Disability Advocacy Center, is an international human rights organization that uses the law to secure equality, inclusion and justice for people with mental disabilities worldwide. The organization works at a global, regional, and local level to reduce the gap between rhetoric and practice for human dignity, respect and inclusion for all disabled individuals. It has intervened in many serious violations of human rights including the mistreatment of Romani people (gypsies) in Europe, warehousing of mentally ill individuals, and violations of international laws that impinge on the treatment, education, development, and exclusion of mentally ill individuals. Its human rights interventions and legal representations have occurred in the UK, Russia, Estonia, Czech Republic, and many other European countries. More recently the organization has investigated the status of treatment and housing of mentally ill individuals in Zambia, Kenya, Argentina, and India. Validity is headquartered in Budapest, Hungary, has participatory status with the Council of Europe, and special consultative status with the United National Economic and Social Council.

  The Nominating Committee is comprised of members of the Council on International Psychiatry (James Griffith, MD, Brandon Kohrt, MD), the Council on Minority Mental Health and Health Disparities (Deb Carter, MD, Eric Yarbrough, MD), the Assembly Committee of Representatives of

Minority/Under-Represented Groups (Francis Sanchez, MD), and Black Psychiatrists of America, Inc. (Samuel Okpaku, MD).

- **Caucus on Global Mental Health and Psychiatry:** Under the leadership of the Caucus Chair, Khurshid Khurshid, MD, the Caucus has established an Executive Committee structure, comprised of candidates not elected to the Caucus Chair position in the previous election, including Richa Bhatia, MD, and Gabriel Ivbijaro, MD, to help with the coordination of abstract submissions for the 2018 APA Annual Meeting and to provide guidance and mentorship to Caucus members interested in submitting abstracts. While it has been reported that several submissions by Caucus members were accepted by the Scientific Programs Committee, those whose submissions were not accepted where given the guidance to consider submitting their abstracts as a poster submissions. Caucus members accepted as international poster presenters may also have the opportunity to participate in the International Poster Engagement Program being coordinated by the Council.

- **International Poster Engagement Program:** Following the approval by the APA Board of Trustees to incorporate the International Poster Engagement Program into the charge of the Council on International Psychiatry, the Council, under the leadership of Council Chair, Bernardo Ng, MD, and Council Member, U.K. Quang-Dang, MD, have begun to discuss preparations for managing the program for the 2018 APA Annual Meeting. While several Council members have already been identified to serve as reviewers for the program, the Council is also coordinating with the APA Caucus on Global Mental Health and Psychiatry, to reach out to Caucus members who may also be interested in participating as reviewers. Reviewers will then be connected with identified program participants to coordinate in-person meetings during the International Poster Session at the APA Annual Meeting to provide feedback on research posters and presentations, in addition to providing information about opportunities for participants to connect with APA through member activities and benefits. APA staff is coordinating with the Scientific Programs Office to contact international poster presenters whose abstracts were accepted by the Scientific Programs Committee to participate in the program.

- **International Medical Graduate Psychiatrists:** After connecting with the leadership of the APA International Medical Graduate (IMG) Psychiatrists Caucus, including Anthony Fernandez, MD, and Rajesh Tampi, MD, to learn more about the focus of the IMG Psychiatrists Caucus, the Council began discussions around the benefits and challenges of bicultural and multicultural psychiatrists in the United States. Discussions included a preliminary literature review (see Attachment 1) by Council Member Vincenzo Di Nicola, MD, which included both anthropological and philosophical perspectives on culture and psychiatry as well as a discussion of issues pertaining to language and communication, cultural adaptation and integration, and health care policy and advocacy. Throughout the discussion, it was noted that personal narratives serve as an important component to better understanding the scope of issues impacting IMG psychiatrists. This discussion evolved into an additional focus on the work of the Society for the Study of Psychiatry and Culture, including webinars such as a recent one on “Culture, Violence, and Mental Well-Being: Understanding Culture’s Double-Edged Sword”, which revealed a large number of members of the Council also serving as both members and leadership of SSPC. This includes Council Members, James Griffith, MD who was recently elected to serve as the incoming SSPC President-Elect. The Council noted that it will continue to focus on discussing and uncovering issues impacting IMG psychiatrists, through

continued coordination with the APA IMG Caucus, including issues that intersect with the work of the SSPC in order to strengthen the relationship between APA and SSPC.

- **Climate Change and Mental Health:** After connecting with the leadership of a group of APA members proposing the establishment of an APA Caucus on Climate Change and Mental Health, including Robin Cooper, MD, and David Pollack, MD, the Council began discussions around the issue of how climate change impacts mental health and the process for the establishment of a Caucus. Over the series of two conference calls, Council members expressed an overwhelming amount of support for the issue, noting the impact of climate change on those with mental disorders and vulnerable populations, including small-island nations, and its impact on migration issues. While the Council supports the establishment of a Caucus on this issue, there was concern expressed that the focus of this Caucus, as presented, may not inherently fit into the scope of the Council. During the Council's initial discussion with Drs. Cooper and Pollack, it was noted that this issue and the focus of the proposed Caucus does span more than one Council. The Council plans to reconnect with Drs. Cooper and Pollack to share the Council's feedback and discuss possible next steps for the establishment of a Caucus on Climate Change and Mental Health. The Council welcomes any guidance from the Joint Reference Committee.

- **Position Statement on Mental Health Needs of Undocumented Immigrants, including Childhood Arrivals, Asylum-Seekers, and Detainees:** The Council on Minority Mental Health and Health Disparities reached out to the Council on International Psychiatry to discuss the development of a position statement on undocumented immigrants and to share a draft for review and feedback. While the Council expressed support for the draft "Position Statement on Mental Health Needs of Undocumented Immigrants, including Childhood Arrivals, Asylum-Seekers, and Detainees" it was also noted that this position statement may best serve as a complement to the recently passed "Position Statement on the Role of Psychiatrists in Addressing Care for People Affected Forced Displacement" (see attachment 2) which states APA's support of the treatment of immigrants, refugees, and displaced persons, the development of partnerships with elected officials and immigration detention centers, and training psychiatrists to deliver trauma-informed and culturally competent care to immigrants, refugees, and displaced populations. Together these position statements could provide direction to federal policy makers and responsible agency officials to ensure that detained individuals with mental disorders receive appropriate mental health treatment.

ATTACHMENT 1: INTERNATIONAL MEDICAL GRADUATE (IMG) PSYCHIATRISTS PRELIMINARY LITERATURE REVIEW

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APA Official Actions

Role of Psychiatrists in Addressing Care for People Affected by Forced Displacement

Approved by the Board of Trustees, July 2017
Approved by the Assembly, May 2017

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

Issue:
An unprecedented level of migration due to a variety of socio-political and economic factors has marked the 21st century. Currently, 65.3 million persons worldwide have been forcibly displaced by armed conflict, political oppression, starvation, or other catastrophes (1). While people who are displaced both within and out of countries can demonstrate high levels of resiliency, they can also experience disabling posttraumatic disorders or other consequences that adversely impact medical, psychological, social, and spiritual well-being. These consequences can range from demoralization to various sequelae involving simple and complex trauma complicated by the migratory journey and resettlement process. Perpetuating factors can include limited access to basic services, including appropriate medical and mental health care, legal and financial stressors, as well as discrimination faced in the host community, all of which can contribute to poorer mental health outcomes. These migration-related and post-migration stressors can produce demoralization, grief, loneliness, loss of dignity, and feelings of helplessness as normal syndromes of distress that impede refugees from living healthy and productive lives (2, 3, 4).

Position:
American psychiatrists have broad skill sets for relieving suffering inflicted upon immigrants and refugees by displacement from and within their home countries and can provide direct psychotherapeutic and psychosocial interventions, as well as programmatic leadership, for the care of persons suffering posttraumatic symptoms and other migration-related syndromes of distress (5, 6, 7, 8, 9, 10).

The American Psychiatric Association (APA) supports the following:

1. The treatment of all immigrants, refugees and displaced persons with dignity and respect during all stages of the migratory process.

2. The development of partnerships between health and mental health providers, communities, elected officials, social and spiritual groups, immigration and customs enforcement (ICE) detention centers, and the asylum evaluation process, to address gaps in providing comprehensive, appropriate, and culturally competent care for these patients.

3. The identification of patients who have unidentified or unmet mental health needs and intervention when appropriate.

4. The appropriate training of psychiatrists to improve competency in delivering trauma-informed and culturally competent care to diverse immigrant, refugee, and displaced populations.

Authors: Council on Minority Mental Health and Health Disparities (Francis Lu, M.D., Evaristo Akerele, M.D., Samra Sahlu, M.D., Carine Nzodom, M.D.), Council on International Psychiatry (James Griffith, M.D., Dyani Loo, M.D., Colin Buzza, M.D., M.P.H., M.Sc.), Council on Children, Adolescents, and Their Families (Kimberly Gordon, M.D.), Council on Psychiatry and Law (Furqan Nusair, M.B.B.S., Rachel Robitz, M.D.)

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ATTACHMENT 3: COUNCIL MINUTES - DECEMBER

Council Name: Council on International Psychiatry
Date: December 14, 2017
Time: 8:00 PM – 9:00 PM
Location: Conference Call

Council Members Present: B. Ng, G. Jayaram, K. Busch, J. Griffith, V. Di Nicola, B. Kohrt, S. Okpaku, E. Pi, U.K. Quang-Dang, M. Riba, C. Buzza, R. De Similien, J. Winfield Tan, N. Karingula, A. Shrestha

Council Members with Excused Absences: B. Acharya, A. Tasman, S. Iqbal, J. McIntyre, G. Raviola, E. Sorel, A. Vahabzadeh, M. K. Smith, M. Komrad, N. Goodsmith, L. McIntyre, T. Nicholson

Council Members with Unexcused Absences: None

Guests in Attendance: Khurshid Khurshid, MD, Amanda Ruiz, MD, Samra Sahlu, MD, Robin Cooper, MD, David Pollack, MD

Staff in Attendance: R. Juarez

Council Minutes

The Council approved the minutes of the October 26 conference call with edits including the correct dates for the World Association of Cultural Psychiatry meeting, October 11-13, 2018 and the submission deadline as January 15, 2018. It was also noted that the results of the WPA Election needed to be updated to reflect that Masatoshi Takeda continues to the Secretary of Meetings and that the WPA Finance Secretary is Armen Soghoyan.

Board of Trustees Update

Dr. Ng provided an updated on recent actions by the Board of Trustees, following their meeting in early December. This included the International Poster Engagement Program being officially incorporated in the Council's charge, the approval of the Mental Disability Advocacy Center to receive the 2018 Chester M. Pierce Human Rights Award, and the approval of position statements on Human Rights, Human Trafficking, and Health Care, Including Mental Health, as a Human Right.

Climate Change and Mental Health Discussion

Dr. Robin Cooper and Dr. David Pollack, who are part of a group of APA members with interest and expertise in mental health and climate change, shared that they have been working with a group of APA members to identify a Council to take into consideration the establishment of a Caucus on this issue. It was noted that in the past year, there has been a tipping point reached with the interest around this and similar issues by APA members, and that the issues that climate and health represent are so broad, including impacts to under-represented and minority groups around the world, that it has been a challenge to find an APA component, though APA leadership has provided the guidance the Council on International Psychiatry should be able to provide an appropriate level of scope. Several Council members expressed support for the global impact of the issue including the impact on vulnerable

populations and areas, including small-island nations. It was noted that the issue may span more than one Council, but that the Council on International Psychiatry could serve as a hub for communications with other Councils as necessary. Council members also noted that climate change impacts migration issues as well with several members speaking in support of the establishment of the Caucus. It was shared that the issues of health and mental health are much bigger than the APA, but the Caucus could find a home in the Council. Drs. Pollack and Cooper noted that they reached out to APA candidates to share some information. Several Council members expressed that it would be good to get some additional background information on the linkage between climate change and mental health. Background information will be provided for the next Council call.

U.S. Immigration Reform Discussion with Minority Council Liaisons

Dr. Amanda Ruiz and Dr. Samra Salu from the Council on Minority Mental Health and Health Disparities shared with the Council on International Psychiatry that the Minority Council is discussing a potential position statement on immigration that will fold into it multiple perspectives. They noted that they are looking at merging the position statement on detained immigrants and mental illness with a position statement on the mental health needs of undocumented immigrants including DACA, Deferred Action for Childhood Arrivals. It was noted that the Minority Council may be able to share a draft of the position statement with the International Council for review and feedback. While it was noted that other Councils are not involved in the development of this position statement, there were several members of the Council on International Psychiatry who expressed interest in being part of its development, including Dr. Angela Shrestha and Dr. Nikki Goodsmith. It was also noted that feedback has been received from Dr. Jennifer Severe, a former Fellow of the Council on International Psychiatry, and Dr. Ralph de Similen.

World Psychiatric Association

Dr. Ed Pi shared that since the WPA Election, things have been quiet, but that a WPA thematic congress focused on innovation in psychiatry is scheduled for February in Melbourne, Australia. The theme for the WPA International Congress of Psychiatry schedule for September 2018 in Mexico City will be about psychiatry standing firm for mental health. The deadline for submissions for the WPA International Congress in Mexico is January 15, 2018. Dr. Bernardo Ng shared that he is part of the local organizing committee and is also the President-Elect for the Mexican Psychiatric Association, so he encourages the members of the Council on International Psychiatry to consider attending the congress and to visit their website.

Global Integrated Care Survey

Dr. Ralph de Similien provided an update electronically to share with the Council noting that some restructuring of the information gathered is necessary in order for the collected data to be useful to the Council. It was identified that some of the provided data has conflicting information and reflects information from the national level and from the level of local clinics. The group working on this survey will continue to work on finalizing the data for review by the Council.

Caucus on Global Mental Health and Psychiatry

Dr. Khurshid Khurshid, the Chair of the APA Caucus on Global Mental Health and Psychiatry, shared with the Council that the Caucus has generated a good amount of interest about APA session proposals. It was noted that at least seven people informed them that their proposals were accepted for the 2018 APA Annual Meeting, including proposals submitted by Dr. Geetha Jayaram and Dr. Richa Bhatia. The Caucus divided into sub groups to work in certain areas with mentors and those whose abstract submission were not accepted were encouraged to submit a poster. Dr. Khurshid also shared that, in order to support the Council's International Poster Engagement Program, that he would work with Council members to be a review and to ensure that the opportunity to be a reviewer is disseminated to other Caucus members.

International Poster Engagement Program

Dr. Bernardo Ng and Dr. UK Quang-Dang provide an overview of the International Poster Engagement Program, which is now part of the Council's charge and encouraged everyone on the Council to volunteer to be reviewers. The list of those who volunteered to be reviewers include the following: Dr. Khurshid Khurshid, Dr. Mary Kay Smith, Dr. Bernardo Ng, Dr. Angela Shrestha, Dr. Vincenzo Di Nicola, and Dr. Jack McIntyre. The group noted that it would discuss an opportunity for scheduling a work group to focus on the coordination of the program.

Chester M. Pierce Human Rights Award

With the approval of the 2018 Chester M. Pierce Human Rights Award to be awarded to the Mental Disability Advocacy Center, Dr. James Griffith, the Chair of the Chester M. Pierce Human Rights Award Nominating Committee, provided some background on the work of MDAC. This included highlights of the organizations use of force of law to advocate on behalf of organizations focused on mental illness, not that a lot of work has been done in Eastern Europe where they have won multiple cases under the force of law. Details about the presentation of this award at the APA Annual Meeting are in the works and more information will be provided to the Council in the coming months.

Society for the Study of Psychiatry and Culture

Dr. James Griffith announced that he will be the President-Elect to the Society for the Study of Psychiatry and Culture (SSPC). It was noted by the Council members that there is much overlap between the membership of SSPC and the Council on International Psychiatry. It was shared that SSPC has produced multiple webinars including a recent webinar on "Culture, Violence, and Mental Well-Being: Understanding Culture's Double-Edged Sword." Dr. Griffith was a presenter focusing on social-neuroscience, Dr. Larry Merkel did a presentation on Charlottesville regarding communities and background context, and Dr. Cecile Rousseau from McGill University focused her presentation on aggression. The SSPC 39th Annual Meeting was announced for April 2018 at the Kroc Institute for Peace and Justice at the University of San Diego.

ATTACHMENT 4: COUNCIL MINUTES - OCTOBER

Council Name: Council on International Psychiatry
Date: October 26, 2017
Time: 8:00 PM – 9:00 PM
Location: Conference Call

Council Members Present: B. Ng, G. Jayaram, K. Busch, J. Griffith, V. Di Nicola, B. Kohrt, S. Okpaku, E. Pi, U.K. Quang-Dang, M. Riba, C. Buzza, R. De Similien, J. Winfield Tan, N. Karingula, A. Shrestha

Council Members with Excused Absences: B. Acharya, A. Tasman, S. Iqbal, J. McIntyre, G. Raviola, E. Sorel, A. Vahabzadeh, M. K. Smith, M. Komrad, N. Goodsmith, L. McIntyre, T. Nicholson

Council Members with Unexcused Absences: None

Guests in Attendance: Khurshid Khurshid, MD

Staff in Attendance: R. Juarez

Council Minutes

The Council approved the minutes of the September 15 in-person meeting without edit.

Joint Reference Committee Update

Following the October 17 in-person meeting of the JRC, Dr. Ng shared with the Council the following updates reported out by the JRC:

- *International Poster Engagement Program:* The JRC approved recommending to the APA Board of Trustees to add this to the charge of the Council. This proposal goes to the APA Board of Trustees in December for final approval.
- *2018 Chester M. Pierce Human Rights Award:* The JRC approved recommending to the APA Board of Trustees to award the 2018 Award to the Mental Disability Advocacy Center.
- *Human Rights Position Statement:* The JRC approved forwarding the position statement to the APA November Assembly meeting for review prior to being sent to the Board of Trustees.
- *Human Trafficking Position Statement:* The JRC approved forwarding the position statement to the APA November Assembly meeting for review prior to being sent to the Board of Trustees.
- *Healthcare as a Human Right Position Statement:* The JRC approved recommending to the APA Board of Trustees to approve the position statement.

World Psychiatric Association Update

The Council thanked Dr. Michelle Riba, a 2018 WPA candidate for President-Elect and recently completing her term as the WPA Secretary for Publications, for her many years of service in the WPA. Dr. Riba thanked all the members of the Council for their help and support throughout the election

process and expressed thanks to all those who worked with her throughout the campaign. The WPA Election results were shared as follows:

- President: Helen Herrman
- President-Elect: Afzal Javed
- Secretary General: Roy Kallivayalil
- Secretary of Education: Roger Ng
- Secretary of Publications: Michel Botbol
- Secretary of Sections: Thomas Schulz

It was also shared that the position of WPA Secretary of Meetings continues to be Masatoshi Takeda and that the WPW Secretary of Finance is Armen Soghoyan. It was noted that appointments to WPA Standing Committees may also occur in the near future.

Global Integrated Care Survey

The Council members working on the Global Integrated Care Survey, including Dr. de Similien, provided an update on the survey noting that more completed surveys have been received, including from Brazil, Chile, Israel, Italy, and Russia. More are expected to come from Mexico and Colombia as well. In total, about 16-17 countries have responded and completed the instrument that was distributed.

World Medical Association Declaration of Geneva Revisions

APA staff shared a report summarizing recent revisions to the World Medical Association (WMA) Declaration of Geneva, which is considered as the "contemporary successor to the Hippocratic Oath" developed and adopted by the WMA, with the Council for feedback to share with the APA CEO and Medical Director, Saul Levin. It was noted that revisions included greater priority and additional language included that address patient rights and physician well-being including the following:

As a Member of the Medical Profession:

- I will respect the autonomy and dignity of my patient
- I will practice my profession with conscience and dignity
- I will attend to my own health, well-being, and abilities in order to provide care of the highest standard.
- I will give to my teachers, colleagues, and students the respect and gratitude that is their due

Council members expressed no issue with the revisions to the Declaration. This information will be shared with the APA Medical Director's Office.

Indian Association of Private Psychiatry

APA staff shared that representatives of the Indian Association of Private Psychiatry (IAPP) recently reached out with interest in developing a stronger relationship with the APA. Several Council members expressed interest in being part of a group to help make the connection with the organization, including Geetha Jayaram, Michelle Riba, and Samuel Okpaku. Staff will coordinate with Council members and the IAPP representatives.

Society for the Study of Psychiatry and Culture

Several Council members strongly encouraged members of the Council to plan to attend the annual meeting of the Society for the Study of Psychiatry and Culture (SSPC) scheduled for April 19-21, 2018 in San Diego, CA. It was noted that multiple members of the SSPC Board are members of the Council. It was also noted that the 2018 World Association for Cultural Psychiatry is scheduled for January 18, 2018 in New York, NY.

WPA International Congress of Psychiatry – Mexico

Dr. Ng shared that he has been invited to be part of the organizing and planning committee for the WPA International Congress of Psychiatry scheduled for September 27-30, 2018 in Mexico City. It was noted that this congress will be the first WPA congress in the new modality.

Executive Summary
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 AADPRT, ADMSEP, AACDP and the ABPN.

Information Item – Comment on ACGME Institutional Requirements
The Council weighed in on submission of a comment to revise the Institutional Requirements for residency and fellowship programs accredited by the Accreditation Council for Graduate Medical Education (ACGME). The comment from the APA supported the establishment of an ACGME accreditation standard III. C. in the section "The Learning and Working Environment".

> **"Diversity Programs and Partnerships**
> The sponsoring institution has effective policies and practices in place, and engages in ongoing, systematic, and focused recruitment and retention activities, to achieve mission-appropriate diversity outcomes among its residents/fellows, faculty, senior administrative staff, and other relevant members of its clinical learning environment. These activities include the use of programs and/or partnerships aimed at achieving diversity among qualified applicants for residency/fellowship training program admission and the evaluation of program and partnership outcomes."

Update on Expanding Access to Psychiatry Subspecialty Fellowships (ASM2017A1 12.H)
The action paper asks that American Psychiatric Association urge the ACGME to consider mechanisms to enable residents of AOA accredited programs to be eligible to enter ACGME accredited psychiatry subspecialty fellowships. Dr. Gorrindo has included this in his report to the ACGME and will present this in person the first week of February.

Update on Projects of the Council
The Council continues to be involved in several projects, Survey on Teaching and Receiving Feedback, and Personal Learning Project Tool. The Council is also rewriting our charge to reflect the current state of medical education and lifelong learning.

Joint Sponsorship of CME Credit for Allied Associate groups.
With input from the Council on Medical Education and Lifelong Learning, APA expanded its Joint Sponsorship program to new Allied Associates, American Society of Hispanic Psychiatry, and Mexican Psychiatric Association. Goals of the Joint Sponsorship program include: strengthening allied relationships and expanded business opportunities; furthering educational goals; enhancing the APA learning management system and bringing in new learners.

American Board of Psychiatry and Neurology (ABPN) MOC Part III Pilot Project
The Council is staying informed about the ABPN "pilot program" that is an option for some diplomates in 2019 to replace the recertification examination. Participants in the pilot program will read and answer questions on 30-40 journal articles selected by the ABPN Pilot Project Test Writing Committees. The Pilot Project Test Writing Committees include nominated members from the ABPN and from

professional societies (APA, AACAP, AAN, and CNS). The Committees develop a content outline, select journal articles relevant to clinical practice, and write questions related to those articles. The articles reflect topics on the content outline. Link to ABPN for more detail https://www.abpn.com/maintain-certification/moc-part-iii-pilot-project/

The Council met by phone on October 26, 2017 (minutes attached)

COUNCIL ON MEDICAL EDUCATION AND LIFELONG LEARNING
Minutes
CMELL - Council Call Thursday October 26, 2017 5-6 pm eastern time

Attending the Call: Mark Rapaport MD Chair, Marshall Forstein MD Vice Chair (ASM), Edward Silberman MD Member, Steven Fischel MD, PhD Member, Justin Hunt MD Member (ASM), Rashi Aggarwal MD Member, Jose Vito MD Member, Julie Chilton MD Member (ECP), Benoit Dube MD Member, Tony Hu DO Corresponding Member, Phil Luber MD Corresponding Member, Marcy Verduin MD, Corresponding Member (AAP), Leon Cushenberry MD RFM, Linda Drozdowicz MD RFM, Claudine Jones-Bourne MD RFM, Erica Lubliner MD RFM, Muhammed Zeshan MD RFM, Tristan Gorrindo, MD APA Administration, Kristen Moeller, APA Administration, Francis Lu, MD guest.

Not attending: Eitan Kimchi MD Member, Erick Hung MD Member, Chris Thomas MD Member, Venkata Kolli MD Consultant, Paul Nestadt MD Consultant, Rick Summers MD Corresponding Member, John Spollen MD Corresponding Member (ADMSEP), Sandra DeJong MD Corresponding Member (AADPRT), Larry Faulkner MD Corresponding Member (ABPN), Ian Hsu MD, M.Phil. RFM, Jessica Merritt MD RFM, Laura Pientka D.O. RFM, J.Corey Williams MD RFM, Albert Ning Zhou MD, RFM

Minutes

1. Welcome to the call – Mark Rapaport
2. Meet during the Annual Meeting – Saturday May 5, 2018 1:30 – 4:00
3. Francis Lu: reported on an action from the Council on Diversity to the JRC. The JRC assigned the action to the Medical Director's Office and the APA Director of Education. Dr. Lu sought input from the Council. The Council voted agreement with the communication to ACGME.

   Action Item (Content): The APA will communicate to the ACGME its support of the establishment of an ACGME accreditation standard for the Common Program Requirements, which would apply to psychiatry residency training programs, on diversity programs and partnerships to achieve health care equity and eliminate health care disparities.

   Proposed language to be added to Common Program requirements:

   "Diversity Programs and Partnerships
   A residency training program has effective policies and practices in place, and engages in ongoing, systematic, and focused recruitment and retention activities, to achieve mission-appropriate diversity outcomes among its students, faculty, senior administrative staff, and other relevant members of its academic community. These activities include the use of programs and/or partnerships aimed at achieving diversity among qualified applicants for residency training program admission and the evaluation of program and partnership outcomes."

Background: ACGME Common Program requirements are being revised now. The public comment period is soon to open. The Council on Diversity sent an action to the JRC asking that APA formally submit comment to the ACGME asking for an addition to the common program requirements. LCME already includes this statement in their requirements policies. The Council unanimously supported public comment from the APA to request an addition to ACGME Common program requirements as above. The Council thanked Francis Lu for his leadership.

During discussion, questions and comments from the Council included: what is meant by partnerships; how will this be measured; will programs be evaluated on this; the total pool is not large, how well does psychiatry do?
AADPRT has the same action pending. Phil Luber volunteered to bring the same action to AAMC diversity group.

4. **Projects:**
   Survey Project – Update provided by Marshall Forstein.
   Marshall and the survey project sub-group made refinements to the survey and are working on details. He plans to have a final survey by May; he is hoping for interagency assistance from AADPRT to survey residents and training directors.
   Personal Learning Project –to be discussed on the next call. Prototype - http://apapsy.ch/plp

5. **MOC update:** ABMS is forming a Commission to review continued certification. ABMS is getting input from stakeholders about what MOC should encompass. ABPN is initiating a "pilot program" as an option to the 10-year exam.

6. Brief discussion of Medical students entering psychiatry.

7. The Council was provided with a summary of updates to the JRC regarding recent actions.

   A. <u>Expanding Access to Psychiatry Subspecialty Fellowships (ASM2017A1 12.H)</u>

   B. <u>Fostering Medical Student Interest and Training in Psychiatry: The Importance of Medical Student Clerkships (ASM2017A1 12.K)</u>

   C. <u>Educational Strategies to Improve Mental Illness Perceptions of Medical Students (ASM2017A1 12.I)</u>

   The Joint Reference Committee thanked the council for the update and requested that a detailed response from the Divisions of Communications and Education be developed specifying what programs and activities are currently implemented at the APA to address the issues raised in the action paper.

   D. <u>Educational Strategies to Improve Mental Illness Perceptions of Non-Mental Health Medical Professionals (ASM2017A1 12.J)</u>

   The Joint Reference Committee thanked the council for this update and requested that a detailed response from the Divisions of Communications and Education be developed specifying what programs and activities are currently implemented at the APA to address the issues raised in the action paper.

E. <u>Addressing Physician Burnout, Depression, and Suicide — Within Psychiatry and Beyond (ASM2017A1 12.N)</u>

7. Charge of the Council - The Charge of the Council will be circulated to the subgroup

Item JRC 8.I
Joint Reference Committee
February 2018

Executive Summary
Council on Minority Mental Health and Health Disparities

Christina Mangurian, M.D., M.A.S., Chairperson

The Council on Minority Mental Health and Health Disparities (CMMH/HD) advocates for minority and underserved populations and psychiatrists who are underrepresented within the profession and APA. CMMH/HD seeks to reduce mental health disparities in clinical services and research, which disproportionately affect women and minority populations. CMMH/HD aims to promote the recruitment and development of psychiatrists from minority and underrepresented groups both within the profession and APA.

Action Items

ACTION: Will the Joint Reference Committee (JRC) recommend that the Assembly approve the revised Position Statement on "Abortion?" (1978)

ACTION: Will the JRC recommend that the Assembly approve the revised Position Statement on "Resolution Against Racism and Racial Discrimination and Their Adverse Impacts on Mental Health?" (2006)

ACTION: Will the JRC recommend that the Assembly approve the revised Position Statement on "Religious Persecution and Genocide?" (1997)

ACTION: Will the JRC recommend that the Assembly approve a new Position Statement on "Mental Health Needs of Undocumented Immigrants, including Childhood Arrivals, Asylum-Seekers, and Detainees?"

ACTION: Will the JRC recommend that the Assembly approve a new Position Statement on "Equitable Treatment of Substance Use Disorders Across Racial Lines?"

ACTION: Will the JRC recommend that the Assembly approve a new Position Statement on "Mental Health Equity and the Social and Structural Determinants of Mental Health?"

ACTION: Will the JRC recommend that the Assembly approve a new Position Statement on "Police Brutality and African-American Males?"

ACTION: Will the JRC recommend that the Assembly approve a new Position Statement on "Discrimination of Religious Minorities?"

ACTION: Will the JRC recommend that the Assembly retire the Position Statement on "Detained Immigrants with Mental Illness?" (2013)

Information Items

2nd Vice Chair Appointed
CMMH/HD leadership appointed Eric Yarbrough, M.D., as the 2nd Vice Chair. This appointment comes with several responsibilities including overseeing Position Statements (e.g. New, Revised, etc.) being developed and reviewed by CMMH/HD. Duties of the 2nd Vice Chair are outlined in the attachment "2nd Vice Chair Position Description of Roles and Responsibilities."

APA Stress and Trauma Toolkit Update
CMMH/HD, Division of Diversity and Health Equity (DDHE), Division of Communications, in collaboration with the Office of the Medical Director, is organizing a toolkit about stress and trauma related to the current state of the political and social environment in the U.S. The toolkit aligns with CMMH/HD's mission of creating resources that focus on diversity and inclusion. Several workgroups, consisting of members from M/UR Caucuses and CMMH/HD, were formed to develop this resource. Final drafts are in process. Final versions will be vetted by experts in treating minority populations. CMMH/HD leadership anticipates content completion by the end of Q3 2018. DDHE will continue to provide staff support.

Accepted Submissions for 2018 Annual Meeting
CMMH/HD is pleased to report that 20 abstracts, developed by members of CMMH/HD, APA M/UR Caucuses, and Council affiliates, were accepted by the Scientific Program Committee. See the attached list. We are planning to submit many more for the 2018 IPS meeting in October.

Workgroup Discussions
Continuing the work outlined from the 2017 September Components meeting, the Council has progressed with its effort to provide support to M/UR psychiatrists, the communities they serve, and general APA membership. Workgroup leaders are currently organizing action plans which will include meeting times, roadmaps, etc. Workgroups are organized around the following topics:

- Increasing M/UR membership (Co-led by a CMMH/HD Council member and a M/UR Caucus leader)
- Community-based work and reducing stigma
- History & Intergenerational relationships

Mental Health Disparities: Diverse Populations Fact Sheets
CMMH/HD worked with M/UR Caucuses and DDHE to produce fact sheets on mental health disparities in diverse populations. The fact sheets can be viewed at https://www.psychiatry.org/psychiatrists/cultural-competency/mental-health-disparities.

Position Statements (3 Revisions; 5 New; 1 Retired)

CMMH/HD developed four new Position Statements, in addition to revising four Position Statements that were up for 5-year review. One Position Statement is recommended for retirement.

The list is as follows:

Three Revised Position Statements:

- Revised Position Statement on Abortion (1978)
- Revised Position Statement on "Resolution Against Racism and Racial Discrimination and Their Adverse Impacts on Mental Health" (2006)
- Revised Position Statement on "Religious Persecution and Genocide" (1997)

Five New Position Statements:

- New Position Statement on "Mental Health Needs of Undocumented Immigrants, including Childhood Arrivals, Asylum-Seekers, and Detainees"
- New Position Statement on "Equitable treatment of substance use disorders across racial lines"
- New Position Statement on "Mental Health Equity and the Social and Structural Determinants of Mental Health"
- New Position Statement on "Police Brutality and African-American Males"
- New Position Statement on "Discrimination of Religious Minorities"

Position Statements recommended for retirement:

- Position Statement on "Detained Immigrants with Mental Illness" (2013)

Position Statements

Revised Position Statements:

"Abortion (1978)"

In Spring 2017, CMMH/HD revised APA's 1978 Position Statement on "Abortion" at the request of the BOT. The workgroup included members of CMMH/HD, APA's Caucus of Women Psychiatrists and APA Administration (DDHE and Legal).

"Resolution Against Racism and Racial Discrimination and Their Adverse Impacts on Mental Health (2006)"

In Spring 2017, members of CMMH/HD revised and approved the 2006 Position Statement on "Resolution Against Racism and Racial Discrimination and Their Adverse Impacts on Mental Health" as requested by the BOT.

"Religious Persecution and Genocide" (1997)

In Spring 2017, members of CMMH/HD separated the retired Position Statement on Religious Discrimination, Persecution, and Genocide into two Position Statements as requested by the JRC. Accordingly, a revised Position Statement on Religious Persecution and Genocide materialized.

New Position Statements:

"Mental Health Needs of Undocumented Immigrants, including Childhood Arrivals, Asylum-Seekers, and Detainees"

CMMH/HD drafted a new Position Statement to address challenges related to the Deferred Action for Childhood Arrivals (DACA). The new statement— "Mental Health Needs of Undocumented Immigrants,

including Childhood Arrivals, Asylum-Seekers, and Detainees"—incorporates content from the existing 2013 Position Statement on "Detained Immigrants with Mental Illness" and includes additional resources that address the current political and social climate. To eliminate duplicative publications, CMMH/HD recommends that the Position Statement on "Detained Immigrants with Mental Illness" be retired. The new Position Statement, vetted and supported by the Council on International Psychiatry and the Caucus of Hispanic Psychiatrists, is being submitted to the JRC for approval.

"Equitable Treatment of Substance Use Disorders Across Racial Lines"

CMMH/HD formed a workgroup to draft a new Position Statement on "Equitable treatment of substance use disorders across racial lines." The statement was inspired by CMMH/HD members who noticed that APA did not have a formal stance on this issue which has impacted the mental health of many ethnic/racial minorities. This Position Statement is being submitted to the JRC for approval.

"Mental Health Equity and the Social and Structural Determinants of Mental Health"

A workgroup of CMMH/HD members drafted a new Position Statement on "Mental Health Equity and the Social and Structural Determinants of Mental Health." This is an attempt to solidify APA's stance on literature that is not prevalent in current policy. The Position Statement is being submitted to the JRC for approval.

"Police Brutality and African-American Males"

Responding to a call to action by CMMH/HD leadership, a CMMH/HD workgroup drafted a new Position Statement on "Police Brutality and African-American Males." The statement received support from the Caucus of Black Psychiatrists.

"Discrimination of Religious Minorities"

In Spring 2017, members of CMMH/HD separated the retired Position Statement on Religious Discrimination, Persecution, and Genocide into two Position Statements as requested by the JRC. Accordingly, a new Position Statement on the "Discrimination of Religious Minorities" emerged.

Position Statements recommended for retirement:

"Detained Immigrants with Mental Illness" (2013)

CMMH/HD recommends that the Position Statement on "Detained Immigrants with Mental Illness" be retired. A newly drafted Position Statement— "Mental Health Needs of Undocumented Immigrants, including Childhood Arrivals, Asylum-Seekers, and Detainees"—incorporates content from "Detained Immigrants with Mental Illness" and includes additional resources that address the current political and social climate. To eliminate duplicative publications, CMMH/HD recommends the Position Statement be retired.

Attachments

1. Revised Position Statement on Abortion (1978)
2. Revised Position Statement on "Resolution Against Racism and Racial Discrimination and Their Adverse Impacts on Mental Health" (2006)
3. Revised Position Statement on "Religious Persecution and Genocide" (1997)
4. Background on "Religious Persecution and Genocide" (1997)
5. New Position Statement on "Mental Health Needs of Undocumented Immigrants, including Childhood Arrivals, Asylum-Seekers, and Detainees"

6. New Position Statement on “Mental Health Equity and the Social and Structural Determinants of Mental Health”
7. New Position Statement on “Equitable Treatment of Substance Use Disorders Across Racial Lines”
8. New Position Statement on “Police Brutality and African-American Males”
9. New Position Statement on “Discrimination of Religious Minorities”
10. Background on “Discrimination of Religious Minorities”
11. 2013 Position Statement on “Detained Immigrants with Mental Illness”
12. 2nd Vice Chair Position Description of Roles and Responsibilities
13. List of Accepted Submissions

Attachment #9
Item 2017A1 4.B.9
Assembly
May 19-21, 2017

Position Statement on Abortion

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Issue:

Historically, there was concern that abortion may be associated with negative adverse mental health outcomes for women. This has been refuted by a growing body of research carefully conducted with appropriate comparison groups. Currently available evidence does not support that having an abortion is associated with an increase in depressive, anxiety or post traumatic stress symptoms. ~~Quality studies suggest few differences between women who had abortions and their respective comparison groups in terms of mental health sequelae.[i] Evidence fails to support opinions that link abortion to mental health problems as opposed to pre-existing and co-occurring risk factors.[ii]~~

~~In contrast, emotional and medical consequences of unwanted pregnancies are both profound and disturbing. From a mental health perspective, unwanted pregnancies may lead to long-standing life distress and disability; the children of unwanted pregnancies are at higher risk for abuse, neglect, mental illness, and deprivation. Studies have noted mothers of unwanted children suffer higher rates of depression and anxiety. Other complications of unwanted pregnancies may include post-partum psychiatric disorders. Medically and psychiatrically, unwanted pregnancies may lead to other problems for the family as a unit. For example, the rate of maternal mortality in Texas spiked from 18.6 deaths per 100,000 live births in 2010 to more than 30 per 100,000 in 2011 and remained over 30 per 100,000 through 2014, according to a study in the medical journal *Obstetrics and Gynecology*.[iii,iv] Experts linked the spike in maternal death to decreased access to family planning clinics and abortion.[v] Medical complications of unwanted pregnancies include the adverse effects of a mother's necessary psychotropic medication on a fetus, which cannot be underestimated always be predicted.[vi]~~

~~Finally, violence against women escalates during unwanted pregnancies and in the post-partum period. This affects millions of families, increasing risk for depression and posttraumatic stress disorder.[vii] Each of the above-noted consequences creates its own unintended ripple effect.~~

APA Position~~POSITION~~:

1) **Abortion is a medical procedure and a decision about an abortion should be between a woman and her physician.**

~~**Governmental restrictions on Because of these considerations, and in the interest of public welfare, the American Psychiatric Association 1)family planning and abortion services are opposed. Abortion opposes all constitutional amendments, legislation, and regulations curtailing family planning and abortion services to any segment of the population; 2) reaffirms its position that abortion is a medical procedure and a decision about an abortion should be between a woman and her physician.**~~

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2) ~~3)~~ Providers should c~~C~~onsideration ~~should be given for~~ consulting a psychiatrist when treating ~~in the case of any~~ pregnant woman with current mental health symptoms ~~for whom there are mental health concerns~~

3) Governmental restrictions on family planning and abortion services are opposed.

~~in which physicians should respect the patient's right to freedom of choice – psychiatrists may be called on as consultants to the patient or physician in those cases in which the patient or physician requests such consultation to expand mutual appreciation of motivation and consequences; and 3) affirms that the freedom to act to interrupt pregnancy must be considered a medical and mental health imperative with major social and mental health implications.~~

Authors:

~~This~~The original statement was approved by the Assembly of District Branches at its October 15, 1978 meeting and by the Board of Trustees at its December 10, 1977 meeting. ~~This final~~ That draft was drawn up by a subcommittee appointed by the Reference Committee to collate an Area I Action Paper and information provided by the Committee on Women, the Council on National Affairs, the Council on Children, Adolescents, and Their Families, and the American Academy of Child Psychiatry. In ~~September 2016,~~November 2017, the Council on Minority Mental Health and Health Disparities edited the position statement to include cultural perspectives and updated available evidence.

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Background Information

Relevant Citations:

Biggs MA, Upadhyay UD, McCulloch CE et al: Women's mental health and well-being 5 years after receiving or being denied an abortion: A prospective, longitudinal cohort study. JAMA Psychiatry 2017; 74:169-178.

Biggs MA, Rowland B, McCulloch CE: Does abortion increase women's risk for post-traumatic stress? Findings from a prospective longitudinal cohort study. BMJ Open 2016; 6:e009698.

Horvath S, Schreiber CA: Unintended pregnancy, induced abortion, and mental health. Curr Psychiatry Rep 2017; 19:77.

Major B, Appelbaum M, Beckman L et al: Abortion and mental health: Evaluating the evidence. Am Psychol 2009; 64: 863-90.

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[i] Charles, Vignetta et al, "Abortion and long-term mental health outcomes: a systematic review of the evidence:" **ScienceDirect;** Volume 78, Issue 6, December 2008, Pages 436–450.

[ii] Major et al, "Abortion and mental health: Evaluating the evidence." American Psychologist, Vol 64(9), Dec 2009, 863-890. http://dx.doi.org/10.1037/a0017497

[iii] Jervis, Rick, "Texas' maternal death rates top most industrialized countries." USA Today, September 10, 2016, accessed: http://www.usatoday.com/story/news/health/2016/09/10/texas-maternal-mortality-rate/90115960/

[v] MacDorman, Marian; "Recent Increases in the U.S. Maternal Mortality Rate, Disentangling Trends from Measurement Issues," Obstetrics and Gynecology; Vol. 128, No. 3, September 2016, Pages 447-455.

[vi] Lithium, valproate, and tegretol, for example, are all listed as pregnancy category D, or unsafe; evidence of risk that may in certain clinical situations be justifiable.

[vii] Kendall-Tackett, Kathleen; "Violence Against Women and the Perinatal Period: The Impact of Lifetime Violence and Abuse on Pregnancy, Postpartum, and Breastfeeding;" Impact Factor: 3.191 | Ranking: Social Work 1 out of 41 | Family Studies 2 out of 43 | Criminology & Penology 3 out of 57. Accessed 9/13/2016 at: http://tva.sagepub.com/content/8/3/344.short

APA Official Actions

Position Statement: Resolution Against Racism and Racial Discrimination and Their Adverse Impacts on Mental Health

Approved by the Board of Trustees, XXXX
Approved by the Assembly, XXXX

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POSITION:

The American Psychiatric Association recognizes that racism and racial discrimination adversely affect mental health by diminishing the victim's self-image, confidence, and optimal mental functioning. Racism also renders the perpetrator unprepared for the 21st century society that is becoming increasingly multicultural and global. Racism and racial discrimination are two of ~~the~~ several factors leading to mental health care disparities. A recent meta-analysis indicated that exposure to racism was associated with poorer mental health, including depression and anxiety. ~~Further, the~~ The APA ~~strongly opposes~~believes that all forms of racism and racial discrimination ~~that adversely~~ affect mental health and wellbeing, and negatively impact the nation as a whole.

Therefore, the American Psychiatric Association:

1. Supports current and future actions ~~A believes that attempts should be made~~ to eliminate racism and racial discrimination by fostering a respectful appreciation of multiculturalism, ~~and~~ diversity and efforts of greater inclusion.
2. ~~The APA and its members should~~ Encourages mental health professionals to be mindful of the existence and impact of racism and racial discrimination in the lives of patients and their families, in clinical encounters, and in the development of mental health services
3. ~~In addition, the APA s~~Supports ~~enhanced~~ member and public education about impacts of racism and racial discrimination, advocacy for equitable mental health services for all patients, and further research into the impacts of racism and racial discrimination as an important public mental health issue.
4. Recognizes especially the ~~the~~ detrimental effects that racism has on the mental health of people of color, and supports policies and laws which would reduce further harm.

Authors:
Council on Minority Mental Health and Health Disparities

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APA Official Actions

Position Statement on Religious ~~Discrimination,~~ Persecution~~,~~ and Genocide

Approved by the Board of Trustees, XXXX
Approved by the Assembly, XXXX

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POSITION:

Given the significant adverse mental health impacts of religious ~~discrimination,~~ persecution~~,~~ and genocide~~,~~ the American Psychiatric Association 1) condemns acts of religious ~~bigotry,~~ persecution, ~~discrimination,~~ and genocide on the basis of any national, ethnic, racial, or religious identity; 2) urges psychiatrists to speak out against religious persecution and genocide through professional and political channels; and 3) calls for further research on the mental health impacts of trauma due to religious persecution or genocide, as well as potential treatment strategies for working with populations that have experienced these.

~~affirms findings in the literature that isolation of religious minorities in the U.S. further exacerbates negative mental health effects resulting from religious discrimination; 3) urges practicing psychiatrists to reach out to and support patients and communities of religious minority groups in the U.S., and 4) calls for further research and education of psychiatrists and allied disciplines on the mental health impacts of religious discrimination, persecution, and genocide as well as potential treatment strategies to ameliorate these traumas.~~

Background on Religious Persecution and Genocide

Religious persecution and genocide pose significant threats to the mental health of large groups of people in the world today. Religious persecution is a key risk factor for mental health problems in in refugee children resettled in high-income countries, according to a large recent meta-analysis of numerous studies.[1] The United Nations Convention on Prevention and Punishment of the Crime of Genocide proclaims that genocide, whether committed in time of peace or in time of war, to be a crime under international law that the contracting parties were to pledge to prevent and punish. The convention defines genocide as acts intended to destroy, in whole or in part, a national, ethnical, racial, or religious group[2]. This includes:

- Killing members of the group;
- Causing serious bodily or mental harm to members of the group;
- Deliberately inflicting on the group conditions of life calculated to bring about its physical destruction in whole or in part;
- Imposing measures intended to prevent births within the group; and
- Forcibly transferring children of the group to another group.

[1]Fazel M., Reed R., Panter-Brick C., Stein A. Mental health of displaced and refugee children resettled in high-income countries: risk and protective factors. Lancet 2012; 379:266-82.

[2] http://legal.un.org/avl/ha/cppcg/cppcg.html

APA Official Actions

Position Statement on ~~Religious~~ Discrimination of Religious Minorities~~, Persecution, and Genocide~~

Approved by the Board of Trustees, XXXX
Approved by the Assembly, XXXX

"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*

POSITION:

Given the significant adverse mental health impacts of religious discrimination, ~~persecution, and genocide,~~ the American Psychiatric Association 1) condemns acts of ~~religious bigotry, persecution,~~ discrimination~~, and genocide on the basis of~~ against any ~~national, ethnic, racial, or~~ religious minority~~identity~~; 2) affirms findings in the literature that isolation of religious minorities in the U.S. further exacerbates negative mental health effects resulting from religious discrimination; 3) urges practicing psychiatrists to reach out to and support patients and communities of religious minority groups in the U.S., and 4) calls for further research and education of psychiatrists and allied disciplines on the mental health impacts of and treatment options ~~to address of~~ for religious discrimination.~~ , persecution, and genocide as well as potential treatment strategies to ameliorate these traumas.~~

Background on ~~Religious~~ Discrimination of Religious Minorities~~, Persecution and Genocide~~

Religious discrimination~~, persecution, and genocide~~ poses serious threats to the mental health of large groups of people in the world today. Discrimination is a~~and persecution are~~ key risk factor~~s~~ for mental health problems in refugee children resettled in high-income countries, according to a large recent meta-analysis of numerous studies.[1] This study also found that protective factors included social support, community integration, and a sense of belonging at school. For religious minorities in the United States, particularly Muslims in the post-9/11 era, religious discrimination is a common experience. A survey of Muslims living in America found that more than half had experienced verbal harassment and/or ~~,~~ discriminatory acts, and over 80% had heard anti-Muslim comments.[2] The authors describe the 9/11 attacks as a "collective trauma" for Muslims living in the U.S. Muslims in this study who reached out to Americans of other religions experienced more posttraumatic growth, while those who chose to isolate themselves experienced more depression and anger. A study of Sikh Americans, who are sometimes mistakenly identified for Muslims in the U.S. because of wearing turbans or scarves, also demonstrated a relationship between religious discrimination and mental health. The study found that Sikhs in America who wear turbans or scarves are more likely to experience discrimination than those who do not wear these articles of faith, and that discrimination was significantly associated with poorer self-reported mental and physical health.[3]

~~The United Nations Convention on Prevention and Punishment of the Crime of Genocide proclaims that genocide, whether committed in time of peace or in time of war, to be a crime under international law that the contracting parties were to pledge to prevent and punish. The convention defines genocide as acts intended to destroy, in whole or in part, a national, ethnical, racial, or religious group[4]. This includes:~~

- ~~Killing members of the group;~~
- ~~Causing serious bodily or mental harm to members of the group;~~
- ~~Deliberately inflicting on the group conditions of life calculated to bring about its physical destruction in whole or in part;~~
- ~~Imposing measures intended to prevent births within the group; and~~

[1]Fazel M., Reed R., Panter-Brick C., Stein A. Mental health of displaced and refugee children resettled in high-income countries: risk and protective factors. Lancet 2012; 379:266-82.
[2]Abu-Raiya H., Pargament K., Mahoney A. Examining coping methods with stressful interpersonal events experienced by Muslims living in the United States following the 9/11 attacks. Psychology of Religion and Spirituality 2011; 3(1):1-14.
[3]Nadimpalli S., Cleland C., Hutchinson M., Islam N., Barnes L., Van Devanter N. The association between discrimination and the health of Sikh Asian Indians. Health Psychology 2016; 35(4):351-355.
[4] ~~http://legal.un.org/avl/ha/cppcg/cppcg.html~~

- ~~Forcibly transferring children of the group to another group.~~

Title: **Position Statement on Mental Health Needs of Undocumented Immigrants, including Childhood Arrivals, Asylum-Seekers, and Detainees**

Issue: Thirteen percent of the United States population is foreign-born, and a quarter of those are undocumented immigrants (1, 2). Undocumented immigrants have limited access to healthcare, are less likely to seek out health care, and have less satisfying healthcare encounters (3). Studies have demonstrated a link between restrictive immigration policies and poorer mental health among undocumented immigrants and recent immigrants (4, 5). For example, among adults eligible for Deferred Action for Childhood Arrivals (DACA) and children of DACA eligible adults, mental health burden fell a significant degree after the introduction of DACA (6, 7). A subset of undocumented immigrants are asylum seekers; this population carries a high burden of trauma from their country of origin (8). Asylum seekers who obtain legal status wait on average 3.9 years for that change (2), sometimes in detention centers, and in the meantime are at risk of further trauma and worsening of mental illness (8).

APA Position Statement:

1. The APA advocates for improvement of access to mental and physical health care for undocumented immigrants.
2. The APA urges federal policy makers to recognize the impact that immigration policy has on the mental health of undocumented immigrants. More specifically:
    - the APA acknowledges the benefits that DACA conferred on the mental health of eligible persons and recommends that federal policy makers consider mental health consequences when debating DACA's continuation.
    - the APA recognizes that trauma and the threat of trauma in one's home country negatively impact the mental health of asylum seekers and recommends that this be considered when determining the status of asylum seekers.
    - the APA recognizes the deleterious effects of detention centers on the mental health of asylum seekers and immigrants detained for legal proceedings; therefore, it encourages the use of less restrictive alternatives for monitoring.
3. The APA urges federal policy makers and responsible agency officials to ensure that detained individuals with mental disorders receive appropriate mental health treatment.
4. The APA encourages public government officials to be mindful of the need to use respectful language when referencing undocumented immigrants, and their country of origin, to reduce the emotional burden and stigma felt by this vulnerable groups.

Authors: In December 2017, a subcommittee appointed by the Council on Minority Mental Health and Health Disparities drafted the Position Statement.

Adoption Date: Pending

Background

Citations:

(1) US Census Bureau. "Selected Social Characteristic in the United States, 2015 American Community Survey 1-Year Estimates." Available at https://factfinder.census.gov

(2) Baker B, Rytina N. "Estimates of the Unauthorized Immigrant Population Residing in the United States: January 2012." Population Estimates (March 2013), DHS Office of Immigration Statistics, available at: https://www.dhs.gov/sites/default/files/publications/Unauthorized%20Immigrant%20Population%20Estimates%20in%20the%20US%20January%202012_0.pdf

(3) Ortega AN, Fang H, Perez VH, Rizzo JA, Carter-Pokras O, Wallace SP, Gelberg L. Health care access, use of services, and experiences among undocumented Mexicans and other Latinos. *Archives of Internal Medicine* 2007; 167 (21): 2354-60.

(4) Martinez, O., Wu, E., Sandfort, T., Dodge, B., Carballo-Dieguez, A., Pinto, R., … Chavez-Baray, S. Evaluating the Impact of Immigration Policies on Health Status Among Undocumented Immigrants: A Systematic Review. *Journal of Immigrant and Minority Health / Center for Minority Public Health* 2015; *17*(3), 947–970.

(5) Hatzenbuehler ML, Prins SJ, Flake M, Philbin M, Frazer MS, Hagen D, Hirsch J. Immigration policies and mental health morbidity among Latinos: A state-level analysis. *Social Sciences and Medicine* 2017; 174:169-178.

(6) Venkataramani AS, Shah SJ, O'Brien R, Kawachi I, Tsai AC. Health consequences of the US Deferred Action for Childhood Arrivals (DACA) immigration programme: a quasi-experimental study. *Lancet* 2017; 2(3): e175-e181.

(7) Hainmueller J, Lawrence D, Marten L, Black B, Figueroa L, Hotard M, Jimenez TR, Mendoza F, Rodriguez MI, Swartz JJ, Laitin DD. Protecting unauthorized immigrant mothers improves their children's mental health. *Science* epub 31 Aug 2017.

(8) Silove D, Steel Z, Waters C. Policies of deterrence and the mental health of asylum seekers. *Journal of the American Medical Association* 2000; 284 (5): 604-611.

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Position Statement on Mental Health Equity and the Social and Structural Determinants of Mental Health

Authors: Enrico G. Castillo, Helena Hansen, Evita Rocha

Issue: Unequal access to social resources perpetuate mental health disparities, particularly for patients and their families who belong to groups that are marginalized or under-resourced. Unequal allocation of resources and application of institutional and public policies worsen these disparities. *Social determinants of mental health* include social supports, employment, civic engagement, socioeconomic and educational status, discrimination, and mental health stigma among other factors. *Structural determinants of mental health* include the actions and norms of systems and policies, such as the economic, legal, political, and healthcare systems. *Health equity* is a public health paradigm and quality goal that aims to promote equitable access to health-related opportunities when needs are equal, provide enhanced opportunities when needs are greater, and address systemic issues that perpetuate inequalities.

The APA includes in its values statement "advocacy for patients" and "care and sensitivity for patients and compassion for their families." This position statement is relevant to the APA because understanding and improving the social and structural determinants of health involves sensitivity to the lives and environments of patients and families, and promotion of mental health equity represents leadership and advocacy in this area. Psychiatrists have a key role in promoting mental health equity in clinical care, research, education, interventions, administration and public policy advocacy.

Position

The American Psychiatric Association:

- Supports legislation and policies that promote mental health equity and improve the social and structural determinants of mental health, and formally objects to legislation and policies that perpetuate structural inequities.
- Advocates for the dissemination of evidence-based interventions that improve both the social and mental health needs of patients and their families.
- Urges healthcare systems to build their capacity to screen, understand, and improve the structural and social determinants of mental health.
- Supports medical and public education on the structural and social determinants of mental health, mental health equity, and related evidence-based interventions.
    - Urges medical school and graduate medical education accrediting and professional bodies to emphasize educational competencies in structural and social determinants of mental health and mental health equity.
    - Urges psychiatry residency training directors and other psychiatric educators to use systematic approaches to teaching about structural and social determinants of mental health.
    - Supports the training of psychiatrists, in graduate and continuing medical education, in best practices to address the structural and social determinants of mental health and promote health equity.
- Advocates for increased funding for research to better understand the mechanisms by which structural and social determinants affect mental illness and recovery and to develop new evidence-based interventions to promote mental health equity.

Background

Social factors, such as a person's income or social supports, and institutional and policy structures, such as educational and healthcare policies, have the potential to facilitate or obstruct individuals' paths to well-being and recovery. As such, it is vital for an organization like the American Psychiatric Association to advocate for greater understanding of these social and structural determinants of mental health and to urge action to reduce disparities and promote mental health equity.

The Model for Analysis of Population Health and Health Disparities by the Centers for Population Health and Health Disparities of the National Institutes of Health describes three categories of social and structural determinants of health disparities. Distal determinants include social conditions and politics; intermediate factors include physical and social contexts and relationships, and proximal determinants include demographics, behaviors, and biological factors at the individual level. Research has shown that social and structural factors can affect mental health outcomes and recovery. Relevant citations for emerging research, public policies, and initiatives are included below.

Broadly speaking, health equity has 3 aims: to promote equitable access to health-related opportunities when needs are equal (horizontal equity), to provide enhanced opportunities when needs are greater (vertical equity), and to address the systems issues that perpetuate inequalities. Health equity reforms are emerging across the country. Organizations including the Substance Abuse and Mental Health Services Administration, Centers for Disease Control, the American Medical Association, and the American Public Health Association have declared health equity to be central to their missions. This speaks to the importance of these issues for patients; their relevance to psychiatric practice, education, and training; and the need for advocacy by the American Psychiatric Association.

The American Psychiatric Association should advocate for healthcare and other public policies that promote mental health equity. This position statement is in line with the mission of the American Psychiatric Association's Division of Diversity and Health Equity. Promoting mental health equity and addressing the structural/social inequities are central to the eradication of disparities in mental health and healthcare. Psychiatrists should consider the structural and social determinants of mental health and recovery in their clinical care, research, education, interventions, administration and public policy advocacy.

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6. Ehlinger EP: We need a Triple Aim for Health Equity. Minn Med 98: 28–29, 2015.
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6. Los Angeles County Department of Health Services: Bringing Housing to Scale: Housing for Health Progress Report, 2017.
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16. Los Angeles County Department of Mental Health: Health Neighborhoods: A Toolkit for Service Delivery Providers, 2015.
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Position Statement on the Equitable Treatment of Substance Use Disorders Across Racial Lines

Issue:
In the United States, substance use and substance use disorders are equally prevalent across racial lines[1]; however, blacks and Latinos are prosecuted and incarcerated for substance use at phenomenally higher rates than their white counterparts,[2] who are more likely to be offered drug court or drug treatment.[3] This discrepancy exists despite evidence that the majority of illegal drug users and dealers are white,[4] white youth are ⅓ times more likely to have sold illegal drugs,[5] and whites have three times as many drug related emergency department visits.[6] Increased levels of imprisonment lead to difficulty obtaining housing, difficulty obtaining social services, discrimination from employment, and higher rates of recidivism.[7]

Furthermore, restricting access to appropriate substance use treatment leads to higher rates of relapse, lost productivity, crime, and other adverse health outcomes.[8] Completion of treatment allows for better health, fewer relapses, fewer readmissions, less future criminal involvement, improved employment, and longer term abstinence.[9] Despite the multitude of positive effects of substance use treatment, racial disparities persist in the available resources for treatment, referral to treatment, treatment completion, and quality of treatment. Offering substance use treatment as the primary response to drug related crime, as well as allocating public funding for substance use treatment, can help mitigate the effects of racial discrimination in the criminal justice system, alongside the positive benefits from successful societal re-entry.

Position:
The American Psychiatric Association:

1. Believes that individuals charged with a non-violent drug related offense, regardless of race, should be offered substance use treatment as a primary response.
2. Advocates that racial minorities should be offered substance use treatment in an equitable fashion.

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[1] Hedden, S. L., Kennet, J., Lipari, R., Medley, G., Tice, P., Copello, E., & Kroutil, L. (n.d.). Behavioral health trends in the United States: results from the 2014 National Survey on Drug Use and Health (pp. 1-37) (USA, Department of Health and Human Services).
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[3] Marc Mauer, *Race to Incarcerate,* rev. ed. (New York: The New Press, 2006).
[4] Alexander, M. (2012). The New Jim Crow: Mass Incarceration in the Age of Colorblindness. New York, NY: New Press.
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[7] Alexander, M. (2012). The New Jim Crow: Mass Incarceration in the Age of Colorblindness. New York, NY: New Press.
[8] Position Statement on Treatment of Substance Use Disorders in the Criminal Justice System
[9]Mennis, J., & Stahler, G. J. (2016). Racial and Ethnic Disparities in Outpatient Substance Use Disorder Treatment Episode Completion for Different Substances. Journal of Substance Abuse Treatment, 63, 25-33.

3. Supports legislation and policies that address barriers and improve access for substance use treatment, including access to methadone and buprenorphine, for people from all racial and socioeconomic backgrounds.

Background Information

In 1982, President Reagan announced his administration's War on Drugs; in 1985, crack cocaine emerged as a cheaper alternative to powder cocaine, leading to increased crack use by the poor. The Anti-Drug Abuse Act of 1986 led to a framework for mandatory minimum sentences in which one gram of crack cocaine was legally considered to be the equivalent of one hundred grams of powder cocaine, and expanded use of the death penalty for serious drug related offenses.[10] Two thirds of crack users are white or Hispanic, yet in 1994 84.5% of those convicted of crack possession were black. Bill Clinton signed the Personal Responsibility and Work Opportunity Reconciliation Act which created Temporary Assistance to Needy Families (TANF) which placed a lifetime ban on eligibility for welfare and food stamps for anyone convicted of a felony drug offense.

This information sets the stage for the incredible impact the War on Drugs has had upon black communities. Human Rights Watch reported in 2000 that in seven states blacks constitute 80 to 90 percent of all drug offenders sent to prison; in fifteen states, blacks are admitted to prison on drug charges at a rate from twenty to fifty seven times greater than that of white men. This is despite government data that has demonstrated blacks were no more likely to be guilty of drug crimes than whites. In fact, data has demonstrated that white youth, aged 12-17, are ⅓ times more likely to have sold illegal drugs, and whites are three times more likely to visit the emergency department related to drug use. Yet, black men have been admitted to state prison on drug charges at a rate that is more than thirteen times higher than white men.

The racial bias, if not inherent in the grossly disproportionate numbers presented above, is evident in multiple studies examining approaches and beliefs regarding drug use. In 1995, a survey examined participant's notions of the "drug user;" 95% of respondents pictured a black drug user, in stark contrast to the reality of blacks constituting only 15% of total drug users in 1995. In 2002, a study conducted by the University of Washington found that high arrest rates of blacks was related to the police department's focus on crack, a drug more likely to be sold by blacks, and on outdoor drug markets that targeted black neighborhoods. These findings suggest a societal construction of drug use as a "black" problem, despite data suggesting otherwise.

This is made particularly clear by the following figures: 98.4% of those serving a life sentence under the "two strikes and you're out" sentencing scheme in Georgia were black. This provision allowed for life imprisonment after a second drug offense; this provision was invoked for 16% of black defendants, but only for 1% of white defendants. In Florida, 1,000 highway stops by state troopers captured on video found more than 80% of the people stopped and searched were minorities, despite African Americans or Latinos constituting only 5% of drivers. In Illinois, Latinos comprised 30% of motorists stopped by drug officers, despite making fewer than 3% of personal vehicle trips.

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[10] Provine, Unequal Under Law: Race in the War on Drugs

This data, alongside the differential treatment of whites for alcohol use related behaviors, including drunk driving, suggest a clear pattern of racial discrimination in reference to substance use disorders, and significant deleterious effects of discrimination, including the imprisonment and marginalization of blacks across the country.

Beyond the racial discrimination demonstrated within the criminal justice system, racial disparities exist across multiple domains of substance use treatment. Evidence demonstrates that engagement in substance use treatment is associated with improved substance use, employment, and criminal justice outcomes,[11] and completion of treatment leads to better health, fewer relapses, fewer readmissions, less future criminal involvement, higher levels of employment and wages, and longer term abstinence.[12] Given these findings, the data on racial disparities across domains of substance use treatment are appalling.

Blacks and Latinos are significantly less likely than whites to receive substance use treatment in the context of a criminal history; this disparity compounds further when controlling for socioeconomic status.[13] Substance use treatment for youth is incredibly important, and has been found to significantly lower likelihood of future substance use, yet black adolescents receive less specialty care for substance use than their white counterparts.[14] Blacks and Latinos experience significant disparities in diversion to treatment.[15] Despite attempts to minimize the role of race in substance use treatment referral, through standardizing measures such as Proposition 36 in California, blacks with criminal histories continue to remain less likely to receive referral to treatment from court than their white counterparts.[16]

In addition to the disparities in the reception of substance use treatment, disparities persist in the completion of treatment once engaged. Blacks are significantly less likely to complete an episode of treatment than their white counterparts, a disparity that persists across substances.[17] This is particularly important as differing substances have differing levels of treatment completion, yet blacks remain significantly less likely to complete treatment

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regardless of substance. These disparities in completion rates persist, frequently but not universally, across state lines.[18]

In the context of the more recent opioid epidemic, racial disparities in the context of access to appropriate pharmacological treatment highlight disparities in access. The Drug Addiction Treatment Act of 2000 did not improve access to methadone while simultaneously restricting access to buprenorphine through a variety of bureaucratic measures; these intentional measures have inhibited minorities from receiving equal access to opiate substitution treatments.[19] Data also suggests despite the utility of substance use treatment, blacks still remain more likely to be rearrested.[20]

The etiology of these detrimental disparities is unclear, and demands improving access, referral, and completion of substance use treatment across racial lines, as well as the funding of additional research and investigation into the possible racial component driving these findings.

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Position Statement on Police Brutality and Black Men

PROBLEM:

In recent years, a cluster of highly publicized killings of African-American males at the hands of law enforcement has spawned widespread national protests and generated justifiable national concern. According to the United States Census Bureau, black/African-American persons make up approximately 13.3% of the American population. In 2007, the Census Bureau approximated that nearly 48% of the African-American population in the United States were male. This means that, roughly, 6% of the American population are black men. Unfortunately, although black men make up such a small number of the population, they accounted for 22% of individuals shot and killed by police in 2017. This is consistent with 2016 statistics that demonstrate African-American men comprising 23% of the total individuals shot and killed by police. While quite a few of the cases of black males being seemingly unjustifiably killed, particularly when unarmed, by police officers have brought into question the role of racism, prejudice, and discrimination; it is quite important to note that statistics demonstrate that black and white police officers are equally likely to use force against black males. Furthermore, socioeconomic status does not appear to be a distinguishing factor either as high income blacks are just as likely to be killed by police officers as low income blacks (Krieger, 2015).

Blacks are significantly more likely to experience police brutality than are whites (Kahn, 2016). Additionally, young black men, within the ages of 15-34, were 9 times more likely than other Americans to be killed by police officers as of data collected in 2015; which was 4 times the rate of young white men (the Guardian, 2017). The use of unnecessary force against black males is often viewed as a manifestation of racial discrimination and racial profiling by law enforcement. As identified by English, Lambert, Evans, and Zondervan (2014), one explanation for this may be “the gendered and racialized stereotypes that remain ubiquitous throughout US society that depict African-American males as deviant and violent”. (Williams and Mohammed, 2009). Further considering the perception of African-American males, research has demonstrated a link between the percentage of young African-American men in a neighborhood and greater perceptions of crime levels, even given equivalent neighborhood characteristics and crime levels (Quillian and Pager, 2001). This may indicate the greater likelihood that they are profiled and discriminated against (English et al., 2014). Furthermore, it must be understood that repeated examples and depictions of police brutality and use of unwarranted deadly force against black males has a profound impact on the emotional and psychological well-being of African-American families and communities, creating a living environment of fear and uncertainty; the loss of family and community members diminishes their social and economic resources as well. Research has demonstrated a strong and consistent link between depressive symptoms and experienced racial discrimination (Pascoe and Smart Richman, 2009). Perceived racism and discrimination have been identified as being associated with depression, increased substance use, and feelings of hopelessness among African American youths (Gibbons, 2004; Nyborg, 2003), which in turn are associated with suicidal behaviors in adolescents (Goldston, 1999; Goldston et al. 2001). As highlighted in the American Psychiatric Association’s (APA) Toolkit for Providers Treating African-Americans (2017), negative social factors such as racism, racial bias and discrimination contribute to poor physical and mental health among racial/ethnic minority populations (Jones, 2008). The mental health of African-American males, as well as of the

African-American community at large, is negatively impacted by overt and covert racism, as well as explicit and implicit bias. Microaggressions, a form of covert racism, manifests as a perceived slight wherein the recipient has an intuitive sense that an act of prejudice occurred during the interaction; with frequent exposure to microaggressions serving as a conduit for chronic stress (APA, 2017; Charkraborty & McKenzie, 2002). African-American males are disproportionately profiled to be criminals and are frequently stopped and searched based on the perceived notion of wrong doing with many profiled persons subsequently developing symptoms of anxiety and PTSD (APA, 2017; Aymer, 2016).

POSITION:

The American Psychiatric Association (APA) condemns the brutal treatment of black males, the use of excessive force against black males, and the use of unwarranted and unnecessary deadly force against black males by law enforcement agencies and police departments in America.

RECOMMENDATIONS:

1. The APA encourages initiatives, such as the Gang Resistance Education and Training (G.R.E.A.T.) Program Model, that foster direct collaboration between law enforcement and African-American communities in order to engender trust, cooperation, and understanding. Other necessary initiatives include community policing and racial diversification of law enforcement officers and leadership.
2. The APA encourages programs, such as the Crisis Intervention Team (CIT) model, that foster collaboration between law enforcement and mental health professionals for the purpose of bidirectional dialogue, psychoeducation, and cultivating positive interactions with black males and the African-American community at large.
3. The APA encourages the development of training programs for police departments/law enforcement agencies to train administrators and officers on racial bias/racial trauma and its response and impact on the mental health of the communities they serve.
4. The APA encourages continued research into the mental health effects of police brutality and the unethical use of excessive/deadly force on African-American males and the African-American community.
5. The APA encourages the development of novel approaches and strategies to address the unique mental health needs of African-American males who have either, directly, or indirectly experienced police brutality and/or the use of unwarranted excessive/deadly force by law enforcement, as well as the mental health needs of their family and community members.

Authors:
Council on Minority Mental Health and Health Disparities

Background Information

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Position Statement on Detained Immigrants with Mental Illness

Approved by the Board of Trustees, December 2013
Approved by the Assembly, November 2013

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

The American Psychiatric Association urges federal policy makers and responsible agency officials to ensure that detained individuals with mental disorders receive appropriate mental health treatment.

Authors:
Daniel B. Martinez, M.D.
Patricia Recupero, M.D., J.D
Andres Pumariega, M.D.
Collaborating Councils:
Council on Psychiatry and the Law,
Council on Minority Mental Health and Health Disparities
With special thanks to:
Alex Vaicius
American Association for Social Psychiatry
APA Hispanic Caucus

See the related APA resource document HERE.

ROLE DESCRIPTION
2ND VICE CHAIR

- Present update at every conference call on Position Papers and toolkit status (1/2 hour per month)
- Assign Position Papers (or secondary assignments or special projects) to liaisons as they come up and f/u on these items (1/2 hour per month)
- Communicate with DDHE monthly re: updates on Position Papers, toolkits and Caucus/Council Liaisons reporting (1/2 hour per month)
- Review JRC report (30 minutes for each quarterly report)

In addition to roles/responsibilities of all members, specifically:

- Attend monthly conference calls
- Attend September Components meeting
- Participate in May meeting if available
- Liaison with Councils or Caucuses (or both)

AM2018 ACCEPTED SUBMISSIONS

Reported by:	Sponsorship/Endorsement	Fellow Initiated	Stress/Trauma Toolkit Submission	M/UR Caucus & CMMH/HD Joint Submission	Format/Session Title
Dr. Alan Fung	Council on Minority Mental Health and Health Disparities		✓	✓	Workshop 1501–Addressing Asian Mental Health and Wellbeing during this Challenging Political Climate
Dr. Carine Nzodom	Council on Minority Mental Health and Health Disparities		✓	✓	Workshop 1792–Promoting wellbeing of African Americans: Tools to treat mental health needs and promote wellbeing during the current political and social climate
Dr. Christina Mangurian Dr. Carine Nzodom	Council on Minority Mental Health and Health Disparities		✓	✓	Workshop 1914–Parental Leave: Luxury or Necessity?
Dr. Christina Mangurian	Council on Minority Mental Health and Health Disparities		✓	✓	Workshop 2477–Promoting Wellbeing Among Women in the Current Political and Social Environment
Dr. Emily Wu	Council on Minority Mental Health and Health Disparities Caucus of Asian American Psychiatrists				Workshop 1121–Digital Mental Health Innovations for Minority Populations: A Potential Solution to Fulfill Unmet Needs
Dr. Emily Wu	Group for Advancement of Psychiatry				Workshop 1932–Inside the Matrix: A Workshop on the Ethics, Evaluation, and Opportunity of Mental Health Video Games
Dr. Emily Wu		✓			Poster 1012–Increasing Engagement in Depression Care by Chinese Americans through a Customized and Culturally Relevant Smartphone Platform
Dr. Francis Lu	Caucus on Religion, Spirituality and Psychiatry				Symposium 1124–Defining Core Competencies for Dealing with Spirituality and Religion in Psychiatry
Dr. Francis Lu	Council on Minority Mental Health and Health Disparities		✓	✓	Symposium 2794–At Risk: Undocumented Immigrant Mental Health in the Current Political Climate
Dr. Francis Lu	Council on Minority Mental Health and Health Disparities				Media Workshop 2844–Cultural Depictions of Resilience in the Face of Inevitable Family Dissolution in the Films “Make Way for Tomorrow” and “Tokyo Story”
Dr. Jai Gandhi		✓			Workshop 2370–Black and White: The Cost of Unexamined Racial Bias
Dr. Muhammad Zeshan		✓			Poster 1576–Copycat Suicide Attempt Following Netflix Show “13 Reasons Why” : A Case Report and Literature Review
Dr. Muhammad Zeshan		✓			Poster 2179-- Does thirty-day readmission has relevance in psychiatric patient population?
Dr. Muhammad Zeshan		✓			Workshop 1431–Mental Health Provider’s Primer Regarding Terminology, Lessons and Resources on Sexual Orientation and Gender Identity and Expression
Dr. Muhammad Zeshan		✓			Workshop 2066–Suicide During Transition of Care; What Clinicians Can Do to Lower Suicide Rate?
Dr. Muhammad Zeshan		✓			Workshop 2126–Finding Your Match: The Process of Obtaining Residency and Fellowship Positions
Dr. Vabren Watts	Council on Minority Mental Health and Health Disparities				Workshop 1176–Conversations on Diversity
Dr. Vabren Watts					Workshop 1198–Women of Color and Intersectionality
Dr. Vabren Watts					Workshop 2778–Building a Network of Future Leaders in Organized Psychiatry #mentorshipgoals
Dr. Esperanza Diaz	M/UR Caucus for Hispanic Psychiatrists			✓	Toward Hispanic-American Well-Being: Understanding Cultural Concepts of Distress, Responses to Stress/Trauma, and Adaptation of Services

COUNCIL ON PSYCHIATRY AND LAW

EXECUTIVE SUMMARY:
The Council on Psychiatry and Law has continued its work evaluating legal developments of national significance, proposed legislation, regulations, and other government intervention that will affect the practice of psychiatry, including the subspecialty of forensic psychiatry. The Council has had several phone calls through individual workgroups. This year the Council has nine fellows and has several participants who were either former members or interested APA members who have volunteered to contribute to the development of work products. The Council is attempting to develop mentoring through the workgroup chairs by having more experienced members work with more junior or new members to develop written documents for approval.

1. **ACTION: Will the Joint Reference Committee recommend approval of the proposed "Position Statement on Weapons Use in Hospitals and Patient Safety"?**

   The Council on Psychiatry and Law has developed a Position Statement on Weapons Use in Hospitals and Patient Safety (*Attachment #1*). The draft Position Statement was revised by the Council in response to feedback from the Joint Reference Committee after considering the draft document during its October meeting. Specifically, revisions were made to clarify that the document focuses on appropriate clinical responses to patient violence, and that the usual clinical response from clinical personnel should never include weapons use.

Informational Items:

1. **GUN SEIZURE LAWS WORKGROUP**

   The Gun Seizure Laws Workgroup, chaired by Dr. Reena Kapoor, is continuing its work to develop a Resource Document. At this time, the document's working title, subject to change, is "Gun Seizure Laws Based on Dangerousness."

2. **WORKGROUP ON INVOLUNTARY CIVIL COMMITMENT FOR SUBSTANCE USE DISORDER**

   The Council has formed a Workgroup, jointly chaired by Dr. Debra Pinals and Dr. Elie Aoun, a volunteer participant in Council of Psychiatry and the Law for several years and a SAMHSA Substance Abuse Fellow on the Council on Addiction Psychiatry, with consultation and assistance from Mr. Richard Bonnie, to draft a position statement on the topic of involuntary civil commitment for Substance Use Disorder. This work began in collaboration with the Council on Addiction Psychiatry, and has taken into account work that the Council on Addiction Psychiatry previously did to develop a position, with the plan to have both Councils endorse the proposed position statement prior to sending to the Joint Reference Committee. The topic is one that leads to debate as to the proper stance to take in a position statement and will likely emphasize the importance of access to treatment as a main theme. The Workgroup has met and is currently working on a draft position statement.

3. WORKGROUP ON MOBILE MEDICAL APPS INVOLVING PSYCHIATRY

The Council has formed a Workgroup to consider the emerging issue of mobile medical apps involving psychiatry. The Workgroup, chaired by Dr. Patricia Recupero, has reviewed literature on the issue and its preliminary assessment is that some advice, likely in the nature of a draft resource document, would be helpful to psychiatrists in dealing with the new world of medical apps. The Workgroup will continue to explore the issue; it may be considered as a potential topic for the joint meeting of the Council and its Committee on Judicial Action in September 2018, although there is little litigation on the subject to date.

4. WORKGROUP ON STALKING AND INTRUSIVE BEHAVIORS BY PATIENTS TOWARD PSYCHIATRISTS

The Workgroup on Stalking and Intrusive Behaviors by Patients Toward Psychiatrists was formed in response to concerns raised during the September 2017 Components Meeting. The Workgroup is chaired by APA member and volunteer to the Council Dr. Maya Prabhu, with support from co-chair Dr. Debra Pinals. It had its first organizing call in December 2017, and has developed a tentative outline to draft a potential resource document to offer guidance to psychiatrists who have been the subject of stalking or other intrusive behaviors by patients or former patients. The Workgroup aspires to have a draft product for review by the full Council in May 2018.

5. WORKGROUP ON INVOLUNTARY PSYCHIATRIC CIVIL COMMITMENT

The Council has formed a Workgroup, chaired by Dr. Marvin Swartz, to consider the issue of involuntary psychiatric civil commitment and to review the APA's existing Position Statement on this topic in light of current existing other Position Statements. The Workgroup should have more information to report at the May 2018 meeting.

6. WORKGROUP ON PHARMACEUTICAL MARKETING TO CRIMINAL JUSTICE ENTITIES

The Council has formed a Workgroup, jointly chaired by Dr. Carl Fisher and APA/APAF Leadership Fellow Dr. Michael Langley-DeGroot, to consider the topic of marketing to criminal justice entities by pharmaceutical companies. The Workgroup arose from concerns expressed by Council members during the September Components Meeting about the practice of marketing to drug courts in particular. The Workgroup has evaluated potential strategies and plans to begin work on a document on the issue.

7. PLANS TO PUBLISH PHYSICIAN ASSISTED DEATH RESOURCE DOCUMENT

The Council is making efforts, led by Dr. Stuart Anfang, to have the previously-approved Resource Document "Physician Assisted Death" published in a journal. Permission to seek publication of the document was granted by the Board in December 2017.

8. COMMITTEE ON JUDICIAL ACTION

The Committee on Judicial Action, a subcomponent of the Council chaired by Dr. Marvin Swartz, continues to consider and make recommendations about APA involvement as a friend of the court in cases at every level of the judicial system that concern the practice of psychiatry or related issues. Recently, the Committee considered the possibility of APA participation in a brief for *Doe v. Boyertown Area School District*, a Third Circuit case considering bathroom and locker room access for transgender students. The Committee also continues to monitor the case of *Rosen v. Regents*, in which APA joined an amici curiae brief with a number of organizations. The case concerns whether a university or its employees had a legal duty to protect adult students against criminal acts by a third person; oral argument was held before the California Supreme Court earlier this month.

Position Statement on Weapons Use in Hospitals and Patient Safety

Issue:

The Joint Commission reports that occurrences of armed violence have increased in the clinical and public spaces of hospitals.[1] Hospitals are designed as therapeutic environments. The vulnerability of many hospital patients and the need to be responsive to staff safety highlights the importance of maintaining a safe and secure environment. One study of hospital-based shootings identified 154 such incidents between 2000 and 2011.[2] Contrary to the impression sometimes created by media reports, only 4% of these shootings were perpetrated by patients with mental illness. In most cases, the circumstances raised questions about hospital policy and practice. For example, in 18% of the cases, perpetrators obtained the firearm in the hospital. On 13 occasions, the shooting event was initiated by the perpetrator taking a security or police officer's gun.

Further indirect evidence of the scale of the problem derives from data describing violence against hospital staff. Healthcare workers are at an increased risk for workplace violence. Eighty percent of violent incidents in hospitals are by patients on staff. Incidents of serious workplace violence (requiring days off work) are four times more common in healthcare settings than in private industry. Psychiatric aides experienced the highest rate of violent injuries in 2013 at approximately 590 injuries per 10,000 full-time employees. This compares to a rate of 4.2 injuries per 100,000 employees in U.S. industries as a whole.[3,4] Despite these statistics, the use of weapons by staff in hospitals warrants particular scrutiny and demands specific safeguards. When patients present with behavioral dysregulation, clinical responses are to be distinguished from security responses.

APA Position:

The American Psychiatric Association does not support the use of weapons* as a clinical response in the management of patient behavioral dyscontrol in emergency room and inpatient settings because such use conflicts with the therapeutic mission of hospitals. Weapons use by properly trained and authorized law enforcement personnel will occasionally be necessary to deal with armed individuals to ensure the safety of patients and the public. However recent reports have described situations where clinical staff failed to use appropriate clinical responses to psychiatric patient violence, weapons were used, and patients were harmed.[5,6] The routine management of patient violence risk is a clinical task that should be properly resourced. Weapons use is not part of routine clinical management.

Clinical staff are not trained to decide when weapons should be used and weapons do not have a role in clinical patient care, especially when that care involves restraint or seclusion of a patient.[7] Measures known to reduce the need for weapon use are available. Hospital security personnel, the police[8] and clinical staff should receive regular training in safely managing and de-escalating agitated, disruptive and violent patient behavior. Staffing levels should be sufficient to ensure that weapons

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* Weapons are here defined (as they are also defined in the CMS State Operations Manual: CMS. State Operations Manual Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals Section 482.13(e) https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf) as "includes, but is not limited to, pepper spray, mace, nightsticks, tazers [sic], cattle prods, stun guns, and pistols."

use by security staff to respond to patient violence is a last resort. Medication usage in management of violent patients is complex, requires psychiatric input,[9] remains the subject of ongoing research,[10, 11] but has the potential to be an effective therapeutic tool. Seclusion and restraint reduction strategies used in clinical settings should be sensitive to issues of trauma among patients and staff.

The following steps are suggested to reduce weapon use overall by staff in hospitals when dealing with behaviorally disturbed patients[12]:

a) **Hospitals should minimize the unauthorized presence of weapons on their premises. Where appropriate these steps should include screening patients for weapons before admission to psychiatric emergency rooms and or psychiatric inpatient units and, where appropriate, screening patients assessed to be at high risk to others prior to admission to non-psychiatric inpatient units.**

b) **Patients who pose a risk of harm to others should be managed by clinical staff using clinical approaches. These usual clinical approaches will typically involve psychological interpersonal interventions and may include, when less restrictive alternatives fail, the use of involuntary emergency medication, physical seclusion and physical or mechanical restraint following guidelines issued by The Joint Commission and CMS. If hospital security staff acting in a clinical capacity are needed to assist during an incident of patient violence, the particular security staff should have been trained in clinical approaches and the chief clinician present should remain in charge of the usual clinical response to patient violent incidents. The clinical response does not involve the use of weapons.**

c) **Hospital clinical staff and security staff acting under the supervision of clinical staff should receive regular training from the clinical perspective in safely managing the risks posed by patients who present with agitation and are disruptive and engaging in escalating behavior. Cross-training by security can help staff be prepared for more significant acts of violence.**

d) **Hospital administration should ensure that staffing levels are sufficient to facilitate proper clinical approaches to the management of patient violence risk that are sufficient to resolve the great majority of behavioral incidents.**

e) **Weapons should never be used by clinical staff or hospital security staff acting in a clinical capacity as a means of subduing a patient, or in placing a patient in restraint or seclusion or otherwise managing violence risk.**

f) **Hospitals should have a policy in place to define when clinical control of a situation is being ceded to law enforcement or hospital security staff acting in a law enforcement capacity for management of patient violence. This might occur when there exists an imminent risk of life threatening injury that cannot be managed using the usual clinical response (for example, active shooter situations involving a patient). Critical incident reviews should be conducted following such episodes.**

Authors: Jeffrey S. Janofsky, M.D. (Chair); Miguel Alampay, M.D.; Richard Bonnie, LL.B.; Alec Buchanan, M.D., Ph.D.; Michael Champion, M.D.; Elizabeth Ford, M.D.; Tanuja Gandhi, M.D.; Steven K. Hoge, M.D.; Varma Penumetcha, M.D.; Debra A. Pinals, M.D. for the Council on Psychiatry and Law

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1 Joint Commission: Preventing violence in the health care setting. Sentinel Event Alert, Issue 45. June 3, 2010 http://www.jointcommission.org/assets/1/18/SEA_45.PDF

2 Kelen GD, Catlett CL, Kubit JG, Hsieh YH. Hospital-based shootings in the United States: 2000 to 2011. Ann Emerg Med. 2012 Dec;60(6):790-798. doi:10.1016/j.annemergmed.2012.08.012. PubMed PMID: 22998757

3 Workplace Violence in Healthcare: Understanding the Challenge. U.S. Department of Labor Occupational Safety and Health Administration. OSHA 3826 - 12/2015 https://www.osha.gov/Publications/OSHA3826.pdf (accessed 09/20/2017)

4 Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers. U.S. Department of Labor Occupational Safety and Health Administration. OSHA 3148-04R 2015. https://www.osha.gov/Publications/osha3148.pdf accessed 09/20/2017)

5 579: My Damn Mind, Prologue and Act One, This American Life, February 12, 2016, https://www.thisamericanlife.org/radio-archives/episode/579/my-damn-mind accessed 09/20/2017)

6 Rosenthal E: When the Hospital Fires the Bullet. New York Times. February 12, 2016. http://nyti.ms/1LkEfjW accessed 09/20/2017)

7 CMS. State Operations Manual Appendix A Survey Protocol, Regulations and Interpretive Guidelines for Hospitals Section 482.13(e) https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf accessed 9/20/2017

8 We recognize that some state and federal hospital facilities use sworn police officers as part of their routine security force. Such sworn police officers need special training in dealing with agitated, disruptive or threatening psychiatric patients, and should not respond with weapons as a usual clinical response.

9 Douglas-Hall P, Whicher EV. As required' medication regimens for seriously mentally ill people in hospital. Cochrane Database of Systematic Reviews 2015, Issue 12. Art. No.: CD003441.DOI: 10.1002/14651858.CD003441.pub3.

10 Allen MH, Currier GW, Carpenter D, Ross RW, Docherty JP; Expert Consensus Panel for Behavioral Emergencies 2005.. The expert consensus guideline series. Treatment of behavioral emergencies 2005. J Psychiatr Pract. 2005 Nov;11 Suppl 1:5-108; quiz 110-2. PubMed PMID: 16319571.

11 Lehman AF, Lieberman JA, Dixon LB, McGlashan TH, Miller AL, Perkins DO et al. Practice Guideline for the Treatment of Patients with Schizophrenia, Second Edition. American Journal of Psychiatry. 2004 Feb;161(2 SUPPL.). available at: http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/schizophrenia.pdf accessed 9/20/17

12 Hospitals in this document do not include correctional hospitals.

Item #8.K

Joint Reference Committee
February 11, 2018

Executive Summary

The Council on Psychosomatic Medicine (CPM) focuses on psychiatric care of persons who are medically ill and/or pregnant and works at the interface of psychiatry with all other medical, obstetrical, and surgical specialties. It recognizes that integration of biopsychosocial care is vital to the well-being and healing of patients and that full membership in the house of medicine is essential for our profession.

Since the JRC report in June, the Council has focused on the following issues:

- **Name Change:** Last year all appropriate entities approved the name change from Psychosomatic Medicine to Consultation-Liaison Psychiatry. The Council is working with the Academy of Psychosomatic Medicine (APM) on branding the name change. Specifically, the Council is identifying opportunities to communicate the new name change to APA members, other professional groups, and the public through Psychiatric News, the Annual Meeting, and developing resources that may be shared to illustrate the breadth and depth of Consultation-Liaison Psychiatry. The Council is requesting a formal name change through the JRC as requested below.

- **Resource Documents:** The Council has workgroups in the process of developing Resource Documents on the following topics:
    - "The Assessment of Capacity for Medical Decision Making"
    - "QTc Prolongation and Psychiatric Disorders"
    - "The Assessment of Capacity for Medical Decision Making", and
    - "Emergency Department Boarding of Individuals with Acute Mental Illness".

  We anticipate the Resources Documents on "Emergency Department Boarding of Individuals with Mental Illness" and "QTc Prolongation and Psychiatric Disorders" will be ready for the JRC's next meeting.

  As included below, the Council is requesting approval of the Resource Document on "The Assessment of Capacity for Medical Decision Making".

- **HIV Steering Committee:** The Committee developed a Position Statement and accompanying resource document on Pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) for HIV prevention. Given that antiretroviral-based therapy is relatively new, they have received questions on the topic and want to provide guidance through a Position Statement. The Position Statement is going through the approval process and will be ready for the JRC by the next meeting.

  In September 2017, SAMHSA funding for the five-year HIV/AIDS Training Grant ended due to lack of funds. The Committee will continue to do trainings, both in-person and virtually via webinars.

Actions requested.

1) **Will the JRC approve the Council's name change to Council on Consultation-Liaison Psychiatry to conform with the official name change of the subspecialty?**

2) **Will the JRC approve the Council's Resource Document on "The Assessment of Capacity for Medical Decision Making"?** (attachment 1)

   The authors of the Resource Document reviewed the classic and emerging literature on decisional capacity, including literature on clinical approaches to determination of decisional capacity, specific psychiatric and neurologic illness affecting decisional capacity, use of standardized rating instruments, and modification of clinical examination techniques specific to decisional capacity determinations. The authors cover nine topic areas pertinent to decisional capacity determinations, with review of the relevant literature for each topic, and offer a proposed clinical methodology for decisional capacity determinations in the context of comprehensive psychiatric evaluations.

Council on Psychosomatic Medicine Call

Thursday, January 11

3:00-4:00 pm ET

Call-in number: 1-202-602-1295 Conference ID: 733-481-365#

MEETING MINUTES

- Roll Call (3:00-3:05 pm)
  Attendance: Daena Petersen, Megan Riddle, Chandan Abhisek, Adrienne Taylor, Cathy Crone, Dave Gitlin, Mira Zein, Madeleine Becker, Sanjeev Sockalingam, Sejal Shah, James Bourgeois, Robert Boland, Maria Tiamson-Kassab, James Rundell, Margo Funk
  Decline: Diana Robinson, Jon Levenson, Kim Nordstrom, Robyn Thom, Linda Worley, Durga Roy

- Workgroup Updates (3:05-3:30 pm)
  - Accessing Capacity Resource Document *(Dr. Bourgeois)*
    - Deadline for feedback is on Friday. It will then be shared with the JRC.
  - Video Project *(Dr. Madeleine Becker)*
    - *The workgroup has started talking about developing a second Prezi video. It will be geared towards trainees and educational directors. The focus will be case studies that showcase the different opportunities under CL.*
  - Women's Issues *(Dr. Madeleine Becker)*
    - *Develop patients guides or position statements on issues such as infertility and mental health issues. Pull in the APM SIG for ideas.*
    - *Dr. Rundell will help to coordinate with the APM SIG.*
  - Psych News Articles on Name Change *(Dr. Sanjeev Sockalingam)*
    - *Goal: Support the name change and raise awareness of the breadth and depth of psychiatry through a series of articles in Psych News.*
    - *Sanjeev spoke with Christina Wickman from Psych Times about coordinating articles. They are thinking about how to coordinate with SIGS at APM to generate content for the Psych News articles. There seems to be synergy with a focus on: perinatal/women's mental health, transplant, HIV, cardiac psychiatry, neuro psychiatry, oncology, and pediatric.*
    - *Any concern about this being too close to Psych News and duplicative? The Pysch Times has been more content and knowledge. The Psych News would be more like case studies and the role of CL Psychiatry.*
      - *Chandan – could we also do something for Collaborative/integrated care? The Council will think about how to weave it in as there are different ways to approach it with more general psychiatrists doing Collaborative Care.*
  - QTc and Psychotropic Medications *(Dr. Margo Funk)*
    - *Pretty much at the point of completion except for formatting references. Will not make the JRC meeting but will have council approve and start working with the journal to approve.*
  - HIV Steering Committee *(Dr. Daena Petersen)*
    - *SAMHSA five-year grant was ended in September 2017 due to lack of funding. APA continues to support key initiatives from the grant, including electives and webinars.*
    - *HIV/Psychiatry elective is in the planning stage right now. Working to secure more sites for more opportunity for medical students.*

        - *Position statements: Working on regrouping with the folks who committed to finishing them. The goal is to get them done in the next month.*
        - *Have the Position Statements ready by mid-April.*

- Position Statement Discussion (3:30-3:50 pm)
    - Developing Position Statements. The Council is considering Position Statements it may move forward.
    - Hospital Privileges for Psychologists (CAGR is sending to the JRC for Approval). Dr. Becker helped with drafting the language below. The changes are in red.
        - ~~Hospital Privileges for~~ **Psychologists and Other Mental Health Professionals and Hospital Privileges**
            - Given that hospital treatment is the highest level of treatment available to manage complex psychiatric conditions and often co-morbid general medical disease, the APA advocates that patients hospitalized ~~patients~~ in both psychiatric and medical settings are best served when responsibility for their mental health and substance use disorder care resides with psychiatrists leading cross disciplinary teams. Psychologists, as well as other mental health professionals ~~non-medical professionals~~, are critical members of cross disciplinary teams, and should be eligible for hospital appointment to act in roles consistent with their specialization and training.

- Policy Updates (3:50-4:00 pm)
    - Release of Report from HHS Interdepartmental Serious Mental Illness Coordinating Committee
    - Release of APA White Paper on Improving the Physical Health of Patients with SMI
    - Release of HHS Office of Civil Rights HIPAA Guidance on Information Sharing Related to Mental Health

**The next Council in-person meeting is Tuesday, May 8 in New York. The September Components meeting is from September 12-15. More information on Sept. Components will be available in June.*

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APA Council on Psychosomatic Medicine

Resource Document on Decisional Capacity

Members:

James A. Bourgeois, OD MD

Maria Tiamson-Kassab, MD

Kathleen A. Sheehan, MD

Diana Robinson, MD – Trainee member

Mira Zein, MD – Trainee member

Introduction:

The authors have reviewed the classic and emerging literature on decisional capacity, including literature on clinical approaches to determination of decisional capacity, specific psychiatric and neurologic illness affecting decisional capacity, use of standardized rating instruments, and modification of clinical examination techniques specific to decisional capacity determinations. The authors cover nine topic areas pertinent to decisional capacity determinations, with review of the relevant literature for each topic, and offer a proposed clinical methodology for decisional capacity determinations in the context of comprehensive psychiatric evaluations.

#1: Determine the type of decisional capacity (DC) question.

Considering that capacity is a functional assessment and a clinical determination about a specific decision, the first step is to determine the type of DC question. Common types of DC questions include informed consent, treatment refusal, requests to leave the hospital against medical advice (AMA), and capacity for social function/dispositional capacity. In the case of some

capacity questions, such as informed consent, a full description is needed of the proposed intervention and its risks, benefits, side effects, and alternatives. In the case of dispositional capacity, additional consultation from occupational therapy, physical therapy, and/or social work may be indicated. Defining the specific question is critical because the patient may have capacity in some areas but not others. It can also aid in determining the "decisional capacity gradient"; i.e., the higher the risk of the decision, the higher degree of decisional capacity needed for a specific decision. The most common reason for a capacity evaluation is a patient's refusal of medical treatment. Farnsworth found that between 3% and 25% of requests for psychiatric consultation in hospital settings involve questions about patients' capacity to make a treatment-related decision (1).

Recommendations:

It is important to determine a specific question for decision capacity in order to guide your psychiatric interview, understand the risk involved, and how it may influence recommended workup.

#2: For informed consent decisions, a full description of the proposed intervention and its risks/benefits/side effects is necessary.

The doctrine of informed consent, including its corollary, the right to refuse treatment, is arguably the most important doctrine in medical ethics and health law (2). There are three essential components of informed consent. The consent is given in the absence of coercion or duress, the person is provided information in a language understandable to him/her, and the degree of decisional capacity must be relevant or "proportional" to making a meaningful decision whether or not to accept the treatment offered or whether or not to participate in a

research study. An essential element in informed consent is that the person should have the capacity to understand the information and should be in a position to make and to authorize a choice in how to proceed. Challenges to informed consent have emerged; e.g., what information should be disclosed, how much the person providing consent should understand, and how explicit consent should be (3).

It is important to make an accurate and effective assessment of capacity in patients who need to make a decision using the four elements according to Appelbaum and Grisso in a seminal 1988 article (4). The patient must be able to understand relevant information, appreciate the clinical circumstances, exhibit a rational process of decision making, and be able to communicate a consistent choice (4). By understanding the relevant information, the patient is able to show that he/she understands the illness and its prognosis and the risks and benefits of treatment options, including non-treatment. Several strategies can be employed in enhancing a person's understanding in informed consent: additional simplified written information, extended discussions, audiovisual and multimedia programs, and test/feedback techniques, with particular attention to interventions that are accessible to persons with limited literacy and/or limited English proficiency (5).

To appreciate the situation and its consequences, the patient needs to recognize that his/her welfare is affected by the outcome of the decision and appreciate that he/she will benefit or suffer from the consequences of the decision. One can say that the patient is able to manipulate information rationally is he/she is realistic in his/her decision making and is able to use the information logically to reach a decision. Finally, a patient is able to communicate a choice when he/she is able to express a consistent preference regarding a decision: for or against.

Recommendations:

Capacity determinations in informed consent situations should include the four elements Appelbaum and Grisso described: in short, understanding, appreciation, making a rational decision and ability to make a consistent choice.

#3: Full standardized psychiatric interview and neurocognitive disorders workup.

Decisional capacity can be further evaluated with a standardized psychiatric interview and neurocognitive disorder workup. A full standardized psychiatric interview is critical for determining DC and identifying underlying conditions influencing DC. Boettger et al evaluated inpatient medical consults that determined the patient to have impaired DC and found that the most common psychiatric diagnoses contributing to incapacity were cognitive disorders (54.1%), substance use disorders (37.2%), and psychotic disorders (25%) (6). Among other medical diagnoses, neurological disorders frequently contributed to decisional incapacity (6). Torke et al found that the most common neurologic reasons for impaired DC in hospitalized patients > 65 years old were Alzheimer's disease (39.4%) and delirium (19.0%) (7).

Delirium

11-42% of medical inpatients experience delirium at some time during hospitalization (8). The incidence is higher in post-surgical patients, in those with advanced age and pre-existing brain disease, and is likely under-diagnosed (8). While delirium is a cognitive disorder that is identified as a main source of decisional capacity consults, there is limited data looking at the correlation between delirium and decisional capacity (8, 9). The DSM-5 defines delirium as including disturbances in attention, cognition and awareness that develops over a short period, is a change from baseline, and tends to fluctuate in severity throughout the day (10). By definition,

there is evidence from history, physical examination, or laboratory findings that the disturbance is a direct physiological consequence of another medical condition, substance intoxication or withdrawal, toxin exposure, or multiple etiologies (10)

Mild and Major Neurocognitive Disorders

Several studies have shown that patients with dementias of various etiologies experience impairment in DC when compared with age-matched elderly persons without any cognitive impairment (11). In one study by Karlawish et al (12), 48 patients with mild to moderate dementia due to Alzheimer's disease were tested with the MacArthur Competence Assessment Tool-Treatment (MacCAT-T) and scored lower on all four scales of understanding, appreciation, reasoning and choice, when compared to the scores of 102 family caregivers. Studies have also shown that patients with mild cognitive impairment can also experience problems in making competent decisions. Two studies by the same group (13, 14) utilized the Capacity to Consent to Treatment Instrument (CCTI) to compare patients that met criteria for MCI vs normal comparison subjects; in both studies, patients with MCI had lower scores on understanding, appreciation and reasoning.

As part of the psychiatric interview, a workup for neurocognitive disorders should be considered for all patients. Cognitive disorders were the most common psychiatric condition in patients with diminished DC (15). At minimum this workup should include a Mini-Mental State Exam (MMSE) or Montreal Cognitive Assessment (MoCA). Kahn et al evaluated 52 patients with cognitive disorders on an inpatient medical consult service and found that a MMSE score less than 24 was 83% sensitive and 90% specific for finding impaired DC; a MMSE less than 21 was 69% sensitive and 100% specific and for finding impaired DC (16). In a study of 78 skilled nursing

facility residents by Allen et al., better global cognitive ability (as determined by MMSE score) was correlated with the ability to understand the treatment situation ($p = 0.001$) and the ability to appreciate the consequences of their treatment choice ($p = 0.042$) (17). Gurrera et al. conducted neuropsychological tests on 159 geriatric patients with and without significant cognitive impairment. Assessments included the MacArthur Competence Assessment Tool-Treatment and 11 neuropsychological tests commonly used in the cognitive assessment of older individuals. They found that performance on neuropsychological assessments was correlated with DC performance (18). Also, when decisional abilities were considered separately, the prevalence of incapacity was greater than expected regardless of the presence of significant cognitive impairment (18). Burton et al. found that impairment on a number of verbal abilities (verbal learning, memory, and fluency) during neuropsychological testing as well as global cognitive function correlated with diminished DC in a population of 110 hospice patients without chart evidence or history of cognitive impairment (19).

Recommendations:

1. A capacity assessment should start with a full psychiatric interview, as several psychiatric diagnoses are associated with greater impairment in DC.
2. Cognitive assessments such as MMSE or MoCA, with additional testing as indicated (e.g., Hamilton Depression Rating Scale, Young Mania Rating Scale, Positive and Negative Symptoms Scale, neuropsychological testing) should be performed for any DC evaluation, as cognitive impairment is highly associated with DC impairment. An MMSE score < 21 is acceptably sensitive and highly specific for finding impaired DC (16).

#4: Other conditions affecting DC and proposed psychiatric workup.

Substance use Disorders

Substance use disorders are another area that can lead to impaired DC, particularly in the setting of substance intoxication or withdrawal and a substance-induced delirium. Unless there is significant acute decompensation, psychotic and bipolar or depressive disorders are less likely to lead to impaired DC, though these should be included in the differential and workup.

There is limited data on DC in substance use disorders (SUDs). Studying capacity empirically in this population is thought to be difficult as an individual while sober can perform well on standard capacity assessment tools but may have poor self-care and decision-making chronically due to neurocognitive changes of long-term substance use (20, 21). When using standard assessment measures such as MacCAT-T in patients who are not intoxicated or withdrawing and do not have dual psychiatric diagnoses or cognitive sequelae, rates of decisional incapacity are found to be low (16, 21, 22). Hazelton et al recommend delaying assessment of capacity until acute effects of intoxication and delirium have resolved, considering evidence of impaired judgment, and differentiating cognitive deficits from poor insight/judgment (22).

Psychotic disorders

Studies of patients with schizophrenia have found significant heterogeneity in DC when assessed by tools such as the MacCAT-T and MacCAT-CR (MacCAT version for clinical research) (23-26). A review of the decisional capacity literature found that 5 schizophrenia studies looked at association between severity of psychopathology and decisional capacity. These studies found that the psychopathology correlation was much lower than correlations between overall

cognitive performance and decisional capacity (26). Correlations between negative symptoms and DC were stronger than for positive symptoms and DC (26). In one study, decreased understanding was also correlated with severity of negative symptoms and of general psychopathology, but not with age, education, severity of positive or depressive symptoms, or level of insight (23).

Depressive, Bipolar, and Anxiety Disorders

There have been limited studies on mood disorders (including bipolar disorder, depression, and anxiety disorders). A study by Misra et al (27) examined manic patients' ability to provide consent for three hypothetical research studies. Manic patients performed worse than did non-manic bipolar patients on the first trial, but by the third hypothetical study consent there were no significant differences between the groups in understanding (27). In contrast, a British study found that 97% of patients admitted to a psychiatric unit in a manic state were deemed to be incapable of making a treatment decision (28). In contrast, studies looking at depressive disorders have consistently found lower rates of depressed patients were found to lack capacity (6, 20, 21, 28-30), with decisional incapacity occurring in depressed patients that also demonstrated worse cognitive scores on assessment (29).

Psychiatric Workup

A psychiatric work up is useful to determine causes of decisional incapacity. In addition to the psychiatric interview and neuropsychological testing, a thorough history with collateral is essential to obtain the time course of patient's presentation, psychiatric history and treatment, and medical history including any recent changes in medications or diagnoses. For certain presentations, quick bedside assessments such as the Confusion Assessment Method (CAM) for

delirium, Hamilton Rating Scale for Depression (HAM-D) for depressive disorders, Young Mania Rating Scale (YMRS) for mania, Positive and Negative Syndrome Scale (PANSS) for psychosis can help elucidate diagnoses. A focused physical examination can help differentiate between neurologic and psychiatric diagnoses, as well as shed light on underlying medical conditions that may be contributing to delirium if present (31). Certain general examination findings (e.g., asterixis, neurological findings, and autonomic instability may help guide laboratory testing and imaging. Focal or lateralized neurologic signs are more consistent with a primary neurologic (as opposed to psychiatric) disorder (31).

Targeted laboratory testing is helpful in identifying causes of delirium, the presence of substance use, certain medication toxicities, other underlying causes of mood or cognition changes (31). Common laboratory tests include serum electrolytes, creatinine, glucose, calcium, complete blood count, and urinalysis and urine culture. Therapeutic drug levels, toxicology screen, liver associated enzymes, rapid plasma reagin (RPR), thyroid stimulating hormone (TSH) and vitamin levels are appropriate for specific clinical scenarios, particularly to rule out reversible causes of depressive disorders and neurocognitive impairment (31). Neuroimaging and lumbar puncture are reserved for patients with delirium and/or other cognitive impairment with inconclusive initial workup. EEG testing is useful in patients with altered level of consciousness in order to rule out suspected non-convulsive/subclinical seizures, or confirm the diagnosis of delirium; e.g. due to metabolic or infectious causes, that have characteristic EEG patterns (31).

Recommendations:

1. Assumptions should not be made that all patients with psychiatric illnesses,

including cognitive disorders, lack capacity, nor that patients on psychiatric commitment order necessarily lack capacity.

2. Efforts should be made to determine underlying factors contributing to incapacity and to correct any reversible factors in an effort to restore capacity. Such workup includes a thorough history, interview, focused physical examination, laboratory testing, and additional imaging and procedures where needed.

#5: For informed consent cases, if there is evidence of cognitive impairment, modify the consent process to facilitate understanding.

In their discussion of assessing decisional capacity for informed consent, Jeste and Saks state that explicit assessment is needed when the treatment or study involves more than minimal risk and the treatment or protocol is specifically intended for a population that is reasonably expected to have diminished DC (20). Patients with cognitive impairments due to a variety of psychiatric and medical illnesses, including dementia, psychotic disorders, brain metastases, and multiple sclerosis fall into the latter category (19, 20, 29, 32-34). Initial interventions to help enhance decisional capacity in these populations include performing the evaluation in the patient's native language and identifying and correcting potentially treatable conditions such a delirium or depressive disorder (11, 20, 29). In addition, evidence indicates that there are methods by which the consent process can be modified to facilitate understanding and enhance decisional capacity in individuals with cognitive impairment (11, 20, 32, 33, 35-39)

Dunn and Jeste reviewed 34 published studies of interventions across specialties designed to improve subject understanding of informed consent (36). Of these, 25 out of 34 studies reviewed found that subjects' understanding or recall showed improvement with various

interventions. More highly structured and more uniform consent processes, better organized, shorter, and more readable consent forms, and simplified and illustrated formats all improved subjects' understanding. Corrected feedback, multiple learning trials, ''advance organizers'' (which alert subjects to information about to be presented), and summaries of information also enhanced understanding.

Modification of capacity assessments and consent processes, depending on the types of cognitive impairment, is indicated in a variety of diagnoses. In a study on multiple sclerosis, interventions such as cueing and repetition helped patients with diminished cognitive function to display understanding equivalent to the control group (32). Similarly, in a review of informed consent challenges in cognitively impaired adults due to major neurocognitive disorders, modifying consent procedures with variables such as timing (i.e., completing informed consent procedures in the A.M. to avoid the effects of "sun-downing"), providing correcting feedback, and modifying consent content to plain language were useful in enhancing capacity (35).

Research has also shown that modifying consent processes is also helpful for patients with cognitive impairments due to psychosis and bipolar disorder (20, 36-39). In a study of errors in informed consent in patients with schizophrenia or schizoaffective disorder, administration of the MacCAT-CR along with informed consent processes found that cognitive deficits, particularly recall of disclosed information, was seen in 65.6% of patients. Interventions such as iterative disclosure of the information, corrective feedback, and emphasis of key points helped improve recall (37). In a similar study, patients with schizophrenia and bipolar disorder were both found to have worse scores on the MacCAT-CR secondary to neurocognitive deficits compared with healthy controls, which in turn significantly correlated with poor decisional capacity. Repeating

the missed information improved the level of understanding in all groups (39). Lastly, patients with schizophrenia randomized to multimedia consent procedures had improved scores on the MacCAT-CR and the University of California San Diego Brief Assessment for Capacity to Consent (UBACC) when compared with patients randomized to written consent (38).

Recommendations:

1. In patients assessed to have underlying cognitive impairment, any correctible factors should be addressed first.
2. Consent procedures should be modified to maximize cognitive domains such as understanding, reasoning, and recall in patients with cognitive impairments.
3. Multimedia and other new technologies should be explored as methods to improve informed consent procedures for patients with cognitive impairments.

#6: When obtaining informed consent, separately address the primary elements of decisional capacity

While legislation about informed consent varies across jurisdictions, there are consistent legal and ethical principles that guide this process in most Western countries. In general, patients who have capacity have autonomy and the right to make their own treatment decisions. Treating clinicians must assess whether their patients are capable to accept or decline treatments and interventions when they are proposed. When clinicians suspect that a patient is not capable of consent, then a substitute decision maker is usually sought to make this decision on the patient's behalf. While this assessment is usually implicit in the clinical encounter, given the legal and ethical importance of decisional capacity and provision of informed consent, a structured approach can assist with evaluation and documentation. Appelbaum and Grisso

published a landmark paper which operationalized DC assessment, which has since been widely adopted in clinical practice (4).

This approach requires patients to be provided with pertinent information about the risks and benefits of a proposed management plan. Clinicians must then assess whether the patient is able to fulfill four criteria: 1) communicate a choice; 2) understand the relevant information; 3) appreciate the situation and its consequences; and 4) reason about treatment options (4).

Recommendations:

When obtaining informed consent, clinicians should evaluate each of the four domains of DC for the proposed treatment or intervention. Each domain has been associated with patient and clinician tasks, as well as suggested questions for clinical assessment (40). Appelbaum recommended that, when obtaining informed consent, clinicians should determine whether the patient can (40):

1. Communicate a choice
    a. Patient task: clearly indicate a preferred treatment
    b. Clinician approach: ask patient to indicate a treatment choice
2. Understand the relevant information
    a. Patient task: grasp the fundamental meaning of information communicated by the physician
    b. Clinician approach: encourage the patient to paraphrase disclosed information about regarding the medical condition and treatment
3. Appreciate the situation and its consequence

   a. Patient task: acknowledge their medical condition and the likely consequences of treatment options
   b. Clinician approach: ask the patient to describe views of their medical condition, proposed treatments, and likely consequences of accepting or declining each of these options

4. Reason about treatment options
   a. Patient task: Engage in a rational process of manipulating the relevant information
   b. Clinician approach: ask the patient to compare the treatment options and potential consequences, and offer reasons why their choice is the best one for them

#7: Consider decisional capacity-specific instruments

In general, the determination of whether a patient has decisional capacity for medical treatment has been based on clinical assessment and judgment. However, research suggests that there is often poor inter-rater reliability among clinicians about DC. Moreover, clinicians often do not recognize incapacity, when compared to expert rating or a standardized assessment (41-43). Numerous structured instruments have been developed to assist clinicians with DC assessments, although no one is considered to be a gold standard tool (for reviews see 25, 44, 45). These tools vary in the specific domains of DC that they assess. For example, some assess all four of the above domains (expressing a choice, understanding, appreciation, and reasoning), while others assess only two or three of these domains. Furthermore, the tools vary in the way that they assess these domains. Several of the tools use predetermined situations or vignettes to determine the patient's ability to fulfill the domains, while others can be modified to include

information about the patient's specific clinical situation and decision to be made. All of the tools require a structured or semi-structured interview, and none provide a dichotomous decision about whether a patient has DC or not. Rather, they help clinicians to assess separate domains in a structured manner. Evidence suggests that utilization of a DC assessment tool or instrument increases the reliability of decisional capacity assessment among clinicians, as well as agreement with expert raters (46-48).

DC specific tools differ in the ways that they have been evaluated (e.g., how and whether data on inter-rater and test-re-test reliability, external and predictive validity, and consistency, have been measured and published), as well as the populations (healthy controls, medical or psychiatric inpatients, individuals with known cognitive or neurological issues) with which they have been studied. These limitations have been highlighted in the literature on this topic and identified as an area where further research is greatly needed.

Recommendations:

DC tools can supplement, but do not replace clinical assessment and judgment in the determination of capacity. When utilizing a DC specific instrument, clinicians should:

1. Have the relevant training required for its administration, which varies among tools
2. Consider the purpose of using the tool, with some tools being more appropriate for screening of DC and others being more appropriate as a comprehensive assessment
3. Be aware of the domains of DC assessed by the specific tool and acknowledge that there is often a lack of consistency among tools in how they define each domain
4. Usually use a DC instrument which can incorporate the specific medical treatment decision being proposed

#8: Dispositional capacity/social function

Requests for decisional capacity evaluations go beyond informed consent for a treatment, procedure or participation in research. They can include threats to leave the hospital against medical advice, ability to care for self if discharged, ability to manage finances, testamentary capacity and maternal competency (capacity to care adequately for a newborn without assistance) (49), among others. Bourgeois, et. al, in their review article in 2017 introduced the concept of "dispositional capacity" as a subtype of decisional capacity where it is supplemented with an in-vivo demonstration of self-management skills (15).

Determination of the patient's capacity to live independently is quite broad and includes almost all areas of functioning. Factors that influence dispositional capacity according to Bourgeois et al include age and stage of the illness, sensory capacities, mobility, and ability to perform activities of daily living and instrumental activities of daily living (15). Evaluating the patient's cognitive capacity and presence of psychiatric or addicting disorders and social factors such as housing status and status of social support are essential in the overall assessment. Therefore, a comprehensive assessment of a patient's capacity to live independently necessarily involves a multidisciplinary team involving psychiatry/psychology, medical/surgical staff, nursing and social work and all other staff involved in the care of the patient.

Marson, et al. proposed a conceptual model used for determining financial capacity that contains three elements: declarative knowledge, which is the ability to describe facts, concepts, events related to financial activities (knowledge of currency, concepts such as interest rate or loans, and personal financial data); procedural knowledge, which is the ability to carry out

motor based, overlearned practical financial skills and routines (such as making change and writing checks); and judgment which is the ability to make financial decisions with self-interest, in both every day and also novel or ambiguous situations (50).

Maternal competency is a challenging and making an error has serious consequences either way. The protocol recommended by Nair et al is as follows:
Examination of the mother, direct observation of mother with the child, verbal and written report of the cross-disciplinary staff directly involved with the mother's or the child's care. Mother needs to be advised of the lack of confidentiality and should be asked about her plans for herself or the baby (49).

Recommendations:

Dispositional capacity should not be limited to a psychiatric evaluation. Instead, it should be comprehensive and involve all the disciplines who are involved in the disposition of the patient.

#9: Summary of diagnosis, formulation, & DC status specific to the question.

Decisional capacity and dispositional capacity determinations are an important part of clinical psychiatric practice with ethical and medico-legal implications for patient care. The literature, including recent reviews, provides guidance for a framework for decisional capacity determinations (4, 11, 51-53). The literature on decisional capacity in specific illness states associates many psychiatric (and neurologic) illnesses with impaired decisional capacity (6, 7, 9, 14, 16-19, 23, 24, 29, 32-34, 54-58). Therefore, it is appropriate and literature-supported to integrate a standard approach to decisional and dispositional capacity cases. It is shown in the literature that patients with impaired decisional capacity and/or dispositional capacity have a

high rate neurocognitive disorders; less commonly, other psychiatric illness(es) may be associated with impaired decisional capacity/dispositional capacity, as has been discussed earlier in this document (6, 7, 9, 14, 16-19, 23, 24, 29, 32-34, 51, 54-58). It is recommended that consultation-liaison and general psychiatrists not limit their assessments to a sole focus on the "capacity question(s)." Rather, psychiatrists should conduct comprehensive assessments for the various psychiatric illnesses (e.g., neurocognitive disorder, psychotic disorder, substance use disorder) as well as the various purely social variables (sometimes in the absence of explicit psychiatric illness) that may be present in the patient on whom decisional and/or dispositional capacity questions arise in the context of medical and surgical care.

Recommendations:

An integrated approach to decisional and/or dispositional capacity cases in the context of a comprehensive consultation-liaison psychiatry evaluation should include the following elements (4, 11, 51-53):

1. Ascertain the type of capacity concern (i.e., informed consent re interventions vs global treatment refusal vs AMA (decisional capacity) vs capacity for independent function (dispositional capacity); many patients may need evaluation for both types of decision simultaneously, depending on the complexity of the case
2. Standardized consultation-liaison psychiatry interview, including a neurocognitive disorders workup (e.g., standard cognitive rating scale, relevant laboratory studies to elucidate reversible causes of neurocognitive disorders, consideration of neuroimaging). To quantitate depressive symptoms, use a Hamilton Depression Rating Scale or other standardized rating scales

3. Formulate a psychiatric diagnosis(es) (or “no psychiatric illness” if none is found), with diagnostic summary and proposed additional assessment (e.g., neuroimaging, laboratory) and recommended clinical intervention(s)
4. For informed consent for medical/surgical procedure(s), have the patient provide a full description of the proposed procedure and its risks/benefits/side effects. If there is clinical evidence of cognitive impairment, modify consent process to facilitate patient performance. Separately address the four Appelbaum and Grisso factors pertinent to the proposed intervention (Understanding, Appreciation, Rationality, Communication of Choice for or against intervention) to ascertain which one(s) are impaired in the finding of impaired decisional capacity.
5. Consider decisional capacity-specific instruments, if the clinician is experienced in their use and they are readily available
6. For dispositional capacity/social function assessments, consider supplementing standard consultation-liaison psychiatry interview with in vivo assessment using OT/other supplemental assessments
7. Summary of case diagnosis(es) and formulation
    a. Decisional and/or dispositional status specific to the decisional/dispositional capacity question(s) at hand
    b. Whether treatment could change decisional capacity findings
    c. Summary of “differential capacity” findings (e.g. if a patient could choose a substitute decision maker even if not able to consent/refuse surgery per se)

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Item JRC #8.L
Joint Reference Committee
February 2018

Executive Summary

Action Item

- Currently, the Council on Quality Care does not request action by the JRC.

Referral Updates

As originally requested by the JRC in June 2017, the Council on Quality Care continued to work with several APA component groups to address the varying resolves found within the Action Paper: Providing Education and Guidance for the Use and Limitations of Pharmacogenomics in Clinical Practice (ASM2017A1 12.G).

- The APA Staff Liaison to the Council on Research shared the Council on Research-charged Work Group on Biomarkers draft paper on the use of pharmacogenomics and the treatment of depression (recently approved by the Board of Trustees for submission to the American Journal of Psychiatry or AJP) with the Council on Quality Care.

- After reviewing the paper, the Council discussed and agreed there is insufficient evidence to draft a resource document describing the use and limitations of pharmacogenomics in psychiatric clinical practice. The Council agreed they would charge the Committee on Practice Guidelines with including pharmacogenomics considerations as part of systematic literature reviews, when appropriate to the practice guidelines topic under development.

- They also suggested the APA Staff Liaison to the Council on Research speak with AJP staff about the possibility of linking this paper to practice guidelines, when appropriate recommendations are made on the subject of pharmacogenomics.

Meeting Minutes

- Please see the minutes of the December 2017 meeting of the Council on Quality Care, attachment.

Teleconference Minutes
Council on Quality Care
December 15, 2017

Attendees: Carol Alter, MD, Melissa Arbuckle, MD, PhD (Vice-Chair), Margie Balfour, MD, PhD, Jacob Behrens, MD, Greg Dalack, MD, Jerry Halverson, MD, Ray Hsiao, MD, Grayson Norquist, MD (Chair), Harold Pincus, MD, Bonnie Zima, MD, MPH

Invited Guests: Laura Fochtmann, MD, Brent Nelson, MD, Michael Trangle, MD

Administration: Eileen Carlson, RN, JD, Diana Clarke, PhD, MSc, Jennifer Medicus, Samantha Shugarman, MS, Nathan Tatro, Phil Wang MD, DrPH

Absent: Steve Altchuler, MD, PhD, Nkemka Esiobu MD, MPH, Matthew Isles-Shih, MD, Roger Kathol, MD, Roberto Montenegro, MD, PhD, Megan Pruett, MD, Kunmi Sobowale, MD, Steven Starks, MD, Alex Young, MD, MSHS

I. Opening/Introductions: Grayson Norquist, MD, Chair
   A. Conflict of Interest/Disclosure Statements
      No new conflicts reported. Dr. Norquist welcomed all meeting participants and informed invited guests of when their participation would be allowed.

II. Minutes from last meeting: Grayson Norquist, MD, Chair
   A. The Council members voted and approved the minutes from the September 14, 2017 meeting. (Without edits requested, Dr. Behrens's motioned to vote on the document, and Dr. Hsiao seconded.)

III. PsychPRO: Registry Discussion: Phil Wang, MD, DrPH and Diana Clarke, PhD, MSc
   A. Progress Update
      Drs. Wang and Clarke updated meeting participants that:
      a. PsychPRO now has over 400 registered users.
      b. Now that the patient portal is active, APA Registry staff developed educational webinars for registered users. These educational opportunities provide clinician-users information on how they may utilize this portal to report their quality data for MIPS, especially if they do not employ a certified electronic health record (EHR) system. These webinars also inform registered clinician-users how to involve patients in submitting first-person outcome data (i.e. patient reported outcomes, or PROs).
      c. While not yet announced by CMS, the registry was successfully designated by the Centers for Medicare and Medicaid Services (CMS) as a Qualified Clinical Data Registry (QCDR) for the 2018 Merit-Based Incentive Payment System (MIPS) performance year. This means that beginning on January 1, 2018, PsychPRO can collect and submit MIPS quality data on behalf of registered users who are also MIPS participants.
      d. Drs. Wang and Clarke informed meeting participants that FigMD (PsychPro's vendor), is working on a potential solution to permit PsychPRO and other FigMD registries to work with the Epic EHR system. FigMD intends to work seamlessly with – and be completely harmonized between

– the EHR system and the user portals.

IV. Reporting Component Update

A. Workgroup on Gender Dysphoria: Samantha Shugarman, MS, Council Liaison
Ms. Shugarman updated those on the call that since the Council vote to support this change, the Workgroup on Gender Dysphoria had been successfully reassigned to the Council on Minority Mental Health and Health Disparities.

B. Caucus on Psychotherapy: Samantha Shugarman, MS, Council Liaison

a. Review charge and discuss alternative Council to manage
Ms. Shugarman reminded the Council members of their preliminary consideration around the Caucus being better served by an APA council that aligns with the goals and initiatives of the Caucus during the September 2017 CQC meeting. Following that meeting, Ms. Shugarman obtained the Caucus's mission statement and shared it with the Council for discussion during today's meeting. Those on the call agreed that it would be helpful to review the Council charge and compare it with the mission of the Caucus. This review will help determine whether the Caucus is appropriately assigned to the CQC.

Dr. Norquist informed those on the call that he had been in limited contact with Mark Rapaport, M.D, the chair of the Council on Medical Education and Lifelong Learning (CMELL) on this issue. Dr. Rapaport agreed that should the CQC agree that the Caucus would be better served by CMELL, that the Caucus reassignment would be included for discussion and vote during an upcoming CMELL meeting.

Action: Ms. Shugarman will share the CQC charge and Caucus on Psychotherapy mission with CQC members so they may determine the appropriate council assignment for the Caucus. This will be discussed on the next CQC call.

C. Workgroup on Performance and Quality Measurement (Committee on Performance Measurement): Carol Alter, MD, Chair
Dr. Alter reported on the recent activities of the Workgroup. This included the following:

a. The Board of Trustees (BOT) approval of the modified Committee charge.
b. She explained the updates of the draft Gap Analysis document, which is a modification of an original draft by the Committee on Performance Measurement. Though the CQC will soon view the final Workgroup approved draft, she provided an overview of the document and described it as an "establishment of important domains" for inclusion into future APA quality measure development projects. The Workgroup will vote on the final version of the document, before sharing it with the CQC for recommendation to the JRC for BOT approval.
c. A position statement on Measurement-Based Care (MBC), as charged by the CQC, is being drafted by the Workgroup. The position statement will communicate that APA believes MBC should become part of standard psychiatric practice in certain care settings, but not mandated. It will describe where MBC is most valuable, and where it should not be used.
d. Dr. Alter summarized the accomplishments of the recent in-person meeting of the Workgroup (held on December 11, 2017). In addition to the Workgroup members, Laura Fochtmann, MD, consultant to APA Clinical Practice Guidelines, and Michael Schoenbaum, PhD, Senior Advisor for Mental Health Services, Epidemiology, and Economics at the National Institute of Mental Health, joined the meeting as consultants. The main goals consisted of prioritizing quality measure topics for the APA, and to begin the process of developing fully formed quality measure concepts so the Association can submit an application for the CMS measure development grant opportunity.

In addition to informing the CMS grant application, the discussions during the meeting, and work generated after the meeting, will allow the APA to better position itself within the quality measurement landscape. By the conclusion of the in-person meeting, the Workgroup and consultants decided they would examine four measure concepts:

1. MBC across different psychiatric disease states. These omnibus measures will track patient symptoms from diagnosis through the various follow-up intervals. For example, the PHQ-9 tracks clinical outcomes of patients with Major Depressive Disorder (MDD) between diagnosis and follow-up visits. There is value to developing something similar for patients with anxiety disorders. This measure could be useful as a measure that cuts across various medical specialties, like the PHQ-9.
2. The measurement of outcomes for patients with psychotic disorders including the management of functional outcomes and the treatment of medication-related side effects. The Workgroup agreed there is evidence to measure the quality of the care administered by physicians and related patient outcomes. Despite the existence of evidence-based practices for patients with psychotic disorders, there continues to be a lack of data on outcomes for these interventions.
3. Quality measurements for treatment of opioid and alcohol use disorder. Considering the intensified scrutiny of opioid use disorder (OUD), and the upcoming publication of the APA clinical practice guidelines on the "Pharmacological Treatment of Patients with Alcohol Use Disorder," the Workgroup participants agreed it would be beneficial to consider these topics for measure concept development, but consultation with addiction psychiatry experts is needed. To drive the consideration of these subjects as quality measurement concepts, Ms. Shugarman will work with the staff liaison to the APA Council on Addiction Psychiatry to find experts to provide advice on these topics.
4. Suicide measurement and the utilization of mortality measures based on emergency department data and mortality tracking over time. While this concept isn't ready for quality measurement for accountability programs, the group discussed the need for more effective use of suicide screenings.

Following Dr. Alter's overview of Workgroup activities, Council members discussed the impact of the MBC position statement on the standardized screening tools integrated into PsychPRO. Meeting participants considered whether APA should define criteria to identify validated rating tools for registry and quality measure users. Dr. Alter explained Workgroup members have discussed this idea and plan to address it soon. In addition, the Workgroup will work with the Registry subcommittee on quality measures to determine what measures may be best for PsychPRO.

D. Committee on Practice Guidelines: Michael Vergare, MD, Chair

Because Dr. Vergare was unable to participate in this meeting, Dr. Fochtmann and Ms. Medicus provided an update on the activities overseen by the Committee. At a recent meeting the BOT voted to increase the Committee budget (extra $500,000.00) so APA could outsource the systematic literature review process and support the additional responsibilities involved with these reviews. This will improve systematic literature reviews, the backbone of the practice guideline development effort, and allow them to occur at a more rapid pace, which will increase the speed of the entire practice guideline development process.

Ms. Medicus explained that with these additional funds, writing groups other than the

previously formed groups on eating disorders, bipolar disorders, and schizophrenia, may be considered. She listed delirium, general anxiety disorder, panic disorder, and MDD, as the subjects of upcoming systematic literature reviews.

a. Pre-publication version of Practice Guidelines
Ms. Medicus described the idea of posting a "pre-published" version of the BOT approved practice guidelines on psychiatry.org. The benefit of posting this version is that APA approved policy and evidence-based practice will reach members and other users more quickly. With resistance from APA Publishing on permitting "pre-published" versions for posting to psychiatry.org, the Council learned that obtaining Council support and communicating this to the JRC and the BOT could prompt a change to this policy.

The Council voted to recommend this policy change to the JRC, and that the BOT approve a policy on posting BOT approved "pre-published" practice guidelines to psychiatry.org.

Action: Ms. Shugarman and Ms. Medicus will work with the Chief of Policy, Programs & Partnerships on how to best communicate the Council recommendation to the JRC.

b. APA producing non-guideline/resource materials to help members
Due to the limited time left for this teleconference the Council agreed to table this discussion until the next Council meeting. Considerations the Council will discuss include:
   i. How to get other relevant clinical information out to members
   ii. "Mega" web page or web site (web-based collection of resources) that would include guidelines and other qualified materials.
      1. Member benefit only?
   iii. Who would oversee the web-based collection of resources?
   iv. How should materials be vetted? What kinds of materials are vetted?
   v. Disclaimers or approvals required?
      1. For information only, not APA endorsement.
   vi. Other considerations for this kind of web-based collection of resources?

Action: The Council asked the Committee to develop a one-page paper outlining the pros/cons of developing guidelines that would focus on specific clinical issues and could be produced rapidly.

E. Committee on Mental Health and Information Technology: Brent Nelson, MD, Chair
Dr. Nelson described several initiatives of the Committee.
   a. The Committee is identifying and developing tools to preserve the knowledge of the Committee and promote electronic collaboration between members using methods other than email. Once the group achieves this goal, they will share it with the CQC and other components, so all groups can consider using the procedures or programs the Committee finds most advantageous.
   b. The group is working to modify and refine the APA App Evaluation Model and make it more interactive. The hope is the traffic to this psychiatry.org webpage will increase, and the information provided will become more useful.
   c. Committee members recently reviewed and provided feedback to the Office of the National Coordinator for Health Information Technology (ONC, federal agency responsible for the national health information technology efforts) on the new ONC Playbook and the section for behavioral health specialists. The Playbook is intended to offer strategies, recommendations, and best practices for a variety of clinical settings to improve the implementation and use of health information technology in clinical practice while

advancing care information and delivery.

d. Much of the Committee's work includes advocating for comprehensive EHR capabilities for psychiatrists. Planned to begin in the Spring of 2018, Health Level Seven International (HL7; an organization providing a comprehensive framework and related standards for the electronic health information that supports clinical practice and the management, delivery and evaluation of health services) and the American Medical Informatics Association (AMIA; an organization dedicated to the development and application of biomedical and health informatics in the support of patient care, teaching, research, and health care administration) announced their interest in collaborating with mental health organizations to develop specific EHR mental health capabilities. The Committee plans to provide their expertise and l offer assistance when appropriate.

V. Old Business

A. Letter to the Journal of the American Academy of Child and Adolescent Psychiatry (JAACAP) Editor: Bonnie Zima, MD, MPH

Dr. Zima reminded meeting participants of the letter she drafted addressing her concerns related to the JAACAP June 2017 article entitled, "Specific Components of Pediatricians' Medication-Related Care Predict Attention-Deficit/Hyperactivity Disorder Symptom Improvement." The article attempts to identify components of ADHD care that best predict patient outcomes. Dr. Zima is most troubled by the authors' suggestion that "physicians do not need to necessarily rely on office visits to monitor medication response and side effects in the week(s) after initially prescribing medication but instead could use phone calls or email correspondence to check in with the family." During today's meeting and in the letter, she explained this advice has the potential to be misinterpreted as meaning phone or email contact is acceptable clinical practice to monitor stimulant medication safety and efficacy, especially during the maintenance phase. While the message communicated within the JAACAP article is intended to improve care for this patient population, there potential unintended consequences that could result if readers don't understand the limitations of the study and its conclusions..

Following discussion of the letter's content and the value of having it signed by the APA Council on Quality Care, Ms. Shugarman informed those on the call that the letter drafted by Dr. Zima had been shared with the APA Council on Children, Adolescents, and their Families. Of the response she received from individual members of that council, these child and adolescent psychiatrists agreed with Dr. Zima.

Before the Council voted to approve the letter be signed by the APA Council on Quality Care, Dr. Norquist explained that signing the document as the Council, rather than as individuals, provides greater credibility to the letter's message.

Action: Ms. Shugarman will work internally to ensure the next steps are taken to achieve permission for the Council to sign the letter.

B. JRC Action Referral: Samantha Shugarman, MS, Council Liaison

Providing Education and Guidance for the Use and Limitations of Pharmacogenomics in Clinical Practice (ASM2017A1 12.G)

a. Resource Document Development Discussion

i. Discuss Bio-Marker Taskforce paper

Ms. Shugarman reminded the group that following the September 2017 Council meeting she shared a non-published version of the Taskforce on Bio-Marker's (charged by the APA

Council on Research) authored paper, "Clinical Implementation of Pharmacogenetic Decision Support Tools for Antidepressant Drug Prescribing." Dr. Wang, working with the Taskforce, informed the CQC members that the Executive Committee of the BOT voted favorably for the Taskforce to submit the paper to the American Journal of Psychiatry (AJP) for publication. After reviewing the paper, the Council discussed and agreed there is insufficient evidence to draft a resource document describing the use and limitations of pharmacogenomics in psychiatric clinical practice.

After determining a resource document would not be developed, the Council agreed they would charge the Committee on Practice Guidelines with including pharmacogenomics considerations as part of systematic literature reviews, when appropriate to the practice guidelines topic under development. They also suggested Dr. Wang speak with AJP staff about the possibility of linking this paper to practice guidelines, when appropriate recommendations are made on the subject of pharmacogenomics.

C. Ligature Risk Assessment Issue Update: Samantha Shugarman, MS, Council Liaison
Ms. Shugarman apprised the meeting participants of the activity related to the recent increased scrutiny over suicide and self-harm risk assessments on inpatient psychiatric hospital units. APA continues to hear from members concerned by the increasing number of citations and related financial costs imposed on inpatient psychiatric hospital units, who say the standards guiding surveyors to make these citations have not been communicated with the facilities and the administrators responsible for patient safety. Ms. Shugarman and Ms. Carlson updated the group that this issue was discussed at the Assembly meeting in November 2017, an article was published on this topic in Psych News, and APA staff is working with CMS as part of a technical expert panel to assist CMS with this safety issue, and other areas that impact hospital inpatients with psychiatric conditions.

VI. Announcements: Samantha Shugarman, MS, Council Liaison (5:55-6:00 PM)

A. IPS 2018: Chicago from October 4 to October 7, 2018
   a. Abstract Submission Period
   Ms. Shugarman invited CQC members to make abstract submissions by January 18, 2018 for the next IPS meeting.

B. Annual Meeting (AM)
   a. Council will meet during the AM 2018 on Monday, May 7
   Ms. Shugarman requested that CQC members planning to attend the Annual Meeting in New York City in May 2018 reserve time in their schedule for the in-person Council meeting.
   b. AM 2019 Abstract Submission Period open June 2018
   She also announced that the abstract submission process will begin in June 2018, for those interested in submitting an abstract for potential inclusion at the AM 2019.

VII. Adjourned

COUNCIL ON RESEARCH (CoR)
REPORT TO THE JOINT REFERENCE COMMITTEE (JRC)

Executive Summary

1. **Action Items:**
   - **ACTION 1:** Will the JRC recommend that the Assembly vote to approve the revised Position Statement on Mental Health Screening, Diagnosis, and Treatment During Pregnancy and Postpartum (**Attachment 1**)?

2. **Referral Item Updates:**

   Agenda Item #: 8.M.2
   Title: Proposed Position Statement: Mental Health Screening, Diagnosis, and Treatment During Pregnancy and Postpartum (LEAD).
   Update: In response to the JRC recommendation, the working group appointed by the CoR to create a position statement has revised the attached statement to be clear, concise and short (**Attachment 1**).

3. **ATTACHMENTS:**

   Attachment 1: Position Statement on Mental Health Screening, Diagnosis, and Treatment During Pregnancy and Postpartum

APA Position Statement: Screening and Treatment of Mood and Anxiety Disorders During Pregnancy and Postpartum

Issue: The incidence of mood and/or anxiety disorders in the antenatal and postnatal periods is surprisingly high in the United States and has become a serious public health problem; 1 out of 7–10 pregnant women and 1 out of 5–8 postpartum women will develop a depressive and/or anxiety disorder, and 1 out of 1,000 perinatal women will develop a psychotic disorder. The incidence of these disorders is highest in women from lower socioeconomic backgrounds. Even though depressive disorders are among the most common, emerging evidence warrants a more comprehensive conceptualization of perinatal psychiatric illness to include bipolar disorder and common comorbid illnesses such as general anxiety disorder, obsessive compulsive disorder, and panic disorder. Many studies have shown that depressive symptoms during pregnancy are associated with decreased prenatal care and adverse perinatal outcomes such as preterm birth and low birth weight. Perinatal mental health disorders can be severe; maternal suicide is the second leading cause of death among postpartum women, and approximately 300 infanticides occur in the United States each year. Untreated postpartum mood disorders are also associated in studies with impairments in cognitive, behavioral, and emotional development in the offspring during childhood and adolescence. However, early treatment of mothers with these disorders may prevent these developmental problems. At this time, only a minority of clinicians are using validated screening tools to detect these disorders. Despite the availability of evidence-based treatments, most pregnant and postpartum women with these disorders do not receive adequate assessment or treatment. To improve obstetric outcomes and maternal health, achieve optimal child development, and lower the numbers of maternal and infant deaths, it is imperative that the APA take the lead in prioritizing education and research about these disorders, as well as their screening, diagnosis, and treatment.

POSITIONS

The APA recognizes that the risks for psychiatric illness in women are greatest during the reproductive years of their lives, including during pregnancy and the postpartum periods. To prevent long-lasting, adverse effects on the mother, infant, and family, the APA strongly recommends the following:

- All pregnant and postpartum women should be assessed for both the presence of and risks for a psychiatric disorder.
- All obstetrical care providers should provide education to perinatal women on how to recognize the symptoms of depressive, anxiety, and psychotic disorders.
- All obstetrical care providers should screen for depression with a validated screening tool twice during pregnancy and once postpartum; all pediatric clinicians should screen for depression throughout the first six months postpartum. A systematic response to screening should be in place to ensure that psychiatric disorders are appropriately assessed, treated, and followed.
- The APA recommends that behavioral health clinicians educate their patients about the risks associated with untreated psychiatric illness during pregnancy and lactation, as well as the risks and benefits—for both the woman and her baby—of using psychotropic medications while pregnant or breastfeeding.

Authors

Nancy Byatt, DO, MS, MBA
Debbie Carter, MD
Kristina M. Deligiannidis, MD
C. Neill Epperson, MD
Samantha Meltzer-Brody, MD, MPH
Jennifer L. Payne, MD
Gail Robinson, MD, CM, O.Ont
Nazanin E. Silver, MD, MPH, FACOG
Zachary Stowe, MD
Maureen Sayres Van Niel, MD
Katherine L. Wisner, MD, MS
Kim Yonkers, MD

RESOURCE DOCUMENT:
PSYCHIATRIC IMPACT OF ENVIRONMENTAL TOXICANTS*
*(Note: Toxicologists prefer the term "toxicants" or "toxics" when referring to chemical toxins whereas "toxins" generally refers biological toxins, i.e. toxic substances produced by a living organism (e.g. plants, animals, fungi, bacteria)
The use of "toxins" in the Action Paper mentioned below is due to not having this information available previously but still refers to chemical rather than biological toxins which are not addressed in this document.

I. PURPOSE AND BACKGROUND

This document aims to facilitate implementation of Action Paper (AP) which passed the Assembly in May 2015 (ASM May15 12T—"Addressing the Impact of Environmental Toxins on Neurodevelopment and Behavior") The intent the paper was to educate psychiatrists about this issue and endeavored to do so by establishing a "Work Group comprised of researchers and clinicians knowledgeable in the area of the neuro-developmental and behavioral effects of environmental toxins". This Work Group was to "consult with the Scientific Program Committee and the APA Division of Education to help develop an educational plan aimed at raising awareness of the scientific, clinical and regulatory aspects of this issue among the general membership of the APA".

In February 2017, the JRC recommended formation of an Assembly Work Group on this issue, the first task of which was to develop a Resource Document. A group of four current and two former Assembly Representatives was convened for this purpose. In addition to development the Resource Document, the Work Group also developed a symposium on the topic to be presented at national APA meetings. Presenters for the symposium include prominent academic researchers in the field as well as clinicians and physician advocates(see acknowledgments).

Members of the Assembly Work Group are as follows:
James Fleming, MD, Chair and Assembly Representative, Missouri Psychiatric Physicians Association. Dr Fleming is the primary author of this document
Elias Sarkis, MD, APA member and former Assembly Representative
Dionne Hart, MD, Assembly Representative, Minnesota Psychiatric Psychiatric Society
Harold Ginzburg, MD, Assembly Representative, Oklahoma Psychiatric Physicians Association
Ludmila De Faria, MD, APA Member and former Assembly Representative
Nigel Bark, MD, Assembly Representative West Hudson Psychiatric Society

This resource document aims to fulfill tow goals: 1 educate the APA membership, and 2. lay the groundwork needed to eventually lead to a position statement on this issue. This is an important consideration since several major medical organizations have either developed guidelines or issued statements to raise awareness among practitioners as well as the public regarding health risks and/or preventive action steps regarding environmental toxicant exposure(1,2). These organizations include: the American Medical Association, the American College of Obstetrics and Gynecology, the National Medical Association, the American Nurses Association and the American Academy of Pediatrics (the latter has also endorsed guidelines on the prevention of prenatal and childhood exposure to known toxics). In contrast, there has been little recognition in organized or academic psychiatry of the impact of such exposure and at present, neither the APA

nor the American Academy of Child and Adolescent Psychiatry (AACAP) has established guidelines for the assessment or prevention of these problems in either adults or children.

This document will first address the challenges inherent in assessing the broad scope and the ongoing, cumulative risks of exposure to toxicants known to have neuropsychiatric effects or suspected to. These substances will then be briefly reviewed, followed by a review of regulatory aspects in the context of the recent major shift in federal environmental policy.

Two other important aspects of this problem will not be addressed in this document: Preventive strategies and treatment approaches. Preventative guidelines aimed at avoidance or limitation of toxic chemical exposures are available from various sources including medical organizations, non-profit organizations and government agencies, a systematic listing and assessment of these resources will require the development of a separate document. Treatment approaches, such as those discussed through courses at the Institute of Functional Medicine (https://www.ifm.org/) often involve nutritional strategies which augment the same endogenous biotransformation pathways by which pharmaceuticals are processed in the body. Again, a separate document is needed to adequately describe and assess these strategies.

NOTE: Much of the information for this Resource Document was drawn from the Consensus Statement from the 2016 Project TENDR (Targeting Environmental Neuro-Developmental Risk) which was funded in part by the National Institute of Environmental Health Sciences (an NIH institute). That document was the product of a multidisciplinary coalition of scientists, clinicians and children's health and disability advocates and was endorsed by several medical societies. It is the intention of the Assembly Work Group that the TENDR document accompany this Resource Document(3).

II. SCOPE AND COMPLEXITY OF THE PROBLEM

There are several important factors that an assessment of the psychiatric impact of environmental toxicants a challenging, as well as a timely and important enterprise:

1. The sheer number of industrial chemicals which have been released in the environment is, from a research and public health perspective standpoint, staggering; a 2009 Institute of Medicine (IOM) report identifies 82,000 such chemicals. Some of these have been demonstrated to be either clearly toxic to neuro-developlment or otherwise clearly harmful to human health. For others toxicity is suggested by association studies but not proven and, according to the IOM report: "we know very little about basic properties of the majority of these chemicals and even less about the human health impact of these exposures." This unfortunate situation is largely due to the way industrial chemicals regulated in the U.S. (4) (see also Section IV below).

2. When one considers the existence of multiple, simultaneous chemical exposures from various sources: air, water, food, soil and occupational contact or contact with household products, the number of potential variables grows exponentially.

3. Some classes of chemicals (known as persistent organic pollutants or POPS) undergo very slow or negligent metabolism leading to bioaccumulation, raising the risk of increasing toxicity over time from low level but ongoing exposure.

4. Critical developmental stages of vulnerability to toxic exposure have been identified and are related to several complex, interacting factors. Contributing factors include: a) a very high rate of neurogenesis (in the prenatal period when an average of **250,000 neurons are added per minute); b)** dynamic dysregulation by certain chemicals coupled with immature detoxification systems and c) increased susceptibility to both genetic damage and epigenetic dysregulation (5,6).

5. The potential role of environmental toxicants must be considered if we are to understand rising prevalences over the last two decades of several developmental disabilities (7,8). It is estimated that these conditions, which include ADHD, autism spectrum disorder, and other developmental and learning disorders, affect 1 out of 6 children in the U.S., a 17% increase over the prior decades. In fact, several classes of toxic chemicals have been associated with problems in learning, behavioral, or intellectual impairment, as well as specific neurodevelopmental disorders such as ADHD or autism spectrum disorder(3,7,8,9,10). In the case of autistic spectrum disorders which have risen in prevalence at a particularly steep rate, careful quantitive analyses suggest that a significant fraction of the increase may not be explained by artifacts such as "diagnostic substitution"or greater public awareness leading to more frequent requests for assessments. Evidence exists for genetic, epigenetic and direct effects on the developing brain as mechanisms of toxicant contribution to autism (10) and when population impact is considered (rather than individual risk only), the contributions of chemicals to FSIQ loss in children are substantial, in some cases exceeding those of other recognized risk factors for neurodevelopmental impairment in children for various disorders including autism (11). This could lead to higher detection rates due to a greater number of individuals with a threshold level of impairment.
6. Chemical toxins interact in a multifactorial fashion with both genetics and other environmental factors including nutrition, maternal health, and social stressors adding complexity to issues of causation(13).
7. It has been demonstrated in several studies since 1987 that poor and minority communities have experience higher level of exposure to environmental toxins from various sources including lead in homes, air pollution from automobiles and coal-fired power plants, and location of toxic waste sites. These communities also face many other stressors and often have fewer resources available to mitigate the effects of all these factors including toxic exposure (14,15,16).
8. There are huge economic costs associated with neurodevelopment disorders including educational costs which one study reported were twice as high for children with these disorders than those without them. On the other hand there is also the potential for huge savings when prevention strategies are implemented as reported by an analysis in the U.S. in 2009 which found that for every $1 spent to reduce exposures to lead, which is known to be a potent neurotoxicant, society would save between $17 and $221 (i.e. 1700% to 22,100% times the "investment" (17).

III. Neuropsychiatric Toxics: State of the Science

As indicated above, the science of neuropsychiatric toxicology is beset with challenges of magnitude (e.g. number of potential toxicants) and complexity which preclude a succinct summary of the state of the science of the field. Each class of chemicals and in many cases, individual chemicals within each class must be considered separately. Ideally, the vast number of industrial and household chemicals could be divided in categories along continuum with known toxicants at one end and known safe chemicals at the other. However "proving" safety—difficult under any circumstances as indicated by the extensive testing necessary for approval of pharmaceuticals— is particularly difficult under the current regulations for industrial chemicals and, as is the case for medications, substances which were once thought to be safe, are sometimes later shown to have adverse or even lethal effects. And as indicated in the aforementioned IOM report, there is not nearly enough information to know where along the toxicity continuum most of the 82,000 chemicals lie. In addition, some toxics have well known, **primarily non-psychiatric health effects but because of the severity of their other health effects, there is an indirect mental health effect on the individual, their family members or caregivers and in some cases on the community.**

With these caveats in mind, based on available data, what follows is a preliminary categorization of this type. For simplicity, three categories will be identified, acknowledging that this categorization is somewhat arbitrary. Putative fourth or fifth classes of known safe substances and those about which we know very little are not included for the reasons mentioned above.

A. Known neuropsychiatric toxicants: lead, mercury, polychlorinated biphenyls (PCBs), some organochlorine (OC) pesticides such as DDT, aldrin, and dieldrin. There is little, if any debate about the neurotoxic effects of these compounds (3).

B. Likely neuropsychiatric toxicants (significant evidence): Multiple epidemiologic studies in the U.S. and other countries, spanning diverse populations in both urban and agricultural settings have linked organophosphate pesticides OP exposures during fetal development with poorer cognitive, behavioral and social development in children. (7,8,11) One OP pesticide, chlorpyrifos, received much recent media attention because of the EPA Administrator's decision to not ban the chemical despite the EPA's own risk assessments indicating neurotoxicity (12). Other OP pesticides with significant evidence for neurotoxicity include polybrominated diphenyl ethers (PBDEs, found in flame retardants) and polyaromatic hydrocarbons (3), PAHs which are present in polluted air along with other known toxicants including nitrogen dioxide particulate matter).

C. Possible neuropsychiatric toxicants (less definitive evidence) : bisphenol A (BPA, found in many plastic products), phthalates cosmetics and personal care products used in consumer products such as flexible plastic and vinyl toys, shower curtains, wallpaper, vinyl mini-blinds, food packaging, and plastic wrap (3).
Part of the controversy over these classes of potential toxins stem from the the widespread use of the relevant products and types of exposure as well the large

number of different chemicals each requiring both separate as well as concurrent study. Even so, despite the lower degree of risk certainty, the federal government has banned some of these compounds such as some phthalates.

When considering research in this area it's important to understand that, despite the numerous challenges involved, the evidence base has been steadily growing, the quality of study design is becoming more sophisticated and there is greater attention to the various interacting factors mentioned above (genetics, maternal diet, etc). Examples include the work of two prominent researchers: Irva Hertz-Picciotto, PhD at UC Davis who has been considering the interaction between genetics, maternal stress and diet and environmental toxins and the work of Frederica Perera, PhD at Columbia who has been engaged in ongoing prospective studies following children born to mothers with varying levels of exposure to air pollutants. Dr Hertz-Picciotto was also one of the principle authors of the TENDR document and, in collaboration with colleagues is finalizing an updated version.

IV. URGENCY OF ACTION AND THE CURRENT REGULATORY ENVIRONMENT

A major shift in the political and regulatory environment since the 2016 U.S. national election has raised the stakes for physician and psychiatrist awareness and advocacy and created a sense of urgency across a wide spectrum of stakeholders. To understand the context of these changes with respect to environmental toxicants a brief review of federal regulatory issues will be helpful.

Since 1976 regulation of industrial chemicals in the U.S. fell under the Toxic Substances Control Act (TSCA) which was widely felt to provide inadequate safety protection. The passage of the bipartisan Frank R. Lautenberg Chemical Safety for the 21st Century Act(18)—signed into law by President Obama in June 2016— was hailed as a significant improvement by lawmakers, industry groups (some of which help formulate the law) and by some (but not all) environmental advocacy groups. Industry groups supported the law because if better defined how regulations are implemented and enforced. In December 2016 the EPA released a list and algorithm for chemical risk evaluations on "High-Priority Substances" and subsequent information has been published by the EPA on TSCA as amended by the 2016 law(4).

One of the major problems with the earlier (1976) version of TSCA was the phenomenon of "regrettable substitution": when a toxic chemical or category of chemicals is removed from the market due to safety concerns, manufacturers often substitute similar chemicals which could pose similar risks as the banned chemical and/or have had little if any testing for toxicity. Several examples of this involving likely neurotoxicants are mentioned in the TENDR document(4). It is not clear whether the amended law calls for elimination or correction of the problem of "regrettable substitution" but the EPA's summary of the bill does not make any mention of this problem. A very recent report (19) indicates that new EPA policies will allow industry to continue to capitalize on this loophole and in addition new rules will allow chemicals which are known to be toxic for one type of use to be released for use **prior to testing if used for a different application**. Public health leaders as well as members of Congress who were involved

in the passage of the Frank Lautenberg law have expressed the concern that the new rules essentially nullifies "the spirit as well as the letter" of the law(19)

In general, concerns about the change of direction of environmental regulation under the current Administration have been expressed by scientists, health care professionals, child advocates and science-based environmental groups such as the Environmental Defense Fund whose scientists were instrumental in the passage of the amended TSCA law in 2016. One major concern is the Administration's proposal to cut the EPA by 30-40% with large cuts in enforcement. In December 2017 the New York Times reported that 700 employees had left the EPA President Trump took office including more than 200 scientists, 96 environmental protection specialists (a broad category including scientists as well as others experienced in investigating and analyzing pollution levels) and more than a dozen toxicologists. Most of the employees who have left are not being replaced due to budgetary goals of the Administration.

There is also alarm among from various quarters about an "anti-science" agenda. For example in March of 2017, an international group of scientists, the Environmental Data and Governance Initiative (https://envirodatagov.org/about/) which tracks changes in federal regulations, alerted the media that EPA's Office of Science and Technology Policy had removed the word "science" in the paragraph describing what it does (20). And instead of "science-based" standards with respect to water pollution, the office now describes it's mission in terms of developing "economically and technologically achievable standards". This is one example which has raised alarm among a broad range of academic, scientific and lay advocacy groups about a major shift from the stated purpose of the EPA (protection of public health and safety) with more deference to the interests of industry than to that of the public(21).

Specific examples of this policy shift relevant to neuropsychiatric toxicity include the decision to not ban the insecticide chlorpyrifos (mentioned in 3B above) and the EPA's decision in April 2017, to delay enforcement of regulations to prevent coal-fired power plants from releasing known toxins such as mercury, lead and arsenic into the air.

V. SUMMARY AND RECOMMENDATIONS

The foregoing information and data highlights the need prioritize the development of educational programs for member psychiatrists aiming to increase awareness and knowledge about the neuropsychiatric risks of environmental toxicants. The growing evidence base of risk associated with a several classes of industrial and household chemicals and likely risks of many others can not be ignored by prudent physicians including psychiatrists. Guidelines should be developed for outlining how to screen for and reduce toxicant exposure and prevent toxicity as recently occurred in the case of lead(22). While the APA may not be able to take on this task alone for all the known or suspected neuropsychiatric toxicants, educating the APA membership is an important first step in bringing organized psychiatry into the deliberations. The unprecedented shift federal regulatory policy described above makes this involvement even more timely and critical.

All physicians are aware of what happens when evidence emerges that a particular class of medications seems to have serious adverse effects not previously described: neither organized

medicine nor individual practitioners would wait until "all the data is in" to begin to take steps to maximize safety and advise patients. The same sense of urgency should apply when have data on toxicants . And given the potentially devastating, long term impact specifically of **neurodevelopment** toxicants on individuals, families and society in general, action should be even stronger and more rapid, as the following quote from the multidisciplinary TENDR document (see acknowledgments) illustrates:

"We as a society should be able to take protective action when scientific evidence indicates a chemical is of concern, and not wait for unequivocal proof that a chemical is causing harm to our children. Evidence of neuro-developmental toxicity of any type—epidemiological or toxicological or mechanistic—by itself should constitute a signal sufficient to trigger prioritization and some level of action. Such an approach would enable policy makers and regulators to proactively test and identify chemicals that are emerging concerns for brain development and prevent widespread human exposures. "

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Presenters for a proposed symposium at the 2018 IPS Conference mentioned above were also instrumental in helping develop this Resource Document. They are:

Irva Hertz-Picciotto, PhD, Director, Environmental Health Sciences Center, UC Davis
Professor, Department of Public Health Sciences and the MIND Institute

Frederica Perera, PhD, Frederica P. Perera, DrPH, PhD, Professor of Public Health
Director, Columbia Center for Children's Environmental Health
Department of Environmental Health Sciences
Mailman School of Public Health Columbia University

Mark A. Mitchell M.D., MPH, FACPM
Chair, National Medical Association Council on Medical Legislation
Co-Chair, National Medical Association Commission on Environmental Health
Founder and Senior Policy Advisor, Connecticut Coalition for Environmental Justice

Aly Cohen, M.D., FACR
Founder & Medical Director-Integrative Rheumatology Associates, PC
Faculty, Academy of Integrative Health and Medicine (AIHM)
Co-Editor/Contributor: "Integrative Environmental Medicine", Oxford University Press, 2017
****

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A Section 508–conformant HTML version of this article is available at http://dx.doi.org/10.1289/EHP358.

Project TENDR: Targeting Environmental Neuro-Developmental Risks. The TENDR Consensus Statement

http://dx.doi.org/10.1289/EHP358

Summary: Children in America today are at an unacceptably high risk of developing neurodevelopmental disorders that affect the brain and nervous system including autism, attention deficit hyperactivity disorder, intellectual disabilities, and other learning and behavioral disabilities. These are complex disorders with multiple causes—genetic, social, and environmental. The contribution of toxic chemicals to these disorders can be prevented. **Approach:** Leading scientific and medical experts, along with children's health advocates, came together in 2015 under the auspices of Project TENDR: Targeting Environmental Neuro-Developmental Risks to issue a call to action to reduce widespread exposures to chemicals that interfere with fetal and children's brain development. Based on the available scientific evidence, the TENDR authors have identified prime examples of toxic chemicals and pollutants that increase children's risks for neurodevelopmental disorders. These include chemicals that are used extensively in consumer products and that have become widespread in the environment. Some are chemicals to which children and pregnant women are regularly exposed, and they are detected in the bodies of virtually all Americans in national surveys conducted by the U.S. Centers for Disease Control and Prevention. The vast majority of chemicals in industrial and consumer products undergo almost no testing for developmental neurotoxicity or other health effects. **Conclusion:** Based on these findings, we assert that the current system in the United States for evaluating scientific evidence and making health-based decisions about environmental chemicals is fundamentally broken. To help reduce the unacceptably high prevalence of neurodevelopmental disorders in our children, we must eliminate or significantly reduce exposures to chemicals that contribute to these conditions. We must adopt a new framework for assessing chemicals that have the potential to disrupt brain development and prevent the use of those that may pose a risk. This consensus statement lays the foundation for developing recommendations to monitor, assess, and reduce exposures to neurotoxic chemicals. These measures are urgently needed if we are to protect healthy brain development so that current and future generations can reach their fullest potential.

A Call to Action

The TENDR Consensus Statement is a call to action to reduce exposures to toxic chemicals that can contribute to the prevalence of neurodevelopmental disabilities in America's children. The TENDR authors agree that widespread exposures to toxic chemicals in our air, water, food, soil, and consumer products can increase the risks for cognitive, behavioral, or social impairment, as well as specific neurodevelopmental disorders such as autism and attention deficit hyperactivity disorder (ADHD) (Di Renzo et al. 2015; Gore et al. 2015; Lanphear 2015; Council on Environmental Health 2011). This preventable threat results from a failure of our industrial and consumer markets and regulatory systems to protect the developing brain from toxic chemicals. To lower children's risks for developing neurodevelopmental disorders, policies and actions are urgently needed to eliminate or significantly reduce exposures to these chemicals. Further, if we are to protect children, we must overhaul how government agencies and business assess risks to human health from chemical exposures, how chemicals in commerce are regulated, and how scientific evidence informs decision making by government and the private sector.

Trends in Neurodevelopmental Disorders

We are witnessing an alarming increase in learning and behavioral problems in children. Parents report that 1 in 6 children in the United States, 17% more than a decade ago, have a developmental disability, including learning disabilities, ADHD, autism, and other developmental delays (Boyle et al. 2011). As of 2012, 1 in 10 (> 5.9 million) children in the United States are estimated to have ADHD (Bloom et al. 2013). As of 2014, 1 in 68 children in the United States has an autism spectrum disorder (based on 2010 reporting data) (CDC 2014).

The economic costs associated with neurodevelopmental disorders are staggering. On average, it costs twice as much in the United States to educate a child who has a learning or developmental disability as it costs for a child who does not (Chambers et al. 2004). A recent study in the European Union found that costs associated with lost IQ points and intellectual disability arising from two categories of chemicals—polybrominated diphenyl ether flame retardants (PBDEs) and organophosphate (OP) pesticides—are estimated at 155.44 billion euros ($169.43 billion dollars) annually (Bellanger et al. 2015). A 2009 analysis in the United States found that for every $1 spent to reduce exposures to lead, a potent neurotoxicant, society would benefit by $17–$221 (Gould 2009).

Vulnerability of the Developing Brain to Chemicals

Many toxic chemicals can interfere with healthy brain development, some at extremely low levels of exposure (Adamkiewicz et al. 2011; Bellinger 2008; Committee on Improving Analysis Approaches Used by the U.S. EPA 2009; Zoeller et al. 2012). Research in the neurosciences has identified "critical windows of vulnerability" during embryonic and fetal development, infancy, early childhood and adolescence (Lanphear 2015; Lyall et al. 2014; Rice and Barone 2000). During these windows of development, toxic chemical exposures may cause lasting harm to the brain that interferes with a child's ability to reach his or her full potential.

The developing fetus is continuously exposed to a mixture of environmental chemicals (Mitro et al. 2015). A 2011 analysis of the U.S. Centers for Disease Control and Prevention's (CDC) biomonitoring data found that 90% of pregnant women in the United States have detectable levels of 62 chemicals in their bodies, out of 163 chemicals for which the women were screened (Woodruff et al. 2011). Among the chemicals found in the vast majority of pregnant women are PBDEs, polycyclic aromatic hydrocarbons (PAHS), phthalates, perfluorinated compounds, polychlorinated biphenyls (PCBs), perchlorate, lead and mercury (Woodruff et al. 2011). Many of these chemicals can cross the placenta during pregnancy and are routinely detected in cord blood or other fetal tissues (ATSDR 2011; Brent 2010; Chen et al. 2013; Lien et al. 2011).

Prime Examples of Neurodevelopmentally Toxic Chemicals

The following list provides prime examples of toxic chemicals that can contribute to learning, behavioral, or intellectual impairment, as well as specific neurodevelopmental disorders such as ADHD or autism spectrum disorder:

- Organophosphate (OP) pesticides (Eskenazi et al. 2007; Fortenberry et al. 2014; Furlong et al. 2014; Marks et al. 2010; Rauh et al. 2006; Shelton et al. 2014).
- PBDE flame retardants (Chen et al. 2014; Cowell et al. 2015; Eskenazi et al. 2013; Herbstman et al. 2010).
- Combustion-related air pollutants, which generally include PAHs, nitrogen dioxide and particulate matter, and other air pollutants for which nitrogen dioxide and particulate matter are markers (Becerra et al. 2013; Clifford et al. 2016; Jedrychowski

et al. 2015; Kalkbrenner et al. 2014; Suades-González et al. 2015; Volk et al. 2013).
- Lead (Eubig et al. 2010; Lanphear et al. 2005; Needleman et al. 1979).
- Mercury (Grandjean et al. 1997; Karagas et al. 2012; Sagiv et al. 2012).
- PCBs (Eubig et al. 2010; Jacobson and Jacobson 1996; Schantz et al. 2003).

The United States has restricted some of the production, use and environmental releases of these particular chemicals, but those measures have tended to be too little and too late. We face a crisis from both legacy and ongoing exposures to toxic chemicals. For lead, OP pesticides, PBDEs and air pollution, communities of color and socioeconomically stressed communities face disproportionately high exposures and health impacts (Adamkiewicz et al. 2011; Engel et al. 2015; Zota et al. 2010).

Policies to ban lead from gasoline, paints and other products have been successful in lowering blood lead levels in the American population (Jones et al. 2009), yet lead exposure continues to be a preventable cause of intellectual impairment, ADHD and maladaptive behaviors for millions of children (CDC 2015). Scientists agree that there is no safe level of lead exposure for fetal or early childhood development (Lanphear et al. 2005; Schnur and John 2014), and studies have documented the potential for cumulative and synergistic health effects from combined exposure to lead and social stressors (Bellinger et al. 1988; Cory-Slechta et al. 2004). Thus, taking further preventive actions is imperative.

Epidemiological, toxicological, and mechanistic studies have together provided evidence that clearly demonstrates or strongly suggests neurodevelopmental toxicity for lead, mercury, OP pesticides, air pollution, PBDEs, and PCBs. The level and type of available evidence linking exposures to toxic chemicals with neurodevelopmental disorders, including the examples in this statement, vary both within and among chemical classes. In light of this extensive evidence and continued widespread exposure, the risks for learning and developmental disorders can likely be lowered through targeted exposure reduction, starting with these example chemicals.

Majority of Chemicals Untested for Neurodevelopmental Effects

The examples of developmental neurotoxic chemicals that we list here likely represent the tip of the iceberg. Of the tens of thousands of chemicals on the U.S. Environmental Protection Agency (EPA) chemical inventory, nearly 7,700 are manufactured or imported into the United States at ≥ 25,000 pounds per year (U.S. EPA 2012). The U.S. EPA has identified nearly 3,000 chemicals that are produced or imported at > 1 million pounds per year (U.S. EPA 2006).

Only a minority of chemicals has been evaluated for neurotoxic effects in adults. Even fewer have been evaluated for potential effects on brain development in children (Grandjean and Landrigan 2006, 2014). Further, toxicological studies and regulatory evaluation seldom address combined effects of chemical mixtures, despite evidence that all people are exposed to dozens of chemicals at any given time.

Need for a New Approach to Evaluating Evidence

Our failures to protect children from harm underscore the urgent need for a better approach to developing and assessing scientific evidence and using it to make decisions. We as a society should be able to take protective action when scientific evidence indicates a chemical is of concern, and not wait for unequivocal proof that a chemical is causing harm to our children.

Evidence of neurodevelopmental toxicity of any type—epidemiological or toxicological or mechanistic—by itself should constitute a signal sufficient to trigger prioritization and some level of action. Such an approach would enable policy makers and regulators to proactively test and identify chemicals that are emerging concerns for brain development and prevent widespread human exposures.

Some chemicals, like those that disrupt the endocrine system, present a concern because they interfere with the activity of endogenous hormones that are essential for healthy brain development. Endocrine-disrupting chemicals (EDCs) include many pesticides, flame retardants, fuels, and plasticizers. One class of EDCs that is ubiquitous in consumer products are the phthalates. These are an emerging concern for interference with brain development and therefore demand attention (Boas et al. 2012; Ejaredar et al. 2015; Mathieu-Denoncourt et al. 2015; Miodovnik et al. 2014; U.S. Consumer Product Safety Commission 2014).

Regrettable Substitution

Under our current system, when a toxic chemical or category of chemicals is finally removed from the market, chemical manufacturers often substitute similar chemicals that may pose similar concerns or be virtually untested for toxicity. This practice can result in "regrettable substitution" whereby the cycle of exposures and adverse effects starts all over again. The following list provides examples of this cycle:
- When the federal government banned some uses of OP pesticides, manufacturers responded by expanding the use of neonicotinoid and pyrethroid pesticides. Evidence is emerging that these widely used classes of pesticides pose a threat to the developing brain (Kara et al. 2015; Richardson et al. 2015; Shelton et al. 2014).
- When the U.S. Government reached a voluntary agreement with flame retardant manufacturers to stop making PBDEs, the manufacturers substituted other halogenated and organophosphate flame retardant chemicals. Many of these replacement flame retardants are similar in structure to other neurotoxic chemicals but have not undergone adequate assessment of their effects on developing brains.
- When the federal government banned some phthalates in children's products, the chemical industry responded by replacing the banned chemicals with structurally similar new phthalates. These replacements are now under investigation for disrupting the endocrine system.

Looking Forward

Our system for evaluating scientific evidence and making decisions about environmental chemicals is broken. We cannot continue to gamble with our children's health. We call for action now to prevent exposures to chemicals and pollutants that can contribute to the prevalence of neurodevelopmental disabilities in America's children.

We need to overhaul our approach to developing and assessing evidence on chemicals of concern for brain development. Toward this end, we call on regulators to follow scientific guidance for assessing how chemicals affect brain development, such as taking into account the special vulnerabilities of the developing fetus and children, cumulative effects resulting from combined exposures to multiple toxic chemicals and stressors, and the lack of a safety threshold for many of these chemicals (Committee on Improving Analysis Approaches Used by the U.S. EPA 2009). We call on businesses to eliminate neurodevelopmental toxicants from their supply chains and products, and on health professionals to integrate knowledge about environmental toxicants into patient care and public health practice.

Finally, we call on policy makers to take seriously the need to reduce exposures of all children to lead—by accelerating the clean up from our past uses of lead such as in paint and water pipes, by halting the current uses of lead, and by better regulating the industrial processes that cause new lead contamination.

We are confident that reducing exposures to chemicals that can interfere with healthy brain development will help to lower the prevalence of neurodevelopmental disabilities, and thus enable many more children to reach their full potential.

TENDR Statement Authors

Scientists

Deborah Bennett, PhD
Associate Professor, Department of Public Health Sciences, School of Medicine, University of California, Davis

David C. Bellinger, PhD, MSc
Boston Children's Hospital
Harvard Medical School
Harvard T.H. Chan School of Public Health

Linda S. Birnbaum, PhD, DABT, A.T.S
Director, National Institute of Environmental Health Sciences,
Director, National Toxicology Program

Asa Bradman, PhD, MS
Associate Director, Center for Environmental Research and Children's Health (CERCH)
Associate Adjunct Professor of Environmental Health Sciences, School of Public Health, UC Berkeley

Aimin Chen, MD, PhD
Associate Professor, Division of Epidemiology
Department of Environmental Health
University of Cincinnati College of Medicine

Deborah A. Cory-Slechta, PhD
Professor of Environmental Medicine, Pediatrics and Public Health Sciences;
Acting Chair, Department of Environmental Medicine;
Director, University of Rochester Medical School Environmental Health Sciences Center

Stephanie M. Engel, PhD
Associate Professor, Department of Epidemiology,
Gillings School of Global Public Health University of North Carolina, Chapel Hill

M. Daniele Fallin, PhD
Sylvia and Harold Halpert Professor and Chair,
Dept. of Mental Health; Director, Wendy Klag Center for Autism and Developmental Disabilities, Johns Hopkins Bloomberg School of Public Health

Alycia Halladay, PhD
Chief Science Officer, Autism Science Foundation, Adjunct, Dept. of Pharmacology and Toxicology,
Rutgers University

Russ Hauser, MD, ScD, MPH
Frederick Lee Hisaw Professor of Reproductive Physiology; Professor of Environmental and Occupational Epidemiology, Harvard T.H. Chan School of Public Health; Professor of Obstetrics, Gynecology and Reproductive Biology, Harvard Medical School

Irva Hertz-Picciotto, PhD
Director, UC Davis Environmental Health Sciences Center; Professor,
Department of Public Health Sciences & Medical Investigations of Neurodevelopmental Disorders (MIND) Institute,
University of California, Davis

Carol F. Kwiatkowski, PhD
Executive Director, The Endocrine Disruption Exchange (TEDX)
Assistant Professor Adjunct, Dept. of Integrative Physiology, University of Colorado, Boulder

Bruce P. Lanphear, MD, MPH
Clinician Scientist, Child & Family Research Institute, BC Children's Hospital
Professor, Faculty of Health Sciences, Simon Fraser University, Vancouver, BC

Emily Marquez, PhD
Staff Scientist
Pesticide Action Network North America

Melanie Marty, PhD
Adjunct Associate Professor
University of California, Davis

Jennifer McPartland, PhD
Senior Scientist
Environmental Defense Fund

Craig J. Newschaffer, PhD
Director, A.J. Drexel Autism Institute
Professor, Epidemiology and Biostatistics,
Drexel University

Devon Payne-Sturges, DrPH
Assistant Professor, Maryland Institute for Applied Environmental Health,
School of Public Health,
University of Maryland

Heather B. Patisaul, PhD
Professor, Biological Sciences, Center for Human Health and the Environment,
WM Keck Center for Behavioral Biology, NC State University

Frederica P. Perera, DrPH, PhD
Professor of Public Health
Director, Columbia Center for Children's Environmental Health; Professor, Dept. of Environmental Health Sciences, Mailman School of Public Health, Columbia University

Beate Ritz MD, PhD
Professor of Epidemiology
Center for Occupational and Environmental Health
Fielding School of Public Health, University of California Los Angeles

Jennifer Sass, PhD
Senior Scientist, Natural Resources Defense Council
Professorial Lecturer, George Washington University

Susan L. Schantz, PhD
Professor of Toxicology and Neuroscience, Illinois Children's Environmental Health Research Center; Director, Beckman Institute for Advanced Science and Technology, University of Illinois, Urbana-Champaign

Thomas F. Webster, DSc
Professor, Department of Environmental Health, Boston University School of Public Health

Robin M. Whyatt, DrPH
Professor Emeritus, Department of Environmental Health Sciences, Mailman School of Public Health, Columbia University

Tracey J. Woodruff, PhD, MPH
Professor and Director, Program on Reproductive Health and the Environment,
Dept. of Obstetrics, Gynecology and Reproductive Sciences, University of California, San Francisco

R. Thomas Zoeller, PhD
Professor of Biology
Director, Laboratory of Molecular & Cellular Biology,
University of Massachusetts Amherst

Health Professionals and Providers

Laura Anderko, PhD, RN
Robert and Kathleen Scanlon Endowed Chair in Values Based Health Care & Professor, School of Nursing and Health Studies, Georgetown University,
Director, Mid-Atlantic Center for Children's Health and the Environment

Carla Campbell, MD, MS, FAAP
Visiting Clinical Associate Professor of Public Health University of Texas at El Paso

Jeanne A. Conry, MD, PhD
Past President, American College of Obstetricians and Gynecologists; Assistant Physician in Chief, The Permanente Medical Group

Nathaniel DeNicola, MD, MSHP, FACOG
American College of Obstetricians & Gynecologists Liaison to American Academy of Pediatrics Executive Council on Environmental Health; Clinical Associate in Obstetrics & Gynecology, U. of Pennsylvania

Robert M. Gould, MD
Associate Adjunct Professor, Program on Reproductive Health and the Environment,
Dept. of Obstetrics, Gynecology and Reproductive Sciences, UCSF School of Medicine; Immediate Past President, Physicians for Social Responsibility

Deborah Hirtz, MD
Professor, Neurological Sciences and Pediatrics
University of Vermont School of Medicine

Katie Huffling, RN, MS, CNM
Director of Programs
Alliance of Nurses for Healthy Environments

Philip J. Landrigan, MD, MSc, FAAP
Dean for Global Health, Arnhold Institute for Global Health; Professor of Preventive Medicine and Pediatrics, Icahn School of Medicine at Mount Sinai

Arthur Lavin, MD, FAAP
Advanced Pediatrics
Associate Clinical Professor of Pediatrics
Case Western Reserve University School of Medicine

Mark Miller, MD, MPH
Director, University of California San Francisco Pediatric Environmental Health Specialty Unit

Mark A. Mitchell, MD, MPH
President, Mitchell Environmental Health Associates
Chair, Council on Medical Legislation and
Co-Chair, Commission on Environmental Health
National Medical Association

Leslie Rubin, MD
President, Innovative Solutions for Disadvantage and Disability; Associate Professor, Dept. of Pediatrics, Morehouse School of Medicine; Co-director, Southeast Pediatric Environmental Health Specialty Unit, Emory University; Medical Director, Developmental Pediatric Specialists

Ted Schettler, MD, MPH
Science Director
Science and Environmental Health Network

Ho Luong Tran, MD, MPH
President and CEO
National Council of Asian Pacific Islander Physicians

Children's Health and Disabilities Advocates

Annie Acosta
Director of Fiscal and Family Support Policy
The Arc

Charlotte Brody, RN
National Coordinator, Healthy Babies Bright Futures Vice President of Health Initiatives, BlueGreen Alliance

Elise Miller, MEd
Director, Collaborative on Health and the Environment (CHE)

Pamela Miller, MS
Executive Director
Alaska Community Action on Toxics

Maureen Swanson, MPA
Healthy Children Project Director
Learning Disabilities Association of America

Nsedu Obot Witherspoon, MPH
Executive Director, Children's Environmental Health Network

Organizations that Endorse or Support the TENDR Consensus Statement

American College of Obstetricians and Gynecologists (ACOG)
ACOG supports the value of this clinical document as an educational tool (March 2016)

Child Neurology Society

Endocrine Society

International Neurotoxicology Association

International Society for Children's Health and the Environment

International Society for Environmental Epidemiology

National Council of Asian Pacific Islander Physicians

National Hispanic Medical Association

National Medical Association

Address correspondence to I. Hertz-Picciotto, University of California, Davis, Department of Public Health Sciences, MS1C, One Shields Ave., Davis, California USA 95616-8500. Telephone: 530-752-3025. E-mail: ihp@ucdavis.edu; melissarose6899@gmail.com

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D.B. has served as an expert witness in civil litigation cases and criminal cases involving exposures to environmental chemicals. He has been paid for these activities. He has provided opinions for plaintiffs and for defendants, depending on the facts of the case. He also served as a paid expert witness to a Commission of Inquiry into lead contamination in Hong Kong's drinking water. A.B. has served as a consultant to nonprofit organizations developing environmental health educational curricula for child care programs and has participated as a volunteer member on the Board of the Organic Center, a nonprofit organization that provides information for scientific research about organic food and farming. C.K. is employed by The Endocrine Disruption Exchange (TEDX), a U.S. 501(c)3 organization that occasionally provides consultation, legal assistance, or expert testimony on the topic of endocrine-disrupting chemicals. Neither C.K. nor TEDX stands to gain or lose financially through the publication of this article. This work was supported by private foundations that did not have scientific or editorial input or control. J.S. is employed by the Natural Resources Defense Council, an environmental nongovernmental organization (NGO) that routinely engages in public advocacy, lobbying, and litigation to expand protections for the environment and public health and to enforce existing environmental laws regulating toxic chemicals, including some of the chemicals identified in this manuscript. I.H-P. has received travel reimbursements for her service on the Scientific Advisory Committee of Autism Speaks, in which she provided comments on broad directions for the organization's research programs. She also received payment for reviewing grant proposals for the Research Screening Committee of the California Air Resources Board, which is a branch of the California state government involved in air quality regulation. E.M. works at Pesticide Action Network, an NGO advocating for a farming system that is not reliant on pesticides. M.S. is the Director of the Healthy Children Project for the Learning Disabilities Association of America. Her position is funded by the John Merck Fund, which also contributed some of the funding for Project TENDR.

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Item 2015A1
Reference Committee
Assembly
May 15-17, 2015

ACTION PAPER

TITLE: Addressing the Impact of Environmental Toxins on Neurodevelopment and Behavior

WHEREAS:
Whereas, there is growing evidence that human exposure to environmental toxins is increasing and that this exposure has significant adverse effects on neurodevelopment and subsequent behavior.

According to a 2009 Institute of Medicine report, there are 82,000 man-made chemicals which have been released into the environment and—according to that report—currently "we know very little about basic properties of the majority of these chemicals and even less about the human health impact of these exposures."

Approximately 200 foreign chemicals have been detected in umbilical cord blood and some of these chemicals have well know neurotoxicity as well as other health risks; the developing human brain is uniquely vulnerable to toxic chemical exposure, and important windows of developmental vulnerability occur in utero as well as during infancy and early childhood.

Whereas, results from extensive research on developmental neurotoxicity has shown that for known neurotoxins (such as methyl mercury and lead) long-term, serious adverse cognitive, neurological and other health consequence occur at much lower exposure levels than had previously been thought to be safe and for some of these chemicals no safe level has been established. Since recognition of widespread subclinical toxicity often did not occur until decades after the initial evidence of neurotoxicity, thousands of other chemicals—both individually and in combination with each other—could conceivably turn out to have similar adverse, long term effects.

Whereas, the American Academy of Pediatrics has endorsed guidelines on the prevention of prenatal and childhood exposure to known toxins. Other medical organizations including the American Medical Association, the American College of Obstetrics and Gynecology, the National Medical Association and the American Nurses Association have issued recent statements and/or guidelines aimed at raising awareness of the health risks of environmental toxic exposure.

There has been little recognition in organized or academic psychiatry of the impact of such exposure and at present the APA has not established guidelines for the assessment or prevention of these problems in either adults or children. On the other hand, in late 2015, the APA's online "Psychiatric News Alerts" carried reports of two studies linking early exposure to persistent organic pollutants to ADHD in children and another report linking similar exposure in elderly subjects to Alzheimer's disease.

Whereas, the effects of early exposure to neurotoxins leads to loss of cognitive skills, reduces subsequent academic and economic achievement and in some cases may lead to violent behavior (there is compelling evidence for lead exposure in this regard), all of which are highly detrimental to individuals, families and societies.

Whereas, minority and underserved communities are disproportionately exposed to and affected by such outcomes, further adding to individual and community stress and trauma in these communities.

Greater exposure occurs in minority communities largely due to location of these communities in urban areas where the concentration of pollutants have been shown to be greater, as well as lack of access to information about how to minimize toxic exposure and economic factors which limit acting on this information if available.

Whereas, damage from environmental neurotoxins could render otherwise effective treatments for common psychiatric conditions such as ADHD less effective or ineffective.

Research has demonstrated that prevention of developmental neurotoxicity caused by industrial chemicals can be highly cost effective as shown in a 1994 study that quantified gains resulting from the phase-out of lead additives to gasoline in the U.S. This study estimated an economic benefit of $200 billion in each annual birth cohort beginning in 1980.

Whereas, because many environmental toxins undergo very slow or negligible metabolism (thus the term: persistent organic pollutants or POPS), they bioaccumulate in living organisms. Therefore the risk from these substances can only be expected to increase.

Whereas, in the United States, industrial chemicals are regulated by the Toxic Substance Control Act of 1976. However, unlike medication which require rigorous testing for safety in animals first and then in humans, the standard for industrial chemicals is much lower: under this law, these substances are essentially considered “safe until proven otherwise”, i.e. they can be produced and used unless they have been specifically shown to be harmful.

There are efforts under way in the U.S. Congress to reduce or even eliminate the current governmental regulations; there has also been bipartisan efforts in the U.S. Senate (with input from medical experts, government agencies and the chemical industry) which would make the regulation of environmental toxins stronger, replacing the outdated Toxic Substance Control Act (e.g. Chemical Safety Improvement Act—CSIA).

Whereas, the benefits of greater awareness of these issues in academic and organized psychiatry are of potentially enormous benefit to our patients, their families and our society. On the other hand, failure to address these issues is likely to be increasingly harmful and costly to these same stakeholders.

BE IT RESOLVED:
That the APA will establish a Work Group comprised of researchers and clinicians knowledgeable in the area of the neuro-developmental and behavioral effects of environmental toxins and this Work Group will also include representatives from the Council on Children, Adolescents and Their Families, the Council on Minority Mental Health and Health Disparities and the Council on Research;

That this Work Group will consult with the Scientific Program Committee and the APA Division of Education to help develop an educational plan aimed at raising awareness of the scientific, clinical and regulatory aspects of this issue among the general membership of the APA.

AUTHORS:
James L. Fleming, M.D., Deputy Representative, Missouri Psychiatric Association
jflemingmd@yahoo.com
Elias Sarkis, M.D., Representative, Florida Psychiatric Society
Ludmila De Faria, M.D., Representative, Women Psychiatrists

Dionne A. Hart, M.D., Representative, Minnesota Psychiatric Society
Jose De La Gandara, M.D., Representative, Hispanic Psychiatrists

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ENDORSED BY:

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APA STRATEGIC GOAL: Advocating for Patients, Enhancing the Scientific Basis of Psychiatric Care

REVIEWED BY RELEVANT COMPONENT: PENDING
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April 8, 2015

These are responses to questions about the "charge" of the Work Group from APA Staff sent to us by Alison Bondurant, Associate Director, APA Division of Diversity and Health Equity:

Dr. Fleming: "We are trying to get the APA to acknowledge that toxic exposure is an important area for psychiatrists to be aware of and to begin to address, thus the stated goal. I would hope that the charge of the work group would expand to include develop of a symposium type of CME program at the annual meeting or IPS and also to be able to advise policy makers about this issue…the work of the group would be ongoing and hopefully expanding."

Dr. Sarkis: "The main issue is that physicians in general and psychiatrists in particular have little awareness of environmental toxins and their effects on human development and behaviors. The main intention of this AP is to raise awareness of the impact of environmental toxins on human health including mental health. We want docs to think of toxins as part of the differential when faced with illnesses. So, we need more education on this topic by the researchers who have been doing the work."