Joint Reference Committee
American Psychiatric Association

DRAFT AGENDA

Location: APA Headquarters, Arlington, VA

Saturday, June 17, 2017
Meeting: 9:00 am – 4:00 pm
Breakfast: 8:30 am – 9:00 am
Lunch: 12:30 noon – 1:30 pm

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

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

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

3 Report of the CEO and Medical Director – Saul Levin, MD, MPA
(see attachment 3)

No action required

3.1 Referral Update: Return of Interest for ABPN Continuous Pathways Payments (JRCFEB176.2; ASMNOV1612.B)
Completed. APA Administration sent an official communication to ABPN stating:
1) There should not be an exam every 10 years for MOC;
2) Certification should be an integrated, ongoing process relevant to actual practice;
3) Exam questions should be related to the psychiatrist's subspecialty or practice setting;
4) No psychiatrist should be forced to maintain general and subspecialty certification through more than one process; and
5) ABPN should lobby and advocate that ABMS eliminate Part 4 of MOC.

No action required

3.2 Referral Update: Exhibitor-Funded Scholarships for Consumer Presenters at Annual Meetings (JRCFEB176.7; ASMNOV1612.J)
The APA Annual Meeting and IPS: Mental Health Services Conference are accredited educational activities and therefore subject to standards established by the Accreditation Council for Continuing Medical Education (ACCME).

The ACCME prohibits pharmaceutical and device companies from providing support for speakers to participate in accredited educational activities outside of formal per activity contracts which outline the financial support provided for each activity (ACCME Standards for Commercial Support 3.4, 3.8, and 3.9).

The guidelines for speakers apply to physicians, patients, or any other speaker within the accredited program. ACCME would allow commercial funds to be used to support speakers at the Annual Meeting if there were signed individual agreements between the pharmaceutical companies and the APA as the meeting's accreditor.

Contracts could not be signed with APAF since the Foundation is not an accreditor. APA would be required to report the commercial support received by each company to the ACCME. Currently the APA Board of Trustees (BOT) has prohibited the APA from receiving this kind of funding for its live events.

Creating a pooled fund within APAF merely creates a pass-through for pharmaceutical and device companies to provide funds to meeting speakers and is therefore prohibited under ACCME rules.

Further, ACCME rules require that the agreement for commercial support be with the accreditor (in this case APA, not APAF) which would contradict current APA policy.

Although this Action specifically asks that influence by external dollars be minimized through a series of conditions that reduce influence given to the commercial funder, it must still go to the Board for consideration of a revision of existing policy related to accepting commercial funds for speakers -- a necessary first step in reversing the aforementioned policy regarding commercial support.

3.3 Referral Update: Protecting the Seriously Mentally Ill Incarcerated Individuals (JRCFEB176.10; ASMNOV1612.N)

1) APA administration will continue to advocate for increased psychiatric workforce at the federal and state levels.
2) APA Administration has found no AMA policy that focuses on workforce in correctional facilities, and will discuss with the delegation at the AMA Annual meeting the development of a resolution for a new policy or an amendment to current related policy. Pending AMA Delegation discussion at the June 2017 HOD meeting.
3) APA Administration will continue to advocate for the strong opposition of psychologists or pharmacists to prescribe medications in correctional settings.
4) APA Administration, through our CMS grant is also advocating for collaborative care training in diverse settings, like correctional institutions. A training was held last year in a Michigan correctional facility. Training in collaborative care is ongoing.
5) General psychiatry and fellowship trainings are set by the ACGME. Specific recommendations for minimum requirements are submitted by groups such as the APA and AADPRT. The APA regularly communicates recommendations to AADPRT and the ACGME for increased emphasis in training through its liaisons in the APA Administration and in the Council on Medical Education and Lifelong Learning. We will work with subspecialty groups, such as the Association for Community Psychiatrists, on these efforts.

3.4 Referral Update: Task Force on Fighting Discrimination (JRCFEB176.13; ASMNOV1612.R)

Completed. APA Administration developed a fact sheet that elucidates the process and response mechanism. Please see attachment.

3.5 Referral Update: Proposed Position Statement: Patient Bill of Rights – What to Expect When Seeking Behavioral Health Treatment (JRCFEB178.F.4)

HCSF Council recommended sunsetting the bill of rights. CAGR recommended its continuation.
JRC has asked the CEO's office to reach out to allied groups to see if they are interested in resigning this document.
Since the last JRC meeting, APA has been conducting multiple joint advocacy efforts with allied organizations regarding healthcare delivery changes and ensuring the retention of MH/SUD benefits for patients. Due to these developments, APA and many of the allied groups who were originally part of the Bill of Rights" have signed on to different statements and letters together.

Due to the ever-changing healthcare legislative environment and that we have had multiple joint sign on letters in the last 5-6 months, the APA administration recommends we not move forward endorsement for allied groups at this time.

3.6 Referral Update: Joint Statement on Conversion Therapy (JRCFEB178.I.2; JRCJUNE166.21; ASMMAY1612.Z)
[see also item 9]

APA currently has policy opposing conversion therapy in gay and lesbian populations. The Joint Statement on Conversion Therapy relates specifically to conversion therapy aimed at transgender people.

APA's research and legal teams are working jointly to compile literature regarding the issue of whether there is any data supporting the idea that conversion therapy on transgender patients is harmful. The Administration plans to take these findings to the Council on Minority Mental Health and Health Disparities, as well as the Council on Research.

The Administration aims to present research to the Councils at the September Components Meetings so that they may make a recommendation as to whether APA should sign on to the Joint Statement on Conversion Therapy

The Ethics Committee is also being consulted due to the multiple references in the proposed document that implicate conversion therapy of transgender individuals is unethical.

4 Charge to the Joint Reference Committee

5 Assignment of Position Statements to Councils for Review

6 **Report of the Assembly** – Bob Batterson, MD

6.1 Involuntary Psychiatric Commitment for Individuals with Substance Use Disorders (ASM2017A1 12.A)
(Attachment 1A – AP; Attachment 1B – Cost Estimate & Administration Comments)
The action paper asks that the American Psychiatric Association develop a comprehensive position statement on the use of involuntary psychiatric commitment for the treatment of substance use disorders.

Will the JRC refer the action paper *2017A1 12.A: Involuntary Psychiatric Commitment for Individuals with Substance Use Disorders* to the appropriate Component(s) for input or follow-up?

APA Administration recommends referral to: **Council on Psychiatry and Law (LEAD) and Council on Addiction Psychiatry**

6.2 Opposition to Psychologist Prescribing (ASM2017A1 12.B)
(Attachment 2A – AP; Attachment 2B – Cost Estimate & Administration Comments)
The action paper asks that the appropriate committee create a Position Statement that reflects that the APA, in the service of patients with mental illness, opposes prescribing privileges of Psychologists.

Will the JRC refer the action paper *2017A1 12.B: Opposition to Psychologist Prescribing* 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 Healthcare Systems and Financing**

6.3 Adopting Neuroscience-based Nomenclature (NbN) for Medications (ASM2017A1 12.D)
(Attachment 3A – AP; Attachment 3B – Cost Estimate & Administration Comments)
The action paper asks:

That the APA promote the international Neuroscience-based Nomenclature (NbN) standard terminology developed by ACNP, ECNP, CINP, AsCNP, and IUPHAR, in its publications, policies, and communications;

That the APA seek opportunities to promote adoption of NbN terminology by payers and policymakers; and

That the APA CEO and Medical Director be responsible for carrying out these promotion activities.

Will the JRC refer the action paper *2017A1 12.D: Adopting Neuroscience-based Nomenclature (NbN) for Medications* to the appropriate Component(s) for input or follow-up?

APA Administration recommends referral to: **Council on Research, Council on Healthcare Systems and Financing, and the DSM Steering Committee**

6.4 Revising the Nomenclature, Definition, and Clinical Criteria for Partial Hospitalization Program (ASM2017A1 12.E)
(Attachment 4A – AP; Attachment 4B – Cost Estimate & Administration Comments)
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.

Will the JRC refer the action paper *2017A1 12.E: Revising the Nomenclature, Definition, and Clinical Criteria for Partial Hospitalization Program* 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 Quality Care**

6.5 Providing Education and Guidance for the Use and Limitations of Pharmacogenomics in Clinical Practice (ASM2017A1 12.G)

(Attachment 5A – AP; Attachment 5B – Cost Estimate & Administration Comments)

The action paper asks that:

1. The APA educate its members about the use and limitations of pharmacogenomic testing in clinical 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 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

Will the JRC refer the action paper *2017A1 12.G: Providing Education and Guidance for the Use and Limitations of Pharmacogenomics in Clinical Practice* to the appropriate Component(s) for input or follow-up?

APA Administration recommends referral to: **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 Relations**

6.6 Expanding Access to Psychiatry Subspecialty Fellowships (ASM2017A1 12.H)

(Attachment 6A – AP; Attachment 6B – Cost Estimate & Administration Comments)

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, such as extending ACGME accreditation to prior years of training ("grandfathering") during this period of transition.

Will the JRC refer the action paper *2017A1 12.H: Expanding Access to Psychiatry Subspecialty Fellowships* to the appropriate Component(s) for input or follow-up?

APA Administration recommends referral to: **Council on Medical Education and Lifelong Learning**

6.7 Educational Strategies to Improve Mental Illness Perceptions of Medical Students (ASM2017A1 12.I)
(Attachment 7A – AP; Attachment 7B – Cost Estimate & Administration Comments)

The action paper asks: That the APA charge the Council on Medical Education and Lifelong Learning (CMELL) to

1. Ascertain with the Association of Directors of Medical Student Education in Psychiatry (ADMSEP) and the American Association of Chairs of Departments of Psychiatry (AACDP), the need for and their interest in implementing educational training strategies for improving medical students' perceptions regarding mental illness and psychiatry, and if there is sufficient interest,
2. Partner with ADMSEP in reviewing and developing educational strategies that particularly involve exposure or contact with patients who have experienced and successfully recovered from mental illness, and discussions of medical students' own perceptions and attitudes regarding mental illness, early on in medical student education,
3. APA to support the developed product and advocate for implementing the developed strategies to various medical education organizations including ADMSEP, AACDP and ACGME.

Will the JRC refer the action paper 2017A1 12.I: *Educational Strategies to Improve Mental Illness Perceptions of Medical Students* to the appropriate Component(s) for input or follow-up?

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

6.8 Educational Strategies to Improve Mental Illness Perceptions of Non-Mental Health Medical Professionals (ASM2017A1 12.J)
(Attachment 8A – AP; Attachment 8B – Cost Estimate & Administration Comments)

The action paper asks:

1. APA to charge the APA Department of Education to work with APA's AMA delegation and with other interested medical professional organizations to ascertain their interest in implementing educational strategies to improve negative perceptions of mental illness across primary care fields; if there is sufficient interest;
2. APA, in partnership with interested medical professional organizations and in conjunction with American Psychiatric Association Foundation, American Psychiatric Association Publishing and mental health advocacy groups, support and develop educational curriculum and video series depicting and emphasizing successful recovery models of mental illness in patients for use by non-mental health medical professionals;
3. In the spirit of collaborative care, APA support and develop, in conjunction with American Psychiatric Association Publishing and other educational organizations, a training curriculum and video series for non-mental health medical professional on how to comfortably communicate with, assess, and treat mentally ill persons, and when to refer patients to psychiatrists;
4. APA to advocate to AMA, AAFP and other non-mental health medical professional organizations, as to the importance and availability of above educational strategies in improving perceptions and care of persons with mental illness.

Will the JRC refer the action paper 2017A1 12.J: *Educational Strategies to Improve Mental Illness Perceptions of Non-Mental Health Medical Professionals* to the appropriate Component(s) for input or follow-up?

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

6.9 Fostering Medical Student Interest and Training in Psychiatry: The Importance of Medical Student Clerkships (ASM2017A1 12.K)
(Attachment 9A – AP; Attachment 9B – Cost Estimate & Administration Comments)
The action paper asks that the APA tasks the Council on Medical Education and Lifelong Learning (CMELL) with drafting a position statement on recommended guidelines for the Psychiatry Clerkship. The CMELL should partner with other organizations invested in psychiatric education, such as ADMSEP and AADPRT, in the drafting of this position statement.

This statement should be used to provide recommendations to the Liaison Committee on Medical Education (LCME) and the American Osteopathic Association (AOA) Commission on Osteopathic College Accreditation (COCA) on minimum requirements for psychiatric training. The statement should describe the importance of psychiatry clerkships as the key formative experience for all medical students, and best practices that promote medical student education and interest in psychiatry. Specific components integral to the psychiatry clerkship should include:

- A minimum duration of a six-week equivalent full-time experience in the evaluation and treatment of psychiatric patients.
- Exposure to both inpatient and ambulatory practice settings, ideally including exposure to subspecialty (e.g. – child and adolescent, addictions, geriatrics, consultation and liaison) and developing models of practice designed to better serve psychiatric populations (e.g. – collaborative or integrated care).

Will the JRC refer the action paper 2017A1 12.K: *Fostering Medical Student Interest and Training in Psychiatry: The Importance of Medical Student Clerkships* to the appropriate Component(s) for input or follow-up?

APA Administration recommends referral to: **Council on Medical Education and Lifelong Learning**

6.10 Requesting the APA Draft a Position Statement on Prescription Drug Monitoring Programs (PDMPs) (ASM2017A1 12.L)
(Attachment 10A – AP; Attachment 10B – Cost Estimate & Administration Comments)
The action paper asks:

- That the American Psychiatric Association draft a position statement regarding Prescription Drug Monitoring Programs.
- That such PDMP position statement addresses PDMP best practices including design, operation, confidentiality, privacy, physician/staff burden utilization and interstate access.in correctional psychiatry in order to increase the number of psychiatrists working in correctional settings.

Will the JRC refer the action paper 2017A1 12.L: *Requesting the APA Draft a Position Statement on Prescription Drug Monitoring Programs (PDMPs)* to the appropriate Component(s) for input or follow-up?

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

6.11 Juvenile Solitary Confinement (ASM2017A1 12.M)
(Attachment 11A – AP; Attachment 11B – Cost Estimate & Administration Comments)
The action paper asks:
That the APA support the AMA policy statement opposing the use of solitary confinement in juveniles, and that the APA draft its own position statement by May of 2018.

H-60.922
Our AMA: (1) opposes the use of solitary confinement in juvenile correction facilities except for extraordinary circumstances when a juvenile is at acute risk of harm to self or others; (2) opposes the use of solitary confinement of juveniles for disciplinary purposes in correctional facilities; and (3) supports that isolation of juveniles for clinical or therapeutic purposes must be conducted under the supervision of a physician.

With the following preamble:
Solitary confinement is defined as the placement of an incarcerated individual in a locked room or cell with minimal or no contact with people other than staff of the correctional facility. It is used as a form of discipline or punishment.

Will the JRC refer the action paper 2017A1 12.M: *Juvenile Solitary Confinement* to the appropriate Component(s) for input or follow-up?

APA Administration recommends referral to: **Council on Psychiatry and Law (LEAD), Council on Children, Adolescents, and Their Families, Council on Minority Mental Health and Health Disparities**

6.12 Addressing Physician Burnout, Depression, and Suicide —Within Psychiatry and Beyond (ASM2017A1 12.N)
(Attachment 12A – AP; Attachment 12B – Cost Estimate & Administration Comments)
The action paper asks:
That the APA continue the mission of the Ad Hoc Workgroup on Physician Well-Being by developing resources for increasing awareness about physician burnout, depression and suicide, as well as interventions for promoting physician wellness, including recommendations for institutional response to physician suicide;
That the APA revise its 2011 "Position Statement on Physician Wellness" to affirm the APA's commitment to ensuring the well-being of its members and to encourage members to serve as leaders in promoting well-being initiatives within their institutions, training programs, and systems of care;
That the APA promote further investigation of the underlying causes of increased rates of burnout, depression, and suicide among physicians and to expand the evidence base for innovative wellness interventions;
That the APA Government Relations staff work with stakeholder organizations including the Federation of State Medical Boards to remove questions about psychiatric or substance use disorder treatment from licensing applications (initial or renewal) as well as employment

applications, instead focusing on relevant, current functional impairment due to either physical or mental illness;

That the APA's AMA delegation continue to collaborate with the AMA to develop joint initiatives to prioritize these issues.

Will the JRC refer the action paper 2017A1 12.N: *Addressing Physician Burnout, Depression, and Suicide —Within Psychiatry and Beyond* to the appropriate Component(s) for input or follow-up?

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

6.13 Health Care Is a Human Right (ASM2017A1 12.0)
(Attachment 13A – AP; Attachment 13B – Cost Estimate & Administration Comments)
The action paper asks that the American Psychiatric Association adopt the following position statement: "Health care, inclusive of mental health care, is a human right".

Will the JRC refer the action paper 2017A1 12.O: *Health Care Is a Human Right* to the appropriate Component(s) for input or follow-up?

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

6.14 Making Access to the Voting Page a Default Action During Elections (ASM2017A1 12.P)
(Attachment 14A – AP; Attachment 14B – Cost Estimate & Administration Comments)
The action paper conveys that the Assembly recommends that the APA Administration work to make access to voting as prominent as possible and user friendly on the APA website, and reconsider the value of mailing ballots to all members.

Will the JRC refer the action paper 2017A1 12.P: *Making Access to the Voting Page a Default Action During Elections* to the appropriate Component(s) for input or follow-up?

APA Administration recommends referral to: **CEO/MDO Office – Division of Communications and Marketing**

6.15 Dues Relief for District Branch Members from the Commonwealth of Puerto Rico (ASM2017A1 12.Q)
(Attachment 15A – AP; Attachment 15B – Cost Estimate & Administration Comments)
The action paper asks that general member psychiatrists who are members of the Puerto Rico Psychiatric Society, a District Branch of the APA shall be granted the same annual APA dues as our Canadian counterparts, which is $375 per general member per year for the next five years.

Will the JRC refer the action paper 2017A1 12.Q: *15. Dues Relief for District Branch Members from the Commonwealth of Puerto Rico* 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, Finance and Budget Committee**

6.16 Streamlining the Application Process for Former APA Members (ASM2017A1 12.R)
(Attachment 16A – AP; Attachment 16B – Cost Estimate & Administration Comments)
The action paper asks that the APA staff streamline the application process for former APA members on the website as follows:
1. Once an applicant answers yes to being a former member of the APA on the website, the individual is given an online, pre-filled application.
2. Remove the requirement for the applicant to resubmit the residency training certificate (this can be verified by APA staff from previous membership records).
3. Remove the requirement for the applicant to submit a valid medical license (this can be verified by APA staff from online, public databases).
That the APA staff advertise the changes to the streamlined application process for former APA members.

Will the JRC refer the action paper 2017A1 12.R: *Streamlining the Application Process for Former APA Members* to the appropriate Component(s) for input or follow-up?

APA Administration recommends referral to: **Membership Committee**

6.17 APA Referendum Voting Procedure (ASM2017A1 12.T)
(Attachment 17A – AP; Attachment 17B – Cost Estimate & Administration Comments)
The action paper asks:
1. If 2/3 of the voting members approve a referendum statement, but the requirement of 40% of eligible voters voting has not been met, the BOT will schedule a vote on the referendum statement or a modified version of it for voting by members of the BOT and the Assembly. If the referendum statement or its modified version does not get a 2/3 votes by both these bodies and thus fails to pass, or if the lead petitioner of the referendum statement does not agree to the modified version, then the original referendum statement will be placed again on the ballot to be voted on by the entire membership; but this time the referendum ballot will be sent with the yearly dues statement/solicitation for contributions to all voting members. If it fails again it will not be automatically placed on the ballot again. If it passes, it will supersede any modified version passed by the BOT and the Assembly.
2. If the BOT rejects resolved #1, then an alternative for a viable referendum process shall be prepared by the Board of Trustees, with participation of Assembly Representatives jointly selected by the Speaker and the President, and presented to the Assembly at the Fall 2017 meeting.

Will the JRC refer the action paper 2017A1 12.T: *APA Referendum Voting Procedure* to the appropriate Component(s) for input or follow-up?

APA Administration recommends referral to: **Board of Trustees**

6.18 Revised 2015 Position Statement: Use of the Concept of Recovery (JRCFEB178.M.1/ASM2017A1 4.B.20)

(Attachment 18A – AP; Attachment 18B – Cost Estimate & Administration Comments)

The Assembly voted to refer the Revised 2015 Position Statement: *Use of the Concept of Recovery* to the Assembly Committee on Public and Community Psychiatry. The Committee revised the Position Statement and is submitting it for review and approval by the Joint Reference Committee and, if approved, referral to the appropriate Component(s) for input or follow-up.

Will the JRC refer the Revised Position Statement: *Use of the Concept of Recovery* to the appropriate Component(s) for input or follow-up?

APA Administration recommends referral to: **Council on Quality Care (LEAD), Council on Minority Mental Health and Health Disparities.**

8 Reports from Councils

9:30 am – 9:50 am

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 does not have action items.

No action required

8.H.1 Referral Update: Retire Position Statement: Confidentiality of Medical Records: Does the Physician Have a Right to Privacy Concerning His or Her Own Health Records? (1981) (JRCFEB176.15; JRCJUNE168.J.1; ASMNOV164.B.8)

The JRC referred the action to the Council on Medical Education and Lifelong Learning (LEAD), Council on Psychiatry and Law and the Ethics Committee to draft a new position statement on this topic.

The Council reviewed the 1981 PS and the 2015 PS on Inquiries about Diagnosis and Treatment of Mental Disorder in Connection with Credentialing and Licensing. The Council sees much similarity in the content of the two statements. However, the 1981 PS explicitly addresses the question of keeping existing medical records confidential. While this is implied in the 2015 PS by limiting the scope of questions asked by licensing boards and credentialing organizations, it is not specifically addressed.

The Council is supportive of a new position statement on the confidentiality of physician medical records, or amending the 2015 PS noted above. The Council believes that they are not the appropriate body to draft a new position statement. This is an issue for all psychiatrists and as such, requires a broader scope of expertise (ethics/medical-legal issues around confidentiality) than exists within the Council on Medical Education and Lifelong Learning.

9:50 am – 10:10 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 Permission to Publish Component Work Product: EEG Prediction of Treatment Response in Depressive Episodes

Will the Joint Reference Committee recommend that the Board of Trustees grant permission to publish the component work product manuscript *EEG Prediction of Treatment Response in Depressive Episodes?*

No action required

8.M.2 Referral Update: APA Position Statement on Screening and Treatment for Mental Health Disorders During Pregnancy and Postpartum (JRCFEB176.6; ASMNOV1612I)

The action paper asks that the APA develop a position statement on Screening and Treatment for Mental Health Disorders During Pregnancy and Postpartum.

The Council on Research has convened a small work group to develop a position statement.

10:10 am – 10:30 am

Robert Roca, MD – *via speakerphone*

8.E **Council on Geriatric Psychiatry**

Please see item 8.E for the Council's report, summary of current activities and information items. The council does not have action items.

10:30 am – 10:50 am

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. The council does not have action items.

10:50 am – 11:10 am

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 Request for Funding: Assembly M/UR Caucus Representatives to the Council Meeting at the September Component Meetings (see item 8.B, page 2)

Will the Joint Reference Committee approve the Council's request to invite the Representatives from the Assembly M/UR Caucuses to attend the Council's meeting at the September Component's meeting at an estimated cost of $10,000?

N.B. This is a one-time request. The purpose is detailed in the Council's report.

8.I.2 Proposed Position Statement: Domestic Violence Against Women

Will the Joint Reference Committee recommend that the Assembly approve the proposed Position Statement: *Domestic Violence Against Wo*men and if approved, forward it to the Board of Trustees for consideration?

8.I.3 Proposed Position Statement: Prevention of Violence

Will the Joint Reference Committee recommend that the Assembly approve the proposed Position Statement: *Prevention of Violence* and if approved, forward it to the Board of Trustees for consideration?

8.I.4 Revised Position Statement: Religious Discrimination, Persecution, and Genocide

Will the Joint Reference Committee recommend that the Assembly approve the revised Position Statement: *Religious Discrimination, Persecution, and Genocide* and if approved, forward it to the Board of Trustees for consideration?

8.I.5 Proposed Position Statement: Human Trafficking

Will the Joint Reference Committee recommend that the Assembly approve the proposed Position Statement: *Human Trafficking* and if approved, forward it to the Board of Trustees for consideration?

11:10 am – 11:30 am
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 Proposed Position Statement: Police Interactions with Persons with Mental Illness

Will the Joint Reference Committee recommend that the Assembly approve the proposed Position Statement *Police Interactions with Persons with Mental Illness*, and if approved, forward it to the Board of Trustees for consideration?

8.J.2 Proposed Resource Document: Physician Assisted Death

Will the Joint Reference Committee approve the proposed Resource Document *Physician Assisted Death?*

8.J.3 Permission to Publish: Resource Document on Physician Assisted Death

Will the Joint Reference Committee recommend that the Board of Trustees grant permission to publish the Resource Document Physician Assisted Death?

8.J.4 Proposed Position Statement: Lengthy Sentences Without Parole for Juveniles

Will the Joint Reference Committee recommend that the Assembly approve the proposed Position Statement: *Lengthy Sentences Without Parole for Juveniles*, and if approved, forward it to the Board of Trustees for consideration?

8.J.5 Retire 2011 Position Statement: Review of Sentences for Juveniles Serving Lengthy Mandatory Terms of Imprisonment

Will the Joint Reference Committee recommend that the Assembly retire the 2011 Position Statement: *Review of Sentences for Juveniles Serving Lengthy Mandatory Terms of Imprisonment*, and if retired, forward it to the Board of Trustees for consideration?

Rationale: The 2011 position statement will be replaced by the proposed Position Statement *Lengthy Sentences Without Parole for Juveniles*, in part to account for Supreme Court cases decided after the 2011 Position Statement was adopted.

8.J.6 Retain 2012 Position Statement: Segregation of Prisoners with Mental Illness

Will the Joint Reference Committee recommend that the Assembly retain the 2012 Position Statement: Segregation of Prisoners with Mental Illness, and if retained, forward it to the Board of Trustees for consideration?

Rationale: The Council believes the position statement is current, relevant, and should be retained.

8.J.7 Retain 2012 Position Statement: Assessing the Risk for Violence

Will the Joint Reference Committee recommend that the Assembly retain the 2012 Position Statement: Assessing the Risk for Violence, and if retained, forward it to the Board of Trustees for consideration?

Rationale: The Council believes the position statement is current, relevant, and should be retained.

8.J.8 Retain 2012 Position Statement: Firearms Access: Inquiries in Clinical Settings

Will the Joint Reference Committee recommend that the Assembly retain the 2012 Position Statement: Firearms Access: Inquiries in Clinical Settings, and if retained, forward it to the Board of Trustees for consideration?

Rationale: The Council believes the position statement is current, relevant, and should be retained.

8.J.9 Retain 2007 Position Statement: Use of Jails to Hold Persons Without Criminal Charges Who are Awaiting Civil Psychiatric Hospital Beds

Will the Joint Reference Committee recommend that the Assembly retain the 2007 Position Statement: Use of Jails to Hold Persons Without Criminal Charges Who are Awaiting Civil Psychiatric Hospital Beds, and if retained, forward it to the Board of Trustees for consideration?

Rationale: The Council believes the position statement is current, relevant, and should be retained.

8.J.10 Retain 2007 Position Statement: Psychiatric Services in Jails and Prisons

Will the Joint Reference Committee recommend that the Assembly retain the 2007 Position Statement: Psychiatric Services in Jails and Prisons, and if retained, forward it to the Board of Trustees for consideration?

Rationale: The Council believes the position statement is current, relevant, and should be retained.

8.J.11 Retain 1993 Position Statement: Homicide Prevention and Gun Control

Will the Joint Reference Committee recommend that the Assembly retain the 1993 Position Statement: Homicide Prevention and Gun Control, and if retained, forward it to the Board of Trustees for consideration?

Rationale: The Council believes the position statement is current, relevant, and should be retained.

11:30 am – 11:50 am
Debra Pinals, MD for 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: Hospital Privileges for Psychologists

Will the Joint Reference Committee recommend that the Assembly approve the revised Position Statement: *Hospital Privileges for Psychologists* and if approved, forward it to the Board of Trustees for consideration?

No action required

8.B.2 Referral Update: 2008 Position Statement on Principles for Healthcare Reform for Psychiatry

The Council will be revising the position statement. A small work group was established to amend the language, in addition to incorporating relevant data. The work group will work with the Council on Healthcare Systems and Financing in drafting the revised position statement for presentation to the JRC in October 2017.

No action required

8.B.3 Referral Update: Smart Guns as a Gun Safety Response to Gun Violence, a Public Health Hazard (JRCFEB176.9; ASMNOV1612.M)

The action paper asks that the APA support smart gun technology as one piece of a solution to gun violence.

Taking into consideration two existing APA positions statements and one resource document addressing handguns, the Council recommended reviewing documents for similarities to this action paper. A small work group was established to assess the language and advise next step to the Council by the September Components meeting.

11:50 am – 12:10 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, a summary of current activities, and information items.

8.C.1 Retain Position: United States Ratification of the Convention of the Rights of the Child

Will the Joint Reference Committee recommend that the Assembly approve retaining the endorsement, as APA Policy, of the United States Ratification of the Convention of the Rights of the Child, and if retained, forward it to the Board of Trustees for consideration?

Rationale: The Council believes the position statement is current, relevant, and should be retained.

No action required

8.C.2 Referral Update: *Ending Childhood Poverty* (JRCFEB176.11; ASMNOV1612.O)

The Council has prioritized partnering, on an ad hoc basis, with the APA Foundation, DB/SAs, and allied organizations to advance the relevant issues and legislation designed to reduce and eliminate childhood poverty in America. Synergies in the work of the Council and the APAF were identified (Typical and Troubled®). The Council on Advocacy and Government Relations is working with APA Administration to review APA's current partnerships and advocacy efforts to address the action paper's issues.

12:10 pm – 12:30 pm
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 Revised Position Statement: Need to Maintain Long-Term Care Facilities for Certain Individuals with Serious Mental Illness

Will the Joint Reference Committee recommend that the Assembly approve the revised Position Statement: *The Need to Maintain Long-Term Care Facilities 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, the XXX Position Statement: insert name, will be retired.

8.F.2 Revised Position Statement: Codification of Medical Evaluation and Management Services for Psychotherapy

Will the Joint Reference Committee recommend that the Assembly approve the revised Position Statement: *Codification of Medical Evaluation and Management Services for Psychotherapy,* and if approved, forward it to the Board of Trustees for consideration?

8.F.3 Retire 2010 Position Statement: Psychiatry and Primary Care Integration across the Lifespan

Will the Joint Reference Committee recommend that the Assembly retire the 2010 Position Statement: Psychiatry and Primary Care Integration across the Lifespan and if retired, forward it to the Board of Trustees for consideration?

Rationale: The concepts contained in this position statement are included in other APA position statements such as the 2016 PS *Integrated Care* and the 2008 PS *Principles for Health Care Reform for Psychiatry.*

8.F.4 Retain 2011 Position Statement: Psychiatrists' Time Performing Utilization Review (Endorsement of AMA policy H-385.951)

Will the Joint Reference Committee recommend that the Assembly retain the 2011 Position Statement: *Psychiatrists' Time Performing Utilization Review (Endorsement of AMA policy H-385.951)* and if retained, forward it to the Board of Trustees for consideration?

Rationale: The Council believes the position statement is current, relevant, and should be retained.

8.F.5 Retain 2014 Position Statement: Universal Access to Health Care

Will the Joint Reference Committee recommend that the Assembly retain the 2014 Position Statement: *Universal Access to Health Care* and if retained, forward it to the Board of Trustees for consideration?

Rationale: The Council believes the position statement is current, relevant, and should be retained.

No action required

8.F.6 Referral Update: All Prescribers, not just Physicians, shall be Subject to Open Payments (JRCFEB176.1; ASMNOV1612.A)

The action paper asks the APA to engage with eh AMA and the American Osteopathic Association to pursue regulatory change such that non-physician providers are included along with physician in the Open Payments reports and database.

The Physician Sunshine Act (Open Payments) was instituted as part of the ACA. Any changes to the program must be made through the legislative process. At this time, the AMA and the AOA are not pursuing an advocacy strategy to expand open payments to require non-physicians to participate in the program. CHSF defers to CAGR as to how to prioritize this request within current activity around health reform.

The Council on Government Relations is aware that neither AMA nor AOA have initiated advocacy efforts. The next question would be if any consumer groups are active in advocacy on this issue. Once APA places this as a priority, an advocacy strategy plan can be developed.

No action required

8.F.7 Referral Update: Continuity of Care (JRCFEB176.3; ASMNOV1612.C)

The action paper that the APA 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.

The CHSF will continue to compel information relevant to this request to develop educational materials for APA members. The effort will include a communications plan to educate members. As part of the process, it will be important to identify and potentially resolve and barriers (confidentiality). The Council on Quality Care discussed this and noted that quality measures exist regarding transitions in care.

No action required

8.F.8 Referral Update: Improving the Confidentiality of Prescription Drug Monitoring Programs (JRCFEB176.5; ASMNOV1612.G)

The action paper asks the that APA study the variations in the PDMPs to ensure that they are consistent with current federal regulations, and to make recommendations to improve the PDMP system with special attention to ensure the appropriate confidentiality of patient records.

The CHSF will discuss this on future conference calls and would include representatives from key components. N.B. Brandeis University ‘s Heller School for Social Policy and Management has developed a website titled PDMPassist.org that provides a state by state profile on PDMPs, including the authorized requesters of the PDMP data. Additionally, while nearly all states currently have a PDMP, federal requirements for this program are non-existent.

No action required

8.F.9 Referral Update: Mental Health Parity for Individuals with Intellectual and Developmental Disability (IDD) (JRCFEB176.12; ASMNOV1612.P)

The action paper asks that the APA develop a position statement supporting mental health parity for individuals with IDD.

The CHSF will set up a work group, with representatives from CAGR, the Council on Children and/or Caucus of Psychiatrists Treating Patients with IDD to discuss the action paper, implication of parity and any additional information. The Council on Advocacy and Government Relations discussed the action paper and agreed a position statement is relevant to the current climate and emergency department boarding.

BREAK

1:30 pm – 1:50 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 does not have any action items.

8.G.1 Proposed Position Statement on Human Rights

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

N.B. The proposed position statement is a consolidation of the 1992 PS *Human Rights* and the 2008 PS *Denial of Human Rights Abuses.* If the proposed position statement is approved by the Assembly and the Board of Trustees, these two position statements will be considered retired.

1:50 pm – 2:10 pm

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 does not have action items.

2:10 pm – 2:30 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 does not have action items.

2:30 pm – 2:40 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 does not have action items.

9 OLD BUSINESS

9.A. Discussion of the US Joint Statement on Conversion Therapy

Related APA position statements:

- 1998 PS: *Psychiatric Treatment and Sexual Orientation*
- 2000 PS: *Therapies Focused on Attempts to Change Sexual Orientation (Reparative or Conversion Therapies*
- 2011 PS: *Homosexuality*
- 2013 PS: *Issues Related to Homosexuality*

NEXT JOINT REFERENCE COMMITTEE MEETING

October 14, 2017
APA Headquarters, Arlington, VA
Report Deadline: September 28, 2017

Joint Reference Committee
February 12-13, 2017
DRAFT SUMMARY OF ACTIONS

As of March 1, 2017

JRC Members Present:
Anita Everett, MD: JRC Chairperson: APA President-elect (stipend); receives income Federal Government @ SAMHSA (The roles will be kept separate - Dual relationship)
Theresa Miskimen, MD: stipend for Speaker-elect; income from Rutgers UBHC; State of NJ - psychiatrist leading the involuntary medication panel review for three state hospitals
Altha Stewart, MD: APA Secretary; Full time faculty from University of Tennessee Health Science Center, Small consulting contract with WNBA
James Batterson, MD: Full time faculty Children's Mercy Hospital; receives funding from Pfizer (sertraline) and Psyadon Pharmaceuticals through the hospital.
Lama Bazzi, MD: receives income from Maimonides Medical Center; forensic private practice.
Glenn Martin, MD: Immediate Past Speaker; receives income from the Icahn School of Medicine at Mt. Sinai; receives income from private practice; Medical Director of Information Exchange in Queens. Human Subjects Director for Mt. Sinai; private practice.
Saul Levin, MD, MPA: CEO/Medical Director – APA salary; Chair of the APAF Board of Directors.
Nina Vasan, MD: APAF Leadership Fellow; Resident; Consulting for McKinsey; book royalties, Stanford PGY 4 and Harvard Business School.

Invited Guest: Rahn K. Bailey, MD – Candidate for President-elect. Chair of Psychiatry at Wake Forest; Chairperson of the APA Membership Committee

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

APA Administration:

Yoshie Davison, MSW	Chief of Staff
Jon Fanning, MS, CAE	Chief, Membership and RFM-ECP Officer
Kristin Kroeger	Chief, Policy, Programs, & Partnerships
Ranna Parekh, MD, MPH	Director, Division of Diversity & Health Equity
Shaun Snyder, JD, MBA	Chief Operating Officer

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 October 2016 Joint Reference Committee Meeting **Will the Joint Reference Committee approve the draft summary of actions from the October 2016 meeting?**	The Joint Reference Committee approved the draft summary of actions from the October 2016 meeting.	Shaun Snyder, JD, MBA Margaret Cawley Dewar Laurie McQueen	Association Governance
3	**CEO/Medical Director's Office Report** Update on Referral			
3.1	No action required Referral Update: Joint Consensus Statement: Diagnosing Schizophrenia in Skilled Nursing Centers (JRCOCT168.E.2; JRCJAN166.15 ASMMAY1612.S) (please see item 3) The Joint Reference Committee referred this item to the APA President and the CEO/Medical Director to sign on to this issue as it is consistent with current APA Practice Guidelines. In addition, the Joint Reference Committee refers this issue back to the Council on Geriatric Psychiatry to develop a formal position statement on diagnosing schizophrenia in skilled nursing centers. Status: Via the CEO's Office, the APA signed on to Joint Summary Statement from American Health Care Association. The Division of Policy, Programs, and Partnerships and DDHE are working on a rollout plan. The Council on Geriatric Psychiatry is discussing the need to develop a position statement on diagnosing schizophrenia in skilled nursing centers.	The Joint Reference Committee thanked the CEO/Medical Director for the update on the referral.		n/a
6	**Report of the Assembly** – Theresa Miskimen, MD			

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
6.1	<u>All Prescribers, not just Physicians, shall be Subject to Open Payments</u> (ASMNOV16A12.A) (Please see attachment 1) The action paper asks that the APA engage with the American Medical Association and the American Osteopathic Association to pursue regulatory change such that non-physician providers are included along with physicians in the Open Payments reporting and database. **Will the Joint Reference Committee refer the action paper All Prescribers, not just Physicians, shall be Subject to Open Payments to the appropriate Component(s) for input or follow-up?**	The Joint Reference Committee referred the action paper to the Council on Healthcare Systems and Financing (LEAD), the Department of Government Relations and the APA AMA Delegation. A report to the Joint Reference Committee is requested by the deadline for the June 2017 meeting.	Kristin Kroeger Amanda Grimm Ariel Gonzalez, JD Kristin Kroeger Becky Yowell	Council on Healthcare Systems and Financing (LEAD) Department of Government Affairs APA AMA Delegation Report to the JRC – June 2017 (Deadline June 5, 2017)
6.2	<u>Return of Interest for ABPN Continuous Pathways Payments</u> (ASMNOV1612.B) (Please see attachment 2) The action paper asks that as part of the APA's efforts to have ABPN change its requirements for MOC, APA additionally demand credit for the interest on the monies deposited towards the ten-year examination fee be returned to the psychiatrist either directly or in the form of an appropriate discount on the examination fee. **Will the Joint Reference Committee refer the action paper Return of Interest for ABPN Continuous Pathways Payments to the appropriate Component(s) for input or follow-up?**	The Joint Reference Committee referred the action paper to the APA Leadership via the CEO/Medical Director for integration into the annual discussions between the APA and the ABPN.	Saul Levin, MD, MPA	CEO/Medical Director's Office

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
6.3	Continuity of Care (ASMNOV1612.C) (Please see attachment 3) 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. **Will the Joint Reference Committee refer the action paper Continuity of Care to the appropriate Component(s) for input or follow-up?**	The Joint Reference Committee referred the action paper to the Council on Healthcare Systems and Financing (LEAD) and then to the Council on Quality Care (Secondary). A report to the Joint Reference Committee is requested by the deadline for the June 2017 meeting.	Kristin Kroeger Amanda Grimm Samantha Shugarman	Council on Healthcare Systems and Financing (LEAD) Council on Quality Care (Secondary) Report to the JRC – June 2017 (Deadline June 5, 2017)
6.4	Towards Universal Health Insurance in the United States (ASMNOV1612.D) (Please see attachment 4) Action paper asks: 1. That the APA collaborate with the AMA on its newly adopted resolution to assess various models of healthcare finances including single payer models and universal healthcare and to include data from other developed countries which employ these models; 2. That to facilitate this action, the issue will be referred to the Council on Health Care Systems and Financing and the AMA Delegation of the APA; 3. That a status report will be delivered by the Council on Health Care Systems and Financing and the AMA Delegation of the APA at the May 2017 meeting of the APA Assembly. **Will the Joint Reference Committee refer the action paper Towards Universal Health Insurance in the United States to the appropriate Component(s) for input or follow-up?**	The Joint Reference Committee referred the action paper to the Council on Healthcare Systems and Financing (LEAD) and to the APA AMA Delegation (Secondary). The Assembly requested a report back at the November 2017 meeting. It was noted by APA Administration that the APA AMA Delegation and the AMA are aware of this issue.	Kristin Kroeger Amanda Grimm Kristin Kroeger Becky Yowell	Council on Healthcare Systems and Financing (LEAD) APA AMA Delegation Report to the Assembly – November 2017 (Deadline September 18, 2017)

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
6.5	Improving the Confidentiality of Prescription Drug Monitoring Programs (ASMNOV1612.G) (Please see attachment 5) The action paper asks that the American Psychiatric Association study the variations in the PDMPs to ensure that they are consistent with current federal regulations, and to make recommendations to improve the PDMP system with special attention to ensure the appropriate confidentiality of patient records. **Will the Joint Reference Committee refer the action paper Improving the Confidentiality of Prescription Drug Monitoring Programs to the appropriate Component(s) for input or follow-up?**	The Joint Reference Committee referred the action paper to the Council on Healthcare Systems and Financing (LEAD), Council on Addiction Psychiatry, Council on Psychiatry and Law and the Committee on Mental Health Information Technology. It was noted in the action paper comments that the Department of Government Relations proposed working a baseline study of all 50 states and the District of Columbia to identify the variations among states regarding confidentiality of patient records The Council on Addiction Psychiatry has clarified that the current regulation interpretation is that information from an Opioid Treatment Program (OTP) cannot be included in the PDMPs. The JRC would like to see an articulation of this issue that includes the pros and cons of including information from an OTP be entered into PDMP. Ultimately a position statement on this would be helpful. (Please also see item 8.A.1 on page 17 of this report) A report to the Joint Reference Committee is requested by the deadline for the June 2017 meeting.	Kristin Kroeger Amanda Grimm Bea Eld Alison Crane Nathan Tatro	Council on Healthcare Systems and Financing (LEAD) Council on Addiction Psychiatry Council on Psychiatry and Law Committee on Mental Health Information Technology Report to the JRC – June 2017 (Deadline June 5, 2017)

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
6.6	<u>APA Position Statement on Screening and Treatment for Mental Health Disorders During Pregnancy and Postpartum</u> (ASMNOV1612.I0) (Please see attachment 6) The action paper asks: That the APA develop and announce a position statement recommending: 1) The need for screening and subsequent treatment for mood and anxiety disorders during pregnancy and the postpartum period. 2) The need to address the higher rates of these disorders in low-income women from minority groups. **Will the Joint Reference Committee refer the action paper APA Position Statement on Screening and Treatment for Mental Health Disorders During Pregnancy and Postpartum to the appropriate Component(s) for input or follow-up?**	The Joint Reference Committee referred the action paper the Council on Research (LEAD), the Council on Minority Mental Health and Health Disparities, the Council on Quality Care, and the Assembly Committee on Women. The JRC recommends that the Council on Research develop a position statement to address this. The JRC refers the 2009 APA Resource Document to the Council. *The management of depression during pregnancy: a report from the American Psychiatric Association and the American College of Obstetricians and Gynecologists* Published in final edited form as: Obstet Gynecol. 2009 September; 114(3): 703–713. doi:10.1097/AOG.0b013e3181ba0632 A report to the Joint Reference Committee is requested by the deadline for the June 2017 meeting.	Philip Wang, MD, DrPh Jennifer Shupinka Ranna Parekh, MD, MPH Omar Davis Kristin Kroeger Samantha Shugarman Ranna Parekh, MD, MPH Chair/ASM Cmte on Women	Council on Research (LEAD) Council on Minority Mental Health and Health Disparities Council on Quality Care Assembly Committee of Women Report to the JRC – June 2017 (Deadline June 5, 2017)

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
6.7	Exhibitor-Funded Scholarships for Consumer Presenters at Annual Meetings (ASMNOV1612.J) (Please see attachment 7) The action paper asks: • That a relevant component of the APA or APA Foundation develop a program, at no cost to the APA, to fund a voluntary exhibitor-funded scholarship program intended to defray some or all of the travel, hotel, and registration expenses of consumer presenters who speak at one of the two APA annual meetings; • That exhibitors who voluntarily donate to the scholarship program be recognized in program materials; may not place any conditions on such donations; may not influence the choice of consumer presenter in any manner; and that all such donated funds be pooled such that no speaker would be associated with any specific contributor; • That consumer presenters must adhere to the requirements specified of all presenters; and • That necessary additional expenses incurred by the program be kept to a minimum and be paid out of the pool of donated funds. **Will the Joint Reference Committee refer the action paper Exhibitor-Funded Scholarships for Consumer Presenters at Annual Meetings to the appropriate Component(s) for input or follow-up?**	The Joint Reference Committee was very favorable to the idea of a designated fund that would support attendees of limited means to be able to participate in APA's Annual meetings. The Joint Reference Committee referred the action paper to the American Psychiatric Foundation and the APA Administration via the CEO/Medical Director's Office.	Daniel Gillison Saul Levin, MD, MPA	American Psychiatric Foundation CEO/Medical Director's Office APA Administration

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
6.8	Standards for the Practice of Medicine Pertaining to the Treatment of Patients with Mental Disorders (ASMNOV1612.L) (Please see attachment 8) The action paper asks that: 1. The APA will publicly reaffirm its position that the medical treatment of psychiatric illnesses, including the prescription of psychotropic medication, requires a biologically based medical education and supervised clinical training; 2. Individuals practicing medicine, including those who prescribe medication, should be licensed and regulated by governmental boards with expertise and experience in the practice of medicine. **Will the Joint Reference Committee refer the action paper Standards for the Practice of Medicine Pertaining to the Treatment of Patients with Mental Disorders to the appropriate Component(s) for input or follow-up?**	The Joint Reference Committee referred the action paper to the Board of Trustees to determine if a position statement on the treatment of patients with mental disorders should be developed at this time. The Joint Reference Committee discussed how this action paper relates to psychologist prescribing issues and the APA's stance on the issue. Currently the APA does not have an official position statement on psychologist prescribing. See also item 8.B.1 on page 18 of this report.	Shaun Snyder, JD, MBA Margaret Dewar Ardell Lockerman	**Board of Trustees – March 2017** (Deadline February 15, 2017)

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
6.9	Smart Guns as a Gun Safety Response to Gun Violence, a Public Health Hazard (ASMNOV1612.M) (Please see attachment 9) The action paper asks: • That the American Psychiatric Association (APA) support smart gun technology as one piece of a solution to gun violence, and, be it further • Resolved, that the APA delegation to the American Medical Association (AMA) take this issue to the AMA, and, be it further • Resolved, that the Council on Advocacy and Government Relations and the Council on Psychiatry and the Law review the issues involved and, if so identified, make any additional recommendations to the APA Board of Trustees. **Will the Joint Reference Committee refer the action paper Smart Guns as a Gun Safety Response to Gun Violence, a Public Health Hazard to the appropriate Component(s) for input or follow-up?**	The Joint Reference Committee referred this action paper to the Council on Advocacy and Government Relations and APA AMA Delegation. A report to the Joint Reference Committee is requested by the deadline for the June 2017 meeting.	Ariel Gonzalez, JD Deana McRae Kristin Kroeger Becky Yowell	Council on Advocacy and Government Relations APA AMA Delegation Report to the JRC – June 2017 (Deadline June 5, 2017)

6.10	<u>Protecting the Seriously Mentally Ill Incarcerated Individuals</u> (ASMNOV1612.N) (Please see attachment 10) The action paper asks: 1. That the American Psychiatric Association advocate for an increased number of psychiatrists to provide needed care and treatment for incarcerated individuals, moving towards compliance with the American Psychiatric Association's guideline of 1 FTE psychiatrist for every 150-200 patients with a severe mental illness in prison settings and 1 FTE psychiatrist for every 75-100 patients with a severe mental illness in jail settings. 2. That our AMA delegation advocate at the AMA House of Delegates for an increased number of Primary Care Physicians and Psychiatrists to provide needed care and treatment for detained individuals in correctional facilities. 3. That the APA strongly oppose policies that permit psychologists or pharmacists to prescribe medications in correctional settings. 4. That the APA advocate for psychiatrists to be leaders of multidisciplinary mental health treatment teams in correctional institutions, such as mental health integrated and collaborative care. 5. That the APA collaborate with AADPRT and Public and Community Psychiatry, and Forensic Psychiatry Fellowship Programs to advocate for increased exposure, training and experience in correctional psychiatry in order to increase the number of psychiatrists working in correctional settings. **Will the Joint Reference Committee refer the action paper Protecting the Seriously Mentally Ill Incarcerated Individuals to the appropriate Component(s) for input or follow-up?**	The Joint Reference Committee referred the action paper to the CEO/Medical Director's office. A report to the Joint Reference Committee is requested by the deadline for the June 2017 meeting.	Saul Levin, MD, MPA	CEO/Medical Director's Office Report to the JRC – June 2017 (Deadline June 5, 2017)

6.11	Ending Childhood Poverty (ASMNOV1612.O) (Please see attachment 11) The action paper asks: • That the American Psychiatric Association join with other organizations in acknowledging the detrimental effects of childhood poverty on cognitive and emotional development, self-esteem, academic and vocational achievement, and overall mental and physical health in both childhood and through adulthood; and • That the American Psychiatric Association, in its educational, advocacy, and legislative efforts, make it a priority to partner on an ad hoc basis with other allies and organizations (such as the American Academy of Pediatrics, Children's Defense Fund, First Focus, National Immigration Law Center, Community Action Partnership) to advance relevant issues and/or legislation designed to reduce and eliminate childhood poverty in America; and • That the American Psychiatric Association encourage and support its Areas and District Branches to partner with their local community groups, organizations, and legislators to raise awareness of the impact of childhood poverty on early childhood and brain development and lifetime well-being, including economic stability and mental health; and • That the Board of Trustees establish an ad hoc Workgroup on Ending Childhood Poverty to coordinate such efforts, with particular emphasis on reducing the lifetime consequences on mental health due to early childhood poverty. **Will the Joint Reference Committee refer the action paper Ending Childhood Poverty to the appropriate Component(s) for input or follow-up?**	The Joint Reference Committee referred the action paper to the Council on Children, Adolescents, and Their Families (LEAD), the Council on Minority Mental Health and Health Disparities, and Council on Advocacy and Government Relations. A report to the Joint Reference Committee is requested by the deadline for the June 2017 meeting.	Ranna Parekh, MD, MPH Tatiana Claridad Omar Davis Ariel Gonzalez, JD Deana McRae	Council on Children, Adolescents, and Their Families (LEAD) Council on Minority Mental Health and Health Disparities Council on Advocacy and Government Relations Report to the JRC – June 2017 (Deadline June 5, 2017)

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
6.12	Mental Health Parity for Individuals with Intellectual and Developmental Disability (IDD) (ASMNOV1612.P) (Please see attachment 12) 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. **Will the Joint Reference Committee refer the action paper Mental Health Parity for Individuals with Intellectual and Developmental Disability (IDD) to the appropriate Component(s) for input or follow-up?**	The Joint Reference Committee referred the action paper to the Council on Healthcare Systems and Financing (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.	Kristin Kroeger Amanda Grimm Ranna Parekh, MD, MPH Tatiana Claridad Ariel Gonzalez, JD Deana McRae	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)

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
6.13	Task Force on Fighting Discrimination (ASMNOV1612.R) (Please see attachment 13) Action paper 2016A2 12.R asks: 1) That the Board of Trustees quickly appoint a Task Force on Fighting Discriminatory laws and policies, due to their deleterious effects on mental health, with the following charges: A) Develop a strategic plan to fight discrimination by state and federal legislative and other policy making bodies. B) Help the APA and state associations to quickly respond to discrimination issues. C) Help the state associations to share their knowledge base and collaborate with each other. D) Advise the Board of Trustees about funding for the above. E) Collaborate with the Council on Advocacy and Government Relations and the Division of Government Relations. 2) That the Board of Trustees consider converting this Task Force to a permanent committee in the future, under the Council on Advocacy and Government Relations. **Will the Joint Reference Committee refer the action paper Task Force on Fighting Discrimination to the appropriate Component(s) for input or follow-up?**	The Joint Reference Committee referred the action paper to Dr. Levin for referral to the appropriate APA Administration to develop a one page fact sheet that elucidates the process and response mechanism for these types of issues. In its discussion, the Joint Reference Committee thought that it would be efficient for the Board of Trustees/APA Administration to empanel a quick response group to craft language that could be messaged by the Division of Communications. A report to the Joint Reference Committee is requested by the deadline for the June 2017 meeting.	Saul Levin, MD, MPA Tanya Bradsher	CEO/Medical Director's Office APA Administration FYI – Division of Communications & Public Affairs Report to the JRC – June 2017 (Deadline June 5, 2017)

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
6.14	DB Involvement of Residents and Early Career Psychiatrists Involved with Psychiatry at the National Level (ASMNOV1612.V) (Please see attachment 14) The action paper asks: That the APA: • Revise the APA fellowship application process to incorporate formal introduction by the APA of all applicants to their relevant District Branch leadership for the purpose of engagement, but not awardee or candidate selection. • Explore additional ways to encourage residents and early career psychiatrists who get involved with psychiatry at the national level through the Assembly and APA fellowships and other programs to regularly connect with their local district branches at the same time. **Will the Joint Reference Committee refer the action paper DB Involvement of Residents and Early Career Psychiatrists Involved with Psychiatry at the National Level to the appropriate Component(s) for input or follow-up?**	The Joint Reference Committee referred the action paper to the Membership Committee and requested that they review the paper's request and develop a process to notify the District Branches of individuals in the DB who have engaged in the APA via fellowships. It was noted that the District Branch Executives, in addition to the District Branch Presidents, are important points of contact for engaging individuals at the DB level. A report to the Joint Reference Committee is requested by the deadline for the June 2017 meeting.	Jon Fanning, MS, CAE Stephanie Auditore	Membership Committee Report to the JRC – June 2017 (Deadline June 5, 2017)

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
6.15 Revised 3/1	Retire Position Statement: Confidentiality of Medical Records: Does the Physician Have a Right to Privacy Concerning His or Her Own Health Records? (1981) (JRCJUNE168.J.1; ASMNOV164.B.8) (Please see attachment 15) The Assembly did not approve the retirement of the Position Statement: Confidentiality of Medical Records: Does the Physician Have a Right to Privacy Concerning His or Her Own Health Records? (1981) as the Assembly felt that a new position statement on this issue was required before retiring the statement. **Will the Joint Reference Committee refer the Position Statement: Confidentiality of Medical Records: Does the Physician Have a Right to Privacy Concerning His or Her Own Health Records? (1981) to the appropriate Component(s) for input or follow-up?**	The JRC referred the action paper to the Council on Medical Education and Lifelong Learning (LEAD), Council on Psychiatry and Law and the Ethics Committee to draft a new position statement on this topic. A report to the Joint Reference Committee is requested by the deadline for the June 2017 meeting.	Tristan Gorrindo, MD Kirsten Moeller Alison Crane Colleen Coyle	Council on Medical Education and Lifelong Learning (LEAD) Council on Psychiatry and Law Ethics Committee Report to the JRC – June 2017 (Deadline June 5, 2017)
7	**Council Assessments**			
7.A	Council on Minority Mental Health and Health Disparities	The Joint Reference Committee thanked the Council for their work on behalf of the APA. The council is asked to prioritize its work for the year and provide dates by which the tasks will be completed.	Ranna Parekh, MD, MPH Omar Davis	Council on Minority Mental Health and Health Disparities Update to the JRC – on or before June 2017 (Deadline June 5, 2017)
7.B	Council on Children, Adolescents, and Their Families	The Joint Reference Committee thanked the Council for their work on behalf of the APA. The council is asked to prioritize its work for the year and provide dates by which the tasks will be completed.	Ranna Parekh, MD, MPH Tatiana Claridad	Council on Children, Adolescents, and Their Families Update to the JRC – on or before June 2017 (Deadline June 5, 2017)

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
7.C	Council on Medical Education and Lifelong Learning	The Joint Reference Committee thanked the Council for their work on behalf of the APA. The council is asked to prioritize its work for the year and provide dates by which the tasks will be completed	Tristan Gorrindo, MD Kristen Moeller	Council on Medical Education and Lifelong Learning Update to the JRC – on or before June 2017 (Deadline June 5, 2017)
8.A	**Council on Addiction Psychiatry** Please see item 8.A for the Council's report, summary of current activities and information items.	The Joint Reference Committee thanked the Council for its update and continued work on behalf of the Association, the field, and our patients.		

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
8.A.1	No action required <u>Referral Update: Improving the Efficacy of Prescription Drug Monitoring Programs</u> (JRCJUNE166.12; ASMMAY1612.P) The Council again reviewed the action paper, which advocates that that Opioid Treatment Programs (OTPs) report dispensed or prescribed methadone and buprenorphine to PDMPs. At the request of the JRC, Council reviewed the paper again and reconsidered the recommendations previously submitted. After full consideration, the Council reaffirms its original recommendations on this matter. The Substance Abuse and Mental Health Services Administration issued guidance to OTPs in 2011 indicating that the confidentiality requirements of 42CFR Part 2 limit OTPs to accessing PDMP information; they are not permitted to report information to it. Similar guidance was provided to OTPs by the American Association for the Treatment of Opioid Dependence (AATOD). The Council has had additional discussions with APA's Division of Government Relations as well as the AATOD President. The Joint Commission standards for opioid treatment programs were also reviewed. It believes that current accreditation standards for OTPs appropriately call for patients to receive education and training on potential drug interactions. It also believes that no further modifications to 42CFR be sought. Note: Revised regulations on 42CFR Part 2 were released by SAMHSA the week of January 16. Though there has been insufficient time to complete an in-depth review of them, it does not appear that there is any change that would permit OTPs to report to prescription drug monitoring programs.	The Joint Reference Committee referred this item back to the Council on Addiction Psychiatry and requested that they develop a one page document detailing the pros and cons of the asks of the action paper and to draft proposed position statement on the issue. Doing so would provide the JRC, and other APA entities, with the information necessary to adequately deliberate on the topic. The Joint Reference Committee would like to stimulate a broader discussion on this topic, on the pros and cons, the emerging field, and where the APA may currently stand or want to position itself, regardless of the current regulations and laws. A report to the Joint Reference Committee is requested by the deadline for the June 2017 meeting.	Kristin Kroeger Bea Eld	Council on Addiction Psychiatry Report to the JRC – June 2017 (Deadline June 5, 2017)

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
8.B	**Council on Advocacy and Government Relations** Please see item 8.B for the Council's report, a summary of current activities and informational items.	The Joint Reference Committee thanked the Council for its update and continued work on behalf of the Association, the field, and our patients.		n/a
8.B.1	No action required <u>Referral Update: Position Statement: Hospital Privileges for Psychologists</u> The Council on Advocacy and Government Relations reviewed the Position Statement on Hospital Privileges for Psychologists as directed by the JRC. In September, the Council agreed the intent of the position statement is still applicable to the organization's policy. Members are in the process of amending the statement's language to encompass current issues surrounding prescribing privileges of non-physician practitioners and when ready, will forward the revised statement to the Joint Reference Committee.	The Joint Reference Committee thanked the Council for its update on the referral of the action to revise the position statement on hospital privileges for psychiatrists.		n/a
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.	The Joint Reference Committee thanked the Council for its update and continued work on behalf of the Association, the field, and our patients.		n/a
8.C.1	<u>Proposed Position Statement: Risk of Adolescents' Online Behavior</u> (please see attachment 5) **Will the Joint Reference Committee recommend that the Assembly approve the proposed Position Statement: Risk of Adolescents' Online Behavior 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: *Risk of Adolescents' Online Behavior* and if approved, forward it to the Board of Trustees for consideration.	Shaun Snyder, JD, MBA Margaret Dewar Allison Moraske	Assembly – May 2017 (Deadline March 30, 2017)

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
8.D	**Council on Communications** Please see item 8.D for the Council's report, a summary of current activities, and information items.	The Joint Reference Committee thanked the Council for its update and continued work on behalf of the Association, the field, and our patients.		
8.E	**Council on Geriatric Psychiatry** Please see item 8.E for the Council's report, summary of current activities and information items.	The Joint Reference Committee thanked the Council for its update and continued work on behalf of the Association, the field, and our patients.		
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.	The Joint Reference Committee thanked the Council for its update and continued work on behalf of the Association, the field, and our patients.		
8.F.1	Proposed Position Statement: Out of Pocket Costs a Significant Barrier to Care for Patients with Serious and Recurrent Disabling Mental Disorders (JRCJUNE166.10; ASMMAY1612.J) (Please see item 8.F, page 7) **Will the Joint Reference Committee recommend that the Assembly approve the Proposed Position Statement: Out of Pocket Costs a Significant Barrier to Care for Patients with Serious and Recurrent Disabling Mental Disorders and if approved, forward it to the Board of Trustees for consideration?**	The Joint Reference Committee did not approve the position statement and referred it back to the Council on Healthcare Systems and Financing. The JRC requested that the position be rewritten to be clear and concise and state what the APA stands for rather than what the APA will do. A report to the Joint Reference Committee is requested by the deadline for the June 2017 meeting.	Kristin Kroeger Amanda Grimm	Council on Healthcare Systems and Financing Report to the JRC – June 2017 (Deadline June 5, 2017)

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
8.F.2	Request for Component: Committee on Integrated Care (Please see item 8.F, page 8-9) **Will the Joint Reference Committee recommend that the Board of Trustees establish a Committee on Integrated Care under the Council on Healthcare Systems and Financing with a standard composition at an annual yearly cost of $520?** Please note that a charge for the proposed Committee is included within the Council's report.	The Joint Reference Committee recommended that the Board of Trustees establish a Committee on Integrated Care under the Council on Healthcare Systems and Financing at an estimated annual yearly cost of $520. It is anticipated that the committee member's tenures would begin immediately after the May 2017 Annual Meeting.	Shaun Snyder, JD, MBA Margaret Dewar Ardell Lockerman	**Board of Trustees – March 2017** (Deadline February 15, 2017)
8.F.3	Revised Charge: Committee on Reimbursement for Psychiatric Care (Please see item 8.F, page 10) **Will the Joint Reference Committee recommend that the Board of Trustees approve the revised charge to the Committee on Reimbursement for Psychiatric Care?**	The Joint Reference Committee recommended that the Board of Trustees approve the revised charge to the Committee on Reimbursement for Psychiatric Care.	Shaun Snyder, JD, MBA Margaret Dewar Ardell Lockerman	**Board of Trustees – March 2017** (Deadline February 15, 2017)
8.F.4 Revised 3/1	Proposed Position Statement: Patient Bill of Rights: What to Expect When Seeking Behavioral Health Treatment (Please see item 8.F, page 11) **Will the Joint Reference Committee recommend that the Assembly approve the proposed Position Statement: Patient Bill of Rights: What to Expect When Seeking Behavioral Health Treatment and if approved, forward it to the Board of Trustees for consideration?** N.B., if the proposed position statement is approved, the 2007 PS: Endorsement of Principles for the Provision of Mental Health and Substance Abuse Treatment Services: A Bill of Rights.	The Joint Reference Committee referred the action to the Council on Healthcare Systems and Financing to work together with the participating organizations and advocacy organizations of the original statement to reach consensus on the newly drafted statement. The Joint Reference Committee agreed that the original document needs to be updated and advocated that a revised statement would be strengthened were it to come from a consensus of mental health organizations, led by the APA. A report to the Joint Reference Committee is requested by the deadline for the June 2017 meeting.	Kristin Kroeger Amanda Grimm Saul Levin, MD, MPA	Council on Healthcare Systems and Financing CEO/Medical Director's Office APA Administration Report to the JRC – June 2017 (Deadline June 5, 2017)

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
8.G	**Council on International Psychiatry** Please see item 8.G for the Council's report, summary of current activities and information items.	The Joint Reference Committee thanked the Council for its update and continued work on behalf of the Association, the field, and our patients.		
8.G.1	Rename the Human Rights Award **Will the Joint Reference Committee recommend that the Board of Trustees approve renaming the Human Rights Award the Chester M. Pierce Human Rights Award?**	The Joint Reference Committee recommended that the Board of Trustees approve renaming the Human Rights Award the Chester M Pierce Human Rights Award.	Shaun Snyder, JD, MBA Margaret Dewar Ardell Lockerman	**Board of Trustees – March 2017** (Deadline February 15, 2017)
8.G.2	Request for Component: Chester M. Pierce Human Rights Award Committee **Will the Joint Reference Committee recommend that the Board of Trustees approve the creation of the Chester M. Pierce Human Rights Award Committee under the Council on International Psychiatry with the composition as defined in item 8.G, attachment #3 and the President-elect will appoint the chairperson of the Committee at an estimated annual cost of $520?** (please see attachment 3)	The Joint Reference Committee recommended that the Board of Trustees approve that a nominating Committee be established to manage the "Chester M. Pierce Human Rights Award" with the following representation: 1. Council on International Psychiatry, Member 2. Council on International Psychiatry, Fellow/ECP 3. Council on Minority Mental Health and Health Disparities, Member 4. Council on Minority Mental Health and Health Disparities, Fellow/ECP 5. Assembly Black Psychiatrists Caucus, Member 6. Assembly Black Psychiatrists Caucus, Fellow/ECP Consultant: 7. Black Psychiatrists of America, President/Member (has to be an APA member) The President-elect will select the Committee Members from the APA bodies specified above and designate one member as the chair.	Shaun Snyder, JD, MBA Margaret Dewar Ardell Lockerman Ranna Parekh, MD, MPH	**Board of Trustees – March 2017** (Deadline February 15, 2017) FYI – Division of Diversity and Health Equity

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
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 Joint Reference Committee thanked the Council for its update and continued work on behalf of the Association, the field, and our patients.		
8.H.1	No action required <u>Referral Update: Performance in Practice Certification by American Psychiatric Association</u> (JRCJUNE166.1; ASMMAY1612.A) Since the Council provided information to the JRC on this item in October 2016, CMS has published a final rule and formally listed 92 Clinical Practice Improvement Activities (CPIA) as options for the MACRA/Merit Based Incentive Payment System (MIPS) program, many of which clinicians may already be doing in their practice. Of the listed activities, APA will provide or will provide several qualifying activities: Learning Collaborative participation as part of the CMS Transforming Clinical Practice Initiative; Participation in a Qualified Clinical Data Registry; Completion of training and receipt of approved waiver for provision opioid medication-assisted treatments; and qualifying MOC part IV activities for those participating in Maintenance of Certification.	The Joint Reference Committee thanked the Council for the update on the action paper.		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.	The Joint Reference Committee thanked the Council for its update and continued work on behalf of the Association, the field, and our patients.		

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
8.I.1	Proposed Position Statement: Role of Psychiatrists in Addressing Care for People Affected by Forced Displacement (JRCJUNE166.4; ASMMAY1612.D) please see attachment 1) **Will the Joint Reference Committee recommend that the Assembly approve the proposed Position Statement: Role of Psychiatrists in Addressing Care for People Affected by Forced Displacement, 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: *Role of Psychiatrists in Addressing Care for People Affected by Forced Displacement*, and if approved, forward it to the Board of Trustees for consideration.	Shaun Snyder, JD, MBA Margaret Dewar Allison Moraske	Assembly – May 2017 (Deadline March 30, 2017)
8.I.2	Referral Update: Joint Statement on Conversion Therapy (JRCJUNE166.21; ASMMAY1612.Z) The JRC referred action paper U.S. Joint Statement on Conversion Therapy to the Council for discussion and feedback. The Council discussed the statement and requested member send their additional responses via email. The Council supported the action paper with the only suggestion to consider saying this statement applies across the lifespan.	The Joint Reference Committee thanked the Council for their feedback that the statement should apply across the lifespan. The final joint statement will be reviewed by the JRC and once approved by the Joint Reference Committee; the statement will be referred to Dr. Levin, APA CEO/Medical Director, for potential implementation of the APA signing onto the statement. A report to the Joint Reference Committee is requested by the deadline for the June 2017 meeting.	Saul Levin, MD, MPA Ranna Parekh, MD, MPH Omar Davis	CEO/Medical Director's Office APA Administration Council on Minority Mental Health and Health Disparities Report to the JRC – June 2017 (Deadline June 5, 2017)
8.J	**Council on Psychiatry and Law** Please see item 8.J for the Council's report, summary of current activities and information items.	The Joint Reference Committee thanked the Council for its update and continued work on behalf of the Association, the field, and our patients.		
8.K	**Council on Psychosomatic Medicine** Please see item 8.L for the Council's report, summary of current activities and information items.	The Joint Reference Committee thanked the Council for its update and continued work on behalf of the Association, the field, and our patients.		

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
8.L	**Council on Quality Care** Please see item 8.L for the Council's report, summary of current activities and information items.	The Joint Reference Committee thanked the Council for its update and continued work on behalf of the Association, the field, and our patients.		
8.L.1	APA Platform and Strategy on Performance Measurement (please see item 8.L, page 4) **Will the Joint Reference Committee recommend that the Board of Trustees approve the American Psychiatric Association's Platform and Strategy on Performance Measurement?**	The Joint Reference Committee recommended that the Board of Trustees approve the American Psychiatric Association's Platform and Strategy on Performance Measurement.	Shaun Snyder, JD, MBA Margaret Dewar Ardell Lockerman	**Board of Trustees – March 2017** (Deadline February 15, 2017)
8.L.2	No action required Referral Update: Position Statement: Mental Health Hotlines (JRCJUNE166.3; ASMMAY1612.C) The Council has concluded that there is minimal information on such uniform standards. However, the Council members agree that some form of guidelines do already exist by at least two reputable entities and the Council supports the endorsement of these guidelines.	The Joint Reference Committee thanked the council for the update on this referral. Questions that arose during the discussion was whether there were standards or guidelines for mental health apps and could the council consider this also, given that the focus was on telephone hotlines. Additionally, it was thought that having standards for the creation of hotlines and the training of hotline staff would be beneficial.	Kristin Kroeger Samantha Shugarman	Council on Quality Care Report to the JRC – June 2017 (Deadline June 5, 2017)

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
8.L.3	No action required <u>Referral Update: Pharmacists Substituting Medications with Similar Mechanisms of Action</u> (JRCJUNE166.9; ASMMAY1612.I) In October 2016, the Council was asked to redraft a position statement on pharmacists substituting medications with "similar mechanisms of action" and include in the statement generic and biosimilar medications. During the Council's December 2016 conference call, members agreed they will not include a "generics and biosimilar statement" in their updated position statement as it is "not considered of value within the current statement." The JRC asked that the Council determine why the AMA utilized the term "moiety" in their policy statement "Therapeutic and Pharmaceutical Alternatives by Pharmacists". It was determined that "moiety," defined as "the molecule or ion which is responsible for the physiological or pharmacological action of the drug or chemical substance" is the most accurate term to describe the action expressed in the action paper.	The Joint Reference Committee recommended that the Assembly approve the proposed Position Statement: *Pharmacists Substituting Medications with Similar Mechanisms of Action* and if approved, forward it to the Board of Trustees for consideration.	Shaun Snyder, JD, MBA Margaret Dewar Allison Moraske	Assembly – May 2017 (Deadline March 30, 2017)
8.M	**Council on Research** Please see item 8.M for the Council's report, summary of current activities and information items.	The Joint Reference Committee thanked the Council for its update and continued work on behalf of the Association, the field, and our patients.		

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
8.M.1	Revised Position Statement: Use of the Concept of Recovery (Please see item 8.M, page 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?** N.B. if the revised position statemen is approved the 2015 version will be retired.	The Joint Reference Committee recommended 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.	Shaun Snyder, JD, MBA Margaret Dewar Allison Moraske	Assembly – May 2017 (Deadline March 30, 2017)
9	**Other Reports**			
9.1	Revised Position Statement: Abuse and Misuse of Psychiatry In December 2016, the Board of Trustees referred the Assembly action 9.A.5 Position Statement on Abuse and Misuse of Psychiatry back to the Joint Reference Committee for additional revisions. (Please see attachment 9.1) **Will the Joint Reference Committee recommend that the Board of Trustees approve the Revised Position Statement Abuse and Misuse of Psychiatry?**	The Joint Reference Committee recommended that the Board of Trustees approve the revised Position Statement: *Abuse and Misuse of Psychiatry*.	Shaun Snyder, JD, MBA Margaret Dewar Ardell Lockerman	**Board of Trustees – March 2017** (Deadline February 15, 2017)

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
9.2	Proposed Position Statement on Mental Health and Climate Change In December 2016, the Board of Trustees referred the Assembly action 9.A.10 Position Statement: Mental Health and Climate Change back to the Joint Reference Committee for revision and clarification.) **The JRC is asked to review the document and provide more specifics, including the particular role of psychiatry/APA in addressing issues of climate change and make a recommendation to the Board of Trustees.** (Please see attachment 9.2 for the BOT's comments and the draft position statement	The Joint Reference Committee recommended that the Board of Trustees approve the proposed Position Statement: *Mental Health and Climate Change*. The Assembly Executive Committee discussed and approved the proposed position statement at their meeting on February 12, 2017.	Shaun Snyder, JD, MBA Margaret Dewar Ardell Lockerman	**Board of Trustees – March 2017** (Deadline February 15, 2017)
New Business	Addressing the Impact of Environmental Toxins on Neurodevelopment and Behavior (JRCJUNE15XXX; ASMMAY1512.T) The action papers asked that the APA establish a Work Group comprised of researchers and clinicians knowledgeable in the area of the neuro-developmental and behavioral effects of environmental toxins to advise the Division of Education. That the Assembly of the APA requests that the APA Division of Education develop an educational plan aimed at educating the general membership of the APA on the scientific, clinical and regulatory aspects of the neuro-developmental and behavioral effects of environmental toxins.	In June 2015, the Joint Reference Committee referred the action paper to the Council on Children, Adolescents, and Their Families (LEAD) and the Council on Medical Education and Lifelong Learning. The Council on Children, Adolescents and their Families determined that the scope of a document would be limited to lead and alcohol. The Joint Reference Committee referred the action paper to the Assembly to convene a group of Assembly members and other relevant experts, in consultation with APA councils, to prepare a resource document for the Joint Reference Committee's consideration. A report to the Joint Reference Committee is requested by the deadline for the October 2017 meeting.	Shaun Snyder, JD, MBA Margaret Dewar Allison Moraske	Assembly Report to the JRC – October 2017 (Deadline XXXX, 2017)

Next Joint Reference Committee Meeting: **June 17, 2017** Report/Action Deadline: **June 5, 2017**

APA Rapid Response on Social and Community Issues

- The APA Administration has created a Rapid Response Team to respond to issues that could impact APA members.
- The team consists of: Chief of Staff, General Counsel, Chief of Policy, Programs & Partnerships, Chief Operating Officer, Chief of Membership, Chief of Government Relations, and the Chief of Communications. Depending on the topic additional staff leadership will be brought in.
- The Rapid Response Team recommends to Dr. Levin if a response is warranted and if so, recommend the type of response: leadership cascade, targeted member email, mass member email, respond to query statement, or press release. Dr. Levin consults with the APA President about the issues.
- The recommendation will be based upon the Social Issues Task Force/BOT Criteria:
    1. BOT policy adopted which elaborates 4 points that must be met before APA will consider a response, namely Positions should be relevant to access to care or the prevention, diagnosis, or treatment of psychiatric disorders.
    2. The issue being considered should be significant for psychiatrists and their patients.
    3. The APA should have expertise or perspective to offer.
    4. The APA should develop positions on issues where the APA may have a meaningful impact and positively shape public opinion.
- If a draft is needed to address an issue, Communications, with the assistance of Policy and DGR, is responsible for the first draft and the Rapid Response Team will have 2 hours to review and must respond if they have edits or not. If necessary, the Chief of Communications can call huddles throughout the day based on the evolving situation and the Chiefs will make this a priority.
- The CEO & Medical Director will review/edit the draft and the Chief of Communications will coordinate with the leads of the internal Rapid Response Team to finalize based on comments. When internal review is complete, the CEO and Medical Director and Chief of Communications will seek the review of the APA President and obtain whether further review is warranted and by who.
- We will also be reaching out to the relevant component groups for their expertise.
- If it is determined that the Executive Committee does not need to weigh in, the CEO & Medical Director and APA President will finalize the draft and give to Communications for dissemination.
- If it is determined that another review is needed, that review shall be made by the one Trustee pre-appointed by the president to serve as the BOT reviewer Chief of Communications and General Counsel shall provide the proposed statement to the reviewer and turn around a final statement within 12 hours if possible. The Chief of Communications will send the final statement to the APA President for final approval.
- Once approved, the Chief of Communications will finalize the draft for dissemination.

Communications Strategy for the future

- The American Psychiatric Association should continue to look for opportunities to join other healthcare associations when weighing in on national healthcare issues that are related to mental health. The coalition response will carry more weight in the press.
- This gives us an opportunity to write letters and then convey that action to the membership instead of a more public effort directed at President Trump.
- The coalition will be essential as we navigate the future of the Affordable Care Act.
- The American Psychiatric Association will continue to be asked to weigh in on social issues that may or may not impact mental health. Recommend that we continue to be strategic in our approach and

carefully consider if and when to weigh in, even when such a statement would technically meet the requirements the BOT set for issuing such a statement since our membership is sensitive to weighing into what are perceived as political interest issues and can result in lost members and revenue.

- Also, we should focus on representing members on issues that impact the profession and remaining at the table on those issues. We can't fulfill our mission if we aren't at the table and there are various special interests whose mission is to weigh in on social issues.
- In the times, we are being pushed for a stance, we should look to sign onto letters with the AMA and other medical specialties that are being sent to an agency.

Action	Comments/Recommendations	Administration Responsible	Referral/Follow-up
6.2 Return of Interest for ABPN Continuous Pathways Payments (ASMNOV1612.B) The action paper asks that as part of the APA's efforts to have ABPN change its requirements for MOC, APA additionally demand credit for the interest on the monies deposited towards the ten-year examination fee be returned to the psychiatrist either directly or in the form of an appropriate discount on the examination fee. **Will the Joint Reference Committee refer the action paper Return of Interest for ABPN Continuous Pathways Payments to the appropriate Component(s) for input or follow-up?**	The Joint Reference Committee referred the action paper to the APA Leadership via the CEO/Medical Director for integration into the annual discussions between the APA and the ABPN.	Saul Levin, MD, MPA Tristan Gorrindo, MD Ariel Gonzalez, JD, MA Kristin Kroeger	Completed. APA Administration sent an official communication to ABPN stating: 1) There should not be an exam every 10 years for MOC; 2) Certification should be an integrated, ongoing process relevant to actual practice; 3) Exam questions should be related to the psychiatrist's subspecialty or practice setting; 4) No psychiatrist should be forced to maintain general and subspecialty certification through more than one process; and 5) ABPN should lobby and advocate that ABMS eliminate Part 4 of MOC.
6.7 Exhibitor-Funded Scholarships for Consumer Presenters at Annual Meetings (ASMNOV1612.J) (Please see attachment 7) The action paper asks: • That a relevant component of the APA or APA Foundation develop a program, at no cost to the APA, to fund a voluntary exhibitor-funded scholarship program intended to defray some or all of the travel, hotel, and registration expenses of	The Joint Reference Committee was very favorable to the idea of a designated fund that would support attendees of limited means to be able to participate in APA's Annual meetings. The Joint Reference Committee referred the action paper to the American Psychiatric Foundation and the APA Administration via the CEO/Medical Director's Office.	Saul Levin, MD, MPA Daniel Gillison Tristan Gorrindo, MD	The APA Annual Meeting and IPS: Mental Health Services Conference are accredited educational activities and therefore subject to standards established by the Accreditation Council for Continuing Medical Education (ACCME). The ACCME prohibits pharmaceutical and device companies from providing support for speakers to participate in

Action	Comments/Recommendations	Administration Responsible	Referral/Follow-up
consumer presenters who speak at one of the two APA annual meetings; • That exhibitors who voluntarily donate to the scholarship program be recognized in program materials; may not place any conditions on such donations; may not influence the choice of consumer presenter in any manner; and that all such donated funds be pooled such that no speaker would be associated with any specific contributor; • That consumer presenters must adhere to the requirements specified of all presenters; and • That necessary additional expenses incurred by the program be kept to a minimum and be paid out of the pool of donated funds. **Will the Joint Reference Committee refer the action paper Exhibitor-Funded Scholarships for Consumer Presenters at Annual Meetings to the appropriate Component(s) for input or follow-up?**			accredited educational activities outside of formal per activity contracts which outline the financial support provided for each activity (ACCME Standards for Commercial Support 3.4, 3.8, and 3.9). The guidelines for speakers apply to physicians, patients, or any other speaker within the accredited program. ACCME would allow commercial funds to be used to support speakers at the Annual Meeting if there were signed individual agreements between the pharmaceutical companies and the APA as the meeting's accreditor. Contracts could not be signed with APAF since the Foundation is not an accreditor. APA would be required to report the commercial support received by each company to the ACCME. Currently the APA Board of Trustees (BOT) has prohibited the APA from receiving this kind of funding for its live events. Creating a pooled fund within APAF merely creates a pass-through for pharmaceutical and device companies to provide funds to

Action	Comments/Recommendations	Administration Responsible	Referral/Follow-up
			meeting speakers and is therefore prohibited under ACCME rules. Further, ACCME rules require that the agreement for commercial support be with the accreditor (in this case APA, not APAF) which would contradict current APA policy. Although this Action specifically asks that influence by external dollars be minimized through a series of conditions that reduce influence given to the commercial funder, it must still go to the Board for consideration of a revision of existing policy related to accepting commercial funds for speakers -- a necessary first step in reversing the aforementioned policy regarding commercial support.

Action	Comments/Recommendations	Administration Responsible	Referral/Follow-up
6.10 Protecting the Seriously Mentally Ill Incarcerated Individuals (ASMNOV1612.N) (Please see attachment 10) The action paper asks: 1. That the American Psychiatric Association advocate for an increased number of psychiatrists to provide needed care and treatment for incarcerated individuals, moving towards compliance with the American Psychiatric Association's guideline of 1 FTE psychiatrist for every 150-200 patients with a severe mental illness in prison settings and 1 FTE psychiatrist for every 75-100 patients with a severe mental illness in jail settings. 2. That our AMA delegation advocate at the AMA House of Delegates for an increased number of Primary Care Physicians and Psychiatrists to provide needed care and treatment for detained individuals in correctional facilities. 3. That the APA strongly oppose policies that permit psychologists or pharmacists to prescribe medications in correctional settings. 4. That the APA advocate for psychiatrists to be leaders of multidisciplinary mental health treatment teams in correctional	The Joint Reference Committee referred the action paper to the CEO/Medical Director's office. A report to the Joint Reference Committee is requested by the deadline for the June 2017 meeting.	Saul Levin, MD, MPA Ariel Gonzalez, JD, MA Kristin Kroeger	1) APA administration will continue to advocate for increased psychiatric workforce at the federal and state levels. 2) APA Administration has found no AMA policy that focuses on workforce in correctional facilities, and will discuss with the delegation at the AMA Annual meeting the development of a resolution for a new policy or an amendment to current related policy. Pending AMA Delegation discussion at the June 2017 HOD meeting. 3) APA Administration will continue to advocate for the strong opposition of psychologists or pharmacists to prescribe medications in correctional settings. 4) APA Administration, through our CMS grant is also advocating for collaborative care training in diverse settings, like correctional institutions. A training was held last year in a Michigan correctional facility. Training in collaborative care is ongoing. 5) General psychiatry and fellowship trainings are set by the

Action	Comments/Recommendations	Administration Responsible	Referral/Follow-up
institutions, such as mental health integrated and collaborative care. 5. That the APA collaborate with AADPRT and Public and Community Psychiatry, and Forensic Psychiatry Fellowship Programs to advocate for increased exposure, training and experience in correctional psychiatry in order to increase the number of psychiatrists working in correctional settings.			ACGME. Specific recommendations for minimum requirements are submitted by groups such as the APA and AADPRT. The APA regularly communicates recommendations to AADPRT and the ACGME for increased emphasis in training through its liaisons in the APA Administration and in the Council on Medical Education and Lifelong Learning. We will work with subspecialty groups, such as the Association for Community Psychiatrists, on these efforts.
6.13 Task Force on Fighting Discrimination (ASMNOV1612.R) (Please see attachment 13) Action paper 2016A2 12.R asks: 1) That the Board of Trustees quickly appoint a Task Force on Fighting Discriminatory laws and policies, due to their deleterious effects on mental health, with the following charges: A) Develop a strategic plan to fight discrimination by state and federal legislative and other policy making bodies. B) Help the APA and state associations to quickly respond to discrimination issues.	The Joint Reference Committee referred the action paper to Dr. Levin for referral to the appropriate APA Administration to develop a one page fact sheet that elucidates the process and response mechanism for these types of issues. In its discussion, the Joint Reference Committee thought that it would be efficient for the Board of Trustees/APA Administration to empanel a quick response group to craft language that could be messaged by the Division of Communications.	Saul Levin, MD, MPA Ranna Parekh, MD, MPH Ariel Gonzalez, JD, MA Tanya Bradsher	Completed. APA Administration developed a fact sheet that elucidates the process and response mechanism. Please see attachment.

Action	Comments/Recommendations	Administration Responsible	Referral/Follow-up
C) Help the state associations to share their knowledge base and collaborate with each other. D) Advise the Board of Trustees about funding for the above. E) Collaborate with the Council on Advocacy and Government Relations and the Division of Government Relations. 2) That the Board of Trustees consider converting this Task Force to a permanent committee in the future, under the Council on Advocacy and Government Relations. **Will the Joint Reference Committee refer the action paper Task Force on Fighting Discrimination to the appropriate Component(s) for input or follow-up?**			

Action	Comments/Recommendations	Administration Responsible	Referral/Follow-up
8.F.4 Proposed Position Statement: Patient Bill of Rights: What to Expect When Seeking Behavioral Health Treatment (Please see item 8.F, page 11) **Will the Joint Reference Committee recommend that the Assembly approve the proposed Position Statement: Patient Bill of Rights: What to Expect When Seeking Behavioral Health Treatment and if approved, forward it to the Board of Trustees for consideration?** N.B., if the proposed position statement is approved, the 2007 PS: Endorsement of Principles for the Provision of Mental Health and Substance Abuse Treatment Services: A Bill of Rights.	The Joint Reference Committee referred the action to the Council on Healthcare Systems and Financing to work together with the participating organizations and advocacy organizations of the original statement to craft a new joint statement. The Joint Reference Committee agreed that this document needs to be updated and advocated that such a statement would be strengthened were it to come from a consensus of mental health organizations, led by the APA.	Saul Levin, MD, MPA Kristin Kroeger Ariel Gonzalez, JD, MA	HCSF Council recommended sunsetting the bill of rights. CAGR recommended its continuation. JRC has asked the CEO office to reach out to allied groups to see if they are interested in resigning this document. Since the last JRC meeting, APA has been conducting multiple joint advocacy efforts with allied organizations regarding healthcare delivery changes and ensuring the retention of MH/SUD benefits for patients. Due to these developments, APA and many of the allied groups who were originally part of the Bill of Rights" have signed on to different statements and letters together. Due to the ever-changing healthcare legislative environment and that we have had multiple joint sign on letters in the last 5-6 months the APA administration recommends we not move forward endorsement for allied groups at this time.

Action	Comments/Recommendations	Administration Responsible	Referral/Follow-up
8.I.2 Referral Update: Joint Statement on Conversion Therapy (JRCJUNE166.21; ASMMAY1612.Z) The JRC referred action paper U.S. Joint Statement on Conversion Therapy to the Council for discussion and feedback. The Council discussed the statement and requested member send their additional responses via email. The Council supported the action paper with the only suggestion to consider saying this statement applies across the lifespan.	The Joint Reference Committee thanked the Council for their feedback that the statement should apply across the lifespan. The final joint statement will be reviewed by the JRC and once approved by the Joint Reference Committee; the statement will be referred to Dr. Levin, APA CEO/Medical Director, for implementation of the APA signing onto the statement.	Saul Levin, MD, MPA Ranna Parekh, MD, MPH Phil Wang, MD, Dr.PH Colleen Coyle, JD	APA currently has policy opposing conversion therapy in gay and lesbian populations. The Joint Statement on Conversion Therapy relates specifically to conversion therapy aimed at transgender people. APA's research and legal teams are working jointly to compile literature regarding the issue of whether there is any data supporting the idea that conversion therapy on transgender patients is harmful. The Administration plans to take these findings to the Council on Minority Mental Health and Health Disparities, as well as the Council on Research. The Administration aims to present research to the Councils at the September Components Meetings so that they may make a recommendation as to whether APA should sign on to the Joint Statement on Conversion Therapy. The Ethics Committee is also being consulted due to the multiple references in the proposed document that implicate conversion therapy of transgender individuals is unethical.

5. Joint Reference Committee (JRC)

Composition

Voting members:	• President-Elect (Chairperson) • Speaker-Elect (Vice-Chairperson) • Immediate Past President of the Board of Trustees (one-year term) • One (1) additional member of the Board of Trustees (appointed by the President) • Two (2) additional members of the Assembly (customarily the Immediate Past Speaker and the Recorder) • CEO/Medical Director
Ex-Officio members (nonvoting):	• Chairpersons of the Councils by conference call • One APA Leadership Fellow as Observer will attend JRC meetings in person. The Fellow will hold this position in addition to their assignment to a council. Should multiple fellows desire this assignment, their CVs will be sent to the JRC for consideration and the JRC will make the final determination.

Functions

(1) Hold accountable, monitor, and evaluate the functioning of components with reports from the councils to the JRC and from the JRC to the Board of Trustees.

(2) Serve as a clearinghouse of items between the Board and/or Assembly and the councils. At the specific request of the Assembly Executive Committee, the JRC may rarely refer items directly from the Assembly to the Board. All items that are referred to the JRC are tracked to monitor where issues are in the governance process. The word "item" includes action papers, position statements, and resource documents.

(3) Refer items to the appropriate council or component for review and action as determined by the JRC. Items may also be referred to the Assembly, district branches and/or area councils for review and action as determined by the JRC with a report back to the JRC. With each referral or assignment, reports and updates will be required by a time certain. Wherever possible, individuals responsible for the work will be specified.

(4) Mediate and resolve problems arising between councils.

(5) Authorize the disbursement of funds from the JRC Component Fund to councils to support meetings of committees without budgets for in-person meetings, to support new programs, or to supplement ongoing ones. Requests for monies from this fund are prioritized and voted on during meetings of the JRC; if necessary voting may occur via email or conference call.

(6) Receive position statements that have been developed by a council and refer them back to the same council or other councils for further review or revision or make recommendations to the Board and Assembly for review and adoption.

(7) Receive reports by councils that do not involve policy without additional referral to the Board and/or Assembly (as councils have authority to operate within existing Association policy).

(8) Consider the merits of an item referred by a component and/or Assembly and reach a conclusion without further reference to other APA components or the Board or Assembly.

(9) Consolidate the reports of two or more councils or components with a recommendation for action to the same or other councils or the Board and/or Assembly.

(10) Define the roles of the various components when the concerns are overlapping, including deciding which component should be the lead.

(11) Review reports of award nominees from all components that administer the awards funded by the APA (not the APF) and forward these to the Board for approval. The final responsibility for the creation and continuation of awards remains with the Board of Trustees.

STATUS OF POSITION STATEMENTS
As of June 2017

YEAR APPROVED	YEAR TO BE REVIEWED	POSITION STATEMENT Policy Statement	CURRENT STATUS	REVIEWING COUNCIL	APPROVALS	ADDT'L INFO
2012	2017	Substance Use Disorders	ACTIVE	Addiction Psychiatry	BOT Approved July 2012; ASM Approved May 2012	
2012	2017	Use of Opioid Medications With Terminally Ill Patients	ACTIVE	Addiction Psychiatry	BOT Approved Dec 2012; ASM Approved Nov 2012	
2012	2017	Endorsement of US Ratification of the Convention of the Rights of the Child	ACTIVE	Children, Adolescents and Their Families	BOT Approved July 2012; ASM Approved May 2012	
2012	2017	Use of Antipsychotic Medication in Patients with Dementia (Major Neurocognitive Disorder)	ACTIVE [Revision Pending]	Geriatric Psychiatry	ASM Approved Nov2012	
2012	2017	Banning of Pharmacy Benefit Management Policies that Require the Provision of Dangerous Quantities of Medications	ACTIVE	Healthcare Systems and Financing	BOT Approved July 2012; ASM Approved May 2012	
2012	2017	Improving Patient Access to Psychiatric Services through MCO Provider Panels	ACTIVE	Healthcare Systems and Financing	BOT Approved Dec 2012; ASM Approved Nov 2012	
2012	2017	Peer Support Services (name revised by the BOT)	ACTIVE	Healthcare Systems and Financing	BOT Approved Dec 2012; ASM Approved Nov 2012	
2012	2017	Access to Care for Transgender and Gender Variant Individuals	ACTIVE	Minority Mental Health and Health Disparities	BOT Approved July 2012; ASM Approved May 2012	
2012	2017	Discrimination Against Transgender and Gender Variant Individuals	ACTIVE	Minority Mental Health and Health Disparities	BOT Approved July 2012; ASM Approved May 2012	
2012	2017	Segregation of Prisoners with Mental Illness	ACTIVE	Psychiatry and Law	BOT Approved Dec 20102; ASM Approved Nov 2012	
2012	2017	Assessing the Risk for Violence	ACTIVE	Psychiatry and Law	BOT Approved July 2012; ASM Approved May 2012	

STATUS OF POSITION STATEMENTS
As of June 2017

YEAR APPROVED	YEAR TO BE REVIEWED	POSITION STATEMENT Policy Statement	CURRENT STATUS	REVIEWING COUNCIL	APPROVALS	ADDT'L INFO
2012	2017	Firearms Access: Inquiries in Clinical Settings (formerly: Inquiry into Firearm Access in Clinical Settings - BOT revised the titled)	ACTIVE	Psychiatry and Law	BOT Approved Dec 2012; ASM Approved Nov 2012	
2012 (Revised 2004 PS)	2017	HIV Infection & Pregnant Women	ACTIVE	Psychosomatic Medicine	BOT Approved Dec 2012; ASM Approved Nov 2012	
2012 (Revised 2003 PS)	2017	Syringe Exchange Programs (formerly Needle Exchange Programs)	ACTIVE	Psychosomatic Medicine	BOT Approved July 2012; ASM Approved May 2012	
2012 (Retained 2004 PS)	2017	Occupational HIV Exposure: Protocols and Protections	ACTIVE	Psychosomatic Medicine Research and Quality Care	BOT Affirmed & Retained July 2012; ASM Affirmed & Retained May 2012	
2012 (Retained 2008 PS)	2017	Principles for Healthcare Reform for Psychiatry	ACTIVE	Healthcare Systems and Financing; Advocacy and Government Relations	Reaffirmed by the BOT July 2012; BOT Approved Dec 2008; ASM Approved Nov 2008;	
2012 (Retained 2004 PS)	2017	Universal Access to Health Care	ACTIVE	Healthcare Systems and Financing	July 2012 - Reaffirmed by BOT BOT Approved March 2004	
2012 (Retained 2004 PS)	2017	HIV Infected Psychiatrists	ACTIVE	Psychosomatic Medicine	BOT Affirmed & Retained July 2012; ASM Affirmed & Retained May 2012	

EXECUTIVE SUMMARY
Assembly

The Assembly met in San Diego, California, May 19-21, 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 19.

The Assembly brings the following action items:

1. **Involuntary Psychiatric Commitment for Individuals with Substance Use Disorders (ASM Item #2017A1 12.A) [Attachment 1]**

   Action paper 2017A1 12.A asks that the American Psychiatric Association develop a comprehensive position statement on the use of involuntary psychiatric commitment for the treatment of substance use disorders.

   Action: Will the JRC refer the Assembly passed action paper *2017A1 12.A: Involuntary Psychiatric Commitment for Individuals with Substance Use Disorders* to the appropriate Component(s) for input or follow-up?

2. **Opposition to Psychologist Prescribing (ASM Item #2017A1 12.B) [Attachment 2]**

   Action paper 2017A1 12.B asks that the appropriate committee create a Position Statement that reflects that the APA, in the service of patients with mental illness, opposes prescribing privileges of Psychologists.

   Action: Will the JRC refer the Assembly passed action paper *2017A1 12.B: Opposition to Psychologist Prescribing* to the appropriate Component(s) for input or follow-up?

3. **Adopting Neuroscience-based Nomenclature (NbN) for Medications (ASM Item #2017A1 12.D) [Attachment 3]**

   Action paper 2017A1 12.D asks:

   That the APA promote the international Neuroscience-based Nomenclature (NbN) standard terminology developed by ACNP, ECNP, CINP, AsCNP, and IUPHAR, in its publications, policies, and communications;

   That the APA seek opportunities to promote adoption of NbN terminology by payers and policymakers; and

   That the APA CEO and Medical Director be responsible for carrying out these promotion activities.

   Action: Will the JRC refer the Assembly passed action paper *2017A1 12.D: Adopting Neuroscience-based Nomenclature (NbN) for Medications* to the appropriate Component(s) for input or follow-up?

4. **Revising the Nomenclature, Definition, and Clinical Criteria for Partial Hospitalization Program (ASM Item # 2017A1 12.E) [Attachment 4]**

Action paper 2017A1 12.E 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.

Action: Will the JRC refer the Assembly passed action paper *2017A1 12.E: Revising the Nomenclature, Definition, and Clinical Criteria for Partial Hospitalization Program* to the appropriate Component(s) for input or follow-up?

5. **Providing Education and Guidance for the Use and Limitations of Pharmacogenomics in Clinical Practice (ASM Item # 2017A1 12.G) [Attachment 5]**

Action paper 2017A1 12.G asks that:

1. The APA educate its members about the use and limitations of pharmacogenomic testing in clinical 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 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

Action: Will the JRC refer the Assembly passed action paper *2017A1 12.G: Providing Education and Guidance for the Use and Limitations of Pharmacogenomics in Clinical Practice* to the appropriate Component(s) for input or follow-up?

6. <u>Expanding Access to Psychiatry Subspecialty Fellowships</u> (ASM Item # 2017A1 12.H) [Attachment 6]

Action paper 2017A1 12.H 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, such as extending ACGME accreditation to prior years of training ("grandfathering") during this period of transition.

Action: Will the JRC refer the Assembly passed action paper *2017A1 12.H: Expanding Access to Psychiatry Subspecialty Fellowships* to the appropriate Component(s) for input or follow-up?

7. <u>Educational Strategies to Improve Mental Illness Perceptions of Medical Students</u> (ASM Item #2017A1 12.I) [Attachment 7]

Action paper 2017A1 12.I asks:

That the APA charge the Council on Medical Education and Lifelong Learning (CMELL) to

1. Ascertain with the Association of Directors of Medical Student Education in Psychiatry (ADMSEP) and the American Association of Chairs of Departments of Psychiatry (AACDP), the need for and their interest in implementing educational training strategies for improving medical students' perceptions regarding mental illness and psychiatry, and if there is sufficient interest,

2. Partner with ADMSEP in reviewing and developing educational strategies that particularly involve exposure or contact with patients who have experienced and successfully recovered from mental illness, and discussions of medical students' own perceptions and attitudes regarding mental illness, early on in medical student education,

3. APA to support the developed product and advocate for implementing the developed strategies to various medical education organizations including ADMSEP, AACDP and ACGME.

Action: Will the JRC refer the Assembly passed action paper 2017A1 12.I: *Educational Strategies to Improve Mental Illness Perceptions of Medical Students* to the appropriate Component(s) for input or follow-up?

8. <u>Educational Strategies to Improve Mental Illness Perceptions of Non-Mental Health Medical Professionals</u> (ASM Item #2017A1 12.J) [Attachment 8]

Action paper 2017A1 12.J asks:

1. APA to charge the APA Department of Education to work with APA's AMA delegation and with other interested medical professional organizations to ascertain their interest in implementing educational strategies to improve negative perceptions of mental illness across primary care fields; if there is sufficient interest;

2. APA, in partnership with interested medical professional organizations and in conjunction with American Psychiatric Association Foundation, American Psychiatric Association Publishing and mental health advocacy groups, support and develop educational curriculum and video series depicting and emphasizing successful recovery models of mental illness in patients for use by non-mental health medical professionals;

3. In the spirit of collaborative care, APA support and develop, in conjunction with American Psychiatric Association Publishing and other educational organizations, a training curriculum and video series for non-mental health medical professional on how to comfortably communicate with, assess, and treat mentally ill persons, and when to refer patients to psychiatrists;

4. APA to advocate to AMA, AAFP and other non-mental health medical professional organizations, as to the importance and availability of above educational strategies in improving perceptions and care of persons with mental illness.

Action: Will the JRC refer the Assembly passed action paper 2017A1 12.J: *Educational Strategies to Improve Mental Illness Perceptions of Non-Mental Health Medical Professionals* to the appropriate Component(s) for input or follow-up?

9. <u>Fostering Medical Student Interest and Training in Psychiatry: The Importance of Medical Student Clerkships</u> (ASM Item #2017A1 12.K) [Attachment 9]

Action paper 2017A1 12.K asks that the APA tasks the Council on Medical Education and Lifelong Learning (CMELL) with drafting a position statement on recommended guidelines for the Psychiatry Clerkship. The CMELL should partner with other organizations invested in psychiatric education, such as ADMSEP and AADPRT, in the drafting of this position statement.

This statement should be used to provide recommendations to the Liaison Committee on Medical Education (LCME) and the American Osteopathic Association (AOA) Commission on Osteopathic College Accreditation (COCA) on minimum requirements for psychiatric training. The statement should describe the importance of psychiatry clerkships as the key formative experience for all medical students, and best practices that promote medical student education and interest in psychiatry. Specific components integral to the psychiatry clerkship should include:

- A minimum duration of a six-week equivalent full-time experience in the evaluation and treatment of psychiatric patients.
- Exposure to both inpatient and ambulatory practice settings, ideally including exposure to subspecialty (e.g. – child and adolescent, addictions, geriatrics, consultation and liaison) and developing models of practice designed to better serve psychiatric populations (e.g. – collaborative or integrated care).

Action: Will the JRC refer the Assembly passed action paper 2017A1 12.K: *Fostering Medical Student Interest and Training in Psychiatry: The Importance of Medical Student Clerkships* to the appropriate Component(s) for input or follow-up?

10. <u>Requesting the APA Draft a Position Statement on Prescription Drug Monitoring Programs (PDMPs)</u> (ASM Item #2017A1 12.L) [Attachment 10]

Action paper 2017A1 12.L asks:

• That the American Psychiatric Association draft a position statement regarding Prescription Drug Monitoring Programs.

• That such PDMP position statement addresses PDMP best practices including design, operation, confidentiality, privacy, physician/staff burden utilization and interstate access.in correctional psychiatry in order to increase the number of psychiatrists working in correctional settings.

Action: Will the JRC refer the Assembly passed action paper 2017A1 12.L: *Requesting the APA Draft a Position Statement on Prescription Drug Monitoring Programs (PDMPs)* to the appropriate Component(s) for input or follow-up?

11. <u>Juvenile Solitary Confinement</u> (ASM Item #2017A1 12.M) [Attachment 11]

Action paper 2017A1 12.M asks:

That the APA support the AMA policy statement opposing the use of solitary confinement in juveniles, and that the APA draft its own position statement by May of 2018.

H-60.922
Our AMA: (1) opposes the use of solitary confinement in juvenile correction facilities except for extraordinary circumstances when a juvenile is at acute risk of harm to self or others; (2) opposes the use of solitary confinement of juveniles for disciplinary purposes in correctional facilities; and (3) supports that isolation of juveniles for clinical or therapeutic purposes must be conducted under the supervision of a physician.

With the following preamble:
Solitary confinement is defined as the placement of an incarcerated individual in a locked room or cell with minimal or no contact with people other than staff of the correctional facility. It is used as a form of discipline or punishment.

Action: Will the JRC refer the Assembly passed action paper 2017A1 12.M: *Juvenile Solitary Confinement* to the appropriate Component(s) for input or follow-up?

12. <u>Addressing Physician Burnout, Depression, and Suicide —Within Psychiatry and Beyond</u> (ASM Item #2017A1 12.N) [Attachment 12]

Action paper 2017A1 12.N asks:

That the APA continue the mission of the Ad Hoc Workgroup on Physician Well-Being by developing resources for increasing awareness about physician burnout, depression and suicide, as well as interventions for promoting physician wellness, including recommendations for institutional response to physician suicide;

That the APA revise its 2011 "Position Statement on Physician Wellness" to affirm the APA's commitment to ensuring the well-being of its members and to encourage members to serve as leaders in promoting well-being initiatives within their institutions, training programs, and systems of care;

That the APA promote further investigation of the underlying causes of increased rates of burnout, depression, and suicide among physicians and to expand the evidence base for innovative wellness interventions;

That the APA Government Relations staff work with stakeholder organizations including the Federation of State Medical Boards to remove questions about psychiatric or substance use disorder treatment from licensing applications (initial or renewal) as well as employment applications, instead focusing on relevant, current functional impairment due to either physical or mental illness;

That the APA's AMA delegation continue to collaborate with the AMA to develop joint initiatives to prioritize these issues.

Action: Will the JRC refer the Assembly passed action paper 2017A1 12.N: *Addressing Physician Burnout, Depression, and Suicide —Within Psychiatry and Beyond* to the appropriate Component(s) for input or follow-up?

13. Health Care Is a Human Right (ASM Item #2017A1 12.0) [Attachment 13]

Action paper 2017A1 12.O asks that the American Psychiatric Association adopt the following position statement: "Health care, inclusive of mental health care, is a human right".

Action: Will the JRC refer the Assembly passed action paper 2017A1 12.O: *Health Care Is a Human Right* to the appropriate Component(s) for input or follow-up?

14. Making Access to the Voting Page a Default Action During Elections (ASM Item #2017A1 12.P) [Attachment 14]

Action paper 2017A1 12.P asks that the Assembly recommends that the APA Administration work to make access to voting as prominent as possible and user friendly on the APA website, and reconsider the value of mailing ballots to all members.

Action: Will the JRC refer the Assembly passed action paper 2017A1 12.P: *Making Access to the Voting Page a Default Action During Elections* to the appropriate Component(s) for input or follow-up?

15. Dues Relief for District Branch Members from the Commonwealth of Puerto Rico (ASM Item #2017A1 12.Q) [Attachment 15]

Action paper 2017A1 12.Q asks that general member psychiatrists who are members of the Puerto Rico Psychiatric Society, a District Branch of the APA shall be granted the same annual APA dues as our Canadian counterparts, which is $375 per general member per year for the next five years.

Action: Will the JRC refer the Assembly passed action paper 2017A1 12.Q: *15. Dues Relief for District Branch Members from the Commonwealth of Puerto Rico* to the appropriate Component(s) for input or follow-up?

16. Streamlining the Application Process for Former APA Members (ASM Item #2017A1 12.R) [Attachment 16]

Action paper 2017A1 12.R asks that the APA staff streamline the application process for former APA members on the website as follows:

1. Once an applicant answers yes to being a former member of the APA on the website, the individual is given an online, pre-filled application.
2. Remove the requirement for the applicant to resubmit the residency training certificate (this can be verified by APA staff from previous membership records).
3. Remove the requirement for the applicant to submit a valid medical license (this can be verified by APA staff from online, public databases).

That the APA staff advertise the changes to the streamlined application process for former APA members.

Action: Will the JRC refer the Assembly passed action paper 2017A1 12.R: *Streamlining the Application Process for Former APA Members* to the appropriate Component(s) for input or follow-up?

17. APA Referendum Voting Procedure (ASM Item #2017A1 12.T) [Attachment 17]

Action paper 2017A1 12.T asks:

1. If 2/3 of the voting members approve a referendum statement, but the requirement of 40% of eligible voters voting has not been met, the BOT will schedule a vote on the referendum statement or a modified version of it for voting by members of the BOT and the Assembly. If the referendum statement or its modified version does not get a 2/3 votes by both these bodies and thus fails to pass, or if the lead petitioner of the referendum statement does not agree to the modified version, then the original referendum statement will be placed again on the ballot to be voted on by the entire membership; but this time the referendum ballot will be sent with the yearly dues statement/solicitation for contributions to all voting members. If it fails again it will not be automatically placed on the ballot again. If it passes, it will supersede any modified version passed by the BOT and the Assembly.

2. If the BOT rejects resolved #1, then an alternative for a viable referendum process shall be prepared by the Board of Trustees, with participation of Assembly Representatives jointly selected by the Speaker and the President, and presented to the Assembly at the Fall 2017 meeting.

Action: Will the JRC refer the Assembly passed action paper 2017A1 12.T: *APA Referendum Voting Procedure* to the appropriate Component(s) for input or follow-up?

18. Revised 2015 Position Statement: Use of the Concept of Recovery (JRCFEB178.M.1/ASM Item #2017A1 4.B.20) [Attachment 18]

The Assembly voted to refer the Revised 2015 Position Statement: *Use of the Concept of Recovery* to the Assembly Committee on Public and Community Psychiatry. The Committee revised the Position Statement and is submitting it for review and approval by the Joint Reference Committee and, if approved, referral to the appropriate Component(s) for input or follow-up.

Action: Will the JRC refer the Revised Position Statement: *Use of the Concept of Recovery* 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 candidates as officers of the Assembly from May 2017 to May 2018:

   Speaker-Elect: James R. Batterson, MD (Area 4)

   Recorder: Steven Daviss, MD (Area 3)

2. **Retain 2007 Position Statement Use of Stigma as a Political Tactic (JRCOCT168.B.3/ASM Item #2017A1 4.B.1)**

The Assembly voted, on its Consent Calendar, to approve the retention of the 2007 Position Statement *Use of Stigma as a Political Tactic*. This will be forwarded to the Board of Trustees for consideration in July 2017.

3. **Revised Position Statement: Position Statement on the Role of the Psychiatrist in the Long-Term Care Setting (JRCOCT168.E.1/ ASM Item #2017A1 4.B.2)**

The Assembly voted, on its Consent Calendar, to approve the revised Position Statement: *Position Statement on the Role of the Psychiatrist in the Long-Term Care Setting*. This will be forwarded to the Board of Trustees for consideration in July 2017.

4. **Retire 2009 Position Statement: U.S. Military Policy of "Don't Ask Don't Tell" (JRCOCT168.I.8/ ASM Item #2017A1 4.B.3)**

The Assembly voted, on its Consent Calendar, to approve the retirement of the 2009 Position Statement: *U.S. Military Policy of "Don't Ask Don't Tell".* This will be forwarded to the Board of Trustees for consideration in July 2017.

5. **Retain 2006 Position Statement: Resolution against Racism and Racial Discrimination and Their Adverse Impacts on Mental Health (JRCJOCT168.I.13/ ASM Item #2017A1 4.B.4)**

The Assembly voted, on its Consent Calendar, to approve the retention of the 2006 Position Statement: *Resolution against Racism and Racial Discrimination and their Adverse Impacts on Mental Health*. This will be forwarded to the Board of Trustees for consideration in July 2017.

6. **Retain 2001 Position Statement: Discrimination Against International Medical Graduates (JRCJOCT168.I.14/ ASM Item #2017A1 4.B.5)**

The Assembly voted, on its Consent Calendar, to approve the retention of the 2001 Position Statement: *Discrimination Against International Medical Graduates*. This will be forwarded to the Board of Trustees for consideration in July 2017.

7. **Retain 1999 Position Statement: Diversity (JRCJOCT168.I.15/ ASM Item #2017A1 4.B.6)**

The Assembly voted, on its Consent Calendar, to approve the retention of the 1999 Position Statement: *Diversity*. This will be forwarded to the Board of Trustees for consideration in July 2017.

8. **Retain 1994 Position Statement: Psychiatrists from Underrepresented Groups in Leadership Roles (JRCOCT168.I.17/ ASM Item #2017A1 4.B.7)**

The Assembly voted, on its Consent Calendar, to approve the retention of the 1994 Position Statement: *Psychiatrists from Underrepresented Groups in Leadership Roles*. This will be forwarded to the Board of Trustees for consideration in July 2017.

9. **Retain 1994 Position Statement: Resolution Opposing Any Restriction on the Number of IMGs Entering Graduate Medical Training (JRCOCT168.I.18/ ASM Item #2017A1 4.B.8)**

The Assembly voted, on its Consent Calendar, to approve the retention of the 1994 Position Statement: *Resolution Opposing Any Restriction on the Number of IMGs Entering Graduate Medical Training*. This will be forwarded to the Board of Trustees for consideration in July 2017.

10. **Revised 1978 Position Statement: Abortion (JRCOCT168.I.19/ ASM Item #2017A1 4.B.9)**

The Assembly voted to approve the Revised 1978 Position Statement: *Abortion*. This will be forwarded to the Board of Trustees for consideration in July 2017.

11. **Retain 1977 Position Statement: Affirmative Action (JRCOCT168.I.20/ ASM Item #2017A1 4.B.10)**

The Assembly voted, on its Consent Calendar, to approve the retention of the 1977 Position Statement: *Affirmative Action*. This will be forwarded to the Board of Trustees for consideration in July 2017.

12. **Retire 1976 Position Statement: 1976 Joint Statement on Antisubstitution Laws and Regulations (JRCOCT168.J.4/ ASM Item #2017A1 4.B.11)**

The Assembly voted, on its Consent Calendar, to approve the retirement of the 1976 Position Statement: *1976 Joint Statement on Antisubstitution Laws and Regulations*. This will be forwarded to the Board of Trustees for consideration in July 2017.

13. **Retain 1998 Position Statement: Misuse of Psychiatric Examinations and Disclosure of Psychiatric Records in Sexual Harassment Litigation (JRCOCT168.J.6/ASM Item #2017A1 4.B.13)**

The Assembly voted, on its Consent Calendar, to approve the retention of the 1998 Position Statement: *Misuse of Psychiatric Examinations and Disclosure of Psychiatric Records in Sexual Harassment Litigation*. This will be forwarded to the Board of Trustees for consideration in July 2017.

14. **Retire 2001 Position Statement: Doctors Against Handgun Violence (JRCOCT168.J.7 /ASM Item #2017A1 4.B.14)**

The Assembly voted, on its Consent Calendar, to approve the retirement of the 2001 Position Statement: *Doctors Against Handgun Violence.* This will be forwarded to the Board of Trustees for consideration in July 2017.

15. **Retain 2008 Adoption of AMA Statements on Capital Punishment (JRCOCT168.J.8/ASM Item #2017A1 4.B.15)**

The Assembly voted, on its Consent Calendar, to approve the retention of the 2008 *Adoption of AMA Position Statements on Capital Punishment*. This will be forwarded to the Board of Trustees for consideration in July 2017.

16. **Retain 2010 Position Statement: No "Dangerous Patient" Exemption to Federal Psychotherapist-Patient Testimonial Privilege (JRCOCT168.J.9/ASM Item #2017A1 4.B.16)**

The Assembly voted, on its Consent Calendar, to approve the retention of the 2010 Position Statement: *No "Dangerous Patient" Exemption to Federal Psychotherapist- Patient Testimonial Privilege*. This will be forwarded to the Board of Trustees for consideration in July 2017.

17. **Proposed Position Statement: Risk of Adolescents' Online Behavior (JRCFEB178.C.1/ASM Item #2017A1 4.B.17)**

The Assembly voted to approve the Proposed Position Statement: *Risk of Adolescents' Online Behavior*. This will be forwarded to the Board of Trustees for consideration in July 2017.

18. **Proposed Position Statement: Role of Psychiatrists in Addressing Care for People Affected by Forced Displacement (JRCFEB178.I.1/ASM Item #2017A1 4.B.18)**

The Assembly voted, on its Consent Calendar, to approve the Proposed Position Statement: *Role of Psychiatrists in Addressing Care for People Affected by Forced Displacement*. This will be forwarded to the Board of Trustees for consideration in July 2017.

19. **Proposed Position Statement: Legislative Attempts Permitting Pharmacists to Alter Prescriptions (JRCFEB178.L.3; JRCJUNE166.9; ASMMAY1612.I /ASM Item #2017A1 4.B.19)**

The Assembly voted, on its Consent Calendar, to approve the Proposed Position Statement: *Legislative Attempts Permitting Pharmacists to Alter Prescriptions*. This will be forwarded to the Board of Trustees for consideration in July 2017.

20. **Revised 2015 Position Statement: Use of the Concept of Recovery (JRCFEB178.M.1/ASM Item #2017A1 4.B.20)**

The Assembly voted to refer the Revised 2015 Position Statement: *Use of the Concept of Recovery* to the Assembly Committee of Public and Community Psychiatry. The Committee's revised Position Statement is included as action item #18.

Attachment #1
Item 2017A1 12.A
Assembly
May 19-21, 2017

ACTION PAPER
FINAL

TITLE: Involuntary Psychiatric Commitment for Individuals with Substance Use Disorders

WHEREAS:
The current opioid use disorder epidemic has reached a point where the public and legislators are clamoring for strong action to be taken; and whereas

Many individuals believe that people in the throes of addiction lack decision-making capacity to undertake treatment voluntarily; and whereas

There is some evidence from the forensic literature that the use of coerced treatment has some effect, that mandating participation in drug treatment programs and sobriety in lieu of incarceration can lead to a reduction in drug use; and whereas

There are some who believe that the use of involuntary psychiatric commitment for substance using individuals may similarly lead to reduction in substance use; and whereas

Many states are considering altering their statutes or practice of civil commitment, in the hope of achieving involuntary psychiatric hospitalization for patients with substance use disorders; and whereas

There is much debate about whether there is any evidence to suggest that involuntary hospitalization on psychiatric units provides any benefit for individuals with substance use disorder; and whereas

Many of those proposing involuntary treatment may believe that locked substance abuse treatment centers are available, outside of the current locked psychiatric hospital system; and whereas

Psychiatric hospital units capable of caring for civilly committed individuals are not prepared to manage an influx of individuals with substance use disorders, lacking excess capacity or programming ability to provide appropriate treatment; and whereas

Mandates to increase the number of individuals subject to involuntary psychiatric hospitalization by expanding criteria by diagnosis and behavior will need significantly greater resources, which states are unlikely to be able to allocate; and whereas

There are jurisdictions which allow for coerced treatment by civil commitment, which is used to varying degrees, but which may permit some assessment of the efficacy of such treatment; and whereas

The pressure to “do something” about the opioid epidemic may lead to hasty policy decisions in the absence of evidence; and whereas

APA district branches need assistance with position statements based on science;

BE IT RESOLVED:
That the American Psychiatric Association develop a comprehensive position statement on the use of involuntary psychiatric commitment for the treatment of substance use disorders.

AUTHORS:
Kenneth M. Certa M.D., DLFAPA, Representative, Pennsylvania Psychiatric Society
kenneth.certa@jefferson.edu
Mary Anne Albaugh M.D., Representative, Pennsylvania Psychiatric Society

ESTIMATED COST:
Author: $9,240
APA: $6,160

ESTIMATED SAVINGS:

ESTIMATED REVENUE GENERATED:

ENDORSED BY:

KEY WORDS: substance use disorder; involuntary treatment

APA STRATEGIC PRIORITIES: Advancing Psychiatry

Attachment #2
Item 2017A1 12.B
Assembly
May 19-21, 2017

ACTION PAPER
FINAL

TITLE: Opposition to Psychologist Prescribing

WHEREAS:
Online schools have opened for Psychologists to learn to prescribe psychotropic medications in just a short few months.

Lack of proper education and a residency has major implications on the safety of patients.

The AMA has concluded that there is a higher rate of prescribing controlled substances and a higher number of referrals and tests that are ordered for patients.

Psychologists have no preparation in medical training and are poorly suited to make decisions that can affect multiple systems – not just the brain.

BE IT RESOLVED:
That the appropriate committee create a Position Statement that reflects that the APA, in the service of patients with mental illness, opposes prescribing privileges of Psychologists.

AUTHOR:
Sarit Hovav, M.D., Deputy Representative, International Medical Graduate Psychiatrists
(anisarit@gmail.com)

ESTIMATED COST:
Author: $0
APA: $2,926

ESTIMATED SAVINGS: None

ESTIMATED REVENUE GENERATED: NA

ENDORSED BY:

KEY WORDS: education, nurse practitioner, safety, IMG, physician assistant, APN, NP, APRN, medical license, scope of practice, MUR

APA STRATEGIC PRIORITIES: Advancing Psychiatry, Education

REVIEWED BY RELEVANT APA COMPONENT:

Attachment #3
Item 2017A1 12.D
Assembly
May 19-21, 2017

ACTION PAPER
FINAL

TITLE: Adopting Neuroscience-based Nomenclature (NbN) for Medications

WHEREAS:

Categories of medications have been named for conditions they treat for a very long time (e.g., antihypertensives, antiarrhythmics, antipsychotics) despite most having multiple uses;

The past few decades have seen much greater understanding about the chemical structure and actual mechanisms of action of medications, with changes in how these categories are labeled and grouped together (e.g., angiotensin II receptor antagonists, potassium channel blockers, D2/5HT2 antagonists);

Psychotropic medication categories have not kept up with these advances in nomenclature, resulting in confusion by patients prescribed a medication in a category that does not always fit their condition (e.g., an antipsychotic for bipolar disorder);

Payers have maintained this older nomenclature, sometimes limiting the number of covered medications per category;

There now exists a well-developed and broadly-adopted neuroscience-based nomenclature (NbN) that categorizes psychiatric medications based on pharmacology and mode of action (nbnomenclature.org);

NbN was developed by an international task force of leading scientific organizations, including the American College of Neuropsychopharmacology (ACNP), European College of Neuropsychopharmacology (ECNP), Asian College of Neuropsychopharmacology (AsCNP), International College of Neuropsychopharmacology (CINP), and International Union of Basic and Clinical Pharmacology (IUPHAR);

A growing number of publications and organizations is adopting NbN's standardized terminology to replace the outdated historical categories;

Adoption of this neuroscience-based nomenclature by the APA and its publications would benefit the field and our patients by using specific terminology that uses more accurate descriptions of how psychiatric medications work in the brain; and

Advocacy by APA for policymakers and payers to adopt this nomenclature may facilitate more rational coverage policies resulting in greater access to all NbN categories of medications; therefore

BE IT RESOLVED:

That the APA promote the international Neuroscience-based Nomenclature (NbN) standard terminology developed by ACNP, ECNP, CINP, AsCNP, and IUPHAR, in its publications, policies, and communications;

That the APA seek opportunities to promote adoption of NbN terminology by payers and policymakers; and

That the APA CEO and Medical Director be responsible for carrying out these promotion activities.

AUTHORS:
Steven Daviss, M.D., DFAPA, Representative, Maryland Psychiatric Society (steve@fusehealth.org)

SPONSORS:
Patrick Aquino, M.D., Representative, Massachusetts Psychiatric Society
Jeffrey Bennett, M.D., Representative, Illinois Psychiatric Society
Lisa Catapano-Friedman, M.D., Representative, Vermont Psychiatric Association
Sarit Hovav, M.D., Deputy Representative, International Medical Graduate Psychiatrists
Matthew Kruse, M.D., Area 4 Representative, Assembly Committee of Resident-Fellow Members
Rahul Malhotra, M.D., Area 3 Representative, Assembly Committee of Early Career Psychiatrists
Elizabeth Morrison, M.D., DLFAPA, Representative, Washington Psychiatric Society
Joseph C. Napoli M.D., DLFAPA, Representative, Area 3
James A. Polo, M.D. MBA, Representative, Washington State Psychiatric Association
Roger Peele, M.D., APA Member
Charles Price, M.D., Deputy Representative, Area 7
William Greenberg, M.D., Deputy Representative, Area 3

ESTIMATED COST:
Author: $0
APA: $4,928

ESTIMATED SAVINGS: unknown

ESTIMATED REVENUE GENERATED: unknown

ENDORSED BY:

KEY WORDS: medications, standards, pharmacology, nomenclature, payment policies

APA STRATEGIC PRIORITIES: Advancing Psychiatry, Supporting Research, Education

REVIEWED BY RELEVANT APA COMPONENT:

Example from nbnomenclature.org/authors:

Antipsychotic (Neuroleptics, Major tranquillisers)	**Drugs for psychosis**		
Typical (1st generation)	dopamine	receptor antagonist (D2)	flupenthixol, fluphenazine, haloperidol, perphenazine, pimozide, pipotiazine, sulpiride, trifluoperazine, zuclopenthixol
	dopamine, serotonin	receptor antagonist (D2, 5-HT2)	chlorpromazine, thioridazine
Atypical (2nd generation)	dopamine	receptor antagonist (D2)	amisulpiride
	dopamine, serotonin	receptor antagonist (D2, 5-HT2)	iloperidone, loxapine, lurasidone, olanzapine, perospirone, sertindole, ziprasidone, zotepine
	dopamine, serotonin	receptor partial agonist (D2, 5-HT1A)	aripiprazole
	dopamine, serotonin, noradrenaline	receptor antagonist (D2, 5-HT2, NE alpha-2)	asenapine, clozapine, risperidone, paliperidone
		MM; receptor antagonist (D2, 5-HT2) and reuptake inhibitor (NET)(metabolite)	quetiapine
Anxiolytic	**Drugs for Anxiety**		
(benzodiazepine)	GABA	Positive Allosteric Modulator (GABA-A receptor, benzodiazepine site)	alprazolam, chlordiazepoxide, clonazepam, clorazepate, diazepam, flunitrazepam, lorazepam, oxazepam
	serotonin	receptor partial agonist (5-HT1A)	buspirone
	glutamate	voltage-gated calcium channel blocker	gabapentin, pregabalin

Attachment #4
Item 2017A1 12.E
Assembly
May 19-21, 2017

ACTION PAPER
FINAL

TITLE: Revising the Nomenclature, Definition, and Clinical Criteria for Partial Hospitalization Program

WHEREAS:

1. Partial Hospitalization is a term coined long time ago to distinguish it from complete or total hospitalization when state hospitals provided daily outpatient therapy on hospital grounds at the request of patients discharged after long term inpatient hospitalization to facilitate transition to outside world;
2. Partial Hospitalization Program (PHP) has, over the years, become a recognized and established outpatient treatment program entity vital in the continuum of psychiatric care along with Intensive Outpatient Program (IOP) but the Centers for Medicare/ Medicaid services and the health insurance industry have repeatedly revised the clinical criteria of these programs to suit their own financial agendas;
3. PHP is a confusing misnomer to clinicians, patients and public alike because of the terms: 'partial' frequently mistaken for 'biased' or 'incomplete', and 'hospitalization' for 'inpatient' or pejoratively for "confinement'; some PHP's have shortened the term 'hospitalization program' to 'hospital program' conveying a different meaning; the American Association for Partial Hospitalization (AAPH) also changed its name to Association for Ambulatory Behavioral Health (AABH) partly because of this confusion and to emphasize its outpatient ambulatory aspect;
4. Day Hospitalization Program is a term sometimes used interchangeably with PHP but fraught with same confusion or stigma while Day Treatment Program is another interchangeable term but does not convey the intensity level of treatment;
5. Confusion also exists as to what constitutes PHP in contrast to IOP with differing definitions, criteria and reimbursement rates among insurance providers and clinical facilities.

BE IT RESOLVED:
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.

AUTHOR:
Sudhakar Madakasira, M.D., DLFAPA, Representative, Mississippi Psychiatric Association
(smadakasira@hotmail.com)

ESTIMATED COST:
Author: $0
APA: $53,696

ESTIMATED SAVINGS: None

ESTIMATED REVENUE GENERATED: None

ENDORSED BY:

KEY WORDS: Partial Hospitalization, Intensive Outpatient Program, Stigma

APA STRATEGIC PRIORITIES: Advancing psychiatry, Education

REVIEWED BY RELEVANT APA COMPONENT: Council on Advocacy and Government Relations approves this paper (The recommendations from the Council have been incorporated into the paper).

Attachment #5
Item 2017A1 12.G
Assembly
May 19-21, 2017

ACTION PAPER
FINAL

TITLE: Providing Education and Guidance for the Use and Limitations of Pharmacogenomics in Clinical Practice

WHEREAS:

1. There is an uptick in marketing on the use of pharmacogenomic testing.

2. The content of advertising for pharmacogenomic testing contains:
   A. misleading statements such as "Today there are GeneSight® tests available for depression, anxiety and other behavioral health conditions . . . " which implies the tests are for diagnosing disorders [1]
   B. an unsubstantiated statement that suicide "may possibly be avoided by doing pharmacogenomic (PGx) testing" [2]
   C. a false implication that a physician who was sentenced for 30 years for the death of three patients Is associated with not doing pharmacogenomic testing although the physician recklessly prescribed opioids without medical necessity and the patients overdosed. [3]

3. There should be a sufficient evidence base to support the use of pharmacogenomic testing in clinical practice and that demonstrates beneficial outcomes.

4. A MD, PhD internationally renowned expert on biological psychiatry opined that there isn't sufficient evidence at this time to support the claims of pharmacogenomic testing companies by saying, "Since it's a saliva test, they are spitting in the wind."

5. There have been failed attempts to use biomarkers in psychiatry such as the dexamethasone suppression test and urine testing to differentiate between a serotonergic vs. noradrenergic depression.

6. The use of these tests adds to health care cost, and thus, are they cost-effective?
   [Assurex Health states that its GeneSight® tests have been used for 215,000 patients. [4] If commercial Insurance, Medicare or Medicaid pay for the tests, the average cost of four available GeneSight® test panels is $2,848.50 and the cost for doing all four panels at once is $6,224. (Average cost X 215,000 tests (assuming one test per patient) = $612,427,500 (over ½ billion dollars) If all the tests were psychotropic tests, the health care cost is $5,500 x 215,000 =

---

[1] GeneSight® Brochure

[2] Letter to Dr Joseph Napoli from John Adkins, Consultant for Pharmacogenetic Testing, MedxPrim/Admera, February 20, 2017

[3] https://www.aol.com/article/2016/02/05/california-doctor-gets-30-years-to-life-in-landmark-overdose-cas/21308642/, retrieved 2017-02-02

[4] *Op. cit.* GeneSight® Brochure

$1,182,500,000 (over one billion dollars). (See Attachment.) The cost of testing might be offset to some degree by a savings in the cost of medication.[5]]

7. DNA tests results need to be secured to protect the personal health information of those who are tested, and thus, does the benefit of the test results outweigh the risk of this information not being adequately protected?

8. There is a precedent for an action paper generating a resource document.
   ["APA Position Statement on the Clinical and Forensic Application of Brain Imaging" – J Napoli *et al,* passed by the Assembly in May 2009 resulted in "Consensus Report of the APA Work Group on Neuroimaging Markers of Biomarkers: Resource Document" – M First *et al,* July 2012]

9. Personalized medicine and pharmacogenomic testing might be beneficial, especially in addressing biological diversity to inform treatment.

10. More research is needed to further understand how pharmacogenomic biomarkers correlate with pharmacotherapy and can be predictive for selecting pharmacological agents.

11. Providing education and guidance for the use and limitations of pharmacogenomics in clinical practice would be a service to APA members.

BE IT RESOLVED:
That:

1. The APA educate its members about the use and limitations of pharmacogenomic testing in clinical 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] Winner, JG et al Combinatorial pharmacogenomic guidance for psychiatric medications reduces overall pharmacy costs in a 1 year prospective evaluation Curr Med Res Opin 2015;31(9): 1633-43

5. The Council on Advocacy and Government Relations 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.

AUTHOR:
Joseph C. Napoli, MD, DLFAPA, Representative, Area 3, napoli@resiliency.us

SPONSORS:
Annette Hanson, M.D., Representative, Maryland Psychiatric Society
William Greenberg, M.D., Area 3 Deputy Representative
Charles Blackinton, M.D., Representative, New Jersey Psychiatric Association
Charles Ciolino, M.D., Representative, New Jersey Psychiatric Association
David A. Tompkins, M.D., MHS, M/UR Representative, LGBTQ Psychiatrists
Rahul Malhotra, M.D., Area 3 Representative, Assembly Committee of Early Career Psychiatrists
Steven Daviss M.D., DFAPA, Representative, Maryland Psychiatric Society
Isabel Norian, M.D., Representative, New Hampshire Psychiatric Society
Richard A. Ratner, M.D., ACROSS Representative, The American Society for Adolescent Psychiatry
Lisa K. Catapano-Friedman, M.D., DLFAPA, Representative, Vermont Psychiatric Association
Richard Altesman, M.D. DLFAPA, Representative, Psychiatric Society of Westchester
Eileen McGee, M.D., Representative, Ohio Psychiatric Physicians Association
Mary Anne Albaugh M.D., Representative, Pennsylvania Psychiatric Society
James C West, M.D., Representative, Society of Uniformed Psychiatrists
Patrick R. Aquino, M.D., Representative, Massachusetts Psychiatric Society

ESTIMATED COST:
Author: $4,577
APA: $33,418

ESTIMATED SAVINGS: None

ESTIMATED REVENUE GENERATED: This can generate revenue by providing education and guidance to non-member psychiatrists for a fee.

ENDORSED BY: Area 3, March 4, 2017

KEY WORDS: Advertising, Education, Clinical Practice, Consumer Education, Integrated Collaborative Care, Marketing, Member Service, Pharmacogenomics, Quality Care, Research, Testing

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

REVIEWED BY RELEVANT APA COMPONENT:
Sent to the Council on Advocacy and Government, the Council on Medical Education and Lifelong Learning, the Council on Quality Care and the Council on Research

Attachment

GeneSight® Rates				
Test (Based on medical necessity)	Commercial Insurance, Medicaid or Medicare Pays	Patient on Commercial Insurance or Medicare Advantage Co-Payment (1)	Patient on Medicaid, Medicare or Workers Comp Pays	Direct Pay
Psychotropic	$5,500	$330	0	$1,750 (2)
Analgesic	$4,200	$330	0	$1,750 (2)
ADHD	$1,550	$330	0	$440
MTHFR (Folic Acid)	$150	0	0	$150
Financial Assistance		(1) Patient receives financial assistance application form		
Income $0 - $50,000		$20		
$50,001 - $75,000		$150 or $12.50 per month		
> $75,000		$330 or $27.50 per month		
New York and Florida				
> $150,00		Either pay direct pay rate or difference between what commercial insurance allows and what commercial insurance pays		
(2) Rate of these two tests combined = $1,750 / Rate of all four test combined = $1,750				

Attachment #6
Item 2017A1 12.H
Assembly
May 19-21, 2017

ACTION PAPER
FINAL

TITLE: Expanding Access to Psychiatry Subspecialty Fellowships

WHEREAS:

There have been two separate accreditation systems for residency programs in psychiatry, as in many specialties: the majority accredited by the Accreditation Council on Graduate Medical Education (ACGME) and others accredited by the American Osteopathic Association (AOA); and whereas

The ACGME and AOA have agreed to merge the accreditation process, such that those programs currently under AOA auspices are in the process of applying for ACGME accreditation; and whereas

The Residency Review Committee for psychiatry expects to grant accreditation status for many of the applying programs, but will only be accrediting the current year; and whereas

ACGME rules for psychiatry subspecialty fellowships require that applicants be trained in an ACGME accredited program, for all years of training, meaning that any resident in a current AOA program will not be eligible for fellowships for at least another two years for Child and Adolescent Psychiatry (CAP) or three years for Psychosomatic Medicine (PM), Addiction Psychiatry, Geriatric Psychiatry, and Forensic Psychiatry; and whereas

There are other ACGME specialties which permit exceptions to this ACGME requirement; and whereas

The American Board of Psychiatry and Neurology recently changed its requirement for eligibility to sit for its certification exam, permitting any resident graduating from an ACGME accredited program to apply for certification, even if the program had previously been only AOA accredited; and whereas

The ABPN rules change would now permit AOA-trained residents to apply for both general Psychiatry certification as well as subspecialty certification, removing one of the barriers keeping AOA residents from ACGME fellowship application; and whereas

The fellowship match in psychiatry subspecialties this year left many programs with unfilled positions, with only 70% of CAP positions filled, and PM only filling 48% of its slots; and whereas

Many residents in AOA programs have expressed an interest in ACGME fellowships, but are blocked by the current policies of ACGME, and will never be eligible for fellowships unless they complete additional years of ACGME accredited residencies; and whereas

Subspecialty fellowships are an important part of overall psychiatric education, and are worth encouraging to the extent possible; and whereas

The number of subspecialized psychiatrists is not adequate to meet the needs of our population; and whereas

Efforts by the affected subspecialty organizations to increase fellowship applicants and eligibility have not been successful to this point; therefore

BE IT RESOLVED:

The 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, such as extending ACGME accreditation to prior years of training ("grandfathering") during this period of transition.

AUTHORS:
Kenneth Certa M.D., DLFAPA, Representative, Pennsylvania Psychiatric Society
kenneth.certa@jefferson.edu
Mary Anne Albaugh, M.D., FAPA, Representative, Pennsylvania Psychiatric Society
maryanne.albaugh@gmail.com

SPONSORS:
Joseph Napoli M.D., DFAPA, Representative, Area 3
Sheila Judge, M.D., DLFAPA, Representative, Pennsylvania Psychiatric Society

ESTIMATED COST:
Author: $1,540
APA: $2,310

ESTIMATED SAVINGS:

ESTIMATED REVENUE GENERATED:

ENDORSED BY:

KEY WORDS:

APA STRATEGIC PRIORITIES: Advancing Psychiatry, Education

REVIEWED BY RELEVANT APA COMPONENT:

Attachment #7
Item 2017A1 12.I
Assembly
May 19-21, 2017

ACTION PAPER
FINAL

TITLE: Educational Strategies to Improve Mental Illness Perceptions of Medical Students

WHEREAS:

1. Negative perceptions of mental illness, also referred to as stigma, are a primary barrier to treatment and recovery of the afflicted persons and not uncommon among future generations of physicians as they bring their own perceptions to medical school, then assimilate stereotypes from the medical culture;
2. The negative perceptions of medical students also play a role in reluctance in acknowledging their own mental health problems and choosing a psychiatric career;
3. Medical students' attitudes early on in training tend to be more amenable to change, thus it is possible to change their attitudes and perceptions toward mental illness and psychiatry through proper and early education and training;
4. As APA embarks on a strategic initiative on educating and producing new resources on mental disorders and effective psychiatric care for physicians engaged in integrative and collaborative care, education to decrease negative perceptions of medical students regarding mental illness and psychiatry is critical to this initiative for the long run;
5. Contact-based educational strategies in which medical students are exposed to and interact with persons with mental illness who constitute models of successful recovery, have been effective in changing negative attitudes of medical students;
6. Other successful strategies involve evaluation and discussion of own perceptions and attitudes of medical students toward mental illness as part of early behavioral health course.

BE IT RESOLVED:
That the APA charge the Council on Medical Education and Lifelong Learning (CMELL) to

1. Ascertain with the Association of Directors of Medical Student Education in Psychiatry (ADMSEP) and the American Association of Chairs of Departments of Psychiatry (AACDP), the need for and their interest in implementing educational training strategies for improving medical students' perceptions regarding mental illness and psychiatry, and if there is sufficient interest,
2. Partner with ADMSEP in reviewing and developing educational strategies that particularly involve exposure or contact with patients who have experienced and successfully recovered from mental illness, and discussions of medical students' own perceptions and attitudes regarding mental illness, early on in medical student education,
3. APA to support the developed product and advocate for implementing the developed strategies to various medical education organizations including ADMSEP, AACDP and ACGME.

AUTHORS:
Sudhakar Madakasira, M.D., DLFAPA, Representative, Mississippi Psychiatric Association (smadakasira@hotmail.com)
Valerie Arnold, M.D., Representative, Tennessee Psychiatric Association

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

ESTIMATED SAVINGS: None

ESTIMATED REVENUE GENERATED: None

ENDORSED BY: Mississippi Psychiatric Association, Area 5 council

KEY WORDS: Negative perceptions of mental illness, Medical student education, contact-based recovery model

APA STRATEGIC PRIORITIES: Advancing Psychiatry, Education

References:
Papish A, Kassam A, et al., Reducing the stigma of mental illness in undergraduate medical education. BMC Med Educ 2013; 13:141
Crapanzano K, Vath RJ. Observations: Confronting physician attitudes toward the mentally ill: A challenge to medical educators. J Grad Med Educ 2015 Dec; 7(4):686

Attachment #8
Item 2017A1 12.J
Assembly
May 19-21, 2017

ACTION PAPER
FINAL

TITLE: Educational Strategies to Improve Mental Illness Perceptions of Non-Mental Health Medical Professionals

WHEREAS:

1. Negative perceptions of mental illness, also called stigma, are a major barrier to timely and accessible care, recovery and quality of life of individuals with mental illness;
2. Negative perceptions of mental illness are not uncommon among non-psychiatric physicians and can contribute to discriminating behaviors and practices, diagnostic overshadowing, fragmentation and marginalization, less timely and/or less adequate treatment for medical concerns of people with mental illness, and partly to excess mortality of these patients;
3. As APA embarks on a strategic initiative to educate and produce new resources in education on mental disorders and effective psychiatric care for physicians engaged in integrative and collaborative care, education to decrease the negative perceptions of non-psychiatric physicians regarding mental illnesses and psychiatry is critical to this initiative;
4. A promising evidence-based strategy for improving these negative perceptions in non-psychiatric physicians is exposure to successful recovery model of people who have experienced and lived with mental illness, that can diminish anxiety, heighten empathy and improve understanding regarding mental illness;
5. Another effective strategy is education and training to improve skills to comfortably assess, communicate with and treat persons with mental illness, that can lead to positive attitudes, diminished social and clinical distance and improved patient care.

BE IT RESOLVED:
That:

1. APA to charge the APA Department of Education to work with APA's AMA delegation and with other interested medical professional organizations to ascertain their interest in implementing educational strategies to improve negative perceptions of mental illness across primary care fields; if there is sufficient interest,
2. APA, in partnership with interested medical professional organizations and in conjunction with American Psychiatric Association Foundation, American Psychiatric Association Publishing and mental health advocacy groups, support and develop educational curriculum and video series depicting and emphasizing successful recovery models of mental illness in patients for use by non-mental health medical professionals;
3. In the spirit of collaborative care, APA support and develop, in conjunction with American Psychiatric Association Publishing and other educational organizations, a training curriculum and

video series for non-mental health medical professional on how to comfortably communicate with, assess, and treat mentally ill persons, and when to refer patients to psychiatrists;

4. APA to advocate to AMA, AAFP and other non-mental health medical professional organizations, as to the importance and availability of above educational strategies in improving perceptions and care of persons with mental illness.

AUTHORS:
Sudhakar Madakaira, M.D., DLFAPA, Representative, Mississippi Psychiatric Association (smadakasira@hotmail.com)
Mary Jo Fitz-Gerald, M.D., DFAPA, Representative, Louisiana Psychiatric Medical Association
Rahn Bailey, M.D., Representative, Black Psychiatrists
Ramaswamy Viswanathan, M.D., DMSc, Representative, Brooklyn Psychiatric Society
Judy Glass, M.D., FRCP, Representative, Quebec and Eastern Canada District Branch
Lisa Catapano-Friedman, M.D., DLFAPA, Representative, Vermont Psychiatric Association
Ranga Ram, M.D., Representative, Psychiatric Society of Delaware
Lawrence Miller, M.D., DLFAPA, Representative, Area 5
John de Figueiredo, M.D., Representative, Connecticut Psychiatric Society
Debra Atkisson, M.D., DFAPA, Representative, Texas Society of Psychiatric Physicians
Iqbal Ahmed, M.D., FRCPsych, Hawaii Psychiatric Medical Association
James West, MD, Uniformed Services Rep

ESTIMATED COST:
Author: $0
APA: $3,234

ESTIMATED SAVINGS: None

ESTIMATED REVENUE GENERATED: To be determined by American Psychiatric Association Publishing

ENDORSED BY: Mississippi Psychiatric Association, Area 5 Council

KEY WORDS: Negative perceptions of mental illness, Educating non-psychiatric physicians, Recovery model, Training curriculum

APA STRATEGIC PRIORITIES: Advancing Psychiatry, Education

References:
Knaak S, Modgill G, et al., Key Ingredients of anti-stigma programs for health care providers: A data synthesis of evaluative studies. Can J Psychiatry 2014 Oct; 59(10 suppl): S19-S26.
Ungar T, Knaak S, et al., Theoretical and practical considerations for combating mental illness stigma in health care. Community Ment Health J 2016; 52:262-271.

Attachment #9
Item 2017A1 12.K
Assembly
May 19-21, 2017

ACTION PAPER
FINAL

TITLE: Fostering Medical Student Interest and Training in Psychiatry: The Importance of Medical Student Clerkships

WHEREAS:
Whereas: Psychiatric disorders including addictions are common, with an annual prevalence of at least 30%, and a lifetime prevalence of at least 45%, in the United States alone.

The burden of mental illness is extremely high, consistently ranked by the WHO as one of the costliest causes of disease burden. Psychiatric diseases are also costly, with both direct costs of treatment and loss of health and life, and indirect causes due to lost productivity, premature death, and other losses to society.

Patients with psychiatric disorders and symptoms are frequently seen in general medical and primary care settings. At least 70% of people who died from suicide were seen by generalists within a year of their death, and 40% within the month prior to their death.

Physicians of all specialties, particularly in general medical and primary care practices, will continue to treat patients with mental health issues, including those with severe and persistent mental illness.

Adequate training in psychiatry is a critical component of undergraduate medical education, as this will be the only dedicated training for most non-psychiatric physicians. The complex skills of psychiatric evaluation, diagnosis, and management are not quickly learned.

Whereas: There remains a national shortage of trained psychiatrists, particularly in underserved areas. Because psychiatry has one of the oldest average age of practitioners, there will remain a shortage as the number of graduating psychiatric residents will not surpass those leaving the profession.

Association of American Medical Colleges (AAMC) surveys of graduating medical students indicate that 85% of students who chose a career in psychiatry did not have an initial interest in psychiatry at the beginning of medical school.

Medical students entering the field of psychiatry consistently identify psychiatry clerkships as a fundamental component of deciding to pursue the specialty as a career.

The average length of United States medical school clerkships has been declining over the past 30 years.

Frequently clerkships are primarily inpatient based with limited exposure to other treatment areas and modalities across the field of psychiatry.

Certain medical schools have moved to a transformed curriculum resulting in a psychiatry clerkship that is significantly reduced in duration or eliminated.

Neither the Liaison Committee on Medical Education (LCME) nor the American Osteopathic Association (AOA) Commission on Osteopathic College Accreditation (COCA) have a suggested or required timeframe for duration of psychiatry clerkships.

To continue to recruit medical students to psychiatric residency and practice, steps need to be taken to ensure an adequate and broad exposure to psychiatric practice. Further, ensuring adequate training in psychiatry during undergraduate medical education will improve trainee readiness for residency. Recommendations for the clerkship experience have been previously described in the Association of Directors of Medical Student Education in Psychiatry (ADMSEP) and Association of Academic Psychiatry (AAP) position statement on the length of the psychiatry clerkship.

BE IT RESOLVED:
That the APA tasks the Council on Medical Education and Lifelong Learning (CMELL) with drafting a position statement on recommended guidelines for the Psychiatry Clerkship. The CMELL should partner with other organizations invested in psychiatric education, such as ADMSEP and AADPRT, in the drafting of this position statement.
This statement should be used to provide recommendations to the Liaison Committee on Medical Education (LCME) and the American Osteopathic Association (AOA) Commission on Osteopathic College Accreditation (COCA) on minimum requirements for psychiatric training. The statement should describe the importance of psychiatry clerkships as the key formative experience for all medical students, and best practices that promote medical student education and interest in psychiatry. Specific components integral to the psychiatry clerkship should include:

- A minimum duration of a six-week equivalent full-time experience in the evaluation and treatment of psychiatric patients.
- Exposure to both inpatient and ambulatory practice settings, ideally including exposure to subspecialty (e.g. – child and adolescent, addictions, geriatrics, consultation and liaison) and developing models of practice designed to better serve psychiatric populations (e.g. – collaborative or integrated care).

AUTHORS:
Edward Thomas Lewis, III, M.D., Representative, South Carolina Psychiatric Association
Michael J. Peterson, M.D., PhD, Representative, Wisconsin Psychiatric Association

SPONSORS:
Jack Bonner, M.D., ACROSS Representative, Senior Psychiatrists
Steven Daviss, M.D., Representative, Maryland Psychiatric Society
Mary Fitz-Gerald, M.D., Representative, Louisiana Psychiatric Medical Association
Mark Haygood, M.D., Area 5 Representative, Assembly Committee of Early Career Psychiatrists
Rachel Houchins, M.D., Representative, South Carolina Psychiatric Association
James C. West, M.D., Representative, Society of Uniformed Services Psychiatrists
Clarence Chou, M.D., Representative, Wisconsin Psychiatric Association
Brian Hart, M.D., Representative, Indiana Psychiatric Society

ESTIMATED COST:
Author: $0

APA: $3,080

ESTIMATED SAVINGS:

ESTIMATED REVENUE GENERATED:

ENDORSED BY: Area 5 Council, Assembly Committee of Early Career Psychiatrists (ECPs)

KEY WORDS: Psychiatry, Clerkship, Medical student, Education, Training

APA STRATEGIC PRIORITIES: Advancing Psychiatry, Education

References:
The Psychiatry Clerkship: A Position Statement on the Length of the Psychiatry Clerkship Academic Psychiatry, 2006; 30(2); 103.

Lyons Z. Attitudes of medical students toward psychiatry and psychiatry as a career: A Systematic review. Academic Psychiatry 2013; 37(3); 150-157

Attachment #10
Item 2017A1 12.L
Assembly
May 19-21, 2017

ACTION PAPER
FINAL

TITLE: Requesting the APA Draft a Position Statement on Prescription Drug Monitoring Programs (PDMPs)

WHEREAS:

- According to the Center for Disease Control and Prevention (CDC), 20% of patients presenting to physician offices with non-cancer pain symptoms or pain-related diagnoses (including acute and chronic pain) receive an opioid prescription.
- From 2000 to 2014 nearly half a million persons in the United States died from drug overdoses, primarily prescription opioids and heroin.
- Between 2007 to 2012, opioid prescriptions per capita increased 7%.
- In 2013, 1.9 million persons with opioid use disorders were using prescription opioids.
- The American Psychiatric Association is a member of the American Medical Association Task Force to Reduce Opioid Abuse. The Task Force urges states and physicians to utilize prescription drug monitoring programs (PDMPs).
- PDMPs are state-level electronic databases.
- PDMPs collect, monitor, and analyze prescribing and dispensing data.
- Forty-nine (49) states have operational PDMPs, each with unique rules and regulations.
- PDMPs are proactive efforts to safeguard the public health and the safe medical use of controlled medications.
- PDMPs help ensure that if patients are prescribed controlled medications, the controlled medications are medically necessary and taken as directed.
- PDMPs help reduce harm from possible adverse drug actions and possible adverse drug-drug interactions.
- Physicians prescribing medications without access to PDMP data increase their patients risk of adverse drug actions, adverse drug-drug interactions, substance use disorders, and becoming a target for controlled medication diversion.
- The Comprehensive Addiction and Recovery Act of 2016 established a mechanism to provide grants to strengthen state PDMPs.

BE IT RESOLVED:

- That the American Psychiatric Association draft a position statement regarding Prescription Drug Monitoring Programs.
- That such PDMP position statement addresses PDMP best practices including design, operation, confidentiality, privacy, physician/staff burden utilization and interstate access.

AUTHORS:
Dionne Hart, M.D., Representative, Minnesota Psychiatric Society
Alexander von Hafften, M.D., Representative, Alaska Psychiatric Association

ESTIMATED COST:
Author: $616
APA: $2,310

ESTIMATED SAVINGS: $0.00

ESTIMATED REVENUE GENERATED: $0.00

ENDORSED BY:

KEY WORDS: Prescription Drug Monitoring Programs, Methadone, Opioid epidemic, patient safety

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

Attachment #11
Item 2017A1 12.M
Assembly
May 19-21, 2017

ACTION PAPER
FINAL

TITLE: Juvenile Solitary Confinement

WHEREAS:
1. Solitary confinement of juveniles continues to be used in correctional facilities for periods that exceed the acceptable use of behavioral interventions, such as “time out” (1 hour or less).

2. The brain is not fully developed until the early 20’s.

3. Solitary confinement has been associated and causative with adverse psychiatric consequences such as depression, anxiety, psychosis, or worsening of an existing psychiatric disorder.

4. The A.P.A. does not have an existing position statement regarding the solitary confinement of juveniles.

5. The following organizations DO have position statements on the solitary confinement of juveniles:
- American Academy of Child and Adolescent Psychiatry: “Solitary Confinement of Juvenile Offenders”, (approved April, 2012)
- American Medical Association: “Solitary Confinement of Juveniles in Legal Custody”, (2016)
- United Nations: “Rules for the Protection of Juveniles Deprived of Their Liberty”, section 67, (Dec. 14, 1990)
- National Commission of Correctional Healthcare: position statement (April 10, 2016)

6. The AACAP policy statement on the use of solitary confinement in juveniles has been used nationally by the AMA, ACLU, and others to set policy.

7. This does not affect the APA policy statement for adult seclusion.

BE IT RESOLVED:

That the APA support the AMA policy statement opposing the use of solitary confinement in juveniles , and that the APA draft its own position statement by May of 2018.

H-60.922
Our AMA: (1) opposes the use of solitary confinement in juvenile correction facilities except for extraordinary circumstances when a juvenile is at acute risk of harm to self or others; (2) opposes the use of solitary confinement of juveniles for disciplinary purposes in correctional facilities; and (3) supports that isolation of juveniles for clinical or therapeutic purposes must be conducted under the supervision of a physician.

With the following preamble:

Solitary confinement is defined as the placement of an incarcerated individual in a locked room or cell with minimal or no contact with people other than staff of the correctional facility. It is used as a form of discipline or punishment.

AUTHORS:
Judy Glass, M.D., Representative, Quebec and Eastern Canada District Branch
Louis Kraus, M.D., APA Member

SPONSORS:
Vincenzo Di Nicola, M.D., Representative, Quebec and Eastern Canada District Branch
Lisa Catapano-Friedman, M.D., Representative, Vermont Psychiatric Association
John M. de Figueiredo, M.D., Representative, Connecticut Psychiatric Society
David Fassler, M.D., APA Member
Reena Kapoor, M.D., Representative, Connecticut Psychiatric Society
Simha Ravven, M.D., Area 1 Deputy Representative, Assembly Committee of Early Career Psychiatrists
Michelle P. Durham, M.D., Representative, Massachusetts Psychiatric Society
Gabrielle Shapiro, M.D., Representative, New York

ESTIMATED COST:
Author: $0
APA: $2,156

ESTIMATED SAVINGS: $0

ESTIMATED REVENUE GENERATED: $0

ENDORSED BY: Area 1 Council, Area 2 Council, Assembly Committee on Public and Community Psychiatry

KEY WORDS: Solitary Confinement, Juveniles

APA STRATEGIC PRIORITIES: Advancing Psychiatry

REVIEWED BY RELEVANT APA COMPONENT: Council on Children, Adolescents and Their Families, Council on Psychiatry and Law

Attachment #12
Item 2017A1 12.N
Assembly
May 19-21, 2017

ACTION PAPER
FINAL

TITLE: Addressing Physician Burnout, Depression, and Suicide—Within Psychiatry and Beyond

WHEREAS:
Burnout is a "syndrome of emotional exhaustion, loss of meaning in work, feelings of ineffectiveness, and a tendency to view people as objects rather than as human beings," as defined by the Maslach Burnout Inventory Manual;

Rates of burnout among physicians, including psychiatrists, are estimated to be from 50% to 90%, suggesting a need for a public health approach to reduce burnout throughout the physician workforce;

Depression affects over 25% of resident physicians with a significant increase in depressive symptoms after the start of training, and physicians in general suffer from depression at high rates and are less likely than the general public to seek care or treatment;

Physicians are more likely to die by suicide than age-matched professionals, and such events have a profound impact on patients, other providers, and communities;

Physicians suffering from untreated mental illness or substance use disorders may be impaired and therefore perhaps more at risk for making medical errors that can compromise patient safety;

Promoting physician mental health may also enhance recognition of mental illness in patients;

Many institutions are beginning to look for evidence-based approaches to preventing burnout and depression among physicians, and there are programs being developed around the country whose efficacy can be studied;

Psychiatrists working within healthcare institutions are often local experts in depression and suicide as well as promoting wellness (e.g., process groups and supervision) and are well positioned to lead these efforts;

The APA and Dr. Anita Everett recently convened an Ad Hoc Workgroup on this topic chaired by Dr. Richard Summers;

Certain state licensing boards maintain potentially discriminatory reporting requirements for mental health conditions, as addressed in the APA Position Statement on Inquiries about Diagnosis and Treatment of Mental Disorders in Connection with Professional Credentialing and Licensing;
National organizations such as the Office of the Surgeon General, the Accreditation Council for Graduate Medical Education, and the Association of American Medical Colleges have recognized this problem as a national priority.

BE IT RESOLVED:
That the APA continue the mission of the Ad Hoc Workgroup on Physician Well-Being by developing resources for increasing awareness about physician burnout, depression and suicide, as well as interventions for promoting physician wellness, including recommendations for institutional response to physician suicide;

That the APA revise its 2011 "Position Statement on Physician Wellness" to affirm the APA's commitment to ensuring the well-being of its members and to encourage members to serve as leaders in promoting well-being initiatives within their institutions, training programs, and systems of care;

That the APA promote further investigation of the underlying causes of increased rates of burnout, depression and suicide among physicians and to expand the evidence base for innovative wellness interventions;

That the APA Government Relations staff work with stakeholder organizations including the Federation of State Medical Boards to remove questions about psychiatric or substance use disorder treatment from licensing applications (initial or renewal) as well as employment applications, instead focusing on relevant, current functional impairment due to either physical or mental illness;

That the APA's AMA delegation continue to collaborate with the AMA to develop joint initiatives to prioritize these issues.

AUTHORS:
Jeremy D. Kidd, M.D., MPH, Area 2 Representative, Assembly Committee of Resident-Fellow Members
jeremy.kidd@gmail.com
David Roane, M.D., Representative, New York County District Branch
Matthew L. Goldman, M.D., MS, APA Member
Carol Bernstein, M.D., APA Member
Laurel Mayer, MD, APA Member

ESTIMATED COST:
Author: $2,310
APA: $4,235

ESTIMATED SAVINGS: $0

ESTIMATED REVENUE GENERATED: $0

ENDORSED BY: Area 2 Council, Assembly Committee of Resident-Fellow Members, New York County District Branch

KEY WORDS: Well-being, Physician Well-being, Burnout, Depression

APA STRATEGIC PRIORITIES: Advancing Psychiatry, Education

REVIEWED BY RELEVANT APA COMPONENT:

Attachment #13
Item 2017A1 12.O
Assembly
May 19-21, 2017

ACTION PAPER
FINAL

TITLE: Health Care Is a Human Right

WHEREAS:
Whereas,
Life, liberty, and the pursuit of happiness are intrinsic American values enshrined in the American Declaration of Independence

Whereas,
Health is essential for quality and longevity of life

Whereas,
Health of individuals and populations is an essential asset for robust economies and democracies

Whereas,
Health is essential to a nation's security and prosperity

BE IT RESOVLED:
That the American Psychiatric Association adopt the following position statement: "Health care, inclusive of mental health care, is a human right".

AUTHORS:
Eliot Sorel, M.D., DLFAPA, Representative, Washington Psychiatric Society
Pedro Ruiz, M.D., DLFAPA, APA Member
Roger Peele, M.D., DLFAPA, APA Member
Josepha Immanuel, M.D., APA Member
Constance E. Dunlap, M.D., DFAPA, Representative, Washington Psychiatric Society
Rahn K. Bailey, M.D., DFAPA, Representative, Black Psychiatrists
Bernardo Ng, M.D., DFAPA, APA Member
Vincenzo Di Nicola, M.D., DFAPA, Representative, Quebec and Eastern Canada District Branch
Michelle Riba, M.D., DLFAPA, APA Member
Steve Koh, M.D., FAPA, APA Member

SPONSORS:
Joseph Napoli, M.D., DLFAPA, Representative, Area 3
Ranga Ram, M.D., DFAPA, Representative, Psychiatric Society of Delaware
Manuel Reich, D.O., Representative, Pennsylvania Psychiatric Society
Rahul Malhotra, M.D., Area 3Representative, Assembly Committee of Early Career Psychiatrists
Joseph P. Collins, Jr., M.D., FAPA, APA Member
Eindra Khin Khin, M.D., FAPA, APA Member
Elizabeth M. Morrison, M.D., DLFAPA, Representative, Washington Psychiatric Society

ESTIMATED COST:
Author: $3,542
APA: $7,700

ESTIMATED SAVINGS:

ESTIMATED REVENUE GENERATED:

ENDORSED BY: Washington Psychiatric Society

KEY WORDS: Access to Health Care, Human Rights

APA STRATEGIC PRIORITIES: Advancing Psychiatry, Education, Diversity

REVIEWED BY RELEVANT APA COMPONET: Council on International Psychiatry

Attachment #14
Item 2017A1 12.P
Assembly
May 19-21, 2017

ACTION PAPER
FINAL

TITLE: Making Access to the Voting Page a Default Action During Elections

WHEREAS:
The percentage of eligible APA members who vote in the annual election has dropped from an average of 33% in the first five years of the last decade to an average of 19% in the last 5 years;

Of the 19.5% of eligible members who voted in the 2017 election, 92% of them voted electronically, with 83% of these electronic voters doing so via a link sent to them via email;

Thus, only one-sixth of the voters accessed the elections page by clicking on a link on the APA website, which amounts to only 3% of eligible members doing so;

The field of behavioral economics has found that one of the methods for increasing a desired action (like saving for retirement) in the face of mass inertia is to make the desired action the default action;

Having the voting webpage be automatically served to an APA member when they go to any of the APA websites would be expected to significantly increase the percent of members who complete the balloting process; and

Increasing the voting rate among APA members is a valuable goal towards maintaining an effective, involved, and healthy organization; therefore

BE IT RESOLVED:
The Assembly recommends that the APA Administration work to make access to voting as prominent as possible and user friendly on the APA website, and reconsider the value of mailing ballots to all members.

AUTHOR:
Steven Daviss, M.D., DFAPA, Representative, Maryland Psychiatric Society (steve@fusehealth.org)

SPONSORS:
Mary Anne Albaugh, M.D., Representative, Pennsylvania Psychiatric Society
Constance Dunlap, M.D., Representative, Washington Psychiatric Society
Annette Hanson, M.D., DFAPA, Representative, Maryland Psychiatric Society

Marvin Koss, M.D., Representative, Central New York District Branch
Rahul Malhotra, M.D., Area 3Representative, Assembly Committee of Early Career Psychiatrists
Gabrielle Shapiro, M.D., DFAPA, Representative, New York County Psychiatric Society
James Curt West, M.D., Representative, Society of Uniformed Services Psychiatrists
Lily Arora, M.D., Representative, New Jersey Psychiatric Association
Debra Atkisson, M.D., DFAPA, Texas Society of Psychiatric Physicians
Jeffrey Bennett, M.D., Representative, Illinois Psychiatric Society

ESTIMATED COST:
Author: $924
APA: $2,310

ESTIMATED SAVINGS: $0

ESTIMATED REVENUE GENERATED: Unknown amount from increase in membership

ENDORSED BY:

KEY WORDS: Elections, Voting, Website, Membership

APA STRATEGIC PRIORITIES: Advancing Psychiatry

REVIEWED BY RELEVANT APA COMPONENT:

Attachment #15
Item 2017A1 12.Q
Assembly
May 19-21, 2017

ACTION PAPER
FINAL

TITLE: Dues Relief for District Branch Members from the Commonwealth of Puerto Rico

WHEREAS:
As APA general members, Canadian psychiatrists, from a country much more prosperous than the Commonwealth of Puerto Rico, pay $375 in national dues compared to $575 for US general Members.

Because of economic differences between Puerto Rico, a Commonwealth of the United States, and the 50 States of the Union, APA members in Puerto Rico actually pay proportionally more of their salary for their membership than other Psychiatrists; their rates of Medicaid and Medicare reimbursement are significantly lower. Third party insurance payers follow the Medicare example and are known to pay as little as $20 a session. Also, members are obligated to pay a fixed amount, $300 to the College of Physicians and Surgeons. The past president of APA has publicly stated that the doctors in Puerto Rico are the lowest paid physicians in the USA.

The APA available benefits for psychiatrists practicing in Puerto Rico are fewer. There is no PAC support for psychiatric issues in Puerto Rico. APA-sponsored malpractice insurance is not available to psychiatrists practicing in Puerto Rico. Pragmatically, they receive essentially equivalent services to our Canadian members. Thus, it would seem appropriate that their membership rate should be similar.

BE IT RESOLVED:

That general member psychiatrists who are members of the Puerto Rico Psychiatric Society, a District Branch of the APA shall be granted the same annual APA dues as our Canadian counterparts, which is $375 per general member per year for the next five years.

AUTHORS:
Harold Ginzburg, M.D., Representative, Oklahoma Psychiatric Physicians Association
(haroldginzburg@hotmail.com)
Michael Woodbury-Farina, M.D., Representative, Puerto Rico Psychiatric Society

SPONSORS:
Laurence Miller, M.D., Representative, Area 5
Nazanin Silver, M.D., MPH, Area 3 Deputy Representative, Assembly Committee of Resident Fellow Members
Vincenzo Di Nicola, M.D., Representative, Quebec and Eastern Canada District Branch
Shreekumar Vinekar, M.D., Representative, Oklahoma Psychiatric Physicians Association
Mary Jo Fitz-Gerald, M.D., Representative, Louisiana Psychiatric Medical Association
Judy Glass, M.D., Representative, Quebec and Eastern Canada District Branch
Joseph Napoli, M.D., Representative, Area 3
James Polo, M.D., Representative, Washington State Psychiatric Association

Debra Atkisson, M.D., Representative, Texas Society of Psychiatric Physicians
Jose De La Gandara, M.D., Representative, Hispanic Psychiatrists
Oscar Perez, M.D., Deputy Representative, Hispanic Psychiatrists
Sarah Huertas-Goldman, M.D., Representative, Puerto Rico Psychiatric Society
Gabrielle Shapiro, M.D., Representative, New York County District Branch

ESTIMATED COST:
Author: (**lost revenue**) $30,375 in the first year [$575-$350=$225x135 members=$30,375]
APA: $31,950

ESTIMATED SAVINGS: The loss of more than 60 general psychiatrists represents a loss of approximately $35,000 per year. The more members we can recruit/retain the more we will be saving.

ESTIMATED REVENUE GENERATED: None at first but with more joining, there will be more revenue. If we could get back to 200, which means 65 more general members, we would break even within two years and from then on there would be a "profit." If only 9 more members join, break-even is at 10 years.

ENDORSED BY: Area 5 Council – by unanimous vote

KEY WORDS: Membership, District Branch

APA STRATEGIC PRIORITIES: Advancing Psychiatry, Diversity

REVIEWED BY RELEVANT APA COMPONENT: Resubmission with additional economic data and Area 5 support

Attachment #16
Item 2017A1 12.R
Assembly
May 19-21, 2017

ACTION PAPER
FINAL

TITLE: Streamlining the Application Process for Former APA Members

WHEREAS:
The American Psychiatric Association (APA) had a membership increase in 2016.

The APA continues to explore modalities to increase membership including ways to have former APA members rejoin the organization.

Currently, former APA members interested in rejoining the APA have to complete the same extensive application process as a new, non-former member. The redundancy in the reapplication process may be a barrier for former members to reestablish membership. The application main categories include biographical information, academic training, training, board certification, demographic data, primary practice setting, ethics, professional service, documentation, and agreement.

As a result, streamlining the process for re-applicants may further increase APA membership, demonstrate to former members that the APA values their participation in the organization, and a way to demonstrate to former members that the APA "wants them back."

BE IT RESOLVED:
That the APA staff streamline the application process for former APA members on the website as follows:

1. Once an applicant answers yes to being a former member of the APA on the website, the individual is given an online, pre-filled application.
2. Remove the requirement for the applicant to resubmit the residency training certificate (this can be verified by APA staff from previous membership records).
3. Remove the requirement for the applicant to submit a valid medical license (this can be verified by APA staff from online, public databases).

That the APA staff advertise the changes to the streamlined application process for former APA members.

AUTHORS:
Mark Haygood, D.O., MS, Area 5 Representative, Assembly Committee of Early Career Psychiatrists
Rahul Malhotra, M.D., Area 3 Representative, Assembly Committee of Early Career Psychiatrists
Baiju Gandhi, M.D., Area 3 Deputy Representative, Assembly Committee of Early Career Psychiatrists

ESTIMATED COST:
Author: $616
APA: $616

ESTIMATED SAVINGS:

ESTIMATED REVENUE GENERATED:

ENDORSED BY:

KEY WORDS: Former APA members; Membership; Membership application process

APA STRATEGIC PRIORITIES: Advancing Psychiatry, Diversity

REVIEWED BY RELEVANT APA COMPONENT:

Attachment #17
Item 2017A1 12.T
Assembly
May 19-21, 2017

ACTION PAPER
FINAL

TITLE: APA Referendum Voting Procedure

WHEREAS:
Whereas: The referendum process is a critical component in maintaining the American Psychiatric Association as a member driven organization and allows the membership to determine the need for even major structural or policy changes in the organization, similar to the purpose of the amendment process in the U. S. Constitution.

Whereas: The referendum process was considered a fundamental component of the governing structure of the APA as testified to by its long tenure in the bylaws.

Whereas: The referendum process is currently operationalized by attaching the referendum for membership vote to the APA national officer election ballot.

Whereas: The election of officers occurs by a simple majority of those eligible members who choose to vote, while the passing of a referendum requires a majority of at least 40 percent of all eligible voters.

Whereas: Forty percent of all eligible voters have not voted in an APA national election in almost 20 years with only 15 percent voting in the 2016 election. Thereby, no referendum has passed since 1980, even when the affirmative percentage of voting members was as high as 80 percent, as occurred in 2011. In distinction, in the 2016 officer election, a candidate for office could have won with the votes of 8 percent of eligible voters.

Whereas: A referendum to change the voting procedure would, itself, have to go through the above-referenced process which has clearly been shown to not be functional for establishing the predominant will of the membership in regard to proposals.

Whereas: There is a stipulation in the American Psychiatric Association bylaws §8.4, which states that referenda are "to be voted on in the next annual ballot." It does not specifically stipulate that this "annual ballot" refers to, or only to, the national election ballot.

Whereas: A yearly mailing, both paper and electronic, is distributed which includes the dues statement and/or solicitation for contributions (for non-dues paying but voting members). Obviously, all dues paying members must respond to this mailing to maintain their membership. All non-dues paying but voting members may, and, in fact, are encouraged to respond to the contribution/solicitation aspect of the mailing.

Whereas: This action paper is not calling for a lowering of the percentage of voting members who would have to vote to allow a referendum to pass (40 percent) and it therefore is not in violation of the Washington, D.C. code.

Whereas: A separate envelope could be included with the dues/solicitation mailing, or a separate link or secure form appended to the electronic option, to allow for voter confidentiality.

Whereas: Virtually identical action papers, as originally amended by Reference Committee 5, have been passed now by the Assembly on four separate occasions at four separate Assembly meetings.

Whereas: The cost of attaching referendum voting ballots to the dues/solicitation notice process should not be inherently more expensive than the current practice of attaching them to the officer election ballot process, beyond that of establishing the transition.

BE IT RESOLVED:

1. If 2/3 of the voting members approve a referendum statement, but the requirement of 40% of eligible voters voting has not been met, the BOT will schedule a vote on the referendum statement or a modified version of it for voting by members of the BOT and the Assembly. If the referendum statement or its modified version does not get a 2/3 votes by both these bodies and thus fails to pass, or if the lead petitioner of the referendum statement does not agree to the modified version, then the original referendum statement will be placed again on the ballot to be voted on by the entire membership; but this time the referendum ballot will be sent with the yearly dues statement/solicitation for contributions to all voting members. If it fails again it will not be automatically placed on the ballot again. If it passes, it will supersede any modified version passed by the BOT and the Assembly.

2. If the BOT rejects resolved #1, then an alternative for a viable referendum process shall be prepared by the Board of Trustees, with participation of Assembly Representatives jointly selected by the Speaker and the President, and presented to the Assembly at the Fall 2017 meeting.

AUTHOR:
John P. D. Shemo, M.D., DLFAPA, Representative, Psychiatric Society of Virginia
(shemojohn@pabrcrc.com)

ESTIMATED COST:
Author: $35,000
APA: $41,160

ESTIMATED SAVINGS: Not relevant for this paper.

ESTIMATED REVENUE GENERATED: Not relevant for this paper

ENDORSED BY: Psychiatric Society of Virginia, Area 5 Council

KEY WORDS: APA Referendum/membership driven organization

APA STRATEGIC PRIORITIES: Advancing psychiatry, diversity

REVIEWED BY RELEVANT APA COMPONENT: Submitted to the Bylaws Committee and the Elections Committee.

Attachment #18
Item 2017 A1 4.B.20
Assembly
May 19-21, 2017

Position Statement on Use of the Concept of Recovery

(*Redline Version*)

The American Psychiatric Association endorses and strongly affirms the application of the concept of recovery to the comprehensive care and treatment of individuals with mental illness across the lifespan. ~~chronically and persistently mentally ill adults, including the concept of resilience in seriously emotionally disturbed children~~. The concept of recovery emphasizes a person's capacity to have hope and to lead a meaningful life, and suggests that treatment ~~can~~ be guided by attention to life goals and ambitions. It recognizes that patients often feel powerless or disenfranchised, that these feelings can interfere with initiation and maintenance of ~~mental health~~ psychiatric and medical care, and that the best results come when patients feel that treatment decisions are made in ways that ~~suit~~ are collaborative and consistent with their cultural, spiritual, and personal ideals. ~~It~~ Recovery focuses on hope, wellness and resilience and encourages patients to participate actively in their care, particularly by enabling them to help define the goals of ~~psychopharmacologic and psychosocial~~ treatment~~s~~ and to have meaningful input into the interventions to achieve these.

The concept of recovery has a long history in medicine and its principles are important in the management of all chronic disorders. The concept of recovery enriches and supports medical and rehabilitation models. By applying the concept of recovery as well as rehabilitation ~~techniques~~ and by encouraging ~~other mental health professionals~~ others who treat mental illness to adopt the concept of recovery, psychiatrists can enhance the care of ~~all clinical~~ populations served ~~within the community based and other public sector mental health and behavioral health systems.~~ in all settings where psychiatric services are provided.

The concept of recovery values and maximizes the patient's ~~includes maximization of~~ 1) ~~a each patient's~~ autonomy based on ~~that patient's~~ individual desires and capabilities, 2) ~~patient's~~ dignity and self-respect, 3) ~~patient's acceptance and~~ integration into full community life, and 4) ~~resumption of normal~~ full development. The concept of recovery focuses on increasing the patient's ability to successfully ~~cope with~~ adapt to life's challenges, and to collaborate with the psychiatrist to ~~successfully~~ optimally manage ~~their~~ his/her symptoms. The application of the concept of recovery requires a commitment to a broad range of necessary services and should not be used to justify deprofessionalization or other ~~a~~ retraction of resources.

The concept of recovery is predicated on ~~a~~ the partnership between patient, psychiatrist, and other practitioners~~, and patient~~ in ~~the construction~~ constructing and ~~direction~~ directing ~~of~~ all services aimed at maximizing hope and quality of life.

(original Author: Council on Research)
(revisions: Assembly Committee of Public and Community Psychiatry)

Position Statement on Use of the Concept of Recovery

(*Clean Version*)

The American Psychiatric Association endorses and strongly affirms the application of the concept of recovery to the comprehensive care and treatment of individuals with mental illness across the lifespan. The concept of recovery emphasizes a person's capacity to have hope and to lead a meaningful life, and suggests that treatment be guided by attention to life goals and ambitions. It recognizes that patients often feel powerless or disenfranchised, that these feelings can interfere with initiation and maintenance of psychiatric and medical care, and that the best results come when patients feel that treatment decisions are made in ways that are collaborative and consistent with their cultural, spiritual, and personal ideals. Recovery focuses on hope, wellness and resilience and encourages patients to participate actively in their care, particularly by enabling them to help define the goals of treatment and to have meaningful input into the interventions to achieve these.

The concept of recovery has a long history in medicine and its principles are important in the management of all chronic disorders. The concept of recovery enriches and supports medical and rehabilitation models. By applying the concept of recovery as well as rehabilitation and by encouraging others who treat mental illness to adopt the concept of recovery, psychiatrists can enhance the care of populations served in all settings where psychiatric services are provided.

The concept of recovery values and maximizes the patient's 1) autonomy based on individual desires and capabilities, 2) dignity and self-respect, 3) integration into full community life, and 4) full development. The concept of recovery focuses on increasing the patient's ability to successfully adapt to life's challenges, and to collaborate with the psychiatrist to optimally manage his/her symptoms. The application of the concept of recovery requires a commitment to a broad range of necessary services and should not be used to justify deprofessionalization or other retraction of resources.

The concept of recovery is predicated on the partnership between patient, psychiatrist, and other practitioners in constructing and directing all services aimed at maximizing hope and quality of life.

(original Author: Council on Research)
(revisions: Assembly Committee of Public and Community Psychiatry)

Attachment #19

Assembly
May 19-21, 2017
San Diego, California

DRAFT SUMMARY OF ACTIONS

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2017 A1 1.A.1	Ratification of the APA Bylaws: Will the APA Assembly vote to ratify the amendments to the APA bylaws and Operations (Ops) manual to reflect the new nomination and election process for the M/UR Trustee?	The Assembly voted to ratify the amendments to the APA bylaws and Operations (Ops) manual to reflect the new nomination and election process for the M/UR Trustee.	Chief Operating Officer • Association Governance FYI- Board of Trustees, July 2017
2017 A1 4.B.1	Retain 2007 Position Statement *Use of Stigma as a Political Tactic*	The Assembly voted, on its Consent Calendar, to approve the retention of the 2007 Position Statement *Use of Stigma as a Political Tactic*.	Board of Trustees, July 2017 FYI- Joint Reference Committee, June 2017
2017 A1 4.B.2	Revised Position Statement: *Position Statement on the Role of the Psychiatrist in the Long-Term Care Setting*	The Assembly voted, on its Consent Calendar, to approve the revised Position Statement: *Position Statement on the Role of the Psychiatrist in the Long-Term Care Setting*.	Board of Trustees, July 2017 FYI- Joint Reference Committee, June 2017
2017 A1 4.B.3	Retire 2009 Position Statement: *U.S. Military Policy of "Don't Ask Don't Tell"*	The Assembly voted, on its Consent Calendar, to approve the retirement of the 2009 Position Statement: *U.S. Military Policy of "Don't Ask Don't Tell".*	Board of Trustees, July 2017 FYI- Joint Reference Committee, June 2017
2017 A1 4.B.4	Retain 2006 Position Statement: *Resolution against Racism and Racial Discrimination and Their Adverse Impacts on Mental Health*	The Assembly voted, on its Consent Calendar, to approve the retention of the 2006 Position Statement: *Resolution against Racism and Racial Discrimination and their Adverse Impacts on Mental Health*.	Board of Trustees, July 2017 FYI- Joint Reference Committee, June 2017
2017 A1 4.B.5	Retain 2001 Position Statement: *Discrimination Against International Medical Graduates*	The Assembly voted, on its Consent Calendar, to approve the retention of the 2001 Position Statement: *Discrimination Against International Medical Graduates*.	Board of Trustees, July 2017 FYI- Joint Reference Committee, June 2017
2017 A1 4.B.6	Retain 1999 Position Statement: *Diversity*	The Assembly voted, on its Consent Calendar, to approve the retention of the 1999 Position Statement: *Diversity*.	Board of Trustees, July 2017 FYI- Joint Reference Committee, June 2017
2017 A1 4.B.7	Retain 1994 Position Statement: *Psychiatrists from Underrepresented Groups in Leadership Roles*	The Assembly voted, on its Consent Calendar, to approve the retention of the 1994 Position Statement: *Psychiatrists from Underrepresented Groups in Leadership Roles*.	Board of Trustees, July 2017 FYI- Joint Reference Committee, June 2017
2017 A1 4.B.8	Retain 1994 Position Statement: *Resolution Opposing Any Restriction on the Number of IMGs Entering Graduate Medical Training*	The Assembly voted, on its Consent Calendar, to approve the retention of the 1994 Position Statement: *Resolution Opposing Any Restriction on the Number of IMGs Entering Graduate Medical Training*.	Board of Trustees, July 2017 FYI- Joint Reference Committee, June 2017

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2017 A1 4.B.9	Revised 1978 Position Statement: *Abortion*	The Assembly voted to approve the Revised 1978 Position Statement: *Abortion*.	Board of Trustees, July 2017 FYI- Joint Reference Committee, June 2017
2017 A1 4.B.10	Retain 1977 Position Statement: *Affirmative Action*	The Assembly voted, on its Consent Calendar, to approve the retention of the 1977 Position Statement: *Affirmative Action*.	Board of Trustees, July 2017 FYI- Joint Reference Committee, June 2017
2017 A1 4.B.11	Retire 1976 Position Statement: *1976 Joint Statement on Antisubstitution Laws and Regulations*	The Assembly voted, on its Consent Calendar, to approve the retirement of the 1976 Position Statement: *1976 Joint Statement on Antisubstitution Laws and Regulations*.	Board of Trustees, July 2017 FYI- Joint Reference Committee, June 2017
2017 A1 4.B.12	Retire 1993 Position Statement: *Homicide Prevention and Gun Control*	This item was withdrawn by the Joint Reference Committee.	N/A
2017 A1 4.B.13	Retain 1998 Position Statement: *Misuse of Psychiatric Examinations and Disclosure of Psychiatric Records in Sexual Harassment Litigation*	The Assembly voted, on its Consent Calendar, to approve the retention of the 1998 Position Statement: *Misuse of Psychiatric Examinations and Disclosure of Psychiatric Records in Sexual Harassment Litigation*.	Board of Trustees, July 2017 FYI- Joint Reference Committee, June 2017
2017 A1 4.B.14	Retire 2001 Position Statement: *Doctors Against Handgun Violence*	The Assembly voted, on its Consent Calendar, to approve the retirement of the 2001 Position Statement: *Doctors Against Handgun Violence*.	Board of Trustees, July 2017 FYI- Joint Reference Committee, June 2017
2017 A1 4.B.15	Retain 2008 *Adoption of AMA Statements on Capital Punishment*	The Assembly voted, on its Consent Calendar, to approve the retention of the 2008 *Adoption of AMA Position Statements on Capital Punishment*.	Board of Trustees, July 2017 FYI- Joint Reference Committee, June 2017
2017 A1 4.B.16	Retain 2010 Position Statement: *No "Dangerous Patient" Exemption to Federal Psychotherapist-Patient Testimonial Privilege*	The Assembly voted, on its Consent Calendar, to approve the retention of the 2010 Position Statement: *No "Dangerous Patient" Exemption to Federal Psychotherapist- Patient Testimonial Privilege*.	Board of Trustees, July 2017 FYI- Joint Reference Committee, June 2017
2017 A1 4.B.17	Proposed Position Statement: *Risk of Adolescents' Online Behavior*	The Assembly voted to approve the Proposed Position Statement: *Risk of Adolescents' Online Behavior*.	Board of Trustees, July 2017 FYI- Joint Reference Committee, June 2017
2017 A1 4.B.18	Proposed Position Statement: *Role of Psychiatrists in Addressing Care for People Affected by Forced Displacement*	The Assembly voted, on its Consent Calendar, to approve the Proposed Position Statement: *Role of Psychiatrists in Addressing Care for People Affected by Forced Displacement*.	Board of Trustees, July 2017 FYI- Joint Reference Committee, June 2017
2017 A1 4.B.19	Proposed Position Statement: *Legislative Attempts Permitting Pharmacists to Alter Prescriptions*	The Assembly voted, on its Consent Calendar, to approve the Proposed Position Statement: *Legislative Attempts Permitting Pharmacists to Alter Prescriptions*.	Board of Trustees, July 2017 FYI- Joint Reference Committee, June 2017

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2017 A1 4.B.20	Revised 2015 Position Statement: *Use of the Concept of Recovery*	The Assembly voted to **refer** the Revised 2015 Position Statement: *Use of the Concept of Recovery* to the Assembly Committee of Public and Community Psychiatry.	Joint Reference Committee, June 2017 FYI, Assembly Executive Committee, July 2017
2017 A1 5.A	Will the Assembly vote to approve the minutes of the November 4-6, 2016 meeting?	The Assembly voted to approve the Minutes & Summary of Actions from the November 4-6, 2016 meeting.	Chief Operating Officer • Association Governance
2017 A1 6.B	Will the Assembly vote to approve the Consent Calendar?	Item 2017A1 4.B.20 was removed from the Consent Calendar. The Assembly approved the Consent Calendar as amended.	Chief Operating Officer • Association Governance
2017 A1 6.C	Will the Assembly vote to approve the Special Rules of the Assembly?	The Assembly voted to approve the Special Rules of the Assembly.	Chief Operating Officer • Association Governance
2017 A1 7.A	2017-2018 Election of Assembly Officers	The Assembly voted to elect the following candidates as officers of the Assembly from May 2017 to May 2018: Speaker-Elect: James R. Batterson, MD Recorder: Steven Daviss, MD	Chief Operating Officer • Association Governance
2017 A1 7.B.1	Will the Assembly vote to approve the proposed language to allow for electronic voting on APA Practice Guidelines in the Procedural Code of the Assembly?	The Assembly voted to approve the proposed language to allow for electronic voting on APA Practice Guidelines in the Procedural Code of the Assembly.	Chief Operating Officer • Association Governance
2017 A1 7.B.2	Will the Assembly vote to approve the proposed language to Article 1, Section 7.d (Officers/Vacancies) to note that a special meeting may be held electronically in the Procedural Code of the Assembly?	The Assembly voted to approve the proposed language to Article 1, Section 7.d (Officers/Vacancies) to note that a special meeting may be held electronically in the Procedural Code of the Assembly.	Chief Operating Officer • Association Governance
2017A1 7.K.1	Will the APA adopt the position that decisions regarding licensure, hospital privileges and credentialing and/or participation on insurance panels should not in any way be conditioned upon a physician's completion of or participation in Maintenance of Certification or Osteopathic Continuous Certification?	The Assembly voted to approve that the APA adopt the positon that decisions regarding licensure, hospital privileges and credentialing and/or participation on insurance panels should not in any way be conditioned upon a physician's completion of or participation in Maintenance of Certification or Osteopathic Continuous Certification and that this action be brought by the Speaker to the July 2017 Board of Trustees meeting.	Board of Trustees, July 2017
2017 A1 8.L.1	APA Practice Guideline for the Pharmacological Treatment of Patients with Alcohol Use Disorder	The Assembly voted to approve the APA Practice Guideline for the Pharmacological Treatment of Patients with Alcohol Use Disorder.	Board of Trustees, July 2017

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2017 A1 12.A	Involuntary Psychiatric Commitment for Individuals with Substance Use Disorders	The Assembly voted to approve action paper 2017A1 12.A, which asks that the American Psychiatric Association develop a comprehensive position statement on the use of involuntary psychiatric commitment for the treatment of substance use disorders.	Joint Reference Committee, June 2017
2017 A1 12.B	Opposition to Psychologist Prescribing	The Assembly voted to approve action paper 2017A1 12.B, which asks that the appropriate committee create a Position Statement that reflects that the APA, in the service of patients with mental illness, opposes prescribing privileges of Psychologists.	Joint Reference Committee, June 2017
2017 A1 12.C	Simplification of Electronic Medical Records and Billing Codes	The Assembly did not approve action paper 2017A1 12.C.	N/A
2017 A1 12.D	Adopting Neuroscience-based Nomenclature (NbN) for Medications	The Assembly voted to approve action paper 2017A1 12.D, which asks: That the APA promote the international Neuroscience-based Nomenclature (NbN) standard terminology developed by ACNP, ECNP, CINP, AsCNP, and IUPHAR, in its publications, policies, and communications; That the APA seek opportunities to promote adoption of NbN terminology by payers and policymakers; and That the APA CEO and Medical Director be responsible for carrying out these promotion activities.	Joint Reference Committee, June 2017
2017 A1 12.E	Revising the Nomenclature, Definition, and Clinical Criteria for Partial Hospitalization Program	The Assembly voted to approve action paper 2017A1 12.E, which 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.	Joint Reference Committee, June 2017
2017 A1 12.F	APA Member Survey on Medical Aid in Dying as Option for End-of-Life Care	The Assembly did not approve action paper 2017A1 12.F.	N/A

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2017 A1 12.G	Providing Education and Guidance for the Use and Limitations of Pharmacogenomics in Clinical Practice	The Assembly voted to approve action paper 2017A1 12.G, which asks that: 1. The APA educate its members about the use and limitations of pharmacogenomic testing in clinical 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 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.	Joint Reference Committee, June 2017
2017 A1 12.H	Expanding Access to Psychiatry Subspecialty Fellowships	The Assembly voted, on its Consent Calendar, to approve action paper 2017A1 12.H, which 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, such as extending ACGME accreditation to prior years of training ("grandfathering") during this period of transition.	Joint Reference Committee, June 2017

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2017 A1 12.I	Educational Strategies to Improve Mental Illness Perceptions of Medical Students	The Assembly voted to approve action paper 2017A1 12.I, which asks: That the APA charge the Council on Medical Education and Lifelong Learning (CMELL) to 1. Ascertain with the Association of Directors of Medical Student Education in Psychiatry (ADMSEP) and the American Association of Chairs of Departments of Psychiatry (AACDP), the need for and their interest in implementing educational training strategies for improving medical students' perceptions regarding mental illness and psychiatry, and if there is sufficient interest, 2. Partner with ADMSEP in reviewing and developing educational strategies that particularly involve exposure or contact with patients who have experienced and successfully recovered from mental illness, and discussions of medical students' own perceptions and attitudes regarding mental illness, early on in medical student education, 3. APA to support the developed product and advocate for implementing the developed strategies to various medical education organizations including ADMSEP, AACDP and ACGME.	Joint Reference Committee, June 2017

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2017 A1 12.J	Educational Strategies to Improve Mental Illness Perceptions of Non-Mental Health Medical Professionals	The Assembly voted to approve action paper 2017A1 12.J, which asks: 1. APA to charge the APA Department of Education to work with APA's AMA delegation and with other interested medical professional organizations to ascertain their interest in implementing educational strategies to improve negative perceptions of mental illness across primary care fields; if there is sufficient interest; 2. APA, in partnership with interested medical professional organizations and in conjunction with American Psychiatric Association Foundation, American Psychiatric Association Publishing and mental health advocacy groups, support and develop educational curriculum and video series depicting and emphasizing successful recovery models of mental illness in patients for use by non-mental health medical professionals; 3. In the spirit of collaborative care, APA support and develop, in conjunction with American Psychiatric Association Publishing and other educational organizations, a training curriculum and video series for non-mental health medical professional on how to comfortably communicate with, assess, and treat mentally ill persons, and when to refer patients to psychiatrists; 4. APA to advocate to AMA, AAFP and other non-mental health medical professional organizations, as to the importance and availability of above educational strategies in improving perceptions and care of persons with mental illness.	Joint Reference Committee, June 2017

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2017 A1 12. K	Fostering Medical Student Interest and Training in Psychiatry: The Importance of Medical Student Clerkships	The Assembly voted to approve action paper 2017A1 12.K, which asks that the APA tasks the Council on Medical Education and Lifelong Learning (CMELL) with drafting a position statement on recommended guidelines for the Psychiatry Clerkship. The CMELL should partner with other organizations invested in psychiatric education, such as ADMSEP and AADPRT, in the drafting of this position statement. This statement should be used to provide recommendations to the Liaison Committee on Medical Education (LCME) and the American Osteopathic Association (AOA) Commission on Osteopathic College Accreditation (COCA) on minimum requirements for psychiatric training. The statement should describe the importance of psychiatry clerkships as the key formative experience for all medical students, and best practices that promote medical student education and interest in psychiatry. Specific components integral to the psychiatry clerkship should include: • A minimum duration of a six-week equivalent full-time experience in the evaluation and treatment of psychiatric patients. • Exposure to both inpatient and ambulatory practice settings, ideally including exposure to subspecialty (e.g. – child and adolescent, addictions, geriatrics, consultation and liaison) and developing models of practice designed to better serve psychiatric populations (e.g. – collaborative or integrated care).	Joint Reference Committee, June 2017
2017 A1 12.L	Requesting the APA Draft a Position Statement on Prescription Drug Monitoring Programs (PDMPs)	The Assembly voted to approve action paper 2017A1 12.L, which asks • That the American Psychiatric Association draft a position statement regarding Prescription Drug Monitoring Programs. • That such PDMP position statement addresses PDMP best practices including design, operation, confidentiality, privacy, physician/staff burden utilization and interstate access.	Joint Reference Committee, June 2017

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2017 A1 12.M	Juvenile Solitary Confinement	The Assembly voted to approve action paper 2017A1 12.M, which asks: That the APA support the AMA policy statement opposing the use of solitary confinement in juveniles, and that the APA draft its own position statement by May of 2018 *H-60.922* *Our AMA: (1) opposes the use of solitary confinement in juvenile correction facilities except for extraordinary circumstances when a juvenile is at acute risk of harm to self or others; (2) opposes the use of solitary confinement of juveniles for disciplinary purposes in correctional facilities; and (3) supports that isolation of juveniles for clinical or therapeutic purposes must be conducted under the supervision of a physician*. With the following preamble: Solitary confinement is defined as the placement of an incarcerated individual in a locked room or cell with minimal or no contact with people other than staff of the correctional facility. It is used as a form of discipline or punishment.	Joint Reference Committee, June 2017
2017 A1 12.N	Addressing Physician Burnout, Depression, and Suicide — Within Psychiatry and Beyond	The Assembly voted to approve action paper 2017A1 12.N, which asks: That the APA continue the mission of the Ad Hoc Workgroup on Physician Well-Being by developing resources for increasing awareness about physician burnout, depression and suicide, as well as interventions for promoting physician wellness, including recommendations for institutional response to physician suicide; That the APA revise its 2011 "Position Statement on Physician Wellness" to affirm the APA's commitment to ensuring the well-being of its members and to encourage members to serve as leaders in promoting well-being initiatives within their institutions, training programs, and systems of care; That the APA promote further investigation of the underlying causes of increased rates of burnout, depression and suicide among physicians and to expand the evidence base for innovative wellness interventions; That the APA Government Relations staff work with stakeholder organizations including the Federation of State Medical Boards to remove questions about psychiatric or substance use disorder treatment from licensing applications (initial or renewal) as well as employment applications, instead focusing on relevant, current functional impairment due to either physical or mental illness; That the APA's AMA delegation continue to collaborate with the AMA to develop joint initiatives to prioritize these issues.	Joint Reference Committee, June 2017
2017 A1 12.O	Health Care Is a Human Right	The Assembly voted to approve action paper 2017A1 12.O, which asks that the American Psychiatric Association adopt the following position statement: "Health care, inclusive of mental health care, is a human right".	Joint Reference Committee, June 2017

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2017 A1 12.P	Making Access to the Voting Page a Default Action During Elections	The Assembly voted to approve action paper 2017A1 12.P which asks that the Assembly recommends that the APA Administration work to make access to voting as prominent as possible and user friendly on the APA website, and reconsider the value of mailing ballots to all members.	Joint Reference Committee, June 2017
2017 A1 12.Q	Dues Relief for District Branch Members from the Commonwealth of Puerto Rico	The Assembly voted to approve action paper 2017A1 12.Q which asks that general member psychiatrists who are members of the Puerto Rico Psychiatric Society, a District Branch of the APA shall be granted the same annual APA dues as our Canadian counterparts, which is $375 per general member per year for the next five years.	Joint Reference Committee, June 2017
2017 A1 12.R	Streamlining the Application Process for Former APA Members	The Assembly voted to approve action paper 2017A1 12.R which asks that the APA staff streamline the application process for former APA members on the website as follows: 1. Once an applicant answers yes to being a former member of the APA on the website, the individual is given an online, pre-filled application. 2. Remove the requirement for the applicant to resubmit the residency training certificate (this can be verified by APA staff from previous membership records). 3. Remove the requirement for the applicant to submit a valid medical license (this can be verified by APA staff from online, public databases). That the APA staff advertise the changes to the streamlined application process for former APA members.	Joint Reference Committee, June 2017
2017 A1 12.S	Connecting Psychiatrists to Volunteer Opportunities	The action paper was withdrawn by the author.	N/A
2017 A1 12.T	APA Referendum Voting Procedure	The Assembly approved action paper 2017A1 12.T which asks: 1. If 2/3 of the voting members approve a referendum statement, but the requirement of 40% of eligible voters voting has not been met, the BOT will schedule a vote on the referendum statement or a modified version of it for voting by members of the BOT and the Assembly. If the referendum statement or its modified version does not get a 2/3 votes by both these bodies and thus fails to pass, or if the lead petitioner of the referendum statement does not agree to the modified version, then the original referendum statement will be placed again on the ballot to be voted on by the entire membership; but this time the referendum ballot will be sent with the yearly dues statement/solicitation for contributions to all voting members. If it fails again it will not be automatically placed on the ballot again. If it passes, it will supersede any modified version passed by the BOT and the Assembly. 2. If the BOT rejects resolved #1, then an alternative for a viable referendum process shall be prepared by the Board of Trustees, with participation of Assembly Representatives jointly selected by the Speaker and the President, and presented to the Assembly at the Fall 2017 meeting.	Joint Reference Committee, June 2017

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2017 A1 12.U	November Assembly Dates	The Assembly voted to approve action paper 2017A1 12.U which asks that except for already scheduled Assembly meetings, the APA Assembly will meet the first weekend in November after the US Presidential Election Day, whenever possible.	Assembly Executive Committee, July 2017

Item #8.A
Joint Reference Committee
June 17, 2017

Report of the Council on Addiction Psychiatry

1. Position Statements

The Council plans to work with the Council on Psychiatry and Law and the Council on Advocacy and Government Relations to approve an APA Position Statement on Prescription Drug Monitoring Programs (PDMPS) that focuses on best practices including design, operation, confidentiality, privacy, and utilization. The Council is also working with the Council on Psychiatry and Law to develop a Position Statement on Involuntary Treatment for Substance Use Disorders.

2. Information Items:

- The Council provided feedback on the APA's comment letter on the Office of National Drug Control Policy's 2017 National Drug Control Strategy. The Council was also asked to provide feedback on substance use measures for the *2018 IPPS/LTCH proposed Rule for Medicare Inpatient Hospitals and Long-Term Care Hospitals.*

- A workgroup of the Council continues to make progress on reviewing and scoring open-source curriculum on SUDs. The resources will be organized in educational toolkits that will be made available to general residency programs. This project is funded by the National Institute on Drug Abuse. In addition, a representative from the Council is participating in the American Association of Directors of Psychiatric Residency Training (AADPRT) Taskforce on Addiction Initiatives 2016-2017, which is chaired by AADPRT President Dr. Sandra DeJong.

- Council will continue to remain in frequent communication with the Division of Government Relations and Policy Department as new Administration appointees assume their roles. Efforts will be made to meet with key officials to discuss relevant policy issues and advocate that drug policies maintain the current emphasis on prevention and treatment.

- A workgroup of the Council provided a workshop on tobacco cessation at the 2017 APA meeting that was very well attended. This workgroup will continue its efforts to encourage psychiatrists to provide tobacco cessation treatment for their patients.

- Working with the American Academy of Addiction Psychiatry and the Providers Clinical Support System for Medication Assisted Treatment, members of the Council are working on an implementation project to increase treatment of opioid use disorder in a health care system (to be determined) in Pennsylvania.

COUNCIL ON ADVOCACY AND GOVERNMENT RELATIONS

EXECUTIVE SUMMARY:
The Council on Advocacy and Government Relations (CAGR) met on Tuesday, May 23rd during the American Psychiatric Association's Annual Meeting in San Diego, CA. The Council received updates from APA Administration on major federal and state legislative issues, discussed action items requiring Council feedback, and received an update on APA*PAC*.

The Council discussed several key issues including:

- Involuntary Commitment for Substance Use
- Opioid Epidemic Impact on the States
- Expansion of Prescribing Privileges
- Passage of 21st Century Cures Act and Mental Health Reform
- Future of the American Health Care Act
- Council Advocacy Training Materials

The draft minutes from the meeting are attached **(Attachment #1)**

The Council brings the following Action Item to the Joint Reference Committee:

1. **JRC REFERRAL: POSITION STATEMENT ON HOSPITAL PRIVILEGES FOR PSYCHOLOGISTS**
   The Council on Advocacy and Government Relations reviewed the Position Statement on Hospital Privileges for Psychologists as directed by the JRC. The Council established a small work group to draft amending language to encompass current issues surrounding prescribing privileges of non-physician practitioners.

   ACTION: Will the Joint Reference Committee accept the Council on Advocacy and Government Relations' revisions to the APA Position Statement on Hospital Privileges for Psychologists? **(Attachment #2)**

The Council brings the following Informational Items to the Joint Reference Committee:

1. **JRC REFERRAL: POSITION STATEMENT ON PRINCIPLES FOR HEALTHCARE REFORM FOR PSYCHIATRY**
   The Council on Advocacy and Government Relations discussed the Position Statement on Principles for Healthcare Reform for Psychiatry, as directed by the JRC. Through unanimous consent, the Council selected to revise the Position Statement. A small Council work group was established to amend the language, in addition to incorporating relevant data. The work group will in conjunction with the Council on Healthcare Systems and Financing to draft a revised position statement, to be forwarded to the JRC following the September Component Meeting.

2. **JRC REFERRAL: ACTION PAPER ON SMART GUNS AS A GUN SAFETY RESPONSE TO GUN VIOLENCE, A PUBLIC HEALTH HAZARD**
   The Council on Advocacy and Government Relations discussed the Action Paper on Smart Guns, as directed by the JRC. Taking into consideration two existing APA position statements and one resource document addressing handguns, the Council recommended reviewing the documents

for similarities to this Action Paper. A small work group was established to assess the language and advise next steps to the Council by the September Component Meeting.

3. **JRC REFERRAL: ACTION PAPER ON MENTAL HEALTH PARITY FOR INDIVIDUALS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITY (IDD)**
   The Council on Advocacy and Government Relations discussed the Action Paper on Mental Health Parity for Individuals with IDD. The Council 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 Intellectual Disabilities.

4. **JRC REFERRAL: ACTION PAPER ON ENDING CHILDHOOD POVERTY**
   The Council on Advocacy and Government Relations discussed the Action Paper on Ending Childhood Poverty. The Council asked for the APA Administration to review APA's current partnerships and advocacy efforts to address the matter identified in the Action Paper. Staff will report back to the Council to determine next steps. The Council will report its recommendations to the Council on Children, Adolescents, and their Families.

Council on Advocacy and Government Relations
Component Meeting
May 23, 2017
Marriott Marquis San Diego Marina
San Diego, CA
Meeting Minutes

Members in Attendance:

Chairperson Debra Pinals, MD
Vice Chairperson David Diaz, MD
Member John Bailey, DO
Member Jenny Boyer, MD
Member Napoleon Higgins, MD
Member Katherine Kennedy, MD
Member Steve Koh, MD
SAMHSA Fellow Dakota Carter, MD
Leadership Fellow Morgan Medlock, MD
Diversity Leadership Fellow Natalie Ramirez, MD
Member David Lowenthal, MD
Member Cassandra Newkirk, MD, PC
Member Charles Price, MD (Ex-Officio)
Member (ECP) Jessica Thackaberry, MD
Member (ASM) Craig Frederic Zarling, MD
Consultant Wilsa Charles Malveaux, MD
Consultant Frank Dowling, MD
Spurlock Fellow Laura Willing, MD
Public Psychiatry Fellow Mary C. Vance, MD

Members Absent:

Member Matthew Erlich, MD
Member Barry B Perlman, MD
Member Altha J. Stewart, MD
SAMHSA Fellow Bem Atim, MD
Public Psychiatry Fellow Jacob Izenberg, MD
Public Psychiatry Fellow Rachel Talley, MD
Public Psychiatry Fellow Onyinye Ugorji. MD
Public Psychiatry Fellow Nicole Wimberger, MD

Guests in Attendance:

Saul Levin, M.D., M.P.A., APA Medical Director and CEO
Patrick Runnels, MD, *Chair-elect*
Alexander Threlfall, MD
Ilse Wiechers, MD
William Arroyo, MD

APA Staff in Attendance:

Ariel Gonzalez
Deana McRae
Jeffrey Regan
KJ Hertz
Kaileen Dougherty
Amanda Blecha
Angela Gochenaur
Marsi Thrash
Tim Miller

I. WELCOME, INTRODUCTIONS & REVIEW OF AGENDA

Dr. Pinals welcomed the Council and provided an overview of the meeting agenda. Following the introductions of the Council members, Dr. Pinals referred Council members to review the CAGR reports submitted to the Joint Reference Committee (January 2017) and Assembly (May 2017).

II. ACTION ITEMS

POSITION STATEMENT: Hospital Privileges for Psychologists

The Council reviewed the final draft revising the 2007 APA position statement on Hospital Privileges for Psychologists. Pinals, provided an abbreviated background to the work of the Council and small work group in developing and finalizing the draft. It was moved and seconded to forward the final draft to the JRC for approval.

POSITION STATEMENT: Principles for Healthcare Reform for Psychiatry

The Council discussed the 2008 APA position statement on Healthcare Reform for Psychiatry. Federal Affairs Director Jeff Regan shared, the Council on Healthcare Systems and Financing, the secondary reviewer, would like to include language that reflects a contemporary discussion around health care reform. Pinals recommended, the paper could be more impactful with updated percentages. Diaz agreed, stressing the sections on access to care and parity requires more detail. Zarling suggested, to exclude language surrounding the current debate. Willings, proposed inclusion of CRS information. Pinals summarized, the Council's discussion and concluded a work group to further review and refine the current position statement would be next steps. It was moved and seconded by the Council. Drs. Koh, Kennedy, and Willing volunteered to participate in the work group, reporting back to the Council following a June conference call.

ACTION PAPER: Smart Guns as a Gun Safety Response to Gun Violence, a Public Health Hazard

There was significant discussion on the Action Paper entitled, Smart Guns as a Gun Safety Response to Gun Violence, a Public Health Hazard. As the Council Assembly representative, Zarling shared insight to how quickly the action paper passed through the general body, and thus recommended the Council should consider all critical elements before presenting a recommendation to the JRC. Pinals agreed the Council would need to consolidate thinking, work with other components, and refer to existing APA resources. Boyer pointed out the action paper speaks to a specific enough issue to develop a separate position. Taking into account, the existing APA position statements and resource document, the Council acknowledged there should be a review of the aforementioned documents. This will allow an opportunity to compare APA's current position with the action paper for consistency. Pinals recommended to establish a small work group to perform the task of examining the 2014 and 1993 position statements and determining next steps. She also proposed bringing the recommendations to the Council on Psychiatry and the Law, as contributors to the existing position statements. It was moved and seconded for the Council to establish a work group. Drs. Zarling and Vance volunteered to participate in the Council work group and report back before the September Component Meeting.

ACTION PAPER: Ending Childhood Poverty

The Council discussed the Action Paper entitled, Ending Childhood Poverty. As Assembly representative, Zarling spoke to the complexity of the action paper, to which asks APA to prioritize the issue. He shared with the Council that the action paper moved quickly through the general body, in spite of the policy recommendations and cost implications. Pinals compared the action paper to other documents introduced that do not specifically address mental health or substance abuse. She asked the Council, if this is an issue APA should place on the priority list. Koss agreed this is a huge issue; however, asked the Council to consider where psychiatrists would have influence on this matter, or who would be better suit to advocate on this instead. Zarling recommended the Council to advise emphasis on building a coalition with family and children groups that would be better suited to address the matter. Arroyo added, this action paper aligns closely with Dr. Everett's aim to address social justice. Pinals recommended, APA should work with child and

adolescent groups to develop resources, occasionally child poverty can impact child mental health. Jeff Regan advised the Council, that the Department already advocates for some of the issues included in the action paper, APA would not require to start at square one. APA is supports CHIP and Medicaid funding programs intertwined with mental and physical wellbeing. Boyer proposed developing a resource document that focuses on how poverty effects mental health. It was moved (Zarling) and seconded, APA Administration will review current APA partnerships and advocacy efforts concerning poverty and report back. Provided the outcomes, the Council will determine next steps, working with the Council on Children, Adolescents and their Families.

ACTION PAPER: Mental Health Parity for Individuals with Intellectual and Developmental Disability (IDD)
The Council reviewed the Action Paper entitled, Mental Health Parity for Individuals with Intellectual and Developmental Disability (IDD). Pinals acknowledged the action paper does not specifically identify which components or APA should complete the asks. Members agreed the Council on Healthcare Systems and Financing should take the lead on developing a position statement. It was moved and seconded for the APA Administration survey the current federal and state landscape on this issue. APA staff recommended this is would also require involvement of Sam Muszynski, APA Senior Policy Advisor and Director of Parity Implementation.

III. STATE GOVERNMENT AFFAIRS UPDATE ON OPIOIDS

COUNCIL DISCUSSION: CIVIL COMMITMENTS FOR SUBSTANCE USE

Dr. Pinals welcomed incoming chair to the Council on Addiction Psychiatry, Dr. John A Renner, who joined the Council meeting to discuss APA response to the uptick in state activity concerning involuntary commitment for substance abuse. Dr. Renner emphasized that the matter has become cumbersome. In general, the Council on Addiction Psychiatry is in support of involuntary treatment. He explained that the idea is good in theory and how it is implemented could potentially have a positive impact. Pinals, spoke to the two articles included in the Council's meeting materials written by APA members. She shared the Michigan Legislature passed a civil commitment law in 2014 establishing criteria for determining when involuntary treatment is appropriate for individuals with severe mental illness who cannot seek care voluntarily –making sure that individuals have the proper treatment instead of being directed to emergency rooms. Pinals continued, every state is different in terms of this being an emergency or long standing chronic matter. Zarling, agreed the APA should consider what the next steps will be, as a reasonable goal. Higgins, inquired who is responsible for funding these programs; otherwise the free option would be redirecting them to the prison system. Pinals agreed, the implementation of these laws without designated funding and regulations can place financial distress on facilities like hospitals. Often financial hardship are unintentional consequence states are finding when implementing programs. Lowenthal, inquired if there were different outcomes for individuals who refuse treatment, or who lack the capacity? Pinals suggested, these are all good points for developing a position statement. It is apparent the Council on Addiction is making progress on addressing the matter by supporting involuntary commitment, with caveats. She recommended the Council work with both the Council on Addiction Psychiatry and Council on Psychiatry and the Law in next steps.

State Regional Director Angela Gochenaur presented an update on recent activity in the state addressing the opioid epidemic. The presentation revealed in 47 states, state legislators considered more than 500 bills tackling prescription abuse prevention, including: prescription drug monitoring databases, overdose reversal drugs, and prescribing guidelines. Ms. Gochenaur anticipates a number of bills addressing pain clinics,

involuntary commitment, and provider training will be introduced in the remaining half of the 2017 legislative calendar.

IV. GUEST SPEAKERS

Anita Everett, APA President-Elect

Dr. Everett, APA President-Elect, visited the Council during their component meeting. She expressed her gratitude to the Council for advocating on behalf of the patients they serve, and their commitment to ensure their patients are provided with the best possible care. Dr. Everett shared with the Council her platform as incoming APA President, which would include several advocacy strategies: access to behavioral health for all Americans; innovation in mental health care delivery; and supporting physician wellness and resilience. Dr. Everett emphasized the key role the Council will have in thinking about strategies and encouraging APA members to become more involved.

Saul Levin, M.D., APA Medical Director and CEO

APA's Medical Director and CEO stopped by the Council's meeting to thank them for their commitment to APA. He emphasized that the Council is pivotal to why the organization exists, the work accomplished through the group contributes to the legislative and regulatory actions of the organization. The Council's discussion concerning recent state legislative activity on maintenance of certification has helped steer development of a national strategic plan in opposing legislation. The nation is at defining moment in which the future of the US health care system is facing a major transformation, impacting the healthcare profession and services provided. APA will continue to monitor activity regarding the American Health Care Act. Dr. Levin thanked the Department of Government Relations' staff for their continued hard work. He specifically recognized the outgoing Council Chair Dr. Pinals, presenting her width a plaque of recognition.

V. COUNCIL ADVOCACY WORK PRODUCTS

Advocacy 101 Training Module

Dr. Pinals introduced the latest version of the Advocacy 101 training. She provided background to the progress the Council's small work group has made since September. In addition, she shared with the Council, several APA members have recorded video to be embedded in the interactive online training module. DGR staff is currently working with other APA departments to complete the product for final review. Boyer suggested the training module would be a great training tool for Council members. Drs. Pinals and Dowling proposed the module could be utilized by District Branches, with the inclusion of specific talking points. Following a swift read of presentation, it was moved and second to approve this draft of the Advocacy 101 training, and for APA staff to present a final product by no later than September.

Resource Document: The Current State of Advocacy Teaching in Psychiatry Residency

Dr. Pinals asked Drs. Kennedy and Vance to expand on the progress of the draft resource document. Kennedy thanked Dr. Vance for her work and commitment to completing the document. She also thanked the Council for their contributions, recognizing Dr. Pinals for her assistance in coordinating with the program director at the University of Michigan. Kennedy reassured the Council that she is working on another draft to present to members to attain additional edits.

Advocacy for Access to Medications for the Treatment of Erectile Dysfunction Should Be Covered Under Medicare Part D Formularies

Dr. Pinals requested this topic be postponed until Dr. Perlman could speak to the item.

VI. COUNCIL DISCUSSION: PRIORITIZATION OF ISSUES FOR 2018

Acknowledging the Council's rotation of members and officers, Dr. Diaz drove the discussion for the Council to consider legislative-advocacy priorities for the remaining half of 2017 and 2018. Members presented a number of suggestions for the Council to consider.

Maintenance of Certification

Dr. Boyer emphasized the matter of maintenance of certification is significant to the health care profession. APA's involvement will be impactful, likely increasing membership by making it obvious that state advocacy efforts can be effective. APA should be in the forefront, working with other medical societies in opposing state legislation.

Building APA's Member Advocates

The Council expressed a general sentiment in the importance of building on APA's network of advocates. This is particularly important to support advocacy teaching among residents and medical students. It was also agreed upon that APA should support the District Branches and State Associates in building and sustaining advocacy efforts. Members enthusiastically spoke about the success of the 2015 Fall State Advocacy Conference and suggested that APA consider hosting this event biennially. This could be a foundation for training and assisting APA membership on an advocacy educational platform. Even more important would be for APA to align messaging and resources between national headquarters and District Branches.

VII. FEDERAL LEGISLATIVE UPDATE

Ariel Gonzalez, Chief of the Department of Government Affairs, presented an update to the Council regarding recent legislative activity surrounding the passage of mental health reform and the introduction of the American Health Care Act. In December, a mental health reform package was passed under the guise of the 21st Century Cures Act. He highlighted the successful advocacy efforts, consisting of grassroot campaigns, and coordinated coalition activity to fast-track passage. Since the House passed the American Health Care Act (AHCA) to repeal and replace the Affordable Care Act (ACA), the Senate has been working on their version of an overhaul health care bill. The AHCA contains several provisions that would seriously jeopardize access to mental health and substance use disorder treatment. APA will continue to urge the Senate to set aside the House's bill and start over on new legislation that does not put at risk health care for individuals with mental health and substance use disorders.

VIII. STATE GOVERNMENT AFFAIRS UPDATE

State Regional Directors Amanda Blecha and Tim Miller presented an update on recent activity in the state addressing the unsafe prescribing of psychologists. The presentation revealed thus far in 2017, there have been 18 psychologists prescribing threats, and anticipates several possible bills could be reintroduced in 2018. He highlighted the APA advocacy campaigns—such as continuing to enhance narrative around alternatives and in partnership with DB/SAs in support of bills that address collaborative care, network adequacy, mental health parity, and telepsychiatry—has effectively prevented many straightforward prescriptive authority bills from passing through the state legislature.

State Regional Director Marsi Thrash presented on the recent flurry of activity surrounding the independent practice of advanced practice registered nurses. The presentation noted that: 22 states currently allow independent practice; 16 states have reduced practice; and the remaining 12 states have restricted practice. Ms. Thrash expanded on the obstacles the State Affairs team when advocating to state offices, including

nurses' malpractice premiums are approximately 30% less; and increased presence of nurse practitioners will address the health care workforce shortage. She reiterated that valuable resources, i.e., talking points and targeted messaging, available to APA membership by way of national headquarters and the State Affairs regional directors.

Following the presentations, the Council had an extended discussion on how states are experiencing critical issues with access to care. The consensus among members was to broaden the APA campaign, to educate the District Branches, and to create a uniformed strategy with specific intent and consistent messaging. Zarling moved for the Council to reinforce APA's commitment to support state advocacy; and requested regional directors work with area councils to identify priority issues and potential threats, then accordingly develop concrete steps to address the issue. It was seconded and unanimously approved.

Hospital Privileges for Psychologists

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 hospitalized patients are best served when responsibility for their care resides with psychiatrists leading cross disciplinary teams. Psychologists, as well as other 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.

Item 8.C
Joint Reference Committee
June 2017

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 allied children and adolescent's organizations.

The Council met via conference call on Wednesday, March 22, 2017 and in person on Monday, May 22, 2017 in conjunction with APA Annual Meeting in San Diego. Stemming from the meetings is the following action item. See attachments 1-4 for agendas and minutes of these meetings.

JRC Referrals

In February 2017 the JRC referred Action Paper (Item 2016A2 12) titled *Ending Childhood Poverty* to the Council on Children, Adolescents, and Their Families. The Council reviewed and supported the action paper as written. The Council has made it a priority to partner on an ad hoc basis with the APA Foundation, District Branches/State Associations, and allied organizations such as the American Academy of Child and Adolescent Psychiatry (AACAP) to advance the relevant issues and legislation designed to reduce and eliminate childhood poverty in America. Council members have been identified to serve on the Board of Trustees appointed ad hoc Workgroup on Ending Childhood Poverty. Council members identified synergies in the work of the Council and APA Foundation, specifically regarding Typical or Troubled®. The Council is aware that advocating must come in a timely manner and relied on the Council on Advocacy and Government Relations (CAGR) for their expertise. CAGR asked for the APA Administration to review APA's current partnerships and advocacy efforts to address the matter identified in the Action Paper. Staff will report back to CAGR to determine next steps and CAGR will report its recommendations to the Council on Children, Adolescents, and their Families.

In addition, the JRC recommended the Council establish more robust timeline for completing issues outlined in the Council work plan. The work plan has been revised, see attachment 6.

Action Item

Will the Joint Reference Committee recommend that 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? See attachment 7.

Information Items

1. The Council continues to assess and revise existing APA position statements related to children and adolescents.

2. The Council is cross collaborating with various councils on issues that overlap with the Council's work and primary charge. The Council continues to work with the Council on Psychiatry and Law, Council on Communications, Council on Minority Mental Health and Health Disparities and the Council on International Psychiatry.
3. The Council is collaborating with AACAP on future publications involving anxiety and obsessive related disorders.

Attachments

1. March 2017 Agenda
2. March 2017 Minutes
3. May 2017 Agenda
4. May 2017 Minutes
5. APA Action - Ending Childhood Poverty
6. Council Work Plan – Revised
7. Official Action - Endorsement of United States Ratification of the Convention on the Rights of the Child
8. AACAP Letter to Joseph Penn, M.D.

AMERICAN PSYCHIATRIC ASSOCIATION

AGENDA

Council on Children, Adolescents and Their Families
Wednesday, March 22, 2017
7:00 p.m. – 8:00 p.m. EST
Conference Call – Various Locations

Welcome and Approval of January Minutes J.Penn

JRC Update/Announcements

Subspecialty Forum
David Gitlin, MD, APA Chair, Council on Psychosomatic Medicine would like to collaborate with the Council to create a forum on subspecialty recruitment.

Draft Position Statement on Juvenile Segregation

Annual Meeting Agenda
Call for agenda item ideas

Closing Remarks

Minutes

Council on Children, Adolescents and Their Families
Wednesday, March 22, 2017
7:00 p.m. – 8:00 p.m. EST
Conference Call – Various Locations

Present
Joseph Penn, M.D. (Chair)
Azeesat Babajide, M.D.
Caitlin Costello, M.D.
Tresha Gibbs, M.D.
Mary Ann Schaepper, M.D.
Gabrielle Shapiro, M.D.
Steven Adlesheim, M.D.
Karen Pierce, M.D.
Colby Tyson, M.D.
Caroline De Oleo Brozyna, M.D.
Carlos Fernandez, M.D.
Swathi Krishna, M.D.
Qortni Lang, M.D., M.S.
Ferdnand Osuagwu, M.D.
Lorena Reyna, M.D.

Absent
Toi Harris, M.D.
Kimberly Gordon, M.D.
Michael Houston, M.D.
Jean Thomas, M.D.
Albert Sargent, M.D.
Ricardo Vela, M.D.
Megan Baker, M.D.
Maria Jose Lisotto, M.D.
Cindy Vargas Cruz, M.D.
Erika Bath, M.D.
Anish Dube, M.D.
Kathleen Myers, M.D.

Welcome and Approval of January Minutes **J.Penn**

- The Council approved the January 2017 minutes

JRC Update/Announcements

- The JRC approved the position paper on online activity (Costello and Krishna) and the paper will be reviewed by the Assembly at the 2017 Annual Meeting
- S. Adelsheim recommended contacting the authors of the Childhood Poverty action paper and Ken Thompson for recommendations on how to proceed

Subspecialty Forum

David Gitlin, MD, APA Chair, Council on Psychosomatic Medicine would like to collaborate with the Council to create a forum on subspecialty recruitment

- J. Penn gave a background recap on the ABPN update and Child Fellowship timeline
- T. Gibbs had announced that at AADPRT – ABPN announced a "no-go" but it may be revisited

- S. Krishna and C. Tyson commented on personal experiences
- The forum will take place at the 2017 Annual Meeting

Draft Position Statement on Juvenile Segregation

- Council on Psych and Law partnership
- Instead of endorsing AACAP's statement, have the Councils (Child and Psych & Law) work together to create a product that meets everyone's needs (draft deadline June/July)
- K. Pierce and M. Schaepper provided guidance on the process

Annual Meeting Agenda

Call for agenda item ideas

Closing Remarks **J.Penn**

- S. Krishna sent her regrets and will not be able to make the Annual Meeting, and is willing to write and stay involved

AGENDA

2017 Annual Meeting – Council on Children, Adolescents and Their Families
Monday, May 22, 2016
2:30 p.m. – 5:00 p.m. PT
Marriott Marquis San Diego Marina – Salon F, Level 3

Agenda Item	Presenter
Opening Remarks/Welcome and Introductions	Mary Ann Schaepper, M.D.
Update on AACAP Activities	Gregory Fritz, M.D., President, AACAP Heidi Fordi, CAE, Executive Director, AACAP Carmen Head, MPH, Director of Research, Training and Education, AACAP
Remarks from APA CEO and Medical Director	Saul Levin, M.D., M.P.A.
Update from APA PAC and Foundation	Charles S. Price, M.D.
Update from APA Caucus on College Mental Health	Amy Poon, M.D.
Items to Review (Attachments 1-3)	Mary Ann Schaepper, M.D.
1. March 2017 Minutes	
2. Ending Childhood Poverty	Steven Adelsheim, M.D.
3. APA Endorsement of US Ratification of the Convention on the Rights of the Child (2012)	
4. Assembly Update	Gabrielle Shapiro, M.D.

New Business: 1. *13 Reasons Why*	Steven Adelsheim, M.D.
Council Member Recognitions	Mary Ann Schaepper, M.D.
Closing Remarks	Mary Ann Schaepper, M.D.

MINUTES

APA Council on Children, Adolescents and Their Families
May 22, 2017, 2:30PM-5:00PM PT

Present

- Azeesat Babajide, M.D.
- Caitlin Rose Costello, M.D.
- Tresha A. Gibbs, M.D.
- Kimberly A. Gordon, M.D.
- Mary Ann Schaepper, M.D.
- Gabrielle L. Shapiro, M.D.
- Steven N. Adelsheim, M.D. (Consultant)
- Eraka P. Bath, M.D. (Consultant)
- Anish Ranjan Dube, M.D. (Consultant)
- Karen Pierce, M.D. (Consultant)
- Caroline De Oleo Brozyna, M.D. – Diversity Leadership Fellow
- Megan Elizabeth Baker, M.D. –Public Psychiatry Fellow
- Maria Jose Lisotto, M.D. –SAMHSA Minority Fellow
- Cindy Vargas Cruz, M.D. –SAMHSA Minority Fellow
- Lorena Reyna, M.D. –Diversity Leadership Minority Fellow
- Ferdnand Osuagwu, M.D. –Diversity Leadership Minority Fellow
- Colby Chapman, M.D. –SAMHSA Minority Fellow
- Qortni Lang, M.D. –Child and Adolescent Psychiatry Fellow

Absent

- Joseph V. Penn, M.D.
- Toi Blakley Harris, M.D.
- Michael Houston, M.D.
- Albert John Sargent, M.D.
- Jean M. Thomas, M.D.
- Ricardo M. Vela, M.D.
- Kathleen Mary Myers, M.D.
- Carlos Fernandez, M.D. –SAMHSA Minority Fellow
- Swathi Krishna, M.D. –SAMHSA Minority Fellow

APA Administration

- Tatiana Claridad (Staff Liaison)
- Kristin Kroeger

Guests

- Greg Fritz, M.D.
- Heidi Fordi
- Carmen Head
- Chares Price, M.D.
- Amy Poon, M.D.
- Ludmila De Faria, M.D.
- Mark Chenven, M.D. (incoming consultant)
- Samina Aziz, M.D. (incoming member)
- Warren Ng, M.D. (incoming member)
- Krysti Vo, M.D. (fellow)
- Lila Aboueid, M.D. (fellow)

Continued…

The meeting commenced at 2:38PM PT.

Welcome and Introductions

- Mary Ann Schaepper, MD acted as Chair in Drs. Penn and Harris' absence.
- Member and guest introductions were made.

American Academy of Child and Adolescent Psychiatry (AACAP) Update

- Greg Fritz, MD, President of AACAP, presented his presidential initiatives and projects for AACAP:
  - Pediatric Integrated Care Resource Center (Integratedcare4kids.org)
  - Strengthening collaborations with family practice organizations
    - Maryland Pao, MD is leading efforts in pediatric integrated care
  - Advocacy w/ state and federal agencies
  - Collaborations and partnerships
    - AACAP had a meeting w/ Clare Miller, Director of Partnership for Workplace Mental Health, APA Foundation
- Heidi Fordi, Executive Director of AACAP, gave an update on the AACAP Legislative Conference. This was their biggest conference to date. The conference covered topics such as essential health benefits and workforce initiatives. Heidi reminded the Council that AACAP's elections were being conducted and reminded members of AACAP to vote.
- Heidi updated the Council on AACAP's new Learning Management System, the transition to a new editor in chief of JAACAP, Break the Cycle and the AACAP Annual Meeting in October (DC).
- Carmen Head updated the Council on mentorship opportunities at the AACAP Annual Meeting:
  - 12 consecutive hours of mentorship
  - Great for all career levels
  - AACAP committee members will be serving as mentors
  - Professional development strategies
- Carmen updated the Council on the AACAP awards portfolio, the new psychopharmacology committee, and next publications/guides which will cover anxiety and obsessive related disorders.

APA Foundation Update

- Louis Kraus, MD updated the Council on Foundation initiatives and the Foundation's public education and school based mental health program, Typical or Troubled®. He also touched on the collaborative work between AACAP and APA.
- Christina Cruz, MD (fellow) coming from an educational background gave her insight into Typical or Troubled® and social emotional learning.
- Krysti Vo, MD (fellow) relayed the ideas that were discussed at the APA Foundation workgroup meeting.
- Karen Pierce, MD commented that she uses Typical or Troubled® in most of the schools she works with.
- Cindy Vargas Cruz, MD (fellow) implemented the program in Spanish in Costa Rica, she mentioned that data is important to get funded.
- The Council commented that the APA Foundation needs to figure out what they are going to do and how they are going to involve the Council. The APA Foundation (Louis Kraus, APAF Board Member) will contact the Council and AACAP on next steps.

WORKGROUP: KIM GORDON, CINDY VARGAS-CRUZ, CAITLIN COSTELLO, AZEESAT BABAJIDE,

APA PAC Update

- Charles Price, MD spoke about the APA PAC and invited the Council to the APA PAC Event at the Padre's Stadium.

Caucus on College Mental Health Update

- Amy Poon, MD and Ludmila De Faria, MD updated the Council on:
  - Suicide clusters at universities
  - Mass violence
  - Title IX and sexual assault
  - Solutions? Clinical practice guidelines, advocacy for college mh psychiatrists, run by psychologists
  - Higher Education Mental Health Alliance (HEMA) – APA, Psychology, AACAP, ACHA, AUCCCD, Jed Foundation – actively working with these organizations
  - Legislature, psychiatrists feel isolated, opiate problem
- Gabi Shapiro, MD volunteered to bring actions/products forward to the ASM/JRC

Ending Childhood Poverty

- The authors of the Action Paper on Ending Childhood Poverty attended the meeting to help guide the Council in next steps regarding the paper's "asks". They also gave a brief history and process of the action paper. They recommended creating a Board appointed ad-hoc workgroup that would oversee that APA resources are applied and mechanisms put in place in regards to the action paper (graphics, involving the PTA, advocating).
- Megan Baker, MD (fellow) commented that poverty can contribute to mental health and mental health issues in the populations that we serve, she called for advocacy.
- Warren Ng, MD commented brought up social determinants of health, school nutrition (Typical or Troubled®). He identified synergies in the work and reminded the Council and stakeholders to advocate in a timely manner.

POINT PERSONS: MEGAN BAKER, STVEN ADELSHEIM, WARREN NG

APA Updates

- Kristin Kroeger, APA Chief of Policy, Programs, and Partnerships, relayed that Dr. Levin was not able to attend the meeting due to scheduling difficulties. She touched on Anita Everett's presidential initiatives which included early psychosis, an area that APA has not yet addressed. She recommended having Anita on a future council conference call.
- Steve Adelsheim, MD commented that having child psychiatry really matters and that most of this work is being done from an adult psychiatry lens instead of CAP approach

WORKGROUP: MEGAN BAKER, STEVEN ADELSHEIM, TRESHA GIBBS, LORENA REYNA

Items For Review

- Mary Ann Schaepper made a motion to approve the 2017 March conference call minutes. The minute were approved.
- The Council reviewed the APA Official Action: APA Endorsement of US Ratification of the Convention on the Rights of the Child (2012). The Council voted to retain the action as written.

New Business

13 Reasons Why

- Steve Adelsheim led the conversation on the Netflix series *13 Reasons Why*.
- Members of the Council voiced their opinions on the series. Some described it as a negative message for adolescents.
- Colby Tyson, MD (fellow) noted that her patients who have suicidal ideation refer to the series, recommended that APA make a statement or consult with AACAP.
- AACAP mentioned that they have wrote a letter to Netflix and are open to doing a joint letter.
- Kristin Kroeger brought up the idea of Twitter chats and addressing the series from a social media platform
- Warren Ng described the series as sensationalistic and recommend highlighting how things really happen with more positive and accurate portrayals.
- The Council decided to explore creating a framework and process in responding to issues related to children and mental health. This might entail coordinating with other Councils and organizations and identifying stakeholders and audience.

WORKGROUP: STEVE ADELSHEIM, CAROLINE BROZYNA, WARRNG NG, COLBY TYSON, LILA ABOUEID, ANISH DUBE, MAJO LISOTTO

APA Assembly (ASM) Update

- Gabi Shapiro updated the Council on the ASM activities.
- The Action Paper on Juvenile Solitary Confinement was approved by the ASM with modification.
- The proposed Position Statement *Risk of Adolescents' Online Behavior* was also approved by the ASM.
- Both papers will move forward for Board review in July 2017.

Proposed Presentations

Social Media/Communications – LILA ABOUEID, CAITILIN COSTELLO, GABI SHAPIRO, STEVEN ADELSHEIM, KRYSTI VO

Human Trafficking – KIM GORDON, ERAKA BATH

The Council meeting concluded with Council member appreciations and closing remarks by Mary Ann Schaepper. The meeting ended at 5:15PM PT.

Item 2016A2 12
Reference Committee
Assembly
November 4-6, 2016

ACTION PAPER

TITLE: Ending Childhood Poverty

WHEREAS:

- 19.7% of children under eighteen in America live in poverty (1), and represent the largest impoverished demographic. More than 1 in 5 U.S. children under age 5 live below the Federal Poverty Level; nearly half of them live in extreme poverty on $33 per day for a family of four (2).

- The rate of childhood poverty is the 21st century equivalent of infant mortality as a marker of the health and wellbeing of a society. It is not childhood health or adult health—it is health across the entire life span. It is practicing geriatric medicine and psychiatry for the 22nd century today.

- Poverty has been shown to be associated with smaller white and cortical gray matter and hippocampal and amygdala volumes—regions involved in stress regulation and emotional processing (3). The longer children live in poverty, and the farther below the FPL, the greater the gap with developmental norms; this effect is mediated in part by maturational lags in frontal and temporal lobe gray matter (4).

- Effects of poverty on academic lags are real and measurable. In the first two years of life the human brain triples in size to almost its full adult size; during this same period, disparities based on family economic level have already begun, and widen over time (5). By third grade, gaps in math scores present by school entry have already stabilized; by fourth grade, half of poor children have difficulty reading and never catch up (6).

- Poverty's "toxic stress" effect on early brain and childhood development—that persistent stress and exposure to trauma trigger hormonal production that leads to structural brain alterations and stable epigenetic change (7)—continues its effect into adolescence, with exaggerated response to stress, emotional dysregulation, and impact on memory; higher rates of high school dropout; and more high-risk behaviors (early unprotected sex and increased teen pregnancy, drug and alcohol abuse, increased teen criminal behavior) (8). Young people witnessing and experiencing chronic poverty, trauma, violence, and food insecurity and hunger have levels of long-term anxiety and worry seven times that of their peers in the nation (9).

- The pattern set by deprivations of nutrition and self-esteem alike continues into adulthood, with higher rates of maternal depression, and prevalence of adult depression in impoverished neighborhood four times higher than the national average (10). Poor children become poor adults, with lower academic achievement, self-esteem, productivity, and earnings.

- Childhood poverty rates have been demonstrated to be able to be reduced by concerted societal will and leadership. In 1998, Great Britain addressed its childhood poverty rate of 26.1% as a national issue, and by 2010 had reduced that rate to 10.6% (11).

- Reversing America's rising rates of childhood poverty depends on advocacy on local, state and national levels to influence policymakers and support societal change. Reducing and eliminating childhood poverty will both markedly improve the health and well-being of the nation and dramatically reduce health inequities. It will improve health overall and especially mental health.

- Childhood poverty's effects are particularly psychiatric in nature—on the brain, the mind, on relationships, on learning, on emotions, on worldview. The APA is an organization many of whose members see in daily encounters with those they treat the deleterious effects of food insecurity and hunger, impoverished neighborhoods where substandard housing, trauma, and violence are endured, and the creation and aggravation of anxiety and depression and other mental illness due to long-term cycles of poverty. What psychiatry says matters on this issue.

BE IT RESOLVED:
That the American Psychiatric Association join with other organizations in acknowledging the detrimental effects of childhood poverty on cognitive and emotional development, self-esteem, academic and vocational achievement, and overall mental and physical health in both childhood and through adulthood; and

That the American Psychiatric Association, in its educational, advocacy, and legislative efforts, make it a priority to partner on an ad hoc basis with other allies and organizations (such as the American Academy of Pediatrics, Children's Defense Fund, First Focus, National Immigration Law Center, Community Action Partnership) to advance relevant issues and/or legislation designed to reduce and eliminate childhood poverty in America; and

That Areas and District Branches actively seek ways to partner with their local community groups, organizations, and legislators to raise awareness of the impact of childhood poverty on early childhood and brain development and lifetime well-being, including economic stability and mental health; and

That the Board of Trustees establish an ad hoc Workgroup on Ending Childhood Poverty to coordinate such efforts, with particular emphasis on reducing the lifetime consequences on mental health due to early childhood poverty.

AUTHORS:
Sheila Judge, M.D., DLFAPA, Representative, Pennsylvania Psychiatric Society sjudgemd@comcast.net
Kenneth S. Thompson, M.D., APA Member
Beverly J. Fauman, M.D., DLFAPA, Representative, American Association for Social Psychiatry
Megan E. Baker, M.D., APA Member
Carissa Caban-Aleman, M.D., APA Member
Carl I. Cohen, M.D., DLFAPA, APA Member
Stephanie N. Cripps, M.D., APA Member
James L. Curtis, M.D., DLFAPA, APA Member
Carol R. Koplan, M.D., APA Member
Michael S. Lancaster, M.D., DLFAPA, APA Member
Aida S. Mihajlovic, M.D., FAPA, APA Member
Andres J. Pumariega, M.D., DLFAPA, APA Member
Lawrence A. Real, M.D., DLFAPA, APA Member

Mary Anne Albaugh, M.D., Representative, Pennsylvania Psychiatric Society
Eliot Sorel, M.D., Representative, Washington Psychiatric Society
Constance E. Dunlap, M.D., Representative, Washington Psychiatric Society
Jessica Abellard, M.D., RFM Representative, Area 3
Charles Peter Ciolino, M.D., Representative, New Jersey Psychiatric Association
Annette L. Hanson, M.D., Representative, Maryland Psychiatric Society, Inc.
Gerard Gallucci, M.D., Representative, Psychiatric Society of Delaware
Manuel D. Reich, D.O., Representative, Pennsylvania Psychiatric Society
William M. Greenberg, M.D., Deputy Representative, Area 3
Mary Helen Davis, M.D., Representative, Kentucky Psychiatric Medical Association
Isabel K. Norian, M.D., Representative, New Hampshire Psychiatric Society
Charles H. Blackinton, M.D., Representative, New Jersey Psychiatric Association
Ranga N. Ram, M.D., Representative, Psychiatric Society of Delaware
Judith F. Kashtan, M.D., DLFAPA, Deputy Representative, Women Psychiatrists
Margery Sved, M.D., Representative, Association of Gay and Lesbian Psychiatrists
Lily Arora, M.D., Representative, New Jersey Psychiatric Association
Sudhakar Madakasira, M.D., Representative, Mississippi Psychiatric Association, Inc.
Gabrielle L. Shapiro, M.D., Representative, New York County Psychiatric Society
Michelle P. Durham, M.D., MPH, FAPA, Representative, Massachusetts Psychiatric Society
John E. Pappenheim, M.D., Representative, Alaska Psychiatric Association
Stephen E. Buie, M.D., Representative, North Carolina Psychiatric Association
Debra Atkisson, M.D., DFAPA, Representative, Texas Society of Psychiatric Physicians
John M. De Figueiredo, M.D., Representative, Connecticut Psychiatric Society
Stephen V. Marcoux, M.D., RFM Deputy Representative, Area 5
Joseph C. Napoli, M.D., Representative, Area 3
L. Charolette Lippolis, D.O., MPH, Representative, Colorado Psychiatric Society
Ramaswamy Viswanathan, M.D., DSc, Representative, Brooklyn Psychiatric Society, Inc.
Maureen Sayres Van Niel, M.D., Representative, Women Psychiatrists
James A. Polo, M.D., MBA, Representative, Washington State Psychiatric Association
Rahn K. Bailey, M.D., Representative, Black Psychiatrists
Richard Altesman, M.D., DLFAPA, Representative, Psychiatric Society of Westchester County, Inc.
Steven R. Daviss, M.D., Representative, Maryland Psychiatric Society, Inc.

ESTIMATED COST:
Author: $15,690
APA:

ESTIMATED SAVINGS: $0 – [Untold savings in mental and physical health costs]

ESTIMATED REVENUE GENERATED: $0

ENDORSED BY: Area 3 Council

KEY WORDS: Childhood Poverty, Health Inequity

APA STRATEGIC PRIORITY: Diversity

REVIEWED BY RELEVANT APA COMPONENT:

Council on Advocacy and Government Relations:

"The Council on Advocacy and Government Relations had the opportunity to discuss your pre-submitted Action Paper. They agreed the paper was well written. One member suggested that the Action Paper could be stronger by including a statement on food deserts and malnutrition having a long-term effect on brain development."

Council on Children, Adolescents and their Families (pending review)

REFERENCES:

(1) U.S. Census Bureau, Income and Poverty in the United States: 2015 (September 2016)
(2) Children's Defense Fund, P Hassler, September 13, 2016
(3) The Effects of Poverty on Childhood Brain Development: The mediating effect of caregiving and stressful life events, J Luby et al, JAMA Pediatr 2013:167(12):1135-1142
(4) Association of Child Poverty, Brain Development, and Academic Achievement, JAMA Pediatr 2015:169 (9):822-829
(5) Meaningful Differences in the Everyday Experience of Young American Children, B Hart and T Risley (1995)
(6) U.S. Department of Education, National Center for Education Statistics (2012)
(7) Cumulative effects of early poverty on cortisol in young children: Moderation by autonomic nervous activity, C Blair et al, Psychoneuroendocrinology 2013-11-1, 38:11, pp. 2666-2675
(8) Children in poverty: trends, consequences, and policy options, KA Moore et al, Child Trends Research Brief (2009)
(9) Urban Institute (2013)
(10) KA Moore et al (2009)
(11) Fighting Childhood Poverty In the US and UK: an update, T Smeeting and J Waldfogel (2010)
(12) History, Public Policy, and the Geography of Poverty: Understanding Challenges Facing Baltimore City and Maryland, Maryland General Assembly - Department of Legislative Services, January 2016
(13) Mediators and Adverse Effects of Child Poverty in the United States, JM Pascoe, DL Wood, JH Duffee et al, AAP Committee on Psychosocial Aspects of Child and Family Health, Council on Community Pediatrics, Pediatrics 2016:137(4)
(14) $2.00 a Day: Living on Almost Nothing in America, K Edin and L Shaefer, Boston: Houghton Mifflin, Harcourt, 2015
(15) Neuroscience, molecular biology, and the childhood roots of health disparities: building a new framework for health promotion and disease prevention, Shonkoff JP, Boyce WT, McEwen BS, JAMA 2009;301(21):2252–2259

ADDITIONAL DATA FOR AP: Ending Childhood Poverty

Some members of Area 3 Council and the Council on Advocacy and Government Relations have requested the inclusion of more of the research findings linking poverty in childhood with physical health as well as mental health inequities and compromise through the lifetime. Poverty has been shown to be the common link in complex relationships between biologic and social factors:

- In 2011, 1.5 million U.S. households with 3 million children were living in extreme poverty (income $\leq$ $2 per day per person)—that is, 4% of all families with children (14)

- American poverty is everywhere—cities (inner and non-inner), suburbs, and rural. According to the Brookings Institute, the suburbs are the fast-growing area of people living below the FLP.
- Since the 1960s urban flight has produced dysfunctional inner city neighborhoods, including "food deserts" where there is no available fresh food. Malnutrition coupled with higher teen pregnancy rates--shown to be linked to depression (8, 13)—lead to statistically higher neonatal and infant mortality due to prematurity and low birth weight (8). Up to 30% of a city's population of children may be living in such deserts (12); research shows lack of fresh food also linked to higher rates of obesity and diabetes in children and adults. Without access to nutrient-dense food, cheap available diets are laden with high sugar, trans-fats and empty calories (13).
- The origins of adult disease are increasingly perceived as a direct result of childhood adverse experiences, affecting adult health either through "cumulative damage" or "biological embedding of adversities" (15). Two biological processes in particular—toxic stress mediated by chronic elevation of cortisol, and chronic inflammation—have been demonstrated to result in disease in adults who experienced childhood poverty: higher rates of hypertension, arthritis, and limited mobility (13). An attenuated cardiovascular response to acute stress was evident by age thirteen.
- Affordable housing in a safe and stable environment is a key factor in health outcomes. When there is no affordable housing available, there are tradeoffs between paying the rent, and food, clothing, transportation, and health care. "In children, housing instability is associated with asthma, low weight, developmental delays [e.g. lead exposure], and an increased lifetime risk of depression. In adults, housing instability is associated with reduced access to health care, post-poning needed care and medications, mental distress, difficulty sleeping, and depression" (12).
- Duration of living in impoverished conditions correlates positively and significantly with how the health of the older child and the adult are affected. The Moving to Opportunity demonstration project gave vouchers to families with children living in high poverty public housing, enabling them to move into private housing in low-poverty areas. Ten to fifteen years later, lower rates of obesity, diabetes, depression, and local-area crime were reported. Adult health was positively impacted, but not economics; older children did not seem to benefit. However, those children who were very young when they moved were more likely to attend college and earn higher income in their 20s than control groups, ended up living in better neighborhoods as adults, and were less likely to become single parents (12).
- There are many ways that poverty has been shown to affect academics: almost 17 million children are from low-income families "at risk" of going hungry; hungry kids have poor scores on achievement tests, grade repetition, and absenteeism. In addition, chronic high-noise and exposure to indoor air pollution, especially passive smoking, have been associated with decreased academic performance; asthma accounts for about 10 million days of school missed each year (13). In a recent analysis of data from the National Center for Health Statistics (2009–2011), asthma prevalence was associated with both urban and nonurban poverty. Poorer children are not being enrolled in preschool—where early detection and intervention might offset some of the difference in brain development (3, 4) due to infant deprivation. According to the US Department of Education (2014), 7000 students drop out of high school each day—1.2 million per year; they will earn $1million less over their lifetime than a college graduate.

COUNCIL WORK PLAN

Complete the Template for Current and Future Tasks

A meaningful component work plan should contain:

1) Clear statement of the issue and rationale for a given work product and its strategic utility
2) The work product defined for the given issue/topic. [e.g., position statement, resource document, curriculum, recommendations on policy]
3) Identification of the key resources needed to develop/implement the product (e.g. key components, administrative expertise, funding)
4) A specific plan for development and implementation of the work product. (i.e., tasks to be performed, assignment of responsibility for tasks, coordination of tasks with a defined completion timeline)
5) Plan to execute and monitor and evaluate

Please complete for each primary issue/topic of the Council and place in priority order.

ISSUE:	**Risks of Online Behavior**
Work Product:	Position statement and IPS/APA Annual Meeting workshop
Brief Background/Rationale for the work product:	The product(s) address a new and evolving subject matter in the field of psychiatry and child, adolescent and family mental health.
Required resources:	Council on Psychiatry and the Law, Council on Communications
Responsible Entities:	Council on Children, Adolescents, and Their Families (workgroup)
Tasks:	Draft resources and statement/abstract for Council review and JRC submission
Timeline for Completion:	January 2017 – Final statement and abstract for IPS due, submit to JRC for approval

ISSUE:	**Preventing Violence in America**
Work Product:	Revised position statement
Brief Background/Rationale for the work product:	Current statement is outdated
Required resources:	Committee on Psychiatric Dimensions of Disasters
Responsible Entities:	Council on Children, Adolescents, and Their Families (workgroup)

COUNCIL WORK PLAN

Complete the Template for Current and Future Tasks

Tasks:	Draft resources and statement for Council review and JRC submission
Timeline for Completion:	Identify Child Council members and key supporting Councils (September 2017), Draft revised position statement (January 2018), Finalize and Submit to JRC (May-June 2018)

ISSUE:	**Migrant and Refugee Crisis Around The World**
Work Product:	Revised position statement
Brief Background/Rationale for the work product:	Current statement is outdated
Required resources:	Council on International Psychiatry,
Responsible Entities:	Council on Children, Adolescents, and Their Families (workgroup)
Tasks:	Collaborate with interested councils, draft resources and statement for Council review and JRC submission
Timeline for Completion:	Identify Child Council members and key supporting Councils (September 2017), Draft revised position statement (January 2018), Finalize and Submit to JRC (May-June 2018)

ISSUE:	**Gender Dysphoria**
Work Product:	TBD
Brief Background/Rationale for the work product:	The product(s) address a new and evolving subject matter in the field of psychiatry and child, adolescent and family mental health.
Required resources:	Council on Minority MH and Health Disparities, LGBTQ Caucus
Responsible Entities:	Council on Children, Adolescents, and Their Families (workgroup)
Tasks:	Develop an action plan to address issues, seek opportunities to collaborate with other Councils and APA offices to contribute views, and ways in which to address the issues and fill in membership learning gaps
Timeline for Completion:	Identify Child Council members and key supporting Councils (September 2017), Draft revised position statement (January 2018), Finalize and Submit to JRC (May-June 2018)

COUNCIL WORK PLAN

Complete the Template for Current and Future Tasks

ISSUE:	**New Drugs of Abuse**
Work Product:	APA workshop, resource/educational document, TBD
Brief Background/Rationale for the work product:	The issue is a new and evolving subject minimally addressed by APA
Required resources:	Council on Addiction Psychiatry, APA administrative expertise
Responsible Entities:	Council on Children, Adolescents, and Their Families (workgroup)
Tasks:	Develop an action plan to address issues, seek opportunities to collaborate with other Councils and APA offices to contribute views, and ways in which to address the issues and fill in membership learning gaps
Timeline for Completion:	Identify Child Council members and key supporting Councils (September 2017), Draft revised position statement (January 2018), Finalize and Submit to JRC (May-June 2018)

ISSUE:	**Reactive Attachment Disorder**
Work Product:	Revised position statement
Brief Background/Rationale for the work product:	Current statement is outdated
Required resources:	AACAP
Responsible Entities:	Council on Children, Adolescents, and Their Families (workgroup)
Tasks:	Research existing AACAP statements, draft resources and statement for Council review and JRC submission
Timeline for Completion:	Identify Child Council members and key supporting Councils (September 2017), Draft revised position statement (January 2018), Finalize and Submit to JRC (May-June 2018)

ISSUE:	**Mental Health, Children, and Disasters**
Work Product:	Revised position statement

COUNCIL WORK PLAN

Complete the Template for Current and Future Tasks

Brief Background/Rationale for the work product:	Current statement is outdated
Required resources:	Committee on Psychiatric Dimensions of Disasters, APA administrative expertise
Responsible Entities:	Council on Children, Adolescents, and Their Families (workgroup)
Tasks:	Draft resources and statement for Council review and JRC submission
Timeline for Completion:	Identify Child Council members and key supporting Councils (September 2017), Draft revised position statement (January 2018), Finalize and Submit to JRC (May-June 2018)

ISSUE:	**Prevention of Bullying Related Morbidity and Mortality**
Work Product:	Revised position statement
Brief Background/Rationale for the work product:	Current statement is outdated
Required resources:	AACAP, APA administrative expertise
Responsible Entities:	Council on Children, Adolescents, and Their Families (workgroup)
Tasks:	Research existing AACAP statements, draft resources and statement for Council review and JRC submission
Timeline for Completion:	Identify Child Council members and key supporting Councils (September 2017), Draft revised position statement (January 2018), Finalize and Submit to JRC (May-June 2018)

ISSUE:	**Proposed Legislation Permitting Guns on College and University Campuses**
Work Product:	Revised document
Brief Background/Rationale for the work product:	Current statement is outdated
Required resources:	Caucus on College Mental Health

COUNCIL WORK PLAN

Complete the Template for Current and Future Tasks

Responsible Entities:	Council on Children, Adolescents, and Their Families (workgroup)
Tasks:	Draft resources and document for Council review and JRC submission
Timeline for Completion:	Identify Child Council members and key supporting Councils (September 2017), Draft revised position statement (January 2018), Finalize and Submit to JRC (May-June 2018)

ISSUE:	**Corporal Punishment in Schools**
Work Product:	Revised position statement
Brief Background/Rationale for the work product:	Current statement is outdated
Required resources:	Caucus on College Mental Health
Responsible Entities:	Council on Children, Adolescents, and Their Families (workgroup)
Tasks:	Draft resources and statement for Council review and JRC submission
Timeline for Completion:	Identify Child Council members and key supporting Councils (September 2017), Draft revised position statement (January 2018), Finalize and Submit to JRC (May-June 2018)

ISSUE:	**Child Abuse and Neglect by Adults**
Work Product:	Revised position statement
Brief Background/Rationale for the work product:	Current statement is outdated
Required resources:	AACAP
Responsible Entities:	Council on Children, Adolescents, and Their Families (workgroup)
Tasks:	Research existing AACAP statements, draft resources and statement for Council review and JRC submission

COUNCIL WORK PLAN

Complete the Template for Current and Future Tasks

Timeline for Completion:	Identify Child Council members and key supporting Councils (September 2017), Draft revised position statement (January 2018), Finalize and Submit to JRC (May-June 2018)

Endorsement of United States Ratification of the Convention on the Rights of the Child

Approved by the Board of Trustees, July 2012
Approved by the Assembly, May 2012

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

WHEREAS:

Adopted by the United Nations General Assembly on 20 November 1989, and ratified by all nations except the United States and Somalia,

This compilation and clarification of children's human rights sets out the necessary environment and means to enable every human being to develop to their full potential.

The articles of the Convention, in addition to laying the foundational principles from which all rights must be achieved, call for the provision of specific resources, skills and contributions necessary to ensure the survival and development of children to their maximum capability. The articles also require the creation of means to protect children from neglect, exploitation and abuse.

Described as an international bill of rights for children,

Consisting of a preamble and fifty-four articles,

Defining what constitutes human rights for children and sets an agenda for action to protect and ensure such rights,

Countries that have ratified or acceded to the Convention are legally bound to implement its provisions.

BE IT RESOLVED:

1. That APA supports in principle the United Nations CRC.
2. That APA issues a formal statement in support of the UN CRC.
3. That APA urges the United States Senate to ratify the UN CRC.

This endorsement statement was prepared by Vivian B. Pender M.D., Representative, New York State Psychiatric Association.

For entire text: see attached.
For full explanation from UNICEF:
http://www.unicef.org/crc/index_30160.html

Convention on the Rights of the Child

Adopted and opened for signature, ratification and accession by General Assembly resolution 44/25 of 20 November 1989

entry into force 2 September 1990, in accordance with article 49

Preamble

The States Parties to the present Convention,

Considering that, in accordance with the principles proclaimed in the Charter of the United Nations, recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world,

Bearing in mind that the peoples of the United Nations have, in the Charter, reaffirmed their faith in fundamental human rights and in the dignity and worth of the human person, and have determined to promote social progress and better standards of life in larger freedom,

Recognizing that the United Nations has, in the Universal Declaration of Human Rights and in the International Covenants on Human Rights, proclaimed and agreed that everyone is entitled to all the rights and freedoms set forth therein, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status,

Recalling that, in the Universal Declaration of Human Rights, the United Nations has proclaimed that childhood is entitled to special care and assistance,

Convinced that the family, as the fundamental group of society and the natural environment for the growth and well-being of all its members and particularly children, should be afforded the necessary protection and assistance so that it can fully assume its responsibilities within the community,

Recognizing that the child, for the full and harmonious development of his or her personality, should grow up in a family environment, in an atmosphere of happiness, love and understanding,

Considering that the child should be fully prepared to live an individual life in society, and brought up in the spirit of the ideals proclaimed in the Charter of the United Nations, and in particular in the spirit of peace, dignity, tolerance, freedom, equality and solidarity,

Bearing in mind that the need to extend particular care to the child has been stated in the Geneva Declaration of the Rights of the Child of 1924 and in the Declaration of the Rights of the Child adopted by the General Assembly on 20 November 1959 and recognized in the Universal Declaration of Human Rights, in the International Covenant on Civil and Political Rights (in particular in articles 23 and 24), in the International Covenant on Economic, Social and Cultural Rights (in particular in article 10) and in the statutes and relevant instruments of specialized agencies and international organizations concerned with the welfare of children,

Bearing in mind that, as indicated in the Declaration of the Rights of the Child, "the child, by reason of his physical and mental immaturity, needs special safeguards and care, including appropriate legal protection, before as well as after birth",

Recalling the provisions of the Declaration on Social and Legal Principles relating to the Protection and Welfare of Children, with Special Reference to Foster Placement and Adoption Nationally and Internationally; the United Nations Standard Minimum Rules for the Administration of Juvenile Justice (The Beijing Rules) ; and the Declaration on the Protection of Women and Children in Emergency and Armed Conflict, Recognizing that, in all countries in the world, there are children living in exceptionally difficult conditions, and that such children need special consideration,

Taking due account of the importance of the traditions and cultural values of each people for the protection and harmonious development of the child, Recognizing the importance of international co-operation for improving the living conditions of children in every country, in particular in the developing countries,

Have agreed as follows:

PART I

Article 1

For the purposes of the present Convention, a child means every human being below the age of eighteen years unless under the law applicable to the child, majority is attained earlier.

Article 2

1. States Parties shall respect and ensure the rights set forth in the present Convention to each child within their jurisdiction without discrimination of any kind, irrespective of the child's or his or her parent's or legal guardian's race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status.

2. States Parties shall take all appropriate measures to ensure that the child is protected against all forms of discrimination or punishment on the basis of the status, activities, expressed opinions, or beliefs of the child's parents, legal guardians, or family members.

Article 3

1. In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration.

2. States Parties undertake to ensure the child such protection and care as is necessary for his or her well-being, taking into account the rights and duties of his or her parents, legal guardians, or other individuals legally responsible for him or her, and, to this end, shall take all appropriate legislative and administrative measures.

3. States Parties shall ensure that the institutions, services and facilities responsible for the care or protection of children shall conform with the standards established by competent authorities, particularly in the areas of safety, health, in the number and suitability of their staff, as well as competent supervision.

Article 4

States Parties shall undertake all appropriate legislative, administrative, and other measures for the implementation of the rights recognized in the present Convention. With regard to economic, social and cultural rights, States Parties shall undertake such measures to the maximum extent of their available resources and, where needed, within the framework of international co-operation.

Article 5

States Parties shall respect the responsibilities, rights and duties of parents or, where applicable, the members of the extended family or community as provided for by local custom, legal guardians or other persons legally responsible for the child, to provide, in a manner consistent with the evolving capacities of the child, appropriate direction and guidance in the exercise by the child of the rights recognized in the present Convention.

Article 6

1. States Parties recognize that every child has the inherent right to life. 2. States Parties shall ensure to the maximum extent possible the survival and development of the child.

Article 7

1. The child shall be registered immediately after birth and shall have the right from birth to a name, the right to acquire a nationality and. as far as possible, the right to know and be cared for by his or her parents.

2. States Parties shall ensure the implementation of these rights in accordance with their national law and their obligations under the relevant international instruments in this field, in particular where the child would otherwise be stateless.

Article 8

1. States Parties undertake to respect the right of the child to preserve his or her identity, including nationality, name and family relations as recognized by law without unlawful interference.

2. Where a child is illegally deprived of some or all of the elements of his or her identity, States Parties shall provide appropriate assistance and protection, with a view to re-establishing speedily his or her identity.

Article 9

1. States Parties shall ensure that a child shall not be separated from his or her parents against their will, except when competent authorities subject to judicial review determine, in accordance with applicable law and procedures, that such separation is necessary for the best interests of the child. Such determination may be necessary in a particular case such as one involving abuse or neglect of the child by the parents, or one where the parents are living separately and a decision must be made as to the child's place of residence.

2. In any proceedings pursuant to paragraph 1 of the present article, all interested parties shall be given an opportunity to participate in the proceedings and make their views known.

3. States Parties shall respect the right of the child who is separated from one or both parents to maintain personal relations and direct contact with both parents on a regular basis, except if it is contrary to the child's best interests.

4. Where such separation results from any action initiated by a State Party, such as the detention, imprisonment, exile, deportation or death (including death arising from any cause while the person is in the custody of the State) of one or both parents or of the child, that State Party shall, upon request, provide the parents, the child or, if appropriate, another member of the family with the essential information concerning the whereabouts of the absent member(s) of the family unless the provision of the information would be detrimental to the well-being of the child. States Parties shall further ensure that the submission of such a request shall of itself entail no adverse consequences for the person(s) concerned.

Article 10

1. In accordance with the obligation of States Parties under article 9, paragraph 1, applications by a child or his or her parents to enter or leave a State Party for the purpose of family reunification shall be dealt with by States Parties in a positive, humane and expeditious manner. States Parties shall further ensure that the submission of such a request shall entail no adverse consequences for the applicants and for the members of their family.

2. A child whose parents reside in different States shall have the right to maintain on a regular basis, save in exceptional circumstances personal relations and direct contacts with both parents. Towards that end and in accordance with the obligation of States Parties under article 9, paragraph 1, States Parties shall respect the right of the child and his or her parents to leave any country, including their

own, and to enter their own country. The right to leave any country shall be subject only to such restrictions as are prescribed by law and which are necessary to protect the national security, public order (ordre public), public health or morals or the rights and freedoms of others and are consistent with the other rights recognized in the present Convention.

Article 11

1. States Parties shall take measures to combat the illicit transfer and non-return of children abroad.

2. To this end, States Parties shall promote the conclusion of bilateral or multilateral agreements or accession to existing agreements.

Article 12

1. States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.

2. For this purpose, the child shall in particular be provided the opportunity to be heard in any judicial and administrative proceedings affecting the child, either directly, or through a representative or an appropriate body, in a manner consistent with the procedural rules of national law.

Article 13

1. The child shall have the right to freedom of expression; this right shall include freedom to seek, receive and impart information and ideas of all kinds, regardless of frontiers, either orally, in writing or in print, in the form of art, or through any other media of the child's choice.

2. The exercise of this right may be subject to certain restrictions, but these shall only be such as are provided by law and are necessary:

(a) For respect of the rights or reputations of others; or

(b) For the protection of national security or of public order (ordre public), or of public health or morals.

Article 14

1. States Parties shall respect the right of the child to freedom of thought, conscience and religion.

2. States Parties shall respect the rights and duties of the parents and, when applicable, legal guardians, to provide direction to the child in the exercise of his or her right in a manner consistent with the evolving capacities of the child.

3. Freedom to manifest one's religion or beliefs may be subject only to such limitations as are prescribed by law and are necessary to protect public safety, order, health or morals, or the fundamental rights and freedoms of others.

Article 15

1. States Parties recognize the rights of the child to freedom of association and to freedom of peaceful assembly.

2. No restrictions may be placed on the exercise of these rights other than those imposed in conformity with the law and which are necessary in a democratic society in the interests of national security or public safety, public order (ordre public), the protection of public health or morals or the protection of the rights and freedoms of others.

Article 16

1. No child shall be subjected to arbitrary or unlawful interference with his or her privacy, family, home or correspondence, nor to unlawful attacks on his or her honour and reputation.

2. The child has the right to the protection of the law against such interference or attacks.

Article 17

States Parties recognize the important function performed by the mass media and shall ensure that the child has access to information and material from a diversity of national and international sources, especially those aimed at the promotion of his or her social, spiritual and moral well-being and physical and mental health.

To this end, States Parties shall:

(a) Encourage the mass media to disseminate information and material of social and cultural benefit to the child and in accordance with the spirit of article 29;

(b) Encourage international co-operation in the production, exchange and dissemination of such information and material from a diversity of cultural, national and international sources;

(c) Encourage the production and dissemination of children's books;

(d) Encourage the mass media to have particular regard to the linguistic needs of the child who belongs to a minority group or who is indigenous;

(e) Encourage the development of appropriate guidelines for the protection of the child from information and material injurious to his or her well-being, bearing in mind the provisions of articles 13 and 18.

Article 18

1. States Parties shall use their best efforts to ensure recognition of the principle that both parents have common responsibilities for the upbringing and development of the child. Parents or, as the case may be, legal guardians, have the primary responsibility for the upbringing and development of the child. The best interests of the child will be their basic concern.

2. For the purpose of guaranteeing and promoting the rights set forth in the present Convention, States Parties shall render appropriate assistance to parents and legal guardians in the performance of their child-rearing responsibilities and shall ensure the development of institutions, facilities and services for the care of children.

3. States Parties shall take all appropriate measures to ensure that children of working parents have the right to benefit from child-care services and facilities for which they are eligible.

Article 19

1. States Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child.

2. Such protective measures should, as appropriate, include effective procedures for the establishment of social programmes to provide necessary support for the child and for those who have the care of the child, as well as for other forms of prevention and for identification, reporting, referral, investigation, treatment and follow-up of instances of child maltreatment described heretofore, and, as appropriate, for judicial involvement.

Article 20

1. A child temporarily or permanently deprived of his or her family environment, or in whose own best interests cannot be allowed to remain in that environment, shall be entitled to special protection and assistance provided by the State.

2. States Parties shall in accordance with their national laws ensure alternative care for such a child.

3. Such care could include, inter alia, foster placement, kafalah of Islamic law, adoption or if necessary placement in suitable institutions for the care of children. When considering solutions, due regard shall be paid to the desirability of continuity in a child's upbringing and to the child's ethnic, religious, cultural and linguistic background.

Article 21

States Parties that recognize and/or permit the system of adoption shall ensure that the best interests of the child shall be the paramount consideration and they shall:

(a) Ensure that the adoption of a child is authorized only by competent authorities who determine, in accordance with applicable law and procedures and on the basis of all pertinent and reliable information, that the adoption is permissible in view of the child's status concerning parents, relatives and legal guardians and that, if required, the persons concerned have given their informed consent to the adoption on the basis of such counselling as may be necessary;

(b) Recognize that inter-country adoption may be considered as an alternative means of child's care, if the child cannot be placed in a foster or an adoptive family or cannot in any suitable manner be cared for in the child's country of origin;

(c) Ensure that the child concerned by inter-country adoption enjoys safeguards and standards equivalent to those existing in the case of national adoption;

(d) Take all appropriate measures to ensure that, in inter-country adoption, the placement does not result in improper financial gain for those involved in it;

(e) Promote, where appropriate, the objectives of the present article by concluding bilateral or multilateral arrangements or agreements, and endeavour, within this framework, to ensure that the placement of the child in another country is carried out by competent authorities or organs.

Article 22

1. States Parties shall take appropriate measures to ensure that a child who is seeking refugee status or who is considered a refugee in accordance with applicable international or domestic law and procedures shall, whether unaccompanied or accompanied by his or her parents or by any other person, receive appropriate protection and humanitarian assistance in the enjoyment of applicable rights set forth in the present Convention and in other international human rights or humanitarian instruments to which the said States are Parties.

2. For this purpose, States Parties shall provide, as they consider appropriate, co-operation in any efforts by the United Nations and other competent intergovernmental organizations or non-governmental organizations co-operating with the United Nations to protect and assist such a child and to trace the parents or other members of the family of any refugee child in order to obtain information necessary for reunification with his or her family. In cases where no parents or other members of the family can be found, the child shall be accorded the same protection as any other child permanently or temporarily deprived of his or her family environment for any reason , as set forth in the present Convention.

Article 23

1. States Parties recognize that a mentally or physically disabled child should enjoy a full and decent life, in conditions which ensure dignity, promote self-reliance and facilitate the child's active participation in the community.

2. States Parties recognize the right of the disabled child to special care and shall encourage and ensure the extension, subject to available resources, to the eligible child and those responsible for his or her care, of assistance for which application is made and which is appropriate to the child's condition and to the circumstances of the parents or others caring for the child.

3. Recognizing the special needs of a disabled child, assistance extended in accordance with paragraph 2 of the present article shall be provided free of charge, whenever possible, taking into account the financial resources of the parents or others caring for the child, and shall be designed to ensure that the disabled child has effective access to and receives education, training, health care services, rehabilitation services, preparation for employment and recreation opportunities in a manner conducive to the child's achieving the fullest possible social integration and individual development, including his or her cultural and spiritual development

4. States Parties shall promote, in the spirit of international cooperation, the exchange of appropriate information in the field of preventive health care and of medical, psychological and functional treatment of disabled children, including dissemination of and access to information concerning methods of rehabilitation, education and vocational services, with the aim of enabling States Parties to improve their capabilities and skills and to widen their experience in these areas. In this regard, particular account shall be taken of the needs of developing countries.

Article 24

1. States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.

2. States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures:

(a) To diminish infant and child mortality;

(b) To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care;

(c) To combat disease and malnutrition, including within the framework of primary health care, through, inter alia, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking-water, taking into consideration the dangers and risks of environmental pollution;

(d) To ensure appropriate pre-natal and post-natal health care for mothers;

(e) To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents;

(f) To develop preventive health care, guidance for parents and family planning education and services.

3. States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.

4. States Parties undertake to promote and encourage international co-operation with a view to achieving progressively the full realization of the right recognized in the present article. In this regard, particular account shall be taken of the needs of developing countries.

Article 25

States Parties recognize the right of a child who has been placed by the competent authorities for the purposes of care, protection or treatment of his or her physical or mental health, to a periodic review of the treatment provided to the child and all other circumstances relevant to his or her placement.

Article 26

1. States Parties shall recognize for every child the right to benefit from social security, including social insurance, and shall take the necessary measures to achieve the full realization of this right in accordance with their national law.

2. The benefits should, where appropriate, be granted, taking into account the resources and the circumstances of the child and persons having responsibility for the maintenance of the child, as well as any other consideration relevant to an application for benefits made by or on behalf of the child.

Article 27

1. States Parties recognize the right of every child to a standard of living adequate for the child's physical, mental, spiritual, moral and social development.

2. The parent(s) or others responsible for the child have the primary responsibility to secure, within their abilities and financial capacities, the conditions of living necessary for the child's development.

3. States Parties, in accordance with national conditions and within their means, shall take appropriate measures to assist parents and others responsible for the child to implement this right and shall in case of need provide material assistance and support programmes, particularly with regard to nutrition, clothing and housing.

4. States Parties shall take all appropriate measures to secure the recovery of maintenance for the child from the parents or other persons having financial responsibility for the child, both within the State Party and from abroad. In particular, where the person having financial responsibility for the child lives in a State different from that of the child, States Parties shall promote the accession to international agreements or the conclusion of such agreements, as well as the making of other appropriate arrangements.

Article 28

1. States Parties recognize the right of the child to education, and with a view to achieving this right progressively and on the basis of equal opportunity, they shall, in particular:

(a) Make primary education compulsory and available free to all;

(b) Encourage the development of different forms of secondary education, including general and vocational education, make them available and accessible to every child, and take appropriate measures such as the introduction of free education and offering financial assistance in case of need;

(c) Make higher education accessible to all on the basis of capacity by every appropriate means;

(d) Make educational and vocational information and guidance available and accessible to all children;

(e) Take measures to encourage regular attendance at schools and the reduction of drop-out rates.

2. States Parties shall take all appropriate measures to ensure that school discipline is administered in a manner consistent with the child's human dignity and in conformity with the present Convention.

3. States Parties shall promote and encourage international cooperation in matters relating to education, in particular with a view to contributing to the elimination of ignorance and illiteracy

throughout the world and facilitating access to scientific and technical knowledge and modern teaching methods. In this regard, particular account shall be taken of the needs of developing countries.

Article 29

1. States Parties agree that the education of the child shall be directed to:

(a) The development of the child's personality, talents and mental and physical abilities to their fullest potential;

(b) The development of respect for human rights and fundamental freedoms, and for the principles enshrined in the Charter of the United Nations;

(c) The development of respect for the child's parents, his or her own cultural identity, language and values, for the national values of the country in which the child is living, the country from which he or she may originate, and for civilizations different from his or her own;

(d) The preparation of the child for responsible life in a free society, in the spirit of understanding, peace, tolerance, equality of sexes, and friendship among all peoples, ethnic, national and religious groups and persons of indigenous origin;

(e) The development of respect for the natural environment.

2. No part of the present article or article 28 shall be construed so as to interfere with the liberty of individuals and bodies to establish and direct educational institutions, subject always to the observance of the principle set forth in paragraph 1 of the present article and to the requirements that the education given in such institutions shall conform to such minimum standards as may be laid down by the State.

Article 30

In those States in which ethnic, religious or linguistic minorities or persons of indigenous origin exist, a child belonging to such a minority or who is indigenous shall not be denied the right, in community with other members of his or her group, to enjoy his or her own culture, to profess and practise his or her own religion, or to use his or her own language.

Article 31

1. States Parties recognize the right of the child to rest and leisure, to engage in play and recreational activities appropriate to the age of the child and to participate freely in cultural life and the arts.

2. States Parties shall respect and promote the right of the child to participate fully in cultural and artistic life and shall encourage the provision of appropriate and equal opportunities for cultural, artistic, recreational and leisure activity.

Article 32

1. States Parties recognize the right of the child to be protected from economic exploitation and from performing any work that is likely to be hazardous or to interfere with the child's education, or to be harmful to the child's health or physical, mental, spiritual, moral or social development.

2. States Parties shall take legislative, administrative, social and educational measures to ensure the implementation of the present article. To this end, and having regard to the relevant provisions of other international instruments, States Parties shall in particular:

(a) Provide for a minimum age or minimum ages for admission to employment;

(b) Provide for appropriate regulation of the hours and conditions of employment;

(c) Provide for appropriate penalties or other sanctions to ensure the effective enforcement of the present article.

Article 33

States Parties shall take all appropriate measures, including legislative, administrative, social and educational measures, to protect children from the illicit use of narcotic drugs and psychotropic substances as defined in the relevant international treaties, and to prevent the use of children in the illicit production and trafficking of such substances.

Article 34

States Parties undertake to protect the child from all forms of sexual exploitation and sexual abuse. For these purposes, States Parties shall in particular take all appropriate national, bilateral and multilateral measures to prevent:

(a) The inducement or coercion of a child to engage in any unlawful sexual activity;

(b) The exploitative use of children in prostitution or other unlawful sexual practices;

(c) The exploitative use of children in pornographic performances and materials.

Article 35

States Parties shall take all appropriate national, bilateral and multilateral measures to prevent the abduction of, the sale of or traffic in children for any purpose or in any form.

Article 36

States Parties shall protect the child against all other forms of exploitation prejudicial to any aspects of the child's welfare.

Article 37

States Parties shall ensure that:

(a) No child shall be subjected to torture or other cruel, inhuman or degrading treatment or punishment. Neither capital punishment nor life imprisonment without possibility of release shall be imposed for offences committed by persons below eighteen years of age;

(b) No child shall be deprived of his or her liberty unlawfully or arbitrarily. The arrest, detention or imprisonment of a child shall be in conformity with the law and shall be used only as a measure of last resort and for the shortest appropriate period of time;

(c) Every child deprived of liberty shall be treated with humanity and respect for the inherent dignity of the human person, and in a manner which takes into account the needs of persons of his or her age. In particular, every child deprived of liberty shall be separated from adults unless it is considered in the child's best interest not to do so and shall have the right to maintain contact with his or her family through correspondence and visits, save in exceptional circumstances;

(d) Every child deprived of his or her liberty shall have the right to prompt access to legal and other appropriate assistance, as well as the right to challenge the legality of the deprivation of his or her liberty before a court or other competent, independent and impartial authority, and to a prompt decision on any such action.

Article 38

1. States Parties undertake to respect and to ensure respect for rules of international humanitarian law applicable to them in armed conflicts which are relevant to the child.

2. States Parties shall take all feasible measures to ensure that persons who have not attained the age of fifteen years do not take a direct part in hostilities.

3. States Parties shall refrain from recruiting any person who has not attained the age of fifteen years into their armed forces. In recruiting among those persons who have attained the age of fifteen years but who have not attained the age of eighteen years, States Parties shall endeavour to give priority to those who are oldest.

4. In accordance with their obligations under international humanitarian law to protect the civilian population in armed conflicts, States Parties shall take all feasible measures to ensure protection and care of children who are affected by an armed conflict.

Article 39

States Parties shall take all appropriate measures to promote physical and psychological recovery and social reintegration of a child victim of: any form of neglect, exploitation, or abuse; torture or any other form of cruel, inhuman or degrading treatment or punishment; or armed conflicts. Such recovery and reintegration shall take place in an environment which fosters the health, self-respect and dignity of the child.

Article 40

1. States Parties recognize the right of every child alleged as, accused of, or recognized as having infringed the penal law to be treated in a manner consistent with the promotion of the child's sense of dignity and worth, which reinforces the child's respect for the human rights and fundamental freedoms of others and which takes into account the child's age and the desirability of promoting the child's reintegration and the child's assuming a constructive role in society.

2. To this end, and having regard to the relevant provisions of international instruments, States Parties shall, in particular, ensure that:

(a) No child shall be alleged as, be accused of, or recognized as having infringed the penal law by reason of acts or omissions that were not prohibited by national or international law at the time they were committed;

(b) Every child alleged as or accused of having infringed the penal law has at least the following guarantees:

(i) To be presumed innocent until proven guilty according to law;

(ii) To be informed promptly and directly of the charges against him or her, and, if appropriate, through his or her parents or legal guardians, and to have legal or other appropriate assistance in the preparation and presentation of his or her defence;

(iii) To have the matter determined without delay by a competent, independent and impartial authority or judicial body in a fair hearing according to law, in the presence of legal or other appropriate assistance and, unless it is considered not to be in the best interest of the child, in particular, taking into account his or her age or situation, his or her parents or legal guardians;

(iv) Not to be compelled to give testimony or to confess guilt; to examine or have examined adverse witnesses and to obtain the participation and examination of witnesses on his or her behalf under conditions of equality;

(v) If considered to have infringed the penal law, to have this decision and any measures imposed in consequence thereof reviewed by a higher competent, independent and impartial authority or judicial body according to law;

(vi) To have the free assistance of an interpreter if the child cannot understand or speak the language used;

(vii) To have his or her privacy fully respected at all stages of the proceedings.

3. States Parties shall seek to promote the establishment of laws, procedures, authorities and institutions specifically applicable to children alleged as, accused of, or recognized as having infringed the penal law, and, in particular:

(a) The establishment of a minimum age below which children shall be presumed not to have the capacity to infringe the penal law;

(b) Whenever appropriate and desirable, measures for dealing with such children without resorting to judicial proceedings, providing that human rights and legal safeguards are fully respected. 4. A variety of dispositions, such as care, guidance and supervision orders; counselling; probation; foster care; education and vocational training programmes and other alternatives to institutional care shall be available to ensure that children are dealt with in a manner appropriate to their well-being and proportionate both to their circumstances and the offence.

Article 41

Nothing in the present Convention shall affect any provisions which are more conducive to the realization of the rights of the child and which may be contained in:

(a) The law of a State party; or

(b) International law in force for that State.

PART II

Article 42

States Parties undertake to make the principles and provisions of the Convention widely known, by appropriate and active means, to adults and children alike.

Article 43

1. For the purpose of examining the progress made by States Parties in achieving the realization of the obligations undertaken in the present Convention, there shall be established a Committee on the Rights of the Child, which shall carry out the functions hereinafter provided.

2. The Committee shall consist of ten experts of high moral standing and recognized competence in the field covered by this Convention. The members of the Committee shall be elected by States Parties from among their nationals and shall serve in their personal capacity, consideration being given to equitable geographical distribution, as well as to the principal legal systems.

3. The members of the Committee shall be elected by secret ballot from a list of persons nominated by States Parties. Each State Party may nominate one person from among its own nationals.

4. The initial election to the Committee shall be held no later than six months after the date of the entry into force of the present Convention and thereafter every second year. At least four months before the date of each election, the Secretary-General of the United Nations shall address a letter to States Parties inviting them to submit their nominations within two months. The Secretary-General shall subsequently prepare a list in alphabetical order of all persons thus nominated, indicating States Parties which have nominated them, and shall submit it to the States Parties to the present Convention.

5. The elections shall be held at meetings of States Parties convened by the Secretary-General at United Nations Headquarters. At those meetings, for which two thirds of States Parties shall constitute

a quorum, the persons elected to the Committee shall be those who obtain the largest number of votes and an absolute majority of the votes of the representatives of States Parties present and voting.

6. The members of the Committee shall be elected for a term of four years. They shall be eligible for re-election if renominated. The term of five of the members elected at the first election shall expire at the end of two years; immediately after the first election, the names of these five members shall be chosen by lot by the Chairman of the meeting.

7. If a member of the Committee dies or resigns or declares that for any other cause he or she can no longer perform the duties of the Committee, the State Party which nominated the member shall appoint another expert from among its nationals to serve for the remainder of the term, subject to the approval of the Committee.

8. The Committee shall establish its own rules of procedure.

9. The Committee shall elect its officers for a period of two years.

10. The meetings of the Committee shall normally be held at United Nations Headquarters or at any other convenient place as determined by the Committee. The Committee shall normally meet annually. The duration of the meetings of the Committee shall be determined, and reviewed, if necessary, by a meeting of the States Parties to the present Convention, subject to the approval of the General Assembly.

11. The Secretary-General of the United Nations shall provide the necessary staff and facilities for the effective performance of the functions of the Committee under the present Convention.

12. With the approval of the General Assembly, the members of the Committee established under the present Convention shall receive emoluments from United Nations resources on such terms and conditions as the Assembly may decide.

Article 44

1. States Parties undertake to submit to the Committee, through the Secretary-General of the United Nations, reports on the measures they have adopted which give effect to the rights recognized herein and on the progress made on the enjoyment of those rights

(a) Within two years of the entry into force of the Convention for the State Party concerned;

(b) Thereafter every five years.

2. Reports made under the present article shall indicate factors and difficulties, if any, affecting the degree of fulfilment of the obligations under the present Convention. Reports shall also contain sufficient information to provide the Committee with a comprehensive understanding of the implementation of the Convention in the country concerned.

3. A State Party which has submitted a comprehensive initial report to the Committee need not, in its subsequent reports submitted in accordance with paragraph 1 (b) of the present article, repeat basic information previously provided.

4. The Committee may request from States Parties further information relevant to the implementation of the Convention.

5. The Committee shall submit to the General Assembly, through the Economic and Social Council, every two years, reports on its activities.

6. States Parties shall make their reports widely available to the public in their own countries.

Article 45

In order to foster the effective implementation of the Convention and to encourage international co-operation in the field covered by the Convention:

(a) The specialized agencies, the United Nations Children's Fund, and other United Nations organs shall be entitled to be represented at the consideration of the implementation of such provisions of the present Convention as fall within the scope of their mandate. The Committee may invite the specialized agencies, the United Nations Children's Fund and other competent bodies as it may consider appropriate to provide expert advice on the implementation of the Convention in areas falling within the scope of their respective mandates. The Committee may invite the specialized agencies, the United Nations Children's Fund, and other United Nations organs to submit reports on the implementation of the Convention in areas falling within the scope of their activities;

(b) The Committee shall transmit, as it may consider appropriate, to the specialized agencies, the United Nations Children's Fund and other competent bodies, any reports from States Parties that contain a request, or indicate a need, for technical advice or assistance, along with the Committee's observations and suggestions, if any, on these requests or indications;

(c) The Committee may recommend to the General Assembly to request the Secretary-General to undertake on its behalf studies on specific issues relating to the rights of the child;

(d) The Committee may make suggestions and general recommendations based on information received pursuant to articles 44 and 45 of the present Convention. Such suggestions and general recommendations shall be transmitted to any State Party concerned and reported to the General Assembly, together with comments, if any, from States Parties.

PART III

Article 46

The present Convention shall be open for signature by all States.

Article 47

The present Convention is subject to ratification. Instruments of ratification shall be deposited with the Secretary-General of the United Nations.

Article 48

The present Convention shall remain open for accession by any State. The instruments of accession shall be deposited with the Secretary-General of the United Nations.

Article 49

1. The present Convention shall enter into force on the thirtieth day following the date of deposit with the Secretary-General of the United Nations of the twentieth instrument of ratification or accession.

2. For each State ratifying or acceding to the Convention after the deposit of the twentieth instrument of ratification or accession, the Convention shall enter into force on the thirtieth day after the deposit by such State of its instrument of ratification or accession.

Article 50

1. Any State Party may propose an amendment and file it with the Secretary-General of the United Nations. The Secretary-General shall thereupon communicate the proposed amendment to States Parties, with a request that they indicate whether they favour a conference of States Parties for the purpose of considering and voting upon the proposals. In the event that, within four months from the date of such communication, at least one third of the States Parties favour such a conference, the Secretary-General shall convene the conference under the auspices of the United Nations. Any

amendment adopted by a majority of States Parties present and voting at the conference shall be submitted to the General Assembly for approval.

2. An amendment adopted in accordance with paragraph 1 of the present article shall enter into force when it has been approved by the General Assembly of the United Nations and accepted by a two-thirds majority of States Parties.

3. When an amendment enters into force, it shall be binding on those States Parties which have accepted it, other States Parties still being bound by the provisions of the present Convention and any earlier amendments which they have accepted.

Article 51

1. The Secretary-General of the United Nations shall receive and circulate to all States the text of reservations made by States at the time of ratification or accession.

2. A reservation incompatible with the object and purpose of the present Convention shall not be permitted.

3. Reservations may be withdrawn at any time by notification to that effect addressed to the Secretary-General of the United Nations, who shall then inform all States. Such notification shall take effect on the date on which it is received by the Secretary-General

Article 52

A State Party may denounce the present Convention by written notification to the Secretary-General of the United Nations. Denunciation becomes effective one year after the date of receipt of the notification by the Secretary-General.

Article 53

The Secretary-General of the United Nations is designated as the depositary of the present Convention.

Article 54

The original of the present Convention, of which the Arabic, Chinese, English, French, Russian and Spanish texts are equally authentic, shall be deposited with the Secretary-General of the United Nations. IN WITNESS THEREOF the undersigned plenipotentiaries, being duly authorized thereto by their respective governments, have signed the present Convention.

AMERICAN ACADEMY OF
CHILD & ADOLESCENT
PSYCHIATRY

WWW.AACAP.ORG

May 1, 2017

Joseph Penn, MD, Chair
APA Council on Children, Adolescents, and Their Families
jopenn@UTMB.EDU

Dear Dr. Penn,

I am pleased to share with you that the American Academy of Child and Adolescent Psychiatry's (AACAP's) Psychopharmacology Committee recently convened a group that has begun work on the next publication in the Parents Medication Guide series. AACAP values the partnership of the American Psychiatric Association (APA) and other organizations in developing the important Parent Medication Guide series and looks forward to continued partnership. We feel confident that these resources are very beneficial to the families and others caring for children with mental health disorders.

Fear-based anxiety disorders and obsessive-compulsive disorder will be the focus of the upcoming Guide. Co-chairs Dr. John T. Walkup, of Weill Cornell Medical College and New York Presbyterian Hospital, and Dr. Jeffrey Strawn, of University of Cincinnati and Cincinnati Children's Hospital Medical Center, are leading the group of child and adolescent psychiatrists.

We value APA's partnership in this endeavor to share timely research based information to our colleagues, families, and caregivers regarding mental health challenges that children and adolescents face. The Parents Medication Guide on Autism Spectrum Disorder is meeting that need by delivering accessible information on assessment, treatment options, and medication clinical trials.

To deliver this new Guide through the most expeditious route, we would request that you share with us the following details so they can be incorporated into the timeline for Guide development:

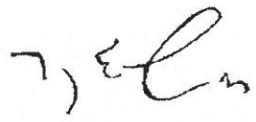
- the names of two APA representatives from the Council on Children, Adolescents, and Their Families who can participate on the workgroup;
- key dates of when the APA's leadership bodies would meet to review the Guide;

- assurance that when revisions or edits are made to the Guide, both APA and AACAP will share changes with their respective approving councils, committees, and boards as soon as possible; and
- assurance that when approvals are received from the respective approving councils and boards the Co-Chairs of the workgroup and AACAP staff are notified.

We sincerely look forward to working together for the benefit of children and adolescents with anxiety disorders and the families and professionals who care for them.

Sincerely,

Adelaide Robb, MD



Timothy Wilens, MD

Co-Chairs, AACAP's Psychopharmacology Committee

cc: Ranna Parekh, MD
Director, APA Division of Diversity and Health Equity

cc: Carmen J. Head MPH, CHES
D irector, AACAP Research, Grants, & Workforce

Item 8.D

Joint Reference Committee

6/2/2017

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 completed the video training webinar designed to help psychiatrists use social media responsibly within the bounds of medical ethics. That webinar is now available on psychiatry.org and is considered a member benefit.

Council members are still engaged in completing short videos that answer commonly asked questions from colleagues regarding communications challenges that they may face. These videos are intended to help members better interact with the media in interviews, and help them produce content on their own to help advance the mission of the APA. Several of these videos have been completed and are on our site.

Resident-fellow members of the Council are collaborating with Psychiatric News staff on a regular column aimed at RFMs and Early Career Psychiatrists. That initiative is progressing, and a new column should make its debut soon.

The Council on Communications intends to revise its charge to make it more up-to-date with today's communications landscape. Council leadership is currently engaged in drafting a new charge for the Council with the help of APA staff. It is the goal of the Council to submit this new charge for JRC review by October.

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:

- Council revised the draft of a position statement on the role of psychiatrists in palliative care.
- Council discussed the progress of and made editorial decisions about the Cultural Competency Guide for the Treatment of Elderly Adults.

Reference Items:

- The JRC referred the council to develop a formal position statement on diagnosing schizophrenia in skilled nursing centers.

Council on Geriatric Psychiatry – Minutes of the Meeting
Council Members Present:

1. Robert Paul Roca, MD (Chair)
2. Anand Kumar, MD (Vice Chair)
3. Brent Forester, MD
4. Marsden McGuire, MD
5. Maria Llorente, MD
6. EJ Santos, MD
7. Marilyn Price, MD
8. Susan Lehmann, MD (via phone)
9. Susan Schultz, MD (via phone)
10. Micheline Dugue, MD
11. Seon Kum, MD(RFM)
12. Ebony Dix, MD (RFM)
13. Rebecca Radue, MD (RFM) (via phone)
14. Dan Sewell, MD (Ex-officio, American Association of Geriatric Psychiatrists (AAGP))

Staff in Attendance:

- Sejal Patel (Staff), APA

Council Members Absent with excused absence:

1. Paul Kirwin, MD
2. Ipsit Vahia, MD
3. Maureen Nash, MD
4. Peter Ureste, MD (RFM)

Council Members Absent with unexcused absence:

1. Olivia Okereke, MD
2. Pachida Lo, MD

Guests in Attendance:

1. Anita Everett, MD, President, APA
2. Saul Levin, MD, CEO and Medical Director, APA
3. Eileen Carlson, Director, Reimbursement Policy, APA
4. Phil Wang, MD, Director, APA Research
5. Diana Clarke, PhD, Dy. Director, APA Research
6. Debbie Gibson, Manager, APA Mental Health Registry
7. Vabren Watts, PhD Deputy Director, Division of Diversity and Health Equity
8. Iqbal “Ike” Ahmed, MD, Past President, AAGP
9. Ilse Weichers, MD, AAGP
10. Alex Threlfall, MD, AAGP

Minutes of the Meeting

Introductions

The meeting began with introductions of all participants and review of the agenda for the meeting.

The topics discussed included the following:

Position Statement on role of psychiatrists in palliative care

A workgroup consisting of volunteers from the Council on Geriatric Psychiatry and the Council on Psychosomatic Medicine is working on this statement. At this meeting the Council on Geriatric Psychiatry made further revisions. As the this writing, a final review is underway by the Council on Psychosomatic Medicine, and the Position Statement is expected to be ready for submission to the Joint Reference Committee by or before Fall 2017.

Position statement on diagnosing schizophrenia in skilled nursing centers

The Council reviewed a statement prepared by a number of other organizations on diagnosing schizophrenia in skilled nursing centers. The Council proposed extensive revisions, which were accepted by the other organizations. The statement has been officially endorsed by APA. The Joint Reference Committee went on to ask the Council to consider developing a formal position statement on this issue. The present Council members discussed this idea in detail and reached the conclusion that there is no need for a formal position statement on this issue in as much as the Council already has developed a position statement on the role of the psychiatrist in long-term care (just approved by the Assembly) and APA has a recently-approved practice guideline on the use of antipsychotics in dementia. It was felt that a position statement on this narrow topic would not add anything to those documents and to the joint statement already endorsed (into which APA had a great deal of input).

Update from APA Division of Government Relations

Jeff Regan informed the Council about the current APA advocacy initiatives and discussed how the repeal of the Affordable Care Act will impact the coverage and the practice of geriatric psychiatry.

He also talked about APA's advocacy efforts in collaboration with the AAGP. In 2015 APA's Department of Government Relations began to liaise with AAGP's Public Policy Caucus. Monthly phone calls were held during which advocacy intelligence and activities were shared between both groups. These calls led to collaborative efforts that continue into the present-day. Efforts have included support for the 21st Century Cures Act (P.L. 114-255) and the mental health reform provisions contained within, and opposition to the American Health Care Act (H.R. 1628).

MIPS Update

Eileen Carlson and Samantha Shugarman of APA's Department of Reimbursement Policy gave an update on Medicare's new quality program, "Merit-based Incentive Payment System" or "MIPS." MIPS reporting begins in 2017 for psychiatrists who see Part B patients. Psychiatrists will be exempt from the program if they have no more than $30,000 in Part B charges or no more than 100 Part B patients per year; for this reason, many psychiatrists will not have to participate. CMS has created a look-up tool where psychiatrists can check their reporting status, and they should also be receiving letters from their Medicare administrator contractor.

Update from American Association of Geriatric Psychiatrists (AAGP)

Dr. Dan Sewell, President, AAGP, gave an update on the AAGP activities. He appreciated the ongoing successful collaboration with the Council on Geriatric Psychiatry which has resulted into productive advocacy efforts. As Dr. Sewell reported, AAGP's last Annual Meeting in Dallas, focused on Integrated Geriatric Mental Health Care Through Innovation. The theme of the 2018 meeting is Inclusivity Geriatric Mental Health. Dr. Sewell expressed concern about a recent drop in AAGP membership. They have established a task force to focus on this issue.

APA Registry Update from Research Division

APA is developing a mental health registry, PsychPRO, to help members to meet quality reporting and maintenance-of-certification (MOC) requirements as well as to advance the field by providing a large database to facilitate research and the creation of new quality measures. Drs. Phil Wang and Diana Clarke provided an update on the progress of the initiative. They briefly explained the registry architecture and discussed the timelines. Dr. Wang informed the council that the CMS certified the registry in early this year. He requested members to help disseminate the information about PsychPRO to other stakeholders.

Visits by APA Leadership

Dr. Anita Everett thanked Council members for their valuable contributions. She said that physician wellness and physician burnout will be one of her top priorities in the presidential year. Dr. Everett has appointed a work group on physician burnout which will develop tools and resources to share with APA members. She invited the council members to share their ideas and experiences about this critical issue.

Dr. Saul Levin congratulated the Council for producing informative and timely products for APA members. He urged the Council to work on products that are useful to psychiatrists who don't specialize in geriatrics. Dr. Levin suggested that Council brainstorm about how to encourage residents to consider careers in geriatric psychiatry.

Annual Meeting Submissions

Council sponsored several sessions at the annual meeting. These included one on the role of psychiatrists in palliative care, and one on sexual intimacy and decision-making capacity in cognitively impaired older adults. They also discussed a few potential topics that can be presented at the 2018 Annual Meeting, including a symposium on collaborative care in geriatrics.

Cultural Competency Guide for the Treatment of Elderly Adults

Dr. Maria Llorente provided an update on the progress of this guide.

The Council on Aging (former name of the Council on Geriatric Psychiatry) developed a cultural competency curriculum to treat elderly patients for in 2004. Dr. Maria Llorente, who worked on the original curriculum, offered to work with the Division of Diversity and Health Equity to revise the document. Dr. Llorente has formed a work group consisting of senior psychiatrists and APA Fellows to work on the guide.

Authors have submitted the first draft of the assigned chapters. Draft chapters were reviewed by Dr. Llorente. Now each chapter will be assigned to one of the council members for one more review. The workgroup is expecting to release the final draft by this Fall.

Below is the draft outline of the guide:

Guide to Cultural Competency & Older Adults: Draft Table of Contents

1. Why is Cultural Competency important for Work with a diverse elderly population?
2. Cultural Competence in Geriatric Psychiatry: Teaching and Evaluative Methods
3. Migration, Acculturation, and Mental Health
4. African American Elderly
5. Indigenous Elderly
6. Asian-American and Pacific Islander Elderly
7. Latino Elderly
8. Lesbian, Gay, Bisexual, Transgender Elderly
9. Rural Elderly
10. The culture of the military, unique occupational exposures, and older Veterans
11. Centenarians

Experiences of APA/APAF Fellows on Council:

The Council has five APA/APAF Fellows assigned currently. Three of them are rotating off this year. They were asked to share their experiences on the Council. One (Dr. Seon Kum) of those three fellows was present for the meeting. He reported that it was a wonderful experience for him. The Chair and the other council members are very receptive of his ideas and actively solicited his participation. He felt heard and valued. He learned a lot by working on council products and would like to continue working with the Council on ongoing projects, including a possible symposium presentation next year.

Subspecialty Councils Meeting to discuss Issues in Recruitment:

David Gitlin, Chair of the Council on Psychosomatic Medicine, proposed a meeting of Council Chairs representing the subspecialties to discuss recruitment of psychiatry residents into fellowship programs. The meeting was attended by the representatives of five *APA subspecialty Councils, Council on Medical Education and Lifelong Learning, and the Office of Education.* Two members (Drs. Robert Roca and Ebony Dix) from the Council in Geriatric Psychiatry participated in this meeting. The participants discussed the following topics:

- *Are subspecialties important to the overall success of the field of psychiatry?*
- *Does APA agree that increased recruitment of psychiatry residents into subspecialties is a desired outcome?*
- *Barriers to recruitment and how to overcome them.*

Executive Summary

Council on Healthcare Systems and Financing
Harsh Trivedi, MD, MBA, Chair

Members of the Council on Healthcare Systems and Financing have been reviewing and providing input to APA administration on issues related to health reform legislation, hospital regulatory issues, and alternative payment methods. Our May meeting focused on health reform updates, discussing the idea of collaborative efforts with non-physician clinicians and reviewing APA position statements. We continue to monitor APA activities on parity implementation and enforcement as well as other regulatory issues.

The Council brings the following Action Items:

Action Item 1: Position Statement on the Need to Maintain Long-Term Mental Hospital Facilities

Background: As part of the standard review process the CHSF reviewed this position and recommends it be retained with revisions (both to the statement and title). The concerns raised remain relevant. The revised position statement incorporates much of what was included in the original position statement. The proposed position statement (with revisions) is below.

ACTION: Will the Joint Reference Committee recommend that the Assembly approve the revised Position Statement: *Position Statement on the Need to Maintain Long-Term Care Facilities for Certain Individuals with Serious Mental Illness*, and if approved, forward it to the Board of Trustees for consideration? (Attachment A (current statement), Attachment B (proposed statement), Attachment C (statement with changes tracked))

Proposed APA Position Statement on the Need to Maintain Long-Term Care Facilities for Certain Individuals with Serious Mental Illness

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 (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, in spite of vigorous therapeutic efforts.

Community mental health centers should be funded and staffed to provide a full wrap-around services to the segment of the SMI population that can be successfully maintained in the community. However, there must remain the option of providing intermediate and long-term treatment in a structured hospital-type environment for those that cannot maintain even a marginal adjustment to the community.

Action Item 2: Position Statement on Codification of Medical Evaluation and Management Services for Psychotherapy

Background: As part of the standard review process the CHSF reviewed this position and recommends it be retained with minor revisions. The position statement remains relevant.

ACTION: Will the Joint Reference Committee recommend that the Assembly approve the revised Position Statement: *Codification of Medical Evaluation and Management Services for Psychotherapy*, and if approved, forward it to the Board of Trustees for consideration? (Attachment D (current statement), Attachment E (proposed statement))

Proposed APA Position Statement on Codification of Medical Evaluation and Management Services in Psychotherapy

Current policies of CMS and AMA's CPT distinguish between psychotherapy and medical evaluation and management. However, psychotherapy provided by psychiatrists includes continuous medical evaluation and management services. Their medical knowledge enables psychiatrists not only to evaluate the medical aspects of the patient's condition and to treat accordingly, but also to provide continuous evaluation of the full biopsychosocial presentation of the patient. All are essential in the practice of psychiatry and in psychotherapy provided by psychiatrists. Such knowledge indeed does provide added value to the clinical encounter of the patient with the psychiatrist, and should be recognized as such.

Action Item 3: Position Statement on Psychiatry and Primary Care Integration across the Lifespan

Background: As part of the standard review process the CHSF reviewed this position statement and recommends it be retired. Members of the CHSF think the concepts contained in this position statement have been included in other APA position statements such as the 2016 Position statement on **Integrated Care and the 2008 Position statement on Principles for Health Care Reform for Psychiatry.**

ACTION: Will the Joint Reference Committee recommend that the Assembly retire the Position Statement: *Integration Position Statement on Psychiatry and Primary Care Integration across the Lifespan*, and forward it to the Board of Trustees for consideration? (Attachment F (Current))

Current Position Statement on Psychiatry and Primary Care Integration across the Lifespan (2010) (recommending retirement)

- Access to and payment for clinically appropriate services provided by psychiatrists should be included as an essential feature in medical/health home initiatives.

- Parity of benefits design for beneficiaries as well as parity in payment for all physicians, particularly psychiatric that does not discriminate by location of service or diagnosis should be provided.
- Psychiatrists should have choices of participation in a new health system, such as fully integrated clinicians and/or managers of the system, as collaborative care partners, and as consultants to it.
- The exact financial formula for these choices should be negotiated such that it is compatible with parity and nondiscrimination regarding both psychiatric patients and psychiatric physicians.

Action Item 4: Position Statement on Psychiatrists' Time Performing Utilization Review (Endorsement of AMA policy H-385.951)

Background: As part of the standard review process the CHSF reviewed this position statement and recommends it be retained (no revisions). Members of the CHSF think the concepts contained in this position statement are still relevant. There have been no revisions to the AMA document on this subject.

ACTION: Will the Joint Reference Committee recommend that the Assembly retain the Position Statement: *Psychiatrists' Time Performing Utilization Review* (Endorsement of AMA policy H-385.951), and if approved, forward it to the Board of Trustees for consideration? (Attachment G (Current))

Current Position Statement on Psychiatrists' Time Performing Utilization Review (AMA Policy H-385.951)

Remuneration for Physician Services

1. Our AMA actively supports payment to physicians by contractors and third party payers for physician time and efforts in providing case management and supervisory services, including but not limited to coordination of care and office staff time spent to comply with third party payer protocols.

2. It is AMA policy that insurers pay physicians fair compensation for work associated with prior authorizations, including pre-certifications and prior notifications, that reflects the actual time expended by physicians to comply with insurer requirements and that compensates physicians fully for the legal risks inherent in such work.

3. Our AMA urges insurers to adhere to the AMA's Health Insurer Code of Conduct Principles including specifically that requirements imposed on physicians to obtain prior authorizations, including precertifications and prior notifications, must be minimized and streamlined and health insurers must maintain sufficient staff to respond promptly

(Sub.Res.814, A-96; Reaffirmation A-02; Reaffirmation I-08; Reaffirmation I-09; Appended: Sub. Res. 126,1-10. Reaffirmed in lieu of Res. 719, A-11 Reaffirmed in lieu of Res. 721, A-11 Reaffirmation A-11 Reaffirmed in lieu of Res. 822, I-11 Reaffirmed in lieu of Res. 711, A-14)

Information Items

See the attached charts of position statements (Attachment I) and JRC referrals (Attachment J)

Council on Healthcare Systems and Financing

Harsh Trivedi, MD, MBA, Chair

Monday, May 22, 2017, 1:00pm-5:00pm PST
Marriott Marquis San Diego Marina Hotel
San Diego, CA

Draft Minutes

Participants

Council Members: Harsh Trivedi, MD, MBA, Chair; Naakesh Dewan, MD; Joseph Mawhinney, MD; Eileen McGee, MD; Susan McLeer, MD; Lori Raney, MD, Vice Chair; Bruce Schwartz, MD; Eliot Sorel, MD; Ole Thienhaus, MD
Fellows: Pilar Abascal, MD; Matthew Goldman, MD, MS; Michael Hann, MD; Shuo Sally He, MD MPH; Aaron Meyer, MD;
Consultants: Laurence Miller, MD
Excused Absence: Robert Cabaj, MD; Susan McLeer, MD (Members); Seth Berger, MD, MBA (Consultant)
Unexcused Absence: Ranota Hall, MD; Sabina Lim, MD, MPH;
Incoming Members: Mark Bradshaw, MD; Sonsunomul Shoyinka, MD;
APA Leadership: Saul Levin, MD, MPA, APA CEO/Medical Director
APA Administration: Eileen Carlson, RN, JD; Michelle Dirst; Kristin Kroeger; Sam Muszynski, JD; Jeffrey Regan; Samantha Shugarman; Becky Yowell
Guests: Gregory Harris, MD, MPH, Chair, APA Committee on RBRVS, Codes and Reimbursements; Conny Huthsteiner, MD (APA member from CA); Phyllis Peterson, PA (AAPA)

Welcome and Introductions

Dr. Trivedi welcomed all, reviewed the agenda and began with a round of introductions with disclosures/conflicts noted.

Minutes

The minutes from the March 2017 conference call were reviewed and approved as written.

Recognition of Outgoing Members

Dr. Trivedi recognized the members concluding their terms on the Council: Susan McLeer, MD, and Bruce Schwartz, MD (Members); Seth Berger, MD and Larry Miller (Consultants); Michael Hann, MD, Tua- Elisabeth Mulligan, MD; Pilar Abascal, MD; Neha Chaudhary, MD; and Shuo Sally He, MD, MPH.

Remarks from the American Academy of Physician Assistants (AAPA)

Phyliss Peterson, PA-C, MPAS, DFAAPA, representing AAPA, addressed those present. She provided background information on the association and indicated that the AAPA is interested in developing a relationship with the APA. She noted that it Is a very small number of PAs that work in mental health. She responded to questions regarding training, stating that PAs have 24-27 months of general medical training, including 1 year of clinical training. All training programs include some mental health training. PAs can earn a Certificate of Added Qualifications (CAQ) after certain standards of experience and passing a qualifying exam. States, such as NY, are developing training programs for PAs. PAs are interested in integrated care. Current CMS regulations may be problematic in terms of supervision by

psychiatrists (psychiatrists cannot supervise PAs doing primary care). Dr. Trivedi thanked Ms. Peterson for attending.

Position Statement from the American Psychiatric Nurses Association (APNA)
The APNA has asked the APA to support their position statement *Whole Health Begins with Mental Health* (Approved by APNA Board of Directors, March 14, 2017). Members of the Council reviewed the statement. There was a general discussion as to what was meant by the term "support," as well as pros and cons of supporting the statement. The Council recommended identifying items of commonality in lieu of supporting the position statement.

Washington, D.C. Update/Strategic Discussion on Health Reform
Jeffrey Regan, Director of Federal Relations and Michelle Dirst, Director of Practice Management and Delivery Systems updated the Council members on the discussions occurring on Capitol Hill regarding repealing/replacing the ACA and the current status of the proposed replacement legislation American Health Care Act of 2017 (AHCA). House passed American Health Care Act (HR 1628) in early May with several problems. Premium tax credits replaced subsidies. Medicaid subsidy mechanism eliminated in 2020 & replaced with per-capita cap system. No thorough analysis done yet of effects however there are seminal changes to Medicaid that would have lasting impacts for a generation. Like APA, all other physician groups, mental health providers, and insurers, opposed the house legislation. Rep. Tom McArthur's amendment made bill even worse, allowing states to avoid essential health benefits, and charge more to older Americans, and those with pre-existing conditions. The bill passed the House with 217 votes, 20 Republicans opposed.

The Senate is working to develop their own version of the bill, which will likely include changes. APA, AMA, AAFP, AAP, ACP, ACOG, AOA, and mental health advocacy organizations remain opposed to what is being proposed. APA and other physician groups sent a letter laying out the priorities for coverage, benefits and consumer protections and included recommendations of what to preserve and what to improve. The message reflects the general principles contained in the 2008 Position Statement on Principles for Health Care Reform for Psychiatry. The group discussed the 2008 position statement and noted that it remains relevant; will make some minor edits and determine if anything needs to be added on alternate payment models.

Concerns were raised regarding possible threats to the Medicaid program, substance use treatment and general mental health care coverage as well. It was noted that there is no current APA policy on subsidies and a request was made to develop such. Drs. Dewan and Thienhaus will develop a draft and circulate it to members of the Council.

The APA through the office of Government Relations and with the assistance of the APA Division of Policy, Payment and Programs will work together along with the APA DBs/SSs to target specific states to build support for key issues at the state level.

Committee/Workgroup Reports
Committee on RBRVS, Codes and Reimbursements, Gregory Harris, MD, Chair
Dr. Harris updated the Council on the recent activities of the Committee. The main focus over the next several months will be on updating and/or developing educational content on CPT coding and documentation. The Committee will also have a discussion as to any current coding gaps

(services/programs for early psychosis, ACT services, etc.) and the impact of APPS on clinical care and coding.

Committee on Reimbursement for Psychiatric Care, Laurence Miller, MD, Chair
In addition to reviewing the revised charge of the Committee, Dr. Miller reported that the group had a discussion about APMs (providing services to the SMI population), carve outs and the need for ongoing discussions with managed care entities. The committee will hold calls every other month. It was reported that CMS has solicited input on APMs in the mental health arena; comments due June 30. Dr. Trivedi reported that CMS was visiting Shepard Pratt to learn more about behavioral health.

Committee on Telepsychiatry, Jay Shore, MD, Chair (Written report)
The Committee has been quite active – see attached report.

Committee on Integrated Care, Lori Raney, MD, Chair (formerly the Workgroup on Integrated Care)
Michelle Dirst, Director of Practice Management and Delivery Systems reported that the new Committee on Integrated Care met Monday morning; Dr. Raney serves as chair. Ms. Dirst noted that the white paper on *Improving the Physical Health of Patients with Seriously Mentally Ill*, was complete. The committee is looking for new activities and have begun a discussion around barriers to the adoption of the Collaborative Care Model by primary care. It was noted that both the Committee on Integrated Care and Committee on Reimbursement were interested in the issue of reverse integration; they will work on collaborating.

Old Business
Position Statement Review: See chart for notes on position statement review.
JRC Action Items (written update): See chart below for notes/updates on JRC items.

Adjournment
4:15 PM (meeting adjourned early to allow participants to attend the Convocation)

Next meeting Friday and Saturday, September 15-16, 2017 (conference call over the summer)

Position Statement on the Need to Maintain Long-Term Mental Hospital Facilities

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 on Professions and Associations. It was prepared by the Committee on Liaison with the American Hospital Association.[1] *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.*

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 view with considerable concern the trend toward the phasing out of the capacity for providing long-term inpatient care and treatment for the mentally ill or disabled.

The American Hospital Association and the American Psychiatric Association recognize and support the importance of continuing to develop and implement new and innovative community programs and treatment modalities for the mentally disabled. However, at the same time it is essential that we not lose sight of the continuing need for a full range or 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.* Pressure to discharge patients from the public mental hospital too often results in discharging patients without adequate planning, which in turn results in their living in substandard and dehumanizing circumstances, be it in nursing homes, boarding homes, or the streets of a ghetto. A portion of the significantly impaired psychiatric patient population will continue to lack 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 can be successfully maintained in the community; but there must remain the capability for providing long-term inpatient treatment for that segment of the patient population which cannot maintain even a marginal adjustment in the community.

[1]The Committee on Liaison with the American Hospital Association included: Gerald R. Clark, M.D., chairman, Raymond W. Waggoner, Jr., M.D., Ethel M. Bonn, M.D., Francis de Marneffe, M.D., J. T. May, M.D., and Samuel Hibbs, M.D.

Proposed

Position Statement on the Need to Maintain Long-Term Care Facilities for Certain Individuals with Serious Mental Illness

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, in spite of vigorous therapeutic efforts.

Community mental health centers should be funded and staffed to provide ~~a~~ full wrap-around services to the segment of the SMI population that can be successfully maintained in the community. However, there must remain the option of providing intermediate and long-term treatment in a structured hospital-type environment for those that cannot maintain even a marginal adjustment to the community.

.

[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)

Changes Tracked

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

~~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~~ 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~~

[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)

~~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.

.

Position Statement on Codification of Medical Evaluation and Management Services in Psychotherapy

Approved by the Board of Trustees, December 1997
Approved by the Assembly, November 1997

"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*.

Current policies of HCFA and AMA's CPT distinguish between psychotherapy and medical evaluation and management. However, psychotherapy provided by psychiatrists includes continuous medical evaluation and management services. Their medical knowledge enables psychiatrists not only to evaluate the medical aspects of the patient's condition and to prescribe correctly, but also to provide continuous evaluation of the full biopsychosocial presentation of the patient. All are essential in the practice of psychiatry and in psychotherapy provided by psychiatrists. Such knowledge indeed does provide added value to the clinical encounter of the patient with the psychiatrist, and should be recognized as such.

Proposed

APA Position Statement on Codification of Medical Evaluation and Management Services in Psychotherapy

Current policies of CMS and AMA's CPT distinguish between psychotherapy and medical evaluation and management. However, psychotherapy provided by psychiatrists includes continuous medical evaluation and management services. Their medical knowledge enables psychiatrists not only to evaluate the medical aspects of the patient's condition and to treat accordingly, but also to provide continuous evaluation of the full biopsychosocial presentation of the patient. All are essential in the practice of psychiatry and in psychotherapy provided by psychiatrists. Such knowledge indeed does provide added value to the clinical encounter of the patient with the psychiatrist, and should be recognized as such.

Position Statement on Psychiatry and Primary Care Integration across the Lifespan

Approved by the Board of Trustees, September 2010
Approved by the Assembly, May 2010

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

- Access to and payment for clinically appropriate services provided by psychiatrists should be included as an essential feature in medical/health home initiatives.
- Parity of benefits design for beneficiaries as well as parity in payment for all physicians, particularly psychiatric that does not discriminate by location of service or diagnosis should be provided.
- Psychiatrists should have choices of participation in a new health system, such as fully integrated clinicians and/or managers of the system, as collaborative care partners, and as consultants to it.
- The exact financial formula for these choices should be negotiated such that it is compatible with parity and nondiscrimination regarding both psychiatric patients and psychiatric physicians.

Prepared by Eliot Sorel, M.D., Anita Everett, M.D., Roger Peele, M.D., Catherine May., M.D., Michael Houston, M.D., Hind Benjelloun, M.D., Kayla Pope, M.D., and Jack Mcintyre, M.D. (consultant).

Position Statement on Remuneration for Psychiatrists' Time Performing Utilization Review (Endorsement of AMA policy H-385.951)

Approved by the Board of Trustees, December 2011
Approved by the Assembly, November 2011

"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*.

AMA Policy H-385.951
Remuneration for Physician Services

1. Our AMA actively supports payment to physicians by contractors and third party payers for physician time and efforts in providing case management and supervisory services, including but not limited to coordination of care and office staff time spent to comply with third party payer protocols.
2. It is AMA policy that insurers pay physicians fair compensation for work associated with prior authorizations, including pre-certifications and prior notifications, that reflects the actual time expended by physicians to comply with insurer requirements and that compensates physicians fully for the legal risks inherent in such work.
3. Our AMA urges insurers to adhere to the AMA's Health Insurer Code of Conduct Principles including specifically that requirements imposed on physicians to obtain prior authorizations, including pre-certifications and prior notifications, must be minimized and streamlined and health insurers must maintain sufficient staff to respond promptly

(Sub.Res.814, A-96; Reaffirmation A-02; Reaffirmation I-08; Reaffirmation I-09; Appended: Sub. Res. 126,1-10.)

Position Statement Review
Council on Healthcare Systems and Financing
May 2017

	Position Statement	Reviewers	Recommendation/Rationale
Action Item 1	Position Statement on the Need to Maintain Long-Term Mental Hospital Facilities	Ole Thienhaus, MD Tua-Elisabeth Mulligan, MD	**Recommendation: Revise**; the revisions incorporate elements contained in the original position statement on the Need to Maintain Long-Term Inpatient Psychiatric Hospitals, 1974, the Position Statement on Federal Exemption from Medicaid Institutions for Mental Disease, 2014; and the testimony of Jeffrey Geller, MD, MPH at a hearing of the US House of Representatives Committee on Energy and Commerce "Where have all the Patients Gone: Examining the Psychiatric Bed Shortage, 2014. The recommendation includes a title change: *Position Statement on the Need to Maintain Long-Term Care Facilities for Certain Individuals with Serious Mental Illness* **Rationale:** This statement remains relevant.
Action Item 2	Position Statement on Codification of Medical Evaluation and Management Services for Psychotherapy	Greg Harris, MD, MPH Naakesh Dewan, MD	**Recommendation: Retain with minor revisions.** **Rationale:** This statement remains relevant.
Action Item 3	Position Statement on Psychiatry and Primary Care Integration across the Lifespan	Eileen McGee, MD Eliot Sorel, MD	**Recommendation: Retire**; Motion (Thienhaus/Raney) was made and supported to retire this statement. **Rationale:** There is newer APA policy (2016 PS on Integrated Care) which covers the key items contained in this document.
Action Item 4	Psychiatrists' Time Performing Utilization Review (Endorsement of AMA policy H-385.951)	Becky Yowell (APA Staff)	**Recommendation: Retain (as written)** **Rationale:** This is an endorsement of an existing AMA policy which has remained unchanged; it remains relevant in light of the ongoing prior authorization activity.
Info Item	Position Statement on Carve-Outs and Discrimination	Greg Harris, MD, MPH Pilar Abascal, MD Aaron Meyer, MD	**Recommondation:** APA administration will pull together a list of principles that should be in place whether MH services are carved in or carved out. Motion (Dewan/Thienhaus) was made to retire the position statement once the principles and an action plan have been developed.

	Position Statement	Reviewers	Recommendation/Rationale
			Rationale: Problems can exist regardless of whether ornot MH is carved in or cared out. The principles would apply to either scenario to ensure care is provided appropriately. (At present there are 16 states that are carving it back in; would be helpful to have something to ensure it is done properly.)
Info Item	Principles for Healthcare Reform for Psychiatry	ALL	**Recommendation**: Retain with revisions. Revisions include updating references to DSM and Medicare copay; Will consider adding statements re alternative payment models. **Rationale:** General enough to remain relevant; will revise and submit for October JRC.
Info Item	Banning of Pharmacy Benefit Management Policies that Require the Provision of Dangerous Quantities of Medications	Eileen McGee	Will discuss on a future conference call
Info Item	Peer Support Services	Ann Sullivan	Will discuss on a future conference call
Info Item	Improving Patient Access to Pscyhiatric Services	To be assigned	Will discuss on a future conference call

JRC Summary of Actions

Items referred to the Council on Healthcare Systems and Financing

Action	Comments/Recommendation	Referral/Follow-up & Due Date	Notes
All Prescribers, not just Physicians, shall be Subject to Open Payments (ASMNOV16A12.A) *Action Paper Attached* The action paper asks that the APA engage with the American Medical Association and the American Osteopathic Association to pursue regulatory change such that non-physician providers are included along with physicians in the Open Payments reporting and database.	The Joint Reference Committee referred the action paper to the Council on Healthcare Systems and Financing (LEAD), the Department of Government Relations and the APA AMA Delegation. A report to the Joint Reference Committee is requested by the deadline for the June 2017 meeting.	Council on Healthcare Systems and Financing (LEAD) Department of Government Affairs APA AMA Delegation Report to the JRC – June 2017 (Deadline June 5, 2017)	The Physician Sunshine Act, also known as Open Payments, was instituted as part of the ACA. Any changes to the program must be made through the legislative process. At this time, the AMA and AOA are not pursuing an advocacy strategy to expand open payments to require non-physicians to participate in the program. CHSF defers to the CAGR/Department of Government Affairs as to how to prioritize this request in light of the current activity around health reform (ACHA). CAGR feedback: Because we are aware that neither the AMA or the AOA have initiated advocacy efforts, the next question would be if any consumer groups are active in any advocacy on this issue. Once APA places this as a priority, an advocacy strategy plan should be developed.
Continuity of Care (ASMNOV1612.C) *Action Paper Attached* 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.	The Joint Reference Committee referred the action paper to the Council on Healthcare Systems and Financing (LEAD) and then to the Council on Quality Care (Secondary). 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 Quality Care (Secondary) Report to the JRC – June 2017 (Deadline June 5, 2017)	The CHSF will continue to compile information relevant to this request to develop educational materials for APA members. The effort will include a communications plan to educate members. As part of the process, it will be important to identify and potentially resolve any barriers (confidentiality) The Council on Quality discussed this paper and noted that quality measures exist regarding transitions in care.
Towards Universal Health Insurance in the United States (ASMNOV1612.D)	The Joint Reference Committee referred the action paper to the	Council on Healthcare Systems and Financing (LEAD)	

Action Paper Attached Action paper asks: 1. That the APA collaborate with the AMA on its newly adopted resolution to assess various models of healthcare finances including single payer models and universal healthcare and to include data from other developed countries which employ these models; 2. That to facilitate this action, the issue will be referred to the Council on Health Care Systems and Financing and the AMA Delegation of the APA; 3. That a status report will be delivered by the Council on Health Care Systems and Financing and the AMA Delegation of the APA at the May 2017 meeting of the APA Assembly.	Council on Healthcare Systems and Financing (LEAD) and to the APA AMA Delegation (Secondary). The Assembly requested a report back at the November 2017 meeting. It was noted by APA Administration that the APA AMA Delegation and the AMA are aware of this issue.	APA AMA Delegation Report to the Assembly – November 2017 (Deadline September 18, 2017)	
Improving the Confidentiality of Prescription Drug Monitoring Programs (ASMNOV1612.G) *Action Paper Attached* The action paper asks that the American Psychiatric Association study the variations in the PDMPs to ensure that they are consistent with current federal regulations, and to make recommendations to improve the PDMP system with special attention to ensure the appropriate confidentiality of patient records.	The Joint Reference Committee referred the action paper to the Council on Healthcare Systems and Financing (LEAD), Council on Addiction Psychiatry, Council on Psychiatry and Law and the Committee on Mental Health Information Technology. It was noted in the action paper comments that the Department of Government Relations proposed working a baseline study of all 50 states and the District of Columbia to identify the variations among states regarding confidentiality of patient records The Council on Addiction Psychiatry has clarified that the current regulation interpretation is that information from an Opioid Treatment Program (OTP)	Council on Healthcare Systems and Financing (LEAD) Council on Addiction Psychiatry Council on Psychiatry and Law Committee on Mental Health Information Technology Report to the JRC – June 2017 (Deadline June 5, 2017)	The CHSF will be discussing this on a future conference call and would include representatives from the key components. (Brandeis University's Heller School for Social Policy and Management has developed a website titled PDMPassist.org that provides a state by state profile on PDMPS, including the authorized requesters of the PDMP data. Additionally, while nearly all states currently have a PDMP, federal requirements for this program are non-existent.)

	cannot be included in the PDMPs. The JRC would like to see an articulation of this issue that includes the pros and cons of including information from an OTP be entered into PDMP. Ultimately a position statement on this would be helpful. (Please also see item 8.A.1 on page 17 of this report) A report to the Joint Reference Committee is requested by the deadline for the June 2017 meeting.		
<u>Mental Health Parity for Individuals with Intellectual and Developmental Disability (IDD)</u> (ASMNOV1612.P) Action Paper Attached 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)	CHSF will set up a small workgroup to include representatives from CAGR and the Council on Children and/or the Caucus of Psychiatrists Treating Patients with IDD to discuss the action paper, implications of parity and any additional information (legislative landscape, etc). 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.

APNA POSITION STATEMENT
Whole Health Begins With Mental Health

Mental health and substance use problems continue to negatively impact our productivity as a nation. Mental health drives wellness. Sound mental health provides the stable foundation upon which a person can build, in partnership with providers of care as needed, their own long-term physical health and well-being. This in turn leads to healthy communities which meaningfully contribute to society.

Burden of Mental Health Problems under Current System

- Approximately 56 million of American adults experience mental illness and/or a substance use disorder in a given year.[1]
- 75% of chronic mental health conditions begin by age 24, yet the delay between the first appearance of symptoms and intervention is an average of almost a decade.[2]
- Persons living with serious mental illness die on average 25 years sooner than the rest of the American population, in large part due to treatable medical conditions.[3]
- Approximately 46% of homeless adults staying in shelters live with severe mental illness and/or substance use disorders and about 20% of state prisoners have a recent history of a mental health condition.[4]
- Serious mental illness costs America $193.2 billion in lost earnings per year.[4]
- Currently one third of Medicaid recipients have a mental health or substance use disorder.[5]

APNA Position: Whole Health Begins with Mental Health

The American Psychiatric Nurses Association, an organization representing all levels of psychiatric-mental health nursing, asserts that **whole health *begins* with mental health**. APNA takes the position that mental health promotion, through prevention, recognition and adequate care and treatment, must be at the starting point of and comprehensively woven throughout the delivery of services within the American health care system. Further, our definition of health must be transformed to one which recognizes mental health as foundational for all health.

This position is supported by the following points:

- Health is a "state of complete physical, mental, and social well-being and not merely the absence of a disease or infirmity"[6]
- There is a broad consensus amongst experts in health care that transforming America's system to a proactive one that promotes health and wellness, rather than reactively treating illness, is a necessity.[7]
- Mental illnesses are risk factors that affect the incidence and prognosis of 'noncommunicable' diseases and addressing mental illnesses delays progression, improves survival outcomes, and reduces health care costs associated with noncommunicable diseases.[8]
- Research shows a strong link between adverse childhood experiences and long-term negative health and well-being outcomes.[9]

Recommendations for the Future

- Health care systems should be structured to address mental health and substance use both at the first point of contact as well as throughout the patient's journey within the system.
- All providers should have facility with mental health and substance use screenings to allow for prevention, early identification, brief intervention, and referral to treatment.
- National, state, and local policies and regulations must ensure universal access to affordable services that promote mental health, prevent mental illness and substance use disorders, and offer care and treatment as necessary, which are provided by qualified health care professionals.

Conclusion

A successful and healthy society depends upon the mental health of its constituents. As it stands now, the prevalence of mental illness and substance use disorders continues to exact a toll across our communities. National, state, and local policies and regulations must take immediate action to ensure that policies are put into place which promote a proactive approach to wellness. The American Psychiatric Nurses Association believes that this proactive approach must recognize that mental health serves as the foundation for overall health and therefore mental health and substance use services must be affordable, accessible, and integrated throughout the continuum of care.

Approved by the APNA Board of Directors March 14, 2017.

1. Center for Behavioral Health Statistics and Quality. (2015). Behavioral health trends in the United States: Results from the 2014 National Survey on Drug Use and Health (HHS Publication No. SMA 15-4927, NSDUH Series H-50). Retrieved from http://www.samhsa.gov/ data/
2. National Alliance on Mental Illness (n.d.). Mental Health Screening. Retrieved from http://www.nami.org/Learn-More/Mental-Health-Public-Policy/Mental-Health-Screening
3. Parks, J., Svendsen, D., Singer, P., Foti, M. E., & Mauer, B. (2006). Morbidity and mortality in people with serious mental illness. *Alexandria, VA: National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council*, *25*.
4. National Alliance on Mental Illness. (n.d.). Mental health by the numbers. Retrieved from http://www.nami.org/Learn-More/Mental-Health-By-the-Numbers
5. Japsen, Bruce (March 6, 2017). House GOP Obamacare replacement hurts mental health, Republican Senators say. *Forbes*. Retrieved from https://www.forbes.com/sites/brucejapsen/2017/03/06/house-gop-obamacare-replacement-hurts-mental-health-republican-senators-say/#339b29532b54
6. World Health Organization. (n.d.). Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948. Geneva, Switzerland: Author.
7. Murphey, D., Stratford, B., Gooze, R., Bringewatt, E., Cooper, P., Carney, R., & Rojas, A. (2014). Are the children well? A model and recommendations for promoting the mental wellness of the nation's young people. *Robert Wood Johnson Foundation (Ed.), Policy brief*, 1-53.
8. Kolappa, K., Henderson, D. C., & Kishore, S. P. (2013). No physical health without mental health: lessons unlearned?. *Bulletin of the World Health Organization*, *91*(1), 3-3a.
9. Felitti V. J., Anda R. F., Nordenberg D., Williamson D. F., Spitz A. M., Edwards V., Marks J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. American Journal of Preventive Medicine, 14, 245-258.

Update of the Committee on Telepsychiatry to the Council on Healthcare Systems and Financing May 2017

The Committee on Telepsychiatry is presenting at APA's 2017 Annual Meeting, with most of the Committee—and some external experts—serving as panelists. Their workshop is titled, "Integrating successful Telepsychiatry models into psychiatric practice." The Committee has also recently grown its Telepsychiatry Toolkit, which now has 33 pages of content, including educational videos and other resources.

Additionally, the Committee is finalizing content for its upcoming Telepsychiatry Blog, to be featured on psychiatry.org, which will include topical news articles, research insights, and an "Ask the Experts" spot, featuring members of the Committee. Finally, the Committee is in the initial stages of collaborating with the American Telemedicine Association (ATA) to develop a joint APA-ATA "best practice" guidance document on practicing Telepsychiatry.

Psychiatry's Role in Improving the Physical Health of Patients with Serious Mental Illness

Executive Summary

Patients with serious mental illnesses (SMI) die years earlier than the general population, with the majority of excess deaths due to general medical conditions. A growing body of evidence-based interventions can successfully prevent and effectively treat medical conditions in this population.

In recent years, many programs and policies have been developed that hold the potential to address this problem. The 2008 Mental Health Parity and Addiction Equity Act (MHPAEA) helped ensure adequate mental health benefits and financial protections for individuals with mental and substance use disorders. The Affordable Care Act of 2010 (ACA) expanded Medicaid and the private insurance market, and funded demonstration programs that could help improve the well-being of individuals with SMI, including those with comorbid medical and substance use conditions.

Several recent policy developments could have significant implications for addressing the physical health of people with SMI. Repeal of the ACA could eliminate federal matching for Medicaid expansion and subsidies for insurance exchanges, remove essential health benefit requirements, curtail funding for demonstration projects addressing care coordination, and reduce funding for the public health and social safety net. The coming years will likely see greater autonomy for States in determining the scope and structure of Medicaid benefits and social services. Finally, bipartisan mental health reform legislation could help refocus policy attention on individuals with SMI.

In 2016, the American Psychiatric Association (APA) Workgroup on Integrated Care convened an expert panel to address Psychiatry's role in improving the physical health of patients with serious mental illness (SMI). Based on a systematic review of the peer-reviewed literature, including recent policy developments, the panel developed the following recommendations:

1. **Clinical Care:** Psychiatrists' medical training makes them uniquely positioned to support the delivery of high quality, medical treatment, prevention, and mental health care to their patients with SMI. To achieve this goal, it is essential to provide training programs in prevention and medical care during psychiatry residency, combined Medical/Psychiatry residency programs, CME programs for practicing psychiatrists, and cross-training opportunities for psychiatrists and primary care medical providers. Quality improvement initiatives should be implemented across the full range of settings in which patients with SMI are treated, including community-based mental health clinics, primary care clinics, and emergency rooms.

2. **Health Care Organizations:** Psychiatrists can play critical leadership roles in mental and health care delivery systems that treat patients with SMI. In these roles, they can implement population models and integrated payment systems that foster communication, use of patient registries, and delivery of evidence-based interventions.

3. **Research:** While a robust body of literature supports the practice of primary care-based behavioral health integration, fewer studies examine models to improve the physical health of people with SMI. Further research is needed to inform initiatives addressing the physical health of patients with SMI, as well as to understand the optimal role of psychiatrists in these models.

4. **State Policy:** With the increase in the role of state policymakers in shaping health and mental health care, Psychiatry can play a key role in advocating for States to improve the health of people with SMI and provide input on program design and reform efforts. Advocacy efforts should include Medicaid directors, state mental health authorities, and other state agencies (e.g., departments of corrections).

5. **Federal Health Policy:** Even as states assume greater responsibility for setting policies, the Federal government must continue to provide vital functions for patients with SMI. Psychiatry should advocate for these key functions including developing and implementing surveillance and monitoring efforts to track the health of people with SMI; and providing regulatory oversight and enforcement of existing policies to ensure insurance coverage, access, and quality of care for these patients.

6. **Public Health Policy:** Premature mortality in populations with SMI is ultimately a public health problem, which will require addressing prevention and treatment of medical problems, mental and substance use disorders, health behaviors (smoking, diet, physical activity), and social factors (poverty, stigma). Psychiatrists should advocate for a robust public health infrastructure that ensures prevention and treatment of ill health in individuals with SMI, and addresses the community and social risk factors underlying poor outcomes in this vulnerable population.

Expert panel to address psychiatry's role in improving physical health for persons with serious mental illness (SMI)

In 2016, the American Psychiatric Association (APA) Workgroup on Integrated Care convened an expert panel charged with addressing Psychiatry's role in improving the physical health of patients with

Serious Mental Illness. The group conducted a systematic review of the peer reviewed and gray literature, including recent policy developments on the topic, and developed a set of recommendations grounded in this review.

Poor physical health and premature death among people with serious mental illnesses

Though advances in treatment have greatly impacted medical outcomes in the general population, the outcomes for individuals with mental illness have lagged. This has resulted in a widening disparity in lifespan, with pooled relative risk for all-cause mortality significantly elevated among those with any mental disorder, particularly those with serious mental illness (SMI).[1,2] More than a decade has passed since data published from the National Association of State Mental Health Directors revealed that people with SMI treated in the public mental health system were dying, on average, 25 years earlier than the general population.[1] However, little progress has been made in rectifying this disparity, and recent data reveals that the mortality gap for those with SMI remains substantial.[3,4]

Though accidental causes were initially thought to explain the mortality gap, with experts focusing on suicide and other violent death as late as 1985,[5] increasing evidence has emerged in the last two decades linking psychiatric and medical illness. Rates of medical illness in those with SMI exceed those of the general population in every disease category,[1,6] and those with SMI experience higher standardized mortality ratios compared to the general population for cardiovascular, respiratory, and infectious diseases.[1] Premature death from natural causes has been estimated to contribute approximately 60% to early mortality in SMI,[7] and a recent meta-analysis found that 67% of deaths among people with mental illness were due to natural causes.[2] For patients with comorbid substance use disorders, infectious diseases, cancers, and accidents are particularly important causes of early death.[8]

The relationship between mental illness, medical comorbidity, and premature mortality is complex and multifactorial. Adverse health behaviors contribute heavily. Modifiable risk behaviors including tobacco use, other substance use disorders, poor diet, lack of physical activity, and lack of adherence to treatments, contribute to the excess morbidity and early mortality related to chronic diseases. Patients with SMI engage in these behaviors at higher rates than the general population, placing them at risk for chronic medical conditions and poorer outcomes.[3] Adverse social determinants of health, including the effects of economic disadvantage and chronic stress, likely also play a part.[9] Side effects of medications prescribed for patients with SMI also contribute significantly, with weight gain and glucose dysregulation being noted most prominently with antipsychotic drugs.[10] Finally, those with mental illness are at risk for receiving poor-quality medical care. This is likely a significant determinant for adverse health outcomes in this population.[11] Some individuals with SMI may be treated only in the general medical sector, present only to emergency rooms, or may receive no care at all for their medical or behavioral problems. Many

patients with SMI underuse primary care services and overuse emergency and medical inpatient care,[12] resulting in fragmented and irregular services and lower rates of preventative care.[9] Individuals with SMI are also less likely to receive adequate, standard of care treatment for medical conditions when compared to age-matched controls,[1,13-15] likely contributing to premature mortality. Many reasons underlie the lack of quality medical care for persons with SMI, including lack of insurance and the cost of care;[16] the effects of stigma on patient-provider interactions;[17] and the symptoms of mental illness, which impose challenges to accessing care and adhering to recommended treatments.[18]

Research addressing the problem

Over the past decade, studies have provided substantial evidence for the effectiveness of both pharmacologic and behavioral interventions to target cardiovascular risk factors among persons with serious mental illness (SMI). In particular, effective interventions are available to support smoking cessation and to promote weight loss among obese individuals, addressing the two leading causes of preventable mortality in the US (smoking and obesity). Behavioral and pharmacologic interventions have demonstrated effectiveness among individuals with SMI, and the magnitude of effects appear to be comparable to those seen in general population studies. In addition, trials and demonstration projects support strategies to improve care for individuals with SMI through systematic coordination and collaboration among treating providers.[19] Systematic coordination should also be done to address high rates of co-occurring substance use disorders, typically around 50 percent or more, which adversely impacts outcomes.[20] Integration of substance abuse and mental health services has been shown to be more effective than less integration.[21]

A 2016 comprehensive review identified one hundred and eight randomized controlled trials and observational studies testing interventions to address medical conditions and risk behaviors among persons with schizophrenia and bipolar disorder between January 2000 and June 2014. The majority of included studies (n= 80) examined interventions to address overweight and obesity. These reviews concluded that the strength of the evidence was high for four interventions: metformin and behavioral interventions had beneficial effects on weight loss; and bupropion and varenicline reduced tobacco smoking.[22] The conclusion that these four interventions are effective is consistent with previous systematic reviews[23,24] as well as a more recent randomized trial.[25]

Clinical trials of lifestyle modification interventions to reduce obesity among persons with SMI indicate that lifestyle health promotion programs of longer duration (3 or more months) consisting of a manualized, combined education- and activity-based approach, and incorporating both nutrition and physical exercise are likely to be the most effective in reducing weight, improving physical fitness and improving overall health.[26] Large-scale randomized control trials (RCTs)[27] suggest that up to 40% of

patients can achieve clinically significant weight loss (defined as >5% of initial body weight). Average (mean) weight loss across trials has been more modest 3-4 kg or 4 % of IBW.[23]

Similar magnitudes of weight loss have been reported in studies of pharmacologic strategies to target obesity, including metformin (3 kg in 16-week trial),[28] and trials of switching an antipsychotic medication with high metabolic liability to one with lower metabolic liability (3.6 kg in 24 weeks).[29] Metformin is not currently FDA-approved for weight loss, and there is no research to inform duration of treatment beyond 16 weeks. The combination of metformin and lifestyle modification also results in clinically significant weight loss among individuals with SMI.[30] This may be particularly important among young adults experiencing a first episode of psychosis, given that this population presents an opportunity for primary prevention,[31] as weight gain and adverse metabolic effects appear to begin within the first two months of treatment.[32] RCT provide evidence for the effectiveness of metformin for preventing olanzapine-induced weight gain[33] and amenorrhea[34] among persons with a first episode of psychosis.

There has been little research involving persons with SMI who have co-morbid chronic medical conditions. Individuals with SMI are typically excluded from large clinical trials of medical interventions, and in the studies included in the above-cited reviews, medical outcomes (such as hemoglobin A1c, BP, LDL) were secondary outcomes in weight loss intervention studies. The Agency for Health Research and Quality (AHRQ) review cited above identified a single study of persons with schizophrenia and diabetes. This weight loss intervention resulted in clinically significant weight loss, but there was no effect on A1c, likely because mean A1c was normal at baseline.[35] One recent 24-week trial found that metformin treatment had significant effect on improving antipsychotic-associated dyslipidemia. In this study, improvement of lipid profile was at least partly independent of reducing insulin resistance.[36] Chronic illness self-management groups improve individuals' patient activation, and physical health-related quality of life,[37] but studies of such interventions have not demonstrated improvements in medical outcomes.

Strategies to improve care which are based on the chronic illness management model,[38] such as systematic care coordination and collaboration among treating providers, have been evaluated among SMI populations. Care management based in community mental health centers appears to improve engagement in primary care and 10-year cardiovascular disease (CVD) risk.[39] However, a large multicenter 3-arm trial that evaluated lifestyle modification vs. lifestyle modification + care coordination vs. usual care did not find superior effectiveness in either intervention arm in reducing 10-year CVD risk.[40]

Models of care to integrate physical health monitoring and provision of primary care services represent a continuum of level of collaboration and practice structure. One recent RCT evaluated the effectiveness of a behavioral health home developed as a partnership between a community Mental Health Center (CMHC) and Federally Qualified Health Center (FQHC) compared to usual care.

Compared to usual care, the behavioral health home was associated with significant improvements in quality of cardiometabolic care and increased use of preventive services. Both groups in the trial experienced improvements in general medical outcomes, however there were no statistically significant differences between the two groups over time.[41]

Findings from the above research have been incorporated into expert consensus guidelines. For example, the 2014 UK National Institute for Health and Care Excellence (NICE) Guidelines for the Treatment of Adults with Schizophrenia specifically recommend that people with psychosis or schizophrenia, especially those taking antipsychotic medications, should be offered a combined healthy eating and physical activity program by their mental healthcare provider and also varenicline and bupropion for smoking cessation if they are current smokers. In addition, performance indicators should be tracked and reported to ensure compliance with quality standards on the monitoring and treatment of cardiovascular and metabolic disease in people with psychosis or schizophrenia.[42]

There is still much work to be done to identify or develop best practices to improve the medical care and medical outcomes among persons with SMI, and to increase access to evidence-based care.[43] Future studies should test long-term interventions for cardiovascular risk factors and health-risk behaviors, and evaluate the impact of interventions on all-cause mortality. Studies are also needed to evaluate strategies to disseminate more widely effective interventions in real world settings. In many instances, significant resources might need to be dedicated to enhance engagement in care; and the most feasible and appropriate settings for intervention may not be clinical settings. Family support interventions and innovative collaborations with other disciplines and community partners may address some of the social determinants of health that increase risk factors and limit engagement, which are among the most challenging barriers to reducing premature mortality in this vulnerable population.

Given the high burden of chronic medical conditions, such as hypertension and diabetes, interventions are needed to specifically target the treatment of these disorders. In particular, studies should explore how to optimize the roles of a diverse multidisciplinary workforce, including peer support specialists, as a stepped-care approach to match intensive services to high need individuals. Technological innovations to support service delivery and care coordination should also be leveraged to integrate behavioral and physical healthcare for this population. Finally, models that can simultaneously address mental health, substance use, and medical conditions will be needed to address the high levels of co-occurrence and the adverse consequences of comorbidity among them.

Community Innovations: SAMHSA's Primary Behavioral Healthcare Initiative (PBHCI) program

The Substance Abuse and Mental Health Service Administration (SAMHSA) Primary Behavioral Healthcare Initiative (PBHCI) program has funded over 200 projects in community mental health centers

since 2009. These programs seek to improve health by creating partnerships between CMHCs and primary care organizations, facilitating coordination of care between these organizations, tracking health outcomes by using a registry, and offering evidence-based programs for creating change, including smoking cessation, for example.

Even though these programs have been vigorously funded, there is relatively little outcome data on their effectiveness. The RAND Corporation conducted the evaluation of the PBHCI program following its first year.[44] Comparison was done between three PBHCI centers and three similar CMHC sites that had not been funded. PBHCI consumers had greater mean reductions for total cholesterol, and LDL cholesterol and greater increases in HDL cholesterol, however there were no significant PBHCI effects for any other health indicators.[41]

In terms of implementation of planned programming, PBHCI programs experienced several challenges, including lower-than-expected rates of consumer enrollment, financial sustainability, communication within the actual team, and creating an integrated clinic culture. Smoking cessation programs also proved difficult to effectively implement. SAMHSA has made changes in grantee expectations because of these findings, adding greater structure and standardization to participation requirements. Sustainability of these programmatic changes has been difficult for many PBHCI grantees at the end of the grant period. Some CMHC's have been unable to sustain relationships with primary care partners, and some have transformed themselves into agencies that provide both mental health and primary care, such as FQHCs.

Based on the experience of some of the more successful programs, best practices in community mental health settings most likely include development and use of a registry function; acculturation and training of mental health case managers to include the care of physical health as part of their core mission; taking seriously the slow and difficult culture change in the CMHC that is required at all levels; the use of evidence-based behavior change technologies, including motivational interviewing; and involvement of CMHC personnel in larger initiatives to support funding, such as state-wide Medicaid initiatives. Funding arrangements that make possible team-based coordinated care are needed, often at the level of state Medicaid waivers, and in the long term, should be feasible. A second evaluation is in process, to be continued through 2020.[42]

Emerging Roles for Psychiatrists

Psychiatrists can provide a range of services to address the poor health of patients with SMI. These activities can include screening for medical conditions; counseling patients to reduce cardiovascular risk factors; treating adverse health behaviors including smoking; limiting side effects from

psychotropic medications; coordinating with medical care providers; and providing medical services and Medication Assisted Treatment for patients who do not currently have primary medical providers.[45]

The decision about what treatments psychiatrists should provide for which patients depend on a number of factors, including:

1. the acuity and severity of the medical problem;
2. patients' access to medical care;
3. psychiatrists' medical training and permissible scope of practice;
4. the capacity of the mental health organization to provide medical care; and
5. patient preferences for medical treatment.[46]

There is an important role for psychiatrists who are knowledgeable about this work to be involved with planning such funding innovations. Psychiatrists in leadership roles can also play an important role in promoting better physical health for patients. Medical directors of CMHCs or of behavioral health homes should establish protocols and monitor outcomes for their medical staff.

Federal and State Policies Addressing Care for Persons with SMI

Improving health care delivery and health outcomes for people with serious mental illnesses requires a robust medical safety net. The last decade has seen the passage of landmark Federal legislation improving insurance coverage and testing new models of care delivery that could have an important positive impact on the lives of people with SMI.

Insurance Coverage: Employers have historically provided the bulk of health insurance in the United States. Because serious mental illness makes it difficult to obtain and maintain a job, people with serious mental illnesses are disproportionately likely to be uninsured or covered by Medicaid.[47] Prior to the passage of the Affordable Care Act, nearly one in five Americans covered in the individual market had no coverage for mental health services,[48] and an estimated 12 million individuals with mental and/or substance use disorders lacked insurance.[47] For those who had insurance, annual and lifetime caps limited benefits and raised the risk of bankruptcy or financial hardship due to mental health expenditures.

The 2008 Mental Health Parity and Addiction Equity Act (MHPAEA) provided a first step towards improving access to health insurance and reducing financial burden for patients with serious mental illnesses.[49] The act provided that large group health plans cannot impose annual or lifetime dollar limits on mental health benefits that are less favorable than limits imposed on medical/surgical benefits.[50] A final regulation implementing MHPAEA took effect in January of 2014.

The Affordable Care Act of 2010 built on the MHPAEA to expand health insurance coverage for patients with mental illnesses.[51,52] First, it provided access to many uninsured Americans through private health insurance in the individual and small group markets, the Marketplaces, and Medicaid alternative

benefit plans (ABPs). Second, it included both mental health benefits and routine medical care (e.g., outpatient care, emergency room visits, and pharmaceuticals) as Essential Health Benefits for health insurance purchased through individual and small group markets and Medicaid ABPs.

Demonstration projects: In addition to expanding insurance, the Affordable Care Act included funding for demonstration projects to improve care for high cost, complex patients including people with serious mental illnesses. Section 2703 of the Act provided funding for states to design health homes to provide comprehensive care coordination for Medicaid beneficiaries with chronic conditions including mental illnesses. As of September 2016,19 states and the District of Columbia had developed a total of 28 approved Medicaid health home models, with the vast majority including a focus on enrollees with SMI.[53] The Center for Medicare and Medicaid Innovation (CMMI) and Patient Centered Outcomes Research Institute (PCORI) are funding large-scale demonstration projects and pragmatic trials of new models of services delivery for patients with serious mental illnesses.

The Protecting Access to Medicare Act (H.R. 4302), includes a demonstration program testing Certified Community Behavioral Health Clinic (CCBHCs), which provide community-based services to individuals with serious mental illnesses.[54] On December 1, 2016 the Department of Health and Human Services (HHS) announced the eight states selected to participate which include Oregon, Pennsylvania, Missouri, Nevada, Oklahoma, New York, New Jersey and Minnesota.[55] These participating CCBHCs must have a psychiatrist medical director who ensures the medical component of care and the integration of behavioral health and primary care. Quality metrics include preventive services including BMI screening for adults and children, diabetes screening for patients with schizophrenia or bipolar disorder using antipsychotic medications, and tobacco screening and cessation intervention.[56,57] There are six Quality Bonus Payment measures; however, none of these are tied to physical health indicators. States can require additional quality measures to enhance provision of quality physical health care. Care coordination is an important aspect and includes the requirement of "partnerships or MOUs (Memorandum of Understanding) with FQHCs and RHCs for primary care services to the extent these services are not provided by the CCBHC."

Several major policy developments in 2017 could have significant implications for addressing the health and health care of people with serious mental illnesses. First, the new administration and Congress have made repealing the Affordable Care Act a high priority. Changes could occur under the reconciliation process and an Executive Order, which would roll back subsidies for Medicaid expansions and insurance exchanges, and the essential health benefits requirements[58,59] Funding for demonstration projects including 2703 Medicaid health homes could also be at risk. Because patients with serious mental illnesses are more likely to have barriers to access and coordination of care, these changes could disproportionately affect these individuals. The future of the Affordable Care Act's Prevention and Public

Health Fund, which provides funding for a range of preventive and community service, is also currently uncertain.[60]

These changes will also likely result in greater autonomy for States in determining the scope and structure of Medicaid benefits through block grants, spending caps and/or waivers.[61] Block grants, which could result in restrictions both on eligibility for Medicaid and generosity of benefits for existing enrollees, could be particularly problematic for poor and vulnerable populations including those with serious mental illnesses.[61] Individuals with SMI, who are disproportionately likely to be poor and unemployed, are also dependent on the social safety net, including support for income, food, and housing. The coming years will likely see an increasingly important role for state mental health and authorities in Medicaid agencies in providing funding and services for people with serious mental illnesses.

Finally, bipartisan mental health reform legislation titled the 21st Century Cures Act was passed by Congress and signed into law by President Obama on December 13, 2016.[62] This legislation establishes a new presidentially appointed Assistant Secretary for Mental Health and Substance Use Disorders as well as a requirement that SAMHSA have a Chief Medical Officer who will be appointed by the Assistant Secretary. The program would authorize funding for several programs delivering evidence-based prevention and treatment services for individuals with serious mental illnesses and "supporting the improvement of integrated care models for primary care and behavioral health care to improve the overall wellness and physical health of adults with a serious mental illness or children with a serious emotional disturbance." This legislation can help keep policy attention focused on individuals with mental illnesses.

These developments continue to evolve, and it is difficult to fully predict how they will play out over the coming years. However, it will be critical for advocates, researchers, and policymakers to keep a focus on the health and well-being of people with SMI in the coming years.

Recommendations

Based on the findings from this literature and policy review, the expert panel developed the following recommendations for Psychiatry to address physical health of people with serious mental illnesses:

1. **Clinical Care:** Psychiatrists' medical training makes them uniquely positioned to support the delivery of high quality, medical treatment, prevention, and mental health care to their patients with SMI. To achieve this goal, it is essential to provide training programs in prevention and medical care during psychiatry residency, combined Medical/Psychiatry residency programs, CME programs for practicing psychiatrists, and cross-training opportunities for psychiatrists and primary care medical providers. Quality improvement initiatives should be implemented across

the full range of settings in which patients with SMI are treated, including community-based mental health clinics, primary care clinics, and emergency rooms.

2. **Health Care Organizations:** Psychiatrists can play critical leadership roles in mental and health care delivery systems that treat patients with SMI. In these roles, they can implement population models and integrated payment systems that foster communication, use of patient registries, and delivery of evidence-based interventions.

3. **Research:** While a robust body of literature supports the practice of primary care-based behavioral health integration, fewer studies examine models to improve the physical health of people with SMI. Further research is needed to inform initiatives addressing the physical health of patients with SMI, as well as to understand the optimal role of psychiatrists in these models.

4. **State Policy:** With the increase in the role of state policymakers in shaping health and mental health care, Psychiatry can play a key role in advocating for States to improve the health of people with SMI and provide input on program design and reform efforts. Advocacy efforts should include Medicaid directors, state mental health authorities, and other state agencies (e.g., departments of corrections).

5. **Federal Health Policy:** Even as states assume greater responsibility for setting policies, the Federal government must continue to provide vital functions for patients with SMI. Psychiatry should advocate for these key functions, including developing and implementing surveillance and monitoring efforts to track the health of people with SMI; and providing regulatory oversight and enforcement of existing policies to ensure insurance coverage, access, and quality of care for these patients.

6. **Public Health Policy:** Premature mortality in populations with SMI is ultimately a public health problem, which will require addressing prevention and treatment of medical problems, mental and substance use disorders, health behaviors (smoking, diet, physical activity), and social factors (poverty, stigma). Psychiatrists should advocate for a robust public health infrastructure that ensures prevention and treatment of ill health in individuals with SMI, and addresses the community and social risk factors underlying poor outcomes in this vulnerable population.

REFERENCES

1. Parks J, Svendsen D, Singer P, Foti ME: Morbidity and mortality in people with serious mental illness. NASMHPD. Alexandria VA 2006
2. Walker ER, McGee RE, Druss BG: Mortality in mental disorders and global disease burden implications: a systematic review and meta-analysis. JAMA Psychiatry 2015; 72(4):334-41
3. Druss BG, Zhao L, Von Esenwein S, et al: Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. Med Care 2011; 49(6):599-604
4. Olfson M, Gerhard T, Huang C, et al: Premature mortality among adults with schizophrenia in the United States. JAMA psychiatry 2015; 72(12):1172-81
5. Black DW, Warrack G, Winokur G: The Iowa record-linkage study. I. Suicides and accidental deaths among psychiatric patients. Arch Gen Psychiatry 1985; 42(1):71-5
6. De Hert M, Correll CU, Bobes J, et al: Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care. World Psychiatry Feb 2011; 10(1):52-77
7. Eaton WW, Martins SS, Nestadt G, et al: The burden of mental disorders. Epidemiol Rev 2008; 30:1-14
8 Walker ER, Pratt LA, Schoenborn CA, Druss BG. Excess mortality among people who report lifetime use of illegal drugs in the United States: A 20-year follow-up of a nationally representative survey. Drug Alcohol Depend 2017;171:31-38
9. Druss BG: WERE: The Synthesis Project: mental disorders and medical comorbidity: Robert Wood Johnson Foundation 2011
10. Newcomer JW: Second-generation (atypical) antipsychotics and metabolic effects: a comprehensive literature review. CNS drugs 2005; 19 Suppl 1:1-93
11. Druss BG, von Esenwein SA, Glick GE, et al: Randomized trial of an integrated behavioral health home: The Health Outcomes Management and Evaluation (HOME) Study. Am J Psychiatry 2016
12. Mental Health America 2012. Position Statement 16: Health and wellness for people with serious mental illness. Alexandria, VA
13. McEvoy JP, Meyer JM, Goff DC, et al: Prevalence of the metabolic syndrome in patients with schizophrenia: baseline results from the Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) schizophrenia trial and comparison with national estimates from NHANES III. Schizophr res 2005; 80(1):19-32
14. Nasrallah HA, Meyer JM, Goff DC, et al: Low rates of treatment for hypertension, dyslipidemia and diabetes in schizophrenia: data from the CATIE schizophrenia trial sample at baseline. Schizophrenia research. 2006; 86(1-3):15-22
15. Newcomer JW, Hennekens CH: Severe mental illness and risk of cardiovascular disease. JAMA 2007; 298(15):1794-6
16. Druss BG, Rosenheck RA: Mental disorders and access to medical care in the United States. Am J Psychiatry 1998;155(12):1775-7
17. McCabe MP, Leas L: A qualitative study of primary health care access, barriers and satisfaction among people with mental illness. Psychol Health Med 2008;13(3):303-12
18. Viron MJ, Stern TA: The impact of serious mental illness on health and healthcare. Psychosomatics 2010; 51(6):458-65
19. Gerrity M, Zoller E, Pinson N, et al: Integrating primary care into behavioral health settings: What works for individuals with serious mental illness. Milbank Memorial Fund December 17, 2014
20 Drake RE, Mueser KT, Brunette MF: Management of persons with co-occurring severe mental illness and substance use disorder: program implications. *World Psychiatry* (2007); *6*(3), 131–136
21 Brunette MF, Mueser KT, Drake RE: A review of research on residential programs for people with severe mental illness and co-occurring substance use disorders. *Drug and Alcohol Review* (2004)23: 471–481
22. McGinty EE, Baller J, Azrin ST, et al: Interventions to address medical conditions and health-risk behaviors among persons with serious mental illness: a comprehensive review. SCHBUL. 2015
23. Gierisch JM, Nieuwsma JA, Bradford DW, et al: Interventions to improve cardiovascular risk factors in people with serious mental illness. Comparative Effectiveness Review No. 105. AHRQ Publication No. 13-EHC063-EF. Rockville, MD: Agency for Healthcare Research and Quality April 2013
24. Tsoi DT, Porwal M, Webster AC. Interventions for smoking cessation and reduction in individuals with schizophrenia. Cochrane Database of Systematic Reviews 2010, Issue 6. Art. No.: CD007253

25. Anthenelli RM, Benowitz NL, West R, et al: Neuropsychiatric safety and efficacy of varenicline, bupropion, and nicotine patch in smokers with and without psychiatric disorders (EAGLES): a double-blind, randomised, placebo-controlled clinical trial. Lancet 2016; 387(10037):2507-20
26. Bartels S, Desilets R: Health promotion programs for people with serious mental illness (Prepared by the. Dartmouth Health Promotion Team). Washington, DC SAMHSA-HRSA Center for Integrated Health Solutions January 2012
27. Daumit GL, Dickerson FB, Appel LJ: Weight loss in persons with serious mental illness. N Engl J Med 2013; 369(5):486-7
28. Jarskog LF, Hamer RM, Catellier DJ, et al: Metformin for weight loss and metabolic control in overweight outpatients with schizophrenia and schizoaffective disorder. Am J Psychiatry 2013;170(9)
29. Stroup TS, McEvoy JP, Ring KD, et al: A randomized trial examining the effectiveness of switching from olanzapine, quetiapine, or risperidone to aripiprazole to reduce metabolic risk: Comparison of Antipsychotics for Metabolic Problems (CAMP). Am J Psychiatry 2011;168(9):947-56
30. Wu R-R, Zhao J-P, Jin H, et al: Lifestyle intervention and metformin for treatment of antipsychotic-induced weight gain. JAMA 2008; 299(2)
31. Phutane VH, Tek C, Chwastiak L, et al: Cardiovascular risk in a first-episode psychosis sample: a 'critical period' for prevention? Schizophr Res 2011; 127(1-3):257-61
32. Kane JM, Robinson DG, Schooler NR, et al: Comprehensive versus usual community care for first-episode psychosis: 2-year outcomes from the NIMH RAISE Early Treatment Program. Am J Psychiatry 2016;173(4):362-72
33. Wu R-R, Zhao J-P, Guo X-F, et al: Metformin addition attenuates olanzapine-induced weight gain in drug-naive first-episode schizophrenia patients: a double-blind, placebo-controlled study. Am J Psychiatry 2008;165(3):352-8
34. Wu R-R, Jin H, Gao K, et al: Metformin for treatment of antipsychotic-induced amenorrhea and weight gain in women with first-episode schizophrenia: a double-blind, randomized, placebo-controlled study. Am J Psychiatry 2012;169(8):813-21
35. McKibbin CL, Patterson TL, Norman G, et al: A lifestyle intervention for older schizophrenia patients with diabetes mellitus: a randomized controlled trial. Schizophr Res. 2006; 86(1-3):36-44
36. Wu RR, Zhang FY, Gao KM, et al: Metformin treatment of antipsychotic-induced dyslipidemia: an analysis of two randomized, placebo-controlled trials. Mol Psychiatry. 2016; 1(11):1537-44
37. Kelly EL, Fenwick KM, Barr N, et al: A systematic review of self-management health care models for individuals with serious mental illnesses. Psychiatr Serv. 2014; 65(11):1300-10
38. Wagner EH, Austin BT, Von Korff M: Organizing care for patients with chronic illness. Milbank Q. 1996; 74(4):511-44
39. Druss BG, von Esenwein SA, Compton MT, et al: A randomized trial of medical care management for community mental health settings: the Primary Care Access, Referral, and Evaluation (PCARE) study. Am J Psychiatry 2010; 167(2):151-9
40. Speyer H, Christian BNH, Birk M, et al: The CHANGE trial: no superiority of lifestyle coaching plus care coordination plus treatment as usual compared to treatment as usual alone in reducing risk of cardiovascular disease in adults with schizophrenia spectrum disorders and abdominal obesity. World Psychiatry 2016; 15(2):155-65
41. Scharf DM, Schmidt Hackbarth N, Eberhart NK, et al: General medical outcomes from the primary and behavioral health care integration grant program. Psychiatr Serv 2016; 67(11):1226-32
42. Brown, J: PBHCI Primary and Behavioral Health Care Integration program cross-site evaluation summer 2016, Grantee Regional Meetings. Webinar 2016
43. Chwastiak L: Making evidence-based lifestyle modification programs available in community mental health centers: why so slow? J Clin Psychiatry 2015 Apr;76(4)
44. Scharf DM, Eberhart NK, Schmidt NS, et al: Evaluation of the SAMHSA Primary and Behavioral Health Care Integration (PBHCI) grant program: Final Report (Task 13). Santa Monica, CA, RAND Corporation 2014
45. American Psychiatric Association. Position paper on the role of psychiatrists in reducing physical health disparities in patients with mental illness 2015
46. Vanderlip ER, Raney LE, Druss BG: A framework for extending psychiatrists' roles in treating general health conditions: Am J Psychiatry 2016; 173(7):658-63
47. Garfield RL, Zuvekas SH, Lave JR, Donohue JM: The impact of national health care reform on adults with severe mental disorders. Am J Psychiatry 2011;168(5):486-94

48. ASPE Issue Brief. Essential health benefits: comparing benefits in small group products and state and federal employee plans [Internet], ‖ ed. U.S. Department of Health & Human Services 2011
49. Barry CL, Goldman HH, Huskamp HA: Federal parity in the evolving mental health and addiction care landscape. Health Aff (Millwood) 2016; 35(6):1009-16
50. The Center for Consumer Information & Insurance Oversight. The Mental Health Parity and Addiction Equity Act (MHPAEA) 2008
51. Beronio K, Glied S, Frank R: How the Affordable Care Act and mental health parity and addiction equity act greatly expand coverage of behavioral health care. J Behav Health Serv Res 2014; 41(4):410-28
52. Beronio K, Po R, Skopec L, Glied S: Affordable Care Act expands mental health and substance use disorder benefits and federal parity protections for 62 million Americans, ASPE 2013
53. The Medicaid Health Home Information Resource Center 2016
54. Healthcare NCfC. Excellence in Mental Health Act 2016
55. Department of Health and Human Services. HHS selects eight states for new demonstration program to improve access to high quality behavioral health services 2016
56. Substance Abuse and Mental Health Services Administration (SAMHSA). Criteria for the demonstration program to improve community mental health centers and to establish certified community behavioral health clinics 2016
57. Substance Abuse and Mental Health Services Administration. Quality Measures 2016
58. Jost T: Day one and beyond: what Trump's election means for the ACA. Health Affairs Blog 2016
59. Oberlander J: The end of Obamacare. N Engl J Med 2017; 376(1):1-3
60. O'Donnell J: Obamacare repeal threatens public health funding to states. USA Today January 16, 2017
61. Rosenbaum S, Schmucker S, Rothenberg S, et al: What would block grants or limits on per capital spending mean for Medicaid. November 2016. Contract No. 39
62. Levin A: Obama signs landmark legislation with major mental health provisions. Psychiatr News January 6, 2017

Item 8.G
Joint Reference Committee
June 17, 2017

EXECUTIVE SUMMARY

ACTION: Will the Joint Reference Committee recommend to the Assembly and the Board of Trustees to approve the proposed Position Statement on Human Rights? (see attachment 1)

Item 8.G
Joint Reference Committee
June 17, 2017

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.

Joint Reference Committee Referral Updates

- **Position Statement on Human Rights:** Following a referral from the Joint Reference Committee, the Council on International Psychiatry, in consultation with the Council on Psychiatry and Law and APA Administration, consolidated the following two APA position statements related to human rights: (1) "Position Statement on Human Rights" (1992); (2) "Position Statement on Denial of Human Rights Abuses" (2008). Recommendations from members of both Councils were incorporated including the addition of examples of human rights abuses recognized by the APA such as the misuse of involuntary psychiatric confinement for political purposes, the denial of access to care, and human trafficking. Attachment 1 of this report outlines the edits made, with relevant background information provided, and provides the final consolidated version for review. If the proposed "Position Statement on Human Rights" is approved, then the two other position statements on human rights mentioned may be retired.

  Will the Joint Reference Committee recommend to the Assembly and the Board of Trustees to approve the proposed Position Statement on Human Rights? (see attachment 1)

International Membership

- **International Group Membership:** Following the recent confirmation of the addition of a group of 50+ members from the South African Society of Psychiatrists, several Council members are working with the Membership Committee and APA Administration to identify other potential opportunities for group membership. The Council and APA Administration have identified potential interest by psychiatric organizations in Mexico, Egypt, and Japan, and Council members are expected to reach out to organizations in India as well.

- **International Distinguished Fellowship:** The Council welcomed the new incoming International Distinguished Fellows, Dr. Fernando Lolas of Chile, Dr. Victor Buwalda of the Netherlands, and Dr. Michael Wise of the United Kingdom, recognized at the 2017 APA Annual Meeting Convocation Ceremony, at the Council's meeting and included them in the Council's discussions. The new International Distinguished also provided remarks at the International Member Welcome hosted by the Membership Committee. The Council looks forward to liaising with these individuals on future projects. Council members are currently involved in supporting the nomination of International Distinguished Fellows for the 2018 APA Annual Meeting.

International Development and Engagement

- **International Participation in Research Colloquium for Junior Investigators:** Council members worked in concert with the Division of Research and APA Administration to increase international participation in the Research Colloquium for Junior Investigators and looks forward to supporting participation for the 2018 APA Annual Meeting. The Council members and members of the Caucus on Global Mental Health and Psychiatry are interested in engaging with participants further.

- **International Poster Engagement Pilot Program:** In coordination with the Scientific Programs Committee, the Division of Education, and APA Administration, the Council on International Psychiatry developed a pilot program designed to connect Council members with international poster presenters in-person at the APA Annual Meeting. The goal of the pilot program was to establish relationships for knowledge exchange, collaboration, and the recruitment of International Members to the APA. The Council worked with APA staff to reach out to 90+ international poster presenters, accepted to present their research at the 2017 APA Annual Meeting, to solicit participation in the pilot program. Eleven individuals opted to participate in the pilot program of which the majority were not APA members. Council members were assigned as reviewers and connected with presenters on an individual basis via email and in-person during the Annual Meeting.

International Poster Engagement Pilot Program Participants		
Name	**Member Status**	**Poster Presentation Title**
Dr. A. Alhadi	International Fellow (Saudi Arabia)	Doctors' Attitudes Toward Becoming Mentally Ill in Saudi Arabia: Disclosure and Treatment Preferences
Dr. R. Basekar	Fellow (Canada)	Repeat Presentation to the ED and Readmission to the Psychiatric Unit for Mental Health Needs: Identifying Risk Factors and Complex Care Intervention
Dr. B. Mendonca Coelho	International Fellow (Brazil)	Persistence and comorbidity of mood, anxiety, and eating disorders among preoperative bariatric patients
Dr. M. Seleem	International Fellow (Egypt)	Parenting discipline styles and child psychopathology among a sample of Egyptian children with accidental eye trauma
Dr. S. Apfelbaum	Non-member	Comparison of screening instruments for detection of bipolar disorder
Dr. D. Delmonte	Non-member	Electroconvulsive Therapy in Treatment-Resistant Depression: A 12-Month Cohort Study in the City of Milan, Italy
Dr. J. Irastorza	Non-member	Adult ADHD Patients and Their Parental Competencies
Dr. Y. Jen	Non-member	Aripiprazole-induced fast decrease in prolactin levels and rebound of psychotic symptoms in patients with schizophrenia
Dr. A. Lepri	Non-member	On Off and or Life Death Fight Escape
Dr. A. Thour	Non-member	Depression Among Patients with Diabetes Mellitus in North India Evaluated Using Patients Health Questionnaire-9
Dr. S. Wong	Non-member	Non-Monosymptomatic Enuresis is Strongly Associated with Attention Deficit Hyperactivity Disorder in Chinese Children

Overall feedback from participants present at the APA Annual Meeting in San Diego noted that their participation in the pilot program made them more engaged with learning more about APA opportunities and connecting with APA members on future collaborations. The Council will continue to review the findings of the pilot to determine the feasibility and scalability of the pilot program by the Council moving forward and welcomes any feedback from the Joint Reference Committee.

- **Immigrant and Refugee Mental Health:** The Council was notified by the Council's Assembly liaison that the Position Statement on the "Role of Psychiatrists in Addressing Care for People Affected by Forced Displacement," developed by several Council members, was approved by the Assembly and is now official APA policy. The Council noted that the APA now has several position statements addressing immigrant and refugee mental health and reviewed and discussed them during the Annual Meeting:

  - Role of Psychiatrists in Addressing Care for People Affected by Forced Displacement (2017)
  - Xenophobia, Immigration, and Mental Health (2014)
  - Detained Immigrants with Mental Illness (2013)

  The Council was also notified that a position statement on human trafficking was under development and looks forward to reviewing it. The Council welcomes any feedback and recommendations from the JRC regarding the development of educational resources by the Council around the topic of immigrant and refugee mental health to increase member engagement.

- **Human Rights Award:** The 2017 Human Rights Award was presented to the National Consortium of Torture Treatment Programs at the APA Annual Meeting during the Council supported workshop "Refugee Psychiatry: Practical Tools for Building Resilience of Displaced Persons and Refugee Communities to Migration-Related Stressors" and was well attended (50-60 attendees). The Council looks forward to receiving notification of the appointments to the Chester M. Pierce Human Rights Award Nominating Committee and working with the Committee to identify the 2018 award recipient and coordinating their recognition at the APA Annual Meeting in New York with APA Administration.

- **Global Mental Health and International Psychiatry Sessions:** The Council noted that there were 25 sessions (see attachment 2) at the 2017 APA Annual Meeting addressing topics on global mental health and international psychiatry, many of which were supported by either members of the Council on International Psychiatry and the Caucus on Global Mental Health and Psychiatry. The Council looks forward to reviewing all the sessions and coordinating a series of appropriate submissions for the 2018 APA Annual Meeting.

Item 8.G
Joint Reference Committee
June 17, 2017

2017 Annual Meeting Sessions Supported by Council and Caucus Members	
Africa Discussion Group (Open Forum)*	Council
APA Caucus on Global Mental Health and Psychiatry Meeting (Open Forum)*	Caucus
Building Human Capacity for Mental Health in Low- and Middle-Income Countries	Council
Caring for Trafficked Persons: How Psychiatrists Can Utilize a Collaborative and Innovative Approach to Care for this Vulnerable Population	Council
Global Issues in Mental Health: Primary Care and School Mental Health, Ethics and Culture, and Migrant and Refugee Mental Health	Caucus
MAANASI—Of Sound Mind—A Program by Women for Women: Mental Health of Six Million People on a Shoe String Budget	Council
Paving the Way to Improving Global Mental Health in High- and Low-Resource Countries	Caucus
Perspectives in Global Mental Health (Small Group Discussions of AJP Case Studies)* -"Trauma and Depression in Ethiopia" -"Syrian Refugees in Greece" -"Personality Disorders in Spain" -"Jinn Possession in Pakistan" -"Understanding Social Withdrawal in Japan" -"Treatment of Postpartum in Iran" -"Displaced Iraqi Families in Kurdistan" -"Caring for Syrian Refugees in Oregon"	Caucus
Primary Care Psychiatry: Global Perspectives	Council
Refugee Psychiatry: Practical Tools for Building Resilience of Displaced Persons and Refugee Communities to Migration-Related Stressors	Council
The Role of Culture in Mental Health and Mental Illness: An International Perspective	Council
The United Nations, the APA's NGO Status and Current International Crises	Council
The Unwanted Immigrant: Mental Health and Social Responsibility	Council
Thinking Globally, Working Locally: Establishing and Maintaining Global Mental Health Training Programs in Low-Resource Countries	Council

*not part of scientific program

ATTACHMENT 1: POSITION STATEMENT ON HUMAN RIGHTS

APA Official Actions

Position Statement on Human Rights

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:

The American Psychiatric Association (APA) recognizes that human rights abuses, such as, unjust incarceration, cruel and unusual punishment, torture, the misuse of involuntary psychiatric confinement for political purposes, the denial of access to care, and human trafficking, have adverse psychiatric consequences on victims of such abuses and their families. The denial or cover-up of well-documented human rights abuses by governments and institutions is antithetical to a humane society and the ability to attend properly to the psychiatric needs of those who have been subject to such abuse. APA supports working with agencies and organizations dedicated to advancing human rights and fighting human rights abuses.

NOTE: The above DRAFT position statement is a consolidation of the following:

- **Position Statement on Human Rights** (1992)
- **Position Statement on Denial of Human Rights Abuses** (2008)

It also includes recommendations for edit (*~~strikethrough~~ and double underline below*) from the Council on International Psychiatry and the Council on Psychiatry and Law.

Recommended Edits:

The American Psychiatric Association (APA) ~~is concerned about~~ recognizes that ~~the psychiatric consequences of~~ human rights ~~violations~~ abuses, such as, unjust incarceration, ~~and~~ cruel and ~~or~~ unusual punishment, ~~including terror and~~ torture, the misuse of involuntary psychiatric confinement for political purposes, the denial of access to care, and human trafficking, have adverse psychiatric consequences on victims of such abuses and their families. ~~The World Psychiatric Association goals include: to educate psychiatrist and other professionals about human rights abuses and the persecution of physicians who speak out against their governments; to encourage psychiatrists and other professionals about human rights abuses and the persecution of physicians who speak out against their governments; to encourage psychiatrist to use all their efforts against the use of torture and for the rehabilitation of torture victims; to promote research on the effects of human rights violations; and to prevent human rights violations.~~ The denial or cover-up of well-documented human rights abuses ~~When well documented human rights abuses are denied or covered up~~ by governments and other institutions, ~~such denial is a further violation of human rights of the victims and~~ is antithetical to a humane society and the ability to attend properly to the psychiatric needs of those who have been subject to such abuse ~~the mental health of victims and their families~~. APA supports working with agencies and organizations dedicated to advancing human rights and fighting human rights abuses.

ATTACHMENT 1: POSITION STATEMENT ON HUMAN RIGHTS

Background Information for Position Statement on Human Rights

Position Statement on Human Rights (1992)

In December 1992, the American Psychiatric Association (APA) Board of Trustees approved the "Position Statement on Human Rights" which was originally prepared by the now sunset APA components, Council on International Affairs and the Committee on Human Rights. It states that "the American Psychiatric Association is concerned about the psychiatric consequences of human rights violations—violations such as unjust incarceration and cruel or unusual punishment, including terror and torture."[2] It also mentions the goals of the World Psychiatric Association (WPA) as being "to educate psychiatrists and other professionals about human rights abuses and the persecution of physicians who speak out against their governments; to encourage psychiatrists to use all their efforts against the use of torture and for the rehabilitation of torture victims; to promote research on the effects of human rights violations; and to prevent human rights violations."[2]

A review of the updated WPA missions and objectives found that, with regards to goals related to human rights, they include "to be a voice for the dignity and human rights of the patients and their families, and to uphold the rights of psychiatrists", "to preserve the rights of the mentally ill", and "to promote the development and observance of the highest ethical standards in psychiatric care, teaching and research."[7] The APA is a member society of the WPA and coordinates with the WPA on issues related to human rights, such as torture.

In 2013, following a report from the *United Nations (UN) Special Rapporteur on Torture* to the *UN Human Rights Council*, the APA and WPA issued a joint statement addressing portions of the report that regarded the possible definition of "torture" as encompassing a range of practices employed by psychiatrists, including involuntary civil commitment, the use of restraint, and the provision of treatment delivered under the auspices of guardianship and other currently accepted legal processes.[6] The joint response was included in the publication "Torture in Health Care Settings: Reflections on the Special Rapporteur on Torture's 2013 Thematic Report" published by the *Center for Human Rights and Humanitarian Law*.

Resolution Condemning the Role of Psychiatrist Radovan Karadzic in Human Rights Abuses in the Former Yugoslavia (1993, 2008)

In March 1993, the APA Board of Trustees approved the Position Statement "Resolution Condemning the Role of Psychiatrist Radovan Karadzic in Human Rights Abuses in the Former Yugoslavia", reaffirming it in 2008, which was originally prepared by the now sunset APA components, Council on International Affairs and the Committee on Human Rights. It states that the APA "deplores and condemns Dr. Karadzic for his brutal and inhumane actions as the Bosnian Serb leader" and notes that "those actions deserve condemnation by all civilized persons", including psychiatrists, as Dr. Karadzic "claims membership in our profession" and "his actions as a political leader constitute a profound betrayal of the deeply humane values of medicine and psychiatry."[3]

A review of the Position Statement by the APA Council on International Psychiatry in 2016, revealed that the statement was still relevant as the former Bosnian Serb leader, after a five-year trial with 18 months

of deliberation, was "found guilty of genocide and crimes against humanity during the 1992-95 Bosnian war" at a United Nations tribunal in The Hague on March 24, 2016, and sentenced to 40 years in prison.[5] The Council on International Psychiatry recommended to retain this APA policy on the basis of the recent verdict and due to reports from Dr. Karadzic's representation that the decision would be appealed.

Position Statement on Denial of Human Rights Abuses (1993, 2008)

In December 1993, the APA Board of Trustees approved the "Position Statement on Denial of Human Rights Abuses", reaffirming it in 2008, which was originally prepared by the now sunset APA components, Council on International Affairs and the Committee on Human Rights. It states that "when well documented human rights abuses are denied or covered up by governments and other institutions, such denial is a further violation of human rights of the victims and is antithetical to the mental health of victims and their families."[1]

In 2013, the APA began to follow the potentially inappropriate and unjust psychiatric confinement of Mr. Mikhail Kosenko to a Russian psychiatric facility by Russian authorities following his arrest at a political demonstration. After corroborating reports with the *U.S. Department of State Bureau of European and Eurasian Affairs*, the human rights organizations *Amnesty International* and *Human Rights Watch,* and the WPA member society the *Russian Independent Psychiatric Association*, the APA issued a statement to the U.S. Ambassador to the Russian Federation to investigate such reports. APA continues to follow instances of potential human rights abuses through organizations dedicated to human rights issues, such as those mentioned in this report, in addition to others, such as the organization *Physicians for Human Rights*, and coordinates with them when appropriate.

Position Statement on Human Rights (Consolidated, 2017)

In 2016, the APA Joint Reference Committee requested that the 1992 "Position Statement on Human Rights" and the 1993 "Position Statement on the Denial of Human Rights" be consolidated into one statement, and approved the development of a Position Statement on human trafficking which is currently being drafted for review by the Council on Minority Mental Health and Health Disparities, the Council on International Psychiatry, the Council on Psychiatry and Law, and the Council on Children, Adolescents, and Their Families. Currently, the Joint Reference Committee is consolidating position statements on the misuse and abuse of psychiatry.

The 2017 consolidated "Position Statement on Human Rights" takes into consideration current APA policy addressing human rights, the update of the position statements on the misuse and abuse of psychiatry, the development of a position statement on human trafficking, and relevant actions of the APA over the past two decades as documented.

References

1. American Psychiatric Association. (2008). Position Statement on Denial of Human Rights.
2. American Psychiatric Association. (1992). Position Statement on Human Rights.
3. American Psychiatric Association. (2007). Resolution Condemning the Role of Psychiatrist Radovan Karadzic in Human Rights Abuses in the Former Yugoslavia.

4. "Putin critic Kosenko confined to psychiatric ward." *BBC News*. 9 Oct 2013. Retrieved from http://www.bbc.com/news/world-europe-24451016
5. "Radovan Karadzic: Former Bosnian Serb leader." *BBC News.* 24 Mar 2016. Retrieved from http://www.bbc.com/news/world-europe-19960285
6. "Torture in Healthcare Settings: Reflections on the Special Rapporteur on Torture's 2013 Thematic Report." Center for Human Rights and Humanitarian Law. Washington, DC: American University Washington College of Law, 2014
7. World Psychiatric Association, *About the World Psychiatric Association*, Retrieved from http://www.wpanet.org/detail.php?section_id=5&content_id=4

Position Statement on Human Rights

Approved by the Board of Trustees, December 1992

"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 is concerned about the psychiatric consequences of human rights violations—violations such as unjust incarceration and cruel or unusual punishment, including terror and torture. The World Psychiatric Association goals include: to educate psychiatrists and other professionals about human rights abuses and the persecution of physicians who speak out against their governments; to encourage psychiatrists to use all their efforts against the use of torture and for the rehabilitation of torture victims; to promote research on the effects of human rights violations; and to prevent human rights violations.

Position Statement on Denial of Human Rights Abuses

Approved by the Board of Trustees, December 1993
Approved by the Assembly, November 1993
Reaffirmed, 2008

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

When well documented human rights abuses are denied or covered up by governments and other institutions, such denial is a further violation of human rights of the victims and is antithetical to the mental health of victims and their families.

Global Mental Health & International Psychiatry

Sessions Listing

Saturday 20 May 2017

8:00 a.m. - 11:00 a.m.
Mentally Ill and Traumatized Populations in South Sudan: Community Outreach and Breath-Body-Mind Treatment for Impoverished States
Chairperson(s): Patricia Gerbarg, Richard Brown
Presenter(s): Atong Ayuel Akol
San Diego Convention Center, Room 29D

8:00 a.m. - 11:00 a.m.
Paving the Way to Improving Global Mental Health in High- and Low-Resource Countries
Chairperson(s): Milton Wainberg
Presenter(s): Gary Belkin, Annika Sweetland, Francine Cournos, Pamela Collins
San Diego Convention Center, Room 25A

10:00 a.m. - 11:30 a.m.
Mental Health Impact on Immigrants and Refugees
Chairperson(s): Mackenzie Varkula
Presenter(s): Carlos Molina, Ambreen Ghori
San Diego Convention Center, Room 24C

11:00 a.m. - 12:00 p.m.
Perspectives in Global Mental Health
APA Caucus on Global Mental Health and Psychiatry
"Trauma and Depression in Ethiopia" (Discussion)
"Syrian Refugees in Greece" (Discussion)
San Diego Convention Center, Exhibit Halls A-C, APA Central, Resident and ECP Hub

1:00 p.m. - 2:00 p.m.
Perspectives in Global Mental Health
APA Caucus on Global Mental Health and Psychiatry
"Personality Disorders in Spain" (Discussion)
"Jinn Possession in Pakistan" (Discussion)
San Diego Convention Center, Exhibit Hall A-C, APA Central, Resident and ECP Hub

2:00 p.m. - 5:00 p.m.
Caring for Trafficked Persons: How Psychiatrists Can Utilize a Collaborative and Innovative Approach to Care for this Vulnerable Population
APA Council on International Psychiatry
Chairperson(s): Rachel Robitz, Vivian Pender
Presenter(s): Jamie Gates, Eraka Bath, Tom Jones, Crystal Isle, Charisma de los Reyes, Laura McLean, Susan Munsey
San Diego Convention Center, Room 30A

3:30 p.m. - 5:00 p.m.
Global Mental Health and Substance Use Disorders: Relevant Today, Tomorrow, and Always
APA Council on Minority Mental Health and Health Disparities
Chairperson(s): Evaristo Akerele, Magalie Hurez, Craig Katz
Discussant(s): Dolores Malaspina
San Diego Convention Center, Room 28E

4:00 p.m. - 5:00 p.m.
Africa Discussion Group
Facilitator(s): Samuel Okpaku (Open Forum)
Marriott Marquis, Cardiff Room

Sunday 21 May 2017

8:00 a.m. - 10:00 a.m.
APA Caucus on Global Mental Health and Psychiatry
Chairperson(s): Vincenzo Di Nicola (Meeting and Open Forum)
Marriott Marquis, Santa Rosa Room

10:00 a.m. - 10:20 a.m.
MAANASI—Of Sound Mind—A Program by Women for Women: Mental Health of Six Million People on a Shoe String Budget
APA Caucus on Global Mental Health and Psychiatry
Part of Rapid-Fire Talks: Focus on Women's Health
Presenter(s): Geetha Jayaram
San Diego Convention Center, Room 27B

1:30 p.m. - 3:00 p.m.
Refugee Psychiatry: Practical Tools for Building Resilience of Displaced Persons and Refugee Communities to Migration-Related Stressors
APA Council on International Psychiatry
APA Human Rights Award Presentation to NCTTP
Chairperson(s): James Griffith, Dyani Loo
Presenter(s): Amitha Prasad, SuZan Song
San Diego Convention Center, Room 28E

2:00 p.m. - 4:00 p.m.
International Research Posters
See List of Posters in Program Guide (pp. 162-167)
San Diego Convention Center, Exhibit Hall A

Monday 22 May 2017

10:00 a.m. - 11:30 a.m.
Disaster Psychiatry: Current Needs in Managing Climate Change
Chairperson(s): Joshua Morganstein
Presenter(s): Robin Cooper, Lise Van Susteren, James West
San Diego Convention Center, Room 28E

Global Mental Health & International Psychiatry

Sessions Listing

11:00 a.m. - 12:00 p.m.
Perspectives in Global Mental Health
APA Caucus on Global Mental Health and Psychiatry
"Understanding Social Withdrawal in Japan" (Discussion)
"Treatment of Postpartum in Iran" (Discussion)
San Diego Convention Center, Exhibit Hall A-C, APA Central, Resident and ECP Hub

1:00 p.m. - 2:00 p.m.
Perspectives in Global Mental Health
APA Caucus on Global Mental Health and Psychiatry
"Displaced Iraqi Families in Kurdistan" (Discussion)
"Caring for Syrian Refugees in Oregon" (Discussion)
San Diego Convention Center, Exhibit Hall A-C, APA Central, Resident and ECP Hub

1:30 p.m. - 3:00 p.m.
Culture, Ethics, Communication, and the International Medical Graduate
APA George Tarjan Award
Lecturer(s): Ramaswamy Viswanathan
San Diego Convention Center, Room 33C

1:30 p.m. - 3:00 p.m.
Thinking Globally, Working Locally: Establishing and Maintaining Global Mental Health Training Programs in Low-Resource Countries
Chairperson(s): Nakita Natala, Danielle LaRocco
Presenter(s): Carol Bernstein, Gordon Donnir, Sammy Ohene
San Diego Convention Center, Room 28E

3:30 p.m. - 5:00 p.m.
Opportunities for Psychiatrists in Global Health Engagement: Lessons Learned
Chairperson(s): Eric Meyer, Jeffrey Millegan, Kenneth Richter
San Diego Convention Center, 29D

Tuesday 23 May 2017

8:00 a.m. - 9:30 a.m.
A Hippocratic Oath for Global Mental Health
Chairperson(s): Allen Dyer
Presenter(s): Catherine May, Fatima Noorani, Philip Candilis
San Diego Convention Center, Room 29A

8:00 a.m. - 11:00 a.m.
Primary Care Psychiatry: Global Perspectives
APA Council on International Psychiatry
Chairperson(s): Eliot Sorel
Presenter(s): Dinesh Bhugra, Helen Herrman, Anita Everett, Solomon Rataemane, Michelle Riba, Jennifer Severe
San Diego Convention Center, Room 28A

2:00 p.m. - 5:00 p.m.
Building Human Capacity for Mental Health in Low- and Middle-Income Countries
Chairperson(s): Samuel Okpaku
Presenter(s): Robert Kohn, Janice Cooper, Samuel Okpaku, David Ndetei, Sergio Villaseñor-Bayardo, Milton Wainberg, Geetha Jayaram
Discussant(s): Mary Kay Smith
San Diego Convention Center, Room 28E

2:00 p.m. - 5:00 p.m.
The Unwanted Immigrant: Mental Health and Social Responsibility
American Association for Social Psychiatry
Chairperson(s): Eugenio Rothe
Presenter(s): Andres Pumariega, Aida Spahic-Mihajlovic, Jacob Sperber, Ateaya Lima
Discussant(s): Pedro Ruiz
San Diego Convention Center, Room 30A

3:30 p.m. - 5:00 p.m.
The United Nations, the APA's NGO Status and Current International Crises: What Can APA Members Do?
Chairperson(s): Aleema Zakers, Vivian Pender
Presenter(s): Dyani Loo, Jennifer Severe, Rachel Robitz
San Diego Convention Center, Room 29B

Wednesday 24 May 2017

8:00 a.m. - 11:00 a.m.
The Role of Culture in Mental Health and Mental Illness: An International Perspective
Chairperson(s): Bernardo Ng, Rama Rao Gogineni
Presenter(s): Pedro Ruiz, Vincenzo Di Nicola, Suni Jani, Jennifer Severe, Atong Ayuel Akol
Discussant(s): Michelle Riba
San Diego Convention Center, Room 28E

2:00 p.m. - 5:00 p.m.
Global Issues in Mental Health: Primary Care and School Mental Health, Ethics and Culture, and Migrant and Refugee Mental Health
APA Caucus on Global Mental Health and Psychiatry
Chairperson(s): Vincenzo Di Nicola, Fernando Lolas
Presenter(s): Fernando Lolas, Nakita Natala, Aleema Zakers, Gabriel Ivbijaro, Vincenzo Di Nicola, David Ndetei, Victoria Mutiso
Discussant(s): Eliot Sorel
San Diego Convention Center, Room 28E

ATTACHMENT 3: COUNCIL MINUTES – JANUARY

Council Name: Council on International Psychiatry
Date: January 12, 2017
Time: 8:00 PM – 9:00 PM
Location: Conference Call

Council Members Present: B. Ng, A. Becker, K. Busch, J. Griffith, D. Jeste, S. Okpaku, U.K. Quang-Dang, E. Pi, M. Riba, R. Rao Gogineni, E. Sorel, N. Natala, J. Severe, J. Immanuel, D. Loo, J. Winfield Tan

Council Members with Excused Absences: B. Acharya, P. Ruiz, A. Tasman, J. McIntyre, G. Raviola, J. Srinivasaraghavan (Dr. Van), I. Vihang Vahia, D. Henderson, G. Jayaram, S. Jani, C. Buzza, A. Zakers, R. De Similien

Council Members with Unexcused Absences: None

Guests in Attendance: Vincenzo Di Nicola (GMH Caucus Chair), Vivian Pender (United Nations Liaison)

Staff in Attendance: R. Juarez

Council Minutes

The minutes of the December 12 Council meeting were approved with the addition of Dr. Di Nicola's excused absence to host the APA President-Elect candidates.

World Bank

Dr. Sorel presented the report from the World Bank "Mental Health Among Displaced People" noting that the Council should be mindful of opportunities for collaboration with the World Bank. Dr. Sorel also noted that it may be useful for Dr. Pender, the United Nations liaison to share the document at the United Nations.

Human Rights Award

Thanks to Ricardo with helping to usher the process for changing the name of the APA Human Rights Award to the Chester Pierce Human Rights Award expeditiously with the hope of its approval in time for the APA Annual Meeting in May. Council members noted their appreciation for the extensive background information pulled together on Dr. Pierce's lifetime achievements. It was noted that in order for this initiative to be successful that the support of other components and a consensus of endorsement from the Council members. The Council expressed their thanks for the support communicated by the received letters of support from the Black Psychiatrists of America and the Caucus of Asian American Psychiatrists. Appreciation was also expressed to all the Council members for their input on this process and to Dr. Sorel.

The question was raised if there was any group that would be contributing to a fund to support the award. The suggestion received was to not deal with the financial aspect now, but to move the action forward so that in future years identifying donors, including possibly the Pierce family, can be explored.

World Psychiatric Association

With the submission deadline approaching for the WPA World Congress of Psychiatry, scheduled for October 8-12, 2017, several Council members shared their submissions and plans with attending. Dr. Sorel is submitting two submission proposal through the WPA's Section on Conflict Management, one on "Euthanasia: European, American, and Global Perspectives" which includes Belgian, Canadian, and Chilean presenters, and the other is on the integration of refugees into German society. Dr. Okpaku is submitting a proposal on capacity building which includes Dr. Milton Wainberg (US) and Dr. David Ndetei (Kenya) as presenters. Dr. Di Nicola is submitting a symposium with Bulgarian psychiatrists through the philosophy section of the WPA. Dr. Busch is planning to submit a proposal with Dr. Bruce Hershfield and Dr. Rahn Bailey on gun violence in America. It was noted that Dr. Ruiz is putting together a symposium and that should anyone have any German colleagues interested in Positive Psychiatry, they should contact Dr. Gogineni. It was asked if submissions for the WPA can be made under the Council's name and it was shared that is not the process. Anyone receiving notice of accepted submissions should forward the information to Ricardo. In addition to those Council members submitting proposals, Drs. Natala and Severe expressed interest with attending the WPA World Congress. The deadline for poster submissions is March 27, 2017.

Announcements

The Council shared that the Women's March is occurring in Washington, DC and noted that it is welcoming participants. Dr. Di Nicola announced that a session submitted by the APA Caucus on Global Mental Health and Psychiatry, co-chaired by he and Dr. Fernando Lolas of Chile, was accepted for the APA Annual Meeting and includes presentations from Dr. Gabriel Ivbijaro and Dr. David Ndetei as well as two of the Council's Fellows, Drs. Natala and Zakers. Dr. Sorel is also the discussant for the presentation. Ricardo will draft a timeline of Council sessions to share with Council members. Drs. Gogineni and Tan volunteered to be reviewers for the international poster pilot program. The World Association of Social Psychiatry launched the initiative "Global Mental Health Mentors and Mentees Network" as a LinkedIn Group. Dr. Ng briefly discussed the fact that the APA does not have representation by Mexican Psychiatrists and will connect with the Council's Assembly Liaison, Dr. Busch, about the possibility of developing an Action Paper to make Mexico a District Branch.

ATTACHMENT 4: COUNCIL MINUTES – FEBRUARY

Council Name: Council on International Psychiatry
Date: February 15, 2017
Time: 8:00 PM – 9:00 PM
Location: Conference Call

Council Members Present: B. Ng, A. Becker, K. Busch, J. Griffith, S. Okpaku, E. Pi, R. Rao Gogineni, J. McIntyre, E. Sorel, N. Natala, J. Severe, J. Immanuel, D. Loo, A. Zakers,

Council Members with Excused Absences: B. Acharya, D. Jeste, U.K. Quang-Dang, M. Riba, P. Ruiz, A. Tasman, G. Raviola, J. Srinivasaraghavan (Dr. Van), I. Vihang Vahia, D. Henderson, G. Jayaram, S. Jani, C. Buzza, R. De Similien, J. Winfield Tan

Council Members with Unexcused Absences: None

Guests in Attendance: Vincenzo Di Nicola (GMH Caucus Chair), Vivian Pender (United Nations Liaison)

Staff in Attendance: R. Juarez

Council Minutes

The minutes of the January 12 Council meeting were approved without edit.

Joint Reference Committee Update

The Council received an update of the February meeting of the Joint Reference Committee, noting that both the renaming of the Human Rights Award to the Chester Pierce Human Rights Award, along with the establishment of a joint nominating committee for the award, were approved to go to the Board of Trustees for review and approval. It was also noted that the position statement the "Role of Psychiatrists in Addressing Care for People Affected by Forced Displacement" was approved to go to the Assembly for review and approval.

APA Election Results

The Council received an update on the results of the 2017 APA Election which included the election of Dr. Altha Stewart to President-Elect, making her the first African-American President-Elect.

APA Statement on Immigration Executive Order

The Council reviewed and supported statement that went out from the APA in response to the Executive Order impacting immigration. It was noted that while the response was good it did not express any overt criticism of the order.

Response to ICD-11 Reclassification of Dementia

The Council reviewed and supported statements from the APA and the World Association of Social Psychiatry noting that many organizations have responded to the reclassification of dementia in ICD-11.

APA Annual Meeting

The Council reviewed a schedule of session for the Annual Meeting on topics following under the primary topics of "Global, Political and Social Issues" and "International Collaborations" which included sessions supported by the Council on International Psychiatry and the Caucus on Global Mental Health and Psychiatry.

World Psychiatric Association

Dr. Pi reported that a WPA International Zonal Congress is scheduled to occur May 3-5 in Northern Europe, Lithuania. Council members interested in attending should coordinate with Dr. Pi.

Announcements

The Mexican Psychiatric Association is scheduled to have their international congress November 16-20 in Yucatan. Dr. Tanya Gandhi may be interested in joining the Council. What is the impact on the Mexican people with the current administration – consult Dr. Freedman about submitting something for Mexico – Dr. Ng and Sorel. Montreal DB meeting on global mental helath – caucus meeting in San Diego – caucus symposium in San Diego. Create a joint communication to international membership and international presidents communicating sessions.

ATTACHMENT 5: COUNCIL MINUTES – MARCH

Council Name: Council on International Psychiatry
Date: March 16, 2017
Time: 8:00 PM – 9:00 PM
Location: Conference Call

Council Members Present: B. Ng, J. Griffith, S. Okpaku, E. Pi, P. Ruiz, R. Rao Gogineni, E. Sorel, N. Natala, J. Severe, J. Immanuel, D. Loo, J. Winfield Tan

Council Members with Excused Absences: B. Acharya, A. Becker, K. Busch, D. Jeste, U.K. Quang-Dang, M. Riba, A. Tasman, J. McIntyre, G. Raviola, J. Srinivasaraghavan (Dr. Van), I. Vihang Vahia, D. Henderson, G. Jayaram, A. Zakers, S. Jani, C. Buzza, R. De Similien

Council Members with Unexcused Absences: None

Guests in Attendance: Vincenzo Di Nicola (GMH Caucus Chair)

Staff in Attendance: R. Juarez

Council Minutes

The minutes of the February 15 Council meeting were approved without edit.

Board of Trustees Meeting Update

The Council discussed the results of the March Board of Trustees meeting which resulted in the approval of the renaming of the Human Rights Award after Chester M. Pierce. Staff is in the process of updating information on the award webpage. Additionally, the Council discussed the formation of the nominating committee for the award, the Chester M. Pierce Human Rights Award Nominating Committee which will report to the Council on International Psychiatry. With regards to the appointment process for the Nominating Committee, the incoming President, Dr. Anita Everett, will be making 2017-2018 appointments to the nominating committee. The Council discussed providing possible recommendations and suggested recommending Dr. Eliot Sorel to be appointed to the nominating committee. Staff will connect with Governance about the details of the appointment process.

Position Statement Update

The Council discussed the status of several pending position statements:

1) **Role of Psychiatrists in Addressing Care for People Affected by Forced Displacement:** This position statement is scheduled to be reviewed by the Assembly at their May meeting during the Annual Meeting. The result of their approval should be known by the date of the Council's in-person meeting in San Diego

2) **Abuse and Misuse of Psychiatry:** A consolidation of the position statements on the misuse and abuse of psychiatry and the definition of the misuse and abuse of psychiatry is in the process of being reviewed by the Joint Reference Committee for approval.
3) **Human Trafficking:** The Council on Minority Mental Health and Health Disparities is coordinating the development of a position statement on human trafficking, which stems from a passed Assembly Action Paper reviewed by the Council on International Psychiatry. It is expected that a draft will be available for review by the Council by their May meeting.
4) **Human Rights:** The Council reviewed a draft of the consolidation of the position statement on "Human Rights" and the "Denial of Human Rights Abuses", which was requested by the Joint Reference Committee, and provided feedback. It was noted that the draft did not provide the "denial of access to care" as a recognized human rights abuse. The Council discussed including this term in the drafted position statement and sending it to the Council on Psychiatry and Law for additional feedback. The Council on International Psychiatry will review the drafted position statement and any feedback received from the Council on Psychiatry and Law during their May meeting.

The Council continued to discuss the denial of access to care as a fundamental human rights and Dr. Sorel discussed authoring an Action Paper for the upcoming May Assembly on the matter and reached out to interested Council members to join as co-authors.

Annual Meeting

Dr. Sorel discussed the symposium chaired by him and Dr. Riba accepted for the upcoming APA Annual Meeting, titled "Primary Care Psychiatry: Global Perspectives" and invited the Council members to attend. The symposium features presentations by the President and President-Elect of the World Psychiatric Associatoin, Drs. Bhugra and Herrman, the APA President-Elect, Dr. Anita Everett, as well as Dr. Solomon Rataemane of South Africa and Dr. Jennifer Severe, a Fellow on the Council on International Psychiatry. Dr. Sorel also shared that a reception will follow the symposium at 11:30am at the Hyatt. Council members are invited to attend the reception as well.

ATTACHMENT 6: COUNCIL MINUTES – APRIL

Council Name: Council on International Psychiatry
Date: April 25, 2017
Time: 8:00 PM – 9:00 PM
Location: Conference Call

Council Members Present: B. Ng, J. Griffith, K. Busch, E. Pi, U.K. Quang-Dang, M. Riba, P. Ruiz, R. Rao Gogineni, J. McIntyre, E. Sorel, N. Natala, J. Severe, J. Immanuel, **Council Members with Excused Absences:** B. Acharya, A. Becker, K. Busch, D. Jeste, S. Okpaku, A. Tasman, G. Raviola, J. Srinivasaraghavan (Dr. Van), I. Vihang Vahia, D. Henderson, G. Jayaram, A. Zakers, S. Jani, C. Buzza, R. De Similien, D. Loo, J. Winfield Tan

Council Members with Unexcused Absences: None

Guests in Attendance: None

Staff in Attendance: R. Juarez

Council Minutes

The minutes of the March 15 Council meeting were approved without edit.

Human Rights Award Update

The Council was notified that the President-Elect, Anita Everett, was reviewing the rosters of the relevant APA components for appointments to the Human Rights Award Nominating Committee. The recommendation of Dr. Eliot Sorel was forwarded by APA Administration. A letter to the Black Psychiatrists of America from APA Administration also went out notifying them of the consultant position on the committee and requesting recommendations for appointment.

International Poster Engagement Pilot Program

The Council members coordinating the International Poster Engagement Pilot Program, including Drs. U.K. Quang-Dang, Josepha Immanuel, and Jennifer Severe, provided the Council with an update of the participation and assignment of reviewers. Twelve participants opted to participate in the pilot program with broad representation around the world including APA members and non-members from Saudi Arabia, Brazil, Egypt, and Italy. Six Council members were identified as reviewers and assigned to each of the participants. The reviewers include Drs. Winfield Tan, Josepha Immanuel, Jennifer Severe, UK Quang-Dang, Bernardo Ng, and Rao Gogineni. Participants are scheduled to present their research posters on Sunday afternoon of the APA Annual Meeting on a wide range of topics. Reviewers are also reaching out to participants in advance electronically and have prepared questions for each of the participants in order to engage in a face-to-face discussion to see how the Council on International Psychiatry can be helpful to them in their professional development. While one participant noted that

their poster was accepted for presentation, they were not able to travel to the Annual Meeting, but wished to participate in the program anyways. It was clarified that all participants in the pilot program had their research posters reviewed and accepted by the Scientific Programs Committee prior to being contacted to participate in the pilot program. Council members noted that the pilot seemed liked a good opportunity for exchange and engagement. Council members noted that it may be good to have coverage by Psychiatric News and to follow up with a research paper providing accounts of the program.

Integrated Care Around the World Update

Dr. Eliot Sorel provided an update on this project, noting that a few months ago, Council members had volunteered to provide information on different regions regarding the different used of integrated and collaborative care models. The assignments were noted as follows:

Americas – Drs. Bernardo Ng and Pedro Ruiz
Africa – Dr. Samuel Okpaku
Asia Pacific – Drs. Geetha Jayaram and Ed Pi
Europe – Drs. Eliot Sorel and Vincenzo Di Nicola
Middle East – Dr. James Griffith

It was shared that this group intends to kick off the project this summer so that they can have a report ready for the Council's in person meeting in September. Dr. Sorel provided clarification that the instrument to be used is a one page outline to be completed by the assigned reviewers.

WPA Update

Dr. Ed Pi shared that the World Psychiatric Association World Congress of Psychiatry is scheduled for October 8-12, 2017 in Berlin, Germany. It also shared that there was a meeting about a month ago between WPA leadership and the Asian Association of Mental Health in Abu Dhabi which discussed, in part, the classification of dementia in the ICD-11 beta draft revision. While it seems that dementia will not be reclassified as previously notified, these groups are still monitoring the revision as it moves forward. Dr. Michelle Riba shared that WPA leadership is participating in an upcoming meeting in Lithuania and that the WPA Nominations Committee is also meeting there. After this meeting the slate of candidates for the upcoming WPA Elections, though it was mentioned that Drs. Edgard Belfort of Argentina and Afzal Javed of Pakistan, both sitting Secretaries on the WPA Executive Committee, are set to run as candidates for President-Elect. It was also noted that Dr. Wolfgang Gaebel of Germany was not expected to run for President-Elect. It was shared that the weights of votes puts the United States at a disadvantage. Council members asked how they can support Dr. Riba's candidacy and she noted that it would be important to connect with the respective delegates for each voting organization, which is the president. Several Council members shared that it be worthwhile to develop a campaign committee and strategy to determine areas of strength and weakness. It was also noted that many delegates will be present at the APA Annual Meeting and that it would be important to form a personal connection with each of the voting presidents and to confirm that they will be the voting delegate come October.

APA Annual Meeting

The Council discussed the agenda for their in person May meeting during the Annual Meeting noting that it would be good to invite the International Distinguished Fellows being recognized at the Annual Meeting. It was also suggested that Dr. Milton Wainberg should be invited as he is recently involved in coordinating grant funded mental health research in Sub-Saharan Africa. It was also suggested that the leadership of the Assembly Caucus of International Medical Graduates be invited to the Council meeting as well. APA staff will follow up with each of the invited individuals to see if they are available to attend the Council meeting in San Diego.

APA COUNCIL ON MEDICAL EDUCATION AND LIFELONG LEARNING
Report to the JRC

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.

Referral Update:

Referral from the JRC: 1981 position statement -
"Confidentiality of Medical Records: Does the Physician Have a Right to Privacy Concerning His or Her Own Health Records". Sent to the Council by the JRC. Should the 1981 position on confidentiality be retired? Does the 2015 statement "Position Statement on Inquiries about Diagnosis and Treatment of Mental Disorders in Connection with Professional Credentialing and Licensing" sufficiently replace it?

Council Report back to the JRC:
The council reviewed the 1981 statement and the 2015 statement. The Council sees much similarity in the content in the 2015 position statement. However, the Council noted that the 1981 position statement explicitly addresses the question of keeping existing medical records confidential. While this is implied in the 2015 position statement by limiting the scope of questions asked by licensing boards and credentialing organizations, it is not addressed specifically.

The Council on Medical Education and Lifelong Learning would be supportive of a new position statement on the confidentiality of physician medical records, or an amendment to the 2015 position statement noted above, but the Council does not feel that they are the appropriate body to draft this document. Experts in ethics and medical-legal issues around confidentiality would be better equipped to understand the issues. This is an issue for all psychiatrists, not just trainees, and as such requires a broader scope of expertise than exists within the Council on Medical Education.

Members of the Council also reviewed other APA position statements indexed under the term "confidentiality" and reported that only these two position statements were relevant to the discussion.

Information Items

Oversight of the APA CME Program - The Council has General Oversight of the APA CME program in support of lifelong Learning.
The American Psychiatric Association was awarded Accreditation with Commendation in November 2016 by the Accreditation Council for Continuing Medical Education (ACCME).
APA's commendation status recognizes the efforts APA is making around quality improvement, innovation, standardization, and partnership within our education program.

ACCME introduced new criteria for commendation. The new criteria encourage and reward accredited CME providers for implementing best practices in pedagogy, engagement, evaluation, and change management and for focusing on generating meaningful outcomes. The new commendation criteria will recognize the achievements of organizations that advance interprofessional collaborative practice, address public health priorities, create behavioral change, show leadership, leverage educational technology, and demonstrate the impact of education on health care professionals and patients.

Joint Sponsorship Continuing Medical Education Program - With input from the Council on Medical Education and Lifelong Learning, APA has expanded the Joint Sponsorship of Continuing Medical Education credit program to Allied Associates: New Jersey District Branch of AACAP, ADMSEP, Cohens Veterans Network, and UC Davis- Train New Trainers Primary Care Psychiatry Fellowship Program. In 2016, in its annual report to ACCME, APA reported 57 jointly provided activities, providing a significant service to its District Branches and Allied Associate partners.

Personal Learning Project Tool - The Council continues its work to develop an educational tool, *Personal Learning Project Tool*, based on the Canadian Model introduced at the 2016 Education Summit of the Council. The tool would provide members with a mechanism to earn CME credit and meet MOC requirements for self-directed learning projects directly related to practice and improvement. Members of the council had consensus regarding features of the tool: Record my clinical questions as part of practice based learning activity; Record my learning activities based on clinical practice; Document my practice based learning for MOC requirements. The Personal Learning Project activity could be published in FOCUS and credit would be documented through the online education center, education.psychiatry.org as a pilot program with next steps of building an app. The personal Learning Project Beta program can be viewed at: http://apapsy.ch/plp

Caucus on Maintenance of Certification issues

The APA's Caucus on Maintenance of Certification exists under the purview of the Council on Medical Education and Lifelong Learning. The Caucus, under the leadership of Dr. Viswanathan, organized a meeting of the Caucus on MOC at the Annual Meeting. Approximately 15 people were in attendance, including APA Leadership (BOT - Dr Viswanathan, Dr Muskin, and Dr Everett; CMELL - Dr Rapaport), members of the APA Administration (Dr Gorrindo and Dr Wang), members of the ABPN staff and Board of Directors for Psychiatry (Dr Faulkner, Ms Vondrak, Dr Thomas, Dr Keepers), and approximately 6 general members of the APA. A respectful discussion took place regarding the current MOC system. Members continued to express concern regarding MOC fees, the relevance of the MOC exam, alternative pathways for MOC examination, and the relevance/importance of the MOC-4 activities.

Forum on Subspecialty Recruitment

The Council participated in the Forum on Subspecialty Recruitment organized by Council on Psychosomatic Medicine on May 23, 2017.

Attachments:

1981 Position Statement
2015 Position Statement
Minutes of the Council on Medical Education and Lifelong Learning, May 20, 2017 with reports from Allied Education groups: ABPN, AADPRT, ADMSEP, and APA Division of Education

COUNCIL ON MEDICAL EDUCATION AND LIFELONG LEARNING MAY 20, 2017
APA Annual Meeting
Marriott Marquis San Diego Marina,
Mission Hills Room

Minutes
COUNCIL ON MEDICAL EDUCATION AND LIFELONG LEARNING

Attendance:
Mark Hyman Rapaport, M.D. – Chairperson
Marshall Forstein, M.D. – Vice Chair
Lynneice Bowen, M.D. – APAF/Diversity Leadership Fellow
Sandra De Jong, M.D., AADPRT, Corresponding Member
Benoit Dube, M.D., Member
Linda Drozdowicz, M.D. – APAF/Leadership Fellow
Larry R. Faulkner, M.D. – ABPN, Corresponding Member
Ondria C. Gleason, M.D. – AACDP, Corresponding Member
Rashad Hardaway, M.D., APAF/Diversity Leadership Fellow
Justin Hunt, M.D., Member
Tony Hu, M.D. Corresponding Member
Erick Kwan Jo Hung, M.D., Member
Venkata B. Kolli, M.D., Consultant
M. Philip Luber, M.D., Corresponding Member
Laura Pientka, D.O. – APAF/Leadership Fellow
Lisette Rodriguez-Cabezas, M.D. – APAF/SAMHSA Fellow
Edward Kenneth Silberman, M.D., Member
John Spollen, M.D. – ADMSEP, Corresponding Member
Richard Summers, M.D., Corresponding Member
Christopher R. Thomas, M.D., Member
Jose P. Vito, M.D., Member
Melinda Young, M.D., Member

APA Administration:
Tristan Gorrindo, M.D.
Kristen Moeller

Not Attending:
Rashi Aggarwal, M.D., Member
Nicole Albrecht, M.D. – APAF/Diversity Leadership Fellow
Ashley Curry, M.D. – APAF/Public Psychiatry Fellow
Steven Fischel, MD, Member
Claudine Jones-Bourne, M.D. – APAF/Diversity Leadership Fellow
Erica Lubliner, M.D. – APAF/Diversity Leadership Fellow
Stefania Prendes-Alvarez, M.D., M.P.H. – APAF/SAMHSA Fellow

Welcome and Appreciation
Mark Rapaport M.D., welcomed the group. Certificates of Appreciation were distributed to outgoing members.

Visit from APA CEO and Medical Director - Saul Levin, M.D., M.P.H., Medical director and CEO visited the Council.

Allied Groups updated the Council on their activities related to the work of the council.

ABPN	Larry Faulkner, M.D. (Attachment)
AADPRT	Sandra De Jong, M.D. (Attachment)
AAP	Amin Azzam, M.D. (Attachment)
AACDP	Ondria Gleason, M.D.
ADMSEP	John Spollen, M.D.

Personal Learning Project – Chris Thomas, M.D., The group accessed and used the beta model personal learning project

http://apapsy.ch/plp

Feedback Survey Project – Marshall Forstein, M.D. provided an update on the Feedback Project. Next steps will be to finalize the survey with the small group. Dr. Hu and Dr. Drozdowicz will join the sub-group working on the feedback project.

General Discussion of Maintenance of Certification

- importance of MOC to be relevant
- use of MOC for licensing and hospital privileges

Referral from the JRC: 1981 position statement - Venkata Kolli, M.D., Mark Rapaport, M.D.(attachments)

Question from the JRC

"Confidentiality of Medical Records: Does the Physician Have a Right to Privacy Concerning His or Her Own Health Records". Sent to the Council by the JRC. Should the 1981 position on confidentiality be retired? Does the 2015 statement "Position Statement on Inquiries about Diagnosis and Treatment of Mental Disorders in connection with Professional Credentialing and Licensing" sufficiently replace it.

Council to Report back to the JRC:

The council reviewed the 1981 statement and the 2015 statement. The Council sees much similarity in the content in the 2015 position statement. However, the Council noted that the 1981 position statement explicitly addresses the question of keeping existing medical records confidential. While this is implied in the 2015 position statement by limiting the scope of questions asked by licensing boards and credentialing organizations, it is not addressed specifically.

The Council on Medical Education and Lifelong Learning would be supportive of a new position statement on the confidentiality of physician medical records, or an amendment to the 2015 position statement noted above, but the Council does not feel that they are the appropriate body to draft this document. Experts in ethics and medical-legal issues around confidentiality

would be better equipped to understand the issues. This is an issue for all psychiatrists, not just trainees, and as such requires a broader scope of expertise than exists within the Council on Medical Education.

Venkata Kolli, M.D., reviewed other APA position statements indexed under the term "confidentiality" and reported that only these two position statements were relevant to the discussion.

Division of Education
Tristan Gorrindo provided an update on Division of Education activities (attachment) and innovation such as collaborative care training; the Psych Pro registry and how data from the registry could be a documented assessment of what psychiatrists do in practice.

Council Considerations for 2017 and 2018

MOC
Workforce development
Physician Wellness

Reminders

Forum on Subspecialty Recruitment - representatives from the Council to attend this meeting – a Multi-Council meeting to discuss fellowship recruitment.

Caucus on Maintenance of Certification Issues

The Council Will Meet During Fall Component Meetings
September 13-16, 2017
Hilton Crystal City at Washington Reagan National Airport.

American Board of Psychiatry and Neurology, Inc.

MEMORANDUM

TO: APA CMELL Report

FROM: Larry R. Faulkner, M.D.
President and CEO

DATE: May 2017
SUBJECT: ABPN Report

1. New ABPN Directors

   - Dr. Imran Ali, from University of Toledo was elected to replace Dr. Noor Pirzada on January 1, 2017.
   - Dr. Josepha Cheong from University of Florida was elected to replace Dr. Kailie Shaw on January 1, 2017.

2. Certification Fees

   Candidate certification fees were decreased by 12% in 2008 (No increase in 2006, 2007, 2009, 2010, 2011, or 2012), were decreased another 10% in 2013 and another 7% in 2014, remained the same in 2015, were decreased 5% in 2016, will remain the same in 2017, and will be decreased 5% in 2018

3. Combined Training

   The ABPN established an Alternative Pathway Program Oversight Committee to develop policies and procedures for the approval and review of combined training programs and to update guidelines for existing combined programs. To date, 34 combined training programs involving psychiatry have been approved and 2 new applications are under consideration.

   The ABPN also decided to assume the supervision of the Post Pediatric Portal Programs (PPPPs) beginning in 2016. To date, 4 PPPPs have been approved and 1 new application is under consideration.

4. ABPN Faculty Fellowship

The ABPN established a Faculty Innovation in Education Program (Faculty Fellowship Program) to promote innovative education and/or evaluation initiatives for psychiatry and neurology residents or practitioners. Four psychiatry and four neurology faculty will be supported per year. Each ABPN Fellow will receive $50,000 per year for two years. Three new ABPN Faculty Fellows were selected in October, 2016.

5. ABPN Senior Resident Administrative Fellowship

The ABPN established a Senior Resident Administrative Fellowship for one senior psychiatry resident and one senior neurology resident each year. Fellows will spend three months at the ABPN office under the direct supervision of the President and CEO and will learn about the structure and function of the ABPN, complete a research project of their choice, participate in a weekly administrative seminar, and accompany the President and CEO to professional meetings. Salary (if necessary) and living and travel expenses will be paid by the ABPN. The third ABPN Fellows were selected for the 2016-2017 year in December, 2015.

6. ABPN Crucial Issues Forums

The ABPN decided to fund a series of Crucial Issues Forums during which representatives from various professional organizations and perspectives will discuss important issues pertinent to the ABPN. The first ABPN Crucial Issues Forum on Subspecialties was held on April 6-7, 2014; the second ABPN Crucial Issues Forum on Resident Competence Requirements was held on May 3-4, 2015; and the third ABPN Crucial Issues Forum on MOC was held on April 10-11, 2016. An ABPN Crucial Issues Forum on Physician Wellness and Burnout was held on April 9-10, 2017 and focused on the following issues:

- Drivers of Physician Wellness and Burnout
- The Role of Medical Schools, Residencies, and Certifying Boards in promoting Physician Wellness and Preventing Burnout
- The Role of Specialty Societies in Promoting Physician Wellness and Preventing Burnout

7. ABPN Research Award Program

The ABPN has established a Research Award Program to promote research pertinent to the mission of the ABPN. Four $100,000 research awards will be granted each year (two in psychiatry and two in neurology) to academic faculty who are diplomates of the ABPN. Three Research Awardees were selected in October 2016 for funding in 2017.

8. Continuous MOC Program

    - Began for diplomates certified or recertified in 2012.
    - No end date on certificate.
    - Requirements for Continuous MOC:
        - Unrestricted medical license(s)
        - Cognitive examination every 10 years
        - Specific MOC activities every 3 years
            - 24 CME hours of Self-assessment activities
            - 90 CME hours (includes the 24 SA CME)
            - 1 PIP Unit (Clinical and Feedback Modules)
    - Annual registration on the ABPN Folio.
    - Annual MOC fee ($175 for 2016).
        - No additional fee for one MOC cognitive examination in 10 years.

9. MOC Credit for Diplomate Activities

    - "Meaningful participation" in the ABMS Portfolio Program (1 PIP credit).
    - Completion of ACGME-accredited subspecialty fellowship and passing ABPN subspecialty examination (3 years of MOC credit).
    - Completion of institutional QI activities that fulfill ABPN MOC Part 4 requirements.
    - Completion of professional society QI activities that fulfill ABPN MOC Part 4 requirements (e.g., registries).
    - Completion of MOC Part IV activities of other Member Boards.
    - Participation in special accredited programs with QI activities (e.g., Stroke Centers) for Part 4 Credit.
    - Participation in relevant JCAHO OPPE activities for Part 4 credit.
    - Completion of international MOC activities (e.g., RCPS-C) that meet ABPN requirements.

10. ABPN Non-CME Self-assessment Activities

    ABPN diplomates may now have 8 SA CME credits waived for completing one of the following activities:
    - Certification/MOC examination
    - Peer reviewed grant
    - Peer reviewed scientific paper
    - Non-CME patient safety SA
    - Peer supervision (4 hours)
    - Peer review committee review

    A maximum of 16 SA CME credits may be waived every 3 years.

11. ABPN MOC Feedback Modules Now May Provide Part 4 Credit

    ABPN dipomates may complete Feedback Modules to earn Part 4 credit. Diplomates may choose one of the following types of feedback activities to complete every 3 years:
    - Patient Surveys (at least 5 patients selected by diplomate)
    - Peer Surveys (of General Competencies)*
    - Institutional Peer Review (of General Competencies)*
    - Supervisor Evaluation (of General Competencies)
    - Resident Evaluations (of General Competencies)*
    - 360˚ Evaluation (of General Competencies)*

      *Must include at least 5 evaluators

12. ABPN Patient Safety Course Requirements

    - Part of the 2015 ABMS MOC Standards.
    - Begins for diplomates certified or recertified in 2016.
    - Diplomates must complete an ABPN-approved Patient Safety Course in the 3 years prior to certification or in the first 3-year period of the Continuous MOC Program.
    - Patient Safety Courses must include didactic information, questions, and performance feedback.
        - Must include Required Topics and Optional Topics (See ABPN website).
        - May or may not earn CME credits.
    - Non-CME Patient Safety Courses must be administered by accredited institutions (e.g., hospitals, clinics, training programs).
        - ABPN will accept any patient safety activity developed by accredited institutions.

13. Options for MOC Part III

    The ABPN is considering two options to its general MOC Examinations:
    - Modular MOC Examinations in which diplomates can opt to complete a module of 50 subspecialty questions in addition to 150 general questions.
    - Self-assessment examinations passed in each 3-Year CMOC block in lieu of the general MOC Examination.

    Additional Board discussion will be necessary before a final decision will be made about permitting one or both of these options.

14. Double Counting PGY-4 for Subspecialty Training (in addition to CAP)

    Opinions about this issue from psychiatry and neurology organizations are mixed. The ABPN has decided that no changes in policy will be made pending a more in-depth discussion.

15. Requirement for ABPN Subspecialists (Other than CAP) to Maintain Primary Certification

    A clear majority of psychiatry and neurology organizations favor maintaining the current ABPN policy of requiring ABPN subspecialists (other than CAP) to maintain their primary certification. The ABPN has decided that no change in policy will be made at this time.

16. Recognition of AOA Training

    The ABPN has decided that it will recognize any training completed in AOA-accredited programs as long as the residents graduate from ACGME-accredited programs.

LRF/atk

American Association of Directors of Psychiatric Residency Training

PO BOX 30618
Indianapolis IN 46230

May 12, 2017

Dear Members of the APA Council on Medical Education and Lifelong Learning:

Thank you for the opportunity to share with you the activities of the American Association of Directors of Psychiatry Residency Training. As you know, our mission is "to promote excellence in the education and training of future psychiatrists," and we view APA CMELL as an important partner in this effort. Our very successful 2017 Annual Meeting took place on March 8-11, 2017, at the Hilton San Francisco Union Square. The 2018 Annual Meeting will be in New Orleans Feb. 28-March 3.

Current initiatives:

1. Resident Wellness. In the wake of burgeoning concerns about physician wellness and burnout, in 2016 President Art Walaszek established a Taskforce on Resident Wellness chaired by Heather Vestal, MD. The revised ACGME Common Program Requirements, effective July 1, 2017, include a section on resident wellness (e.g., 24/7 access to mental health evaluation), and underscore the importance of this topic. To date Taskforce members have conducted a Resident Wellness Survey of the AADPRT membership (report forthcoming); completed an inventory of similar initiatives among other specialty organizations (including President Everett's APA taskforce); begun to compile a resident wellness toolkit; participated in a Presidential Symposium on Resident Wellness at the AADPRT Annual Meeting; and attended the ACGME Symposium on Physician Wellbeing and the ABPN Crucial Issues Forum on Physician Wellness and Burnout. In March 2017, the Taskforce was reappointed for another year.

2. Faculty Development. Deb Cowley, MD, chairs our Faculty Development Task Force. A joint symposium was held at AAP in September 2016. The Taskforce conducted a survey of AADPRT members in November 2016. Results included 70% reporting burnout in teaching faculty and 63% in themselves; strong interest in workshops on how to implement a faculty development program (83.7%); lack of time for teaching, education and scholarship, as well as the 24/7 nature of the job and high workload and low pay as some of the identified barriers to seeking careers in GME.

3. Virtual Training Office (VTO). AADPRT's website has historically been a repository for curricula, assessment instruments, and administrative tools for residency training directors. In 2015, we launched our new website. After a vetting and reorganization process, the VTO is now up and running, and we will continue to use it as a platform for dissemination.

4. PGY4 and Fast Tracking. After conducting two membership surveys, AADPRT has taken a position in favor of permitting subspecialty fellowship fast-tracking into only Child/Adolescent Psychiatry (CAP), and not psychosomatics, forensics or addictions. However, AADPRT believes some additional important questions need to be addressed: How should training director assess readiness for a PGY3 to fast-track into CAP? What is the best educational use of the PGY4 year? What are "best practices" for PGY4 training? A PGY4 Taskforce was established in 2016, chaired by Adrienne Bentman, MD, to examine these questions.

American Association of Directors of Psychiatric Residency Training

5. Entrustable Professional Activities, Milestones, and Assessment. We are now in the third year of milestones/sub-competency implementation for general psychiatry residencies, and in the second year for fellowships. Our EPA Task Force and CAP Milestones Task Forces worked on disseminating best practices in these areas. Our ACGME Liaison Committee has initiated regular phone calls with the leadership of the ACGME Psychiatry Review Committee to raise and address concerns related to ACGME requirements. Given the ongoing importance of assessment in GME, in March 2017, AADPRT's Executive Council voted to create a new Assessment Committee into which these previously existing taskforces will be subsumed. John Q. Young, MD, is the chair.

6. Residency Recruitment. We have seen a welcome but challenging increase in the number of applicants to Psychiatry residencies. A "Skills Fair" workshop at our Annual Meeting focused on how to help Training Directors cope. NRMP reports psychiatry offered 1,495 PGY1 positions (up by 111 since 2016), and all except four (99.7%) filled. NRMP has noted a decrease in both US citizen and non-citizen IMG applicants (down by 430 in all specialties), although psychiatry remains in the top 5 preferred specialties for IMGs. Our Recruitment Committee is surveying our members in the near future regarding areas of concern in the recruitment process.

7. National Neuroscience Curriculum Initiative (NNCI). We continue to support and serve as a platform for NNCI, which presents the day-long BRAIN conference during each Annual Meeting. NNCI, an NIH-funded program, is in the process of creating comprehensive resources to help train psychiatry residents and psychiatrists in modern neuroscience, specifically integration into clinical practice. Pursuing ongoing funding is a current focus of interest.

8. IMG Issues. In the context of the executive orders for travel bans issued by President Trump, AADPRT, Art Walaszek and the IMG Caucus (Consuela Cagande, MD, Chair) sponsored a Presidential Symposium to highlight the particular needs of IMGs and resources to support them. Invited guests included Tristan Gorrindo from APA and Eleanor Fitzpatrick from the Educational Commission for Foreign Medical Graduates (ECFMG). Resources from that symposium are posted on the AADPRT website. We expect this to be a continued area of focus for us.

9. Addictions. In March 2017, as my presidential initiative and in the context of the national addictions crisis, AADPRT approved an Addictions Taskforce chaired by Ann Schwartz, MD. The Taskforce will be a group of AADPRT members working to improve addictions training in residencies and CAP fellowships. An Advisory Board consisting of representatives from APA, AAAP, AACAP and ADMSEP provides ongoing consultation. The tasks of this group are:
   - To learn (through surveys, regional rep meetings, etc.) what training programs need in order to implement expert recommendations on addictions training and identify ways to meet those needs
   - To use this data to develop a strategic plan for improving addictions training, including an outline of a developmental approach across training to the acquisition of milestones-based competencies that apply to addictions assessment and treatment
   - To provide a clearing-house for existing educational resources and a platform for disseminating them
   - To develop educational modules that turn content into dynamic, interactive adult-learning sessions
   - To offer "train the trainer" sessions at our Annual Meeting

We thank you for the continued opportunity to work with APA CMELL on the critical task of training future psychiatrists.

Sincerely,

Sandra DeJong, MD

Sandra DeJong, MD, MSc
President, AADPRT

Confidentiality of Medical Records: Does the Physician Have a Right to Privacy Concerning His or Her Own Health Records ?

POSITION STATEMENT

Approved by the Board of Trustees, December 1980
Approved by the Assembly, May 1981

"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.*

Prepared by the Task Force on the Impaired Physician[*] of the Council on Medical Education and Career Development.

It has been proposed that physicians (and students aspiring to become physicians) have a special duty to the public which can only be discharged by requiring that the physician's own health record, especially information pertaining to the physician's mental health, be exposed to the scrutiny of those who oversee the quality of medical care or the fitness of individuals to practice medicine. This supposed duty of disclosure is said to arise from the special role physicians have in society and the vulnerability of the public to potential harm from inept, malicious, or otherwise dangerous doctors. This role also places a burden on those who select physicians and scrutinize their performance so that the public interest is adequately safeguarded. This raises the general question, Does the expectation of medical confidentiality extend to the physician's own health records when the physician is a patient?

The short answer to this question is, No convincing argument has been advanced to show that a patient should be deprived of the right to the privacy of his or her medical record simply because he or she has chosen to study or practice medicine.

The traditional privacy of communications between a patient and his or her physician rests on the judgment that society benefits when sick people have unimpeded access to necessary medical treatment. This expectation of medical confidentiality is reflected in medical ethics (1), contract law (2), and the common law (3) and has been enacted into statutory law in a majority (N=36) of jurisdictions (4).[**] Recently, a federal district court found that the right to privacy of medical records has a Constitutional basis (5). We have been unable to find laws that except physicians from these protections when they become ill and seek treatment.

In attempting to balance the danger to the public from mental disorders in physicians against the rights of all patients to privacy, we believe that the reasonable protection of patients does not require the assumption that anyone who is or who has been a psychiatric patient is potentially so harmful to patients that he or she cannot practice medicine without first presenting his or her otherwise private medical record for public scrutiny. There is no evidence to suggest that the hazard is so great that normal safeguards are inadequate. Moreover, there is, in our view, a greater danger that individuals needing treatment will be barred from obtaining professional help if getting it would require them to bare their innermost secrets to public or private overseers. More likely, they would try to conceal the need and continue to practice without diagnosis and treatment for what might be curable ills.

---

[*]The Task Force (now a committee) included Robert E. Jones, M.D. (chairperson), Manuel M. Pearson, M.D., Stephen Scheiber, M.D., Douglas A. Sargent, M.D., and Robert Marvin, M.D. (Assembly liaison).

[**]As of February 1983, 42 states plus the District of Columbia had enacted psychotherapist-patient privilege statutes. The authority is the case of Zuniga v. Pierce (714 Federal Reporter 2d, 632-642, 1983).

The American Psychiatric Association is a national medical specialty society, founded in 1844, whose 36,500 physician members specialize in the diagnosis and treatment of mental and emotional illnesses and substance use disorders.

The American Psychiatric Association
1400 K Street NW • Washington, D.C. 20005
Telephone: (888) 357-7924 • Fax: (202) 682-6850 • Email: apa@psych.org

The competition for admission to medical school is severe and begins early. If it were to become generally known that potential physicians who had consulted psychiatrists or other mental health professionals would be required to disclose that fact in the medical school application process, many needing treatment either would not get it or would conceal the fact, viewing a “psychiatric history” as an impediment to acceptance. Further, as Silver and associates (6) have shown, there are no data correlating psychiatric diagnosis and treatment with performance in medical school or practice.

What is true for medical students is even more likely in the case of the practicing physician, who stands to lose his or her means of livelihood, cannot easily change a career already launched, and does not have the student's option of simply choosing not to enter medicine rather than have his or her secrets known. Recent experience with “snitch laws” in New York and elsewhere (7) suggests that this fear of disclosure is real and not merely theoretical, confirming Slovenko's suggestion (8) that mental disorder is today's “loathsome disease,” the analogue of those socially impairing conditions that first led to the development of the physician-patient privilege. Citing Eldridge's *The Law of Defamation*, Slovenko said,

Surveys indicate that the general public regards a person seeking a psychiatrist with fear, distrust, or dislike. The public generally acts differently toward a psychiatric patient. This is reflected in the law of defamation where it is provided that a statement that a person is mentally ill is an “imputation of want of ability to discharge the duties of that person's ... profession ...” and thus slander on its face.

It is no comfort to the disturbed medical student or physician that the public's prejudices may not be shared by medical school admissions committees or medical practice boards, especially since experience suggests that physicians share the public view of psychiatry and our patients. Far from protecting the public, it is likely that abolition of the confidentiality of the physician's or medical student's personal health record would simply discourage troubled people, many with treatable disorders, from finding appropriate medical help and would hamper those who try to help them. We are naturally concerned, since we believe that such an impaired individual is far more likely to endanger patients than would be the case if medical treatment were a private matter for medical practitioners as it is for others.

Medical schools, hospitals, licensure boards, and other regulatory bodies seeking to know whether a history of medical or psychiatric disorder impairs present functioning are advised to do so on a case-by-case basis, as such a history has little predictive value. A medical psychiatric evaluation by a consultant hired for the purpose of determining present competence should be obtained for evaluating applicants whose fitness is questioned and who have given voluntary, informed consent. Such evaluations should be made only for cause and should not be routinely required of all applicants.

In short, the mandatory disclosure of the physician's confidential medical or personal history is without merit.

Both tradition and public policy, as reflected in the laws of privacy, favor access to therapy for all who need it, including physicians. The supposedly heightened protections for patients sought by those who would exclude physicians from the traditional safeguards of medical confidentiality are illusions. We urge support for the traditional view and oppose forced disclosure, which seems to promise more benefit than we think it can deliver.

1. American Medical Association Judicial Council: Section 9, in Principles of Medical Ethics. Chicago, AMA, 1969
2. Horne v Patton, 287 S 2d 824 (Ala S Ct 1974)
3. Warren SD, Brandeis S: The right to privacy. Harvard Law Review 4:193, 1890
4. Slovenko R: Psychotherapist-patient testimonial privilege: a picture of misguided hope. Catholic University Law Review 23:649-673, 1974
5. Hawaiian Psychiatric Society, District Branch, American Psychiatric Association v Ariyoshi, 481 S Supt 1028, 1052 (D Hawaii 1979)
6. Silver LB, Nadelson CC, Joseph EJ, et al: Mental health of medical school applicants: the role of the admissions committee. J Med Educ 54:534-538, 1979
7. Block MA: Disabled physician: rehabilitation versus punishment. NY State J Med 79:1025-1028, 1979
8. Slovenko R: Accountability and abuse of confidentiality in the practice of psychiatry. Int J Law Psychiatry 2:431-454, 1979

The American Psychiatric Association • 1400 K Street NW • Washington, D.C. 20005
Telephone: (888) 357-7924 • Fax: (202) 682-6850 • Email: apa@psych.org

APA Official Actions

Position Statement on Inquiries about Diagnosis and Treatment of Mental Disorders in Connection with Professional Credentialing and Licensing

Approved by the Board of Trustees, July 2015
Approved by the Assembly, May 2015

"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:
The APA recognizes the important role served by licensing boards, institutional privileging committees, insurance credentialing panels, and other entities charged with protecting the public from impaired physicians, attorneys, and other licensees. In discharging their responsibilities, these entities legitimately may inquire about current functional impairment in professional conduct and, when relevant, current general medical or mental disorders that may be associated with such impairment. However, the APA believes that prior diagnosis and treatment of a mental disorder are, *per se*, not relevant to the question of current impairment and that oversight entities should not include questions about past diagnosis and treatment of a mental disorder as a component of a general screening inquiry.

APA Position Statement:
The APA recommends the following principles to guide licensing boards and other regulatory agencies, and training programs.

1. **General screening inquiries about past diagnosis and treatment of mental disorders are overbroad and discriminatory and should be avoided altogether. A past history of work impairment, but not a report of past treatment or leaves of absence, may be requested.**
2. **The salient concern for licensing entities is always the professional's current capacity to function and/or current functional impairment. Questions on application forms should inquire only about the conditions that currently impair the applicant's capacity to function as a licensee, and that are relevant to present practice. As examples of questions that might be asked, the following are suggested:**
   Question: Are you currently using narcotics, drugs, or intoxicating liquors to such an extent that your ability to practice [law / medicine / other profession] in a competent, ethical and professional manner would be impaired? (Yes/No)
   Question: Are you currently suffering from any condition that impairs your judgment or that would otherwise adversely affect your ability to practice [law / medicine / other profession] in a competent, ethical and professional manner? (Yes/No)

3. **If a relevant impairment of functioning has been acknowledged by the applicant or documented by other sources, inquiries about mental health treatment may be appropriate for the sole purpose of understanding current functioning and future performance.**
4. **If conduct that would otherwise provide grounds for denial or revocation of a professional license or privileges has been documented or acknowledged by the applicant, it would also be appropriate to ask the applicant whether a disorder or condition was raised to explain that conduct.**
5. **Applicants must be informed of the potential for public disclosure of any information they provide on applications.**

Authors: Council on Psychiatry and the Law.
Written by Richard Bonnie, Paul Appelbaum, and Patricia Recupero.

Background

Professional licensing agencies have traditionally made wide-ranging inquiries into applicants' past psychiatric histories. Although the passage of the Americans with Disabilities Act in 1990 raised serious doubts about the legality of these inquiries, licensing agencies have been reluctant to abandon them, notwithstanding official statements disapproving them by the American Bar Association in 1994[1] and the American Psychiatric Association in 1997. The issue has recently received renewed attention in the press, in the legal literature and in the courts. Against this backdrop, the Department of Justice's Civil Rights Division launched a formal investigation of Louisiana's attorney licensure system in 2011, culminating in a settlement agreement in August, 2014.[2] The provisions of this agreement significantly clarify the position of the Justice Department regarding the scope and type of questions about mental health histories and current condition that may be used in professional licensing inquiries. In light of these developments, it is likely that responsible licensing and privileging agencies will be reconsidering their current practices. This Position Statement is designed to summarize the key principles that ought to guide these agencies as they review their questionnaires and protocols.

The APA's Position Statement is congruent, in principle, with the 1994 Resolution adopted on this subject by the American Bar Association, which states:

BE IT RESOLVED, That the American Bar Association recommends that when making character and fitness determinations for the purpose of bar admission, state and territorial bar examiners, in carrying out their responsibilities to the public to admit only qualified applicants worthy of the public trust, should consider the privacy concerns of bar admission applicants, tailor questions concerning mental health and treatment narrowly in order to elicit information about current fitness to practice law, and take steps to ensure that their processes do not discourage those who would benefit from seeking professional assistance with personal problems and issues of mental health from doing so.

BE IT FURTHER RESOLVED, That fitness determinations may include specific, targeted questions about an applicant's behavior, conduct or any current impairment of the applicant's ability to practice law.

The prefatory paragraph of the APA's Position Statement briefly reaffirms the basic anti-discrimination principle that lies at the heart of the ADA. Overly broad inquiries about past behavioral health treatment discriminate against applicants by: making overbroad and unwarranted inquiries regarding applicants' behavioral health diagnoses and treatment; subjecting applicants to burdensome supplemental investigations triggered by their behavioral health status or treatment; making unwarranted licensure or admissions recommendations based on stereotypes of persons with disabilities; imposing additional financial burdens on people with disabilities; failing to provide adequate confidentiality protections during the licensing or admissions process; and implementing burdensome, intrusive, and unnecessary conditions on licensure or admissions that are improperly based on individuals' behavioral health diagnoses or treatment.

The APA's Position Statement enunciates 5 principles:

- The first principle declares that open-ended inquiries about past mental health diagnosis and treatment, or proxy questions pertaining to leaves of absence, are unacceptable. The DOJ-Louisiana Settlement Agreement acknowledges this principle.

- The second principle declares that inquiries about the person's current mental and physical condition are acceptable if and only if they relate to the person's current capacity to carry out professional functions. The illustrative questions are similar to the questions used by the National Conference of Bar Examiners and were specifically endorsed in the DOJ-Louisiana

Settlement Agreement. The meaning of "current" condition is not defined in the Settlement Agreement or the APA Position Statement.

- The third and fourth principles are designed to address the limited circumstances under which licensing agencies may inquire about past mental health history and treatment. They may do so only when they are exploring the current and future significance of past impairments of functioning or misconduct documented in the record or acknowledged by the applicant. The kinds of questions that would be compatible with these principles are illustrated in paragraph 14 of the DOJ-Louisiana Settlement Agreement which specifically endorses question 27 on the National Conference of Bar Examiners questionnaire:

  27. Within the past five years, have you engaged in any conduct that:
  (1) resulted in an arrest, discipline, sanction or warning;
  (2) resulted in termination or suspension from school or employment;
  (3) resulted in loss or suspension of any license;
  (4) resulted in any inquiry, any investigation, or any administrative or judicial proceeding by an employer, educational institution, government agency, professional organization, or licensing authority, or in connection with an employment disciplinary or termination procedure; or
  (5) endangered the safety of others, breached fiduciary obligations, or constituted a violation of workplace or academic conduct rules?
  If so, provide a complete explanation and include all defenses or claims that you offered in mitigation or as an explanation for your conduct.

- The fifth principle is designed to assure that applicants are advised of the circumstances under which information obtained during the agency's inquiry are accessible to the public

---

[1] ABA Bar Admissions Resolution, 18 Mental and Physical Disability Law Reporter 597 (1994)

[2]Settlement Agreement Between the United States of America and the Louisiana Supreme Court under the Americans with Disabilities Act, August 13, 2014, http://www.ada.gov/louisiana-supreme-court_sa.htm

AMERICAN PSYCHIATRIC ASSOCIATION
Education

To: **Council on Medical Education and Lifelong Learning**
From: **Tristan Gorrindo, MD | Director, Division of Education**
Date: **05/03/2017**
Re: **Update on American Psychiatric Association Activities**

The American Psychiatric Association (APA) remains committed to supporting the education and training needs of our members and the educators that foster the next generation of psychiatrists. Below, we outline a number of policies and initiatives that work towards that goal.

General Updates

- APA received "**Accreditation with Commendation**" from the Accreditation Council for Continuing Medical Education (ACCME). This is the highest level of distinction given by the ACCME and speaks to the quality and value of the roughly 350,000 of CME credit awarded by the APA each year.

- A summary of APA's accredited activities is shown below:

Type of Activity Directly Provided	**Activities**	**Hours of Instruction**	**Physician Participants**	**Other Learners**
Course	20	143.50	8,221	2,141
Internet Live Course	22	34.50	1,412	1,950
Test Item Writing	1	10.00	2	0
Internet Activity Enduring Material	175	828.75	21,440	1,064
Enduring Material	11	216.00	1,945	37
Journal-based CME	46	160.00	7,130	100
Manuscript Review	3	9.00	120	21
Sub-total Directly Provided	**278**	**1,401.75**	**40,270**	**5,313**
Type of Activity Jointly Provided	**Activities**	**Hours of Instruction**	**Physician Participants**	**Other Learners**
Course	57	349.00	3,422	818
Sub-total Jointly Provided	57	349.00	3,422	818
Total for all activities	**335**	**1,750.75**	**43,692**	**6,131**

- We continue to bring new learning opportunities to our live meetings. At the APA's **2017 Annual Meeting in San Diego,** we will feature additional learning formats and new ways for attendees to connect and engage. These new opportunities include a mystery-based

experiential learning lab, a novel “treatment-lab”, an EduTour to the Naval Medical Center San Diego Balboa Base and *USNS Mercy* hospital ship, expansion of our learning lab opportunities, and the launch of the APA’s Mental Health Innovation Zone. The Innovation Zone is dedicated to answering the question "What is next in technology?" and serves as the premiere showcase and catalyst for the advancement of new mental health technologies. We will also be launching a rebooted version of the “monitors” program called the “APA Scholar Program” which will allow trainees to register for the meeting at no cost in exchange for their assistance in gathering formative feedback for faculty.

- The Division of Education is working with APA Publishing to launch several new features as part of ***Focus: The Journal of Lifelong Learning***. While the journal will continue to provide a program of lifelong learning and offer MOC and CME credit for subscribers, new features are being added to the journal to broaden its perspective beyond a focus on a specific topic. New features include a section entitled *The Applied Armamentarium*, which focuses on changes in treatment; a column called the *21st Century Psychiatrist,* which focuses on changes in systems of care; and a *Year In Review* highlighting the most promising breakthroughs in the psychiatric literature. *Focus* is currently seeking submissions within the new sections. Details can be found at Focus.psychiatryonline.org.

- **Expanded access to training in the collaborative care model:** In collaborating with the AIMS Center at the University of Washington, the APA exceeded its year one training goals for training residents and practicing psychiatrists in the collaborative care model. The APA has trained over 1,300 psychiatrists and scores of primary care physicians in the collaborative care model during the last 12 months and is currently providing a virtual learning collaborative and technical assistance in implementing the model. Additionally, the APA’s efforts to support the development of payment codes has yielded three new collaborative care codes from CMS, which went into effect on January 2, 2017. This reduces a major barrier for the implementation of this model nationally. Participation in the learning collaborative fulfills specific MOC requirements and may also be used toward MACRA/MIPS improvement activity fulfillment.

- The **APA's PsychPRO registry** has become an approved clinical data registry (CDR). Participation in PsychPRO will help psychiatrists meet federal MIPS reporting requirements and MOC requirements and will assist them in improving their own practice through dynamic and evidence-based dashboards. So far we have engaged with 6 systems/institutions and 200+ individuals as we roll out the registry.

- **APA Learning Center:** In December 2015, the Membership and Education departments began a free-CME opportunity for all APA members. Each month, a new online course is promoted to members, which they could complete for Category 1 CME credit. To date, 13 courses have launched, and thousands of members have taken advantage of this benefit. In total, the APA Learning Center has over 200 educational offerings. In Q4 of 2016, 24,000+ users visited the APA Learning Center. Looking ahead, we plan to launch a multi-part suicide assessment course designed to meet the evolving patient safety requirements in many states. We also plan to

launch a revised buprenorphine training course and a companion book to accompany the course.

- In 2016, the APA's Board of Trustees approved an **expansion of the Joint Sponsorship CME program**. We are currently using the expanded program to support our affiliated groups, such as the Association of Directors of Medical Student Education in Psychiatry (ADMSEP) and other organizations by providing low-cost CME accreditation for their meetings.

- In November 2016, the APA responded to Dr. Nasca's request for comment on common program requirements. The APA used this opportunity to underscore the importance of resident wellness. The APA asked that the ACGME consider requiring residency programs to inform residents of how to access confidential mental health and substance use treatment services within their institutions and/or with off-campus clinicians, and that the ACGME consider a formal wellness-focused curricular requirement.

- The APA collaborated with the Association of Medicine and Psychiatry to develop the APA's first **massive open online course (MOOC)** focusing on preventive medical care skills for psychiatrists. The MOOC allowed learners the opportunity to connect with experts through professor office hours, peer-to-peer engagement, and one-week staggered content designed to maximize retention of presented information.

- In 2016, the APA's Board of Trustees approved an **expansion of the Joint Sponsorship CME program**. We are currently using the expanded program to support our affiliated groups, such as the Association of Directors of Medical Student Education in Psychiatry (ADMSEP) by providing low-cost CME accreditation for their annual meeting.

- The APA would like to extend congratulations to the **2017 Vestermark Award winner, Sandra Sexson**. She will be presenting her award lecture at the APA Annual Meeting in San Diego.

Association for Academic Psychiatry

562 S. Hillcrest Avenue
Elmhurst, IL 60126
www.academicpsychiatry.org

phone 770/222.2265
fax 866/884.6103
lhedrick@academicpsychiatry.org

Report to APA Council on Medical Education & Lifelong Learning

Dear APA CMELL Council:

It is a pleasure to update your committee on the work of the Association for Academic Psychiatry (AAP) over the past year. Here are the relevant highlights:

1. **Academic Psychiatry governance letter**: Along with our sister organizations ADMSEP, AACDP, AADPRT, we received a letter from the governance board of *Academic Psychiatry* to develop a longitudinally-sustainable fiscal model to maintain the journal. In partnership with the presidents of these three organizations, we crafted a joint response that proportionately distributes expenses across our organizations. It is our hope this will set us on a path towards sustained growth for the journal and our members.

2. **Signatory organization to the AAMC statement on US President Trump's Executive Order on Immigration**: Along with nearly 70 other health-related organizations, the AAP signed the AAMC- initiated joint letter to president Trump regarding potential unintended impacts of the January 27th Executive Order on Immigration. We additionally crafted our own AAP Position Statement on this issue.

3. **AAP Annual Meeting**

   a. The AAP Annual Meeting will take place September 6 – 9 in Denver, Colorado. Our theme this year is "*High Stakes, Higher Hopes for Psychiatric Education*." We have had a record number of submissions and anticipate a large turnout. Meeting highlights include the following:
      i. *Master Educator Certificate*: meeting participants have the option to pursue the AAP Master Educator certificate
      ii. *Keynote*: Our keynote speaker will be James Heilman, MD, speaking about the "*Wikiproject Medicine*" community within the larger Wikipedia movement.
      iii. *Plenary*: Our plenary speaker Jonathan Bolton, MD will speak about "*Climbing to Higher Ground: Finding your meaning as an educator*."
      iv. *Workshops*: there will be over 50 interactive workshops covering a spectrum of faculty & educator development topics.
      v. *AAP Presidential Book Club*: we are inaugurating an AAP book club discussion, this year focusing on "*Fun Home—a Family Tragicomic*" by Allison Bechtel.

vi. *U. Colorado Anschutz campus tour*: In partnership with the Department of Psychiatry at the University of Colorado, Denver, we will offer a free campus tour for AAP meeting participants to learn about opportunities within the department.

4. **Awards**: We continue our annual tradition of honoring excellence in psychiatric education across the career spectrum through the following awards:
   a. Psychiatric Education Award **(*note nomination deadline has been extended to June 15*)**
   b. Roberts Award for Mentorship
   c. AAP Lifetime Achievement
   d. Distinguished Fellow
   e. Early Career Educator Award
   f. Fellowship Award
   g. Medical Student Essay Contest

   More information about our awards—including past awardees & nomination process—can be found at our website: http://www.academicpsychiatry.org/

5. **Technology Adoption**: We are moving ahead with embracing a number of technology-related elements as follows:

a. Beginning at our fall 2017 Annual Meeting we will use a meeting app for managing all aspects of the meeting.
b. We will increase the effort dedicated to live-tweeting at our Annual Meeting.
c. We've moved our administrative infrastructure to a cloud-based system through an AAP subscription to Box.
d. We have initiated a call for proposals to revamp our website, with a target completion of fall 2018.

Thanks for the opportunity to share our relevant efforts. We stand in mutual commitment to educate future generations of mental health professionals.

Best,

Amin Azzam, MD, MA
AAP President

Item JRC 8.I
Joint Reference Committee
June 2017

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) support an expansion of the Council's meeting to 1.5 days and invite an Assembly Representative of each M/UR Caucuses (or the Assembly Representative can designate the Deputy Representative or President of the Caucus) to attend 2017 September Components meeting of CMMH/HD at APA expense? This would be a one-time basis, with an evaluation.

ACTION: Will the JRC recommend that the Assembly approve the Position Statement on "Domestic Violence Against Women?"

ACTION: Will the JRC recommend that the Assembly approve the Position Statement on the "Prevention of Violence?"

ACTION: Will the JRC recommend that the Assembly approve the Position Statement on "Religious Discrimination, Persecution, and Genocide?"

ACTION: Will the JRC recommend that the Assembly approve the Position Statement on "Human Trafficking?"

Information Items

Financial Support for M/UR Assembly Representatives to attend 2017 September Components

1. **Reasons for Attending**

- During the 2017 Annual Meeting at *Conversations on Diversity*—a session sponsored by APA's Division of Diversity and Health Equity (DDHE)—there were several recommendations raised to improve diversity and inclusivity in APA. These included proposed action items to enhance collaborations among M/UR Caucuses and CMMH/HD.
- Generate the "APA Toolkit on Stress and Trauma related to the Political and Social Environment." CMMH/HD and M/UR Committee leadership believe the inclusion of M/UR Caucus leadership would be important to synergize this effort. In addition to monthly meetings and work that CMMH/HD and M/UR Caucuses are doing together prior to the 2017 September Components meeting, these small workgroups could help finalize the toolkit.
- Given APA's desire to diversify and increase APA membership, M/UR Caucus leadership, and CMMH/HD would work collaboratively to recommend feasible action steps to diversify and increase APA membership.

2. **Outcomes**
   - A prioritized list of recommendations from the 2017 Annual Meeting session titled, *Conversations on Diversity* will be created.
   - "APA Toolkit on Stress and Trauma related to the Political and Social Environment" nearly finalized by October 2017.
   - An action plan with specific, pragmatic, and feasible steps for increasing APA membership from key APA Allied groups, such as Black Psychiatrists of American (BPA) and The Association of LGBTQ Psychiatrists (AGLP)
   - At least 4 workshops or symposium, co-sponsored by CMMH/HD and M/UR will be submitted for the APA Annual Meeting in New York City.

3. **Cost Estimate**
   - DDHE, the division responsible for funding, estimates that the cost of providing financial support for 7 M/UR Assembly Representatives would total $10,000.00.

If the outcomes are successful, CMMH/HD and members of the M/UR groups would like the APA leadership to consider repeating this pilot.

This action item has been reviewed and approved by the M/UR Committee Chair and all M/UR Caucuses.

Conversations on Diversity

At the 2016 September Components meeting, some CMMH/HD members and M/UR Caucus members described concern that systemic racism was not adequately addressed in the organization and that several Black APA members had become distrustful of the organization.

To address this issue, DDHE facilitated conversations about diversity and inclusion at APA 2017 Annual Meeting that involved CMMH/HD members, M/UR Caucus members, and APA leadership. DDHE restructured its *Conversations on Diversity* session to strategize ways to increase diversity and inclusion within APA. A total of 55 people attended which included representation from M/UR groups, CMMH/HD and APA leadership. *Conversations on Diversity will continue at* APA IPS 2017.

Renaming the APA Human Rights Award to the Chester M. Pierce Human Rights Award
The idea was brought forward by the members of the Council on International Psychiatry, CMMH/HD, and the Caucus of Black Psychiatrists (BPA). The objective of the award is to recognize Dr. Pierce's contributions to the field of psychiatry. APA staff liaisons met with leadership components of the nominating organizations including APA Governance and DDHE staffs to finalize selection process. The slate of Selection Committee recommendations await approval by APA's President-Elect.

APA Toolkit: Stress and Trauma related to the Political and Social Environment
CMMH/HD, DDHE, APA Communications, in collaboration with the Office of the Medical Director, is developing a toolkit and educational resource for patients, consumers, and providers in regard to stress and trauma related to the current state of the political and social environment in U.S. The toolkit aligns with CMMH/HD's mission of creating resources that focuses on diversity and inclusion. Several workgroups, consisting of members from M/UR Caucuses and CMMH/HD, were formed to develop this resource. DDHE will continue to provide staff support. CMMH/HD leadership anticipates content completion by October 2017.

Improving Mental Health of M/UR Communities Through Production of Academic Publications and Op Eds.
Members of CMMH/HD expressed the need to develop publications that focus on topics related to structural racism and immigration. In addition, CMMH/HD members want to receive some training from people with expertise on op-eds to amplify their voice (some APA members have this expertise). CMMH/HD will discuss more at the September Components.

M/UR Recruitment Strategy
CMMH/HD, Membership Committee, and APA Membership Department and DDHE are working to develop a strategy to better target M/UR groups in response to CMMH/HD's concern that the number of M/UR members is decreasing. The strategic plan will be presented to the BOT for approval by Fall 2017.

Council on Minority Mental Health and Health Disparities

May Meeting

Sunday, May 21, 2017 01:00 – 04:00 p.m. (PST)

Santa Rosa, Level 1, Marriott Marquis San Diego Marina

Roll Call

Present:

1. Christina Mangurian, MD (Chair)
2. Helena Hansen, MD (Vice Chair)
3. Felix Torres, MD (ASM)
4. Debbie Carter, MD
5. Christine Crawford, MD (APAF/SAMHSA Fellow)
6. Lauren Douglas, MD (APAF/Diversity Leadership Fellow)
7. Jai Gandhi, MD (APAF/SAMHSA Fellow)
8. Amanda Graves, MD
9. Keith Hermanstyne, MD
10. Francis Lu, MD
11. Travis Meadows, MD (APAF/Diversity Leadership Fellow)
12. Jessica Moore, MD (APAF/SAMHSA Fellow)
13. Carine Nzodom, MD (APAF/Diversity Leadership Fellow)
14. Evita Rocha, MD (APAF/SAMHSA Fellow)
15. Mary Roessel, MD (Corresponding Member)
16. Samra Sahlu, MD (APAF/Diversity Leadership Fellow)
17. Puneet Sahota, MD (APAF/SAMHSA Fellow)

Staff:

1. Ranna Parekh, MD
2. Vabren Watts, PHD
3. Omar Davis, CAPM

Absent:

1. Matthew Dominguez, MD (APAF/SAMHSA Fellow)
2. Tatiana Falcone, MD (Consultant)
3. Sidney Hankerson, MD (ECP)
4. Elizabeth Horstmann, MD

Excused Absence:

1. Evaristo Akerele, MD (Consultant)
2. Enrico Castillo, MD
3. Amy Gajaria, MD (APAF/Public Psychiatry Fellow)
4. Donald Williams, MD

Guests:

1. Saul Levin, MD, CEO and Medical Director, APA
2. Jeffrey Regan, Federal Relations, APA
3. Ijeoma Chukwu, MD
4. Russell Lim, MD
5. Rachna Dayal, MD
6. Emanuel Demissie (Howard Program Student)
7. Rajae Gayle (Howard Program Student)
8. Norman Harris II (Howard Program Student)

Agenda

I. Review of important events
   a. Caucus meetings
   b. M/UR award lectures
   c. Council Workshops/Symposium
   d. Reception for Dr. Altha Stewart

II. Review of progress over past year
   e. Position Statement list
   f. Liaisons
   g. Dr. Altha Stewart's historic election
   h. Plan for M/UR awards for next cycle

III. APA Division of Government Relations (DGR) Update & Council Brainstorming
   i. APA Toolkit: Stress and Trauma Related to the Political and Social Environment
   j. Academic papers
   k. Op-eds

II. A Tribute to Dr. Brian Benton

III. Break

IV. DDHE Report

V. Council/Caucus liaison reports

VI. Presentation of Certificates for departing members
VII. Visitors (Drs. Levin and Everett)
VIII. Closing Remarks

Minutes of the Meeting

I. Review of important events

a. Caucus Meetings
    i. Dr. Mangurian mentioned the conflict with ongoing M/UR Caucus meetings and asked all liaisons to debrief CMMH/HD on caucus related activity towards the end of the council meeting.
b. M/UR award lectures
    i. Mr. Davis highlighted M/UR awards presentations and lectures, and encouraged all members to support. (M/UR Award nominations are due June 30)
c. Council Workshops/Symposium
    i. Members promoted various member-led sessions such as *Conversations on Diversity*, sponsored by APA Division of Diversity and Health Equity (DDHE)
    ii. Dr. Mangurian described Dr. Alta Stewart's reception and the historic significance of her election as the APA's first African-American female President-elect

II. Dr. Mangurian thanked CMMH/HD for their work on Position Statements

a. CMMH/HD reviewed and voted to retain the following Position Statements:
    i. Affirmative Action (McMillan, M. et al. 1977)
    ii. Discrimination Against International Medical Graduates (APA. 2001)
    iii. Discrimination Against Persons with Previous Psychiatric Treatment (Council on Psychiatry and Law. 1977)
    iv. Diversity (APA. 1999)
    v. Psychiatrists from Underrepresented Groups in Leadership Roles (Robinson, G. et al. 1994)
    vi. Resolution against Racism and Racial Discrimination and Their Adverse Impacts on Mental Health (Walker, S. et al. 2006)
    vii. Resolution Opposing Restriction on Number of International Medical Graduates (IMGs) Entering Graduate Medical Training (APA. 1994)
b. CMMH/HD reviewed and revised the following Position Statements:
    i. Abortion (Futterman, E. et al. 1978)
    ii. Prevention of Violence (APA. 2007)

iii. Religious Persecution and Genocide (APA. 1977)

c. CMMH/HD reviewed and retired the following Position Statement:
   i. US Military Policy of Don't Ask Don't Tell (2009)
   ii. A workgroup consisting of members of the Board of Trustees, CMMH/HD, Council on Children, Adolescents and Their Families, and the Council on International Psychiatry was formed to develop a Position Statement on Human Trafficking. The Position Statement will be presented to the JRC for approval by June.
      1. Workgroup members included:
         a. Board of Trustees (Vivian Pender, M.D.)
         b. CMMH/HD (Amy Gajaria, M.D., Carine Nzodom, M.D., Mary Roessel, M.D., and Ludmilla de Faria, M.D. [past member])
         c. Council on International Psychiatry (Michelle Riba, M.D.)
         d. Council on Children, Adolescents and Their Families (Carlos Fernandez, M.D.)

III. Dr. Mangurian welcomed the three Howard Program Students and encouraged them to contribute to the conversation

IV. Action Paper and Position Statement on Climate Change and Mental Health

a. Dr. Robin Cooper (Guest) revisited an Action Paper on Climate Change and Mental Health. The paper originated out of CMMH/HD and now being considered for a Position Statement. The Position Statement would recognize that APA understands the profound impact of climate change. The topic needs to be expanded to vulnerable minority populations which are severely impacted. To this end, Dr. Cooper would like to create a caucus on climate change to tackle this important issue and has asked for volunteers. Dr. Vivian Pender was instrumental in bringing this topic to the forefront.

V. APA Division of Government Relations (DGR) Update & Council Brainstorming

a. APA Toolkit: Stress and Trauma Related to the Social and Political Environment
   i. A sense of crisis over racism, immigration, etc. prompted the birth of this Toolkit. It will provide practitioners with tools to help patients impacted by discrimination. Several members volunteered to share narratives. Resources will be housed on APA website. Volunteers have organized by subgroups. First drafts are due by July 1st.
   ii. The resource will be developed by psychiatrists for psychiatrists.
   iii. It was suggested that these resources will need to highlight age differences and generational issues. Members agree that wording may be

somewhat challenging. A draft will be sent out to the group for feedback to address any challenges.

iv. The resource will be streamlined and easy to read. DDHE will distribute the template. Dr. Mary Roessel offered to send a sample of what she has done with the American-Indian population.

b. Op-eds and Academic Papers
    i. Stemming from the February CMMH/HD meeting, Dr. Hansen continues to seek narratives that describe ways that practitioners have observed stress and trauma in patients that is related to the social and political environment. For example, immigrant families are going underground, pulling students out of school, individuals are not showing up for services, etc. All of this is impacting mental health. An op-ed featured in a notable publication can reach a mass of readers.
    ii. Members volunteered to learn more about writing op-eds. Dr. Hansen will work with them to secure op-ed trainers
    iii. Members expressed concern that the current administration does not care about minority/underserved patients.
c. DGR update by Jeff Reagan, Director, Federal Relations
    i. All members are encouraged to get involved with APA's opposition to the American Health Care Act (AHCA) of 2017
    ii. The House bill in its current form is disastrous as it replaces tax subsidies with tax credits, dismantles Medicaid limits and payments to the states. It is estimated that 24 million people are expected to lose coverage while 7.5 million could lose mental health coverage.
    iii. Every physicians' group opposed it.
    iv. The Senate has begun conversations to draft a new bill and APA are actively engaging members. APA has created a diverse coalition to tackle this challenge.
    v. Members are encouraged to become active in both their local and federal settings. Mr. Reagan will send info on how each member can get actively involved. Remember, personal narratives from members are important. APA will unveil their new political strategy over the next week. Dr. Mangurian asked members to think about donating to APA's PAC.
    vi. Mr. Reagan announced the selection of Dr. Sabin Bera as the 2017-2018 Jeanne Spurlock Congressional fellow. Efforts are underway to identify suitable offices for her to serve out her fellowship.

VI. A Tribute to Dr. Brian Benton

a. Dr. Mary Roessel commented that he was Cherokee and apart of the American-Indian, Alaska Native and Native Hawaiian Psychiatrists Caucus. He was very involved in the Assembly and a great advocate for the caucus.
b. Dr. Mangurian led the council in a moment of silence after Dr. Roessel's remarks

VII. DDHE Update

a. APA/APAF Fellowship programs are thriving.
    i. Increase in the number of applicants
    ii. Increase in the number of HBCU applicants
        1. Number of 2016 applicants: 5
        2. Number of 2017 applicants: 10
    iii. Applicant pool increased from 165 to 173, from 2015 to 2017.
    iv. Dr. Watts noted that DDHE did not receive any applicants from the following states: Montana, Oklahoma, North Dakota, Idaho and Alaska.
    v. DDHE will work with District Branches to increase geographical diversity and need support from CMMH/HD to do so.
b. DDHE is recruiting mentors for the recently launched Mentorship Program for APA/APAF Fellows
c. Other programs currently underway are as follows
    i. Mental Health Disparities Program in Appalachia
    ii. Howard Pilot Program
    iii. LGBTQ Mental Health Disparities Program for Medical Students/Residents

VIII. Dr. Levin's remarks

a. Dr. Levin mentioned that diversity is one of APA's key strategic initiatives. APA relies on CMMH/HD for its expertise on diversity. Sometimes the Board of Trustees (BOT) doesn't know how to respond to certain issues around diversity so CMMH/HD must be relied upon. He encouraged CMMH/HD not to wait for the BOT to respond to issues.
b. Dr. Levin thanked CMMH/HD and DDHE staff for its work on the toolkit and tasked members with helping majority members – white men – to become culturally competent.
c. He also encouraged members to become actively involved in the political conversation.

Position Statements:

"Domestic Violence Against Women"

Following on a referral by the JRC, in Spring 2017 members of CMMH/HD combined and revised Position Statements on "Domestic Violence" and "Domestic Violence Against Women" in accordance with APA's 5-year review cycle. Background document and Position Statement are attached.

"Prevention of Violence"

Following on a referral by the JRC, in Spring 2017 members of CMMH/HD combined and revised Position Statements on "Prevention of Violence" and "Violence in America Can and Must Be

Prevented: A Call for Action from Medicine Nursing and Public Health" in accordance with APA's 5-year review cycle. Background document and Position Statement are attached.

"Religious Discrimination, Persecution, and Genocide"

Following on a referral by the JRC, in Spring 2017 members of CMMH/HD revised the Position Statement on "Religious, Persecution, and Genocide" in accordance with APA's 5-year review cycle. The above referenced Action Item recommends inserting the word "Discrimination," which places emphasis on the unjust treatment of religious groups. Background document and Position Statement are attached.

"Human Trafficking"

As directed by the Office of the Medical Director, CMMH/HD has formed a workgroup consisting of members of the Board of Trustees, CMMH/HD, Council on Children, Adolescents and Their Families, and the Council on International Psychiatry developed a Position Statement on "Human Trafficking" in Spring 2017. Background document and Position Statement are attached.

Position Statement on Domestic Violence Against Women

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:

The American Psychiatric Association (APA) recognizes the major psychological sequelae of domestic violence against women and as such strongly advocates prevention and better detection of domestic violence against women, improve treatment of victims, offenders, and children, and continued research into the causes, consequences, and prevention of such violence. In addition, the APA recommends that its members learn about the prevention of domestic violence and that psychiatrists:

1. Participate in the formulation and implementation of protocols for the identification of family violence
2. Have knowledge of applicable laws concerning reporting of domestic violence and protection of victims.
3. Participate with local, state, and national government and advocacy agencies which support advocacy for increased funding for the prevention, recognition, protection, and treatment of victims and perpetrators of domestic violence and children exposed to domestic violence.
4. Participation in multidisciplinary research efforts on the mental health effects and service needs of those exposed to domestic violence and of those who perpetrate domestic violence
5. Plan and implement psychiatric education on domestic violence prevention, identification, and rehabilitation for medical students, residents, and physicians.

Background on Domestic Violence Against Women

Domestic violence against women is an extensive and pervasive problem in our society. Such violence includes physical harm, distraction of property, and marital rape. Estimates are that one out of three women have been victims of physical violence by an intimate partner in their lifetime [1]. In United States, anywhere from 2 to 4 million women are abused each year. Women are more likely to be assaulted, raped, or killed by their partners or ex-partners then by any stranger. Victims are found in all age, ethnic, religious, socioeconomic, sexual orientation, and educational groups. There's a high correlation between substance abuse and the occurrence of such violence.

Domestic violence against women has serious consequences. It is estimated that 37% of women who visit hospital emergency departments are there for symptoms of ongoing abuse [2]. 55% of the women murdered in the United States were killed by their partner or ex-partner [3]. Domestic violence also leads to serious psychological consequences, including anxiety, depression, suicide, dramatic stress disorder, and substance abuse. In addition, domestic violence against women has a serious impact on children, who are more likely to have social and educational problems. Boys who grow up in households where women are battered are more likely to become abusers themselves, whereas girls are more likely to end up in abusive relationships.

*In 2017, the APA Council of Minority Mental Health and Health Disparities merged two position statements ("Domestic Violence" and "Domestic Violence against Women") and updated with recent data.

1. National Coalition Against Domestic Violence. *Statistics*. 2017 [cited 2017 May 5]; Available from: http://ncadv.org/learn-more/statistics.
2. National Network to End Domestic Violence. *Emergency Rooms Screening for Domestic Violence*. 2017 [cited 2017 May 5]; Available from: http://dcsafe.org/2013/02/emergency-rooms-screening-for-domestic-violence/.
3. Bureau of Justice Statistics. *Female Victims of Violence*. 2009 [cited 2017 May 5]; Available from: https://www.bjs.gov/content/pub/pdf/fvv.pdf.

APA Official Actions

Position Statement on the Prevention of Violence

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*

Issue:
Psychiatry has a public health role related to the prevention of violence. The prevention/reduction of abuse, trauma and violence and sophisticated approaches to intervention are part of the mission of the profession.

The psychiatrist must take a leadership role in the prevention, diagnosis, and treatment of victims and perpetrators of violence.

Position:
The APA should support primary, secondary and tertiary approaches to the prevention of violence and should advocate for the education of trainees and practicing psychiatrists about violence prevention.

Background Information on the Role of Psychiatrists in Prevention of Violence

The APA reaffirms its commitment to the recommendations of the *Commission for the Prevention of Youth Violence* December 2000* as delineated below:

"It is time for health professionals to take their place in the growing violence prevention movement – time to join with educators, judges, lawyers, social workers, police, community activists, clergy, and others in taking a firm stand against the violence that is devastating families and communities throughout this country.

With our combined knowledge and voices, we must mobilize a violence prevention movement to overcome those factors that place children, youth, and families at risk for violence and capitalize on factors that promote healthy development and resilience such as close parental bonds, safe and stable communities, and good consistent health and mental health care. More school suspensions and more prisons are not the answer. The answer, rooted in public health, is prevention.

Together we must find the will and the way to:

- Support the development of healthy families
- Promote healthy communities
- Enhance services for early identification and intervention for children, youth, and families at risk for or involved in violence
- Increase access to health and mental health care services
- Reduce access to and availability of guns for children and youth
- Reduce exposure to media violence
- Ensure national support and advocacy for solutions to violence through research, public policy, legislation, and funding"

**The Commission for the Prevention of Youth Violence:*

American Academy of Child and Adolescent Psychiatry;
American Academy of Family Physicians;
American Academy of Pediatricians;
American College of Physicians-American Society of Internal Medicine;
American Medical Association;
American Medical Association Alliance;
American Nurses Association;
American Psychiatric Association;
American Public Health Association;
US Department of Health and Human Services.

Position Statement on Religious Discrimination, 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 any national, ethnic, racial, or religious 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 religious discrimination, persecution, and genocide as well as potential treatment strategies to ameliorate these traumas.

Background on Religious Discrimination, Persecution and Genocide

Religious discrimination, persecution, and genocide pose serious threats to the mental health of large groups of people in the world today. Discrimination and persecution are key risk factors 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, 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
- 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]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

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.)

Background on Human Trafficking

The US Department of State defines human trafficking as the "act of recruiting, harboring, transporting, providing, or obtaining a person for forced labor or commercial sex acts through the use of force, fraud, or coercion"[1]. The International Labor Organization estimates that almost 21 million people are victims of forced labor of which 11.4 million are women and girls and 9.5 million are men and boys[2]. There is limited data on the percentage of LGBTQ individuals affected by human trafficking, however these communities are particularly vulnerable to traffickers as many of these individuals are marginalized in their countries of origin [3].

Individuals are exploited through several means such as: commercial sex, domestic servitude, forced manual labor, and forced criminality. Some of the most at risk populations for human trafficking in North America include Native American communities, individuals with disabilities, non-citizens, homeless youth, under-resourced communities, and LGBTQ individuals[4,5,6].

The Federal Bureau of Investigation "has acknowledged human trafficking as the fastest-growing business of organized crime and the third-largest criminal enterprise in the world"[7]. This is a difficult to describe population as most of human trafficking happens underground, and it is unclear how accurately the identified cases represent those cases that have not been identified. Of those cases in the United States identified by the US Department of justice, 80% are sex trafficking and 10% are labor trafficking. Sex trafficking victims tend to be born in the United States (80% domestic born), and 95% of labor trafficking victims tend to be born internationally [8].

Moreover, there are high rates of mental health diagnoses in this population with studies indicating that trafficked populations have a high incidence of PTSD and depressive symptoms with recurrent thoughts of events being as high as 75% and feeling as if the individual did not have a future as high as 65%[9]. Studies have indicated that 41% of sex trafficking victims have attempted suicide and more than 30% of sex trafficked youth have self-harmed[10,11]. Early evidence shows that individuals who have been trafficked have different clinical presentations than those with other trauma[12]. While victims of human trafficking can suffer from a range of mental health problems, the most prominent and those for which there is significant research documenting their presentation tend to be anxiety disorders, mood disorders, dissociative disorders, and substance-related disorders.

Studies indicate that 28-87.8% of human trafficking victims have been seen by a medical provider while in captivity[10,13]. Identifying trafficking victims is an important opportunity to provide appropriate care and referrals and possibly helping to end their exploitation. Trafficking victims may suffer from an array of physical and psychological health issues stemming from inhumane living conditions, poor sanitation, inadequate nutrition, and poor personal hygiene. Many individuals develop severe health issues as preventative care is virtually nonexistent for sexually transmitted diseases, HIV/AIDS, unwanted pregnancies, tuberculosis, cardiovascular or

respiratory problems, infertility from chronic untreated sexually transmitted infections, unsafe abortions and in extreme cases, death from physical abuse[14].

References :

1. https://www.state.gov/j/tip/rls/tiprpt/2013/210543.htm. Accessed 04/06/2017
2. http://www.ilo.org/global/about-the-ilo/newsroom/news/WCMS_182109/lang--en/index.htm. Accessed 04/06/2017
3. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4204396/. Accessed 04/06/2017
4. https://www.state.gov/j/tip/rls/tiprpt/2014/226646.htm. Accessed 04/06/2017
5. https://www.gao.gov/products/GAO-17-325. Accessed 5/1/17
6. https://www.csvanw.org/. Accessed 5/1/17
7. https://leb.fbi.gov/2011/march/human-sex-trafficking. Accessed 04/06/2017
8. Banks, Duren, and Tracey Kyckelhahn. Characteristics of Suspected Human Trafficking Incidents, 2008-2010. Rep. US Department of Justice, Apr. 2011. Web. 15 May 2016.
9. https://aspe.hhs.gov/report/evidence-based-mental-health-treatment-victims-human-trafficking. Accessed 04/07/217
10. Lederer, Laura J., and Christopher A. Wetzel. "The Health Consequences of Sex Trafficking and Their Implications for Identifying Victims in Healthcare Facilities." *Annals of Health and Law* 23 (2014): 61-91. Print.
11. Ijadi-Maghsoodi, R., et al. (2016). "Understanding and Responding to the Needs of Commercially Sexually Exploited Youth: Recommendations for the Mental Health Provider." Child Adolesc Psychiatr Clin N Am **25**(1): 107-122.
12. Cole, J., et al. (2016). "The Trauma of Commercial Sexual Exploitation of Youth: A Comparison of CSE Victims to Sexual Abuse Victims in a Clinical Sample." J Interpers Violence **31**(1): 122-146.
13. https://www.futureswithoutviolence.org/userfiles/file/ImmigrantWomen/Turning%20Pain%20intoPower.pdf. Accessed 4/16/17
14. https://www.acf.hhs.gov/sites/default/files/orr/health_problems_seen_in_traffick_victims.pdf.Accessed 04/09/2017

Item JRC 8.I
Joint Reference Committee
June 2017

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) support an expansion of CMMH/HD's meeting to 1.5 days and invite an Assembly Representative of each M/UR Caucuses (or the Assembly Representative can designate the Deputy Representative or President of the Caucus) to attend 2017 September Components meeting at APA expense? This would be a one-time basis, with an evaluation.

ACTION: Will the JRC recommend that the Assembly approve the Position Statement on "Domestic Violence Against Women?"

ACTION: Will the JRC recommend that the Assembly approve the Position Statement on the "Prevention of Violence?"

ACTION: Will the JRC recommend that the Assembly approve the Position Statement on "Religious Discrimination, Persecution, and Genocide?"

ACTION: Will the JRC recommend that the Assembly approve the Position Statement on "Human Trafficking?"

Information Items

Financial Support for M/UR Assembly Representatives to attend 2017 September Components

1. **Reasons for Attending**

- During the 2017 Annual Meeting at *Conversations on Diversity*—a session sponsored by APA's Division of Diversity and Health Equity (DDHE)—there were several recommendations raised to improve diversity and inclusivity in APA. These included proposed action items to enhance collaborations among M/UR Caucuses and CMMH/HD.
- Generate the "APA Toolkit on Stress and Trauma related to the Political and Social Environment." CMMH/HD and M/UR Committee leadership believe the inclusion of M/UR Caucus leadership would be important to synergize this effort. In addition to monthly meetings and work that CMMH/HD and M/UR Caucuses are doing together prior to the 2017 September Components meeting, these small workgroups could help finalize the toolkit.
- Given APA's desire to diversify and increase APA membership, M/UR Caucus leadership, and CMMH/HD would work collaboratively to recommend feasible action steps to diversify and increase APA membership.

2. **Outcomes**
   - A prioritized list of recommendations from the 2017 Annual Meeting session titled, *Conversations on Diversity* will be created.
   - "APA Toolkit on Stress and Trauma related to the Political and Social Environment" nearly finalized by October 2017.
   - An action plan with specific, pragmatic, and feasible steps for increasing APA membership from key APA Allied groups, such as Black Psychiatrists of American (BPA) and The Association of LGBTQ Psychiatrists (AGLP)
   - At least 4 workshops or symposium, co-sponsored by CMMH/HD and M/UR will be submitted for the APA Annual Meeting in New York City.

3. **Cost Estimate**
   - DDHE, the division responsible for funding, estimates that costs would not only include $10,782.00 for 7 M/UR groups but also an additional $7,094.00 for CMMH/HD members. Please see below for the breakout of estimated expenditures.

	CMMH/HD Members (Est. 13)	**M/UR Assembly Members (Est. 9)**
Air/Train	500	500
Lodging (2 days)	500	500
Meals (2 days)	148	148
Ground transportation	50	50
Subtotal	15574	10782
2017 Components Budget	-8480	N/A

Total Budget Request	*7094*	*10782*

If the outcomes are successful, CMMH/HD and members of the M/UR Caucuses would like APA leadership to consider repeating this pilot.

This action item has been reviewed and approved by the M/UR Committee Chair and all M/UR Caucuses.

Conversations on Diversity

At the 2016 September Components meeting, some CMMH/HD members and M/UR Caucus members described concern that systemic racism was not adequately addressed in the organization and that several Black APA members had become distrustful of the organization. To address this issue, DDHE facilitated conversations about diversity and inclusion at APA 2017 Annual Meeting that involved CMMH/HD members, M/UR Caucus members, and APA leadership. DDHE restructured its *Conversations on Diversity* session to strategize ways to increase diversity and inclusion within APA. A total of 55 people attended which included representation from M/UR groups, CMMH/HD and APA leadership. *Conversations on Diversity* will continue at APA IPS 2017.

Renaming the APA Human Rights Award to the Chester M. Pierce Human Rights Award

The idea was brought forward by the members of the Council on International Psychiatry, CMMH/HD, and the Caucus of Black Psychiatrists (BPA). The objective of the award is to recognize Dr. Pierce's contributions to the field of psychiatry. APA staff liaisons met with leadership components of the nominating organizations including APA Governance and DDHE staffs to finalize selection process. The slate of Selection Committee recommendations await approval by APA's President-Elect.

APA Toolkit: Stress and Trauma related to the Political and Social Environment

CMMH/HD, DDHE, APA Communications, in collaboration with the Office of the Medical Director, is developing a toolkit and educational resource for patients, consumers, and providers in regard to stress and trauma related to the current state of the political and social environment in U.S. The toolkit aligns with CMMH/HD's mission of creating resources that focuses on diversity and inclusion. Several workgroups, consisting of members from M/UR Caucuses and CMMH/HD, were formed to develop this resource. DDHE will continue to provide staff support. CMMH/HD leadership anticipates content completion by October 2017.

Improving Mental Health of M/UR Communities Through Production of Academic Publications and Op Eds.

Members of CMMH/HD expressed the need to develop publications that focus on topics related to structural racism and immigration. In addition, CMMH/HD members want to receive some

training from people with expertise on op-eds to amplify their voice (some APA members have this expertise). CMMH/HD will discuss more at the September Components.

M/UR Recruitment Strategy

CMMH/HD, Membership Committee, and APA Membership Department and DDHE are working to develop a strategy to better target M/UR groups in response to CMMH/HD's concern that the number of M/UR members is decreasing. The strategic plan will be presented to the BOT for approval by Fall 2017.

AMERICAN PSYCHIATRIC ASSOCIATION

Council on Minority Mental Health and Health Disparities

May Meeting

Sunday, May 21, 2017 01:00 – 04:00 p.m. (PST)

Santa Rosa, Level 1, Marriott Marquis San Diego Marina

Roll Call

Present:

1. Christina Mangurian, MD (Chair)
2. Helena Hansen, MD (Vice Chair)
3. Felix Torres, MD (ASM)
4. Debbie Carter, MD
5. Christine Crawford, MD (APAF/SAMHSA Fellow)
6. Lauren Douglas, MD (APAF/Diversity Leadership Fellow)
7. Jai Gandhi, MD (APAF/SAMHSA Fellow)
8. Amanda Graves, MD
9. Keith Hermanstyne, MD
10. Francis Lu, MD

11. Travis Meadows, MD (APAF/Diversity Leadership Fellow)
12. Jessica Moore, MD (APAF/SAMHSA Fellow)
13. Carine Nzodom, MD (APAF/Diversity Leadership Fellow)
14. Evita Rocha, MD (APAF/SAMHSA Fellow)
15. Mary Roessel, MD (Corresponding Member)
16. Samra Sahlu, MD (APAF/Diversity Leadership Fellow)
17. Puneet Sahota, MD (APAF/SAMHSA Fellow)

Staff:

1. Ranna Parekh, MD
2. Vabren Watts, PHD
3. Omar Davis, CAPM

Absent:

1. Matthew Dominguez, MD (APAF/SAMHSA Fellow)
2. Tatiana Falcone, MD (Consultant)
3. Sidney Hankerson, MD (ECP)
4. Elizabeth Horstmann, MD

Excused Absence:

1. Evaristo Akerele, MD (Consultant)
2. Enrico Castillo, MD
3. Amy Gajaria, MD (APAF/Public Psychiatry Fellow)
4. Donald Williams, MD

Guests:

1. Saul Levin, MD, CEO and Medical Director, APA
2. Jeffrey Regan, Federal Relations, APA
3. Ijeoma Chukwu, MD
4. Russell Lim, MD
5. Rachna Dayal, MD
6. Emanuel Demissie (Howard Program Student)
7. Rajae Gayle (Howard Program Student)
8. Norman Harris II (Howard Program Student)

Agenda

I. Review of important events

a. Caucus meetings

b. M/UR award lectures
c. Council Workshops/Symposium
d. Reception for Dr. Altha Stewart

II. Review of progress over past year

e. Position Statement list
f. Liaisons
g. Dr. Altha Stewart's historic election
h. Plan for M/UR awards for next cycle

III. APA Division of Government Relations (DGR) Update & Council Brainstorming

i. APA Toolkit: Stress and Trauma Related to the Political and Social Environment
j. Academic papers
k. Op-eds

II. A Tribute to Dr. Brian Benton
III. Break
IV. DDHE Report
V. Council/Caucus liaison reports
VI. Presentation of Certificates for departing members
VII. Visitors (Drs. Levin and Everett)
VIII. Closing Remarks

Minutes of the Meeting

I. Review of important events

a. Caucus Meetings
    i. Dr. Mangurian mentioned the conflict with ongoing M/UR Caucus meetings and asked all liaisons to debrief CMMH/HD on caucus related activity towards the end of the council meeting.
b. M/UR award lectures
    i. Mr. Davis highlighted M/UR awards presentations and lectures, and encouraged all members to support. (M/UR Award nominations are due June 30)
c. Council Workshops/Symposium
    i. Members promoted various member-led sessions such as *Conversations on Diversity*, sponsored by APA Division of Diversity and Health Equity (DDHE)
    ii. Dr. Mangurian described Dr. Alta Stewart's reception and the historic significance of her election as APA's first African-American female President-elect

II. Dr. Mangurian thanked CMMH/HD for their work on Position Statements

a. CMMH/HD reviewed and voted to retain the following Position Statements:

i. Affirmative Action (McMillan, M. et al. 1977)
ii. Discrimination Against International Medical Graduates (APA. 2001)
iii. Discrimination Against Persons with Previous Psychiatric Treatment (Council on Psychiatry and Law. 1977)
iv. Diversity (APA. 1999)
v. Psychiatrists from Underrepresented Groups in Leadership Roles (Robinson, G. et al. 1994)
vi. Resolution against Racism and Racial Discrimination and Their Adverse Impacts on Mental Health (Walker, S. et al. 2006)
vii. Resolution Opposing Restriction on Number of International Medical Graduates (IMGs) Entering Graduate Medical Training (APA. 1994)

b. CMMH/HD reviewed and revised the following Position Statements:
   i. Abortion (Futterman, E. et al. 1978)
   ii. Prevention of Violence (APA. 2007)
   iii. Religious Persecution and Genocide (APA. 1977)
c. CMMH/HD reviewed and retired the following Position Statement:
   i. US Military Policy of Don't Ask Don't Tell (2009)
d. A workgroup consisting of members of the Board of Trustees, CMMH/HD, Council on Children, Adolescents and Their Families, and the Council on International Psychiatry was formed to develop a Position Statement on Human Trafficking. The Position Statement will be presented to the JRC for approval by June.
      1. Workgroup members included:
         a. Board of Trustees (Vivian Pender, M.D.)
         b. CMMH/HD (Amy Gajaria, M.D., Carine Nzodom, M.D., Mary Roessel, M.D., and Ludmilla de Faria, M.D. [past member])
         c. Council on International Psychiatry (Michelle Riba, M.D.)
         d. Council on Children, Adolescents and Their Families (Carlos Fernandez, M.D.)

III. Dr. Mangurian welcomed three Howard Program students and encouraged them to contribute to the conversation

IV. Action Paper and Position Statement on Climate Change and Mental Health

a. Dr. Robin Cooper (Guest) revisited an Action Paper on Climate Change and Mental Health. The paper originated out of CMMH/HD and is now being considered for a Position Statement. The Position Statement would recognize

that APA understands the profound impact of climate change. The topic needs to be expanded to vulnerable minority populations which are severely impacted. To this end, Dr. Cooper would like to create a caucus on climate change to tackle this important issue and has asked for volunteers. Dr. Vivian Pender was instrumental in bringing this topic to the forefront.

V. APA Division of Government Relations (DGR) Update & Council Brainstorming

a. APA Toolkit: Stress and Trauma Related to the Social and Political Environment
    i. A sense of crisis over racism, immigration, etc. prompted the birth of this Toolkit. It will provide practitioners with tools to help patients impacted by discrimination. Several members volunteered to share narratives. Resources will be housed on APA website. Volunteers have organized by subgroups. First drafts are due by July 1st.
    ii. The resource will be developed by psychiatrists for psychiatrists.
    iii. It was suggested that these resources will need to highlight age differences and generational issues. Members agree that wording may be somewhat challenging. A draft will be sent out to the group for feedback to address any challenges.
    iv. The resource will be streamlined and easy to read. DDHE will distribute the template. Dr. Mary Roessel offered to send a sample of what she has done with the American-Indian population.
b. Op-eds and Academic Papers
    i. Stemming from the February CMMH/HD meeting, Dr. Hansen continues to seek narratives that describe ways that practitioners have observed stress and trauma in patients that is related to the social and political environment. For example, immigrant families are going underground, pulling students out of school, individuals are not showing up for services, etc. All of this is impacting mental health. An op-ed featured in a notable publication can reach a mass of readers.
    ii. Members volunteered to learn more about writing op-eds. Dr. Hansen will work with them to secure op-ed trainers
c. DGR update by Jeffrey Reagan, Director, Federal Relations
    i. All members are encouraged to get involved with APA's opposition to the American Health Care Act (AHCA) of 2017
    ii. The House bill in its current form is disastrous as it replaces tax subsidies with tax credits, dismantles Medicaid limits and payments to the states. It is estimated that 24 million people are expected to lose coverage while 7.5 million could lose mental health coverage.
    iii. Every physicians' group opposed it.
    iv. The Senate has begun conversations to draft a new bill and APA are actively engaging members. APA has created a diverse coalition to tackle this challenge.

v. Members expressed concern that the current administration does not care about minority/underserved patients.
vi. Members are encouraged to become active in both their local and federal settings. Mr. Reagan will send info on how each member can get actively involved. Remember, personal narratives from members are important. APA will unveil their new political strategy over the next week. Dr. Mangurian asked members to think about donating to APA's PAC.
vii. Mr. Reagan announced the selection of Dr. Sabin Bera as the 2017-2018 Jeanne Spurlock Congressional fellow. Efforts are underway to identify suitable offices for her to serve out her fellowship.

VI. A Tribute to Dr. Brian Benton

a. Dr. Mary Roessel commented that he was Cherokee and apart of the American-Indian, Alaska Native and Native Hawaiian Caucus of Psychiatrists. He was very involved in the Assembly and a great advocate for the caucus.
b. Dr. Mangurian led the council in a moment of silence after Dr. Roessel's remarks

VII. DDHE Update

a. APA/APAF Fellowship programs are thriving.
    i. Increase in the number of applicants
    ii. Increase in the number of HBCU applicants
        1. Number of 2016 applicants: 5
        2. Number of 2017 applicants: 10
    iii. Applicant pool increased from 165 to 173, from 2015 to 2017.
    iv. Dr. Watts noted that DDHE did not receive any applicants from the following states: Montana, Oklahoma, North Dakota, Idaho and Alaska.
    v. DDHE will work with District Branches to increase geographical diversity and need support from CMMH/HD to do so.
b. DDHE is recruiting mentors for the recently launched Mentorship Program for APA/APAF Fellows
c. Other programs currently underway are as follows
    i. Mental Health Disparities Program in Appalachia
    ii. Howard Program for African American men (undergraduates) who are interested in the field of psychiatry
    iii. LGBTQ Mental Health Disparities Program for Medical Students/Residents

VIII. Dr. Levin's remarks

a. Dr. Levin mentioned that diversity is one of APA's key strategic initiatives. APA relies on CMMH/HD for its expertise on diversity. Sometimes the Board of Trustees (BOT) doesn't know how to respond to certain issues around diversity so CMMH/HD must be relied upon. He encouraged CMMH/HD not to wait for the BOT to respond to issues.

b. Dr. Levin thanked CMMH/HD and DDHE staff for its work on the toolkit and tasked members with helping majority members – white men – to become culturally competent.
c. He also encouraged members to become actively involved in the political conversation.

Position Statements:

"Domestic Violence Against Women"

Following on a referral by the JRC, in Spring 2017 members of CMMH/HD combined and revised Position Statements on "Domestic Violence" and "Domestic Violence Against Women" in accordance with APA's 5-year review cycle. Background document and Position Statement are attached.

"Prevention of Violence"

Following on a referral by the JRC, in Spring 2017 members of CMMH/HD combined and revised Position Statements on "Prevention of Violence" and "Violence in America Can and Must Be Prevented: A Call for Action from Medicine Nursing and Public Health" in accordance with APA's 5-year review cycle. Background document and Position Statement are attached.

"Religious Discrimination, Persecution, and Genocide"

Following on a referral by the JRC, in Spring 2017 members of CMMH/HD revised the Position Statement on "Religious, Persecution, and Genocide" in accordance with APA's 5-year review cycle. The above referenced Action Item recommends inserting the word "Discrimination," which places emphasis on the unjust treatment of religious groups. Background document and Position Statement are attached.

"Human Trafficking"

As directed by the Office of the Medical Director, CMMH/HD has formed a workgroup consisting of members of the Board of Trustees, CMMH/HD, Council on Children, Adolescents and Their Families, and the Council on International Psychiatry developed a Position Statement on "Human Trafficking" in Spring 2017. Background document and Position Statement are attached.

Background on Domestic Violence Against Women

Domestic violence against women is an extensive and pervasive problem in our society. Such violence includes physical harm, distraction of property, and marital rape. Estimates are that one out of three women have been victims of physical violence by an intimate partner in their lifetime [1]. In United States, anywhere from 2 to 4 million women are abused each year. Women are more likely to be assaulted, raped, or killed by their partners or ex-partners then by any stranger. Victims are found in all age, ethnic, religious, socioeconomic, sexual orientation, and educational groups. There's a high correlation between substance abuse and the occurrence of such violence.

Domestic violence against women has serious consequences. It is estimated that 37% of women who visit hospital emergency departments are there for symptoms of ongoing abuse [2]. 55% of the women murdered in the United States were killed by their partner or ex-partner [3]. Domestic violence also leads to serious psychological consequences, including anxiety, depression, suicide, dramatic stress disorder, and substance abuse. In addition, domestic violence against women has a serious impact on children, who are more likely to have social and educational problems. Boys who grow up in households where women are battered are more likely to become abusers themselves, whereas girls are more likely to end up in abusive relationships.

*In 2017, the APA Council of Minority Mental Health and Health Disparities merged two position statements ("Domestic Violence" and "Domestic Violence against Women") and updated with recent data.

1. National Coalition Against Domestic Violence. *Statistics*. 2017 [cited 2017 May 5]; Available from: http://ncadv.org/learn-more/statistics.
2. National Network to End Domestic Violence. *Emergency Rooms Screening for Domestic Violence*. 2017 [cited 2017 May 5]; Available from: http://dcsafe.org/2013/02/emergency-rooms-screening-for-domestic-violence/.
3. Bureau of Justice Statistics. *Female Victims of Violence*. 2009 [cited 2017 May 5]; Available from: https://www.bjs.gov/content/pub/pdf/fvv.pdf.

Position Statement on Domestic Violence Against Women

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:

The American Psychiatric Association (APA) recognizes the major psychological sequelae of domestic violence against women and as such strongly advocates prevention and better detection of domestic violence against women, improve treatment of victims, offenders, and children, and continued research into the causes, consequences, and prevention of such violence. In addition, the APA recommends that its members learn about the prevention of domestic violence and that psychiatrists:

1. Participate in the formulation and implementation of protocols for the identification of family violence
2. Have knowledge of applicable laws concerning reporting of domestic violence and protection of victims.
3. Participate with local, state, and national government and advocacy agencies which support advocacy for increased funding for the prevention, recognition, protection, and treatment of victims and perpetrators of domestic violence and children exposed to domestic violence.
4. Participation in multidisciplinary research efforts on the mental health effects and service needs of those exposed to domestic violence and of those who perpetrate domestic violence
5. Plan and implement psychiatric education on domestic violence prevention, identification, and rehabilitation for medical students, residents, and physicians.

Background Information on the Role of Psychiatrists in Prevention of Violence

The APA reaffirms its commitment to the recommendations of the *Commission for the Prevention of Youth Violence* December 2000* as delineated below:

"It is time for health professionals to take their place in the growing violence prevention movement – time to join with educators, judges, lawyers, social workers, police, community activists, clergy, and others in taking a firm stand against the violence that is devastating families and communities throughout this country.

With our combined knowledge and voices, we must mobilize a violence prevention movement to overcome those factors that place children, youth, and families at risk for violence and capitalize on factors that promote healthy development and resilience such as close parental bonds, safe and stable communities, and good consistent health and mental health care. More school suspensions and more prisons are not the answer. The answer, rooted in public health, is prevention.

Together we must find the will and the way to:

- Support the development of healthy families
- Promote healthy communities
- Enhance services for early identification and intervention for children, youth, and families at risk for or involved in violence
- Increase access to health and mental health care services
- Reduce access to and availability of guns for children and youth
- Reduce exposure to media violence
- Ensure national support and advocacy for solutions to violence through research, public policy, legislation, and funding"

**The Commission for the Prevention of Youth Violence:*

American Academy of Child and Adolescent Psychiatry;
American Academy of Family Physicians;
American Academy of Pediatricians;
American College of Physicians-American Society of Internal Medicine;
American Medical Association;
American Medical Association Alliance;
American Nurses Association;
American Psychiatric Association;
American Public Health Association;
US Department of Health and Human Services.

APA Official Actions

Position Statement on the Prevention of Violence

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*

Issue:
Psychiatry has a public health role related to the prevention of violence. The prevention/reduction of abuse, trauma and violence and sophisticated approaches to intervention are part of the mission of the profession.

The psychiatrist must take a leadership role in the prevention, diagnosis, and treatment of victims and perpetrators of violence.

Position:
The APA should support primary, secondary and tertiary approaches to the prevention of violence and should advocate for the education of trainees and practicing psychiatrists about violence prevention.

Background on Religious Discrimination, Persecution and Genocide

Religious discrimination, persecution, and genocide pose serious threats to the mental health of large groups of people in the world today. Discrimination and persecution are key risk factors 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, 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
- 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]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

Position Statement on Religious Discrimination, 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 any national, ethnic, racial, or religious 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 religious discrimination, persecution, and genocide as well as potential treatment strategies to ameliorate these traumas.

Background on Human Trafficking

The US Department of State defines human trafficking as the "act of recruiting, harboring, transporting, providing, or obtaining a person for forced labor or commercial sex acts through the use of force, fraud, or coercion"[1]. The International Labor Organization estimates that almost 21 million people are victims of forced labor of which 11.4 million are women and girls and 9.5 million are men and boys[2]. There is limited data on the percentage of LGBTQ individuals affected by human trafficking, however these communities are particularly vulnerable to traffickers as many of these individuals are marginalized in their countries of origin [3].

Individuals are exploited through several means such as: commercial sex, domestic servitude, forced manual labor, and forced criminality. Some of the most at risk populations for human trafficking in North America include Native American communities, individuals with disabilities, non-citizens, homeless youth, under-resourced communities, and LGBTQ individuals[4,5,6].

The Federal Bureau of Investigation "has acknowledged human trafficking as the fastest-growing business of organized crime and the third-largest criminal enterprise in the world"[7]. This is a difficult to describe population as most of human trafficking happens underground, and it is unclear how accurately the identified cases represent those cases that have not been identified. Of those cases in the United States identified by the US Department of justice, 80% are sex trafficking and 10% are labor trafficking. Sex trafficking victims tend to be born in the United States (80% domestic born), and 95% of labor trafficking victims tend to be born internationally [8].

Moreover, there are high rates of mental health diagnoses in this population with studies indicating that trafficked populations have a high incidence of PTSD and depressive symptoms with recurrent thoughts of events being as high as 75% and feeling as if the individual did not have a future as high as 65%[9]. Studies have indicated that 41% of sex trafficking victims have attempted suicide and more than 30% of sex trafficked youth have self-harmed[10,11]. Early evidence shows that individuals who have been trafficked have different clinical presentations than those with other trauma[12]. While victims of human trafficking can suffer from a range of mental health problems, the most prominent and those for which there is significant research documenting their presentation tend to be anxiety disorders, mood disorders, dissociative disorders, and substance-related disorders.

Studies indicate that 28-87.8% of human trafficking victims have been seen by a medical provider while in captivity[10,13]. Identifying trafficking victims is an important opportunity to provide appropriate care and referrals and possibly helping to end their exploitation. Trafficking victims may suffer from an array of physical and psychological health issues stemming from inhumane living conditions, poor sanitation, inadequate nutrition, and poor personal hygiene. Many individuals develop severe health issues as preventative care is virtually nonexistent for sexually transmitted diseases, HIV/AIDS, unwanted pregnancies, tuberculosis, cardiovascular or

respiratory problems, infertility from chronic untreated sexually transmitted infections, unsafe abortions and in extreme cases, death from physical abuse[14].

References :

1. https://www.state.gov/j/tip/rls/tiprpt/2013/210543.htm. Accessed 04/06/2017
2. http://www.ilo.org/global/about-the-ilo/newsroom/news/WCMS_182109/lang--en/index.htm. Accessed 04/06/2017
3. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4204396/. Accessed 04/06/2017
4. https://www.state.gov/j/tip/rls/tiprpt/2014/226646.htm. Accessed 04/06/2017
5. https://www.gao.gov/products/GAO-17-325. Accessed 5/1/17
6. https://www.csvanw.org/. Accessed 5/1/17
7. https://leb.fbi.gov/2011/march/human-sex-trafficking. Accessed 04/06/2017
8. Banks, Duren, and Tracey Kyckelhahn. Characteristics of Suspected Human Trafficking Incidents, 2008-2010. Rep. US Department of Justice, Apr. 2011. Web. 15 May 2016.
9. https://aspe.hhs.gov/report/evidence-based-mental-health-treatment-victims-human-trafficking. Accessed 04/07/217
10. Lederer, Laura J., and Christopher A. Wetzel. "The Health Consequences of Sex Trafficking and Their Implications for Identifying Victims in Healthcare Facilities." *Annals of Health and Law* 23 (2014): 61-91. Print.
11. Ijadi-Maghsoodi, R., et al. (2016). "Understanding and Responding to the Needs of Commercially Sexually Exploited Youth: Recommendations for the Mental Health Provider." Child Adolesc Psychiatr Clin N Am **25**(1): 107-122.
12. Cole, J., et al. (2016). "The Trauma of Commercial Sexual Exploitation of Youth: A Comparison of CSE Victims to Sexual Abuse Victims in a Clinical Sample." J Interpers Violence **31**(1): 122-146.
13. https://www.futureswithoutviolence.org/userfiles/file/ImmigrantWomen/Turning%20Pain%20intoPower.pdf. Accessed 4/16/17
14. https://www.acf.hhs.gov/sites/default/files/orr/health_problems_seen_in_traffick_victims.pdf.Accessed 04/09/2017

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.)

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 met in San Diego and discussed a number of topics. The draft minutes from the meeting are attached. (*Attachment #1*). The Committee on Judicial Action also held a separate meeting in San Diego.

1. **ACTION: PROPOSED POSITION STATEMENT ON POLICE INTERACTIONS WITH PERSONS WITH MENTAL ILLNESS**
   The Council on Psychiatry and Law has developed a proposed Position Statement on police interactions with persons with mental illness. (*Attachment #2*)

   Will the Joint Reference Committee approve the request of the Council to approve the proposed "Position Statement on Police Interactions with Persons with Mental Illness"?

2. **ACTION: PROPOSED RESOURCE DOCUMENT ON PHYSICIAN ASSISTED DEATH**
   The Council on Psychiatry and Law has developed a Resource Document regarding the topic of physician assisted death. (*Attachment #3*)

   Will the Joint Reference Committee approve the request of the Council to approve the proposed Resource Document "Physician Assisted Death"?

3. **ACTION: PERMISSION TO PUBLISH**
   The Council would like permission to publish in a suitable journal the proposed Resource Document "Physician Assisted Death," which has been submitted to the JRC for approval with this report.

   Will the Joint Reference Committee approve the request of the Council to grant permission to publish the proposed Resource Document "Physician Assisted Death"?

4. **ACTION: PROPOSED RETIREMENT OF POSITION STATEMENT ON REVIEW OF SENTENCES FOR JUVENILES SERVING LENGTHY MANDATORY TERMS OF IMPRISONMENT (2011)**
   The Council on Psychiatry and Law believes the existing Position Statement on Review of Sentences for Juveniles Serving Lengthy Mandatory Terms of Imprisonment (2011) (*Attachment #4*) should be replaced with a revision it has developed, in part to account for Supreme Court cases decided after the 2011 Position Statement was adopted.

   Will the Joint Reference Committee approve the request of the Council to retire the "Position Statement on Review of Sentences for Juveniles Serving Lengthy Mandatory Terms of Imprisonment" (2011)?

5. ACTION: PROPOSED POSITION STATEMENT ON LENGTHY SENTENCES WITHOUT PAROLE FOR JUVENILES

The Council on Psychiatry and Law has developed a Position Statement on lengthy sentences without parole for juveniles, which is intended to revise and replace the 2011 Position Statement. (*Attachment #5*). An explanation for the Council's reasoning is provided in the Report to the Council on Psychiatry and Law of the Workgroup on the Revision of the APA Position on the Mandatory Sentencing of Juveniles (*Attachment #6*).

Will the Joint Reference Committee approve the request of the Council to approve the proposed "Position Statement on Lengthy Sentences Without Parole for Juveniles"?

6. ACTION: APA POSITION STATEMENT REVIEW:

a. Segregation of Prisoners with Mental Illness (2012) (*Attachment #7*)

The Council believes the Position Statement is current, relevant and should be retained.

Will the Joint Reference Committee approve the request of the Council to retain the "Position Statement on Segregation of Prisoners With Mental Illness" (2012)?

b. Assessing the Risk for Violence (2012) (*Attachment #8*)

The Council believes the Position Statement is current, relevant and should be retained.

Will the Joint Reference Committee approve the request of the Council to retain the "Position Statement on Assessing the Risk for Violence" (2012)?

c. Firearms Access: Inquiries in Clinical Settings (2012) (*Attachment #9*)

The Council believes the Position Statement is current, relevant and should be retained.

Will the Joint Reference Committee approve the request of the Council to retain the "Position Statement on Firearms Access: Inquiries in Clinical Settings" (2012)?

d. Use of Jails to Hold Persons Without Criminal Charges Who Are Awaiting Civil Psychiatric Hospital Beds (2007) (*Attachment #10*)

The Council believes the Position Statement is current, relevant and should be retained.

Will the Joint Reference Committee approve the request of the Council to retain the "Position Statement on Use of Jails to Hold Persons Without Criminal Charges Who Are Awaiting Civil Psychiatric Hospital Beds" (2007)?

e. Psychiatric Services in Jails and Prisons (1988, Reaffirmed 2007) (*Attachment #11*)

The Council believes the Position Statement is necessary but that some elements of it have become outdated and need revision. The Council on Psychiatry and Law plans to draft a revised version. Until the revision can be developed, the Council believes the existing Position Statement should be retained.

Will the Joint Reference Committee approve the request of the Council to temporarily retain the "Position Statement on Psychiatric Services in Jails and Prisons" (1988, Reaffirmed 2007), pending revision by the Council on Psychiatry and Law?

f. Homicide Prevention and Gun Control

The Council considered for an additional time the Position Statement on Homicide Prevention and Gun Control (1993) (*Attachment #12*), particularly in light of the existence of the Position Statement on Firearm Access, Acts of Violence and the Relationship to Mental Illness and Mental Health Services. (2014) (*Attachment #13*). The consensus of the Council is that the 1993 Position Statement on Homicide Prevention and Gun Control should be retained, in addition to the 2014 Position Statement without change. The Council believes that the 1993 Position Statement is the only document that the APA has that affirmatively supports gun control in principle.

Will the Joint Reference Committee approve the request of the Council to retain the "Position Statement on Homicide Prevention and Gun Control" (1993)?

Informational Items:

1. **RESTRICTING FIREARMS ACCESS DURING A CRISIS**

   A workgroup, chaired by Dr. Reena Kapoor, has developed and is continuing to refine a draft guidance document regarding risk-based gun seizure laws that is intended to be helpful to District Branches and individual psychiatrists who may confront such issues.

2. **WEAPONS USE IN HOSPITAL AND PATIENT SAFETY**

   Dr. Jeff Janofsky chairs a workgroup that is continuing to work on a proposed position paper regarding use of weapons in clinical emergency room and inpatient settings.

3. **RESEARCH WITH INVOLUNTARY PATIENTS**

   Another workgroup, with Dr. Carl Fisher as its chair, is continuing work to develop a proposed position paper concerning research on involuntary psychiatric patients.

4. **PHYSICIAN HEALTH PROGRAMS WORKGROUP**

   A workgroup, chaired by Dr. Pat Recupero, is preparing a proposed resource document with the intent of providing guidance on recommended best practices for physician health programs.

5. **Psychiatric Services in Jails and Prisons (1988, Reaffirmed 2007)**

   As referred to above, the Council has formed a workgroup to revise the Position Statement on Psychiatric Services in Jails and Prisons (1988, Reaffirmed 2007).

COUNCIL ON PSYCHIATRY AND LAW

2017 APA Annual Meeting
Tuesday, May 23, 2017 | 7:00 PM – 11:00 PM
Marriott Marquis San Diego Marina, Santa Rosa, Level 1
San Diego, California

PRESENT:
Members: Steven K Hoge, MD, Chair; Stuart Anfang, MD; Peter Ash, MD; Carl Erik Fisher, MD; Richard Frierson, MD; Jeffrey Metzner, MD; Patricia Recupero, MD, JD; Robert Trestman, MD, PhD; Cheryl Wills, MD; **Corresponding Members:** Paul Appelbaum, MD; Alec Buchanan, MD, PhD; Liza Gold, MD; Debra Pinals, MD; Marvin Stanley Swartz, MD; **Legal Advisor:** Richard Bonnie, LLB; **Consultant:** David Lowenthal, MD; **Ex-Officio/AAPL:** Jeffrey Stuart Janofsky, MD; **Visiting Members from Committee on Judicial Action:** Michael Champion, MD; Robert Weinstock, MD; Howard Zonana, MD; **APA Leadership Fellows:** Tanuja Gandhi, MD; Furqan Nusair, MBBS; Seth Michael Judd, DO; **APAF Public Psychiatry Fellows:** Jessica Bayner, MD; Rachel Robitz, MD; **Guests:** Saul Levin, MD, MPA, CEO and Medical Director of APA; Renee Binder, MD; Elie Aoun, MD; Louis Kraus, MD; Reena Kapoor, MD; Connor Darby, MD; Philip Candilis, MD; Maya Prabhu, MD; Li-Wen Lee, MD; **APA Staff:** Phil Wang, MD, Director of Research; Zhuoyin Yang; Alison Crane

I. Greetings, Introductions, and Conflict of Interest Disclosures
Dr. Hoge opened the meeting by welcoming the attendees. Attendees identified themselves by name and affiliation and reported any conflicts of interest. Dr. Ash worked on the position statement on sentencing adolescents and he consults on cases involving that (this is not considered a conflict by the Council). Dr. Fisher disclosed that he consults to a tele-psychiatry company.

II. Approval of September Council Minutes
Dr. Hoge presented the minutes from the 2016 September Components Meeting and asked if there were any amendments or changes required. A motion to approve the minutes passed unanimously.

ACTION: The Council on Psychiatry and Law voted to approve the September 2016 minutes as written.

III. Electronic Screening Tool for jails to use to screen detainees for serious mental illness, substance use disorders and suicide
Dr. Binder spoke to introduce the Stepping Up initiative as a project of the Foundation. One of the products of the Foundation and Stepping Up initiative is a screening tool for individuals entering the criminal justice system. Dr. Phil Wang, APA Director of Research, presented information about the tool. It needs to have ability to provide automatic scoring and provide an alert flag for intake officer as to needed follow up. Goal was to have a platform to also serve other functions necessary (such as referral and tracking). It needed to meet requirements pertaining to criminal justice populations and be secure to meet HIPAA, etc. There is still work being done on a companion suicide screening tool. The tool is in

prototype stage and not yet in use. Some County Jail intake personnel have been helping to test it, but it is not yet ready for implementation with jail populations. APAF is in the process of applying to APA's IRB for approval to begin using and testing in county jail populations; it must also get HHS Secretarial level approval to test in criminal justice populations. Ultimately APAF plans to build the tool into PsychPRO registry using these measures, adapting the dashboard for use by jails and state administrators of jails. Commonwealth of Va is interested because screening is mandated in all 50 county jails. Some concerns with tool were expressed by CPL members, including encouragement not to test until there is suicide prevention screen included. Dr. Appelbaum noted the questions are in a "psychiatrist voice"; he encouraged getting feedback from corrections officers about how to phrase. Dr. Binder recommended that people interested in project can be consulting group for tool, since it is iterative process. Dr. Wills, Dr. Kapoor, Dr. Bayner, Dr. Metzner, Dr. Fisher, Dr. Lee, Dr. Champion, Dr. Zonana, Dr. Aoun, Dr. Pinals all volunteered.

IV. Visit from APA CEO and Medical Director, Saul Levin, MD, MPA

Dr. Levin thanked the Council for the production of excellent materials and resources for the APA. This Council produces excellent writing. Dr. Levin thanked Dr. Hoge as the Chair, and Dr. Pinals for taking over, and Dr. Swartz for work for Committee on Judicial Action. Dr. Levin commented on the work regarding physician assistance with dying, law enforcement responses to persons with mental illness, and gun seizure laws. MOC is very important issue to membership. Dr. Levin honored Dr. Hoge as outgoing Chair of Council with Dr. Binder participating on behalf of the Board.

V. Report of the Committee on Judicial Action

Dr. Marvin Swartz, Chair of the Committee on Judicial Action, reported on Committee meeting that took place on May 22, 2017 at the Annual Meeting. The Committee reviewed a number of cases where the APA was following issues and/or had filed briefs, including:

(1) *Volk v. DeMeerleer* – APA supported DB on case involving *Tarasoff* duties in Washington State; unfortunately outcome was not favorable to APA's position. Washington group is trying to draft legislation to limit scope of this since it would extend duty of mental health professionals to any victim.

(2) *Wollschlaeger v. Gov Fl* – law which prohibited physician from inquiring about guns in the home; court eventually struck down all but the discrimination provision of the law.

(3) *Joseph H v. Ca* – juvenile who shot father who was a Nazi leader; issue involved when it is appropriate for juvenile to be mirandized. Court did not take case. Dr. Ash working on manuscript about the case should issue come up again.

(4) *Endrew F v. Douglas County School*– case involving IDEA; APA did not join case due to timing, but Supreme Court did find for family and ruled that previous standard which allowed for only de minimis progress was insufficient

(5) *Gloucester County School Board v GG* – APA joined, but Supreme Court vacated and remanded back to 4th Circuit based on Trump Administration withdrawal of guidance for schools dealing with transgender issues.

(6) *McWilliams v. Dunn* – APA joined; death penalty case involving whether person with mental health condition is entitled to expert assistance for his defense
(7) *Strickland v. Day* – MS DB asked us not to participate, so APA did not; case involving custody of child after divorce of same sex couple
(8) *Travel Ban cases* –Don't know yet will case will come from, but APA did join brief prepared by AAMC opposing the travel ban. APA's position in joining reflected concerns about effects on healthcare personpower.
(9) Re-discussed case involving Minnesota involuntary commitment of sexual predators; at 8th Circuit level decided not to join, but now expect Supreme Court will likely grant cert so reconsidered whether will join the case. Treatment at issue is under-resourced and no one has graduated from program, so it is unclear whether the treatment is effective in the involuntary sex offender civil commitment context and it raises the challenges these decisions presented at the outset
(10) *Ayestas v Davis* – complicated case involving need for expert in death penalty case and the standard for getting expert assistance in event of suspected mental illness. After robust discussion, still undecided whether APA will participate, so will continue via email.

VI. Law Enforcement Responses to Persons with Mental Illness

Dr. Debra Pinals, chair of the workgroup, reviewed purpose of document – responding to shootings of individuals by police and also wanting to provide guidance. Received request from CAGR to include something about race as factor in consideration. Suggestion was also received to include something about follow up training. Dr. Buchanan made suggestion to mention police shooting people with mental illness; he also suggested overall psychiatry is responsible to look inward a little more (because police do bring people to hospitals and they are released and it ends up being a cycle). Dr. Hoge echoed this sentiment, that psychiatry needs to take more responsibility for taking people into system, given preference for treatment over arrest. Dr. Hoge thinks more could be said in favor of tipping scales towards treatment over arrest. Dr. Wills encouraged being very careful about how to portray role of psychiatry to avoid putting onus on already strapped system, to seem realistic rather than aspirational. Dr. Frierson suggested adding "when feasible" or "when possible". Edits welcome and will send to JRC with report deadline for upcoming meeting. Resource Document may be next thing that is done on this topic.

VII. Physician Assisted Death

Dr. Stuart Anfang, chair of the workgroup, reviewed the discussion that was had by the Council in September. The feedback was helpful and incorporated. Workgroup has made explicit it is not establishing a position statement for APA; it is meant to be resource document pulling together legal and clinical information for DBs and individual psychiatrists who may be facing this issue. Psychiatrists are not frontline on this issue and this was always intended to be resource document to provide information (not to state position of APA). Mr. Bonnie noted that there remains a significant possibility that neurologists will take a position on this but Dr. Anfang noted in document that no major

organization has come out in support of physician assisted death). Dr. Appelbaum says this is great work, well-written and beautifully done; feels introduction to conclusion section doesn't do justice to this document. Dr. Zonana noted impetus behind Assembly action item of wanting to survey members is AMA is against this and may feel it is unethical to do which raised question of whether APA is bound to follow AMA. Dr. Pinals takes issue with statement that no major medical organization has spoken in support of issue because she would consider American Medical Women's Association a major organization. Dr. Anfang is open to striking sentence. APA has a position against euthanasia but hasn't taken a formal position on physician assisted death. Decision is to take out first and last sentence of section to address the evolving landscape of some medical organizations. Dr. Buchanan notes that in the screening tools section could emphasize given gravity of what is at stake, balance must be in favor of sensitivity. Dr. Anfang welcomes specific wording changes to be sent to him. Will follow same procedure of editing and then submitted to JRC. Will also consider possible avenues for publication.

VIII. Gun Seizure Laws

Dr. Reena Kapoor, chair of workgroup, reviewed some background of how project began – resource document arose from an action paper that thought document explaining gun seizure laws may be helpful to DBs and psychiatrists. Dr. Pinals noted a statute may not have been properly included. Mr. Bonnie noted work was done by consortium and they included it, but he will review the source material. Dr. Buchanan noted this is helpful resource, and wondered if might be better off sticking to gun seizure law and including another section on how gun seizure law affect clinical practice; less data than typically have for these type of reviews and it may read as over enthusiastic so perhaps a more conservative tone of "there is no evidence to suggest." Dr. Fisher agrees on point to focus clinical practice (issue of re-wording to tie risk assessment always to seizure law). Plan of action is to prepare another draft ready for Council's September meeting.

IX: Firearms in Hospitals/ERs

Dr. Jeff Janofsky, chair of the workgroup, reviewed history. Dr. Recupero noted word "firearms" doesn't appear in document, and weapons is broad term. Dr. Janofsky said that document itself defines use of "weapons" and he believes neither lethal nor non-lethal force should be used as typical clinical response to patients. Title of document has changed to remove "firearms" and replace with "weapons". Dr. Pinals noted she has concerns about items (f) and beyond, as having the option to use weapons is in conflict with what comes beforehand in document. Dr. Binder suggested changing word "search" to "screen" for weapons. Dr. Fisher shares a similar concern as Dr. Pinals about items (f) and beyond. One possibility is deletion of beyond (f) as something perhaps APA does not need a position statement about. Dr. Janofsky noted many hospitals frequently use off duty security officers who carry weapons – there was resistance to coming out opposing that. Dr. Hoge says we need to say what we think is right and whether some facilities will need to change their policies or be outside our policies that is not something that should constrain us. Dr. Wills says it isn't policy there should be procedure in place for (f), and a number of hospitals (including childrens hospitals) do have armed police forces and that is by design, so it might be exceeding scope of expertise in terms of how those work together with hospital

function. Dr. Zonana says our codes have point where it is no longer clinical operation (once it has been taking over as police action) and that is a clear dividing line, so can put a code like that in for dividing point of where it is no longer clinical. Dr. Weinstock noted that one issue is whether there is clinical staff shortage and what happens when there is. Dr. Lowenthal says that once you get to item (f) you are no longer talking about clinical management, law enforcement will be taking over and out of realm of clinical management. Dr. Hoge suggests some break in format of paper to divide between clinical. Some confusion about what happens on medical units, where ways that things are handled changes (as opposed to emergency rooms), so it might be useful to parse more precisely in the document. Context will drive what interventions ought to be and who leads them. Some of the commenters will be brought into the workgroup circulation for a redraft; try to prepare for the fall meeting.

X. Research with Involuntary Patients

Dr. Carl Fisher, chair of the workgroup, reviewed history of its product. Dr. Buchanan thought tone is too contentious for a position statement. Patients are too dependent on staff which raises important issues about whether patient's consent is truly voluntary when their doctor asks. Voluntariness should not be assumed by law. Dr. Fisher says main intent is that should not shift assumption that voluntariness is not present simply because of involuntary status, and perhaps Council should discuss whether there is consensus for that. Agree that involuntary patients should not automatically be excluded from research. Dr. Buchanan agrees with that but that is not to say there are not real issues with consent when people are so dependent on others. Dr. Appelbaum suggests one way to deal with it is to suggest that with higher level research consideration be given to involuntariness (like what you would say about decision-making capacity if reasons to think it might be impaired). Mr. Bonnie agrees it should not automatically be presumed that you can't voluntarily consent if you are involuntarily committed, but it is odd to shift presumption to say that voluntariness should be assumed. Confirming that is not intent and just want to make individualized assessment in such circumstances of voluntariness. Dr. Recupero says one value not highlighted in here is autonomy of patient in being decision-maker and exercising benevolence in helping world, would support more affirmative statement reinforcing autonomy. Dr. Pinals notes this is a tough issue and all that is said gets a little undercut with number 4, because some people say that undue influence is unavoidable in context. Perhaps solution is removal of last few words. Dr. Metzner would caution about getting to special population because it's very hard to do research with prisoners. Dr. Lowenthal thinks needs both IRB and clinician input. Draft will be revised with goal of presenting at September meeting.

XI. Physician Health Programs

Dr. Patricia Recupero, chair of the workgroup, reviewed background and request from Dr. Levin to look into what is happening with physician health programs. This is shortened version of document focused on relationship of physician to PHP. Dr. Appelbaum will send some edits. Dr. Metzner solicited comments from former presidents of Federation and shared them - (i) should make clear PHPs do NOT provide treatment; (ii) concern on page 10 – need to allow for choice of physician who does not have needed expertise; (iii) should call "participants" or "clients", but not patients, (iv) concern about 2(d)

because if physician knows code it is easier to game the system; (v) agree with concept that PHPs should not be designed as profit-making enterprise. Dr. Fisher says California is planning to reenact a PHP. One macro level issue is still within addiction and allegation is PHPs don't deal with other psychiatric illnesses. Context for referral part should specify where recommendations are coming from – reads like a PS instead of Resource Document. Dr. Prabhu encourages expanding on challenges around fees – if physician is mandated to participate the cost of fees can become problematic. Dr. Appelbaum says issues of critiques made of PHPs needs to be laid out. Dr. Candilis wonders to what degree should workgroup respond to criticisms that may not be accurate. Dr. Prabhu notes that the models vary so much by state and unknown how much data will be available as to criticisms. Dr. Wills's concern is PHPs don't have standards for selecting facilities. Dr. Hoge says some things addressed in Addiction Council document, so should consider that with this moving forward. Will include wider group by email in next iteration and move towards fall for next move.

XII: Revision of the Position Statement on Review of Sentences for Juveniles Serving Lengthy Mandatory Terms of Imprisonment

Dr. Peter Ash, chair of workgroup, reviewed history of how this PS came before certain Supreme Court cases. He views 2011 PS as having 3 components: (1) lengthy juvenile sentences should not be given; (2) states should review if given – but he notes that if they are mandatory, review may not make sense to contemplate; and (3) If not going to review these, recommendations of what should do are moot. Workgroup left out whether these considerations should apply to other juveniles (over age 18). Dr. Ash suggests that gist of not liking long mandatory sentences makes sense but drop review stuff as moot. Dr. Binder suggests coordinating with Council on Children (Dr. Joseph Penn). Dr. Bonnie says could get rid of word "mandatory" and still accomplish what want to do (because sentences is lengthy without giving kid a chance to have something shorter but thing that would be missing is judicial discretion at the beginning). Dr. Wills thinks it needs to be "mandatory minimum" language. Dr. Appelbaum raises concerns with very lengthy sentences even with possibility of parole, and if are concerned about that then this position could also address that and discourage use of such sentences and recommend that juveniles being sentenced have opportunity for consideration for parole. Dr. Ash will revise with Dr. Bonnie's help and aim to submit to JRC by June 5th.

XII. Report of the Manfred S. Guttmacher Award Committee

Dr. David Lowenthal, Chair of the Guttmacher Aware Committee, described that the submissions were of high quality, but still having difficulty getting enough submissions for consideration. Review of issues with timing of award this year. Conflict with CPL update is something we will take care of moving forward. No objection to combining the two award presentations. Attendance this year was positive development. Dr. Janofsky raised issue about what plaque should say – AAPL feels it should be from APA (not APAF). Dr. Janofsky raised question of whether the award committee will still be under this Council (or APAF). Dr. Binder says this Council will still recommend who will be on awards committee.

XIV: Report of the Isaac Ray Awards Committee

Dr. Liza Gold, Chair of the Isaac Ray Award Committee, spoke about her uneasiness about what is going on. This is second or third year in a row and described it as "touch and go" this year in terms of how things were going to work out. Sees what is going on as a devaluing the Isaac Ray award. As Chair of committee was not invited to have opinion until after the fact. Dr. Hoge confirms awards were taken out of convocation. Dr. Binder suggests that letter should be written from Council and chairs of committees to Dr. Levin. Winner of this year's award suggestion was to move it to AAPL, but there does not seem to be consensus for that. Dr. Gold says it deserves to have some thought put into it and someone to have responsibility to address is. Move to Foundation is one issue, doesn't explain why taken out of convocation. Dr. Binder says she is responsible for that and spoke to why taken out of convocation. Dr. Hoge asks if Dr. Binder could spearhead. Dr. Binder suggests that it be added as item to JRC. Need discussion about where it goes (continue to link with Guttmacher?); confirm all appointments will be suggested by chair of council and done with president-elect every year because committees require special expertise; desire some explanation for change from APA to APAF; urge inclusion of chairs of committees in decisions moving forward.

XV. Potential Retirement of 1993 Position Statement and interest in revising 2014 Position Statement on Firearm Access

Discussion of history of 2014 Position Statement and the sentence regarding semi-automatic weapons being removed. CAGR is reviewing a statement on smart guns that came from this 2017 May Assembly. Dr. Hoge recommends that CPL recommend retaining 1993 PS and do nothing to change 2014 PS. Dr. Binder recommends that 1993 PS be retired. Uncertainty about what Assembly will do is factor. Question about what 1993 PS has to do with psychiatry by Dr. Frierson who recommends retirement. Dr. Anfang suggested reaffirmation of 1993 PS. Dr. Hoge says his sense after broad discussion is that Council wants to keep 2014 PS and not reopen it and to recommend retaining 1993 PS.

XVI: APA Position Statement Review

There were several APA Position Papers that have been assigned to the Council on Psychiatry and Law for review:

1. Segregation of Prisoners with Mental Illness (2012) – The position statement is current, relevant and should be retained.

2. Assessing the Risk for Violence (2012) - The position statement is current, relevant and should be retained.

3. Firearms Access: Inquiries in Clinical Settings (2012) - The position statement is current, relevant and should be retained.

4. Review of Sentences for Juveniles Serving Lengthy Mandatory Terms of Imprisonment (2011) - Council on Psychiatry and Law has revised the position statement and will submit

the revision to the JRC in June 2017, with a request that the 2011 PS be retired and replaced with the revision.

5. Use of Jails to Hold Persons Without Criminal Charges Who Are Awaiting Civil Psychiatric Hospital Beds (2007) – The position statement is current, relevant and should be retained.

6. Psychiatric Services in Jails and Prisons (2007; retained 1988 PS) – Until revision can be drafted by Council on Psychiatry and Law, the position statement should be retained. Council on Psychiatry and Law will revise the position statement and submit to the JRC with a request that the 2007 version be retired and replaced with the revision it creates. Revision is necessary because some elements of the document are outdated. Dr. Trestman will lead a workgroup to revise the position statement.

XVII: Informational Item: AMA and ABA Gun Violence Prevention Event

Consensus that APA Council on Psychiatry and Law should collaborate with ABA and AMA, have role in policy discussions, and provide resources to DB and APA members. 2014 PS addresses most of this.

XVIII. New Business

Council considered joint meeting with CJA in the fall. One possibility is competency restoration wait and a broader issue there would be about bed supply in general. Some others ideas include what we know about sex offender treatment, the Goldwater Rule, and police interactions with the mentally ill. Council members encouraged to send ideas or feedback to ideas to Drs. Pinals and Swartz.

Dr. Hoge raised possibility of rolling out corrections workgroup into its own Committee (to have APA component dedicated to jails and prisons). Dr. Pinals notes that funding is a reality to be tackled as drawback. Dr. Binder notes that committees are corresponding committees (meaning there is not much funding, they do not meet at September components; APA will provide room at annual meeting). Dr. Metzner and Dr. Trestman would not favor taking it out of Council if it will be corresponding committee.

Dr. Appelbaum noted Dr. Hoge's service to Council for many years. Dr. Hoge presented certificates of appreciation to outgoing Council members (including fellows)

The Council meeting adjourned at 10:58pm.

Council on Psychiatry and the Law

Position Statement

Police Interactions with Persons with Mental Illness

Draft

May 29, 2017

Background:

It is by now well-known that police are first responders in a range of crisis situations. It is increasingly recognized that crisis calls may involve responding to individuals who are agitated, disorganized, and behaving erratically and who might also, even in the absence of extreme behavior, have mental illness, intellectual disabilities, developmental disabilities, neurocognitive disorders, substance use disorders, and other conditions that result in behavioral challenges. Unless known from the outset, the presence of these conditions may not be obvious to responding officers. The context of police crisis contacts can be further complicated by a host of other factors that might be relevant such as racial, ethnic, socioeconomic, political or cultural variables; veteran status; sentiments and political pressures in the community; years of experience of the officer, and the officer's previous encounters; and level of training. With all of the variables potentially at play, when police are called to respond to a call involving a behavioral health crisis, the potential volatility of the situation can result in tragic outcomes, including injury or death of the individual in distress, the responding officers and others. In *San Francisco v. Sheehan* (2015)[i], the United States Supreme Court left open the question as to whether such encounters require accommodations consistent with the Americans with Disabilities Act (1990) or whether the direct threat exception makes such accommodations unnecessary. With legal ambiguity remaining as to requirements for accommodations and no uniform requirements for training of officers to deal with encounters involving mental health issues, jurisdictions decide individually on training and policies in these areas. Because people in psychiatric care or in need of such care are commonly encountered by police[ii], it is incumbent on organizations such as the American Psychiatric Association to take an active interest in supporting safer communities through advocacy and education for our patients and our profession.

Position Statement:

Law enforcement officers play a critical role as first responders to crisis events who need to be able to perform safely and successfully under stress. The American Psychiatric Association (APA) strongly supports efforts to enhance the ability of law enforcement to manage crises involving emotionally disturbed persons and persons with serious mental illness, developmental or intellectual disabilities, neurocognitive disorders, or substance use disorders. Such efforts should include:

1) Implementation of a curriculum for law enforcement officers that includes basic information about mental disorders and their symptom presentations, specific de-escalation techniques, and increased awareness of the impact of personal biases related to the stigma surrounding mental disorders, race, and other factors, as well as the role of trauma for all involved in these encounters. Formalized Crisis Intervention Team (CIT) training is an example of an important model with a growing evidence base, though there remain questions about how best to measure its impact. Regardless of model, training should extend to all levels of law enforcement, including new recruits, veteran officers, and police leadership. Because of its importance, efforts should be made to prioritize this type of training and maximize its accessibility.
2) Creation of partnerships between local behavioral health and law enforcement systems to develop policies regarding their respective roles and responsibilities in managing mental health crises within and across communities and regions. Such policies should give priority to treatment over arrest of emotionally disturbed persons and persons with mental disorders, to the extent that is appropriate and safe. Ongoing and regular cross-training, including refresher trainings, in such policies and protocols between local law enforcement and emergency mental health services should be encouraged and supported. These partnerships should address the need for innovative approaches to shared information systems that address confidentiality concerns.
3) Behavioral health system partnerships with law enforcement that maximize clinical crisis response capacity should be prioritized, including providing settings that facilitate police diversion from arrest and proper clinical assessment and treatment of the person in crisis.

Workgroup:

Debra A. Pinals, MD (Chair), Elie Aoun, MD, Michael Champion, MD, Richard Frierson, MD, Elizabeth Ford, M.D., Tanuja Gandhi, MD, Reena Kapoor, MD, Simha Ravven, MD, Mardoche Sidor, MD

---

[i] *City and County of San Francisco v. Sheehan* 575 U.S. ___, 135 S. Ct. 1765 (2015)

[ii] Livingston JD. Contact between police and people with mental disorders: A review of rates. *Psychiatric Services* 67:850-857, 2016

APA RESOURCE DOCUMENT ON PHYSICIAN ASSISTED DEATH

Council on Psychiatry and Law
(Task Force: Stuart Anfang (chair), Richard Bonnie, Rebecca Brendel, Donna Chen, Vivek Datta, Tanuja Gandhi, Steven K. Hoge, Robert Weinstock)

DRAFT—FOR REFERRAL TO JRC
6/1/17

INTRODUCTION

Over the past two decades, a number of US states have enacted statutes legalizing the practice of physician-assisted death (PAD).[1] [2] In 1997, Oregon passed the first statute that legalized PAD. Washington (2008), Vermont (2013), California (2015), and Colorado (2016) have followed suit. In addition, a state court ruling in Montana legalized PAD in 2009. In 2015, the Supreme Court of Canada ruled PAD to be legal and the Canadian Parliament subsequently enacted a law to implement PAD. In February 2017, PAD was legalized in the District of Columbia. Legalization of PAD has been proposed in about half of all states in recent years (for details, see www.deathwithdignity.org). There appears to be a broad movement to consider legalization of PAD that may lead to legislation in other states. In the United States, PAD statutes have been restricted to patients with terminal illness, typically defined as an illness that is irreversible and likely to lead to death within six months.[3]

The legalization of PAD has a variety of implications for psychiatrists and psychiatric patients. First, current and recently proposed statutes require patients to have the capacity to make the decision to die. In some cases, the attending physician will refer patients of questioned capacity to psychiatrists for consultation. In addition, recognizing that end-of-life decision-making may be complicated by depression or other mental impairments, these laws require the attending physician

[1] This is a controversial topic, evoking broad ethical debate within the medical profession, and within society at large. The language used---ranging from "physician-assisted suicide (PAS)" and "euthanasia" to "physician-assisted dying" and "death with dignity"---can color the underlying moral and advocacy perspectives. For the purposes of this document, we will use the term "physician-assisted death (PAD)" in an effort to find more neutral language.

[2] As used in this document, PAD does not include activities currently considered as acceptable medical practice within standard palliative and hospice care (i.e., terminal sedation, withdrawal of life support, DNR orders).

[3] Internationally, countries such as the Netherlands, Belgium, and Luxembourg have extended PAD to non- terminally ill patients.

to evaluate patients with suspected mental disorders and, when indicated, refer patients for psychiatric assessment.

The American Medical Association (AMA) Code of Medical Ethics has taken the position that PAD "is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks." (Opinion 2.211, issued June 1994; reissued in 2016 as Opinion 5.17, available at https://www.ama-assn.org/sites/default/files/media-browser/code-of-medical-ethics-chapter-5.pdf). APA members are bound by the AMA Principles of Medical Ethics (Chapter 7, Section 1 of the Bylaws of the APA, May 2003). The American College of Physicians has also taken a position against the legalization of PAD (ACP Ethics Manual, Sixth Edition, 2012 available at https://www.acponline.org/clinical-information/ethics-and-professionalism/acp-ethics-manual-sixth-edition). In December 2016, the APA adopted a position statement on medical euthanasia holding "that a psychiatrist should not prescribe or administer any intervention to a non-terminally ill person for the purpose of causing death."

In view of these developments, this Resource Document was developed to provide background and relevant information to APA members regarding PAD. As policymakers consider proposed PAD laws, APA members, state associations, and district branches will likely play an important role in the legislative process.

This resource document provides a summary of the current legal status of PAD in North America, followed by a review of the reported experience to date in American PAD jurisdictions. We then discuss assessment of decision-making capacity to choose PAD, and assessment of depression in the context of terminal illness and requests for PAD.

This resource document should not be interpreted as an APA endorsement in support of PAD.

SUMMARY OF CURRENT LEGAL STATUS OF PAD IN NORTH AMERICA

As of April 2017, PAD has been legalized in six US states, the District of Columbia, and Canada. The statutes are summarized below.

- Oregon Death With Dignity Act
- Washington Death With Dignity Act
- California End of Life Option Act
- Vermont Patient Choice and Control at End of Life Act
- Canada: An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)

- Montana effectively legalized PAS through court ruling in *Baxter v. Montana* (2009); however, there is little regulatory guidance.
- District of Columbia: Death with Dignity Act
- Colorado: End-of-Life Options Act

Oregon's Death With Dignity Act serves as a framework for later Acts, which largely mirror Oregon's statutory scheme. Some minor differences have emerged.

Eligibility Criteria

PAD statutes consider an individual to be "qualified" to choose to end his or her own life if he or she meets specified requirements. All five states and the District of Columbia require that the individual be a capable/competent adult (18 years of age or older), who is a resident of the state; be determined by medical evaluation as suffering from a terminal disease; and to have made a voluntary expression of the desire to die. California further requires the individual to possess both the physical and mental ability to self-administer the lethal drug.

Canada considers a person eligible for assistance in dying if he or she is 18 years or older; eligible for government-funded health services (or would be eligible, but for any applicable minimum residency requirement or waiting period); suffering from a "grievous and irremediable medical condition"; capable of making decisions regarding his or her health; and has both made a voluntary request for aid in dying, and given informed consent to receive this aid.

Residency

An individual requesting a drug for PAD must currently be a resident of the state in which he or she requests the drug. Oregon, Washington, Vermont, District of Columbia and Colorado require a physician to verify residency (Oregon and Washington specifically reference the patient's attending physician, or the doctor with primary responsibility for the patient's care). Non-exclusive lists of factors demonstrating residency are set out by Oregon, Washington, California and Colorado. These include driver's license, voting registration and evidence of property ownership or lease in the state. Only Oregon and California also list the tax return for most recent year, although this is presumptively acceptable elsewhere since valid proof is not limited to enumerated items.

In Canada, the primary medical practitioner or nurse practitioner and an additional practitioner must provide written confirmation of the patient's residency and eligibility for government-provided health services.

Terminal Disease

All US states define a "terminal disease" as a medically confirmed disease which is incurable and irreversible, and which will, within reasonable medical judgment, produce death within six months. The attending (primary) physician is responsible for making the initial determination that the patient is suffering from a terminal disease, and that determination must be confirmed by a consulting physician who is similarly qualified to make a diagnosis and prognosis of the patient's disease. California emphasizes that a consulting physician should be independent from the attending physician.

Canada utilizes the term "grievous and irremediable medical condition". One exists if the person has a serious and incurable illness, disease or disability, and is in an advanced state of irreversible decline in capability; the person is enduring physical or psychological suffering as a result of the condition, which is intolerable and cannot be relieved under conditions they feel are acceptable; and their natural death has become "reasonably foreseeable" (which does not require a prognosis with any specific length of time). Importantly, the clause regarding psychological suffering introduces an ambiguity regarding whether physician-assisted suicide would be permissible for a patient suffering from intractable depression.[4] Two medical or nurse practitioners are required to confirm in writing that such a condition is present.

Decisional Capacity

Oregon, Washington and Vermont utilize nearly identical language to define capacity to decide to request and use PAD medications. Oregon, Vermont and the District of Columbia use the term "capable" while Washington uses "competent". Colorado specifies "in the opinion of an individual's attending physician, consulting physician, psychiatrist or psychologist, the individual has the ability to make and communicate an informed decision to health care providers."

A person will be considered capable or competent if, in the opinion of the attending and/or consulting physician, psychiatrist or psychologist, the patient has the ability to make and communicate health care decisions to health care providers, including communication through people familiar with that patient's manner of communicating. In Oregon, Vermont and Washington, the attending physician is responsible for the initial determination of capacity or competency, and the consulting physician confirms this determination. In Oregon and the District of Columbia, a court may be called on to determine competence, but is not required to do so as a matter of course.

[4] Another section of the Act states: "9.1 (1) The Minister of Justice and the Minister of Health must, no later than 180 days after the day on which this Act receives royal assent, initiate one or more independent reviews of issues relating to requests by mature minors for medical assistance in dying, to advance requests and to requests where mental illness is the sole underlying medical condition."

California defines "capacity to make medical decisions" as the patient's ability—in the opinion of the attending or consulting physician, psychiatrist or psychologist—to not only make and communicate health care decisions, but also to understand the nature, consequences, benefits, risks and alternatives of those decisions. This determination is made by the attending physician and confirmed by a consulting physician. Canada's Act does not address decisional capacity aside from requiring a patient to be "capable" of making health care decisions.

Informed Decision

Each state requires that a patient's decision to request and ingest life-ending medication be informed. In all cases, the attending physician must discuss certain subjects with the patient in order for him or her to be fully informed, and it is this physician's responsibility to decide whether the patient is making an informed decision. These critical subjects for discussion are enumerated in each state statute: the patient's medical diagnosis and prognosis, the potential risks and probable result of taking the medication to be prescribed, and the feasible alternatives to taking the medication, including hospice care, comfort care and pain control. California also requires the physician to discuss with the patient the possibility that he or she may choose to obtain the medication but ultimately not take it.

Vermont includes in its statute a patient "right to information", which states that the patient is entitled to receive answers to any specific questions about the foreseeable risks and benefits of the medication without the physician withholding any information, and without regard to the purpose of the inquiries. In this way, Vermont ensures that a physician may provide complete information to the patient without being "construed to be assisting in or contributing to a patient's independent decision" to self-administer the medication.

Canada requires that two medical or nurse practitioners confirm in writing that the patient wrote and signed his or her request for aid in dying after he or she was fully informed that he or she has a grievous and irremediable medical condition.

Mental Health Assessments

Oregon, Washington, California, District of Columbia and Colorado direct the attending or consulting physicians to refer patients for mental health assessment under specified circumstances. The Oregon, Washington and District of Columbia statutes require the attending or consulting physician to refer a patient for mental health assessment if either believes that the patient may be suffering from a psychiatric or psychological disorder or depression causing impaired judgment. The Colorado statute specifies that if an attending or consulting physician does not believe an individual to be mentally capable of making an informed decision, then they *must* be evaluated by a mental health professional. California requires physicians to refer patients "if there are indications of a mental disorder", and is not restricted to only patients with evidence of impairment. All five jurisdictions

emphasize that no medication to end life shall be prescribed until a professional determines that the patient is not suffering from a disorder causing impaired judgment.

Vermont's statute places less emphasis on mental health assessments. It simply states that before a prescription is written, a physician must either verify that the patient's judgment is not impaired or refer him or her to a psychiatrist, psychologist or clinical social worker for confirmation that his or her judgment is not impaired. Canada's law does not address mental health assessments.

Legal Requirements for Requests

All five states and the District of Columbia require an oral and a written request for the prescription, and a subsequent reiteration of the oral request. Written requests must be signed and dated by the patient and witnessed by at least two individuals attesting that to the best of their knowledge, the patient is capable, acting voluntarily and not under coercive pressure to request the medication. California's language diverges slightly, requiring attestation of knowledge that the patient is of sound mind and not under duress, fraud or undue influence.

In all five states and the District of Columbia, at least one of the two witnesses to the patient's written request must not be what Vermont calls an "interested person"—the witness cannot be a relative; entitled to a portion of the patient's estate under will or law; the patient's physician; or the owner, operator or an employee of the health care facility in which the patient is receiving care. Only Vermont specifies that the witnesses must be at least 18 years of age. Oregon and the District of Columbia require that if the patient is in a long-term care facility, one witness shall be an individual designated by the facility and having qualifications specified by rule by the Department of Human Services.

Each state directs the attending physician to offer the patient the right to withdraw or rescind his or her request at any time and in any manner, regardless of his or her mental state. This is a right which does not lapse. The offer to rescind must be reiterated after the patient's second oral request for the prescription.

Canada requires a written request, signed and dated by either the informed patient—or, if the patient is unable to sign, by another person on the patient's behalf (so long as that person is 18 years or older, understands the nature of the patient's request and does not know or believe he or she stands to benefit financially or otherwise from the patient's death). The patient must be informed that he or she may withdraw the request at any time and in any manner. Immediately before medication is provided, the patient must again be notified of the opportunity to withdraw, and subsequently must expressly consent to receiving aid in dying if he or she chooses to continue with the process.

Waiting periods

Oregon and Washington require that 15 days elapse between the patient's initial oral request and the writing of the prescription. Vermont, California, Colorado and the District of Columbia specify that the 15-day waiting period is measured from the initial oral request to the time of the reiterated oral request.

With respect to written requests, Oregon and Washington require a 48-hour waiting period between the patient's signing of his or her written request and the writing of the prescription. Vermont's statute states that the physician must write the prescription no fewer than 48 hours after the last to occur of the patient's written request, his or her second oral request, and the physician's reiterated offer of the opportunity to rescind the request. California does not specify the time frame that must elapse between written request and prescription, but a California patient must complete and execute a "final attestation" form within 48 hours of scheduled administration of the drug. The District of Columbia statute states that a written request must be submitted at least 48 hours before the covered medication may be prescribed or dispensed and before the patient makes his or her second oral request.

Canada imposes a 10-day waiting period between the day the patient signed his or her request and the day medication is provided. Deviation is permitted if the two medical or nurse practitioners attesting to the patient's condition and qualification for aid in dying are of the opinion that the patient's death, or loss of capacity to provide informed consent, is imminent—any period shorter than that 10-day window.

Methods of Dispensing Medication

The five states and the District of Columbia have nearly identical provisions regarding medication dispensation. So long as the attending physician complies with applicable state licensing and certification requirements, he or she may directly dispense both the end-of-life prescription and any ancillary medications prescribed to minimize the patient's discomfort. Alternatively, with the patient's consent, the attending physician may contact and deliver the prescription to a pharmacist, who will dispense the medication to the attending physician, the patient or an agent of the patient.

Canada's Act does not address the precise methods of dispensing aid-in-dying medications, but it does require the prescribing physician to notify the dispensing pharmacist of the intended use for the medication prior to dispensation.

Administration of Medication

The Washington, California, Colorado and Vermont statutes contain language referring to the ultimate "self-administration" of the prescribed drug, which

involves the actual act of ingesting the medication. Although Oregon's Act lacks explicit references to self-administration, it contains provisions similar to ones espoused by Washington and Vermont barring "mercy killing" and "active euthanasia" by a physician or any other third person. California specifically states that while a person shall not be subject to liability for assisting a patient in preparing the aid-in-dying drug, assistance with ingestion is not permitted. The District of Columbia says that no person shall be liable criminally or civilly for being present when a qualified patient takes the medication. Canada's bill explicitly permits euthanasia by including in the definition of lawful medical assistance in dying "the administering by a medical practitioner or nurse practitioner of a substance to a person, at their request, that causes their death".

Additional Responsibilities of Attending Physician

Along with making determinations about the patient's qualification for PAD and handling drug requests and dispensation, there are other responsibilities the attending physician must fulfill. All five states and the District of Columbia require that before the attending physician writes the prescription, he or she recommends that the patient notify next of kin (but the Acts also specify that no request for PAD shall be denied if the patient is unable or refuses to do so), and counsels the patient of the importance of having someone with them when they ingest the medication and not doing so in a public place. California requires that the attending physician counsel the patient about hospice program participation and the importance of maintaining the drug in a safe and secure location until he or she chooses to ingest it. The California attending physician is also obligated to obtain confirmation from the patient outside the presence of other parties that the patient's request for medication did not arise from coercion or undue influence.

The attending physician must fulfill state-specific medical record documentation requirements throughout this process, and sign the patient's death report. Canada similarly requires physicians to provide medical records in accordance with regulations promulgated by the Minister of Health.

REPORTED EXPERIENCE TO DATE IN CURRENT PAD JURISDICTIONS

As of April 2017, published data and literature is available only from Oregon and Washington, the first two jurisdictions to enact PAD statutes. There is no published literature or collected data from Montana or Vermont (Vermont maintains a general informational website: http://healthvermont.gov/family/end_of_life_care/patient_choice.aspx), likely reflecting the small population and infrequent use of PAD in those jurisdictions. The statutes in California, Colorado, the District of Columbia and Canada have only recently been enacted, so data has yet to emerge from those jurisdictions. Over the next several years, we can anticipate significant data and published literature to be

available from California (39 million residents) and Canada (36 million residents) given their large populations.

Reported Experience with PAD in Oregon

In 1997 following a three year process, Oregon adopted the Death with Dignity Act (DWDA), becoming the first American state to legalize PAD. The DWDA allows terminally ill Oregon residents to obtain and use prescriptions from their physician for self-administered lethal medications. Under the Act, ending one's life in accordance with the law does not constitute suicide. The DWDA specifically prohibits euthanasia, where a physician or other person directly administers a medication to end another's life. The DWDA mandates that physicians and pharmacies provide data to the Oregon Health Authority regarding prescriptions for lethal medications. As a result, Oregon maintains the largest and most comprehensive database regarding PAD in an American state, publishing annual statistics (http://public.health.orgeon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year19.pdf).

As of January 2017, nearly 1750 people have received prescriptions written under the DWDA, and more than 1100 patients have died from ingesting the medications. From 1998-2013, the number of prescriptions written annually increased at an average of 12%; however, over the past three years, the number of prescriptions written increased by more than 30%, indicating a significant increase in requests under the DWDA. In 2016, 102 physicians provided prescriptions to 204 patients, ultimately resulting in 114 deaths (an additional 19 people died in 2016 ingesting medications prescribed in previous years). More than three quarters (77%) of the patients requesting PAD had cancer; 8% had amyotrophic lateral sclerosis (ALS). The three most frequently mentioned end-of-life concerns were: decreasing ability to participate in activities that made life enjoyable, loss of autonomy, and loss of dignity.

Few patients have been referred for psychiatric assessment. Between 1998-2016, a total of 57 patients (5.1%) out of 1127 who completed PAD under DWDA were referred for psychiatric evaluation; in 2016, 5 patients (3.8%) out of 133 were referred for evaluation. Oregon does not publish data regarding patients who were referred for psychiatric evaluation, but were then found ineligible or who did not ultimately receive a prescription for lethal medication under DWDA.

The Oregon Health Authority maintains a comprehensive website (http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/index.aspx) regarding the DWDA, including a detailed guidebook for health care professionals updated in 2008. As the state with the longest experience with PAD, Oregon provides the context for most of the published

medical literature describing the experience of American physicians and patients (Hedberg 2009; Hedberg 2003).

Psychiatrist Linda Ganzini MD has published several articles relating to physician experience with requests for PAD, including frequency of initial requests compared to final actual deaths (Ganzini 2000; Ganzini 2016). Ganzini and colleagues have published the only articles looking at the impact of depression in Oregon requests for PAD and the attitudes of Oregon psychiatrists. Nearly all (95%) of the psychiatrists were "confident" that they could determine whether a mental disorder was impacting the decision for PAD in the context of a long term treatment relationship, but only 6 per cent were "very confident" that they could make this assessment in a single evaluation (Ganzini 1996). In a 2008 study of 58 Oregonians who requested PAD, 18 received lethal prescriptions including three patients who had met rigorous criteria for major depression. All three died by lethal ingestion within two months of the research interview, although in one case the depression was successfully treated before death and in the other two cases the patients denied that depression was influencing their decision. The authors concluded that the current practice of DWDA may fail to protect adequately some patients whose choices are influenced by depression from receiving a lethal prescription, supporting the need for more active and systematic screening and surveillance for depression to determine which patients should be referred for further mental health evaluation (Ganzini 2008). While advocating for systematic screening to determine need for further expert evaluation, Ganzini has argued against mandatory psychiatric evaluations for all individuals requesting PAD, citing challenges of true need, access, cost, and specialized expertise (Ganzini 2014).

Reported Experience with PAD in Washington State

Washington State's Death with Dignity Act, which came into force in March 2009, allows adult residents in the state with six months or less to live to request lethal doses of medication from a physician. Importantly, the law states that medications must not be prescribed to individuals "suffering from a psychiatric or psychological disorder or depression causing impaired judgment" (Steinbrook 2008). In cases where there is concern that the patient has impaired judgment due to a psychiatric disorder, the attending physician who would prescribe the lethal medication must request a psychiatric or psychological evaluation. Otherwise, no psychiatric or psychological evaluation is routinely required. Since the law's enactment, there has been a steady rise in the number of prescriptions dispensed for PAD. In 2009, medication was dispensed to 63 individuals, 36 of whom died after ingesting the prescribed medication. By 2015 this number had risen to 213 individuals who were dispensed medication, 166 of whom died after ingestion of the medication (Washington State Department of Health data, http://www.doh.was.gov /portals/1/Documents/Pubs).

Few patients have been referred for psychiatric assessment. The proportion of those referred has remained roughly stable, at about 4%. Similar to Oregon, three quarters of the patients completing PAD have cancer, while approximately 10% have a neurodegenerative disorder.

Under the Washington State statute, attending and consulting physicians must verify that the patient is competent to make an informed decision before a prescription for lethal medication is written. The Washington State Psychiatric Association does not provide any specific guidance for psychiatrists consulted to evaluate patients' capacity to participate in Death with Dignity. However, the Washington State Psychological Association does provide such guidance, which appears to be aimed at both psychologists and psychiatrists (Washington State Psychological Association, 2009).

The WSPA guidelines recommend that the evaluating psychiatrist explore the reason for the request, the patient's expectations, fears and values, and their personal assessment of quality of life. They further recommend that the psychiatrist assess whether the decision seems authentic and in keeping with the patient's long-held values. Finally, the guidelines note the importance of distinguishing between a mental disorder, such as major depression disorder or a cognitive disorder, and the effects of the terminal illness, its treatment, or normal psychological reactions in the face of terminal illness.

Washington State collects data on end-of-life concerns of participants, as reported on the After Death reporting form which is completed by the attending physician. In 2015, it was reported that 86% of patients were concerned with losing autonomy, 86% with loss of ability to engage in activities making life enjoyable, 69% with loss of dignity, 52% with being a burden on family and friends, 49% on losing control of bodily functions, 35% with inadequate pain control or concern about it, and 25% with the financial implications of treatment. A study of those requesting Death with Dignity at the Seattle Cancer Care Alliance between 2009 and 2011 found that 97.2% cited loss of autonomy as a reason for participation (Loggers 2013).

Given the very low frequency of psychiatric evaluations requested, it is hard to draw clear conclusions. Although the state keeps information regarding all requests, the identity of the physicians involved is kept confidential. It does appear that a disproportionate number of evaluations are requested from the consultation-liaison psychiatrists at the University of Washington Medical Center and the Seattle Cancer Care Alliance. When the law came into place, the psychiatry department expected to receive a large number of referrals but, as noted above, psychiatric evaluation is infrequently sought (personal communication, 2015). The consultation-liaison service created an informal support system for psychiatrists involved in these evaluations in order to provide consultation and support for difficult cases, but in practice, this was hardly used. It was noted that in at least one case, a patient died while awaiting psychiatric evaluation. In some cases, psychiatric consultation appeared to be requested when the treating physician did not feel comfortable with

the patient's request, where there was a history of psychiatric illness, or where the patient did not wish their family to know (which though encouraged, is not required by law).

REQUESTS FOR PAD: ASSESSING COMPETENCE

As described above, the six U.S. PAD statutes as well as Canada require that the individual requesting a lethal prescription be capable of making medical decisions regarding his or her health.[5] In order to be capable to request physician aid-in dying through a lethal prescription, an individual must be able to make and communicate health care decisions to health care providers. Assistance with communication may be used. The California statute gives additional guidance regarding the standard for capacity to include understanding the nature, consequences, benefits, risks and alternatives of those decisions. The California statute incorporates elements of the predominant standard for capacity assessment for medical decision-making (Appelbaum 1988; Appelbaum 2007). Specifically, decisional capacity for medical decisions requires expression of a preference, a factual understanding, appreciation, and ability to rationally manipulate information in coming to a decision. The Oregon statute similarly gives guidance regarding an "informed decision" based on an appreciation of facts including diagnosis, prognosis, probable risks and results of taking the prescribed medication, and alternatives, incorporating key elements of information relevant to informed consent (Brendel 2007; Weintraub Brendel 2011).

While concepts of capacity and informed consent are generally well established, the evolution of newer practices with prominent legal and ethical features, such as PAD, add complexity to these heretofore broadly accepted frames of reference and were not well established as PAD became legally permissible (Werth 2000). Specific guidelines regarding the content of capacity determinations are absent from the Oregon statute. The Task Force to Improve the Care of Terminally-Ill Oregonians has published a useful guidebook for health care professionals, including a chapter on mental health consultation (Oregon Guidebook, 2008). Attending or consulting physicians must refer an individual seeking a lethal prescription for a mental health evaluation by a psychiatrist or psychologist if the physician believes that the patient may be suffering from a mental health disorder or depression causing impaired judgment. The task of the psychiatric (or psychological) evaluator, then, is to determine whether the patient has the ability to make and communicate health care decisions.

Amongst individual psychiatrists (and psychologists), there is a divergence of opinion regarding the ethical permissibility of PAD (Ganzini 1996; Ganzini 2000; Fenn 1999). Psychiatrists may object to participating in assessments of capacity for

[5] Washington uses the term competence, rather than capacity, but no substantial difference is apparent.

assisted death for conscientious reasons. In addition, forensic psychiatrists who described themselves as morally opposed to PAD were more likely to employ a stringent standard for capacity for PAD and more likely to believe that the presence of depressive symptoms would automatically render a patient lacking in capacity compared to psychiatrists who did not oppose PAD on ethical grounds (Ganzini 2000). It is essential that psychiatrists be aware of their own views regarding PAD and how those views might bias an evaluation of capacity ---either as overly restrictive or overly permissive. The Oregon Task Force's guidelines for capacity assessment specifically state that mental health professionals with strong personal biases for or against PAD "should consider declining the consultation." In addition, if the psychiatrist perceives another type of conflict, financial or of another nature, the evaluation should not proceed.

According to the Oregon task force, the mental health consultant has two roles. The first role, determined by statute, is to assess the patient's specific capacity to make the decision to seek PAD. The task force also cites a second role, a traditional or clinical role, to evaluate the individual for "any remediable sources of suffering." In the process of the capacity evaluation, psychiatrists must be attuned to both. From an ethical perspective, this dual role is also critical to avoid the psychiatrist from becoming a gatekeeper for PAD and focus primary involvement with patients on their roles as healers (Sullivan 1998).

Performing the Capacity Assessment

In terms of the capacity assessment itself, the specific components of the evaluation are not strictly defined. The Oregon Task Force describes the components of the evaluation with broad guidance. The resource document describes a process that will "usually include" record review, discussion with the referring physician, patient interview and assessment, and collateral interviews with family, caregivers, and other important persons in the individual's life. Collateral information may be critical to the evaluation, but should be obtained in accordance with established rules governing confidentiality and consent. Caregivers, especially those working in hospice settings, may be particularly attuned to fluctuations in mental status, causes, and effective remedies.

The Oregon Task Force recommends that the evaluation focus on assessment for mental disorder, decision-making capacity, and factors limiting the individual's ability to make a decision (specifically, symptoms of mental disorder, coercion, and knowledge deficits). The focus of the interview, therefore, should include particular attention to understanding risks and benefits and other possible interventions, including their likelihood of success. Capacity requires both a factual understanding and an appreciation of how facts apply to the individual's own situation (Appelbaum 1988; Appelbaum 2007; Guidebook 2008).

The Task Force reminds psychiatrists to be cognizant of how tiring an evaluation may be for a terminally ill individual and also the importance of rapport.

Psychiatrists should maximize the patient's comfort and ability to demonstrate capacity and also consider the use of standardized instruments and tools. Useful instruments, according to the Task Force, may include the Geriatric Depression Scale, the Folstein MMSE, or the Neurobehavioral Cognitive Status Examination. Ultimately, however, the Task Force concludes that, "In the absence of a mental disorder, evidence of coercion, or knowledge deficits, most patients will qualify for the Oregon Act." Finally, according to the Oregon task force, when a psychiatrist cannot make a determination of capacity with confidence, options include recommending treatment, re-evaluations, and/or referral for additional capacity assessment.

In contrast to the general guidance offered by the Oregon Task Force, Werth and colleagues propose a more exhaustive set of guidelines for evaluation of capacity for PAD (Werth 2000). Much of the structure of the evaluation is consistent with the Oregon Task Force (e.g. record review, consultation, collateral information, use of objective assessment instruments, clinical interview and diagnostic assessment, and assessment of decisional capacity elements). However, Werth and colleagues also advocate for an in-depth exploration of the PAD decision in the context of the individual's perceived quality of life, stated and implied reasons for requesting PAD, and an inquiry into how the decision fits into the person's value structure and would affect others. The strength of the depth of this approach is based on the notion that it is expected to prevent erroneous granting of lethal prescriptions to incapacitated individuals. However, the specificity and depth of the requirements may have the opposite effect of limiting the availability of PAD to those who are held to too high a standard of capacity and meet adequate safeguards for self-determination by PAD.

In response to what may be perceived as the overly-demanding nature of the Werth guidelines, Stewart and colleagues (Stewart 2011) advocated for a standard essentially consistent with that developed by the Oregon Task Force. This approach draws largely on the Appelbaum-Grisso standard for capacity as well as the common law tradition of informed consent, specifically, that patients must be able to comprehend and retain information about the decision for PAD, to weigh the information and reach a decision, express a consistent preference over time, communicate choice, and be free from undue influence.

Ultimately, as PAD practice evolves, psychiatrists can play a key role in elucidating the capacity assessment process and methods of developing rapport and engaging with dying patients.

REQUESTS FOR PAD: ASSESSING DEPRESSION

While most individuals requesting PAD do not carry a diagnosis of depression, studies suggest that between a quarter to a half of requests came from individuals with depression (Wilson 2016; Levene 2011; Ganzini 2008). Presumably most of these individuals were nevertheless considered by their

attending and consultant physicians to have decisional capacity without impaired judgment since only 5% of cases in Oregon and 4% in Washington were referred for a mental health evaluation. It is not clear if the rates of referral should be higher, or if these rates are appropriate since these states' statutes only require evaluation by a mental health professional if there is concern that symptoms impair judgment. Nevertheless, given what is known about under-recognition and under-treatment of depression generally, more involvement with a mental health professional would likely be beneficial.

As noted previously, approximately 75% of the individuals accessing PAD in Oregon and Washington had cancer and approximately 10% had neurodegenerative disease, primarily ALS. Similar patterns are seen in other localities with different regulatory structures (Emanuel 2016). It is likely that similar clinical patterns might emerge in other states that legalize PAD. Therefore, understanding features of a desire for PAD, and more broadly a desire for hastened death, in these groups of individuals in particular will become important. Psychiatrists who perform mental health assessments for PAD will need to be familiar with the presentation of depression in the relevant patient populations.

While PAD accounts for a relatively small proportion of deaths (less than 0.4% of all deaths in both Oregon and Washington in 2015) and requests for PAD are relatively rare even in localities where PAD is legal, a more general desire for death[6] is not uncommon in patients with advanced life-threatening illness. Wilson and colleagues note that although studies range quite a bit in quality, researchers have found that between 11-55% of patients in palliative care settings experience such a desire at least transiently, and from 3-20% report a more pervasive and apparently sincere wish to die (Wilson 2016). Hudson and colleagues note that empirical studies of patients with advanced cancer found that approximately 8-15% of patients express an interest or a desire for hastened death and that studies with less rigorous approaches report higher levels (Hudson 2006). In two separate studies, Rabkin and colleagues found that 19% of individuals with ALS expressed a wish to die (Albert 2005; Rabkin 2015).

Regardless of the prevalence of a desire to die, depression appears to be highly correlated with it, though not universally present. Wilson and colleagues note that an association between depression and the desire for death has been found in every study that has looked at this issue, citing the prevalence of diagnosed depression among individuals expressing a desire for death has ranged from 47-80% (Wilson 2016; Periyakoil 2012; Brenne 2013; Rosenfeld 2006; Lloyd-Williams

[6] The literature in this area refers to similar concepts with different terminology; for example, different authors refer to "desire for death", "desire for hastened death," "thought about hastened death," "wish for death/hastened death" etc. These linguistic and in some cases conceptual differences likely account for some of the different findings among the many research studies addressing questions in this area. In this document, we use the terminology used by the authors in the studies we cite.

2003; Mitchell 2008). At the same time, they emphasize that the desire for death is often surrounded by a broader context of clinically significant psychological distress and note that studies looking more in depth at how individuals arrive at a desire for death have found different pathways. They conclude that the expression of a desire for death by a terminally ill patient should raise concern about the presence of mental health problems, although it is not necessarily diagnostic of active psychiatric illness (Wilson 2016). A similar conclusion is reached by Rabkin and colleagues who find that of the 62 patients in their ALS study who expressed a wish to die (19% of the study participants), only 37% (23 patients) were clinically depressed. They conclude that a wish to die is not always expressed in the context of depression and does not necessarily represent psychopathology in patients with ALS (Rabkin 2015).

Studies focusing in-depth on the *wish to hasten death*, as opposed to a more general desire for death, concur. A review of the qualitative studies of patients expressing a wish to hasten death concludes that such expressions do not necessarily imply a genuine wish to hasten one's death, but rather represent a response to overwhelming emotional distress and carry with them a variety of potential meanings (Monforte-Royo 2012). They identify six main themes giving meaning to an expressed wish to hasten death (WTHD) which they suggest should be taken into consideration when formulating treatment plans: (1) WTHD in response to physical/psychological/ spiritual suffering, (2) loss of self, (3) fear of dying, (4) the desire to live but not this way, (5) WTHD as a way of ending suffering, and (6) WTHD as a kind of control over one's life ('having an ace up one's sleeve just in case'). Despite this, many studies indicate that depression, hopelessness and a low sense of spiritual well-being are the strongest predictors of a desire for hastened death in terminally ill patients (Breitbart 2000; Albert 2005; Rosenfeld 2006; Rodin 2009). Keeping in mind the many potential contributions (including depression) to a WTHD provides for both better understanding of the context of the request and better treatment planning.

The complexity of the desire to hasten death and the variable role played by depression is just one among a variety of contributing factors, including physical symptoms (either present or foreseen), other forms of psychological distress (e.g., hopelessness, fears, etc.), existential suffering (e.g., loss of meaning in life), and social aspects (e.g. feeling that one is a burden) (Balaguer 2016). While treatment for depression is effective at reducing the symptoms of depression in these populations, it is not clear whether treating the depression changes the desire to hasten death. Some studies suggest a strong correlation between ameliorating depression and decreased desire to hasten death (Breitbart 2010; Rosenfeld 2006), while others (conducted by the same research team) do not (Rosenfeld 2014).

Thus, all clinicians working with patients who express a wish for hastened death should understand the complexity of this phenomenon and can prepare to respond in a meaningful way to patients' expressed desire for hastened death, rather than avoiding it as many do. For example, a 2006 review suggests potential

approaches for health professionals to consider when faced with patients' desire to die statements (DTDS) that will enable them to manage the issue with confidence (Hudson 2006). This review includes sample phrases and questions to use when responding to a DTDS that are culled from the literature and expert opinion covering different aspects of these expressed desires, including: (1) current feelings of fears, (2) suffering distress—physical, spiritual, psychosocial, or existential; (3) considering suicide, and (4) seeking health professional assistance with hastened death.

Screening Tools

In light of the high correlation between depression and desire to hasten death in individuals with advanced illness, screening for depression in these individuals, and in particular those who express a desire for hastened death and/or PAD, should be part of any program for providing general medical care for these individuals. Indeed, though not required by statute, the Oregon Task Force recommends screening with PHQ-9 though it is not clear how widely this recommendation is followed. Other screening instruments are also available.

Vodermaier and colleagues provide an extensive review of assessment instruments used to screen for distress in cancer patients. The definition of distress includes affective disorders, anxiety disorders and adjustment disorders (Vodermaier 2009). This paper includes a review of the psychometric properties of a variety of screening tools with emphasis on their sensitivity and specificity. While short verbal scales are helpful for quick screening of depression in hospitalized patients who have difficulty with completing long questionnaires, the longer questionnaires are valuable in their ability to address multiple domains besides depression. The authors indicate that a large variety of scales of varying lengths, including the CES-D, HADS, BDI and GHQ-28 are high quality scales for screening emotional distress. They also note that while many screening tools focus on symptoms of depression, screening measures that cover multiple domains are more valuable because the psychological symptoms in terminally ill patients may vary considerably from symptoms of depression, anxiety, adjustment disorder to mixed states. They provide the psychometric properties of ultrashort, short and long screening tools and discuss the pros and cons of the different instruments.

Some studies indicate that a single question, "Are you depressed?" is an effective screening tool for depression in palliative care patients (Lloyd-Williams 2003; Chochinov 1997). However, other studies indicate that a two-question approach that includes one question about 'depressed mood' and another about 'loss of interest' is more accurate than using either question alone; if using a single question, the 'loss of interest' question is a better screening tool (Mitchell 2008). However, neither the single 'loss of interest question' nor the two question method had a case-finding accuracy of more than 60% and would thus need to be combined with a second method with better positive predictive value. This could be a clinical

diagnostic interview or a structured and validated depression scale. The PHQ-9 is another short screening tool for depression that is widely used in medical settings and has been studied in the cancer patient population (Fann 2009). Thus, a step-wise approach of first using a screening tool followed by an assessment using a validated depression scale would be an effective approach for diagnosing depression (Mitchell 2012). While the simple verbal questions and the PHQ-9 are shorter screening tools for depression, a clinician can choose from a variety of clinical tools with variable length, psychometric properties and strengths based on the need, clinical setting and objective of use (Vodermaier 2009).

Screening for other mental illnesses could also be accomplished with tools like PRIME-MD (all of these are tied to DSM-IV diagnoses). Determining an appropriate instrument for routine screening involves trade-offs between tools of reasonable length and those with adequate psychometric properties. Computerized touch screen versions of screening instruments can be used successfully by patients with advanced illness in hospice care and, when available, touch screen and autoscoring technology ensures continuity and standardization, reduces costs, and lightens the workload of clinical personnel (Vodermaier 2009). In any screening process, a decision has to be made as to the correct balance between sensitivity and specificity. Given the gravity of a PAD decision, the emphasis may be on sensitivity to minimize the number of missed cases of depression.

Regardless of which screening tool is chosen, improved outcomes are dependent on timely referral for treatment and adequate follow-up. Programs that implement routine screening must have the ability to accommodate referrals for specialty mental health care when indicated. For example, while all of the following might result in a positive screen for depression, from a diagnostic and treatment standpoint, it would be important to differentiate a diagnosis of depression from somatic symptoms of a medical condition, medication side-effects, a grief reaction and psychological distress due to the medical condition. Many health systems do not have the ability to accommodate rapid referrals for specialty mental health care that may arise from routine screening, thus complicating implementation.

As systems determine whether and how best to move towards routine screening more generally, clinicians receiving a request from a patient for PAD might consider certain "red flags" in addition to the typical neuro-vegetative symptoms of depression when deciding about further evaluation by a mental health professional. Examples include:

- Psychological symptoms: including depressed mood, tearfulness, feeling of helplessness, feeling of hopelessness, social withdrawal or isolation, lack of interest, feelings of guilt, suicidal ideation, significant anxiety;
- Somatic concerns/preoccupations which appear beyond what would be expected from the patient's physical condition;
- Uncontrollable, poorly managed or intractable pain;

- Distress due to loss of bodily function;
- Feeling of loss of control;
- Fear of becoming a burden on others;
- Limited social supports, marital and family conflicts;
- Functional decline out of proportion to the medical situation;
- Preoccupation with financial concerns;
- Sense of therapeutic nihilism, "quickly get it over with";
- Lack of participation in or refusal of treatment;
- Fearful or loss of hope about their future;
- Dignity related distress; and/or
- Spiritual distress.

Even when further evaluation may not lead to a diagnosis of depression or another treatable mental health problem, many of these distressing experiences could benefit from specific attention by a mental health or palliative care professional, or in some cases by a case manager or social worker. Sometimes, clinicians focused on their patients' medical problems forget that some of their experiences may not be an inevitable part of their advanced illness and overlook the possibility that their distress might be alleviated by specialty care.

CONCLUSIONS

This resource document is intended to provide a summary of existing PAD statutes and states' experience related to implementation. This information may prove useful to psychiatrists, APA District Branches, and state psychiatric organizations in the event that PAD legislation is considered in their jurisdictions. We also offer a summary of relevant research on the psychiatric assessment of capacity and of depression in an effort to assist individual psychiatrists who may be asked to assess patients requesting PAD.

When reviewing this resource document, psychiatrists and policymakers should note the following limitations of the information summarized:

1. All of the currently published data about the implementation of PAD comes from Oregon and Washington State. In comparison to many other US states, these jurisdictions are relatively affluent, white, educated, and culturally homogenous.
2. The number of terminally ill individuals who have elected to seek out PAD has been small.
3. In each of those states, a small select group of attending physicians and psychiatrists has participated in PAD.
4. In those states, referrals to psychiatrists have been relatively uncommon (4-5%).

It is not known how PAD would be employed in other jurisdictions with more diverse populations. There are many potential reasons for concern. Terminally ill patients who are not affluent may be motivated to seek PAD not because they desire a more humane death, but because they cannot afford end-of-life care, have no caregivers to provide assistance, or fear burdening family and friends. It is also likely that among less educated and economically disadvantaged populations (groups with a higher prevalence of depression and other psychiatric illness), the frequency of concerns about decision-making capacity may be higher. Moreover, in more populous states, PAD will involve a larger number of physicians with more varied approaches to capacity assessment and relevant medical assessments. Finally, we have little data about psychiatric assessments that lead to recommendations against PAD due to decisional incapacity or treatable depression. The small number of psychiatric referrals currently reported raises concerns that some instances of treatable depression or decisional incapacity are not being detected.

As our society continues to explore physician-assisted death as a legally available option, collection and analysis of vital data will be essential. We recommend that all jurisdictions follow a mandatory data collection model exemplified by Oregon. Additional information should be collected about patients referred for mental health assessment, their psychiatric diagnoses, the outcomes of referral, and subsequent outcomes. Together with well-designed clinical and health services research studies, this data will be critical to advancing our understanding of the mental health presentation of patients requesting assisted death and best practices in localities where the practice is legal.

REFERENCES

Albert SM, Rabkin JG, Del Bene ML, et al: Wish to die in end-stage ALS. Neurology 2005; 65:68–74

American Medical Association. Code of Medical Ethics (Chicago, 2016).

Antunes B, Mutagh F, Bausewein C, et al: Screening for depression in advanced disease: psychometric properties, sensitivity, and specificity of two items of the Palliative Care Outcome Scale (POS). J Pain Symp Management 2015; 49:277-288

Appelbaum PS, Grisso T: Assessing Patients' Capacities to Consent to Treatment. New Engl J Med 1988; 319:1635-1638

Appelbaum PS: Assessment of Patients' Competence to Consent to Treatment. New Engl J Med 2007; 357:1834-1840

Balaguer A, Monforte-Royo C, Porta-Sales J, et al: An International Consensus Definition of the Wish to Hasten Death and Its Related Factors. PloS One 2016; 11:e0146184

Baxter v. Montana (2009) 224 P. 3d 1211.

Breitbart W, Rosenfeld B, Pessin H, et al: Depression, Hopelessness, and Desire for Hastened Death in Terminally Ill Patients with Cancer. JAMA 2000; 284:2907-11

Breitbart W, Rosenfeld B, Gibson C, et al: Impact of treatment for depression on desire for hastened death in patients with advanced AIDS. Psychosomatics 2010; 51:98–105

Brendel RW, Schouten RA: Legal concerns in psychosomatic medicine. Psych Clin North Am 2007; 30:663-676.

Brenne E, Loge JH, Kaasa S, et al: Depressed patients with incurable cancer: which depressive symptoms do they experience? Palliative and Supportive Care 2013; 11: 491-501

California End of Life Option Act. CMA Legal Counsel resource document. Jan 2016 (http://www.cmanet.org/resource-library/detail/?item=the-california-end-of-life-option-act)

Chochinov HM, Wilson KG, Enns M, Lander S: Are you depressed? Screening for depression in the terminally ill. Am J Psychiatry 1997; 154: 674-676

Chochinov HM: Physician-assisted death in Canada. JAMA 2016; 315:253-4.

Duffy OA: The Supreme Court of Canada Ruling on Physician-Assisted Death: Implications for Psychiatry in Canada. Can J. Psychiatry 2015; 60:591-596

Emanuel E, Onwuteaka-Philipsen B, Urwin J, Cohen J: Attitudes and Practices of Euthanasia and Physician-Assisted Suicide in the United States, Canada, and Europe. JAMA 2016; 316:79-90

Fann JR, Berry DL, Wolpin S, et al: Depression screening using the Patient Health Questionnaire-9 administered on a touch screen computer. Psycho-Oncology 2009; 18: 14-22.

Fenn DS, Ganzini L: Attitudes of Oregon psychologists toward physician-assisted suicide. Prof Psychol Res Pract 1999; 30:235-244.

Ganzini L, Fenn DS, Lee MA, et al: Attitudes of Oregon psychiatrists toward physician-assisted suicide. Am J Psychiatry 1996; 153:1469-1475

Ganzini L, Leong GB, Fenn DS, et al: Evaluation of competence to consent to assisted suicide: views of forensic psychiatrists. Am J Psychiatry 2000; 157:595-600

Ganzini L, Nelson HN, Schmidt TA, et al: Physicians' Experiences with the Oregon Death with Dignity Act. N Engl J Med 2000; 342: 557-563

Ganzini L, Goy E, Dobscha S: Prevalence of depression and anxiety in patients requesting physicians' aid in dying: cross sectional survey. BMJ 2008; 337:a1682

Ganzini L: Psychiatric evaluations for individuals requesting assisted death in Washington and Oregon should not be mandatory. General Hospital Psychiatry 2014; 36: 10-12

Ganzini L: Legalised Physician-Assisted Death in Oregon. QUT Law Review 2016; 16: 76-83

Gopal A: Physician-assisted suicide: Considering the evidence, existential distress and an emerging role for psychiatry. JAAPL 2015; 43:183-90

Hedberg K, Hopkins D, Leman R, Kohn M: The 10-Year Experience of Oregon's Death with Dignity Act: 1998-2007. J Clin Ethics 2009; 20: 124-132

Hedberg K, Hopkins D, Kohn M: Five Years of Legal Physician-Assisted Suicide in Oregon. N Engl J Med 2003; 348: 961-964

Hudson P, Kristjanson L, Ashby M, et al: Desire for hastened death in patients with advanced disease and the evidence base of clinical guidelines: a systematic review. Palliat Med 2006; 20:693-701

Hudson P, Schofield P, Kelly B, et al: Responding to desire to die statements from patients with advanced disease: recommendations for health professionals. Palliat Med 2006; 20:703-10

Levene I, Parker M: Prevalence of depression in granted and refused requests for euthanasia and assisted suicide: a systematic review. J Med Ethics 2011; 37:205-11

Lloyd-Williams M, Payne S, Reeve J, et al: Thoughts of self-harm and depression as prognostic factors in palliative care patients. J Affect Dis 2014; 166:324-329

Lloyd-Williams M, Spiller J, Ward J: Which depression screening tools should be used in palliative care? Palliative Medicine 2003; 17: 40-43

Loggers ET, Starks H, Shannon-Dudley M, et al: Implementing a Death with Dignity program at a comprehensive cancer center. N Engl J Med 2013; 368:1417-1424

McCormack R, Flechais R: The role of psychiatrists and mental disorders in assisted dying practices around the world: A review of the legislation and official reports. Psychosomatics 2012; 53:319-326

Mitchell AJ: Are one or two simple questions sufficient to detect depression in cancer and palliative care? A Bayesian meta-analysis. Br J Canc 2008; 98: 1934-1943

Mitchell AJ, Meader N, Davies E, et al: Meta-analysis of screening and case finding tools for depression in cancer: evidence based recommendations for clinical practice on behalf of the Depression in Cancer Care consensus group. J Affective Disorders 2012; 140: 149-160

Monforte-Royo C, Villavicencio-Chavez C, Tomas-Sabado J, et al: What Lies behind the Wish to Hasten Death? A Systematic Review and Meta-Ethnography from the Perspective of Patients. PloS One. 2012; 7:e37117.

Oregon Death with Dignity Act. Oregon Rev. Stat. 127.800-127.995 (1997)

Oregon Death with Dignity Act: A Guidebook for Health Care Professionals published by the Task Force to Improve the Care of Terminally-Ill Oregonians, Oregon Health and Sciences University, 2008. http://www.ohsu.edu/xd/education/continuing-education/center-for-ethics/ethics-outreach/upload/Oregon-Death-with-Dignity-Act-Guidebook.pdf

Orentlicher D, Pope TM, Rich BA: Clinical Criteria for Physician Aid in Dying. J Palliat Med 2016; 19: 259–262

Periyakoil VS, Kraemer HC, Noda A: Measuring Grief and Depression in Seriously Ill Outpatients Using the Palliative Grief Depression Scale. J Palliative Medicine 2012; 15: 1350-1355

Personal communication. Datta V, University of Washington Medical Center consultation-liaison psychiatry faculty, 2015.

Rabkin J, Goetz R, Factor-Litvak P, et al: Depression and wish to die in a multicenter cohort of ALS patients. Amyotroph Lateral Scler Frontotemporal Degener 2015; 16:265-73.

Rodin G, Lo C, Mikulincer M, et al: Pathways to distress: the multiple determinants of depression, hopelessness, and the desire for hastened death in metastatic cancer patients. Soc Sci Med 2009; 68: 562-569

Rosenfeld B, Breitbart W, Gibson C, et al: Desire for hastened death among patients with advanced AIDS. Psychosomatics 2006; 47:504–512

Rosenfeld, B, Pessin H, Marziliano A, et al: Does desire for hastened death change in terminally ill cancer patients? Soc Sci Med 2014: 111: 35-40.

Steinbrook R: Physician Assisted Death – From Oregon to Washington State. N Engl J Med 2008; 359:2513-2515

Stewart C, Peisah C, Draper B: A test for mental capacity to request assisted suicide. J Med Ethics 2011; 37:34-39

Sullivan MD, Ganzini L, Younger SJ: Should Psychiatrists Serve as Gatekeepers for Physician-Assisted Suicide? Hastings Center Report 1998; 28:24-31

Vodermaier A, Linden W, Siu C: Screening for Emotional Distress in Cancer Patients: A Systematic Review of Assessment Instruments. J Natl Cancer Inst 2009; 101:1464-88.

Walker-Renshaw B, Finley M: Will the SCC's decision on physician-assisted death apply to persons suffering from severe mental illness? Health Law Canada 2016; 36:74-79.

Washington State Death With Dignity Act. RCW 70.245.010 http://app.leg.wa.gov/rcw/default.aspx?cite=70.245.010 (accessed 06/30/2016)

Washington State Psychological Association: Washington Death With Dignity Act: WSPA Guidelines for Mental Health Professionals (2009). http://endoflifewa.org/wp-content/uploads/2014/08/WSPA-DWD_Guidelines_6-3-09.pdf (accessed 06/30/2016)

Weintraub Brendel R, Schouten R, Levenson JL: Legal issues. In: Levenson JL, ed. American psychiatric publishing textbook of psychosomatic medicine: psychiatric care of the medically ill, 2nd ed. Washington, DC: American Psychiatric Publishing; 2011: 19-32

Werth JL: Mental health professionals and assisted death: perceived ethical obligations and proposed guidelines for practice. Ethics Behav 1999; 9:159-83

Werth JL, Benjamin GA, Farrenkopf T: Requests for physician-assisted death: guidelines for assessing mental capacity and impaired judgment. Psychol Public Policy Law 2000; 6:348-72

Wilson KG, Dalgleish TL, Chochinov HM, et al: Mental disorders and the desire for death in patients receiving palliative care for cancer. BMJ Support Palliat Care 2016; 6:170-7

ADDITIONAL SELECTED BIBLIOGRAPHY

Back A, Starks, H, Hsu C, et al: Clinician-Patient Interactions About Requests for Physician-Assisted Suicide. Arch Intern Med2002; 162:1257-65

Brendel R, Epstein L, Cassem N: Care at the End of Life. In Stern T, et al. MGH Comprehensive Clinical Psychiatry, 1st ed, 2008. Chapter 60.

Chochinov, HM, Johnston W, McClement SE, et al: Dignity and distress towards the end of life across four non-cancer populations. PloS One 2016; 11: e0147607

Jamison S: Factors to Consider Before Participating in a Hastened Death. Psychol Public Policy Law 2000; 6:416-33

Kolva E, Rosenfeld B, Liu Y: Using Item Response Theory (IRT) to Reduce Patient Burden When Assessing Desire for Hastened Death. Psychol Assess 2017: 29: 349-353

Monforte-Royo C, Villavicencio-Chavez C, Tomas-Sabado J, et al: The wish to hasten death: a review of clinical studies. Psycho-Oncology 2011; 20: 795-804

Ohnsorge K, Gudat H, Rehmann-Sutter C: Intentions in wishes to die: analysis and a typology–A report of 30 qualitative case studies of terminally ill cancer patients in palliative care. Psycho-Oncology 2014; 23: 1021-1026

Smith K, Harvath T, Goy E, Ganzini L: Predictors of pursuit of physician-assisted death. J Pain Symptom Manage 2015; 49:555-61

Tiernan E, Casey P, O'Boyle, C, et al: Relations between desire for early death, depressive symptoms and antidepressant prescribing in terminally ill patients with cancer. J Royal Soc Med 2002; 95: 386-390

Varghese FT, Kelly B: Countertransference and Assisted Suicide. Issues Law Med 2001; 16: 235-258

Position Statement on Review of Sentences for Juveniles Serving Lengthy Mandatory Terms of Imprisonment

Approved by the Board of Trustees, December 2011
Approved by the Assembly, November 2011

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

The APA affirms the undesirability of long-term mandatory sentences without possibility of parole for offenders who were younger than 18 at the time of the offense. Such sentences fail to take account of the significant prospects of maturation and rehabilitation for most youthful offenders, even those convicted of serious offenses. States should require reviews for all juvenile offenders who are sentenced to lengthy mandatory terms of imprisonment.

The reviews should:

- take place within a reasonable period of time after sentencing and periodically thereafter;
- include evaluations by qualified mental health professionals when an offender's current developmental maturity or mental health status are relevant to the reviews;
- be conducted by mental health professionals trained to evaluate children and adolescents for offenders still under age 18; and
- include a thorough review of the offender's developmental, educational, legal, social, medical, mental health and substance abuse histories; and interviews with knowledgeable informants, including family members; and additional testing when needed.

Prepared by the Council on Psychiatry and the Law.

Position Statement on Lengthy Sentences Without Parole for Juveniles

The APA affirms the undesirability of long-term sentences without possibility of parole for offenders who were younger than 18 at the time of the offense. Such sentences fail to take into account the developmental immaturity, reduced culpability, and prospects for rehabilitation in many youthful offenders, even those convicted of serious offenses.

Report to the Council on Psychiatry and Law

of the Workgroup on the Revision of the APA Position on the Mandatory Sentencing of Juveniles

May 30, 2017

Workgroup: Drs. Ash (chair), Kapoor, Sidor, Gandhi, Zonana, Pinals, and Buchanan

At last September's Component meeting, this workgroup was appointed to consider a revision of the APA Position on Review of Sentences for Juveniles Serving Lengthy Mandatory Terms of Imprisonment that was adopted in 2011 (attached). The essentials of the recommendation below was discussed at the Council meeting on May 23, and reworded slightly following the Council's discussion.

Recommendation

For the reasons discussed below, the Workgroup recommends retiring the 2011 Position and adopting a revised Position with a new title and revised content that would read:

Position Statement on Lengthy Sentences Without Parole for Juveniles

> The APA affirms the undesirability of long-term sentences without possibility of parole for offenders who were younger than 18 at the time of the offense. Such sentences fail to take into account the developmental immaturity, reduced culpability, and prospects for rehabilitation in many youthful offenders, even those convicted of serious offenses.

Rationale for revision

The 2011 Position Statement was adopted before the SCOTUS decision in *Miller v Alabama* in 2012 that held that mandatory life without parole (LWOP) sentences were unconstitutional for minors, but did allow for LWOP sentences for murder on a case-by-case basis. In 2016, in the *Montgomery v Louisiana* holding, *Miller* was held to be retroactive, and the court went on to say that LWOP sentences should be rare. Most of the action regarding mandatory sentences since 2012 has been in LWOP cases, and less attention has been paid to sentences that are lengthy but less than life and do not have the possibility of parole.

As we read the 2011 statement, it has 3 main points:

1. Lengthy mandatory sentences for juveniles should not be given.
2. States should require reviews for those who have been given mandatory long sentences.
3. Various guidelines for those reviews are given.

Our view is that point 1 makes sense and should remain a position, with slight rewording. Points 2 and 3 are problematic and should be deleted.

1. The reasons SCOTUS banned mandatory LWOP sentences apply to other lengthy sentences without parole, so it makes sense to continue to oppose them. We suggest slightly revised wording to make the point that youth should not get long sentences without parole because of their developmental immaturity and diminished culpability, even in cases where significant rehabilitation is unlikely. The court's finding of diminished culpability of adolescents justifies holding a hearing to consider long sentences on a case-by-case basis after the juvenile has had time to mature and show rehabilitation.

2. The 2011 position refers to reviews AFTER the mandatory sentence is given. (It is clear that mental health evaluation should generally be used prior to sentencing, but that's not what this position is about.) For those who have received a mandatory sentence, there is no clear rationale for periodic reviews. How would a review be used? If the review says the person is now rehabilitated, what would a judge do with the finding? The sentence is mandatory. Who would read it? There's no parole board to consider it. There may be statutes in some states that allow reviews of mandatory sentences, but most do not. There are cases in which an inmate brings a *habeas* action, but then the argument is essentially that the mandatory sentence should not have been given (because of ineffective counsel or some such reason), and in those cases, mental health evaluation (which may have been omitted prior to sentencing) is typically obtained.
3. Re the guidelines – first, if the review has no way of getting in front of a judge, how to do it is moot. Second, the last paragraph of the 2011 position statement:

   > "include a thorough review of the offender's developmental, educational, legal, social, medical, mental health and substance abuse histories; and interviews with knowledgeable informants, including family members; and additional testing when needed"

   leaves out the two most important issues that need to be evaluated in post-sentencing evaluations, which are first, how the mitigating factors of youth (impulsivity, peer pressure, imposed adverse environmental factors, and a character that is in flux) relate to the actual crime, and second, the extent to which the inmate has demonstrated rehabilitation since arrest. While this might suggest a move on our part to attempt to improve the guideline, we think that is not the way to go because:
   a) This is a position statement, not a treatment or evaluation guideline.
   b) There is no consensus on what a good evaluation is. Since *Miller*, there has been a lot of action in the area of resentencing juvenile LWOP defendants, and the area is still in flux.
   c) Resentencing criteria are not uniform across the states. For example, some states have laid out specific criteria for resentencing (see, for example, *ex parte Larry Henderson*, 155 So.3d 1130 (2012)) and so evaluations in those states need to address those criteria.
   d) Given that both the legal principles and the clinical issues in this area are changing rapidly, it would be premature for us to establish a guideline.

Therefore, the Position Statement should by shortened to focus on the main point about the undesirability of mandatory sentences for juveniles.

We think the revised position would be helpful to psychiatrists, both those who testify in these cases, and those who are engaged in advocacy work related to adolescent sentencing.

Position Statement on Segregation of Prisoners with Mental Illness

Approved by the Board of Trustees, December 2012
Approved by the Assembly, November 2012

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

Prolonged segregation of adult inmates with serious mental illness, with rare exceptions, should be avoided due to the potential for harm to such inmates. If an inmate with serious mental illness is placed in segregation, out-of-cell structured therapeutic activities (i.e., mental health/ psychiatric treatment) in appropriate programming space and adequate unstructured out-of-cell time should be permitted. Correctional mental health authorities should work closely with administrative custody staff to maximize access to clinically indicated programming and recreation for these individuals.

Background to the Position Statement

The number of persons incarcerated in prisons and jails in the United States has risen dramatically during the past three decades, accompanied by a significant increase in prisoners with serious mental illness. Studies have consistently indicated that 8 to 19 % of prison inmates have psychiatric disorders that result in significant functional disabilities and another 15 to 20 % require some form of psychiatric intervention during their incarceration (1, 2).

Physicians who work in U.S. correctional facilities face challenging working conditions, dual loyalties to patients and employers, and a tension between reasonable medical practices and the prison rules and culture. In recent years, physicians have increasingly confronted a new challenge: the prolonged solitary confinement, or segregation, of prisoners with serious mental illness. This prevalent corrections practice and the difficulties in providing access to care in these settings have received scant professional or academic attention (3).

Segregated inmates are isolated from the general correctional population and receive services and activities apart from other inmates. For the purposes of this position statement, segregation refers to conditions of confinement characterized by an incarcerated person generally being locked in their cell for 23 hours or more per day (4). Inmates may be segregated for institutional safety reasons (administrative segregation), disciplinary reasons (disciplinary segregation), or personal safety (protective custody) (5). Correctional systems vary regarding the specific conditions of confinement in segregation units (e.g., one to two inmates in a cell, inmate access to a radio or television, other property restrictions, visitation privileges, etc.). The definition of "prolonged segregation" will, in part, depend on the conditions of confinement. In general, prolonged segregation means duration of greater than 3-4 weeks.

Several studies have shown that inmates with serious mental illness have more difficulty adapting to prison life than do inmates without a serious mental illness. Morgan, Edwards, and Faulkner (6) reported that seriously mentally ill prisoners were less able to successfully negotiate the complexity of the prison environment, resulting in an increased number of rule infractions leading to more time in segregation and in prison. Lovell and Jemelka (7, 8) found that inmates with serious mental illnesses committed infractions at three times the rate of non-seriously mentally ill counterparts.

Placement of inmates with a serious mental illness in these settings can be contraindicated because of the potential for the psychiatric conditions to clinically deteriorate or not improve (6, 10). Inmates with a serious mental illness who are a high suicide risk or demonstrating active psychotic symptoms should not be placed in segregation housing as previously defined and instead should be transferred to an acute psychiatric setting for stabilization.

References

1. Metzner JL: Guidelines for psychiatric services in prisons. Crim Behav Ment Health 3:252–67, 1993
2. Morrissey JP, Swanson JW, Goldstrom I, Rudolph L, Manderscheid RW: Overview of Mental Health Services by State Adult Correctional Facilities: United States, 1988. Washington, DC: U.S. Department of Health and Human Services, publication (SMA)93-1993, 1993, pp 1–13)
3. Metzner JL, Fellner J: Solitary Confinement and Mental Illness in U.S. Prisons: A Challenge for Medical Ethics. J Am Acad Psychiatry Law 38:104–8, 2010
4. American Psychiatric Association. Psychiatric Services in Jails and Prisons, 2nd Edition. Washington, DC: American Psychiatric Association, 2000
5. National Commission on Correctional Health: Standards for Mental Health Services in Correctional Facilities. Pages 60 – 61, 2008
6. Work Group on Schizophrenia: American Psychiatric Association practice guidelines: practice guideline for the treatment of patients with schizophrenia. Am J Psychiatry 154(suppl):1–63, 1997
7. Morgan DW, Edwards AC, Faulkner LR: The adaptation to prison by individuals with schizophrenia. Bulletin of the American Academy of Psychiatry and the Law, 21, 427-433, 1993
8. Lovell D, Jemelka R: When inmates misbehave: The costs of discipline. The Prison Journal, 76, 165-179, 1996
9. Lovell D, Jemelka R: Coping with mental illness in prison. Family & Community Health, 21, 54-66, 1998
10. Metzner JL, Dvoskin JA: An Overview of Correctional Psychiatry. Psychiatric Clinics N Am , 29: 761-772, 2006

Position Statement on Assessing the Risk for Violence

Approved by the Board of Trustees, July 2012
Approved by the Assembly, May 2012

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

This position statement was proposed by the Workgroup on Violence Risk of the Council on Psychiatry and Law.

During their careers most psychiatrists will assess the risk of violence to others. While psychiatrists can often identify circumstances associated with an increased likelihood of violent behavior, they cannot predict dangerousness with definitive accuracy. Over any given period some individuals assessed to be at low risk will act violently while others assessed to be at high risk will not. When deciding whether a patient is in need of intervention to prevent harm to others, psychiatrists should consider both the presence of recognized risk factors and the most likely precipitants of violence in a particular case.

The members of the Workgroup on Violence Risk are Alec Buchanan, M.D. (Chairperson), Michael A. Norko, M.D., Renee L. Binder, M.D., and Marvin Swartz, M.D.

Position Statement on Firearms Access: Inquiries in Clinical Settings

Approved by the Board of Trustees, December 2012
Approved by the Assembly, November 2012

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

State legislators are considering bills that would restrict physicians from making inquiries of patients and others (e.g., family members) in patient care contexts related to possession of and access to firearms, with the threat of sanctions for those physicians who violate the restrictions. The American Psychiatric Association opposes legislation that restricts healthcare professionals in clinical roles from asking patients and others about possession of and access to firearms because such laws impede physicians from conducting appropriate psychiatric evaluations and taking steps to prevent loss of life by suicide, homicide, and accidental injury.

Background to the Position Statement

Firearm deaths and related injury are a major public health problem. During 2006–2007, firearms accounted for 25,423 homicides and 34,235 suicides among U.S. residents, making firearm-related suicide or homicide among the top three leading causes of death between the ages of 10 and 64 (CDC 2011). Thus, clinical inquiries regarding availability, storage and use of firearms are an important component of preventive medicine by psychiatrists and other healthcare professionals.

Assessment of risk of harm to self or others is a routine part of a appropriate psychiatric evaluation (APA, 2006). This requires a psychiatrist to inquire about thoughts related to self-directed or other-directed harm along with an examination of patients' mental states that might indicate such risk. The inquiry related to risk of harm frequently involves the need to explore whether the patient has access to firearms or other potential weapons. Such an inquiry is often clinically indicated even in the absence of circumstances suggesting an imminent risk of harm and may include discussion of such matters with parents and guardians of minor patients. Failure to make such inquiries would compromise the quality of care provided to our patients and, with regard to outwardly directed violence, the safety of the community.

In psychiatry, as in the all of medicine, questions related to personal or private matters can have important public health and safety benefits and therefore may be a necessary component of clinical practice. Asking patients about access to firearms and other weapons should be considered along the same lines as these other health and safety inquiries (e.g., alcohol and drug use, tobacco use, car seat use, etc). Responses to inquiries related to firearms should be utilized to inform suicide and violence risk assessments, general treatment planning, and patient education.

References:

1. American Psychiatric Association (2006), Practice guideline for the psychiatric evaluation of adults, second edition. American Journal of Psychiatry. 163:6 (Supplement), June 2006.
2. American Psychiatric Association (2003) Practice Guidelines for Treatment of Patients with Suicidal Behaviors
3. Center for Disease Control, Violence-related firearm deaths among residents of metropolitan areas and cities, United States 2006-2007, Morbidity and Mortality Weekly Report, May 13, 2011
4. Center for Disease Control, Injury Center Connection Newsletter Spring/Summer 2011, available at: http://www.cdc.gov/injury/publications/nl2011sp/pubs.html, accessed 1/21/12.

Position Statement on Use of Jails to Hold Persons Without Criminal Charges Who Are Awaiting Civil Psychiatric Hospital Beds

Approved by the Board of Trustees, July 2007
Approved by the Assembly, May 2007

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

Access to appropriate levels of care is essential for persons with mental illness. Where no criminal conduct has been alleged, persons determined to be in need of civil psychiatric commitment for treatment of acute psychiatric symptoms should not be held in jails or other correctional facilities.

The APA encourages psychiatrists to continue to work with local, state, and federal agencies to provide adequate mental health services for civil committees.

Position Statement on Psychiatric Services in Jails and Prisons

Reaffirmed, 2007

This statement was prepared by the Task Force on Psychiatric Services in Jails and Prisons[1] of the Council on Psychiatric Services. It was approved by the Assembly in November 1988 and by the Board of Trustees in December 1988.

The American Psychiatric Association accords a high priority to the care and treatment of patients from groups that are underserved, especially groups that lack strong political constituencies. Such groups include the chronically mentally ill and the mentally ill homeless. Also included, but less visible, are the mentally ill in jails and prisons.

The mentally ill are especially vulnerable to the difficult conditions that typically prevail in our jails and prisons. Psychiatrists practicing in such facilities attempt to provide adequate services under the most difficult working circumstances, with inadequate professional recognition and remuneration, and, perhaps most burdensome of all, in the midst of frequently deplorable conditions.

In the 1974 "Position Statement on Medical and Psychiatric Care in Correctional Institutions" (1), APA called for a "full range of . . . psychiatric services" in jails and prisons. Noting that "an essential part of a minimal medical care delivery system consists of the early detection, diagnosis, treatment, and prevention of psychiatric illness," the APA position statement went on to forcefully state that "the fact of incarceration imposes upon public authority the special duty to provide adequate medical services, including psychiatric services. Availability of such services is and should be a right of the incarcerated individual."

However, a decade later, in 1983, APA was obliged to observe that "providing mental health treatment for persons in jails and prisons has, over the years, proved a refractory problem" (2). In part, this situation persists because of the altered social context of the operations of correctional facilities, which has resulted in tightened admission criteria for psychiatric hospitalization, fewer beds, limits on length of stay, reduced availability and use of civil commitments, and changing sentencing practices that have increased the number of inmates needing mental health services. Legislative demands for fiscal austerity and associated public policies, such as deinstitutionalization, have led to a complex set of circumstances that have been associated with an increase in the number of mentally ill persons who are at risk of incarceration in local jails because of minor charges used to address their disturbed behavior. This situation has resulted in a substantial increase in the population of inmates requiring mental health care.

Severe overcrowding is an additional factor often contributing to the inadequacy of psychiatric services in jails and prisons. Conditions are often so bad in contemporary jails and prisons that both state and federal courts have mandated sweeping changes in their operations. The Supreme Court has ruled that it is the obligation of correctional officials to ensure that the civil rights of the mentally ill are protected. This obligation includes the right to adequate mental health care. Providing adequate mental health care in this context rests on the following principles:

1. The fundamental goal of a mental health service should be to provide the same level of care to patients in the criminal justice process that is available in the community.
2. The effective delivery of mental health services in correctional settings requires that there be a balance between security and treatment needs. There is no inherent conflict between security and treatment.
3. A therapeutic environment can be created in a jail or a prison setting if there is clinical leadership, with authority to create such an environment.
4. Timely and effective access to mental health treatment is a hallmark of adequate mental health care. Necessary staffing levels should be determined by what is essential to ensure that access.
5. Psychiatrists should take a leadership role administratively as well as clinically. Further, it is imperative that psychiatrists define their professional responsibilities to include advocacy for improving mental health services in jails and prisons.
6. Psychiatrists should actively oppose discrimination based on religion, race, ethnic background, or sexual preference, not only for mental health services but for all activities in the judicial-legal process.

Elaborations and explications of these principles can be found in the report of the Task Force on Psychiatric Services in Jails and Prisons, June 1988, which will be available from the APA Office of Psychiatric Services in the near future.

Finally, APA calls on its members to participate in the care and treatment of the mentally ill in jails and prisons, for without an increased commitment and involvement of its membership in providing services to the mentally ill in jails and prisons, position statements such as this will be meaningless. The breadth and depth of these problems demand much more.

[1]The task force included Henry C. Weinstein, M.D. (chairperson and Assembly liaison), James O. Hoover, M.D., Jeffrey L. Metzner, M.D., Robert L. Sadoff, M.D., Veva H. Zimmerman, M.D., and Bruce Kagan, M.D. (APA/Burroughs Wellcome Fellow). Consultants to the task force were Saleem A. Shah, Ph.D., Henry J. Steadman, Ph.D., Rachel Ehrenfeld, Ph.D., and Susan O. Reed, M.P.A.

REFERENCES

1. American Psychiatric Association: Position statement on medical and psychiatric care in correctional institutions. Am J Psychiatry 1974; 131:743
2. American Psychiatric Association Insanity Defense Work Group: American Psychiatric Association statement on the insanity defense. Am J Psychiatry 1983; 140:681–688

Position Statement on Homicide Prevention and Gun Control

This statement was written by the Council on National Affairs.[1] *It was approved by the Assembly in November 1993 and by the Board of Trustees in December 1993.*

In view of the increasing violence in our society and the fact that homicide deaths are now a significant contributor to national death rates, and

In view of the particular relationships of firearms to homicide and personal injury with the resultant threat to life and security, adding to fears and stresses in a crowded urban society, and

In view of the need to reinforce individual and group sanctions against the use of violence as a social instrument, behavioral mode, or adaptational pattern, as psychiatrists have done with drug abuse, suicidal actions, and antisocial behavior,

The American Psychiatric Association recommends that strong controls be placed on the availability of all types of firearms to private citizens.

[1]The council members are Fred Gottlieb (chairperson), M.D., Leah J. Dickstein, M.D., Silvia W. Olarte, M.D., Terry Stein, M.D., Nada L. Stotland, M.D., and Billy Jones, M.D.

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

Approved by the Board of Trustees, December 2014
Approved by the Assembly, November 2014

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

1. Many deaths and injuries from gun violence can be prevented through national and state legislative and regulatory measures. Recognizing that the vast majority of gun violence is not attributable to mental illness, the APA views the broader problem of firearm-related injury as a public health issue and supports interventions that reduce the risk of such harm. Actions to minimize firearm injuries and violence should include:
   a. Requiring background checks and waiting periods on all gun sales or transactions;
   b. Requiring safe storage of all firearms in the home, office or other places of daily assembly;
   c. Regulating the characteristics of firearms to promote safe use for lawful purposes and to reduce the likelihood that they can be fired by anyone other than the owner without the owner's consent;
   d. Banning possession of firearms on the grounds of colleges, hospitals, and similar institutions by anyone other than law enforcement and security personnel; and
   e. Assuring that physicians and other health care professionals are free to make clinically appropriate inquiries of patients and others about possession of and access to firearms and take necessary steps to reduce the risk of loss of life by suicide, homicide, and accidental injury.

2. Research and training on the causes of firearm violence and its effective control, including risk assessment and management, should be a national priority.
   a. Administrative, regulatory and/or legislative barriers to federal support for violence research, including research on firearms violence and deaths, should be removed.
   b. Given the difficulty in accurately identifying those persons likely to commit acts of violence, federal resources should be directed toward the development and testing of methods that assist in the identification of individuals at heightened risk of committing violence against themselves or others with firearms.
   c. The federal government should develop and fund a national database of firearm injuries. This database should include information about all homicides, suicides, and unintentional deaths and injuries, categorized by specific weapon type, as well as information about the individuals involved (absent personal identifiers), geographic location, circumstances, point of purchase, date and other policy-relevant information.
   d. Funding for research on firearm injuries and deaths should draw on a broad range of public and private resources and support, such as the Centers for Disease Control, the National Institutes of Health, and the National Science Foundation.
   e. All physicians and other health professionals should continue to be trained to assess and respond to those individuals who may be at heightened risk for violence or suicide. Such training should include education about speaking with patients about firearm access and safety. Appropriate federal, state, and local resources should be allocated for training of these professionals. Resources should be increased for safety education programs related to responsible use and storage of firearms.

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

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

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

   a. Non-adjudicated events should not serve as sufficient grounds for a disqualification from gun ownership and should not be reported to the NICS system. The adjudicatory process provides important protections that ensure the accuracy of determinations (such as dangerousness-based civil commitment), including the right to representtation and the right to call and cross-examine witnesses.
   b. Rational policy with regard to implementation of such restrictions calls for the duration of the restriction to be based on individualized assessment rather than a categorical classification of mental illness or a history of a mental health-related adjudication.
   c. Although the restrictions on access to firearms recommended in items 1 and 2 above would decrease the risk of suicide and violence in the population, extending restrictions to individuals who voluntarily seek mental health care and incorporating their names and mental health histories into a national registry is inadvisable because it could dissuade persons from seeking care and further stigmatize persons with mental disorder.
   d. A person whose right to purchase or possess firearms has been suspended on grounds related to mental disorder should have a fair opportunity to have his or her rights restored in a process that properly balances the person's rights with the need to protect public safety and the person's own well-being. Accordingly, the process for restoring an individual's right to purchase or possess a firearm following a disqualification relating to mental disorder should be based on adequate clinical assessment, with decision-making responsibility ultimately resting with an administrative authority or court.

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

   a. Early identification and treatment of mental disorders, including school-based screening, should be prioritized in national and local agendas, along with other efforts to augment prevention strategies, reduce the stigma of seeking or obtaining mental health treatment, and diminish the consequences of untreated mental disorders.
   b. For those people with mental illness who may pose an increased risk of harm to themselves or other people, barriers to accessing appropriate treatment should be removed. Access to care and associated resources to enhance community follow up, which includes care and resources to address mental disorders, including substance use disorders, should be maximized to ensure that patients who may need to transition between service providers or settings, e.g., from an inpatient setting to community- based treatment, continue to obtain treatment and are not lost to care.
   c. Because privacy in mental health treatment is essential to encourage persons in need of treatment to seek care, laws designed to limit firearm possession that mandate reporting to law enforcement officials by psychiatrists and other mental health professionals of all patients who raise concerns about danger to themselves or others are likely to be counterproductive and should not be adopted. In contrast to long-standing rules allowing mental health professionals flexibility in acting to protect identifiable potential victims of patient violence, these statutes intrude into the clinical relationship and are unlikely to be effective in reducing rates of violence.
   d. The President of the United States should consolidate and coordinate current interests in improveing mental health care in this country by appointing a Presidential Commission to develop a vision for an integrated system of mental health care for the 21st century.

Item #8.K
Joint Reference Committee
June 17, 2017

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 January 2017, the Council has been focused on the following issues:

- **Quality Measures:** The Council was asked to review two rules related to quality measures – *The 2018 IPPS/LTCH proposed Rule for Medicare Inpatient Hospitals and Long-Term Care Hospitals* and the *Inpatient Prospective Payment System Proposed Rule.* The Council is planning to work with the Council on Quality to explore opportunities for developing measures related to the work of Consult Liaison Psychiatry in in-patient medical hospitals.

- **Fellowship Recruitment for Subspecialties:** Dr. Gitlin, Chair of the Council, worked with APA's Department of Education to organize and host a meeting of the subspecialty Councils, as well as representatives from the Chair's Council, AADPRT, ABPN, and ACGME, during the APA Annual Meeting to discuss recruiting challenges. The Councils agreed to continue to discuss how to work together and develop a position statement to encourage fellowships.

- **Name Change:** The Council continues to work closely with the Academy of Psychosomatic Medicine (APM) on seeking a name change for the specialty from Psychosomatic Medicine to Consultation-Liaison Psychiatry, a change that received overwhelming support by the Council, APM members, ACGME, and the APA Board of Trustees. ABPN has also supported this, and will bring it to ABMS for a vote on the name change in September. The Council is thinking about rebranding opportunities in anticipation of the change.

- **Position Statements:** the Council has been working in partnership with the Council on Geriatric Psychiatry to develop a Position Statement on "Palliative Care and Psychiatry". Final draft is nearing completion and expected to be available for JRC review at next meeting.

- **Resource Documents:** The Council has workgroups in the process of developing Resource Documents on the following topics:
    - "QTc Prolongation and Psychiatric Disorders"
    - "The Assessment of Capacity for Medical Decision Making", and
    - "Emergency Department Boarding of Individuals with Acute Mental Illness".

Lastly, the HIV Steering Committee is working to increase the knowledge of HIV Psychiatry among HIV clinicians through training and developing resources. The application period for the APA HIV Psychiatry Elective, which provides an opportunity for fourth year medical students to participate in a month-long

clinical or research elective in HIV psychiatry at one of several prominent universities across the country, just closed at the end of March 2017. A record number of applicants applied (39) with very diverse backgrounds.

No actions requested.

Item JRC #8.L
Joint Reference Committee
June 2017

Executive Summary

Action Item

- At present time, the Council on Quality Care does not have action items to report.

Referral Updates

- At present time, the Council on Quality Care does not have referrals updates to provide.

Meeting Minutes

- Please see the minutes of the May 2017 meeting of the Council on Quality Care, in the attachment.

COUNCIL ON RESEARCH (CoR)
REPORT TO THE JOINT REFERENCE COMMITTEE (JRC)

Executive Summary

Since the CoR's in person gathering during September 2016 Fall Components Meeting, the workgroups of the CoR have submitted a number of manuscripts for publication in peer-reviews journals, including: *a Consensus Statement* on the *Use of Ketamine in the Treatment of Mood Disorders*, published in JAMA Psychiatry April 2017; Consensus Recommendations for *the Clinical Application of Repetitive Transcranial Magnetic Stimulation (rTMS) in the Treatment of Depression*, published in J Clin Psychiatry May 2017; and a manuscript entitled *S-Adenosylmethionine (SAMe) for Neuropsychiatric Disorders: A Clinician-Oriented Review of Research*, developed in collaboration with members of Caucus on Complementary and Alternative Medicine, currently in press for publication in J of Clinical Psychiatry. In addition, Dr. Widge and colleagues have prepared a manuscript entitled "*EEG Prediction of Treatment Response in Depressive Episodes*" for review and approval by the JRC (***Attachment 1***).

There are plans to develop additional papers, including a review of biomarkers of treatment response in Bipolar Disorder; a review on use of pharmacogenetic testing to predict antidepressant response; meta-analytic review of use of hormones as adjunctive agents for treatment of mood disorders; and a review of micro-dosing with psychedelic drugs for treatment of selected psychiatric disorders (see Taskforce on Biomarkers Update section of the CoR Minutes in ***Attachment 2***). The CoR will hold their next in-person meeting at the 2017 APA Fall Components Meeting in Washington, DC.

1. **The Council brings the following Action Items to the JRC:**

   ACTION 1: Will the JRC vote to approve the manuscript entitled "*EEG Prediction of Treatment Response in Depressive Episodes*" (***Attachment 1***)?

2. **Update on CoR Actions during the APA 2017 Annual Meeting**

   I: The CoR is in favor of review of the topics proposed by the Task Force on Biomarkers (see the Taskforce on Biomarkers Update section in ***Attachment 2***).

   II: CoR members approved a Presidential Symposium on Biomarkers and plan for 1-2 subsequent publications (see Taskforce on Biomarkers Update section in ***Attachment 2***)

   III: The CoR amended and approved list of authors for position statement on "*Mental Health Screening, Diagnosis, and Treatment During Pregnancy and Postpartum* (see ***Attachment 3***).

   IV: CoR approved changing name of the *Caucus on Alternative and Complementary Medicine* to "*Caucus of Complementary and Integrative Psychiatry*".

3. **The CoR brings the following Information Item to the JRC:**

   The CoR wishes to inform the JRC that it has reviewed National Institute of Health (NIH) proposed new approach toward grant funding, aimed at better distribution of grant funds across a larger pool of applicants through imposing limits on the total NIH grant support provided to an individual principal investigator (PI). There was a lengthy discussion among CoR members and the APA leadership regarding the proposed approach. The description of NIH's new approach toward grant funding can be found in (***Attachment 4)***.

4. ATTACHMENTS:

Attachment 1: *EEG Prediction of Treatment Response in Depressive Episodes* – submitted for review by JRC

Attachment 2: Draft Minutes from the Council on Research's Meeting at 2017 APA Annual Meeting

Attachment 3: List of authors for *Position Statement on Mental Health Screening, Diagnosis, and Treatment During Pregnancy and Postpartum*

Attachment 4: New NIH Approach to Grant Funding Aimed at Optimizing Stewardship of Taxpayer Dollars

ATTACHMENT 1

Electroencephalographic Biomarkers for Treatment Response Prediction in Major Depressive Illness: A Meta-Analysis

Alik S. Widge, MD, PhD[1,2,*]; Rebecca Montana, BA[1]; Weilynn Chang, BA[1]; Carolyn I. Rodriguez, MD, PhD[3]; Thilo Deckersbach, PhD[1]; Charles B. Nemeroff, MD, PhD[4]

1: Department of Psychiatry, Massachusetts General Hospital and Harvard Medical School, Boston, MA
2: Picower Institute for Learning & Memory, Massachusetts Institute of Technology, Cambridge, MA
3: Department of Psychiatry, Stanford University School of Medicine, Palo Alto, CA
4: Department of Psychiatry, University of Miami Miller School of Medicine, Miami, FL

*: Correspondence to
Alik S Widge, MD, PhD
149 13th St, Room 2627
Charlestown, MA 02129
awidge@partners.org
617-643-2580

Word Count: XXXX

Commented [AW1]: finalize

Key Points

Question: Is electroencephalography (EEG) able to predict which patients will or will not respond to a given treatment for depressive illness?

Findings: In this meta-analysis, EEG had a pooled sensitivity of 0.74 and specificity 0.69 for predicting treatment response in depression. However, this appears to be driven by strong positive results in small studies with methodologic limitations. Independent replications of prior studies and out-of-sample validation of prediction algorithms were both rare.

Meaning: EEG is promising, but not yet reliable or proven as a treatment response predictor in depression.

Abstract

Importance: Reducing the uncertainty of treatment trials could reduce morbidity from major depressive episodes. Quantitative analysis of the electro-encephalogram (QEEG) might predict treatment response, but the literature has not been quantitatively summarized for a clinical audience.

Objectives: (1) Quantify the reliability of QEEG for treatment response prediction in depressive illness. (2) Identify methodological limitations that reduce the strength of the available evidence.

Data Sources: Articles were identified from MEDLINE searches for articles published between January 1, 2000 and February 16, 2016. Further articles were identified from the reference lists of recent systematic reviews published through the end of December 2016.

Study Selection: We retained all articles that attempted to use QEEG to predict response to a treatment for a major depressive episode, regardless of patient population, treatment, or QEEG analysis.

Data Extraction and Synthesis: Following the PRISMA guidelines, two independent raters extracted 2x2 diagnostic table information. We rated each article on three indicators of good research practice: sample size, correction for multiple statistical testing, and out-of-training-set cross-validation. We entered diagnostic accuracy into univariate and bivariate random-effects meta-analyses, including meta-regression for differential efficacy of specific biomarkers. We constructed a funnel plot to assess publication bias.

Main Outcomes and Measures: Accuracy of QEEG for predicting response to depression treatment, expressed as sensitivity, specificity, and the logarithm of the diagnostic odds ratio (DOR). Our pre-specified hypothesis was no predictive accuracy, i.e. log(DOR)=0.

Results: 41 articles reporting 44 markers were included. Meta-analytic estimates showed sensitivity 0.74 (0.68-0.79), specificity 0.69 (0.63-0.74), log(DOR) 2.02(1.66-2.38), and area under the receiver-operator curve 0.77 (0.72-0.82). No single QEEG biomarker or specific treatment showed greater predictive power than the all-studies estimate (information criterion tests on meta-regression). Funnel plot analysis suggested substantial publication bias (arcsine asymmetry test, t=6.09, p=2.99e-7). Most studies did not use best statistical practices.

Conclusions and Relevance: QEEG does not appear clinically reliable for predicting depression treatment response due to under-reporting of negative results, a lack of out-of-sample validation, and a lack of direct replication of prior findings. Until these limitations are remedied, QEEG is not recommended for guiding psychiatric treatment choice.

Commented [AW2]: 350 words max; currently 341.

Commented [AW3]: Describe guidelines (eg, PRISMA, MOOSE) used for abstracting data and assessing data quality and validity (such as criteria for causal inference and whether data were pooled using a fixed-effect or random-effects model). The method by which the guidelines were applied should be stated (for example, independent extraction by multiple observers).

Commented [AW4]: State clearly if the hypothesis being tested was formulated during or after data collection. Explain outcomes or measurement unfamiliar to a general medical readership.

Commented [AW5]: **Results:** Provide the number of studies and patients/participants in the analysis and state the main quantitative results of the review.

Evaluations of screening and diagnostic tests should include sensitivity, specificity, likelihood ratios, receiver operating characteristic curves, and predictive values.

Major identified sources of variation between studies should be stated, including differences in treatment protocols, co-interventions, confounders, outcome measures, length of follow-up, and dropout rates.

Conclusions and Relevance: The conclusions and their applications (clinical or otherwise) should be clearly stated, limiting interpretation to the domain of the review.

Introduction

Commented [AW6]: Body text limit:3000 words not including figure captions or any other such

Currently 2930 assuming Box 1 is not included.

Major depressive illness remains a leading worldwide contributor to disability, despite a continued growth of our therapeutic armamentarium.[1,2] The persistent morbidity is partly due to the difficulty of treatment selection. An adequate "dose" of cognitive-behavioral therapy for depression is 10-12 weeks. An antidepressant or augmenting medication trial requires titration to adequate dose and at least 4 weeks of adherence to that dose. As a result, patients may spend months to years searching through options before they obtain a response[3]. Knowing sooner whether a treatment would be effective for a given patient could reduce time to response. Pre-treatment and "treatment emergent" biomarkers are one approach to early response prediction. Treatment-emergent markers are aspects of a patient's physiology that change in response to effective treatment, but whose change precedes and predicts the clinical response. If at 1-2 weeks into a treatment trial, we could confidently predict its (non)efficacy, we could move much more quickly through clinical decision trees. For some therapies, such as brain stimulation, treatment emergent markers could also guide "closed loop" treatment, where an aspect of the stimulation is titrated in direct response to the physiologic marker[4–6]. Electroencephalography (EEG) is one promising biomarker. Unlike many blood constituents or genomic profiling, it directly measures the brain, and potentially the brain's function. EEG is potentially more cost-effective than neuro-imaging techniques, such as functional magnetic resonance imaging (fMRI) or nuclear medicine computed tomography (PET/SPECT) that have been proposed as treatment biomarkers[7–12]. EEG equipment is much less expensive than brain scanners and can be fit into most office settings. Finally, EEG has essentially no safety

concerns, whereas PET involves radiation and MRI cannot be used in the presence of metal foreign bodies.

Psychiatric biomarker studies have emphasized "quantitative EEG", or QEEG (see Box 1 for an introduction to EEG terminology). A series of baseline and treatment-emergent biomarkers, qualitatively reviewed by recent authors[13,14], have each been evaluated in multiple studies. These include simple measures such as loudness dependence of auditory evoked potentials (LDAEP)[15–23], low-frequency oscillatory power[15,24–39] and distribution of low-frequency oscillations over the scalp[36,38,40–43]. With the increasing power of modern computers, more complex analyses have become relatively straightforward. This led to biomarkers involving multiple mathematical transformations of the EEG signal at multiple scalp sensors, including a metric named "cordance"[24,27,44–55] and a proprietary formulation termed the "Antidepressant Treatment Response" (ATR) index[55–60]. Each is based on a combination of serendipitous observations and physiologic hypotheses of depressive illness[13,14,61]. LDAEP is believed to measure serotonergic function, oscillations are linked to top-down executive functions that are impaired in depression[62–64], and cordance may reflect cerebral perfusion changes related to fMRI signals. ATR and related multi-variate markers merge these different lines of thought to increase predictive power.

Despite this rich body of primary data and summary reviews, the value of EEG as a treatment response predictor in depressive illness remains unclear. This is in part because

there has been no recent meta-analysis aimed at the general psychiatrist or primary care practitioner. The last formal American Psychiatric Association position statement on the matter was in 1991[65], at which time personal computers were thousands of times less capable than a modern desktop. A 1997 American Academy of Neurology report[66] focused more on epilepsy and traumatic brain injury. The most recent report, from the American Neuropsychiatric Association, was similarly cognition-oriented[67]. Most importantly, all of these are over a decade old. Recent reviews delved deeply into the neurobiology, but did not quantitatively assess QEEG's predictive power[13,14,59,61]. The closest was a meta-analysis from 2011 that combined imaging and EEG to assess the role of the rostral cingulate cortex in MDD[68]. To fill this gap in clinical guidance, we performed a meta-analysis of QEEG as a predictor of treatment response in depression. We cast a broad net, considering all articles on adults with any type of major depressive episode, receiving any intervention, and with any study design or outcome scale. This approach allowed us to broadly evaluate QEEG's utility, without being constrained to specific theories of depression or specific markers.

---Start Box 1

Basics of EEG Terminology and Biomarkers

- Montage: placement of individual sensors (electrodes) on a patient's scalp. The most common is the "International 10-20 System", but many alternatives exist, particularly as the number of sensors increases above 64.

- Quantitative EEG (QEEG): analysis of EEG through standardized and reproducible mathematical algorithms, as opposed to the visual inspection more common in neurologic diagnosis.
- Alpha, Theta, Beta: patterns of rhythmic (sine-wave-like) electrical activity believed to be important for cognition and brain network coordination. Each occurs at a specific frequency (cycles per second, or Hz): 5-8 Hz for theta, 8-15 Hz for alpha, and 15-30 Hz for beta. The definitions are not exact and the boundaries of each "band" vary between authors.
- Evoked Potential: the average brain response to a repeated stimulus, e.g., a pure tone played 100 times. Averaging across the individual presentations (trials) removes background noise, identifying the common/repeatable component.
- Source Localization: applying mathematical transformations to estimate which brain regions likely gave rise to the electrical activity recorded at the scalp. This "inverse problem" has infinite solutions, and many algorithms have been proposed to narrow this to a single "best" answer.
- Cordance: A measure combining multiple mathematical transforms of EEG power across electrodes, often in the prefrontal cortex. Theorized to measure activity related to cerebral perfusion.

---End Box 1

Methods

Our review focused on two primary questions:

1) What is the overall evidence base for QEEG techniques in predicting (non)response in the treatment of depressive episodes?
2) Given recent concerns about reliability in neuro-imaging[12,69,70], how well do the published studies implement practices that support reproducibility and reliability?

We searched MEDLINE for a set of terms related to EEG, major depression, and response prediction (Supplementary Material). We chose articles published since 2000, because older articles tend to use medication algorithms very different from modern psychopharmacology and did not yet reflect computational advances. From these, we kept all that reported prediction of treatment response, to any treatment, in any type of depressive illness, using any type of EEG. Our prospective hypothesis was that EEG cannot reliably predict treatment response. We chose broad inclusion criteria to maximize the chance of a signal detection that falsified our hypothesis. We did not include studies that attempted to directly select patients' medication based on an EEG evaluation, an approach sometimes termed "referenced EEG" or "rEEG"[71,72]. rEEG is not a diagnostic test, and as such does not admit the same form of meta-analysis.

The meta-analysis of diagnostic markers depends on 2x2 tables summarizing correct/incorrect responder/non-responder predictions[73]. Two trained raters extracted these from each article, with discrepancies resolved by discussion and final arbitration by ASW. Where necessary, table values were imputed from other data present in the article (Supplementary Material). For articles with more than one marker or treatment[20,30,50,55,58,74], we considered them as separate studies. We reasoned that

treatments with different mechanisms of action (e.g., rTMS vs. medication) may have different effects on reported biomarkers, even if studied by a single investigator. For studies that reported more than one method of analyzing the same biomarker[24,35,55], we used the predictor with the highest positive predictive value (PPV). This further increased the sensitivity and the chance of a positive meta-analytic result. Articles that did not report sufficient information to reconstruct a 2x2 table[15,16,18,22,26,29,33,34,42,43,75–78] were included in descriptive and study-quality reporting, but not the meta-analysis.

For qualitative reporting, we focused on whether the study used analytic methods that may contribute to more reliable conclusions. Chief among these is independent sample verification or "cross validation" – reporting the algorithm's predictive performance on a sample of patients separate from those originally used to develop it. Cross validation has repeatedly been highlighted, by editors and authors alike, as essential to developing a valid biomarker[12,13,60,66,79,80]. Our two other markers of study quality were total sample size and correction for multiple hypothesis testing. The former has been suggested to inflate effect sizes if too small[80,81], and the latter is a foundation of good statistical practice. The QUADAS[82] and STARD[83] quality frameworks were not well-suited to this analysis. Each is designed mainly to assess whether a new diagnostic test is being accurately compared against a gold standard. All of our articles used effectively the same gold standard: whether patients achieved a given percent change in a clinician-rated scale.

We conducted univariate and bivariate meta-analyses using R's "mada" package for analysis and "metafor" for visualizations[84–86]. The univariate analysis summarized each study as the natural logarithm of its diagnostic odds ratio (DOR), using a random-effects estimator[73]. Bivariate analysis used sensitivity and specificity following the approach of Reitsma et al[87]. From the bivariate analysis, we derived the area under the summary receiver-operator curve (AUC), and computed a confidence interval for the AUC by 500 iterations of bootstrap resampling with replacement. For the univariate analysis, we report I^2 as a measure of study heterogeneity. As secondary analyses, we separated studies by biomarker type (LDAEP, power features, ATR, cordance, and multivariate) and by treatment type (medication, rTMS, or other). These were then entered as predictor variables in bivariate meta-regressions. Finally, to assess the influence of publication bias, we prepared a funnel plot of log(DOR) against its precision (standard error). We tested funnel plot asymmetry with the arcsine method described in Rücker et al.[88], as implemented in the "meta" package[89]. This test has been suggested to be robust in the presence of heterogeneity and is the recommended choice of the Cochrane Collaboration[90]. All of the above were pre-planned analyses. Our analysis and reporting conforms to the PRISMA guidelines[91]; please see Supplementary Material for the checklist.

Results

Descriptive Study Characteristics

We identified 550 articles in our initial screening (Figure 1). 66 of these appeared to discuss response prediction. 56 articles, covering 61 biomarkers, were eligible for descriptive/qualitative analysis. Of these, 41 articles, discussing 44 possible biomarkers, included sufficient information for quantitative meta-analysis.

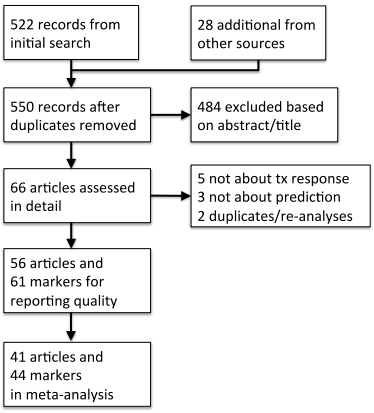


Figure 1, PRISMA diagram for meta-analysis of QEEG biomarkers in depression treatment.

Studies varied in the degree of treatment-resistance, included/excluded diagnoses, details of EEG recording, and specific analytic/statistical approach (Supplementary Table). 70% (43/56) were studies of response to medication, with most of the remaining (11/56, 18%) predicting response to rTMS. Citalopram/escitalopram (considered as a single active molecule) and venlafaxine were the most commonly studied medications, representing 30% (13/43) and 26% (11/43) of studies, respectively. Most reported markers were from resting state EEG (74%, 45/61) and did not source localize the EEG data (74%, 45/61).

The most heavily represented biomarkers were low-frequency EEG power (34%, 21/61) and cordance (25%, 15/61).

No study was a pre-planned, independent-sample replication of a prior investigation. A few markers, however, were studied repeatedly with similar designs. Three LDAEP studies attempted to predict response to citalopram[20,22,92]. They had inconsistent results that appeared to be dependent on source-localization technique. Cook and colleagues used cordance to predict the response to varying medication protocols, but a series of their studies found better-than-chance prediction using the same equipment, outcome measures, and decision rule (cordance decrease at 1 week of treatment)[27,52,53]. Bares and colleagues used different populations (bipolar depression vs. MDD), treatments, and response definitions, but also repeatedly reported successful response prediction with a 1-week cordance decrease[45,48,49]. One pair of studies found that the ATR predicted response to different medications[57,58], although Widge et al. reported that the same version of ATR did not predict response to repetitive transcranial magnetic stimulation (rTMS)[60]. Finally, theta power source-localized to the anterior cingulate cortex was reported by multiple labs as a predictor of response to different monoaminergic medications[15,30,32]. Theta power was unique in being reported as a useful predictor by multiple independent groups.

Study Quality

Study sizes were generally small (median n=25). The distribution had a tri-modal pattern (Figure 2), with peaks at N=22, N=85, and N=660. The last reflects reports from the recently-concluded iSPOT-D study[40,74,93].

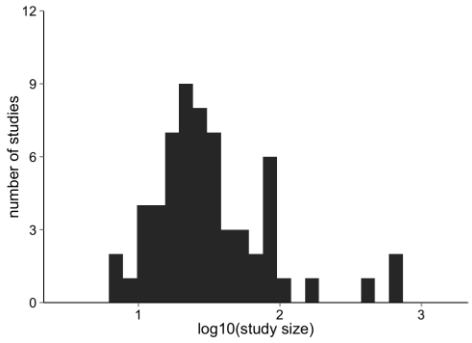


Figure 2: Histogram of study sizes, plotted on log scale due to presence of a few very large studies. Most were small, with the bulk of the distribution below N=100 and the two largest modes at N=22 and N=85.

Most studies did not meet the quality metrics. 32 studies reported testing only a single EEG feature or finding no significant results, and thus did not require multiple-comparisons corrections. Of the 24 that tested multiple features, 63% (15/24) did not report use of a statistical correction. Of 53 markers reported to have significant predictive validity, only 4 (8%) were studied with cross-validation or another out-of-sample verification. 3 of these were from the same first author[94–96]. One article reported using a cross-validation procedure, but did not include cross-validated algorithm performance in its main text or abstract[58].

Overall Efficacy

For all biomarkers taken together, the meta-analysis suggested predictive power above chance (Figure 3). The meta-analytic estimate of sensitivity was 0.74 (0.68-0.79),

specificity 0.69 (0.63-0.74), and log(DOR) 2.02 (1.66-2.38). These correspond to an AUC of 0.77 (0.72-0.82). The univariate analysis did not suggest study heterogeneity as a driver of results (I^2=0.36%, Q=42.8, p(Q)=0.478). This implies that in general, QEEG may have predictive power for treatment response in depressive illness. No biomarker or treatment type showed significantly greater predictive power than another or than the group as a whole. In bi-variate meta-regressions, the Akaike Information Criterion (AIC) increased from its omnibus value of -89.3 to -81 for a model split by biomarker type and to -84.9 for a model split by treatment type. Increases in the model criterion with additional terms suggest that these terms have no true explanatory power[97].

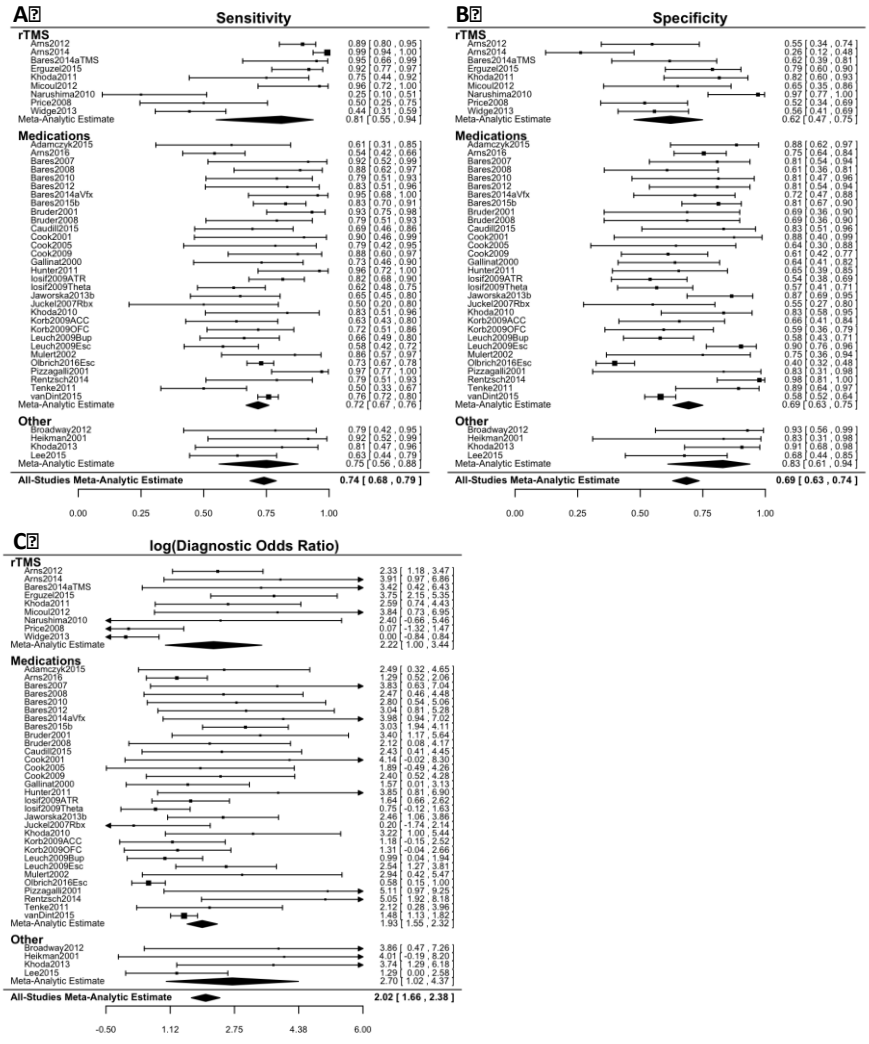


Figure 3: Forest plots for sensitivity (A), specificity (B), and log(DOR) (C) for prediction of clinical antidepressant response based on QEEG biomarkers.

Funnel-plot analysis of the univariate data suggested that QEEG's apparent predictive power is driven by a preponderance of small studies with positive results. The plot was specifically depleted in studies with smaller effect sizes that may not have reached pre-specified significance thresholds (Figure 4). In support of this, an arcsine test for funnel plot asymmetry rejected the null hypothesis (t=6.09, p=2.99e-7). That is, the largest effect sizes were associated with the smallest studies.

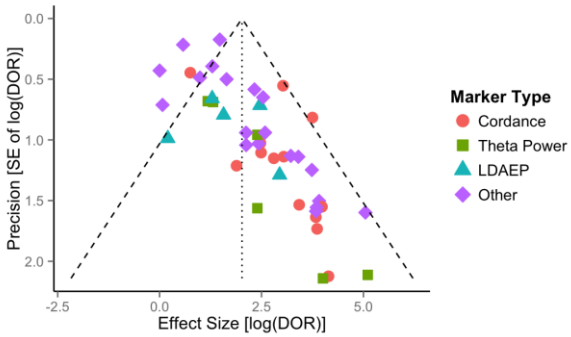


Figure 4: Funnel plot for study effect size (log of diagnostic odds ratio) vs. precision of effect size estimate (standard error of log of DOR). The QEEG literature is specifically lacking small studies with effect sizes between 0 (no effect) and approximately 2 (modest effect), which could reflect small studies remaining unpublished if they lack dramatic conclusions. The lack of small low-effect studies is true across biomarker types, reflected here by different shapes/markers.

Discussion

QEEG is promoted to psychiatrists and our patients as a "brain map" for customizing patients' depression treatment. Our findings suggest this is premature. The QEEG literature does suggest predictive power for response to MDD treatment, but this can be explained as a tendency of small studies to contain strong positive results. These low sample sizes can inflate effect sizes, which may have untoward effects when combined with the wide range of options available to EEG data analysts[80,81]. We observed funnel plot asymmetry that may represent negative/weak findings remaining unpublished. We also identified a common methodological deficit in the lack of cross-validation, which could over-estimate predictive capabilities. Taken together, the findings suggest that community standards in this area of psychiatric research do not yet enforce robust/rigorous practices, despite calls for improvement[13,69,80]. Our results indicate that QEEG is not ready for widespread use. Cordance and cingulate theta power are closest to proof of concept, with studies reporting successful treatment prediction across different medication classes and study designs[15,30,32,45–47,49]. A direct and identical replication of at least some of those findings is still necessary before any move towards wider clinical use.

We designed this meta-analysis for maximum sensitivity, which obscured three critical limitations of QEEG as a response predictor. First, we accepted each individual study's definition of the relevant marker, without enforcing consistent definitions within or between studies. For example, "alpha" EEG has been defined differently for different sets of sensors within the same patient[35] or at different measurement timepoints[58]. Enforcing consistent definitions would likely attenuate the predictive signal, because it reduces

"researcher degrees of freedom"[69]. Whether this is biologically reasonable is a complex question that may not be answerable with our current understanding of EEG.

Second, we did not consider studies as negative if they found significant change in the "wrong" direction. For instance, theta cordance decline during the first week of treatment appears to predict medication response[27,45,46,49,50,53]. Two studies reported instead that a cordance increase predicted treatment response[44,51]. LDAEP studies have reported responders to have both higher[18,20,21] and lower[16] loudness-dependence compared to non-responders. This could be explained by differences in collection technique, or in the biological basis of the interventions (e.g., serotonergic vs. noradrenergic). It could also be explained by true effect sizes of zero, and modeling these discrepancies differently would reduce our estimates of QEEG's efficacy.

Third, and arguably most important, depression itself is heterogeneous[5,98–100]. Defining and subtyping it is one of the major challenges of modern psychiatry, with many proposals for possible endophenotypes[5,10,14,100–102]. When we consider that each primary study effectively recorded from many different neurobiological entities, the rationale for QEEG-based prediction is less clear. As an example, our recent attempts to validate an obsessive-compulsive disorder biomarker, using the originating group's own software, showed a significant signal in the opposite direction from the original study[103,104]. Further, studies often report prediction of antidepressant response for patients receiving medications with diverse mechanisms of action. Considering that patients who do not respond to one medication class (e.g., serotonergic) often respond to another (e.g.,

noradrenergic or multi-receptor), it does not make sense for a single EEG measure to predict response to multiple drug types. Reliable electrophysiologic biomarkers may require "purification" of patient samples to those with identifiable circuit or objective behavioral deficits[5,6,100] or use of medications with simple receptor profiles. It may also be helpful to shift away from resting-state markers to activity recorded during standardized tasks[5], as a way of increasing the signal from a target cortical region.

In light of those limitations, we stress that the most popular QEEG markers have meaningful biological rationales. LDAEP is strongly linked to serotonergic function in animals and humans[105]. Cordance was originally derived from hemodynamic measures[13,52]. Neither cordance nor ATR changed substantially in placebo responders, even though both changed in medication responders[27,57,106]. The low-frequency oscillations emphasized in modern QEEG markers are strongly linked to cognition and executive function[62,107–109]. Our results do not mean that QEEG findings are not "real"; they call into question the robustness and reliability of links between symptom checklists and specific aspects of resting-state brain activity. If future studies can be conducted with an emphasis on rigorous methods and reporting, and with specific attempts to replicate prior results, QEEG still has much potential as a diagnostic and prognostic tool.

Disclosures

ASW and TD have pending patent applications related to the use of electrographic markers to characterize patients and select neuromodulation therapies. ASW has received device donations and consulting income from Medtronic. CBN reports consulting income from Xhale, Takeda, Taisho Pharmaceutical Inc., Prismic Pharmaceuticals, Bracket (Clintara), Total Pain Solutions (TPS), Gerson Lehrman Group (GLG) Healthcare & Biomedical Council, Fortress Biotech, Sunovion Pharmaceuticals Inc., Sumitomo Dainippon Pharma, Janssen Research & Development LLC, and Magstim, Inc. He holds stock in Xhale, Celgene, Seattle Genetics, Abbvie, OPKO Health, Inc., Bracket Intermediate Holding Corp., Network Life Sciences Inc., and Antares, serves on advisory boards for theAmerican Foundation for Suicide Prevention (AFSP), Brain and Behavior Research Foundation (BBRF), Xhale, Anxiety Disorders Association of America (ADAA), Skyland Trail, Bracket (Clintara), RiverMend Health LLC, and Laureate Institute for Brain Research. CBN has patents related to drug delivery and pharmacokinetic assessment.

Acknowledgements

Preparation of this work was supported in part by grants from the Brain & Behavior Research Foundation, Harvard Brain Science Initiative, and National Institute of Mental Health (MH109722, NS100548) to ASW. We thank the American Psychiatric Association's Task Force on Biomarkers for helpful comments. The opinions expressed herein are those of the authors and do not reflect the policy or positions of the American Psychiatric Association or of the sponsoring entities.

References

1. Whiteford HA, Degenhardt L, Rehm J, et al. Global burden of disease attributable to mental and substance use disorders: findings from the Global Burden of Disease Study 2010. *The Lancet*. 2013;382(9904):1575–1586. doi:10.1016/S0140-6736(13)61611-6.

2. Roehrig C. Mental disorders top the list of the most costly conditions in the United States: $201 billion. *Health Aff (Millwood)*. 2016;35(6):1130-1135. doi:10.1377/hlthaff.2015.1659.

3. Trivedi MH, Rush AJ, Wisniewski SR, et al. Evaluation of outcomes with citalopram for depression using measurement-based care in STAR*D: implications for clinical practice. *Am J Psychiatry*. 2006;163(1):28-40. doi:10.1176/appi.ajp.163.1.28.

4. Widge AS, Moritz CT. Closed-loop stimulation in emotional circuits for neuro-psychiatric disorders. In: El Hady A, ed. *Closed Loop Neuroscience*. San Diego, CA: Elsevier; 2016:229-240.

5. Widge AS, Ellard KK, Paulk AC, et al. Treating refractory mental illness with closed-loop brain stimulation: progress towards a patient-specific transdiagnostic approach. *Exp Neurol*. 2017;287(4):361–472. doi:10.1016/j.expneurol.2016.07.021.

6. Widge AS, Arulpragasam AR, Deckersbach T, Dougherty DD. Deep brain stimulation for psychiatric disorders. In: Scott RA, Kosslyn SM, eds. *Emerging Trends in the Social and Behavioral Sciences*. John Wiley & Sons, Inc.; 2015. http://onlinelibrary.wiley.com/doi/10.1002/9781118900772.etrds0103/abstract. Accessed May 30, 2016.

7. Mayberg HS. Modulating dysfunctional limbic-cortical circuits in depression: towards development of brain-based algorithms for diagnosis and optimised treatment. *Br Med Bull*. 2003;65(1):193–207.

8. Mayberg HS, Brannan SK, Tekell JL, et al. Regional metabolic effects of fluoxetine in major depression: serial changes and relationship to clinical response. *Biol Psychiatry*. 2000;48(8):830-843. doi:10.1016/S0006-3223(00)01036-2.

9. Kambeitz J, Cabral C, Sacchet MD, et al. Detecting neuroimaging biomarkers for depression: a meta-analysis of multivariate pattern recognition studies. *Biol Psychiatry*. doi:10.1016/j.biopsych.2016.10.028.

10. Drysdale AT, Grosenick L, Downar J, et al. Resting-state connectivity biomarkers define neurophysiological subtypes of depression. *Nat Med*. 2017;23(1):28-38. doi:10.1038/nm.4246.

11. Fu CHY, Steiner H, Costafreda SG. Predictive neural biomarkers of clinical response in depression: A meta-analysis of functional and structural neuroimaging studies of pharmacological and psychological therapies. *Neurobiol Dis*. 2013;52:75-83. doi:10.1016/j.nbd.2012.05.008.

12. Woo C-W, Chang LJ, Lindquist MA, Wager TD. Building better biomarkers: brain models in translational neuroimaging. *Nat Neurosci*. 2017;20(3):365-377. doi:10.1038/nn.4478.

13. Wade EC, Iosifescu DV. Using electroencephalography for treatment guidance in major depressive disorder. *Biol Psychiatry Cogn Neurosci Neuroimaging*. 2016;1(5):411-422. doi:10.1016/j.bpsc.2016.06.002.

14. Olbrich S, Arns M. EEG biomarkers in major depressive disorder: Discriminative power and prediction of treatment response. *Int Rev Psychiatry*. 2013;25(5):604-618. doi:10.3109/09540261.2013.816269.

15. Mulert C, Juckel G, Brunnmeier M, et al. Rostral anterior cingulate cortex activity in the theta band predicts response to antidepressive medication. *Clin EEG Neurosci*. 2007;38(2):78–81.

16. Linka T, Müller BW, Bender S, Sartory G, Gastpar M. The intensity dependence of auditory evoked ERP components predicts responsiveness to reboxetine treatment in major depression. *Pharmacopsychiatry*. 2005;38(3):139-143. doi:10.1055/s-2005-864126.

17. Gallinat J, Bottlender R, Juckel G, et al. The loudness dependency of the auditory evoked N1/P2-component as a predictor of the acute SSRI response in depression. *Psychopharmacology (Berl)*. 2000;148(4):404–411.

18. Jaworska N, Blondeau C, Tessier P, et al. Response prediction to antidepressants using scalp and source-localized loudness dependence of auditory evoked potential (LDAEP) slopes. *Prog Neuropsychopharmacol Biol Psychiatry*. 2013;44:100-107. doi:10.1016/j.pnpbp.2013.01.012.

19. Jaworska N, De Somma E, Blondeau C, et al. Auditory P3 in antidepressant pharmacotherapy treatment responders, non-responders and controls. *Eur Neuropsychopharmacol*. 2013;23(11):1561-1569. doi:10.1016/j.euroneuro.2013.03.003.

20. Juckel G, Pogarell O, Augustin H, et al. Differential prediction of first clinical response to serotonergic and noradrenergic antidepressants using the loudness dependence of auditory evoked potentials in patients with major depressive disorder. *J Clin Psychiatry*. 2007;68(8):1206-1212.

21. Lee B-H, Park Y-M, Lee S-H, Shim M. Prediction of long-term treatment response to selective serotonin reuptake inhibitors (SSRIs) using scalp and source loudness dependence of auditory evoked potentials (LDAEP) analysis in patients with major

depressive disorder. *Int J Mol Sci*. 2015;16(3):6251-6265. doi:10.3390/ijms16036251.

22. Linka T, Müller BW, Bender S, Sartory G. The intensity dependence of the auditory evoked N1 component as a predictor of reponse to citalopram treatment in patients with major depression. *Neurosci Lett.* 2004;367(3):375-378. doi:10.1016/j.neulet.2004.06.038.

23. Linka T, Sartory G, Gastpar M, Scherbaum N, Müller BW. Clinical symptoms of major depression are associated with the intensity dependence of auditory event-related potential components. *Psychiatry Res*. 2009;169(2):139-143. doi:10.1016/j.psychres.2008.06.009.

24. Arns M, Drinkenburg WH, Fitzgerald PB, Kenemans JL. Neurophysiological predictors of non-response to rTMS in depression. *Brain Stimulat.* 2012;5(4):569-576. doi:10.1016/j.brs.2011.12.003.

25. Knott V, Mahoney C, Kennedy S, Evans K. Pre-treatment EEG and it's relationship to depression severity and paroxetine treatment outcome. *Pharmacopsychiatry*. 2000;33(06):201–205.

26. Arns M, Etkin A, Hegerl U, et al. Frontal and rostral anterior cingulate (rACC) theta EEG in depression: Implications for treatment outcome? *Eur Neuropsychopharmacol*. 2015;25(8):1190-1200. doi:10.1016/j.euroneuro.2015.03.007.

27. Cook IA, Hunter AM, Abrams M, Siegman B, Leuchter AF. Midline and right frontal brain function as a physiologic biomarker of remission in major depression. *Psychiatry Res Neuroimaging*. 2009;174(2):152-157. doi:10.1016/j.pscychresns.2009.04.011.

28. Heikman P, Salmelin R, Mäkelä JP, Hari R, Katila H, Kuoppasalmi K. Relation between frontal 3–7 Hz MEG activity and the efficacy of ECT in major depression. *J ECT*. 2001;17(2):136–140.

29. Hunter AM, Korb AS, Cook IA, Leuchter AF. Rostral anterior cingulate activity in major depressive disorder: state or trait marker of responsiveness to medication? *J Neuropsychiatry Clin Neurosci*. 2013;25(2):126–133.

30. Korb AS, Hunter AM, Cook IA, Leuchter AF. Rostral anterior cingulate cortex theta current density and response to antidepressants and placebo in major depression. *Clin Neurophysiol*. 2009;120(7):1313-1319. doi:10.1016/j.clinph.2009.05.008.

31. Narushima K, McCormick LM, Yamada T, Thatcher RW, Robinson RG. Subgenual cingulate theta activity predicts treatment response of repetitive transcranial magnetic stimulation in participants with vascular depression. *J Neuropsychiatry*. 2010;22(1):75-84. doi:10.1176/appi.neuropsych.22.1.75.

32. Pizzagalli D, Pascual-Marqui RD, Nitschke JB, et al. Anterior cingulate activity as a predictor of degree of treatment response in major depression: evidence from brain electrical tomography analysis. *Am J Psychiatry*. 2001;158(3):405–415.

33. Spronk D, Arns M, Barnett KJ, Cooper NJ, Gordon E. An investigation of EEG, genetic and cognitive markers of treatment response to antidepressant medication in patients with major depressive disorder: A pilot study. *J Affect Disord*. 2011;128(1-2):41-48. doi:10.1016/j.jad.2010.06.021.

34. Woźniak-Kwaśniewska A, Szekely D, Harquel S, Bougerol T, David O. Resting electroencephalographic correlates of the clinical response to repetitive transcranial magnetic stimulation: A preliminary comparison between unipolar and bipolar depression. *J Affect Disord*. 2015;183:15-21. doi:10.1016/j.jad.2015.04.029.

35. Arns M, Cerquera A, Gutiérrez RM, Hasselman F, Freund JA. Non-linear EEG analyses predict non-response to rTMS treatment in major depressive disorder. *Clin Neurophysiol*. 2014;125(7):1392-1399. doi:10.1016/j.clinph.2013.11.022.

36. Bruder GE, Sedoruk JP, Stewart JW, McGrath PJ, Quitkin FM, Tenke CE. Electroencephalographic Alpha Measures Predict Therapeutic Response to a Selective Serotonin Reuptake Inhibitor Antidepressant: Pre- and Post-Treatment Findings. *Biol Psychiatry*. 2008;63(12):1171-1177. doi:10.1016/j.biopsych.2007.10.009.

37. Micoulaud-Franchi J-A, Richieri R, Cermolacce M, Loundou A, Lancon C, Vion-Dury J. Parieto-temporal alpha EEG band power at baseline as a predictor of antidepressant treatment response with repetitive Transcranial Magnetic Stimulation: A preliminary study. *J Affect Disord*. 2012;137(1–3):156-160. doi:10.1016/j.jad.2011.12.030.

38. Price GW, Lee JW, Garvey C, Gibson N. Appraisal of sessional EEG features as a correlate of clinical changes in an rTMS treatment of depression. *Clin EEG Neurosci*. 2008;39(3):131–138.

39. Tenke CE, Kayser J, Manna CG, et al. Current source density measures of electroencephalographic alpha predict antidepressant treatment response. *Biol Psychiatry*. 2011;70(4):388-394. doi:10.1016/j.biopsych.2011.02.016.

40. Arns M, Bruder G, Hegerl U, et al. EEG alpha asymmetry as a gender-specific predictor of outcome to acute treatment with different antidepressant medications in the randomized iSPOT-D study. *Clin Neurophysiol*. 2016;127(1):509-519. doi:10.1016/j.clinph.2015.05.032.

41. Bruder GE, Stewart JW, Tenke CE, et al. Electroencephalographic and perceptual asymmetry differences between responders and nonresponders to an SSRI antidepressant. *Biol Psychiatry*. 2001;49(5):416-425. doi:10.1016/S0006-3223(00)01016-7.

42. Spronk D, Arns M, Bootsma A, van Ruth R, Fitzgerald PB. Long term effects of left frontal rTMS on EEG and ERPs in patients with depression. *Clin EEG Neurosci*. 2008;39(3):118–124.

43. Quraan MA, Protzner AB, Daskalakis ZJ, et al. EEG Power Asymmetry and Functional Connectivity as a Marker of Treatment Effectiveness in DBS Surgery for Depression. *Neuropsychopharmacology*. 2014;39(5):1270-1281. doi:10.1038/npp.2013.330.

44. Adamczyk M, Gazea M, Wollweber B, et al. Cordance derived from REM sleep EEG as a biomarker for treatment response in depression – a naturalistic study after antidepressant medication. *J Psychiatr Res*. 2015;63:97-104. doi:10.1016/j.jpsychires.2015.02.007.

45. Bares M, Brunovsky M, Kopecek M, et al. Changes in QEEG prefrontal cordance as a predictor of response to antidepressants in patients with treatment resistant depressive disorder: A pilot study. *J Psychiatr Res*. 2007;41(3–4):319-325. doi:10.1016/j.jpsychires.2006.06.005.

46. Bares M, Brunovsky M, Kopecek M, et al. Early reduction in prefrontal theta QEEG cordance value predicts response to venlafaxine treatment in patients with resistant depressive disorder. *Eur Psychiatry*. 2008;23(5):350-355. doi:10.1016/j.eurpsy.2008.03.001.

47. Bares M, Brunovsky M, Novak T, et al. The change of prefrontal QEEG theta cordance as a predictor of response to bupropion treatment in patients who had failed to respond to previous antidepressant treatments. *Eur Neuropsychopharmacol*. 2010;20(7):459-466. doi:10.1016/j.euroneuro.2010.03.007.

48. Bares M, Novak T, Brunovsky M, et al. The change of QEEG prefrontal cordance as a response predictor to antidepressive intervention in bipolar depression. A pilot study. *J Psychiatr Res*. 2012;46(2):219-225. doi:10.1016/j.jpsychires.2011.09.006.

49. Bares M, Novak T, Kopecek M, Brunovsky M, Stopkova P, Höschl C. The effectiveness of prefrontal theta cordance and early reduction of depressive symptoms in the prediction of antidepressant treatment outcome in patients with resistant depression: analysis of naturalistic data. *Eur Arch Psychiatry Clin Neurosci*. 2015;265(1):73-82. doi:10.1007/s00406-014-0506-8.

50. Bares M, Brunovsky M, Novak T, et al. QEEG theta cordance in the prediction of treatment outcome to prefrontal repetitive transcranial magnetic stimulation or venlafaxine ER in patients with Major Depressive Disorder. *Clin EEG Neurosci*. 2015;46(2):73–80.

51. Broadway JM, Holtzheimer PE, Hilimire MR, et al. Frontal theta cordance predicts 6-month antidepressant response to subcallosal cingulate deep brain stimulation for

treatment-resistant depression: a pilot study. *Neuropsychopharmacology*. 2012;37(7):1764-1772. doi:10.1038/npp.2012.23.

52. Cook I, Leuchter A. Prefrontal changes and treatment response prediction in depression. *Semin Clin Neuropsychiatry*. 2001;6(2):113-120. doi:10.1053/scnp.2001.21844.

53. Cook IA, Leuchter AF, Morgan ML, Stubbeman W, Siegman B, Abrams M. Changes in prefrontal activity characterize clinical response in SSRI nonresponders: a pilot study. *J Psychiatr Res*. 2005;39(5):461-466. doi:10.1016/j.jpsychires.2004.12.002.

54. Erguzel TT, Ozekes S, Gultekin S, Tarhan N, Hizli Sayar G, Bayram A. Neural network based response prediction of rTMS in major depressive disorder using QEEG cordance. *Psychiatry Investig*. 2015;12(1):61. doi:10.4306/pi.2015.12.1.61.

55. Iosifescu DV, Greenwald S, Devlin P, et al. Frontal EEG predictors of treatment outcome in major depressive disorder. *Eur Neuropsychopharmacol*. 2009;19(11):772-777. doi:10.1016/j.euroneuro.2009.06.001.

56. Caudill MM, Hunter AM, Cook IA, Leuchter AF. The antidepressant treatment response index as a predictor of reboxetine treatment outcome in major depressive disorder. *Clin EEG Neurosci*. 2015;46(4):277–284.

57. Hunter AM, Cook IA, Greenwald S, Tran ML, Miyamoto KN, Leuchter AF. The Antidepressant Treatment Response (ATR) Index and Treatment Outcomes in a Placebo-controlled Trial of Fluoxetine. *J Clin Neurophysiol Off Publ Am Electroencephalogr Soc*. 2011;28(5):478-482. doi:10.1097/WNP.0b013e318230da8a.

58. Leuchter AF, Cook IA, Gilmer WS, et al. Effectiveness of a quantitative electroencephalographic biomarker for predicting differential response or remission with escitalopram and bupropion in major depressive disorder. *Psychiatry Res*. 2009;169(2):132-138. doi:10.1016/j.psychres.2009.04.004.

59. Leuchter AF, Cook IA, Hunter A, Korb A. Use of clinical neurophysiology for the selection of medication in the treatment of major depressive disorder: the state of the evidence. *Clin EEG Neurosci*. 2009;40(2):78-83. doi:10.1177/155005940904000207.

60. Widge AS, Avery DH, Zarkowski P. Baseline and treatment-emergent EEG biomarkers of antidepressant medication response do not predict response to repetitive transcranial magnetic stimulation. *Brain Stimulat*. 2013;6(6):929-931. doi:10.1016/j.brs.2013.05.001.

61. Harmer CJ. Neural predictors of treatment response in depression. *Curr Behav Neurosci Rep*. 2014;1(3):125-133. doi:10.1007/s40473-014-0021-2.

62. Cavanagh JF, Frank MJ. Frontal theta as a mechanism for cognitive control. *Trends Cogn Sci*. 2014;18(8):414-421. doi:10.1016/j.tics.2014.04.012.

63. Fries P. Rhythms for cognition: communication through coherence. *Neuron*. 2015;88(1):220-235. doi:10.1016/j.neuron.2015.09.034.

64. Anastassiou CA, Koch C. Ephaptic coupling to endogenous electric field activity: why bother? *Curr Opin Neurobiol*. 2015;31:95-103. doi:10.1016/j.conb.2014.09.002.

65. Quantitative electroencephalography: a report on the present state of computerized EEG techniques. American Psychiatric Association Task Force on Quantitative Electrophysiological Assessment. *Am J Psychiatry*. 1991;148(7):961-964. doi:10.1176/ajp.148.7.961.

66. Nuwer M. Assessment of digital EEG, quantitative EEG, and EEG brain mapping: Report of the American Academy of Neurology and the American Clinical Neurophysiology Society*. *Neurology*. 1997;49(1):277-292. doi:10.1212/WNL.49.1.277.

67. Coburn PD, Lauterbach MD, Boutros MD, Black MD, Arciniegas MD, Coffey MD. The value of quantitative electroencephalography in clinical psychiatry: A report by the Committee on Research of the American Neuropsychiatric Association. *J Neuropsychiatry Clin Neurosci*. 2006;18(4):460-500.

68. Pizzagalli DA. Frontocingulate dysfunction in depression: toward biomarkers of treatment response. *Neuropsychopharmacology*. 2011;36(1):183. doi:10.1038/npp.2010.166.

69. Poldrack RA, Baker CI, Durnez J, et al. Scanning the horizon: towards transparent and reproducible neuroimaging research. *Nat Rev Neurosci*. 2017;18(2):115-126. doi:10.1038/nrn.2016.167.

70. Eklund A, Nichols TE, Knutsson H. Cluster failure: Why fMRI inferences for spatial extent have inflated false-positive rates. *Proc Natl Acad Sci*. 2016;113(28):7900-7905. doi:10.1073/pnas.1602413113.

71. Suffin SC, Emory WH, Gutierrez N, Arora GS, Schiller MJ, Kling A. A QEEG database method for predicting pharmacotherapeutic outcome in refractory major depressive disorders. *J Am Physicians Surg*. 2007;12(4):104–109.

72. DeBattista C, Kinrys G, Hoffman D, et al. The use of referenced-EEG (rEEG) in assisting medication selection for the treatment of depression. *J Psychiatr Res*. 2011;45(1):64-75. doi:10.1016/j.jpsychires.2010.05.009.

73. Gatsonis C, Paliwal P. Meta-analysis of diagnostic and screening test accuracy evaluations: methodologic primer. *Am J Roentgenol*. 2006;187(2):271-281. doi:10.2214/AJR.06.0226.

74. Olbrich S, Tränkner A, Surova G, et al. CNS- and ANS-arousal predict response to antidepressant medication: Findings from the randomized iSPOT-D study. *J Psychiatr Res*. 2016;73:108-115. doi:10.1016/j.jpsychires.2015.12.001.

75. Canali P, Sferrazza Papa G, Casali AG, et al. Changes of cortical excitability as markers of antidepressant response in bipolar depression: preliminary data obtained by combining transcranial magnetic stimulation (TMS) and electroencephalography (EEG). *Bipolar Disord*. 2014;16(8):809-819. doi:10.1111/bdi.12249.

76. Kalayam B, Alexopoulos GS. A preliminary study of left frontal region error negativity and symptom improvement in geriatric depression. *Am J Psychiatry*. 2003;160(11):2054–2056.

77. Salvadore G, Cornwell BR, Sambataro F, et al. Anterior cingulate desynchronization and functional connectivity with the amygdala during a working memory task predict rapid antidepressant response to ketamine. *Neuropsychopharmacology*. 2010;35(7):1415–1422.

78. Wang Y, Fang Y, Chen X, et al. A follow-up study on features of sensory gating P50 in treatment-resistant depression patients. *Chin Med J Engl Ed*. 2009;122(24):2956.

79. McLoughlin G, Makeig S, Tsuang M. In search of biomarkers in psychiatry: EEG-based measures of brain function. *Am J Med Genet B Neuropsychiatr Genet*. 2014;165(2):111–121. doi:10.1002/ajmg.b.32208.

80. Blackford JU. Leveraging statistical methods to improve validity and reproducibility of research findings. *JAMA Psychiatry*. 2017;74(2):119-120. doi:10.1001/jamapsychiatry.2016.3730.

81. Button KS, Ioannidis JPA, Mokrysz C, et al. Power failure: why small sample size undermines the reliability of neuroscience. *Nat Rev Neurosci*. 2013;14(5):365-376. doi:10.1038/nrn3475.

82. Whiting PF, Rutjes AW, Westwood ME, et al. QUADAS-2: a revised tool for the quality assessment of diagnostic accuracy studies. *Ann Intern Med*. 2011;155(8):529–536.

83. Bossuyt PM, Reitsma JB, Bruns DE, et al. The STARD statement for reporting studies of diagnostic accuracy: explanation and elaboration. *Ann Intern Med*. 2003;138(1):W1-12. doi:10.7326/0003-4819-138-1-200301070-00012-w1.

84. R Core Team. *R: A Language and Environment for Statistical Computing*. Vienna, Austria: R Foundation for Statistical Computing; 2014. http://www.R-project.org/.

85. Doebler P. *Mada: Meta-Analysis of Diagnostic Accuracy*.; 2015. http://CRAN.R-project.org/package=mada.

86. Viechtbauer W. Conducting meta-analyses in R with the metafor package. *J Stat Softw*. 2010;36(3):1–48.

87. Reitsma JB, Glas AS, Rutjes AWS, Scholten RJPM, Bossuyt PM, Zwinderman AH. Bivariate analysis of sensitivity and specificity produces informative summary measures in diagnostic reviews. *J Clin Epidemiol*. 2005;58(10):982-990. doi:10.1016/j.jclinepi.2005.02.022.

88. Rücker G, Schwarzer G, Carpenter J. Arcsine test for publication bias in meta-analyses with binary outcomes. *Stat Med*. 2008;27(5):746-763. doi:10.1002/sim.2971.

89. Schwarzer G. *Meta: General Package for Meta-Analysis*.; 2015. http://CRAN.R-project.org/package=meta.

90. Sterne JAC, Sutton AJ, Ioannidis JPA, et al. Recommendations for examining and interpreting funnel plot asymmetry in meta-analyses of randomised controlled trials. *BMJ*. 2011;343:d4002. doi:10.1136/bmj.d4002.

91. Moher D, Liberati A, Tetzlaff J, Altman DG, Group TP. Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement. *PLOS Med*. 2009;6(7):e1000097. doi:10.1371/journal.pmed.1000097.

92. Mulert C, Juckel G, Augustin H, Hegerl U. Comparison between the analysis of the loudness dependency of the auditory N1/P2 component with LORETA and dipole source analysis in the prediction of treatment response to the selective serotonin reuptake inhibitor citalopram in major depression. *Clin Neurophysiol*. 2002;113(10):1566–1572.

93. van Dinteren R, Arns M, Kenemans L, et al. Utility of event-related potentials in predicting antidepressant treatment response: An iSPOT-D report. *Eur Neuropsychopharmacol*. 2015;25(11):1981-1990. doi:10.1016/j.euroneuro.2015.07.022.

94. Khodayari-Rostamabad A, Reilly JP, Hasey GM, de Bruin H, MacCrimmon D. Using pre-treatment electroencephalography data to predict response to transcranial magnetic stimulation therapy for major depression. In: *Engineering in Medicine and Biology Society, EMBC, 2011 Annual International Conference of the IEEE*. IEEE; 2011:6418–6421. http://ieeexplore.ieee.org/xpls/abs_all.jsp?arnumber=6091584. Accessed May 7, 2016.

95. Khodayari-Rostamabad A, Reilly JP, Hasey G, DeBruin H, MacCrimmon D. Using pre-treatment EEG data to predict response to SSRI treatment for MDD. In: *Engineering in Medicine and Biology Society (EMBC), 2010 Annual International Conference of the IEEE*. IEEE; 2010:6103–6106. http://ieeexplore.ieee.org/xpls/abs_all.jsp?arnumber=5627823. Accessed May 7, 2016.

96. Khodayari-Rostamabad A, Reilly JP, Hasey GM, de Bruin H, MacCrimmon DJ. A machine learning approach using EEG data to predict response to SSRI treatment for major depressive disorder. *Clin Neurophysiol*. 2013;124(10):1975-1985. doi:10.1016/j.clinph.2013.04.010.

97. Akaike H. A new look at the statistical model identification. *Autom Control IEEE Trans On*. 1974;19(6):716–723.

98. Insel TR. Disruptive insights in psychiatry: transforming a clinical discipline. *J Clin Invest*. 2009;119(4):700-705. doi:10.1172/JCI38832.

99. Insel TR, Wang PS. Rethinking mental illness. *J Am Med Assoc*. 2010;303(19):1970-1971. doi:10.1001/jama.2010.555.

100. Widge AS, Deckersbach T, Eskandar EN, Dougherty DD. Deep brain stimulation for treatment-resistant psychiatric illnesses: what has gone wrong and what should we do next? *Biol Psychiatry*. 2016;79(4):e9-e10. doi:10.1016/j.biopsych.2015.06.005.

101. Williams LM. Defining biotypes for depression and anxiety based on large-scale circuit dysfunction: a theoretical review of the evidence and future directions for clinical translation. *Depress Anxiety*. September 2016. doi:10.1002/da.22556.

102. Webb CA, Dillon DG, Pechtel P, et al. Neural correlates of three promising endophenotypes of depression: evidence from the EMBARC study. *Neuropsychopharmacology*. 2016;41(2):454-463. doi:10.1038/npp.2015.165.

103. Bahramisharif A, Mazaheri A, Levar N, Richard Schuurman P, Figee M, Denys D. Deep brain stimulation diminishes cross-frequency coupling in obsessive-compulsive disorder. *Biol Psychiatry*. 2016;80(7):e57–e58. doi:10.1016/j.biopsych.2015.05.021.

104. Widge AS, Zorowitz S, Link K, et al. Ventral capsule/ventral striatum deep brain stimulation does not consistently diminish occipital cross-frequency coupling. *Biol Psychiatry*. 2016;80(7):e59-e60. doi:http://dx.doi.org/10.1016/j.biopsych.2015.10.029.

105. Juckel G. Serotonin: From sensory processing to schizophrenia using an electrophysiological method. *Behav Brain Res*. 2015;277:121-124. doi:10.1016/j.bbr.2014.05.042.

106. Cook IA, Leuchter AF, Morgan M, et al. Early changes in prefrontal activity characterize clinical responders to antidepressants. *Neuropsychopharmacology*. 2002;27(1):120-131. doi:10.1016/S0893-133X(02)00294-4.

107. Cohen MX, Donner TH. Midfrontal conflict-related theta-band power reflects neural oscillations that predict behavior. *J Neurophysiol*. 2013;110(12):2752-2763. doi:10.1152/jn.00479.2013.

108. Mueller EM, Panitz C, Hermann C, Pizzagalli DA. Prefrontal oscillations during recall of conditioned and extinguished fear in humans. *J Neurosci*. 2014;34(21):7059-7066. doi:10.1523/JNEUROSCI.3427-13.2014.

109. Smith EH, Banks GP, Mikell CB, et al. Frequency-dependent representation of reinforcement-related information in the human medial and lateral prefrontal cortex. *J Neurosci*. 2015;35(48):15827-15836. doi:10.1523/JNEUROSCI.1864-15.2015.

PRISMA 2009 Checklist

Section/topic	#	Checklist item	Reported on page #
TITLE			
Title	1	Identify the report as a systematic review, meta-analysis, or both.	Intro
ABSTRACT			
Structured summary	2	Provide a structured summary including, as applicable: background; objectives; data sources; study eligibility criteria, participants, and interventions; study appraisal and synthesis methods; results; limitations; conclusions and implications of key findings; systematic review registration number.	Title Page
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of what is already known.	Intro
Objectives	4	Provide an explicit statement of questions being addressed with reference to participants, interventions, comparisons, outcomes, and study design (PICOS).	Intro
METHODS			
Protocol and registration	5	Indicate if a review protocol exists, if and where it can be accessed (e.g., Web address), and, if available, provide registration information including registration number.	Supp
Eligibility criteria	6	Specify study characteristics (e.g., PICOS, length of follow-up) and report characteristics (e.g., years considered, language, publication status) used as criteria for eligibility, giving rationale.	Supp
Information sources	7	Describe all information sources (e.g., databases with dates of coverage, contact with study authors to identify additional studies) in the search and date last searched.	Supp
Search	8	Present full electronic search strategy for at least one database, including any limits used, such that it could be repeated.	Supp
Study selection	9	State the process for selecting studies (i.e., screening, eligibility, included in systematic review, and, if applicable, included in the meta-analysis).	Methods/Supp
Data collection process	10	Describe method of data extraction from reports (e.g., piloted forms, independently, in duplicate) and any processes for obtaining and confirming data from investigators.	Supp
Data items	11	List and define all variables for which data were sought (e.g., PICOS, funding sources) and any assumptions and simplifications made.	Methods/Supp
Risk of bias in individual studies	12	Describe methods used for assessing risk of bias of individual studies (including specification of whether this was done at the study or outcome level), and how this information is to be used in any data synthesis.	Figure 2
Summary measures	13	State the principal summary measures (e.g., risk ratio, difference in means).	Methods
Synthesis of results	14	Describe the methods of handling data and combining results of studies, if done, including measures of consistency (e.g., I^2) for each meta-analysis.	Methods

Section/topic	#	Checklist item	Reported on page #
Risk of bias across studies	15	Specify any assessment of risk of bias that may affect the cumulative evidence (e.g., publication bias, selective reporting within studies).	Methods
Additional analyses	16	Describe methods of additional analyses (e.g., sensitivity or subgroup analyses, meta-regression), if done, indicating which were pre-specified.	Methods
RESULTS			
Study selection	17	Give numbers of studies screened, assessed for eligibility, and included in the review, with reasons for exclusions at each stage, ideally with a flow diagram.	Fig 1
Study characteristics	18	For each study, present characteristics for which data were extracted (e.g., study size, PICOS, follow-up period) and provide the citations.	Supp Tbl 1
Risk of bias within studies	19	Present data on risk of bias of each study and, if available, any outcome level assessment (see item 12).	Cross-Val
Results of individual studies	20	For all outcomes considered (benefits or harms), present, for each study: (a) simple summary data for each intervention group (b) effect estimates and confidence intervals, ideally with a forest plot.	Fig 3
Synthesis of results	21	Present results of each meta-analysis done, including confidence intervals and measures of consistency.	Fig 3
Risk of bias across studies	22	Present results of any assessment of risk of bias across studies (see Item 15).	Fig 3
Additional analysis	23	Give results of additional analyses, if done (e.g., sensitivity or subgroup analyses, meta-regression [see Item 16]).	Fig 4
DISCUSSION			
Summary of evidence	24	Summarize the main findings including the strength of evidence for each main outcome; consider their relevance to key groups (e.g., healthcare providers, users, and policy makers).	Discussion
Limitations	25	Discuss limitations at study and outcome level (e.g., risk of bias), and at review-level (e.g., incomplete retrieval of identified research, reporting bias).	Discussion
Conclusions	26	Provide a general interpretation of the results in the context of other evidence, and implications for future research.	Discussion
FUNDING			
Funding	27	Describe sources of funding for the systematic review and other support (e.g., supply of data); role of funders for the systematic review.	Ackn

From: Moher D, Liberati A, Tetzlaff J, Altman DG, The PRISMA Group (2009). Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement. PLoS Med 6(7): e1000097. doi:10.1371/journal.pmed1000097

For more information, visit: **www.prisma-statement.org**.

Supplementary Methods

Search Strategy and Article Selection
We searched MEDLINE for articles published since 2000 whose title and/or abstract contained keywords matching the query:

(electroencephalogram OR electroencephalography OR EEG OR QEEG OR event-related potential OR ERP OR cordance OR coherence OR spectral OR spectrum OR alpha OR beta OR theta OR delta OR gamma OR N1 OR P2 OR P300 OR N200 OR SSVEP OR VEP OR AEP OR evoked potential OR oscillation OR electrical activity)
AND
(depression OR depressive OR major depression OR major depressive disorder OR major depressive episode OR depressed OR antidepressant OR mood disorder)
AND
(differential OR predictor OR prediction OR predict OR biomarker OR marker OR phenotype OR response index)
AND
(response OR remission OR treatment response OR responsiveness OR nonresponse OR non-response OR responder OR non-responder OR therapeutic OR outcome OR treatment resistance OR comparative effectiveness OR effectiveness OR treatment selection OR efficacy)

The search was limited to articles in English and to human studies. The search was last conducted on February 19, 2016.

We then added additional articles known to one of the authors or identified through the references of recent reviews. We did not attempt to discover un-published data, as there is no single reasonable point of contact as there would be with a drug or therapeutic device manufacturer. Unpublished data from the authors of individual published studies may have technical flaws, as the acquisition and analysis of EEG is not straightforward.

All abstracts that appeared to involve EEG, treatment prediction, and some form of depressive illness were retained for further review. We removed an article from the analysis if, on detailed reading, it did not attempt to predict treatment response. We also removed two articles that, on careful inspection, were reports of the same marker as another article using a highly overlapping dataset. For these pairs (Cook2009 vs [1], Leuchter2009 vs. [2]), we retained the article with the larger sample size. We retained articles that attempted prediction but found a non-significant result. We accepted one article that used magneto-encephalography (MEG) instead of EEG (Heikman 2001) on the grounds that the two techniques measure very similar signals.

This protocol was not pre-registered.

Data Extraction
9 articles did not directly report the necessary information to reconstruct a 2x2 table enumerating false/true positives and negatives (van Dinteren et al., 2015 ; Arns et al.,

2014 ; Widge et al., 2013 ; Narushima et al., 2010 ; Mulert et al., 2002 ; Pizzagalli et al., 2001 ; Bruder et al., 2001 ; Cook and Leuchter, 2001 ; Heikman et al., 2001).
They did, however, provide sufficient additional information (e.g., a high-resolution ROC plot or all-subjects scatterplot) to infer it. For these studies, we computed diagnostic odds ratio (DOR) at every indicated point on the ROC, then assigned the study the 2x2 values that maximized its DOR. This gives each study the maximum "benefit of the doubt" in the meta-analysis. For studies that reported no association between any target QEEG feature and treatment response, we imputed table values assuming positive and negative predictive values equal to the prior probabilities of the patient sample. We did not identify discrepancies during this that required contact with the original investigators. We accepted each article's individual definition of (non)response, the threshold for which varied between authors. As with most of our design choices, this was meant to bias the meta-analysis in favor of detecting a signal if one exists.

For descriptive analysis, we extracted the type of treatment and the specific biomarker being studied. We coded treatments as medication vs. non-medication, rTMS vs. not, and SSRI vs. any other type of treatment. We further noted articles that used citalopram or venlafaxine as their primary medication, as these were the two most common treatments in the overall sample. For biomarkers, we classified them as resting state vs. task-based, and as calculated in source space vs. sensor space. We coded which articles involved the most common biomarkers in our sample: event-related potentials, auditory evoked potentials, oscillatory asymmetry, oscillatory power amplitude (theta and alpha), cordance, and the Antidepressant Treatment Response index. Each of these was studied in multiple papers, several by multiple investigators.

For study quality reporting, we extracted the total sample size (N), whether the analysis corrected for multiple hypothesis tests, and whether the analysis used any out-of-training-set cross-validation. N was the N reported for each study's EEG analysis, which often differed slightly from that reported in the abstract due to technical difficulties with a small number of EEG recordings. Any type of correction to the significance threshold was considered acceptable. We only required multiple-testing correction if the authors explicitly stated that they tested multiple frequency bands or biomarkers for their correlation with treatment response. For studies reporting analysis of a single biomarker at a single timepoint, we again granted the investigators the benefit of the doubt and treated these as hypothesis-driven studies. Similarly, any type of cross-validation was sufficient to count an article as positive, as long as the cross-validated results were reported in the body of the article.

We did not explicitly extract or code details of the EEG recording (number of channels, the specific amplifier, sampling rate). There is no *a priori* reason why any of these should be related to a study's findings, assuming basic investigator competency. We did not explicitly code whether studies used a "pure" MDD sample vs. any type of depressive diagnosis, nor did we stratify them by response threshold. Depression is a heterogeneous diagnosis, and we have no clear evidence that MDD, "depression NOS", or depressed episodes in bipolar disorder differ in their neurobiology.

Meta-Analysis Procedures

Diagnostic Odds Ratio (DOR), sensitivity, and specificity all may become undefined for studies with zero false positives/negatives. To prevent this, we added 0.5 to all 2x2 table values for all studies (including those that did not report a "perfect" discriminator).

Although we extracted data for specific subclasses of medications, our meta-regression considered only "Medication", "rTMS", and "Other" as treatment classes. More detailed models could not be fit to the dataset.

Supplementary Table

Table S1. Studies included in meta-analysis, with report of quality metrics, study size, and predictive values.

First Author	Year	Journal	Treatment	Marker	Population	Multiple Corrected	Cross Validated	N	Sens	Spec	AUC
Caudill	2015	Clinical EEG and Neuroscience	reboxetine	ATR 4.1	MDD	N/A	N	20	0.71	0.88	0.74
Hunter	2011	Journal of Clinical Neurophysiology	fluoxetine	ATR 4.1	MDD	N/A	N	90	1.00	0.67	0.83
Iosifescu	2009	European Neuropsychopharmacology	SSRI or venlafaxine	ATR 4.1	MDD	N/A	N	90	0.82	0.54	0.72
Leuchter	2009	Psychiatry Research	escitalopram	ATR 4.1	MDD	N/A	N	667	0.58	0.91	0.77
Leuchter	2009	Psychiatry Research	bupropion	ATR4.1	MDD	N/A	N	119	0.88	0.86	
Widge	2013	Brain Stimulation	rTMS	ATR 4.1	MDD	N/A	N/A	17	0.50	0.50	0.5
Adamczyk	2015	Journal of Psychiatric Research	any antidepressant	prefrontal theta cordance	any depression	N/A	N	25	0.63	0.92	0.9
Arns	2012	Brain Stimulation	rTMS	multi-marker weighted	MDD or dysthymia	Y	N	18	0.90	0.55	0.814
Arns	2016	Clinical Neurophysiology	escitalopram, sertraline, or venlafaxine-XR (iSPOT-D)	occipital alpha power & frontal alpha asymmetry	MDD	Y	N	20	0.54	0.76	0.641
Arns	2014	Clinical Neurophysiology	rTMS	non-linear complexity metrics, alpha band	MDD	N/A	N	87	1.00	0.27	0.697
Arns	2015	European Neuropsychopharmacology	Escitalopram, sertraline, or venlafaxine-XR (iSPOT-D)	frontal and rACC theta	MDD	N/A	N	25			
Bares	2007	Journal of Psychiatric Research	any antidepressant	prefrontal theta cordance	MDD	N/A	N	25	1.00	0.83	
Bares	2008	European Psychiatry	venlafaxine	prefrontal theta cordance	MDD	N	N	12	0.92	0.62	
Bares	2010	European Neuropsychopharmacology	bupropion	prefrontal theta cordance	MDD	N/A	N	28	0.82	0.86	
Bares	2012	Journal of Psychiatric Research	any antidepressant	prefrontal theta cordance	BP	N/A	N	18	0.88	0.83	0.8
Bares	2015	European Archives of Psychiatry and Clinical Neurosciences	any antidepressant	prefrontal theta cordance	MDD	N	N	21	0.83	0.82	0.91
Bares	2015	Clinical EEG and	low frequency TMS	prefrontal theta	MDD	N/A	N	25	1.00	0.63	0.75

		Neuroscience		cordance							
Bares	2015	Clinical EEG and Neuroscience	venlafaxine	prefrontal theta cordance	MDD	N/A	N	7	1.00	0.73	0.89
Broadway	2012	Neuropsychopharmacology	deep brain stimulation	theta cordance	MDD or bipolar II	N/A	N	12	0.83	1.00	0.972
Bruder	2008	Biological Psychiatry	fluoxetine	alpha power and asymmetry, occipital	any depression	N/A	N	37	0.82	0.71	
Bruder	2001	Biological Psychiatry	fluoxetine	alpha asymmetry	MDD, female	N/A	N	55	0.95	0.71	
Canali	2014	Bipolar Disorders	sleep deprivation	cortical excitability	BP	N/A	N	29			
Cook	2009	Psychiatry Research	fluoxetine or venlafaxine	frontal theta cordance and power	MDD	N	N	7	0.90	0.60	0.76
Cook	2001	Seminars in Clinical Neuropsychiatry	SSRI or venlafaxine	prefrontal theta cordance	MDD	N/A	N	12	1.00	1.00	
Cook	2005	Journal of Psychiatric Research	any medication	prefrontal theta cordance	MDD	N/A	N	22	0.83	0.67	
Erguzel	2015	Psychiatry Investigation	rTMS	delta and theta cordance	MDD	N/A	Y	82	0.93	0.80	0.894
Gallinat	2000	Psychopharmacology	any SSRI	LDAEP	MDD	N/A	N	82	0.75	0.65	
Heikman	2001	Journal of ECT	ECT	delta and theta MEG power and scalp ratios	MDD	N	N	49	1.00	1.00	
Hunter	2013	Journal of Neuropsychiatry and Clinical Neurosciences	sertraline	rACC theta current density	MDD	N/A	N	48			
Iosifescu	2009	European Neuropsychopharmacology	SSRI or venlafaxine	prefrontal theta power	MDD	N/A	N	20	0.62	0.57	0.66
Jaworska	2013	Progress in Neuro-psychopharmacology and Biological Psychiatry	escitalopram, bupropion, or both	LDAEP	MDD	Y	N	15	0.65	0.88	
Jaworska	2013	European Neuropsychopharmacology	escitalopram, bupropion, or both	auditory oddball ERP	MDD	Y	N	22			
Juckel	2007	Journal of Clinical Psychiatry	citalopram	LDAEP, source localized	MDD	N/A	N/A	22			
Juckel	2007	Journal of Clinical Psychiatry	reboxetine	LDAEP, source localized	MDD	N/A	N/A	27	0.50	0.56	
Kalayam	2003	American Journal of Psychiatry	citalopram	frontal error-related negativity	geriatric MDD	Y	N	22			

Khodayari-Rostamabad	2010	Proceedings IEEE EMBS	any SSRI	Multi-marker weighted	MDD	N	Y	51	0.88	0.86	
Khodayari-Rostamabad	2011	Proceedings IEEE EMBS	rTMS	Multi-marker weighted	MDD	N	Y	37	0.78	0.83	
Khodayari-Rostamabad	2013	Clinical Neurophysiology	any SSRI	Multi-marker weighted	MDD	N/A	Y	37	0.81	0.95	
Knott	2000	Pharmacopsychiatry	paroxetine	power and coherence, multiple bands	MDD	N	N	41			
Korb	2009	Clinical Neurophysiology	fluoxetine, venlafaxine, or placebo	mOFC theta current density	MDD	N/A	N	73	0.73	0.60	0.688
Korb	2009	Clinical Neurophysiology	escitalopram, sertraline, or paroxetine	rACC theta current density (LORETA)	MDD	N/A	N	73	0.64	0.67	0.712
Lee	2015	International Journal of Molecular Sciences	escitalopram, sertraline, or paroxetine	LDAEP, source localized	MDD	N/A	N	16	0.64	0.69	
Linka	2004	Neuroscience Letters	citalopram	LDAEP	MDD	N	N	14			
Linka	2005	Pharmacopsychiatry	reboxetine	LDAEP	any depression	N/A	N	21			
Micoulaud-Franchi	2012	Journal of Affective Disorders	rTMS	alpha power	MDD/BP	Y	N	15	1.00	0.66	0.815
Mulert	2007	Journal of Affective Disorders	citalopram or reboxetine	rACC theta current density, LDAEP	MDD	N	N	17			
Mulert	2002	Clinical Neurophysiology	citalopram	LDAEP, source localized	MDD	N/A	N	32	0.90	0.80	0.88
Narushima	2010	Journal of Neuropsychiatry and Clinical Neurosciences	rTMS	subgenual ACC theta power	vascular depression	N	N	414	0.88	0.86	0.548
Olbrich	2016	Journal of Psychiatric Research	escitalopram or sertraline	vigilance	MDD	N/A	N	184	0.73	0.40	
Olbrich	2016	Journal of Psychiatric Research	venlafaxine	vigilance	MDD	N/A	N	18			
Pizzagalli	2001	American Journal of Psychiatry	nortriptyline	rACC theta current density (LORETA)	MDD	N	N	37	1.00	1.00	
Price	2008	Clinical EEG and Neuroscience	rTMS	alpha power, frequency, asymmetry	MDD	N/A	N/A	12	0.50	0.52	
Quraan	2014	Neuropsychopharmacology	deep brain stimulation	theta and alpha frontal asymmetry	MDD	Y	N	31			

Rentzsch	2014	European Archives of Psychiatry and Clinical Neuroscience	any antidepressant	source-localized power	MDD	Y	N	15	0.82	1.00	0.93
Salvadore	2010	Neuropsychopharmacology	ketamine	pregenual ACC activity and connectivity	MDD	N/A	N	8			
Spronk	2008	Clinical EEG and Neuroscience	rTMS	auditory oddball and alpha asymmetry	MDD	N	N	25			
Spronk	2011	Journal of Affective Disorders	Any antidepressant	Theta power, auditory ERP	MDD	N	N	41			
Tenke	2011	Biological Psychiatry	SSRI or SNRI	multi-electrode alpha power	MDD, dysthymia, or depression NOS	N/A	N	655	0.50	0.92	
van Dinteren	2015	European Neuropsychopharmacology	escitalopram, sertraline, or venlafaxine-XR (iSPOT-D)	auditory ERP latency and amplitude	MDD	N	N	36	0.76	0.58	
Wang	2009	Chinese Medical Journal	any antidepressant	auditory ERP	any depression	N	N	86			
Woźniak-Kwaśniewska	2015	Journal of Affective Disorders	rTMS	prefrontal theta and beta power	MDD/BP	Y	N	18			

ACC, anterior cingulate cortex. ATR, Antidepressant Treatment Response index. BP, bipolar disorder. ECT, electroconvulsive therapy. EEG, electroencephalogram. ERP, event-related potential. iSPOT-D, International Study to Predict Optimized Treatment of Depression. LDAEP, loudness dependence of the auditory evoked potential. LORETA, low resolution electrical tomography. MDD, major depressive disorder. MEG, Magnetoencephalography. NOS, not otherwise specified. rACC, rostral anterior cingulate cortex. rTMS, repetitive transcranial magnetic stimulation. SNRI, selective norepinephrine reuptake inhibitor. SSRI, selective serotonin reuptake inhibitor. TMS, transcranial magnetic stimulation.

Supplementary References

1. Cook IA, Leuchter AF, Morgan M, et al. Early changes in prefrontal activity characterize clinical responders to antidepressants. *Neuropsychopharmacology*. 2002;27(1):120-131. doi:10.1016/S0893-133X(02)00294-4.

2. Cook IA, Hunter AM, Gilmer WS, et al. Quantitative electroencephalogram biomarkers for predicting likelihood and speed of achieving sustained remission in major depression: a report from the Biomarkers for Rapid Identification of Treatment Effectiveness in Major Depression (BRITE-MD) trial. *J Clin Psychiatry*. 2013;74(1):51–56.

Attachment 2

COUNCIL ON RESEARCH (CoR) DRAFT MINUTES
APA 2017 Annual Meeting
San Diego, California
Monday, May 22, 2017
1:30 pm – 4:30 pm

PRESENT
Members: Dwight Evans, MD (Chair); Carolyn Rodriguez, MD PhD (Vice Chair); Tami Benton, MD; Linda Carpenter, MD; Ned Kalin, MD; Anand Kumar, MD; Glenn Martin, MD; William McDonald, MD; Charles Nemeroff, MD; James Potash, MD MPH; Mauricio Tohen, MD, DrPH, MBA; Alik Widge, MD, PhD. Awais Aftab, MD, MBBS (APAF/Leadership Fellow); Jennifer Dwyer, MD, PhD (APAF/Child and Adolescent Fellow)

Staff: Philip Wang, MD, DrPH; Diana Clarke, PhD, MSc; Farifteh Duffy, PhD; Debbie Gibson, MSc

ABSENT
Wilson Compton, MD, MPE; C. Neill Epperson, MD; Michael First, MD; John Krystal, MD; Christine Moutier, MD; Daniel Pine, MD; Rajiv Radhakrishnan, MD (APAF/Diversity Leadership Fellow); Amalia Londono Tobon, MD (APAF/SAMHSA Fellow)

I. Welcome and Introductions: *Dwight Evans, M.D., Chair*

- Meeting called to order by Dr. Evans.
- Member and attendee introductions and disclosure of financial conflicts of interest.

II. Review /Approval of September Component Meeting Minutes

- September 2016 Fall Component Meeting minutes unanimously approved.

III. Task Force on Biomarkers Update: *Charles Nemeroff, MD, PhD*

Update provided by Dr. Nemeroff:

A. Preparation and submission of manuscripts for publication in peer-reviewed journals:

1. A Consensus Statement on the Use of Ketamine in the Treatment of Mood Disorders was published in JAMA Psychiatry, April 2017.
2. Consensus Recommendations for the Clinical Application of Repetitive Transcranial Magnetic Stimulation (rTMS) in the Treatment of Depression was published in J Clin Psychiatry, May 2017.
3. Dr. Carpenter, serving as a liaison to Caucus on Complementary and Alternative Medicine, collaborated to develop a paper on S-adenosylmethionine. The manuscript was approved by APA's governance and submitted to the Journal of Clinical Psychiatry; currently in press.

4. Dr. Tohen is currently leading development and analyses of a manuscript on biomarkers of treatment response in Bipolar Disorder. Paper is now a qualitative review rather than a meta-analytic review due to limited research on the topic.

5. The Task Force sought the COR's approval for review by the Joint Reference Committee (JRC) of the draft manuscript authored by Dr. Widge and colleagues entitled, "*Electroencephalographic Biomarkers for Treatment Response Prediction in Major Depressive Illness: A Meta-Analysis*".

   ACTION: CoR unanimously approved submission of the manuscript to the JRC for final review and approval before possible submission for publication to JAMA Psychiatry. 7828 (NJ)/7319(NC).

B. New Projects:

1. Pharmacogenetic predictors of antidepressant response. Dr. Nemeroff and his colleague Zane Zeier has sent draft to task force members.

   ACTION: Awaiting comments from Kalin and Carpenter. Will circulate next draft. Will include section on how Medicare and FDA approves such tests.

2. Hormones as augmenting agents in the treatment of mood disorders. Led by Ned Kalin. He will recruit COR fellows and statistics expert to include meta-analyses.

3. Use of Psychedelic Drugs, e.g., Psilocybin on Mood Disorder (William McDonald-lead)

   ACTION: The CoR in favor of a review of the topic.

C. Other items for consideration:

1. Biomarkers Symposium for next year's APA (Carolyn Rodriquez and Linda Carpenter, co-chairs). Include Ned Kalin (Intro and definition), Marc Lippman-Univ Miami on Breast Cancer, Charles Nemeroff on Inflammation and Alik Widge on EEG.

   ACTION: CoR members approved a Presidential Symposium and plan for 1-2 subsequent publications.

2. Use of Social Media in Clinical Trials (Carolyn Rodriquez-lead).

3. Two new members of the task force: Dr. Anand Kumar with expertise in cognition and geriatric psychiatry, and Dr. Steven Siegel with expertise in neurobiology, and combined behavioral and molecular studies.

IV. Other Action Items:

A. Action Statement on Mental Health Screening, Diagnosis, and Treatment During Pregnancy and Postpartum

Dr. Maureen Sayres Van Niel, MD, Author of Action Paper "Position Statement on Screening, Diagnosis and Treatment for Mental Health Disorders During Pregnancy and PostPartum", Current president, APA Women's Caucus and Women's of the Assembly and Member, Steering Committee, US Department of Health and Human Services Women's Preventive Services Initiative sought the approval of the CoR for the list of recommended authors to serve as members of Working Group to Write the Action Statement and the nomination of a CoR member to serve on the group. The list of authors included the very top scientists in this field including a representative from the Council on Minority Mental Health and Health Disparities, Dr. Debbie Carter.

ACTION: CoR approved the list of authors and included other recommendations proposed by members of the Council including Drs. Kristina Delgiannadis, Jeffrey Newport, Zachary Stowe, and C. Neill Epperson (a corresponding member of CoR as the council's representative). Dr. Epperson's term as a corresponding member of the CoR ended May 2017. The CoR recommended the extension of Dr. Epperson's term as a corresponding member for 2017, which will enable her to serve as the Council's representative on the workgroup. This recommendation needs to be approved by the current president of the APA, Dr. Anita Everett.

B. **Caucus on Complementary and Alternative Medicine (CAM)**

Drs. Lila Massoumi (chair of the APA Caucus on CAM), Patricia Gerbarg, and Helen Lavretsky represented the caucus on Complementary and Alternative Medicine at the CoR meeting.

The group reported that one in three (3) individuals in the US use CAM across a broad range of health conditions; CAM has a specific use in psychiatry. Dr. Gerbarg co-authored a book with Dr. Richard Brown on Complementary and Integrative Therapies for Psychiatric Disorders. Other publications will be out later this year. The Caucus members requested changing the name of the caucus from "CAM" to "Integrative Psychiatry". The term "Alternative" implies alternate to other treatments, whereas CAM care can be used as an adjunct or complement to other treatments.

ACTION: CoR approved the new Caucus name as "Caucus of Complementary and Integrative Psychiatry".

V. Welcome: Saul Levin, MD, MPA, APA CEO and Medical Director

- presented Dr. Widge with an award for his years of very active service as a member of the CoR.
- noted the Council's input has helped the APA Registry move forward in record time.
- Council questions for Dr. Levin included: Issues regarding the proposed new NIH approach to grant funding, and strengthening the scientific programs at the APA Annual Meeting and Institute on Psychiatric Services (IPS). Both are described in greater detail under item VIII.

VI. APA PsychPRO Registry Discussion: *Philip Wang, MD, DrPH*

- Dr. Wang reported on the value of the APA PsychPRO Registry for future research and thanked the CoR for helping to move the registry development forward. The ongoing issues of onboarding sites with EPIC EHR was discussed to get the CoR's input on how to move this process forward. The CoR recommended that Drs. Levin, Wang, Kalin, Seigel, and Potash have an in-person meeting with EPIC's leadership.

VII. Other Component Updates

A. Committee on Research Training: *Charles Nemeroff, MD, PhD*

1. 2017 Research Colloquium for Junior Investigators:

- Forty-nine (49) junior psychiatrists (mentees) attended – From US (28), Canada (8), and international countries (13) including Jamaica, Nigeria, Uganda, Peru, Argentina, Brazil, Mexico, China, Egypt, Spain, the Netherlands, France, and London.
- Forty-one (41) core senior researchers and ten statistics/methodology mentors were recruited.
- Four successful pre-colloquium webinars were held to introduce mentees to mentors within their research track.

- The APA has collaborated and will continue its partnership with the American College of Neuropsychopharmacology (ACNP) and Society of Biological Psychiatry (SOBP) on this important mentoring initiative. In 2017, of the 49 Colloquium participants, 39 also attended SOBP.
- The American Psychiatric Association Foundation (APAF) R-13 NIDA grant application (Sept 2016) for partial support of the Colloquium was approved. This grant will support efforts to expand the Research Colloquium to:
  i. include pre- and quarterly post-colloquium webinars to enhance the junior investigators' mentorship experience;
  ii. include statistics/methodology mentors to enhance the mentorship experience and network pool for the mentees;
  iii. increase efforts to recruit junior investigators from traditionally underrepresented groups. The grant will cover the expenses for these expansions for the next 3 years (2017 – 2019). Funding began April 2017.
- New tracks for 2018: Substance Use, Treatment, Basic Neuroscience, and Psychophysiology tracks; Health Services Research and Disparities Research. The CoR Committee on Research Training suggested that Dr. Pamela Collins be approached to see her willingness and availability to lead this research track at the 2018 Colloquium.
- CoR members discussed how to broaden the pool of applicants.

  Suggestions include:

  i. Outreach and advertisement via Facebook (Drs. Dwyer and Aftab).
  ii. Two tracks: a) Fellows already involved in research; 2) Fellows who want to conduct research, have ideas, but have not taken steps toward implementing.
  iii. Inviting chairs of universities who are not APA members to receive an award at the APA. These chairs could be also targeted for nominating Research Training applicants.

2. 2017 Early Research Career Breakfast:

- Total of 86 early career psychiatrists in attendance – 49 Research Colloquium participants and 37 APA/APAF fellows.
- Early career psychiatrists had the opportunity to visit 10 different tables organized by area of research interest including: alcohol and drug abuse; child psychiatry; epidemiology/health services; geriatric psychiatry; neuroscience/basic science; psychopharmacology; psychosocial treatment; global mental health; health disparities; and suicide prevention.
- There was a total of 22 senior mentors from various medical institutes and funding agencies (e.g., NIDA, NIMH) in addition to a few members of the APA administration representing the different research tracks.

B. Research Awards: *Diana Clarke, PhD*

List of 2017 awardees include:

- **Kempf Fund Award for Research Development in Psychobiological Psychiatry (2 recipients)**
  - Adrienne C. Lahti, MD (Mentor); Nina V. Kraguljac, MD, MA (Mentee)

- **APAF-AACDP Research Mentorship Award:**
  - Robert C. Malenka, MD, PhD
- **Blanche F. Ittleson Award for Research in Child & Adolescent Psychiatry:**
  - Jeremy Veenstra-VanderWeele, MD
- **APAF Psychiatric Research Fellowship:**
  - Adrienne Grzenda, MS, MD, PhD
- **Judd Marmor Award:**
  - Judy Rapoport, MD
- **Award for Research:**
  - Katherine L. Wisner, MD, MS
- **Health Services Research Senior Scholar:**
  - Michael Compton, MD

- Regarding Kempf award, there are two parts to the award, a small award to the mentor, and a larger award to the mentee. Current rules require both mentors and mentees to be MDs. However, Dr. Nemeroff noted that there are several highly talented PhD researchers that are mentoring MDs. Is it possible to change the rules so that mentors can be non-MDs? The APA staff will learn about this process and will notify CoR. Application deadline for 2018 awards is June 1, 2017. Deadline will be extended. Dr. Clarke asked the CoR members for their help in getting the word out about all the APAF awards.

C. Committee on Psychiatric Dimensions of Disasters: *Robert Ursano, M.D.*

Dr. Ursano was not present at 2017 CoR meeting. No update provided.

D. New Business and Next Steps*: Dwight Evans, M.D.*

1. National Institute of Health (NIH) new "Grant Support Index" proposal

NIH is proposing a new approach toward grant funding, aimed at better distribution of grant funds across a larger pool of applicants through imposing limits on the total NIH grant support provided to an individual principal investigator (PI).
Concerns of CoR members include:

i. may inadvertently lessen opportunities for collaboration.
ii. may inadvertently impact collaboration between senior and junior investigators.

Dr. Widge opened the discussion with a request for a motion for the APA leadership to send a statement to pertinent NIH Institute Directors to move judiciously toward implementing the proposed approach to grant funding. The CoR members encouraged such communication should emphasize how the proposed approach can be improved in a way that brings fairness throughout. Further, it may be beneficial to submit a joint letter in partnership with multiple professional organizations.

Dr. Levin joined the discussion; he mentioned that he met with three of the Institute Directors earlier in the day on 5/22, and the topic of Grant Support Index did not come up. Dr. Levin suggested for him to initiate a dialogue with Institute Directors to see how the proposed approach is being received across the Institutes and their constituents. APA's Government Relations should also follow-up to learn about status of the proposed system and report to the CoR.

E. Other topics discussed with Dr. Levin:

- It would be tremendously helpful for Dr. Levin to approach Directors of Institutes and encourage support of various APA initiatives for research, training, and educational initiatives.
- CoR members raised concern that ACNP and SOBP annual meetings are more science-based and appear to attract more science-based presenters and applicants than APA's annual meetings and Research Training programs. The CoR suggested the strengthening of the scientific focus of the APA Annual and Mental Health Services Research (formerly IPS) meetings. Dr. Levin recommended involving APA's Departments of Education (Dr. Gorrindo) and Membership (Mr. Fanning), to arrive at a balanced program of research and education that meet the needs of members and meeting attendees.

F. Adjournment - Dr. Evans thanked the group for its continued hard work, and the meeting was adjourned at 4:30 p.m.

ATTACHMENT 3

List of Authors for

Working Group on the Position Statement on MH Screening in Pregnancy and Postpartum

Approved by the APA Council on Research, Monday, May 22, 2017.

Dr. Katherine Wisner, MD, MS: Norman and Helen Asher Professor of Psychiatry and Obstetrics and Gynecology, Northwestern University Feinberg School of Medicine; Director, Asher Center for the Study of Perinatal Depression Disorders

Dr. Jennifer Payne, MD: Associate Professor of Psychiatry and Behavioral Sciences, Johns Hopkins University; Director, Women's Mood Disorders Clinic, Johns Hopkins Hospital

Dr. Kim Yonkers MD: Professor of Psychiatry, Epidemiology, Obstetrics and Gynecology, Yale University School of Medicine; Director, Center for Well Being of Women and Mothers, Yale-New Haven Medical Center.

Dr. Nancy Byatt, DO, MS, MBA: Associate Professor of Psychiatry and Obstetrics and Gynecology, University of Massachusetts Medical School; Codirector, McPap for Moms, a national evidence-based protocol model for the treatment of perinatal mood disorders

Dr. Gail Robinson, MD, DPsych, FRCPC: Professor of Psychiatry and Obstetrics and Gynecology, University of Toronto; Director, Women's Mental Health Program, University of Toronto Health Network;

Dr. Elizabeth Fitelson MD: Assistant Professor of Psychiatry, Columbia University Medical School; Director, Woman's Program, Department of Psychiatry, Columbia University Medical Center.

Dr. Samantha Meltzer-Brody, MD, MPH: Associate Professor of Psychiatry, University of North Carolina Medical School at Chapel Hill; Director, Perinatal Psychiatry Program; Director, the University of North Carolina Center for Women's Mental Health

APA REPRESENTATIVES:

Dr. Maureen Sayres Van Niel, MD: Author of Action Paper, Representative from APA Women of the Assembly

Obstetrics and Gynecology Consultation-Liaison Psychiatrist, Harvard Medical School Brigham and Women's Hospital training, Member, Steering Committee US Dept. of Health and Human Services Women's Preventive Services Initiative, 2016-2018; Current president, APA Women's Caucus and APA Women of the Assembly.

Dr. Nazanin Silver, MD, MPH: Representative of RFM/ECP Early Psychiatrists

PGY IV Resident in Psychiatry, Thomas Jefferson University Medical School; Board Certified Obstetrician-Gynecologist and Board Certified UroGynecologic Surgeon; Clinical practice and attending faculty in OBGYN, including Downstate Medical Center 2007-2013, Author: Chapter on Mood Disorders, Maternal-Fetal and Obstetrics Evidence-Based Guidelines, 2016

Dr. Debbie Carter, MD: Representative, Council on Minority Mental Health & Health Disparities

Associate Professor in Psychiatry, University of Colorado School of Medicine, Division of Child and Adolescent Psychiatry. Director, Culturally Informed Education Program.

C. Neill Epperson, MD: Representative, Council on Research

Director of the Penn Center for Women's Behavioral Wellness Professor (with Tenure) of Psychiatry and Obstetrics/Gynecology

OTHER NAMES PROPOSED AND APPROVED BY THE CoR:

Kristina M. Delgiannadis, MD: Associate Professor, Center for Psychiatric Neuroscience, The Feinstein Institute for Medical Research; Director, Women's Behavioral Health, Zucker Hillside Hospital, Northwell Healt; Associate Professor, Psychiatry and Obstetrics & Gynecology, Hofstra Northwell School of Medicine

D. Jeffrey Newport, MD: University of Miami Miller School of Medicine Faculty; Director, Women's Reproductive Mental Health; Professor of Psychiatry & Behavioral Sciences and Obstetrics & Gynecology

Zachary Stowe, MD: Faculty, University of Wisconsin School of Medicine and Public Health

National Institutes of Health
Turning Discovery Into Health

ATTACHMENT 4

THE NIH DIRECTOR

The NIH Director

Photo Gallery

Congressional Testimonies

Advisory Groups

Video & Sound Gallery

Articles

Statements

May 2, 2017

New NIH Approach to Grant Funding Aimed at Optimizing Stewardship of Taxpayer Dollars

Today we want to put forward a new approach to making sure that we are exercising optimum stewardship of the funds that we receive from taxpayers. We will be discussing this approach with our Advisory Councils over the next few weeks, and so we wanted to provide this broad public description. This initiative aims to take advantage of new and powerful ways to assess the effectiveness of NIH research investments to be sure that the funds we are given are producing the best results from our remarkable scientific workforce. We would pursue this strategy regardless of the level of budget support.

Over the last several years, NIH has been acting to address a biomedical research workforce dangerously out of balance. While we have made progress in reversing the decline in grant funding to early-career investigators through various programs and policies, the percentage of NIH awards that support this group remains flat. Unfortunately, gains for early-career investigators have been offset by a decline in the percentage of NIH awards that support mid-career investigators. The only group for which the percentage of grant funding is increasing is late-career investigators.

Moreover, the distribution of NIH grant funding is highly skewed, with 10 percent of NIH-funded investigators receiving over 40 percent of NIH funding. While that might be just fine if the data suggested that this is the best way to get results, analyses conducted by both NIH and others (1, 2, 3, 4,5, 6, 7, 8) has shown that incremental research output gradually diminishes as the amount of support per investigator increases. For anyone who is familiar with the stresses on an investigator trying to balance multiple competing priorities, perhaps this is not a total surprise. Essentially, the more principal investigators must manage in terms of additional projects, personnel, and grant applications, the less additional time they have to dedicate to their research. Thus, the incremental benefit in productivity starts to decline. This is an important new insight. And because scientific discovery is inherently unpredictable, there are reasons to believe that supporting more researchers working on a diversity of biomedical problems, rather than concentrating resources in a smaller number of labs, might maximize the number of important discoveries that can emerge from the science we support and thus, returns on the taxpayers' investments.

To address this new evidence, NIH will be implementing an additional measure to bring the workforce

back into equilibrium by working with NIH grant applicants/recipients to limit the total NIH grant support provided to an individual principal investigator through NIH-supported research. We call it the Grant Support Index (GSI). It is not a new concept, although it is a new name (we introduced it as the Research Commitment Index). In fact, in 1985 Bruce Alberts [(9)] called for the NIH to limit the amount of support it would give to any one investigator, citing both diminishing returns and investigator bandwidth. In 2015, the Federation of American Societies for Experimental Biology, one of the largest scientific organizations in the world representing over 30 scientific societies, made the recommendation pdf to limit the total funding to an individual researcher or laboratory. A similar consensus recommendation emerged from a major stakeholders meeting convened at the University of Wisconsin, Madison [(10)] later that year.

The GSI is a measure of grant support that does not solely focus on grant money, since differing areas of research inherently incur differing levels of cost. Instead, GSI assigns a point value to the various kinds of grants based on type, complexity, and size. Applications for NIH-funding that will support researchers who have GSIs over 21 (the equivalent of 3 single-PI R01 awards) will be expected to include a plan in their applications for how they would adjust those researchers' existing grant load to be within the GSI limits if their application is awarded. While implementation of a GSI limit is estimated to affect only about 6 percent of NIH-funded investigators, we expect that, depending on the details of the implementation, it would free up about 1,600 new awards to broaden the pool of investigators conducting NIH research and improve the stability of the enterprise.

Over the next few months, NIH will be seeking feedback from the scientific community on how best to implement the GSI limit. There are still many details of the policy that need to be worked out and we want those details to be informed by the community. You'll be hearing more about this effort and opportunities to provide input from NIH Deputy Director for Extramural Research Dr. Michael Lauer through his Open Mike Blog.

Francis S. Collins, M.D., Ph.D.
Director, National Institutes of Health

References

1. Basson, J., Lorsch, J., Dorsey, T.Revisiting the Dependence of Scientific Productivity and Impact on Funding Level. NIGMS Feedback Loop Blog. (2016)
2. Doyle, J.M., Quinn, K., Bodenstein, Y.A., Wu, C.O., Danthi, N., Lauer, M.S. Association of percentile ranking with citation impact and productivity in a large cohort of de novo NIMH-funded R01 grants. Molecular Psychiatry (2015) 20:1030-1036.
3. Lauer, M.S., Danthi, N.S., Kaltman, J., Wu C. Predicting Productivity Returns on Investment: Thirty Years of Peer Review, Grant Funding, and Publication of Highly Cited Papers at the National Heart, Lung, and Blood Institute. Circulation Research. (2015) 117:239-243.
4. Lauer, M. Following up on the Research Commitment Index as a Tool to Describe Grant Support. Open Mike Blog. (2017)
5. Fortin, J.M., Currie, D.J. Big Science vs. Little Science: How Scientific Impact Scales with Funding. PLoS One. 2013 Jun 19;8(6):e65263.
6. Cook, I., Grange, S., Eyre-Walker, A. Research groups: How big should they be? PeerJ. 2015 Jun 9;3:e989.
7. Javitz H, Grimes T, Hill D, Rapoport A, Bell R, Fecso R, Lehming R. 2010. U.S. Academic Scientific

Publishing. Working paper SRS 11-201. Arlington, VA: National Science Foundation, Division of Science Resources Statistics.

8. Fortner, R. Diminishing returns?: U.S. Science Productivity Continues to Drop. Scientific American. December 6, 2010
9. Alberts, B.M. Limits to growth: in biology, small science is good science. Cell (1985) 41: 337-338
10. Kimble, J., Bement, W.M., Chang, Q., Cox, B.L., Drinkwater, N.R., Gourse, R.L., Hoskins, A.A., Huttenlocher, A., Kreeger, P.K., Lambert, P.F., Mailick, M.R., Miyamoto, S., Moss, R.L., O'Connor-Giles, K.M., Roopra, A., Saha, K., Seidel, H.S. Strategies from UW-Madison for rescuing biomedical research in the US. eLife. 2015;4:e09305

NIH...Turning Discovery Into Health®

National Institutes of Health, 9000 Rockville Pike, Bethesda, Maryland 20892

U.S. Department of Health and Human Services

Draft of USJS 2.0—5/4/17

U. S. Joint Statement on Conversion Therapy

This joint statement on efforts to change sexual orientation or gender identity was signed by XX major medical and psychological professional organizations representing more than YY healthcare providers in the U.S. It represents a shared commitment to certain principles and guidelines when addressing the needs of people who are questioning their sexual orientation or gender identity. It is specifically concerned with the practice of so-called conversion therapy, also known as reparative or reorientation therapy, or by the scientific terms of sexual orientation change efforts (SOCE) or gender identity change efforts (GICE).

Background

Decades of research findings and clinical expertise have revealed that variations in sexual orientation and gender identity are a normal part of human development. Virtually all major medical and psychological professional associations have concluded that neither same-sex desire or behavior nor the expression of atypical gender identities or characteristics constitute, per se, a mental illness or pathology. Most major professional associations already have position statements relative to Lesbian, Gay, Bisexual, Transgender, Questioning, or Gender NonConforming (LGBTQ/GNC) health and/or the ineffectiveness and potential harms of efforts to change sexual orientation.[1] Research and experience shared by scholars, clinicians, and patients have shown such efforts to be ineffective and harmful.[2] Thus, it raises profound ethical concerns when individuals are led to believe that they can or should change these aspects of their identity. Assertions that such change efforts are viable or desirable are not based on sound evidence. They can themselves be dangerous by exacerbating harmful stigma already suffered by sexual and gender minorities and by framing therapeutic practices in ways that conflict with scientific and ethical principles embraced by the therapeutic professions.

Conversion Therapy May Violate Core Ethical Principles of the Healthcare Professions.

This statement reflects and reinforces some of the core ethical principles of the health professions. The ethical principle of “Respect for People’s Rights and Dignity,” including the right of self-determination[3] requires that each individual is seen as a whole person supported in their right to explore, define, articulate, and live out their own identity.[4] For this reason, it is essential for clinicians to acknowledge the broad spectrum in which individuals may live positively and healthfully with their sexual orientation and gender identity/expression. In order to do so, it is necessary to have an equal understanding of and respect for sexual and gender minorities as well as the religious, spiritual, and other ideological values of individuals, families, and communities. The principle of “Integrity”[5] calls on healthcare professionals to ensure accuracy and truthfulness in their work and to avoid making fraudulent, deceptive, or unclear claims or promises to their patients, while the principle of “Justice” invites professionals to be sure that their biases,

competence, and limitations do not unjustly interfere in their work. To ensure all healthcare providers adhere to the principle of "Beneficence and Nonmaleficence," it is essential to recognize that a person is not mentally ill or developmentally delayed because they experience same-sex attractions or a nonconforming gender identity or expression.[6] The focus of treatment should be to comprehensively assess the sources of distress for the individual about their sexual orientation or gender identity and provide interventions to address such distress, without directly or indirectly pressuring the individual to identify one way or another.

Research or treatment approaches based on stigmatization of or efforts to change sexual orientation or gender identity may violate the above core ethical principles. The focus of treatment when such individuals seek therapeutic assistance should be to reduce the distress such individuals experience regarding their sexual orientation or gender identity,[7] and healthcare providers should seek to grant those in their care the liberty to express their true identity without fear of stigma, pressure, or reprisal. Healthcare professionals should strive to acquire a full understanding of and respect for sexual and gender minorities at the same time and in the same ways as they appreciate the full range of people's religious, spiritual, ideological and other values and experiences forged in families and communities around the world.

Goals and Objectives

The signatories of this statement share a commitment to protecting the public from the risks and harms of conversion therapy and to ensuring full access to the benefits of ethical, affirmative healthcare for sexual and gender minorities. Given the fact that same-sex desire and behavior and gender-variant identity and expression are not mental disorders, and given the lack of evidence showing that conversion therapy can effectively change sexual orientation or gender identity, and given the strong indications that such change efforts can increase stigma and cause other harms to patients and their families, we urge all healthcare professionals to commit themselves to ensure that:

- The public is informed about the research on conversion therapy and the risks thereof;
- Affirmative behavioral, psychological and emotional healthcare interventions are available to reduce the negative effects of minority stress for those experiencing individual or family distress associated with sexual orientation or gender identity;
- Healthcare professionals are made aware of the ethical issues surrounding conversion therapy, including acquiring appropriate training to competently deal with requests for conversion therapy and to provide ethical support to clients in distress over their sexual orientation and/or gender identity;
- Healthcare professionals from various disciplines work together to promote individual and public health through education about the risks and harms of conversion therapy.

A Note about Research

Nothing in this statement is intended to preclude ethical research relative to gender identity or sexual orientation. Nonetheless, research on the effectiveness of conversion therapy presents with significant ethical concerns for the following reasons: (1) It is ethically problematic to subject research participants to practices that are potentially harmful and whose effectiveness has been repeatedly questioned[8]; (2) conversion therapy theories and interventions are based on inaccuracies that pathologize being lesbian, gay, bisexual[9] or transgender[10] and reinforce minority stress while neglecting any potential risks; and (3) research or treatment approaches based on stigmatization of gender identity or sexual orientation are not compatible with the ethical principle of Fidelity and Responsibility, which affirms that treatment be competent, accurate, and based on scientific and professional judgements.[11]

Roles and Responsibilities

This statement does not define a specific list of actions that every organization will carry out. Instead, it sets out a framework by which organizations may be guided in responding to the challenges of treating individuals who present with concerns about their sexual orientation or gender identity. In general, the statement's signatories agree to accept the following roles and responsibilities:

- Each organization will review its codes of ethical conduct for members and consider the need for the creation of specific amendments to those codes;
- Professional associations will ensure that their members have access to the latest information regarding the potential risks and harms of conversion therapy;
- Organizations will work together to create a shared information resource on the potential risks and harms of conversion therapy to assist both professionals and members of the public in accessing up-to-date research on the matter;
- Those with a responsibility for clinical and academic training, and those responsible for continuing professional development, will work to ensure that such programs provide healthcare providers with a sufficient degree of cultural competence to work effectively with sexual and gender minority clients;
- Clinicians who are not sufficiently trained around issues of sexual orientation and/or gender identity/expression will make every effort to seek appropriate training or consultation or to connect patients with clinicians and agencies who are trained to provide culturally competent clinical care;
- Auditing and accrediting organizations will review their current guidelines and policies for practitioners and training organizations to assess the need for more specific standards to demonstrate awareness of and compliance with policies regarding conversion therapy.

We aim to end the use of ineffective and harmful mental health practices; build greater social acceptance of sexual and gender minorities of all ages; account for developmental considerations in each stage of life; and encourage the provision of, and access to, appropriate, affirmative therapies for all individuals who seek treatment. Understanding and supporting the experiences of sexual and gender minorities will help reduce health disparities and improve the health and wellbeing of these individuals, their families and their communities. This joint statement is a collaborative effort that

underscores the depth of our commitment to the ethical treatment of those at risk from conversion therapy.

Review

The undersigned organizations will review the statement 12 months after publication.

Notes:

[1] http://www.ama-assn.org/ama/pub/about-ama/our-people/member-groups-sections/glbt-advisory-committee/ama-policy-regarding-sexual-orientation.page?

http://www.apa.org/about/policy/sexual-orientation.aspx

http://www.socialworkers.org/diversity/new/documents/hria_pro_18315_soce_june_2015.pdf

http://www.psychiatry.org/file%20library/about-apa/organization-documents-policies/policies/position-2013-homosexuality.pdf

http://www.guideline.gov/content.aspx?id=38417#Section420

http://www.aamft.org/iMIS15/AAMFT/Content/about_aamft/position_on_couples.aspx

http://annals.org/article.aspx?articleid=2292051

http://www.counseling.org/news/updates/2013/01/16/ethical-issues-related-to-conversion-or-reparative-therapy

http://www.apsa.org/content/2012-position-statement-attempts-change-sexual-orientation-gender-identity-or-gender

http://www.schoolcounselor.org/asca/media/asca/PositionStatements/PS_LGBTQ.pdf

http://www.cswe.org/File.aspx?id=85010

http://www.wpanet.org/detail.php?section_id=7&content_id=1807

http://hrc-assets.s3-website-us-east-1.amazonaws.com//files/documents/SupportingCaringforTransChildren.pdf

https://www.aacap.org/AACAP/Policy_Statements/2009/Sexual_Orientation_Gender_Identity_and_Civil_Rights.aspx

http://www.jaacap.com/article/S0890-8567(12)00500-X/pdf

[2]http://www.psychotherapy.org.uk/UKCP_Documents/policy/MoU-conversiontherapy.pdf

http://store.samhsa.gov/product/Ending-Conversion-Therapy-Supporting-and-Affirming-LGBTQ-Youth/All-New-Products/SMA15-4928

http://www.paho.org/hq/index.php?option=com_content&view=article&id=6803%3A2012-therapies-change-sexual-orientation-lack-medical-justification-threaten-health&catid=740%3Anews-press-releases&Itemid=1926&lang=en

http://whatweknow.law.columbia.edu/topics/lgbt-equality/what-does-the-scholarly-research-say-about-whether-conversion-therapy-can-alter-sexual-orientation-without-causing-harm/

[3] American Psychiatric Association (2000). *Therapies Focused on Attempts to Change Sexual Orientation (Reparative or Conversion Therapies): COPP Position Statement.* Retrieved July 10, 2016 from https://www.psychiatry.org/file%20library/about-apa/organization-documents-policies/policies/position-2000-therapies-change-sexual-orientation.pdf

[4] Reconciliation and Growth Project (2017). Resolving Distress Between Faith-Based Values and Sexual and Gender Diversity: A Guide for Mental Health Professionals. Retrieved February 21, 2017, from http://www.reconciliationandgrowth.com/

[5] American Psychological Association (2010). *Ethical Principles of Psychologists and Code of Conduct.* Retrieved July 2, 2016, from http://www.apa.org/ethics/code

[6] Reconciliation and Growth Project (2017).

[7] Ibid.

[8] Anton, B. S. (2010). Proceedings of the American Psychological Association for the legislative year 2009: Minutes of the annual meeting of the Council of Representatives and minutes of the meetings of the Board of Directors. *American Psychologist*, 65, 385–475. doi:10.1037/a0019553

[9] American Psychiatric Association, 2000.

[10] World Professional Association for Transgender Health (2011). Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People. Retrieved April 21, 2017, from https://s3.amazonaws.com/amo_hub_content/Association140/files/Standards%20of%20Care%20V7%20-%202011%20WPATH%20(2)(1).pdf

[11] American Psychological Association, 2010.

Attachment #1
Item 2017A1 12.A
Assembly
May 19-21, 2017

ACTION PAPER
FINAL

TITLE: Involuntary Psychiatric Commitment for Individuals with Substance Use Disorders

WHEREAS:
The current opioid use disorder epidemic has reached a point where the public and legislators are clamoring for strong action to be taken; and whereas

Many individuals believe that people in the throes of addiction lack decision-making capacity to undertake treatment voluntarily; and whereas

There is some evidence from the forensic literature that the use of coerced treatment has some effect, that mandating participation in drug treatment programs and sobriety in lieu of incarceration can lead to a reduction in drug use; and whereas

There are some who believe that the use of involuntary psychiatric commitment for substance using individuals may similarly lead to reduction in substance use; and whereas

Many states are considering altering their statutes or practice of civil commitment, in the hope of achieving involuntary psychiatric hospitalization for patients with substance use disorders; and whereas

There is much debate about whether there is any evidence to suggest that involuntary hospitalization on psychiatric units provides any benefit for individuals with substance use disorder; and whereas

Many of those proposing involuntary treatment may believe that locked substance abuse treatment centers are available, outside of the current locked psychiatric hospital system; and whereas

Psychiatric hospital units capable of caring for civilly committed individuals are not prepared to manage an influx of individuals with substance use disorders, lacking excess capacity or programming ability to provide appropriate treatment; and whereas

Mandates to increase the number of individuals subject to involuntary psychiatric hospitalization by expanding criteria by diagnosis and behavior will need significantly greater resources, which states are unlikely to be able to allocate; and whereas

There are jurisdictions which allow for coerced treatment by civil commitment, which is used to varying degrees, but which may permit some assessment of the efficacy of such treatment; and whereas

The pressure to “do something” about the opioid epidemic may lead to hasty policy decisions in the absence of evidence; and whereas

APA district branches need assistance with position statements based on science;

BE IT RESOLVED:
That the American Psychiatric Association develop a comprehensive position statement on the use of involuntary psychiatric commitment for the treatment of substance use disorders.

AUTHORS:
Kenneth M. Certa M.D., DLFAPA, Representative, Pennsylvania Psychiatric Society
kenneth.certa@jefferson.edu
Mary Anne Albaugh M.D., Representative, Pennsylvania Psychiatric Society

ESTIMATED COST:
Author: $9,240
APA: $6,160

ESTIMATED SAVINGS:

ESTIMATED REVENUE GENERATED:

ENDORSED BY:

KEY WORDS: substance use disorder; involuntary treatment

APA STRATEGIC PRIORITIES: Advancing Psychiatry

AMERICAN PSYCHIATRIC ASSOCIATION

Action Paper Worksheet
2017 Action Paper Budget Estimate

Action Paper Title: 12.A: Involuntary Psychiatric Commitment for Individuals with Substance Use Disorders
Action Paper Author(s): Kenneth M. Certa M.D., Representative, Pennsylvania Psychiatric Society
Phone/email: 215-817-9411 kenneth.certa@jefferson.edu
APA Admin. Name: Beatrice Eld, Division of Education
Phone/email 703-907-8598 beld@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		-	-	-	-	-

Non-Staff Costs:

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

Staff Costs:

	Description:	
1	Addiction Psychiatry, CPL, and CAGR need to form a work group to develop position statement	3,080
2	Unclear extent to which other organizations may need to be involved (eg ASAM, AMA) for in person or phone meetings	3,080
3	District branches facing these commitment issues should submit data.	3,080
Total Staff Costs		9,240

Other Costs not included above:

0	-
Total Author Estimate	**$9,240**

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	workgroup works via email and conference calls. Staffing by liaisons to Councils on Addictions and Psych&Law	3,080
2	State legislative staff compile info on existing and proposed statutes re involuntary tx of SUDs	1,540
3	WG members draft statement; share with full Councils, AAAP, & ASAM for endorsement; advance statement to JRC and Assembly	1,540
Total Staff Costs		**6,160**

Other Costs not included above:

0	-
Total Administration Estimate	**$6,160**

Rvsd. Dec. 2016

Action Paper 12.A: Involuntary Psychiatric Commitment for Individuals with Substance Use Disorders

APA Administration Feedback:

Council on Psychiatry and Law
Council on Addiction Psychiatry
Council on Advocacy and Government Relations

A work group comprised of members from the above components will work via email and conference calls to strategize and draft a position statement. Staffing for the work group efforts will be by liaisons to the Council on Addiction Psychiatry and Council on Psychiatry and Law.

Assistance from state legislative staff to compile information on existing and proposed statutes in each state regarding the involuntary treatment of substance use disorders may be requested.

Once developed, the work group's draft position statement will be shared with the full Councils and then proceed through the governance process and be shared with other relevant organizations that share a similar interest.

No estimated savings or estimated revenue generation is anticipated by this action.

Attachment #2
Item 2017A1 12.B
Assembly
May 19-21, 2017

ACTION PAPER
FINAL

TITLE: Opposition to Psychologist Prescribing

WHEREAS:
Online schools have opened for Psychologists to learn to prescribe psychotropic medications in just a short few months.

Lack of proper education and a residency has major implications on the safety of patients.

The AMA has concluded that there is a higher rate of prescribing controlled substances and a higher number of referrals and tests that are ordered for patients.

Psychologists have no preparation in medical training and are poorly suited to make decisions that can affect multiple systems – not just the brain.

BE IT RESOLVED:
That the appropriate committee create a Position Statement that reflects that the APA, in the service of patients with mental illness, opposes prescribing privileges of Psychologists.

AUTHOR:
Sarit Hovav, M.D., Deputy Representative, International Medical Graduate Psychiatrists
(anisarit@gmail.com)

ESTIMATED COST:
Author: $0
APA: $2,926

ESTIMATED SAVINGS: None

ESTIMATED REVENUE GENERATED: NA

ENDORSED BY:

KEY WORDS: education, nurse practitioner, safety, IMG, physician assistant, APN, NP, APRN, medical license, scope of practice, MUR

APA STRATEGIC PRIORITIES: Advancing Psychiatry, Education

REVIEWED BY RELEVANT APA COMPONENT:

AMERICAN PSYCHIATRIC ASSOCIATION

Action Paper Worksheet
2017 Action Paper Budget Estimate

Action Paper Title: 12.B: Limiting Scope of Practice for Nurse Practitioners and the Opposition of Psychologists Prescribing
Action Paper Author(s): Sarit Hovav, M.D., Deputy Representative, International Medical Graduate Psychiatrists
Phone/email: 818-331-0233 / anisarit@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	-	-
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		-	-	-	-	-

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	**$0**

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 review of relevant APA policy and development of position statement	385
2 APA collaborative lobbying with District Branches/State Associations and their respective state medical societies	770
3 develop the resolution(s), seek additional sponsors, develop talking points and coordinate advocacy efforts onsite at the AMA HOD meeting	616
Total Staff Costs	**1,771**
Other Costs not included above:	
research and creation of APA resources for policymakers (i.e., toolkit, white papers)/internal meeting to develop & coordinate grassroot strategies (15 hours)	**1,155**
Total Administration Estimate	**$2,926**

Rvsd. Dec. 2016

Action Paper 12.B: Limiting Scope of Practice for Nurse Practitioners and the Opposition of Psychologists Prescribing

APA Administration Feedback:

Department of Government Relations:
The Department of Government Affairs, working closely with APA membership, has injected a new sense of urgency in defeating inappropriate scope of practice measures sought by non-physician health care professionals. Through the Scope of Practice Partnership, APA collaborates with the American Medical Association and state medical associations to help educate legislators, regulatory agencies, and other policymakers. The Department of Government Relations reviewed the action paper taking in consideration the authors' specific request for advocacy efforts. The projected time and cost would vary widely depending on the scale and scope of the effort that is required. The Department estimates an advocacy campaign based on the premise of the action paper may entail: 5 hours, review of relevant APA policy and development of a position statement; 10 hours, APA collaborative lobbying with District Branches/State Associations and their respective state medical societies; 10 hours, research and creation of APA resources for policymakers, i.e., toolkit, white papers; and 5 hours, internal meeting with APA Communication to coordinate media and grassroot strategy.

APA AMA Delegation:
As the author points out the AMA has several relevant policies that speak to the issue of scope of practice/prescribing. There would be minimal cost for continued advocacy within the AMA House of Delegations unless, in the development of a position statement, the APA position includes some aspect that is not currently covered within existing AMA policy. A review of AMA policy and the development of a resolution would be considered at that time. Much of the heavy lifting on this issue lies with the individual AMA state medical associations. Cost would be primarily staff time to review APA policy, research existing AMA policy, and facilitate a discussion by the APA AMA delegation. If appropriate, develop the resolution(s), seek additional sponsors, develop talking points and coordinate advocacy efforts onsite at the AMA HOD meeting(s). 8 to 10 hours ($616 to $770)

Action Paper Worksheet
2017 Action Paper Budget Estimate

Action Paper Title: 12.B: Opposition to Psychologist Prescribing- REVISED June 2017
Action Paper Author(s): Sarit Hovav, M.D., Deputy Representative, IMG Psychiatrists
Phone/email:
APA Admin. Name: Deana McRae, Department of Government Relations
Phone/email dmcrae@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		-	-	-	-	-

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	**$0**

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	**$0**

Action Paper 12.B: Opposition to Psychologist Prescribing

APA Administration Feedback- REVISED June 2017:

Department of Government Relations:
The Department of Government Affairs, working closely with APA membership, has injected a new sense of urgency in defeating inappropriate scope of practice measures sought by non-physician health care professionals. Through the Scope of Practice Partnership, APA collaborates with the American Medical Association and state medical associations to help educate legislators, regulatory agencies, and other policymakers. The Department of Government Relations reviewed the action paper taking in consideration the authors' specific request for the development of an APA position statement. The projected time and cost would depend on the scale and scope of the research and crafting an official position for the organization, as required. The Department estimates the staff time based on the premise of the action paper may entail: 5 hours, review of relevant APA policy and development of a position statement working in collaboration with other APA Departments and APA District Branches/State Associations.

Attachment #3
Item 2017A1 12.D
Assembly
May 19-21, 2017

ACTION PAPER
FINAL

TITLE: Adopting Neuroscience-based Nomenclature (NbN) for Medications

WHEREAS:

Categories of medications have been named for conditions they treat for a very long time (e.g., antihypertensives, antiarrhythmics, antipsychotics) despite most having multiple uses;

The past few decades have seen much greater understanding about the chemical structure and actual mechanisms of action of medications, with changes in how these categories are labeled and grouped together (e.g., angiotensin II receptor antagonists, potassium channel blockers, D2/5HT2 antagonists);

Psychotropic medication categories have not kept up with these advances in nomenclature, resulting in confusion by patients prescribed a medication in a category that does not always fit their condition (e.g., an antipsychotic for bipolar disorder);

Payers have maintained this older nomenclature, sometimes limiting the number of covered medications per category;

There now exists a well-developed and broadly-adopted neuroscience-based nomenclature (NbN) that categorizes psychiatric medications based on pharmacology and mode of action (nbnomenclature.org);

NbN was developed by an international task force of leading scientific organizations, including the American College of Neuropsychopharmacology (ACNP), European College of Neuropsychopharmacology (ECNP), Asian College of Neuropsychopharmacology (AsCNP), International College of Neuropsychopharmacology (CINP), and International Union of Basic and Clinical Pharmacology (IUPHAR);

A growing number of publications and organizations is adopting NbN's standardized terminology to replace the outdated historical categories;

Adoption of this neuroscience-based nomenclature by the APA and its publications would benefit the field and our patients by using specific terminology that uses more accurate descriptions of how psychiatric medications work in the brain; and

Advocacy by APA for policymakers and payers to adopt this nomenclature may facilitate more rational coverage policies resulting in greater access to all NbN categories of medications; therefore

BE IT RESOLVED:

That the APA promote the international Neuroscience-based Nomenclature (NbN) standard terminology developed by ACNP, ECNP, CINP, AsCNP, and IUPHAR, in its publications, policies, and communications;

That the APA seek opportunities to promote adoption of NbN terminology by payers and policymakers; and

That the APA CEO and Medical Director be responsible for carrying out these promotion activities.

AUTHORS:
Steven Daviss, M.D., DFAPA, Representative, Maryland Psychiatric Society (steve@fusehealth.org)

SPONSORS:
Patrick Aquino, M.D., Representative, Massachusetts Psychiatric Society
Jeffrey Bennett, M.D., Representative, Illinois Psychiatric Society
Lisa Catapano-Friedman, M.D., Representative, Vermont Psychiatric Association
Sarit Hovav, M.D., Deputy Representative, International Medical Graduate Psychiatrists
Matthew Kruse, M.D., Area 4 Representative, Assembly Committee of Resident-Fellow Members
Rahul Malhotra, M.D., Area 3 Representative, Assembly Committee of Early Career Psychiatrists
Elizabeth Morrison, M.D., DLFAPA, Representative, Washington Psychiatric Society
Joseph C. Napoli M.D., DLFAPA, Representative, Area 3
James A. Polo, M.D. MBA, Representative, Washington State Psychiatric Association
Roger Peele, M.D., APA Member
Charles Price, M.D., Deputy Representative, Area 7
William Greenberg, M.D., Deputy Representative, Area 3

ESTIMATED COST:
Author: $0
APA: $4,928

ESTIMATED SAVINGS: unknown

ESTIMATED REVENUE GENERATED: unknown

ENDORSED BY:

KEY WORDS: medications, standards, pharmacology, nomenclature, payment policies

APA STRATEGIC PRIORITIES: Advancing Psychiatry, Supporting Research, Education

REVIEWED BY RELEVANT APA COMPONENT:

Example from nbnomenclature.org/authors:

Antipsychotic (Neuroleptics, Major tranquillisers)	**Drugs for psychosis**		
Typical (1st generation)	dopamine	receptor antagonist (D2)	flupenthixol, fluphenazine, haloperidol, perphenazine, pimozide, pipotiazine, sulpiride, trifluoperazine, zuclopenthixol
	dopamine, serotonin	receptor antagonist (D2, 5-HT2)	chlorpromazine, thioridazine
Atypical (2nd generation)	dopamine	receptor antagonist (D2)	amisulpiride
	dopamine, serotonin	receptor antagonist (D2, 5-HT2)	iloperidone, loxapine, lurasidone, olanzapine, perospirone, sertindole, ziprasidone, zotepine
	dopamine, serotonin	receptor partial agonist (D2, 5-HT1A)	aripiprazole
	dopamine, serotonin, noradrenaline	receptor antagonist (D2, 5-HT2, NE alpha-2)	asenapine, clozapine, risperidone, paliperidone
		MM; receptor antagonist (D2, 5-HT2) and reuptake inhibitor (NET)(metabolite)	quetiapine
Anxiolytic	**Drugs for Anxiety**		
(benzodiazepine)	GABA	Positive Allosteric Modulator (GABA-A receptor, benzodiazepine site)	alprazolam, chlordiazepoxide, clonazepam, clorazepate, diazepam, flunitrazepam, lorazepam, oxazepam
	serotonin	receptor partial agonist (5-HT1A)	buspirone
	glutamate	voltage-gated calcium channel blocker	gabapentin, pregabalin

AMERICAN PSYCHIATRIC ASSOCIATION

Action Paper Worksheet
2017 Action Paper Budget Estimate

Action Paper Title: 12.D: Adopting Neuroscience-based Nomenclature (NbN) for Medications
Action Paper Author(s): Steven Daviss, M.D., DFAPA, Representative, Maryland Psychiatric Society
Phone/email: 410-782-0077 / steve@fusehealth.org
APA Admin. Name: Glenn O'Neal, Office of Communications
Phone/email (703) 907-8502 / goneal@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		-	-	-	-	-

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	**$0**

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 Additional staff hours spent per year editing APA's public facing communications channels to address the author's concerns.	4,928
2	-
3	-
Total Staff Costs	**4,928**
Other Costs not included above:	
0	-
Total Administration Estimate	**$4,928**

Rvsd. Dec. 2016

Action Paper 12.D: Adopting Neuroscience-Based Nomenclature (NbN) for Medications

APA Administration Feedback:

Office of Communications:

APA administration is mindful of the author's concerns. Our staff employs rigorous checks to maintain a high standard of clinical accuracy in all APA-branded materials. In technical materials – especially those fully under our control, such as content that is entirely generated in-house – APA is highly consistent in its use of language and has full-time editors in its employ, including psychiatrist editors-in-chief. However, we note that there are instances when APA produces content for a lay or patient/family audience. When producing content for non-specialized audiences, APA communications staff aims for accessible, plain language that also makes the content discoverable by search engines, which is how the public calls upon much of our content. While terms such as "antidepressants" may not conform to NbN standards, they are high traffic search terms through which a large part of APA's audience finds content on Psychiatry.org.

Taking this into account, APA Communications estimates a minimum of 64 hours of extra staff time per year at a total cost of $4,928 spent editing APA's public facing communications channels to address the author's concerns, and we note that a complete erasure of common search terms may cause our content to be less findable though search engines.

APA Publishing:

This action will not pose any problem, but it will take some time to implement given the nature of publishing schedules.

Attachment #4
Item 2017A1 12.E
Assembly
May 19-21, 2017

ACTION PAPER
FINAL

TITLE: Revising the Nomenclature, Definition, and Clinical Criteria for Partial Hospitalization Program

WHEREAS:

1. Partial Hospitalization is a term coined long time ago to distinguish it from complete or total hospitalization when state hospitals provided daily outpatient therapy on hospital grounds at the request of patients discharged after long term inpatient hospitalization to facilitate transition to outside world;
2. Partial Hospitalization Program (PHP) has, over the years, become a recognized and established outpatient treatment program entity vital in the continuum of psychiatric care along with Intensive Outpatient Program (IOP) but the Centers for Medicare/ Medicaid services and the health insurance industry have repeatedly revised the clinical criteria of these programs to suit their own financial agendas;
3. PHP is a confusing misnomer to clinicians, patients and public alike because of the terms: 'partial' frequently mistaken for 'biased' or 'incomplete', and 'hospitalization' for 'inpatient' or pejoratively for "confinement'; some PHP's have shortened the term 'hospitalization program' to 'hospital program' conveying a different meaning; the American Association for Partial Hospitalization (AAPH) also changed its name to Association for Ambulatory Behavioral Health (AABH) partly because of this confusion and to emphasize its outpatient ambulatory aspect;
4. Day Hospitalization Program is a term sometimes used interchangeably with PHP but fraught with same confusion or stigma while Day Treatment Program is another interchangeable term but does not convey the intensity level of treatment;
5. Confusion also exists as to what constitutes PHP in contrast to IOP with differing definitions, criteria and reimbursement rates among insurance providers and clinical facilities.

BE IT RESOLVED:
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.

AUTHOR:
Sudhakar Madakasira, M.D., DLFAPA, Representative, Mississippi Psychiatric Association
(smadakasira@hotmail.com)

ESTIMATED COST:
Author: $0
APA: $53,696

ESTIMATED SAVINGS: None

ESTIMATED REVENUE GENERATED: None

ENDORSED BY:

KEY WORDS: Partial Hospitalization, Intensive Outpatient Program, Stigma

APA STRATEGIC PRIORITIES: Advancing psychiatry, Education

REVIEWED BY RELEVANT APA COMPONENT: Council on Advocacy and Government Relations approves this paper (The recommendations from the Council have been incorporated into the paper).

AMERICAN PSYCHIATRIC ASSOCIATION

Action Paper Worksheet
2017 Action Paper Budget Estimate

Action Paper Title:	12.E: Revising the Nomenclature, Definition, and Clinical Criteria for Partial Hospitalization Program
Action Paper Author(s):	Sudhakar Madakasira, M.D., DLFAPA, Representative, Mississippi Psychiatric Association
Phone/email:	smadakasira@hotmail.com
APA Admin. Name:	Michelle Dirst, Practice Management and Delivery Systems Policy
Phone/email	mdirst@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		-	-	-	-	-

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	**$0**

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 Working with the President to appoint members to the Taskforce	231
2 Organizing phone calls and producing background material for the Task Force as necessary	2,695
3 Reviewing and proofing a report to the Assembly.	770
Total Staff Costs	**3,696**
Other Costs not included above:	
APA to advocate for the nomenclature, criteria, & definition to be accepted by states, insurance companies, and the federal government would be an intensive, multi-year effort.	**50,000**
Total Administration Estimate	**$53,696**

Rvsd. Dec. 2016

Action Paper 12.E: Revising the Nomenclature, Definition, and Clinical Criteria for Partial Hospitalization Program

APA Administration Feedback:

Division of Policy:
As noted in the paper, the term Partial Hospitalization was coined over 30 years ago and has evolved with differences in state-operated programs, insurance definitions, and geographic convention. There are also definitions in regulations issued by the Centers for Medicare and Medicaid. Having the Task Force review the nomenclature, definition, and clinical criteria with the ultimate goal to achieve uniformity and consistency would be a huge undertaking that may not achieve much change without substantial resources and priority put forth for advocacy given that literature will likely include multiplicity of terms and insurers will continue to set their own criteria. The Council on Health Care Systems and Financing is conducting an analysis of level of care that may be able to address the concern around the confusion of terminology. We don't recommend an additional Task Force at this time until the Council makes its recommendation regarding appropriate endorsement of level of care criteria.

Explanation of Costs:
The cost would be about $3,696 for the Taskforce.

For the Taskforce to be created and complete its work, we anticipate it would take approximately 50 hours of staff time, depending on how much support the Task Force needs. Staff activities include:

- Working with the President to appoint members to the Taskforce
- Organizing phone calls and producing background material for the Task Force as necessary
- Reviewing, proofing, and finalizing a report to the Assembly.

Beyond the Taskforce, it would take a substantial amount of time for staff to advocate for the nomenclature, criteria, and definition to be accepted by states, insurance companies, and the federal government. It would also likely be a multi-year effort. The staff time could cost about $50,000.

Attachment #5
Item 2017A1 12.G
Assembly
May 19-21, 2017

ACTION PAPER
FINAL

TITLE: Providing Education and Guidance for the Use and Limitations of Pharmacogenomics in Clinical Practice

WHEREAS:

1. There is an uptick in marketing on the use of pharmacogenomic testing.

2. The content of advertising for pharmacogenomic testing contains:
   A. misleading statements such as "Today there are GeneSight® tests available for depression, anxiety and other behavioral health conditions . . . " which implies the tests are for diagnosing disorders [1]
   B. an unsubstantiated statement that suicide "may possibly be avoided by doing pharmacogenomic (PGx) testing" [2]
   C. a false implication that a physician who was sentenced for 30 years for the death of three patients Is associated with not doing pharmacogenomic testing although the physician recklessly prescribed opioids without medical necessity and the patients overdosed. [3]

3. There should be a sufficient evidence base to support the use of pharmacogenomic testing in clinical practice and that demonstrates beneficial outcomes.

4. A MD, PhD internationally renowned expert on biological psychiatry opined that there isn't sufficient evidence at this time to support the claims of pharmacogenomic testing companies by saying, "Since it's a saliva test, they are spitting in the wind."

5. There have been failed attempts to use biomarkers in psychiatry such as the dexamethasone suppression test and urine testing to differentiate between a serotonergic vs. noradrenergic depression.

6. The use of these tests adds to health care cost, and thus, are they cost-effective?
   [Assurex Health states that its GeneSight® tests have been used for 215,000 patients. [4] If commercial Insurance, Medicare or Medicaid pay for the tests, the average cost of four available GeneSight® test panels is $2,848.50 and the cost for doing all four panels at once is $6,224. (Average cost X 215,000 tests (assuming one test per patient) = $612,427,500 (over ½ billion dollars) If all the tests were psychotropic tests, the health care cost is $5,500 x 215,000 =

---

[1] GeneSight® Brochure

[2] Letter to Dr Joseph Napoli from John Adkins, Consultant for Pharmacogenetic Testing, MedxPrim/Admera, February 20, 2017

[3] https://www.aol.com/article/2016/02/05/california-doctor-gets-30-years-to-life-in-landmark-overdose-cas/21308642/, retrieved 2017-02-02

[4] *Op. cit.* GeneSight® Brochure

$1,182,500,000 (over one billion dollars). (See Attachment.) The cost of testing might be offset to some degree by a savings in the cost of medication.[5]]

7. DNA tests results need to be secured to protect the personal health information of those who are tested, and thus, does the benefit of the test results outweigh the risk of this information not being adequately protected?

8. There is a precedent for an action paper generating a resource document.
   ["APA Position Statement on the Clinical and Forensic Application of Brain Imaging" – J Napoli *et al,* passed by the Assembly in May 2009 resulted in "Consensus Report of the APA Work Group on Neuroimaging Markers of Biomarkers: Resource Document" – M First *et al,* July 2012]

9. Personalized medicine and pharmacogenomic testing might be beneficial, especially in addressing biological diversity to inform treatment.

10. More research is needed to further understand how pharmacogenomic biomarkers correlate with pharmacotherapy and can be predictive for selecting pharmacological agents.

11. Providing education and guidance for the use and limitations of pharmacogenomics in clinical practice would be a service to APA members.

BE IT RESOLVED:
That:

1. The APA educate its members about the use and limitations of pharmacogenomic testing in clinical 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] Winner, JG et al Combinatorial pharmacogenomic guidance for psychiatric medications reduces overall pharmacy costs in a 1 year prospective evaluation Curr Med Res Opin 2015;31(9): 1633-43

5. The Council on Advocacy and Government Relations 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.

AUTHOR:
Joseph C. Napoli, MD, DLFAPA, Representative, Area 3, napoli@resiliency.us

SPONSORS:
Annette Hanson, M.D., Representative, Maryland Psychiatric Society
William Greenberg, M.D., Area 3 Deputy Representative
Charles Blackinton, M.D., Representative, New Jersey Psychiatric Association
Charles Ciolino, M.D., Representative, New Jersey Psychiatric Association
David A. Tompkins, M.D., MHS, M/UR Representative, LGBTQ Psychiatrists
Rahul Malhotra, M.D., Area 3 Representative, Assembly Committee of Early Career Psychiatrists
Steven Daviss M.D., DFAPA, Representative, Maryland Psychiatric Society
Isabel Norian, M.D., Representative, New Hampshire Psychiatric Society
Richard A. Ratner, M.D., ACROSS Representative, The American Society for Adolescent Psychiatry
Lisa K. Catapano-Friedman, M.D., DLFAPA, Representative, Vermont Psychiatric Association
Richard Altesman, M.D. DLFAPA, Representative, Psychiatric Society of Westchester
Eileen McGee, M.D., Representative, Ohio Psychiatric Physicians Association
Mary Anne Albaugh M.D., Representative, Pennsylvania Psychiatric Society
James C West, M.D., Representative, Society of Uniformed Psychiatrists
Patrick R. Aquino, M.D., Representative, Massachusetts Psychiatric Society

ESTIMATED COST:
Author: $4,577
APA: $33,418

ESTIMATED SAVINGS: None

ESTIMATED REVENUE GENERATED: This can generate revenue by providing education and guidance to non-member psychiatrists for a fee.

ENDORSED BY: Area 3, March 4, 2017

KEY WORDS: Advertising, Education, Clinical Practice, Consumer Education, Integrated Collaborative Care, Marketing, Member Service, Pharmacogenomics, Quality Care, Research, Testing

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

REVIEWED BY RELEVANT APA COMPONENT:
Sent to the Council on Advocacy and Government, the Council on Medical Education and Lifelong Learning, the Council on Quality Care and the Council on Research

Attachment

GeneSight® Rates				
Test (Based on medical necessity)	Commercial Insurance, Medicaid or Medicare Pays	Patient on Commercial Insurance or Medicare Advantage Co-Payment (1)	Patient on Medicaid, Medicare or Workers Comp Pays	Direct Pay
Psychotropic	$5,500	$330	0	$1,750 (2)
Analgesic	$4,200	$330	0	$1,750 (2)
ADHD	$1,550	$330	0	$440
MTHFR (Folic Acid)	$150	0	0	$150
Financial Assistance		(1) Patient receives financial assistance application form		
Income $0 - $50,000		$20		
$50,001 - $75,000		$150 or $12.50 per month		
> $75,000		$330 or $27.50 per month		
New York and Florida				
> $150,00		Either pay direct pay rate or difference between what commercial insurance allows and what commercial insurance pays		
(2) Rate of these two tests combined = $1,750 / Rate of all four test combined = $1,750				

AMERICAN PSYCHIATRIC ASSOCIATION

Action Paper Worksheet
2017 Action Paper Budget Estimate

Action Paper Title:	12.G: Providing Education and Guidance for the Use and Limiations of Pharmacogenomics in Clincial Practice
Action Paper Author(s):	Joseph C. Napoli, M.D, DLFAPA, Representative, Area 3
Phone/email:	201-461-0212 / napoli@resiliency.us
APA Admin. Name:	Samantha Shugarman, Reimbursement Policy
Phone/email	sshugarman@psych.org

Attendance Summary:	**Author**	**APA Administration**
Number of Component Members	-	5
Number of Staff	-	1
Number of Non-Staff	-	-
Total	**-**	**6**

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		-	-	-	-	-

Non-Staff Costs:	
LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	**-**
Staff Costs:	
Description:	
1 Add article to APA Website 0.5 hr $38.50	77
2	-
3	-
Total Staff Costs	77
Other Costs not included above:	
0 for including statements in practice guidelines because this would be included in the cost of producing the practice guidelines / $4,500 for staff and incidental costs for producing a consensus report. This is based on a cost estimate done by APA Admin for the May 2009 action paper, which resulted in a consensus report being produced, increasing the because of the increase of	4,500
Total Author Estimate	**4,577**

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		**-**	**-**	**-**	**-**	**$0**

Non-Staff Costs:	
LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	**-**
Staff Costs:	
Description:	
1 Resolve 1 &2: Online webinar which includes Continuing Medical Education, educational design, remote capture, editing, LMS posting and hosting costs approximately $4500 in in-kind staff time.	4,543
2 Resolve 3A &3B: $20-30k extra per guideline for those where we do the pharmacogenomics search. Additional detail on summary.	26,950
3 Resolve 5: costs associated applied to CAGR staff time.	385
Total Staff Costs	**31,878**
Other Costs not included above:	
Resolve 6: This could cost about 20 hours for the APA staff member, between updating the material to reflect the appropriate audience, and to guide the document through the APA governance chain, before staff post the material on the APA website.	**1,540**
Total Administration Estimate	**33,418**

Rvsd. Dec. 2016

Action Paper 12.G: Providing Education and Guidance for the Use and Limitations of Pharmacogenomics in Clinical Practice

APA Administration Feedback:

Rationale for Costs Assessment: This cost assessment includes many components that rely on the successful advancement of the individual Action Paper Resolves. To provide a reliable assessment, multiple members of the APA Administration were consulted, based on the description of activities in each resolve.

Department of Education/Council on Medical Education and Lifelong Learning

Resolve One and Two were combined, as the activities overlap:

1. "The APA educate its members about the use and limitations of pharmacogenomic testing in clinical 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."

Explanation of Cost: Per Education Department Administration, a presentation at the APA Annual Meeting comes at no cost, but a subject matter expert must submit an abstract for the Annual Meeting and it must be accepted through the peer review process of the scientific program committee. Also, it is important to note that the American Psychiatric Association Foundation (APAF) has an endowed award in pharmacogenomics which provides a lecture each year at the Annual Meeting on the topic of pharmacogenomics. In response to the language that addresses "various educational activities," an online webinar including Continuous Medical Education, educational design, remote-video conferencing capability, editing, Learning Management System posting and hosting costs approximately $4500 in in-kind staff time.

Department of Practice Management/Department of Reimbursement Policy/Council on Quality Care
Based on discussion with Practice Guideline Administration and Consultants and Quality Administration, costs associated with **Resolve Three**:

3. "The Council on Quality Care: A. include a statement on the use and limitations of pharmaco-genomic testing in all 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."

Explanation of Cost: Letter A. of this resolve is estimated to cost $20-30k extra **per practice guideline** for those where we do the pharmacogenomics systematic literature search (whether it was an external or internal review). Additional consideration would have to be made for the size of the literature per topic. Also, it is expected that all costs would rise over time due to the growth of the medical literature and inflation rate.

It should be noted that under the current practice guideline development process, the developers have included some information on pharmacogenomics when it is already part of literature review. But in the

past, pharmacogenomics papers are not always part of the scope of reviews. If they are not part of the reviews, and it is determined by this resolve, that it should be, it might need an independent search of the literature and extraction of the data by APA staff.

To consider the cost estimate of letter B., it would have to be assumed that either a systematic literature review occurred and was paid for based on the cost assessment in A. or each member of the Workgroup would be responsible for participating in this venture (though not sure how reliable an expectation that is) at and that the findings supported the content necessary to develop a resource document. It would require the development of a work group that focuses on this area. From the seating of Workgroup members by APA staff and member-volunteers, plus time related to drafting the manuscript, and pushing the manuscript through the APA governance chain, this would cost approximately 80 hours, or $6160.00.

Department of Research/Council on Research

In consultation with the Department of Research staff on **Resolve Four:**

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."

Explanation of Cost: Appropriate staff explained that they could not provide an assessment, as the cost of staff hours or additional resources could not be ascertained by the information presented in the resolve. Namely, the Council on Research does not promote areas of research, or develop study questions for researchers to answer. Also, it could not be determined if the phrase "addressing study questions" would be meant for the Council on Medical Education and Lifelong Learning, if these questions are intended to assist in education around pharmacogenomics.

Department of Government Relations/Council on Advocacy and Government Relations:

Resolve Five addresses The Council on Advocacy and Government Relations and requests that this group:

5. "…explore whether the APA should advocate for truth in advertising for pharmacogenomic testing, and thus, promote accurate consumer education."

Explanation of Cost: The APA staff liaison to the Council on Advocacy and Government Relations suggested the amount of time required to carry out this resolve be limited to about 5 hours of staff time or $385.00.

Department of Reimbursement Policy/Council on Quality Care:

6. "An article on pharmacogenomic testing and its limitations be placed on the APA Website "Patients & Families" section to provide accurate information for consumers.

Explanation of Cost: Given that this information is related to the resource document detailed in Resolve 3B, it would require staff time and expert-member time to cultivate a document out of the details found within the Resource Document. This could cost about 20 hours for the APA staff member, between updating the material to reflect the appropriate audience, and to guide the document through the APA governance chain, before staff post the material on the APA website.

Attachment #6
Item 2017A1 12.H
Assembly
May 19-21, 2017

ACTION PAPER
FINAL

TITLE: Expanding Access to Psychiatry Subspecialty Fellowships

WHEREAS:

There have been two separate accreditation systems for residency programs in psychiatry, as in many specialties: the majority accredited by the Accreditation Council on Graduate Medical Education (ACGME) and others accredited by the American Osteopathic Association (AOA); and whereas

The ACGME and AOA have agreed to merge the accreditation process, such that those programs currently under AOA auspices are in the process of applying for ACGME accreditation; and whereas

The Residency Review Committee for psychiatry expects to grant accreditation status for many of the applying programs, but will only be accrediting the current year; and whereas

ACGME rules for psychiatry subspecialty fellowships require that applicants be trained in an ACGME accredited program, for all years of training, meaning that any resident in a current AOA program will not be eligible for fellowships for at least another two years for Child and Adolescent Psychiatry (CAP) or three years for Psychosomatic Medicine (PM), Addiction Psychiatry, Geriatric Psychiatry, and Forensic Psychiatry; and whereas

There are other ACGME specialties which permit exceptions to this ACGME requirement; and whereas

The American Board of Psychiatry and Neurology recently changed its requirement for eligibility to sit for its certification exam, permitting any resident graduating from an ACGME accredited program to apply for certification, even if the program had previously been only AOA accredited; and whereas

The ABPN rules change would now permit AOA-trained residents to apply for both general Psychiatry certification as well as subspecialty certification, removing one of the barriers keeping AOA residents from ACGME fellowship application; and whereas

The fellowship match in psychiatry subspecialties this year left many programs with unfilled positions, with only 70% of CAP positions filled, and PM only filling 48% of its slots; and whereas

Many residents in AOA programs have expressed an interest in ACGME fellowships, but are blocked by the current policies of ACGME, and will never be eligible for fellowships unless they complete additional years of ACGME accredited residencies; and whereas

Subspecialty fellowships are an important part of overall psychiatric education, and are worth encouraging to the extent possible; and whereas

The number of subspecialized psychiatrists is not adequate to meet the needs of our population; and whereas

Efforts by the affected subspecialty organizations to increase fellowship applicants and eligibility have not been successful to this point; therefore

BE IT RESOLVED:

The 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, such as extending ACGME accreditation to prior years of training ("grandfathering") during this period of transition.

AUTHORS:
Kenneth Certa M.D., DLFAPA, Representative, Pennsylvania Psychiatric Society
kenneth.certa@jefferson.edu
Mary Anne Albaugh, M.D., FAPA, Representative, Pennsylvania Psychiatric Society
maryanne.albaugh@gmail.com

SPONSORS:
Joseph Napoli M.D., DFAPA, Representative, Area 3
Sheila Judge, M.D., DLFAPA, Representative, Pennsylvania Psychiatric Society

ESTIMATED COST:
Author: $1,540
APA: $2,310

ESTIMATED SAVINGS:

ESTIMATED REVENUE GENERATED:

ENDORSED BY:

KEY WORDS:

APA STRATEGIC PRIORITIES: Advancing Psychiatry, Education

REVIEWED BY RELEVANT APA COMPONENT:

AMERICAN PSYCHIATRIC ASSOCIATION

Action Paper Worksheet
2017 Action Paper Budget Estimate

Action Paper Title:	12.H: Expanding Access to Psychiatry Subspecialty Fellowships
Action Paper Author(s):	Kenneth M. Certa M.D., Representative, Pennsylvania Psychiatric Society
Phone/email:	215-817-9411 kenneth.certa@jefferson.edu
APA Admin. Name:	Kristen Moeller/Tristan Gorrindo, M.D., Division of Education
Phone/email	703-907-8637 kmoeller@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		-	-	-	-	-

Non-Staff Costs:	
LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	-
Staff Costs:	
Description:	
1 Council on Education will need to advocate with the Psychiatry RRC in an attempt to grant an exception to the requirements..	770
2 One would hope that a letter and followup phone contacts would suffice.	770
3	-
Total Staff Costs	1,540
Other Costs not included above:	
0	-
Total Author Estimate	**$1,540**

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 Advocate with the Psychiatry RRC in an attempt to grant an exception to the ACGME requirements for subspecialty	770
2 letter and follow up	770
3 administrative staff time to coordinate Council position	770
Total Staff Costs	**2,310**
Other Costs not included above:	
0	-
Total Administration Estimate	**$2,310**

Rvsd. Dec. 2016

Action Paper 12.H: *Expanding Access to Psychiatry Subspecialty Fellowships*

APA Administration Feedback:

Division of Education:
ACGME says: At this point, there are no exceptions permitted and all years of training must be completed in an ACGME accredited program. The eligibility program requirements are outlined in detail on the single accreditation system page on the ACGME website at www.acgme.org.

The Council on Medical Education and Lifelong learning discussed this action paper and is generally supportive of this position if adequate steps have not already been taken by ABPN and ACGME.

Attachment #7
Item 2017A1 12.I
Assembly
May 19-21, 2017

ACTION PAPER
FINAL

TITLE: Educational Strategies to Improve Mental Illness Perceptions of Medical Students

WHEREAS:

1. Negative perceptions of mental illness, also referred to as stigma, are a primary barrier to treatment and recovery of the afflicted persons and not uncommon among future generations of physicians as they bring their own perceptions to medical school, then assimilate stereotypes from the medical culture;
2. The negative perceptions of medical students also play a role in reluctance in acknowledging their own mental health problems and choosing a psychiatric career;
3. Medical students' attitudes early on in training tend to be more amenable to change, thus it is possible to change their attitudes and perceptions toward mental illness and psychiatry through proper and early education and training;
4. As APA embarks on a strategic initiative on educating and producing new resources on mental disorders and effective psychiatric care for physicians engaged in integrative and collaborative care, education to decrease negative perceptions of medical students regarding mental illness and psychiatry is critical to this initiative for the long run;
5. Contact-based educational strategies in which medical students are exposed to and interact with persons with mental illness who constitute models of successful recovery, have been effective in changing negative attitudes of medical students;
6. Other successful strategies involve evaluation and discussion of own perceptions and attitudes of medical students toward mental illness as part of early behavioral health course.

BE IT RESOLVED:
That the APA charge the Council on Medical Education and Lifelong Learning (CMELL) to

1. Ascertain with the Association of Directors of Medical Student Education in Psychiatry (ADMSEP) and the American Association of Chairs of Departments of Psychiatry (AACDP), the need for and their interest in implementing educational training strategies for improving medical students' perceptions regarding mental illness and psychiatry, and if there is sufficient interest,
2. Partner with ADMSEP in reviewing and developing educational strategies that particularly involve exposure or contact with patients who have experienced and successfully recovered from mental illness, and discussions of medical students' own perceptions and attitudes regarding mental illness, early on in medical student education,
3. APA to support the developed product and advocate for implementing the developed strategies to various medical education organizations including ADMSEP, AACDP and ACGME.

AUTHORS:
Sudhakar Madakasira, M.D., DLFAPA, Representative, Mississippi Psychiatric Association (smadakasira@hotmail.com)
Valerie Arnold, M.D., Representative, Tennessee Psychiatric Association

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

ESTIMATED SAVINGS: None

ESTIMATED REVENUE GENERATED: None

ENDORSED BY: Mississippi Psychiatric Association, Area 5 council

KEY WORDS: Negative perceptions of mental illness, Medical student education, contact-based recovery model

APA STRATEGIC PRIORITIES: Advancing Psychiatry, Education

References:
Papish A, Kassam A, et al., Reducing the stigma of mental illness in undergraduate medical education. BMC Med Educ 2013; 13:141
Crapanzano K, Vath RJ. Observations: Confronting physician attitudes toward the mentally ill: A challenge to medical educators. J Grad Med Educ 2015 Dec; 7(4):686

AMERICAN PSYCHIATRIC ASSOCIATION

Action Paper Worksheet
2017 Action Paper Budget Estimate

Action Paper Title:	12.I: Educational Strategies to Improve Mental Illness Perceptions of Medical Students
Action Paper Author(s):	Sudhakar Madakasira, M.D., DLFAPA, Representative, Mississippi Psychiatric Association
Phone/email:	smadakasira@hotmail.com
APA Admin. Name:	Kristen Moeller/Tristan Gorrindo, M.D., Division of Education
Phone/email	7039078637 kmoeller@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		-	-	-	-	-

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	**$0**

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 40 hours of liaison and strategy development with ADMSEP. Cost estimate does not include program development or execution.	3,080
2	-
3	-
Total Staff Costs	**3,080**
Other Costs not included above:	
0	-
Total Administration Estimate	**$3,080**

Rvsd. Dec. 2016

Action Paper 12.I: Educational Strategies to Improve Mental Illness Perceptions of Medical Students

APA Administration Feedback:

Council on Medical Education and Lifelong Learning (CMELL):
Developing strategies to improve the perception of psychiatry in medical students is a worthy goal. ADMSEP (the Association of Directors of Medical Student Education in Psychiatry) might be the most logical organization where the development and use of such strategies would occur You might consider asking the CMELL to discuss the APA's interest regarding the development and use of such strategies with ADMSEP, ascertain the interest level at ADMSEP, and, if interest exists, CMELL might be able to partner with ADMSEP in research and development. Once developed, APA could reasonably support and advocate for the institution of such strategies.

Explanation of Cost:
40 hours of liaison and strategy development with ADMSEP. Cost estimate **does not include** program development or execution.

Attachment #8
Item 2017A1 12.J
Assembly
May 19-21, 2017

ACTION PAPER
FINAL

TITLE: Educational Strategies to Improve Mental Illness Perceptions of Non-Mental Health Medical Professionals

WHEREAS:

1. Negative perceptions of mental illness, also called stigma, are a major barrier to timely and accessible care, recovery and quality of life of individuals with mental illness;
2. Negative perceptions of mental illness are not uncommon among non-psychiatric physicians and can contribute to discriminating behaviors and practices, diagnostic overshadowing, fragmentation and marginalization, less timely and/or less adequate treatment for medical concerns of people with mental illness, and partly to excess mortality of these patients;
3. As APA embarks on a strategic initiative to educate and produce new resources in education on mental disorders and effective psychiatric care for physicians engaged in integrative and collaborative care, education to decrease the negative perceptions of non-psychiatric physicians regarding mental illnesses and psychiatry is critical to this initiative;
4. A promising evidence-based strategy for improving these negative perceptions in non-psychiatric physicians is exposure to successful recovery model of people who have experienced and lived with mental illness, that can diminish anxiety, heighten empathy and improve understanding regarding mental illness;
5. Another effective strategy is education and training to improve skills to comfortably assess, communicate with and treat persons with mental illness, that can lead to positive attitudes, diminished social and clinical distance and improved patient care.

BE IT RESOLVED:
That:

1. APA to charge the APA Department of Education to work with APA's AMA delegation and with other interested medical professional organizations to ascertain their interest in implementing educational strategies to improve negative perceptions of mental illness across primary care fields; if there is sufficient interest,
2. APA, in partnership with interested medical professional organizations and in conjunction with American Psychiatric Association Foundation, American Psychiatric Association Publishing and mental health advocacy groups, support and develop educational curriculum and video series depicting and emphasizing successful recovery models of mental illness in patients for use by non-mental health medical professionals;
3. In the spirit of collaborative care, APA support and develop, in conjunction with American Psychiatric Association Publishing and other educational organizations, a training curriculum and

video series for non-mental health medical professional on how to comfortably communicate with, assess, and treat mentally ill persons, and when to refer patients to psychiatrists;

4. APA to advocate to AMA, AAFP and other non-mental health medical professional organizations, as to the importance and availability of above educational strategies in improving perceptions and care of persons with mental illness.

AUTHORS:
Sudhakar Madakaira, M.D., DLFAPA, Representative, Mississippi Psychiatric Association (smadakasira@hotmail.com)
Mary Jo Fitz-Gerald, M.D., DFAPA, Representative, Louisiana Psychiatric Medical Association
Rahn Bailey, M.D., Representative, Black Psychiatrists
Ramaswamy Viswanathan, M.D., DMSc, Representative, Brooklyn Psychiatric Society
Judy Glass, M.D., FRCP, Representative, Quebec and Eastern Canada District Branch
Lisa Catapano-Friedman, M.D., DLFAPA, Representative, Vermont Psychiatric Association
Ranga Ram, M.D., Representative, Psychiatric Society of Delaware
Lawrence Miller, M.D., DLFAPA, Representative, Area 5
John de Figueiredo, M.D., Representative, Connecticut Psychiatric Society
Debra Atkisson, M.D., DFAPA, Representative, Texas Society of Psychiatric Physicians
Iqbal Ahmed, M.D., FRCPsych, Hawaii Psychiatric Medical Association
James West, MD, Uniformed Services Rep

ESTIMATED COST:
Author: $0
APA: $3,234

ESTIMATED SAVINGS: None

ESTIMATED REVENUE GENERATED: To be determined by American Psychiatric Association Publishing

ENDORSED BY: Mississippi Psychiatric Association, Area 5 Council

KEY WORDS: Negative perceptions of mental illness, Educating non-psychiatric physicians, Recovery model, Training curriculum

APA STRATEGIC PRIORITIES: Advancing Psychiatry, Education

References:
Knaak S, Modgill G, et al., Key Ingredients of anti-stigma programs for health care providers: A data synthesis of evaluative studies. Can J Psychiatry 2014 Oct; 59(10 suppl): S19-S26.
Ungar T, Knaak S, et al., Theoretical and practical considerations for combating mental illness stigma in health care. Community Ment Health J 2016; 52:262-271.

AMERICAN PSYCHIATRIC ASSOCIATION

Action Paper Worksheet
2017 Action Paper Budget Estimate

Action Paper Title:	12.J: Educational Strategies to Improve Mental Illness Perceptions of Non-psychiatric Physicians
Action Paper Author(s):	Sudhakar Madakasira, M.D., DLFAPA, Representative, Mississippi Psychiatric Association
Phone/email:	smadakasira@hotmail.com
APA Admin. Name:	Kristen Moeller/Tristan Gorrindo, M.D., Division of Education
Phone/email	703-907-8637 kmoeller@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		-	-	-	-	-

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	**$0**

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 40 hours staff time. Does not include product development or execution.	3,080
2 APA-AMA Delegation staff time	154
3	-
Total Staff Costs	**3,234**
Other Costs not included above:	
0	-
Total Administration Estimate	**$3,234**

Rvsd. Dec. 2016

Action Paper 12.J: Educational Strategies to Improve Mental Illness Perceptions of Non-psychiatric Physicians

APA Administration Feedback:

Council on Medical Education and Lifelong Learning (CMELL):
Improving the perception non-psychiatrist physicians have of mental illness and its treatment is a worthy goal. However, rather than asking the APA to unilaterally develop an educational curriculum and a video series without knowing the interest level and specific needs of primary care physicians and their professional organizations, the author might consider asking the APA's AMA delegation, or appropriate liaison group, to ascertain the interest level across the primary care fields. If sufficient interest exists, then the APA could consider partnering with interested professional organizations to develop specific educational tools to meet specific needs.

Explanation of Cost: Education
40 hours to determine interest via engagement with primary care organizations, as well as examine APA's learning management system data and other product metrics to determine current usage by non-psychiatric MD's. Does not include program development or execution

APA AMA Delegation:
The primary task with regard to the 1st resolve is to engage leadership of the key organizations in a discussion of the issue to determine if there is mutual interest in addressing the concerns raised. This could occur thru the respective AMA delegations or through existing contacts with the respective leadership of the organizations involved. This could occur in person or by conference call and may take more than one discussion.

Explanation of Cost: APA AMA Delegation:
Staff time to arrange, develop background materials and participate in calls. Estimate time for APA AMA delegation as two hours.

Attachment #9
Item 2017A1 12.K
Assembly
May 19-21, 2017

ACTION PAPER
FINAL

TITLE: Fostering Medical Student Interest and Training in Psychiatry: The Importance of Medical Student Clerkships

WHEREAS:
Whereas: Psychiatric disorders including addictions are common, with an annual prevalence of at least 30%, and a lifetime prevalence of at least 45%, in the United States alone.

The burden of mental illness is extremely high, consistently ranked by the WHO as one of the costliest causes of disease burden. Psychiatric diseases are also costly, with both direct costs of treatment and loss of health and life, and indirect causes due to lost productivity, premature death, and other losses to society.

Patients with psychiatric disorders and symptoms are frequently seen in general medical and primary care settings. At least 70% of people who died from suicide were seen by generalists within a year of their death, and 40% within the month prior to their death.

Physicians of all specialties, particularly in general medical and primary care practices, will continue to treat patients with mental health issues, including those with severe and persistent mental illness.

Adequate training in psychiatry is a critical component of undergraduate medical education, as this will be the only dedicated training for most non-psychiatric physicians. The complex skills of psychiatric evaluation, diagnosis, and management are not quickly learned.

Whereas: There remains a national shortage of trained psychiatrists, particularly in underserved areas. Because psychiatry has one of the oldest average age of practitioners, there will remain a shortage as the number of graduating psychiatric residents will not surpass those leaving the profession.

Association of American Medical Colleges (AAMC) surveys of graduating medical students indicate that 85% of students who chose a career in psychiatry did not have an initial interest in psychiatry at the beginning of medical school.

Medical students entering the field of psychiatry consistently identify psychiatry clerkships as a fundamental component of deciding to pursue the specialty as a career.

The average length of United States medical school clerkships has been declining over the past 30 years.

Frequently clerkships are primarily inpatient based with limited exposure to other treatment areas and modalities across the field of psychiatry.

Certain medical schools have moved to a transformed curriculum resulting in a psychiatry clerkship that is significantly reduced in duration or eliminated.

Neither the Liaison Committee on Medical Education (LCME) nor the American Osteopathic Association (AOA) Commission on Osteopathic College Accreditation (COCA) have a suggested or required timeframe for duration of psychiatry clerkships.

To continue to recruit medical students to psychiatric residency and practice, steps need to be taken to ensure an adequate and broad exposure to psychiatric practice. Further, ensuring adequate training in psychiatry during undergraduate medical education will improve trainee readiness for residency. Recommendations for the clerkship experience have been previously described in the Association of Directors of Medical Student Education in Psychiatry (ADMSEP) and Association of Academic Psychiatry (AAP) position statement on the length of the psychiatry clerkship.

BE IT RESOLVED:
That the APA tasks the Council on Medical Education and Lifelong Learning (CMELL) with drafting a position statement on recommended guidelines for the Psychiatry Clerkship. The CMELL should partner with other organizations invested in psychiatric education, such as ADMSEP and AADPRT, in the drafting of this position statement.
This statement should be used to provide recommendations to the Liaison Committee on Medical Education (LCME) and the American Osteopathic Association (AOA) Commission on Osteopathic College Accreditation (COCA) on minimum requirements for psychiatric training. The statement should describe the importance of psychiatry clerkships as the key formative experience for all medical students, and best practices that promote medical student education and interest in psychiatry. Specific components integral to the psychiatry clerkship should include:

- A minimum duration of a six-week equivalent full-time experience in the evaluation and treatment of psychiatric patients.
- Exposure to both inpatient and ambulatory practice settings, ideally including exposure to subspecialty (e.g. – child and adolescent, addictions, geriatrics, consultation and liaison) and developing models of practice designed to better serve psychiatric populations (e.g. – collaborative or integrated care).

AUTHORS:
Edward Thomas Lewis, III, M.D., Representative, South Carolina Psychiatric Association
Michael J. Peterson, M.D., PhD, Representative, Wisconsin Psychiatric Association

SPONSORS:
Jack Bonner, M.D., ACROSS Representative, Senior Psychiatrists
Steven Daviss, M.D., Representative, Maryland Psychiatric Society
Mary Fitz-Gerald, M.D., Representative, Louisiana Psychiatric Medical Association
Mark Haygood, M.D., Area 5 Representative, Assembly Committee of Early Career Psychiatrists
Rachel Houchins, M.D., Representative, South Carolina Psychiatric Association
James C. West, M.D., Representative, Society of Uniformed Services Psychiatrists
Clarence Chou, M.D., Representative, Wisconsin Psychiatric Association
Brian Hart, M.D., Representative, Indiana Psychiatric Society

ESTIMATED COST:
Author: $0

APA: $3,080

ESTIMATED SAVINGS:

ESTIMATED REVENUE GENERATED:

ENDORSED BY: Area 5 Council, Assembly Committee of Early Career Psychiatrists (ECPs)

KEY WORDS: Psychiatry, Clerkship, Medical student, Education, Training

APA STRATEGIC PRIORITIES: Advancing Psychiatry, Education

References:
The Psychiatry Clerkship: A Position Statement on the Length of the Psychiatry Clerkship Academic Psychiatry, 2006; 30(2); 103.

Lyons Z. Attitudes of medical students toward psychiatry and psychiatry as a career: A Systematic review. Academic Psychiatry 2013; 37(3); 150-157

AMERICAN PSYCHIATRIC ASSOCIATION

Action Paper Worksheet
2017 Action Paper Budget Estimate

Action Paper Title: 12.K: Fostering Medical Student Interest and Training in Psychiatry: The Importance of Medical Student
Action Paper Author(s): Michael J. Peterson, M.D., PhD, Representative, Wisconsin Psychiatric Association
Phone/email: lewiset@musc.edu; 608-239-1640/mpeterson2@wisc.edu
APA Admin. Name: Kristen Moeller/Tristan Gorrindo, M.D., Division of Education
Phone/email 703-907-8637 kmoeller@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		-	-	-	-	-

Non-Staff Costs:	
LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	-
Staff Costs:	
Description:	
1 Authors are both Assembly members and would present this AP at the Assembly meeting. No additional travel or expenses is anticipated.	-
2	- -
3	- -
Total Staff Costs	-
Other Costs not included above:	
0	-
Total Author Estimate	**$0**

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 Estimated staff time for assisting Council in drafting a position statement and providing recommendations to LCME and COCA	3,080
2	- -
3	- -
Total Staff Costs	**3,080**
Other Costs not included above:	
0	-
Total Administration Estimate	**$3,080**

Rvsd. Dec. 2016

Action Paper # 12.K: Fostering Medical Student Interest and Training in Psychiatry: The Importance of Medical Student Clerkships

APA Administration Feedback:

Division of Education:
The Council on Medical Education and Lifelong Learning (CMELL) briefly discussed this idea. In general, the Council is supportive of this idea but would like to see particulars. Author was connected with Greg Biscoe and Benoit Dube, both on CMELL and also in the organizational leadership at ADMSEP. Greg is the current President of that organization. They said that they would be available as a resource for discussing the issue. The 2006 ADMSEP position statement on clerkship length was provided. ADMSEP Action paper sent as an information attachment.

Explanation of Cost:
Cost of position statement development is 40 hours.

The Psychiatry Clerkship: A Position Statement on the Length of the Psychiatry Clerkship

The Membership and the Executive Council of the Association of Directors of Medical Student Education in Psychiatry, in recognition of the fact that:

Psychiatric disorders are common.

The annual prevalence of all psychiatric disorders, including addictions, is 30% in the United States (1). The lifetime prevalence of any psychiatric disorder in the United States is greater than 45% (2).

The disease burden of psychiatric disorders is high.

The WHO ranks depression as the second leading cause of disease burden in established economies, ahead of cardiovascular disease, and ranks all mental illness as the 2nd illness category of disease burden, ahead of all cancers (3).

Psychiatric disorders are costly.

Mental illness imposes on the U.S. economy an indirect cost—from lost productivity due to illness, premature death, and incarceration—of $79 billion a year, not counting an additional $99 billion in direct costs of mental health care (4).

Patients with psychiatric disorders and psychiatric symptoms are frequently seen in general medical and primary care practices.

Among patients who took their own lives, 70% saw a generalist in the year before their suicide and 40% did so in the month prior (5).

The complex skills of psychiatric evaluation, diagnosis, and management are not quickly learned.

Endorse the following:

1. The psychiatry clerkship must provide a full-time experience in the evaluation and care of psychiatric patients.
2. The psychiatry clerkship must be at least 6 weeks in length or longer.

This position statement was developed and endorsed by the Association of Directors of Medical Student Education in Psychiatry and then endorsed by the Executive Council of the Association of Academic Psychiatry in 2005.

References

1. Kessler RC, Berglund PA, Zhao S, et al. The 12-month prevalence and correlates of serious mental illness, in Mental Health, United States, 1996 (US Department of Health and Human Services Publ No [SNA] 96–3098). Ed. Manderschied RW, Sonnenschein MA. Washington DC, US Govt Printing Office, 59–70, 1996
2. Kessler RD, Berglund P, Demler O, et al: Lifetime prevalence and age-of-onset distributions of *DSM–IV* disorders in the national comorbidity survey replication. Arch Gen Psychiatry 2005; 62:593–602
3. Murray CJL, Lopez AD, (Eds.): The global burden of disease and injury series, volume 1: a comprehensive assessment of mortality and disability from diseases, injuries, and risk factors in 1990 and projected to 2020. Cambridge, M.A: published by the Harvard School of Public Health on behalf of the World Health Organization and the World Bank, Harvard University Press, 1996
4. U.S. Department of Health and Human Services. Mental health: a report of the Surgeon General. Rockville MD, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, 1999
5. Luoma JB, Martin CE, Pearson JL: Contact with mental health and primary care providers before suicide: a review of the evidence. Am J Psychiatry 2002; 159:909–916

Attachment #10
Item 2017A1 12.L
Assembly
May 19-21, 2017

ACTION PAPER
FINAL

TITLE: Requesting the APA Draft a Position Statement on Prescription Drug Monitoring Programs (PDMPs)

WHEREAS:

- According to the Center for Disease Control and Prevention (CDC), 20% of patients presenting to physician offices with non-cancer pain symptoms or pain-related diagnoses (including acute and chronic pain) receive an opioid prescription.
- From 2000 to 2014 nearly half a million persons in the United States died from drug overdoses, primarily prescription opioids and heroin.
- Between 2007 to 2012, opioid prescriptions per capita increased 7%.
- In 2013, 1.9 million persons with opioid use disorders were using prescription opioids.
- The American Psychiatric Association is a member of the American Medical Association Task Force to Reduce Opioid Abuse. The Task Force urges states and physicians to utilize prescription drug monitoring programs (PDMPs).
- PDMPs are state-level electronic databases.
- PDMPs collect, monitor, and analyze prescribing and dispensing data.
- Forty-nine (49) states have operational PDMPs, each with unique rules and regulations.
- PDMPs are proactive efforts to safeguard the public health and the safe medical use of controlled medications.
- PDMPs help ensure that if patients are prescribed controlled medications, the controlled medications are medically necessary and taken as directed.
- PDMPs help reduce harm from possible adverse drug actions and possible adverse drug-drug interactions.
- Physicians prescribing medications without access to PDMP data increase their patients risk of adverse drug actions, adverse drug-drug interactions, substance use disorders, and becoming a target for controlled medication diversion.
- The Comprehensive Addiction and Recovery Act of 2016 established a mechanism to provide grants to strengthen state PDMPs.

BE IT RESOLVED:

- That the American Psychiatric Association draft a position statement regarding Prescription Drug Monitoring Programs.
- That such PDMP position statement addresses PDMP best practices including design, operation, confidentiality, privacy, physician/staff burden utilization and interstate access.

AUTHORS:
Dionne Hart, M.D., Representative, Minnesota Psychiatric Society
Alexander von Hafften, M.D., Representative, Alaska Psychiatric Association

ESTIMATED COST:
Author: $616
APA: $2,310

ESTIMATED SAVINGS: $0.00

ESTIMATED REVENUE GENERATED: $0.00

ENDORSED BY:

KEY WORDS: Prescription Drug Monitoring Programs, Methadone, Opioid epidemic, patient safety

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

AMERICAN PSYCHIATRIC ASSOCIATION

Action Paper Worksheet
2017 Action Paper Budget Estimate

Action Paper Title: 12.L: Requesting the APA Draft a Position Statement on Prescription Drug Monitoirng Programs (PDMPs)
Action Paper Author(s): Alexander von Hafften, M.D., Representative, Alaska Psychiatric Association
Phone/email: avh@gci.net, (907) 227-8148
APA Admin. Name: Beatrice Eld, Division of Education
Phone/email beld@psych.org

Attendance Summary:	**Author**	**APA Administration**
Number of Component Members	24	-
Number of Staff	1	-
Number of Non-Staff	-	-
Total	**25**	**-**

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		-	-	-	-	-

Non-Staff Costs:	
LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	**-**
Staff Costs:	
Description:	
1 Assist review of state PDMPs and related issues (2 hours).	154
2 Coordinate conference calls (1 hour per conference call, 6 conference calls).	462
3 -	-
Total Staff Costs	616
Other Costs not included above:	
0	-
Total Author Estimate	**$616**

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 Schedule and convene conference calls; research issues; discuss with content experts and other stakeholders.	770
2 develop and edit drafts and solicit input and recommendations of other relevant components and staff	1,540
3 -	-
Total Staff Costs	**2,310**
Other Costs not included above:	
0	**-**
Total Administration Estimate	**$2,310**

Rvsd. Dec. 2016

Action Paper 12.L: Requesting the APA Draft a Position Statement on Prescription Drug Monitoring Programs (PDMPs):

APA Administration Feedback:

Council on Addiction Psychiatry, Department of Practice Management and Delivery Systems Policy:

A work group comprised of members from the above component and staff of relevant APA departments will work via email and conference calls to strategize and draft a position statement. Staffing for the work group efforts will be by liaisons to the Council on Addiction Psychiatry and the Department of Practice Management and Delivery Systems Policy.

Once developed, the work group's draft position statement will be shared with the full Council and then proceed through the governance process and be shared with other relevant organizations that share a similar interest.

No estimated savings or estimated revenue generation is anticipated by this action.

The Council on Addiction Psychiatry invited the Action Paper author, Dr. von Hafften, to attend its May 22 meeting to discuss possible position statement development.

Attachment #11
Item 2017A1 12.M
Assembly
May 19-21, 2017

ACTION PAPER
FINAL

TITLE: Juvenile Solitary Confinement

WHEREAS:
1. Solitary confinement of juveniles continues to be used in correctional facilities for periods that exceed the acceptable use of behavioral interventions, such as “time out” (1 hour or less).

2. The brain is not fully developed until the early 20’s.

3. Solitary confinement has been associated and causative with adverse psychiatric consequences such as depression, anxiety, psychosis, or worsening of an existing psychiatric disorder.

4. The A.P.A. does not have an existing position statement regarding the solitary confinement of juveniles.

5. The following organizations DO have position statements on the solitary confinement of juveniles:
- American Academy of Child and Adolescent Psychiatry: “Solitary Confinement of Juvenile Offenders”, (approved April, 2012)
- American Medical Association: “Solitary Confinement of Juveniles in Legal Custody”, (2016)
- United Nations: “Rules for the Protection of Juveniles Deprived of Their Liberty”, section 67, (Dec. 14, 1990)
- National Commission of Correctional Healthcare: position statement (April 10, 2016)

6. The AACAP policy statement on the use of solitary confinement in juveniles has been used nationally by the AMA, ACLU, and others to set policy.

7. This does not affect the APA policy statement for adult seclusion.

BE IT RESOLVED:

That the APA support the AMA policy statement opposing the use of solitary confinement in juveniles , and that the APA draft its own position statement by May of 2018.

H-60.922
Our AMA: (1) opposes the use of solitary confinement in juvenile correction facilities except for extraordinary circumstances when a juvenile is at acute risk of harm to self or others; (2) opposes the use of solitary confinement of juveniles for disciplinary purposes in correctional facilities; and (3) supports that isolation of juveniles for clinical or therapeutic purposes must be conducted under the supervision of a physician.

With the following preamble:

Solitary confinement is defined as the placement of an incarcerated individual in a locked room or cell with minimal or no contact with people other than staff of the correctional facility. It is used as a form of discipline or punishment.

AUTHORS:
Judy Glass, M.D., Representative, Quebec and Eastern Canada District Branch
Louis Kraus, M.D., APA Member

SPONSORS:
Vincenzo Di Nicola, M.D., Representative, Quebec and Eastern Canada District Branch
Lisa Catapano-Friedman, M.D., Representative, Vermont Psychiatric Association
John M. de Figueiredo, M.D., Representative, Connecticut Psychiatric Society
David Fassler, M.D., APA Member
Reena Kapoor, M.D., Representative, Connecticut Psychiatric Society
Simha Ravven, M.D., Area 1 Deputy Representative, Assembly Committee of Early Career Psychiatrists
Michelle P. Durham, M.D., Representative, Massachusetts Psychiatric Society
Gabrielle Shapiro, M.D., Representative, New York

ESTIMATED COST:
Author: $0
APA: $2,156

ESTIMATED SAVINGS: $0

ESTIMATED REVENUE GENERATED: $0

ENDORSED BY: Area 1 Council, Area 2 Council, Assembly Committee on Public and Community Psychiatry

KEY WORDS: Solitary Confinement, Juveniles

APA STRATEGIC PRIORITIES: Advancing Psychiatry

REVIEWED BY RELEVANT APA COMPONENT: Council on Children, Adolescents and Their Families, Council on Psychiatry and Law

AMERICAN PSYCHIATRIC ASSOCIATION

Action Paper Worksheet
2017 Action Paper Budget Estimate

Action Paper Title: 12.M: Juvenile Solitary Confinement
Action Paper Author(s): Judy Glass, M.D., Representative, Quebec and Eastern Canada District Branch
Phone/email: (514) 340-8210/icjg@sympatico.ca
APA Admin. Name: Tatiana Claridad, Division of Diversity and Health Equity
Phone/email (703) 907-7894/tclaridad@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		-	-	-	-	-

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	**$0**

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	Joint APA/AACAP workgroup should be developed to determine strategy. Work via email and conference calls. Staffed by liaisons to relevant councils (Council on Children, Psych and Law).	770
2	Workgroup's product will be shared with and edited by the relevant councils.	616
3	Final product will proceed through APA governance structure and processes.	770
	Total Staff Costs	**2,156**

Other Costs not included above:

n/a	-
Total Administration Estimate	**$2,156**

Rvsd. Dec. 2016

Action Paper 12.M: Juvenile Solitary Confinement

APA Administration Feedback:

Council on Children, Adolescent and Their Families
Council on Psychiatry and Law

Because the action paper has multiple perspectives, a joint work group comprised of the above components and AACAP representatives will work via email and conference call to strategize and determine whether to support the AACAP policy statement or draft a joint position for APA/AACAP. Staff liaisons from the above components will assist in joint work group efforts such as convening all parties, guiding deliberations via email and conference call, and other staff liaison duties as required.

Once a product is developed, the work group's product will be shared with the full Councils and then proceed through the governance process.

No estimated savings or estimated revenue generation is anticipated by this action.

Action Paper Worksheet
2017 Action Paper Budget Estimate

Action Paper Title: 12.M: Juvenile Solitary Confinement- REVISED June 2017
Action Paper Author(s): Judy Glass, M.D., Representative, Quebec and Eastern Canada District Branch
Phone/email: (514) 340-8210/icjg@sympatico.ca
APA Admin. Name: Tatiana Claridad, Staff Liaison
Phone/email (703) 907-7894/tclaridad@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		-	-	-	-	-

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	**$0**

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	Joint Council on Children/Psych and Law workgroup should be developed to determine strategy. Work via email and conference calls. Staffed by liaisons to relevant councils.	770
2	Workgroup's product will be shared with and edited by the relevant councils.	616
3	Final product will proceed through APA governance structure and processes.	770
	Total Staff Costs	**2,156**

Other Costs not included above:

0		-
	Total Administration Estimate	**$2,156**

Rvsd. Dec. 2016

Action Paper #12.M: Juvenile Solitary Confinement

APA Administration Feedback- REVISED June 2017:

DEPARTMENT and/or COMPONENT:
Council on Children, Adolescent and Their Families
Council on Psychiatry and Law

DEPARTMENT and/or COMPONENT: EXPLANATION OF COST:

A joint workgroup comprised of the above components and the APA delegate to the American Medical Association (AMA) will work via email and conference call in order to draft APA's own position by May of 2018. Staff liaisons from the above components will assist in joint workgroup efforts such as convening all parties, guiding deliberations via email and conference call, and other staff liaison duties as required.

Once a draft is developed, the workgroup's draft will be shared with the full Councils and then proceed through the governance process.

No estimated savings or estimated revenue generation is anticipated by this action.

Attachment #12
Item 2017A1 12.N
Assembly
May 19-21, 2017

ACTION PAPER
FINAL

TITLE: Addressing Physician Burnout, Depression, and Suicide—Within Psychiatry and Beyond

WHEREAS:
Burnout is a "syndrome of emotional exhaustion, loss of meaning in work, feelings of ineffectiveness, and a tendency to view people as objects rather than as human beings," as defined by the Maslach Burnout Inventory Manual;

Rates of burnout among physicians, including psychiatrists, are estimated to be from 50% to 90%, suggesting a need for a public health approach to reduce burnout throughout the physician workforce;

Depression affects over 25% of resident physicians with a significant increase in depressive symptoms after the start of training, and physicians in general suffer from depression at high rates and are less likely than the general public to seek care or treatment;

Physicians are more likely to die by suicide than age-matched professionals, and such events have a profound impact on patients, other providers, and communities;

Physicians suffering from untreated mental illness or substance use disorders may be impaired and therefore perhaps more at risk for making medical errors that can compromise patient safety;

Promoting physician mental health may also enhance recognition of mental illness in patients;

Many institutions are beginning to look for evidence-based approaches to preventing burnout and depression among physicians, and there are programs being developed around the country whose efficacy can be studied;

Psychiatrists working within healthcare institutions are often local experts in depression and suicide as well as promoting wellness (e.g., process groups and supervision) and are well positioned to lead these efforts;

The APA and Dr. Anita Everett recently convened an Ad Hoc Workgroup on this topic chaired by Dr. Richard Summers;

Certain state licensing boards maintain potentially discriminatory reporting requirements for mental health conditions, as addressed in the APA Position Statement on Inquiries about Diagnosis and Treatment of Mental Disorders in Connection with Professional Credentialing and Licensing;
National organizations such as the Office of the Surgeon General, the Accreditation Council for Graduate Medical Education, and the Association of American Medical Colleges have recognized this problem as a national priority.

BE IT RESOLVED:
That the APA continue the mission of the Ad Hoc Workgroup on Physician Well-Being by developing resources for increasing awareness about physician burnout, depression and suicide, as well as interventions for promoting physician wellness, including recommendations for institutional response to physician suicide;

That the APA revise its 2011 "Position Statement on Physician Wellness" to affirm the APA's commitment to ensuring the well-being of its members and to encourage members to serve as leaders in promoting well-being initiatives within their institutions, training programs, and systems of care;

That the APA promote further investigation of the underlying causes of increased rates of burnout, depression and suicide among physicians and to expand the evidence base for innovative wellness interventions;

That the APA Government Relations staff work with stakeholder organizations including the Federation of State Medical Boards to remove questions about psychiatric or substance use disorder treatment from licensing applications (initial or renewal) as well as employment applications, instead focusing on relevant, current functional impairment due to either physical or mental illness;

That the APA's AMA delegation continue to collaborate with the AMA to develop joint initiatives to prioritize these issues.

AUTHORS:
Jeremy D. Kidd, M.D., MPH, Area 2 Representative, Assembly Committee of Resident-Fellow Members
jeremy.kidd@gmail.com
David Roane, M.D., Representative, New York County District Branch
Matthew L. Goldman, M.D., MS, APA Member
Carol Bernstein, M.D., APA Member
Laurel Mayer, MD, APA Member

ESTIMATED COST:
Author: $2,310
APA: $4,235

ESTIMATED SAVINGS: $0

ESTIMATED REVENUE GENERATED: $0

ENDORSED BY: Area 2 Council, Assembly Committee of Resident-Fellow Members, New York County District Branch

KEY WORDS: Well-being, Physician Well-being, Burnout, Depression

APA STRATEGIC PRIORITIES: Advancing Psychiatry, Education

REVIEWED BY RELEVANT APA COMPONENT:

AMERICAN PSYCHIATRIC ASSOCIATION

Action Paper Worksheet
2017 Action Paper Budget Estimate

Action Paper Title: 12.N: Addressing Physician Burnout, Depression, and Suicide—Within Psychiatry and Beyond
Action Paper Author(s): Jeremy D. Kidd, M.D., MPH, Area 2 Representative, Assembly Committee of Resident-Fellow Members
Phone/email: 540-921-7064/jeremy.kidd@gmail.com
APA Admin. Name: Kristen Moeller/Tristan Gorrindo, M.D., Division of Education
Phone/email 7039078637 kmoeller@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		-	-	-	-	-

Non-Staff Costs:	
LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	-
Staff Costs:	
Description:	
1 Liaise with the AMA to to develop joint initiatives to prioritize these issues (much of this work could be done by current AMA delegation)	770
2 Liase with the ACGME to encourage residency programs to improve access to mental health treatment for residents and fellows	770
3 Work with stakeholder organizations to encourage state medical boards to remove discriminatory reporting requirements for mental health and substance use disorder treatment	770
Total Staff Costs	2,310
Other Costs not included above:	
0	-
Total Author Estimate	**$2,310**

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 update 2011 position paper on physician wellness	2,310
2 liaise with AMA to develop joint initiatives - AMA delegation	385
3 advocacy to work with state medical boards	770
Total Staff Costs	**3,465**
Other Costs not included above:	
Staff time (ranging from 7 to 10 hours) dedicated to reviewing and updating the position statement with the Council on Geriatric Psychiatry	**770**
Total Administration Estimate	**$4,235**

Rvsd. Dec. 2016

Action Paper 12.N: Addressing Physician Burnout, Depression, and Suicide—Within Psychiatry and Beyond

APA Administration Feedback:

- Regarding the position statement on Physician Wellness - Burnout workgroup is now working on this issue; recommend workgroup be involved in revising and updating position statement.
- (Licensing Board Questions about MH treatment) We would refer the author to the 2015 APA Position Statement on Inquiries about Diagnosis and Treatment of Mental Disorders in Connection with Professional Credentialing and Licensing.
- AMA delegation can continue to collaborate
- A new ACGME requirement, beginning July 2017, mandates that all programs provide access to confidential, affordable mental health assessment, counseling, and treatment, including access to urgent and emergent care 24 hours a day, seven days a week. This then completes one item listed in the action. (ACGME July 2017 requirement for MH treatment for trainees)

Council on Medical Education and Lifelong Learning (CMELL):
Feedback sent to author:
The Council on Medical Education and Lifelong Learning discussed the action paper. In general, the Council is supportive of the idea and the Council discussed the numerous other initiatives which are occurring at other related organizations: ACGME, ABPN, AAMC, AADPRT, AMA.
Anita Everett's APA workgroup, which convened by phone for the first time on Monday, February 27, is tackling almost everything on the list of this action. Rick Summers is the chair of the workgroup and could also discuss what that group is doing.

A new ACGME requirement, beginning July 2017, mandates that all programs provide access to confidential, affordable mental health assessment, counseling, and treatment, including access to urgent and emergent care 24 hours a day, seven days a week. (ACGME July 2017 requirement for MH treatment for trainees)

Explanation of Cost: Education
Cost not known for development of resources for increasing awareness about physician burnout, depression and suicide until task force makes recommendations.

AMA Delegation:
Members of the APA AMA Delegation routinely support resolutions and reports moving forward that touch on the issues of physician burnout, depression (and impact of other mental illness and substance use disorders), and suicide among practicing physicians including medical students, residents and fellows. This includes speaking in support of providing access to mental health care, reducing stigma that could be associated with seeking treatment, and issues of confidentiality. The Delegation will continue to monitor these issues at the AMA and would look to the Ad Hoc Workgroup to provide guidance as to taking any additional actions at the AMA based on the Ad Hoc Workgroups review of the issue.

Department of Government Relations:
Action paper ask for the Department staff (APA Government Relations staff work with stakeholder organizations).

(To my knowledge) APA has not engaged FSMB at a national level to address the issue. I can say that various DBs have been working in their states to remove such questions from applications, including renewals, as they run counter to APA's position and federal directives. It's been an ongoing battle in some states. Part of the problem—like that found in Ohio—is that there are non-physicians on the Medical Board and some of the Board members lack an understanding or appreciation of mental health and substance use and treatment. Our SA in Ohio continues to try to educate them. If staff were tasked with this, it would take a great deal of staff time.

Division of Diversity and Health Equity (DDHE):

The action paper includes an ask to revise and update the position statement on physician wellness which was developed by the Council on Geriatric Psychiatry. The council falls under the purview of DDHE.

Explanation of Cost: DDHE

The cost estimate includes staff time (ranging from 7 to 10 hours) dedicated to reviewing and updating the position statement with the Council on Geriatric Psychiatry. The staff will assist in the development of a workgroup, partake in workgroup meetings via email and/or conference calls, in addition to other related staff liaison duties as required. Once a product is developed, the workgroup's draft will be shared with every member of the Council, and then sent to governance for approval.
No estimated savings or estimated revenue generation is anticipated by this action. Cost Estimate: 10 Hours = $770.00

Attachment #13
Item 2017A1 12.O
Assembly
May 19-21, 2017

ACTION PAPER
FINAL

TITLE: Health Care Is a Human Right

WHEREAS:
Whereas,
Life, liberty, and the pursuit of happiness are intrinsic American values enshrined in the American Declaration of Independence

Whereas,
Health is essential for quality and longevity of life

Whereas,
Health of individuals and populations is an essential asset for robust economies and democracies

Whereas,
Health is essential to a nation's security and prosperity

BE IT RESOVLED:
That the American Psychiatric Association adopt the following position statement: "Health care, inclusive of mental health care, is a human right".

AUTHORS:
Eliot Sorel, M.D., DLFAPA, Representative, Washington Psychiatric Society
Pedro Ruiz, M.D., DLFAPA, APA Member
Roger Peele, M.D., DLFAPA, APA Member
Josepha Immanuel, M.D., APA Member
Constance E. Dunlap, M.D., DFAPA, Representative, Washington Psychiatric Society
Rahn K. Bailey, M.D., DFAPA, Representative, Black Psychiatrists
Bernardo Ng, M.D., DFAPA, APA Member
Vincenzo Di Nicola, M.D., DFAPA, Representative, Quebec and Eastern Canada District Branch
Michelle Riba, M.D., DLFAPA, APA Member
Steve Koh, M.D., FAPA, APA Member

SPONSORS:
Joseph Napoli, M.D., DLFAPA, Representative, Area 3
Ranga Ram, M.D., DFAPA, Representative, Psychiatric Society of Delaware
Manuel Reich, D.O., Representative, Pennsylvania Psychiatric Society
Rahul Malhotra, M.D., Area 3Representative, Assembly Committee of Early Career Psychiatrists
Joseph P. Collins, Jr., M.D., FAPA, APA Member
Eindra Khin Khin, M.D., FAPA, APA Member
Elizabeth M. Morrison, M.D., DLFAPA, Representative, Washington Psychiatric Society

ESTIMATED COST:
Author: $3,542
APA: $7,700

ESTIMATED SAVINGS:

ESTIMATED REVENUE GENERATED:

ENDORSED BY: Washington Psychiatric Society

KEY WORDS: Access to Health Care, Human Rights

APA STRATEGIC PRIORITIES: Advancing Psychiatry, Education, Diversity

REVIEWED BY RELEVANT APA COMPONET: Council on International Psychiatry

AMERICAN PSYCHIATRIC ASSOCIATION

Action Paper Worksheet
2017 Action Paper Budget Estimate

Action Paper Title: 12.O: Health Care Is a Human Right
Action Paper Author(s): Eliot Sorel, M.D., Representative, Washington Psychiatric Society
Phone/email:
APA Admin. Name: Glenn O'Neal, Office of Communications
Phone/email goneal@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		-	-	-	-	-

Non-Staff Costs:

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

Staff Costs:

	Description:	
1	Produce Press Release	462
2	Responding to media queries and conducting interviews	3,080
3		-
	Total Staff Costs	3,542

Other Costs not included above:

0		-
	Total Author Estimate	**3,542**

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	Produce press release.	462
2	Media relations and promotion.	3,080
3	DGR lobbying activities on Capitol hill and DBSA collaboration	4,158
	Total Staff Costs	**7,700**

Other Costs not included above:

0		-
	Total Administration Estimate	**7,700**

Rvsd. Dec. 2016

Action Paper 12.O: Health Care is a Human Right

APA Administration Feedback:

Office of Communications:

The APA Administration is mindful of the authors' concerns and agrees that health care is essential to the well-being of all Americans. A 1 week media campaign to promote this idea would, at a minimum, entail a press release, social media posts, and press outreach. APA Communications staff estimates that 40 hours of staff time at a cost of $3,542 would be necessary to successfully conduct a media campaign of this nature.

Department of Government Relations:

The action paper addresses the human right to receive the highest attainable standards of health care, a priority of APA and APA's Department of Government Relations. The Department reviewed the action paper taking in consideration the authors' request for advocacy efforts. The Department of Government Relations would evaluate federal and state legislation and leverage existing advocacy efforts, as appropriate. The Department projects time and cost associated with an advocacy campaign based on the premise of the action paper may entail 25 to 30 hours of Capitol Hill meetings (roughly the interested members of the relevant House and Senate committees), 10 hours of meeting follow-up (both internal and external stakeholders), 8 hours of research and materials creation, 3 hours of DB/SA collaboration, 3 hours of Executive Branch meetings, and 5 hours of partnership activity.

Attachment #14
Item 2017A1 12.P
Assembly
May 19-21, 2017

ACTION PAPER
FINAL

TITLE: Making Access to the Voting Page a Default Action During Elections

WHEREAS:
The percentage of eligible APA members who vote in the annual election has dropped from an average of 33% in the first five years of the last decade to an average of 19% in the last 5 years;

Of the 19.5% of eligible members who voted in the 2017 election, 92% of them voted electronically, with 83% of these electronic voters doing so via a link sent to them via email;

Thus, only one-sixth of the voters accessed the elections page by clicking on a link on the APA website, which amounts to only 3% of eligible members doing so;

The field of behavioral economics has found that one of the methods for increasing a desired action (like saving for retirement) in the face of mass inertia is to make the desired action the default action;

Having the voting webpage be automatically served to an APA member when they go to any of the APA websites would be expected to significantly increase the percent of members who complete the balloting process; and

Increasing the voting rate among APA members is a valuable goal towards maintaining an effective, involved, and healthy organization; therefore

BE IT RESOLVED:
The Assembly recommends that the APA Administration work to make access to voting as prominent as possible and user friendly on the APA website, and reconsider the value of mailing ballots to all members.

AUTHOR:
Steven Daviss, M.D., DFAPA, Representative, Maryland Psychiatric Society (steve@fusehealth.org)

SPONSORS:
Mary Anne Albaugh, M.D., Representative, Pennsylvania Psychiatric Society
Constance Dunlap, M.D., Representative, Washington Psychiatric Society
Annette Hanson, M.D., DFAPA, Representative, Maryland Psychiatric Society

Marvin Koss, M.D., Representative, Central New York District Branch
Rahul Malhotra, M.D., Area 3Representative, Assembly Committee of Early Career Psychiatrists
Gabrielle Shapiro, M.D., DFAPA, Representative, New York County Psychiatric Society
James Curt West, M.D., Representative, Society of Uniformed Services Psychiatrists
Lily Arora, M.D., Representative, New Jersey Psychiatric Association
Debra Atkisson, M.D., DFAPA, Texas Society of Psychiatric Physicians
Jeffrey Bennett, M.D., Representative, Illinois Psychiatric Society

ESTIMATED COST:
Author: $924
APA: $2,310

ESTIMATED SAVINGS: $0

ESTIMATED REVENUE GENERATED: Unknown amount from increase in membership

ENDORSED BY:

KEY WORDS: Elections, Voting, Website, Membership

APA STRATEGIC PRIORITIES: Advancing Psychiatry

REVIEWED BY RELEVANT APA COMPONENT:

AMERICAN PSYCHIATRIC ASSOCIATION

Action Paper Worksheet
2017 Action Paper Budget Estimate

Action Paper Title:	12.P: Making Access to the Voting Page a Default Action During Elections
Action Paper Author(s):	Steven Daviss, M.D., DFAPA, Representative, Maryland Psychiatric Society
Phone/email:	410-782-0077 / steve@fusehealth.org
APA Admin. Name:	Margaret C. Dewar, Association Governance
Phone/email	mdewar@psych.org

Attendance Summary:	**Author**	**APA Administration**
Number of Component Members	3	-
Number of Staff	4	-
Number of Non-Staff	-	-
Total	**7**	**-**

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		-	-	-	-	-

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

Staff Costs:

	Description:		
1	Discussion with group about options to achieve goal of Action Paper, develop options, and report out.		924
2		-	-
3		-	-
	Total Staff Costs		924

Other Costs not included above:	
0	-
Total Author Estimate	**$924**

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	Staffing Work Group, conference calls, drafting reports, etc.		2,310
2		-	-
3		-	-
	Total Staff Costs		**2,310**

Other Costs not included above:	
0	-
Total Administration Estimate	**$2,310**

Rvsd. Dec. 2016

Action Paper 12.P: Making Access to the Voting Page a Default Action During Elections

APA Administration Feedback:

The action paper requests a work group that would consider changes to the APA election voting process. Specifically, it requests that a workgroup be established to review methods to set up the APA website to direct members who log in during the election period, but who have not yet voted, to the election homepage. This action paper specifically asks for the workgroup to be established, but during the development of the action paper, the APA Administration reviewed the underlying concept of revising the website to achieve the goal of redirecting website traffic. Given that the workgroup would be tasked with that review, we wanted to provide the findings from the Administration's research into that topic.

The proposal suggests that, during the month of January, when voting is taking place, any member who attempts to log into the website to access any locked page would be taken to the election homepage instead of the page they were logging into, after checking with the election vendor that they had not yet voted. This would require two technical enhancements:

1. Creating a direct connection between our election vendor and the APA's membership database, which does not currently exist. We have maintained separate systems to create a firewall during the election process
2. Manually changing coding on each locked webpage page at the start of January to redirect traffic and then changing that coding back at the conclusion of the election period.

Both of these processes will require substantial financial investments (likely $80,000 for the first year and $40,000+ each year thereafter, much of it from staff time required to code and recode webpages), either one time or ongoing for each election year.

Further, the Administration's research indicated that approximately 16% of voters accessed the election page by logging in through the APA website, which is where the effort underlying this action paper would be focused. The other 84% voted by clicking the link in the election email they received or by visiting the election vendor's website.

Finally, from a member experience perspective, there is a concern that members who are attempting to access a locked APA page and then log in, but who are re-directed to the election webpage, may experience frustration from the involuntary re-direct. This will also impact dues revenue since members are directed through various recruitment campaigns to the online payment system. Instead of being brought to that online payment system during the grace period for payment in January, they will instead be redirected to the election page and be forced to find their way to the dues payment system. Moreover, this may interrupt the revenue producing efforts of communications and publishing in the same way.

It may also raise unfounded concerns questions about the firewall between the members' voting information and membership information.

Understanding that the goal is to enhance election turnout, we should note that this has been a focus of both the Elections and Nominating Committees who are tasked with key elements of the APA election

and continually implement new ideas (personalized voting links, candidate videos, candidate biographies, etc.) to offer members comprehensive voter information and easy access to voting.

Action Paper 12.P: Making Access to the Voting Page a Default Action During Elections

APA Administration Feedback- REVISED June 2017:

Information Technology:

Most of the cost is associated with mailing of the ballots. Making the elections more prominent on the website (in ways that haven't been identified), would probably be a small fraction of the cost of the mailing.

Attachment #15
Item 2017A1 12.Q
Assembly
May 19-21, 2017

ACTION PAPER
FINAL

TITLE: Dues Relief for District Branch Members from the Commonwealth of Puerto Rico

WHEREAS:
As APA general members, Canadian psychiatrists, from a country much more prosperous than the Commonwealth of Puerto Rico, pay $375 in national dues compared to $575 for US general Members.

Because of economic differences between Puerto Rico, a Commonwealth of the United States, and the 50 States of the Union, APA members in Puerto Rico actually pay proportionally more of their salary for their membership than other Psychiatrists; their rates of Medicaid and Medicare reimbursement are significantly lower. Third party insurance payers follow the Medicare example and are known to pay as little as $20 a session. Also, members are obligated to pay a fixed amount, $300 to the College of Physicians and Surgeons. The past president of APA has publicly stated that the doctors in Puerto Rico are the lowest paid physicians in the USA.

The APA available benefits for psychiatrists practicing in Puerto Rico are fewer. There is no PAC support for psychiatric issues in Puerto Rico. APA-sponsored malpractice insurance is not available to psychiatrists practicing in Puerto Rico. Pragmatically, they receive essentially equivalent services to our Canadian members. Thus, it would seem appropriate that their membership rate should be similar.

BE IT RESOLVED:

That general member psychiatrists who are members of the Puerto Rico Psychiatric Society, a District Branch of the APA shall be granted the same annual APA dues as our Canadian counterparts, which is $375 per general member per year for the next five years.

AUTHORS:
Harold Ginzburg, M.D., Representative, Oklahoma Psychiatric Physicians Association
(haroldginzburg@hotmail.com)
Michael Woodbury-Farina, M.D., Representative, Puerto Rico Psychiatric Society

SPONSORS:
Laurence Miller, M.D., Representative, Area 5
Nazanin Silver, M.D., MPH, Area 3 Deputy Representative, Assembly Committee of Resident Fellow Members
Vincenzo Di Nicola, M.D., Representative, Quebec and Eastern Canada District Branch
Shreekumar Vinekar, M.D., Representative, Oklahoma Psychiatric Physicians Association
Mary Jo Fitz-Gerald, M.D., Representative, Louisiana Psychiatric Medical Association
Judy Glass, M.D., Representative, Quebec and Eastern Canada District Branch
Joseph Napoli, M.D., Representative, Area 3
James Polo, M.D., Representative, Washington State Psychiatric Association

Debra Atkisson, M.D., Representative, Texas Society of Psychiatric Physicians
Jose De La Gandara, M.D., Representative, Hispanic Psychiatrists
Oscar Perez, M.D., Deputy Representative, Hispanic Psychiatrists
Sarah Huertas-Goldman, M.D., Representative, Puerto Rico Psychiatric Society
Gabrielle Shapiro, M.D., Representative, New York County District Branch

ESTIMATED COST:
Author: (**lost revenue**) $30,375 in the first year [$575-$350=$225x135 members=$30,375]
APA: $31,950

ESTIMATED SAVINGS: The loss of more than 60 general psychiatrists represents a loss of approximately $35,000 per year. The more members we can recruit/retain the more we will be saving.

ESTIMATED REVENUE GENERATED: None at first but with more joining, there will be more revenue. If we could get back to 200, which means 65 more general members, we would break even within two years and from then on there would be a "profit." If only 9 more members join, break-even is at 10 years.

ENDORSED BY: Area 5 Council – by unanimous vote

KEY WORDS: Membership, District Branch

APA STRATEGIC PRIORITIES: Advancing Psychiatry, Diversity

REVIEWED BY RELEVANT APA COMPONENT: Resubmission with additional economic data and Area 5 support

AMERICAN PSYCHIATRIC ASSOCIATION

Action Paper Worksheet
2017 Action Paper Budget Estimate

Action Paper Title: 12.Q: Dues Relief for District Branch Members from the Commonwealth of Puerto Rico
Action Paper Author(s): Harold Ginzburg, M.D., Representative, Oklahoma Psychiatric Physicians Association
Phone/email: haroldginzburg@hotmail.com, 504-858-0066 - cell
APA Admin. Name: Jon Fanning, Chief Membership & Strategy Officer
Phone/email jfanning@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		-	-	-	-	-

Non-Staff Costs:	
LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	**-**
Staff Costs:	
Description:	
1 none	-
2	-
3	-
Total Staff Costs	-
Other Costs not included above:	
Lost revenue costs only - as noted in action paper, initially, $ 30,375, as members rejoin/join the DB in Puerto Rico the lost revenue will decrease and if 20 members join and stay five years - the lost revenue becomes zero and then it will be an income generating action as more members rejoin/join and retention of membership occurs	30,375
Total Author Estimate	**30,375**

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 uncertain if any of the loss revenue per year would be recaptured, or if the loss revenue would become exponentially higher as other groups demanded reduced dues based on economic factors. The action paper also does not indicate how many non-members are in Puerto Rico or the alternative approach that would be used by the DB to recruit if relief were granted. Once dues are lowered, it is nearly impossible to raise them to previous levels if the intended result is not achieved.	**31,950**
Total Administration Estimate	**$31,950**

Rvsd. Dec. 2016

Action Paper 12.Q: Dues Relief for District Branch Members from the Commonwealth of Puerto Rico

APA Administration Feedback:

Membership Department:

In February 2014, various American credit rating agencies downgraded the government of Puerto Rico's debt to non-investment grade. On August 3, 2015, Puerto Rico defaulted on a $58 million bond payment to the Public Financing Corporation, a subsidiary of the Government Development Bank, while other financial obligations were met. The island has continued to struggle financially (Source: Wikipedia).

However, total APA membership in Puerto Rico increased as follows:

Year (January)	# of Members
2013	108
2014	132
2015	147
2016	142
2017	142

This is an increase of 31.5% during the time of the debt crisis.

Moreover, according to the US Bureau of Labor statistics, the mean salary of a psychiatrists in San Juan, Puerto Rico is $182,650. The following states have mean salaries that are lower than this amount.

State	Annual mean Salary
Arkansas	110880
Idaho	112910
District of Columbia	128460
Louisiana	135640
Maine	137570
West Virginia	141310
Hawaii	154040
Oklahoma	170040
Nevada	171430
Illinois	172560
Montana	177380
Massachusetts	180960
Florida	181080

Lowering dues based on economic factors can quickly cascade into a call to reduce dues for reasons such practice setting, geographic region, personal circumstances, etc. In turn, this could quickly put the

organization, which relies on dues revenue, on an unsustainable financial trajectory in which the organization cannot sustain activities related to its mission.

Explanation of Cost: $31,950 per year ($575-$350=$225 X 142).

Attachment #16
Item 2017A1 12.R
Assembly
May 19-21, 2017

ACTION PAPER
FINAL

TITLE: Streamlining the Application Process for Former APA Members

WHEREAS:
The American Psychiatric Association (APA) had a membership increase in 2016.

The APA continues to explore modalities to increase membership including ways to have former APA members rejoin the organization.

Currently, former APA members interested in rejoining the APA have to complete the same extensive application process as a new, non-former member. The redundancy in the reapplication process may be a barrier for former members to reestablish membership. The application main categories include biographical information, academic training, training, board certification, demographic data, primary practice setting, ethics, professional service, documentation, and agreement.

As a result, streamlining the process for re-applicants may further increase APA membership, demonstrate to former members that the APA values their participation in the organization, and a way to demonstrate to former members that the APA "wants them back."

BE IT RESOLVED:
That the APA staff streamline the application process for former APA members on the website as follows:

1. Once an applicant answers yes to being a former member of the APA on the website, the individual is given an online, pre-filled application.
2. Remove the requirement for the applicant to resubmit the residency training certificate (this can be verified by APA staff from previous membership records).
3. Remove the requirement for the applicant to submit a valid medical license (this can be verified by APA staff from online, public databases).

That the APA staff advertise the changes to the streamlined application process for former APA members.

AUTHORS:
Mark Haygood, D.O., MS, Area 5 Representative, Assembly Committee of Early Career Psychiatrists
Rahul Malhotra, M.D., Area 3 Representative, Assembly Committee of Early Career Psychiatrists
Baiju Gandhi, M.D., Area 3 Deputy Representative, Assembly Committee of Early Career Psychiatrists

ESTIMATED COST:
Author: $616
APA: $616

ESTIMATED SAVINGS:

ESTIMATED REVENUE GENERATED:

ENDORSED BY:

KEY WORDS: Former APA members; Membership; Membership application process

APA STRATEGIC PRIORITIES: Advancing Psychiatry, Diversity

REVIEWED BY RELEVANT APA COMPONENT:

AMERICAN PSYCHIATRIC ASSOCIATION

Action Paper Worksheet
2017 Action Paper Budget Estimate

Action Paper Title: 12.R: Streamlining the Application Process for Former APA Members
Action Paper Author(s): Mark Haygood, DO, MS, Area 5 Representative, Assembly Committee of Early Career Psychiatrists
Phone/email: mhaygood78@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		-	-	-	-	-

Non-Staff Costs:	
LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	-
Staff Costs:	
Description:	
1 Creating pre-filled applications for all lapsed but alive members.	616
2	-
3	-
Total Staff Costs	616
Other Costs not included above:	
0	-
Total Author Estimate	**$616**

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 Creating the functionality to pre-fill applications for former members.	616
2	-
3	-
Total Staff Costs	**616**
Other Costs not included above:	
0	-
Total Administration Estimate	**$616**

Rvsd. Dec. 2016

Action Paper 12.R: Streamlining the Application Process for Former APA Members

APA Administration Feedback:

Membership Department:

The Membership team wholly supports the mission to make the reinstatement process as seamless and easy for former members as possible. Our new database system, which was deployed in March 2017 and designed based on member feedback like that in the action paper, presents a pre-populated membership application when a former member uses their email address on file with the APA. Membership also supports the second and third parts of this action paper, and will plan to implement them in the new membership application.

Explanation of Cost:

We agree that it would be a light lift (estimated 8 hours of staff time) to allow members to complete an online, pre-filled application. These changes will result in a more user friendly online experience, save time, and reduce errors.

Attachment #17
Item 2017A1 12.T
Assembly
May 19-21, 2017

ACTION PAPER
FINAL

TITLE: APA Referendum Voting Procedure

WHEREAS:
Whereas: The referendum process is a critical component in maintaining the American Psychiatric Association as a member driven organization and allows the membership to determine the need for even major structural or policy changes in the organization, similar to the purpose of the amendment process in the U. S. Constitution.

Whereas: The referendum process was considered a fundamental component of the governing structure of the APA as testified to by its long tenure in the bylaws.

Whereas: The referendum process is currently operationalized by attaching the referendum for membership vote to the APA national officer election ballot.

Whereas: The election of officers occurs by a simple majority of those eligible members who choose to vote, while the passing of a referendum requires a majority of at least 40 percent of all eligible voters.

Whereas: Forty percent of all eligible voters have not voted in an APA national election in almost 20 years with only 15 percent voting in the 2016 election. Thereby, no referendum has passed since 1980, even when the affirmative percentage of voting members was as high as 80 percent, as occurred in 2011. In distinction, in the 2016 officer election, a candidate for office could have won with the votes of 8 percent of eligible voters.

Whereas: A referendum to change the voting procedure would, itself, have to go through the above-referenced process which has clearly been shown to not be functional for establishing the predominant will of the membership in regard to proposals.

Whereas: There is a stipulation in the American Psychiatric Association bylaws §8.4, which states that referenda are "to be voted on in the next annual ballot." It does not specifically stipulate that this "annual ballot" refers to, or only to, the national election ballot.

Whereas: A yearly mailing, both paper and electronic, is distributed which includes the dues statement and/or solicitation for contributions (for non-dues paying but voting members). Obviously, all dues paying members must respond to this mailing to maintain their membership. All non-dues paying but voting members may, and, in fact, are encouraged to respond to the contribution/solicitation aspect of the mailing.

Whereas: This action paper is not calling for a lowering of the percentage of voting members who would have to vote to allow a referendum to pass (40 percent) and it therefore is not in violation of the Washington, D.C. code.

Whereas: A separate envelope could be included with the dues/solicitation mailing, or a separate link or secure form appended to the electronic option, to allow for voter confidentiality.

Whereas: Virtually identical action papers, as originally amended by Reference Committee 5, have been passed now by the Assembly on four separate occasions at four separate Assembly meetings.

Whereas: The cost of attaching referendum voting ballots to the dues/solicitation notice process should not be inherently more expensive than the current practice of attaching them to the officer election ballot process, beyond that of establishing the transition.

BE IT RESOLVED:

1. If 2/3 of the voting members approve a referendum statement, but the requirement of 40% of eligible voters voting has not been met, the BOT will schedule a vote on the referendum statement or a modified version of it for voting by members of the BOT and the Assembly. If the referendum statement or its modified version does not get a 2/3 votes by both these bodies and thus fails to pass, or if the lead petitioner of the referendum statement does not agree to the modified version, then the original referendum statement will be placed again on the ballot to be voted on by the entire membership; but this time the referendum ballot will be sent with the yearly dues statement/solicitation for contributions to all voting members. If it fails again it will not be automatically placed on the ballot again. If it passes, it will supersede any modified version passed by the BOT and the Assembly.

2. If the BOT rejects resolved #1, then an alternative for a viable referendum process shall be prepared by the Board of Trustees, with participation of Assembly Representatives jointly selected by the Speaker and the President, and presented to the Assembly at the Fall 2017 meeting.

AUTHOR:
John P. D. Shemo, M.D., DLFAPA, Representative, Psychiatric Society of Virginia
(shemojohn@pabrcrc.com)

ESTIMATED COST:
Author: $35,000
APA: $41,160

ESTIMATED SAVINGS: Not relevant for this paper.

ESTIMATED REVENUE GENERATED: Not relevant for this paper

ENDORSED BY: Psychiatric Society of Virginia, Area 5 Council

KEY WORDS: APA Referendum/membership driven organization

APA STRATEGIC PRIORITIES: Advancing psychiatry, diversity

REVIEWED BY RELEVANT APA COMPONENT: Submitted to the Bylaws Committee and the Elections Committee.

AMERICAN PSYCHIATRIC ASSOCIATION

Action Paper Worksheet
2017 Action Paper Budget Estimate

Action Paper Title: 12.T: APA Referendum Voting Procedure
Action Paper Author(s): John Shemo, M.D., Representative, Psychiatric Society of Virginia
Phone/email:
APA Admin. Name: Jon Fanning, Chief Membership & Strategy Officer, RFM-ECP Liaison
Phone/email jfanning@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:

I accept prior APA staff estimate of $35,000 total cost. Work should be doable by existing committeer in the course of their ongoing work.	35,000
Total Author Estimate	**35,000**

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	Additional admin time b/w IT, Membership, Communications, and Governance to carry out the option for electronic voting		6,160
2		-	-
3		-	-
Total Staff Costs			**6,160**

Other Costs not included above:

Cost of contract with third-party management firm to conduct a referendum process	**35,000**
Total Administration Estimate	**41,160**

Rvsd. April 2017

Action Paper #12.T: APA Referendum Voting Procedure

APA Administration Feedback:

Membership Department:
Regarding including the ballot with the dues renewal mailing: The membership department mails dues renewal materials for 2018 to the third-party printing and mailing company in September 2017 so that the first batch of invoices are postmarked by the first week of October 2017. To be included in the mailing, the ballot for a referendum would have to be finalized and printed by the first week of September 2017. The current APA bylaws state that: "The voting members may initiate referenda or change an action of the Board by submitting a petition signed by at least 500 voting members to the Secretary by October 15 to be voted on in the next annual ballot." Consequently, this part of the APA bylaws would need to be changed since changing the dues process would substantially disrupt APA and District Branch dues revenue collection. Also, if the ballot has to be tied to specific individuals, this could increase costs substantially, the lead times mentioned above would need to be increased by a few weeks, and there would need to be an expected margin of error as the mail house attempts to match 30,000 plus invoices with ballots. Membership sends out material to all members and cannot exceed 6 pieces in the envelope without switching to a larger envelop. Currently, 1 invoice, 1 letter, 1 payment plan sign-up form, 1 flyer, and 1 return envelope is included (5 total pieces). To include a ballot and a return envelope for the ballot, if required, would increase postage and envelop costs. If another envelope addressed to a third-party vendor facilitating the elections is included, members are likely to confuse the envelops which will disrupt both the processing of the ballots and dues invoices. Membership would prefer not to be responsible for the management of incoming ballots either through one envelop with dues or by receiving the wrong envelop from members given the confidential and political sensitivity of the process. The increase in hard and soft costs are difficult to calculate until additional clarity pertaining to the above factors are better known.

Association Governance:
The cost of a contract with a third-party management firm to conduct a referendum process (now with the option to vote electronically) is at least $35K.

The option to vote electronically requires approx. 80 hours of additional administration time/salary among IT, membership, communications and governance departments not only to ensure confidentiality of voting and clear and proper communication between APA and membership, but also to develop and provide multiple distribution lists or membership data to both third-party companies: 1. Voting members who are eligible to vote electronically (for election management firm), 2. Non-dues voting members who don't have an email address (for election management firm), 3. Dues paying voting members who don't have an email address (for membership printing and mailing company). The administration cost is approx. $6,160.

The total cost estimate to implement this proposal is over $41K.

<u>Minor corrections of factual information in the Action Paper:</u>

- Fifth paragraph, first sentence: *"Forty percent of all eligible voters have not voted in an APA national election in almost 20 years with only <u>18</u> ~~15~~ percent voting in the 2016 election.*"
- Fifth paragraph, last sentence: *"In distinction, in the 2016 officer election, a candidate for office could have won with the votes of <u>9</u> ~~8~~ percent of eligible voters. "*

Background/History on Action paper submissions:
Submitted: **May, 2013; November 2013; May 2014; May 2016**

May 2013: The authors submitted the Action Paper "APA Referendum Voting Procedure" in May 2013. The Assembly approved the action paper and referred it to the Joint Reference Committee.

In June 2013, the Joint Reference Committee held a lengthy and thoughtful discussion of this action paper. A motion was made to refer the action paper to the Board of Trustees and failed. The action paper was referred to the Assembly Executive Committee for discussion. The AEC discussed the paper at its July 2013 meeting. No action was taken.

November 2013: [*Paper resubmitted*] REFERENCE COMMITTEE #5 recommended: Referral of this action paper to an Ad Hoc Work Group of the Assembly, created by the Speaker of the Assembly, which will include a BOT representative, to address feasible implementation of this action paper. [*Paper was referred to the AEC.*]

At the January 2014 AEC meeting, Dr. Young (Speaker of the Assembly) referred this paper to the Speaker-Elect, Dr. Jenny Boyer, who will work with Dr. David Scasta on the issues outlined in this paper and report back to the AEC at an upcoming meeting.

May 2014: [*Paper resubmitted*] The paper was approved by the Assembly, and referred to the Joint Reference Committee.

The JRC did not support the initial Assembly action to amend the referendum process but believed that the Board would be the appropriate body to consider the larger issue of the importance of the voice of the membership being heard on important or controversial issues.

At the July 2014 Board of Trustees meeting, the Board of Trustees voted to appoint a Work Group (WG) which could consider both the APA referendum process and weigh options available for change or improvement in the current process. The Ad hoc Work Group on APA Referendum Voting Procedures is chaired Dr. Renee Binder with Drs. Jenny Boyer, Glenn Martin and Melinda Young serving as members. [*Board Ad Hoc Work Group report is below.*]

Board Ad Hoc Work Group on APA Referendum Voting Procedures
The Work Group (WG) met by conference call on October 1, 2014. The group noted that the action paper "APA Referendum Voting Procedures" was approved by the Assembly in May 2014 and referred to the JRC meeting later that month. The JRC did not support the action to amend the referendum process but referred it to the Board of Trustees to consider the issue of the importance of the members voices' being heard on important issues, even if the referendum doesn't meet the required numbers to pass.

The WG agreed on the importance of the Board giving thoughtful consideration to concerns raised by large numbers of members on important issues, and considered the best ways to address these concerns. The following options were proposed during the call:

Option 1: Changing the bylaw concerning the referendum process. It was noted, however, that per DC statute, any change to lower the voting percentages for referendum passage would have to be approved by the members at the same percentages contained in the current APA bylaws. It was felt that this was highly unlikely to succeed, given the lower voting percentages for all APA elections over the last decade. The lower voting trend has been seen across many organizations.

Option 2: The Board could consider making a change to the *APA Operations Manual* to add a procedure concerning referenda that reach a minimum designated percentage of affirmative member votes. If this percentage (lower than the APA bylaws minimums) was reached, the Board Chair (APA President) would be instructed to place the item on the next Board agenda for appropriate discussion by the Board of Trustees. If the Board supports this option the following actions should also take place:

a. Information concerning the referendum would be contained within the Tellers Report to the Board of Trustees so members may easily access the information.
b. The Operations Manual would be amended to note the new process and requirement concerning the addition to the Board agenda and appropriate Board discussion.
c. The member communication process on referenda will be addressed by Dr. Levin and Chief of Communications and Public Affairs, Jason Young.
d. General Counsel Coyle will provide any additional legal advice

Option 3: Do not make any changes in the *APA bylaws* or the *Operations Manual*. The Tellers Report will contain information about the referendum and this will serve as notice to the Board of Trustees and encourage the Board Chair (APA President) to have this as an agenda item.

The Work Group did not support Option 1 and presents Option 2 and 3 to the Board for decision making by the Board.

From December 2014 Board of Trustees Meeting:
The Board of Trustees voted to approve option #2 of the report of the Ad Hoc Work Group on APA Referendum Process. The Action Paper was subsequently addressed at the December 2014 Board meeting.

OPTION #2: The Board could consider making a change to the APA Operations Manual to add a procedure concerning referenda that reach a minimum designated percentage of affirmative member votes. If this percentage (lower than the APA bylaws minimums) was reached, the Board Chair (APA President) would be instructed to place the item on the next Board agenda for appropriate discussion by the Board of Trustees.

Approved amendment to the *APA Operations Manual* as follows:

Procedure concerning Referenda that reach a minimum designated percentage of affirmative members votes:
If this percentage (lower than the APA Bylaws minimums) was reached, the Board Chair (APA President) would be instructed to place the item on the next Board agenda for appropriate discussion by the Board of Trustees. If the Board supports this option, the following actions should also take place:

- *Information concerning the referendum would be contained within the Tellers Report to the Board of Trustees so members may easily access the information.*
- *The CEO/Medical Director and the Chief of Communications and Public Affairs will address the member communication process.*
- *The General Counsel will provide an additional legal advice.*

May 2016: The Assembly approved the action paper and referred it to the Joint Reference Committee.

June 2016: The Joint Reference Committee reviewed the history of the requests for changes to the APA Referendum voting procedures. After an extensive discussion of the issues, the JRC determined that implementing this action paper is unfeasible and not in the best interests of the APA. The JRC therefore recommended that the Board of Trustees reaffirm the JRC's action. Dr. Miskimen, the Speaker-elect of the Assembly will follow-up with the originators of the paper.

July 2016: The Board of Trustees reaffirmed the JRC decision that approval and implementation of action paper APA Referendum Voting Procedure (ASMMAY1612.FF) is not feasible.

Action Paper 12.T: APA Referendum Voting Procedure

APA Administration Feedback- REVISED June 2017:

APA General Counsel:

Whether or not the referendum may be considered and approved or vetoes by the Assembly would depend upon what type of action the referendum requests. If it is for something strictly within the purview of the BOT, then the Assembly cannot be asked to vote on it is a manner that could impact the action that the BOT decides upon. The reason for this is that the BOT has fiduciary responsibility legally for certain actions, and those cannot be interfered with by the Assembly since the Assembly does not share in the liability.

Attachment #18
Item 2017 A1 4.B.20
Assembly
May 19-21, 2017

Position Statement on Use of the Concept of Recovery

(*Redline Version*)

The American Psychiatric Association endorses and strongly affirms the application of the concept of recovery to the comprehensive care and treatment of individuals with mental illness across the lifespan. ~~chronically and persistently mentally ill adults, including the concept of resilience in seriously emotionally disturbed children~~. The concept of recovery emphasizes a person's capacity to have hope and to lead a meaningful life, and suggests that treatment ~~can~~ be guided by attention to life goals and ambitions. It recognizes that patients often feel powerless or disenfranchised, that these feelings can interfere with initiation and maintenance of ~~mental health~~ psychiatric and medical care, and that the best results come when patients feel that treatment decisions are made in ways that ~~suit~~ are collaborative and consistent with their cultural, spiritual, and personal ideals. ~~It~~ Recovery focuses on hope, wellness and resilience and encourages patients to participate actively in their care, particularly by enabling them to help define the goals of ~~psychopharmacologic and psychosocial~~ treatment~~s~~ and to have meaningful input into the interventions to achieve these.

The concept of recovery has a long history in medicine and its principles are important in the management of all chronic disorders. The concept of recovery enriches and supports medical and rehabilitation models. By applying the concept of recovery as well as rehabilitation ~~techniques~~ and by encouraging ~~other mental health professionals~~ others who treat mental illness to adopt the concept of recovery, psychiatrists can enhance the care of ~~all clinical~~ populations served ~~within the community based and other public sector mental health and behavioral health systems.~~ in all settings where psychiatric services are provided.

The concept of recovery values and maximizes the patient's ~~includes maximization of~~ 1) ~~a each patient's~~ autonomy based on ~~that patient's~~ individual desires and capabilities, 2) ~~patient's~~ dignity and self-respect, 3) ~~patient's acceptance and~~ integration into full community life, and 4) ~~resumption of normal~~ full development. The concept of recovery focuses on increasing the patient's ability to successfully ~~cope with~~ adapt to life's challenges, and to collaborate with the psychiatrist to ~~successfully~~ optimally manage ~~their~~ his/her symptoms. The application of the concept of recovery requires a commitment to a broad range of necessary services and should not be used to justify deprofessionalization or other ~~a~~ retraction of resources.

The concept of recovery is predicated on ~~a~~ the partnership between patient, psychiatrist, and other practitioners~~, and patient~~ in ~~the construction~~ constructing and ~~direction~~ directing ~~of~~ all services aimed at maximizing hope and quality of life.

(original Author: Council on Research)
(revisions: Assembly Committee of Public and Community Psychiatry)

Position Statement on Use of the Concept of Recovery

(*Clean Version*)

The American Psychiatric Association endorses and strongly affirms the application of the concept of recovery to the comprehensive care and treatment of individuals with mental illness across the lifespan. The concept of recovery emphasizes a person's capacity to have hope and to lead a meaningful life, and suggests that treatment be guided by attention to life goals and ambitions. It recognizes that patients often feel powerless or disenfranchised, that these feelings can interfere with initiation and maintenance of psychiatric and medical care, and that the best results come when patients feel that treatment decisions are made in ways that are collaborative and consistent with their cultural, spiritual, and personal ideals. Recovery focuses on hope, wellness and resilience and encourages patients to participate actively in their care, particularly by enabling them to help define the goals of treatment and to have meaningful input into the interventions to achieve these.

The concept of recovery has a long history in medicine and its principles are important in the management of all chronic disorders. The concept of recovery enriches and supports medical and rehabilitation models. By applying the concept of recovery as well as rehabilitation and by encouraging others who treat mental illness to adopt the concept of recovery, psychiatrists can enhance the care of populations served in all settings where psychiatric services are provided.

The concept of recovery values and maximizes the patient's 1) autonomy based on individual desires and capabilities, 2) dignity and self-respect, 3) integration into full community life, and 4) full development. The concept of recovery focuses on increasing the patient's ability to successfully adapt to life's challenges, and to collaborate with the psychiatrist to optimally manage his/her symptoms. The application of the concept of recovery requires a commitment to a broad range of necessary services and should not be used to justify deprofessionalization or other retraction of resources.

The concept of recovery is predicated on the partnership between patient, psychiatrist, and other practitioners in constructing and directing all services aimed at maximizing hope and quality of life.

(original Author: Council on Research)
(revisions: Assembly Committee of Public and Community Psychiatry)

Position Statement on Therapies Focused on Attempts to Change Sexual Orientation (Reparative or Conversion Therapies)

Approved by the Board of Trustees, March 2000
Approved by the Assembly, May 2000

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

Preamble

In December of 1998, the Board of Trustees issued a position statement (see attached) that the American Psychiatric Association opposes any psychiatric treatment, such as "reparative" or conversion therapy, which is based upon the assumption that homosexuality per se is a mental disorder or based upon the a priori assumption that a patient should change his/her sexual homosexual orientation. In doing so, the APA joined many other professional organizations that either oppose or are critical of "reparative" therapies, including the American Academy of Pediatrics, the American Medical Association, the American Psychological Association, The American Counseling Association, and the National Association of Social Workers (1).

The following Position Statement expands and elaborates upon the statement issued by the Board of Trustees in order to further address public and professional concerns about therapies designed to change a patient's sexual orientation or sexual identity. It *augments* rather than replaces the 1998 statement.

Position Statement

In the past, defining homosexuality as an illness buttressed society's moral opprobrium of same-sex relationships (2). In the current social climate, claiming homosexuality is a mental disorder stems from efforts to discredit the growing social acceptance of homosexuality as a normal variant of human sexuality. Consequently, the issue of changing sexual orientation has become highly politicized. The integration of gays and lesbians into the mainstream of American society is opposed by those who fear that such an integration is morally wrong and harmful to the social fabric. The political and moral debates surrounding this issue have obscured the scientific data by calling into question the motives and even the character of individuals on both sides of the issue. This document attempts to shed some light on this heated issue.

The validity, efficacy and ethics of clinical attempts to change an individual's sexual orientation have been challenged (3,4,5,6). To date, there are no scientifically rigorous outcome studies to determine either the actual efficacy or harm of "reparative" treatments. There is sparse scientific data about selection criteria, risks versus benefits of the treatment, and long-term outcomes of "reparative" therapies. The literature consists of anecdotal reports of individuals who have claimed to change, people who claim that attempts to change were harmful to them, and others who claimed to have changed and then later recanted those claims (7,8,9).

Even though there are little data about patients, it is still possible to evaluate the theories which rationalize the conduct of "reparative" and conversion therapies. Firstly, they are at odds with the scientific position of the American Psychiatric Association which has maintained, since 1973, that homosexuality per se, is not a mental disorder. The theories of "reparative" therapists define homosexuality as either a developmental arrest, a severe form of psychopathology, or some combination of both (10-15). In recent years, noted practitioners of "reparative" therapy have openly integrated older psychoanalytic theories that pathologize homosexuality with traditional religious beliefs condemning homosexuality (16,17,18).

The earliest scientific criticisms of the early theories and religious beliefs informing "reparative" or conversion therapies came primarily from sexology researchers (19-27). Later, criticisms emerged from psychoanalytic sources as well (28-39). There has also been an increasing body of religious thought arguing against traditional, biblical interpretations that condemn homosexuality and which underlie religious types of "reparative" therapy (40-46).

References

1. National Association for Research and Treatment of Homosexuality, (1999), American Counseling Association Passes Resolution to Oppose Reparative Therapy. NARTH Web site: (www.narth.com/docs/acaresolution.html).
2. Bayer, R. (1981), Homosexuality and American Psychiatry; The Politics of Diagnosis. New York: Basic Books.
3. Haldeman, D. (1991), Sexual orientation conversion therapy for gay men and lesbians: A scientific examination. In Homosexuality: Research Implications for Public Policy, ed. J. C. Gonsiorek & J. D. Weinrich. Newbury Park, CA: Sage Pub., pp. 149-161.
4. Haldeman, D. (1994), The practice and ethics of sexual orientation conversion therapy. J. Consulting & Clin. Psychol., 62(2):221-227.
5. Brown, L. S. (1996), Ethical concerns with sexual minority patients. In: Textbook of Homosexuality and Mental Health. ed. R. Cabaj & T. Stein. Washington: American Psychiatric Press, pp. 897-916.
6. Drescher, J. (1997), What needs changing? Some questions raised by reparative therapy practices. New York State Psychiatric Society Bulletin, 40(1):8-10.
7. Duberman, M. (1991), Cures: A Gay Man's Odyssey. New York: Dutton.
8. White, M. (1994), Stranger at the Gate: To be Gay and Christian in America. New York: Simon & Schuster.
9. Isay, R. (1996), Becoming Gay: The Journey to Self-Acceptance. New York: Pantheon.

10. Freud, S. (1905), Three essays on the theory of sexuality. Standard Edition, 7:123-246. London: Hogarth Press, 1953.
11. Rado, S. (1940), A critical examination of the concept of bisexuality. Psychosomatic Medicine, 2:459-467. Reprinted in Sexual Inversion: The Multiple Roots of Homosexuality, ed. J. Marmor. New York: Basic Books, 1965, pp. 175-189.
12. Bieber, I., Dain, H., Dince, P., Drellich, M., Grand, H., Gundlach, R., Kremer, M., Rifkin, A., Wilbur, C., & Bieber T. (1962), Homosexuality: A Psychoanalytic Study. New York: Basic Books.
13. Socarides, C. (1968), The Overt Homosexual. New York: Grune & Stratton.
14. Ovesey, L. (1969), Homosexuality and Pseudohomosexuality. New York: Science House.
15. Hatterer, L. (1970), Changing Homosexuality in the Male. New York: McGraw Hill.
16. Moberly, E. (1983), Homosexuality: A New Christian Ethic. Cambridge, UK: James Clarke & Co.
17. Harvey, J. (1987), The Homosexual Person: New Thinking in Pastoral Care. San Francisco, CA: Ignatius.
18. Nicolosi, J. (1991), Reparative Therapy of Male Homosexuality: A New Clinical Approach. Northvale, NJ: Aronson.
19. Kinsey, A., Pomeroy, W., & Martin, C. (1948), Sexual Behavior in the Human Male. Philadelphia, PA: Saunders.
20. Kinsey, A., Pomeroy, W., & Martin, C. and Gebhard, P. (1953), Sexual Behavior in the Human Female. Philadelphia, PA: Saunders.
21. Ford, C. & Beach, F. (1951), Patterns of Sexual Behavior. New York: Harper.
22. Hooker, E. (1957), The adjustment of the male overt homosexual. J Proj Tech, 21:18-31.
23. Bell, A .& Weinberg, M. (1978), Homosexualities: A Study of Diversity Among Men and Women. New York: Simon and Schuster.
24. Bell, A., Weinberg, M. & Hammersmith S. (1981), Sexual Preference: Its Development in Men and Women. Bloomington, IN: Indiana University Press.
25. LeVay, S. (1991), A difference in hypothalamic structure between heterosexual and homosexual men. Science, 253:1034-1037.
26. Hamer, D., Hu, S., Magnuson, V., Hu, N. & Pattatucci, A. (1993), A linkage between DNA markers on the X-chromosome and male sexual orientation. Science, 261:321-327.
27. Bem, D. (1996), Exotic becomes erotic: A developmental theory of sexual orientation. Psychol. Review, 103(2):320-335.
28. Marmor, J., ed. (1965), Sexual Inversion: The Multiple Roots of Homosexuality. New York: Basic Books.
29. Mitchell, S. (1978), Psychodynamics, homosexuality, and the question of pathology. Psychiatry, 41:254-263.
30. Marmor, J., ed. (1980), Homosexual Behavior: A Modern Reappraisal. New York: Basic Books.
31. Mitchell, S. (1981), The psychoanalytic treatment of homosexuality: Some technical considerations. Int. Rev. Psycho-Anal., 8:63-80.
32. Morgenthaler, F. (1984), Homosexuality Heterosexuality Perversion, trans. A. Aebi. Hillsdale, NJ: The Analytic Press, 1988.
33. Lewes, K. (1988), The Psychoanalytic Theory of Male Homosexuality. New York: Simon and Schuster. Reissued as Psychoanalysis and Male Homosexuality (1995), Northvale, NJ: Aronson.
34. Friedman, R.C. (1988), Male Homosexuality: A Contemporary Psychoanalytic Perspective. New Haven: Yale University Press.
35. Isay, R. (1989), Being Homosexual: Gay Men and Their Development. New York: Farrar, Straus and Giroux.
36. O'Connor, N. & Ryan, J. (1993), Wild Desires and Mistaken Identities: Lesbianism & Psychoanalysis. New York: Columbia University.
37. Domenici, T. & Lesser, R., eds. (1995), Disorienting Sexuality: Psychoanalytic Reappraisals of Sexual Identities. New York: Routledge.
38. Magee, M. & Miller, D. (1997), Lesbian Lives: Psychoanalytic Narratives Old and New. Hillsdale, NJ: The Analytic Press.
39. Drescher, J. (1998) Psychoanalytic Therapy and The Gay Man. Hillsdale, NJ: The Analytic Press.
40. Boswell, J. (1980), Christianity, Social Tolerance and Homosexuality. Chicago, IL: University of Chicago Press.
41. McNeil, J. (1993), The Church and the Homosexual, Fourth Edition. Boston, MA: Beacon.
42. Pronk, P. (1993), Against Nature: Types of Moral Argumentation Regarding Homosexuality. Grand Rapids, MI: Eerdmans.
43. Boswell, J. (1994), Same-Sex Unions in Premodern Europe. New York: Villard Books.
44. Helminiak, D. (1994), What the Bible Really Says About Homosexuality. San Francisco, CA: Alamo Press.
45. Gomes, P. J. (1996). The Good Book: Reading the Bible with Mind and Heart. New York: Avon.
46. Carrol, W. (1997), On being gay and an American Baptist minister. The InSpiriter, Spring, pp. 6-7,11.

Position Statement on Psychiatric Treatment and Sexual Orientation

Approved by the Board of Trustees, December 1998
Approved by the Assembly, November 1998
Reaffirmed , March 2000

"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 Board of Trustees of the American Psychiatric Association (APA) removed homosexuality from the Diagnostic and Statistical Manual of Mental Disorders (DSM) in 1973 after reviewing evidence that it was not a mental disorder. In 1987 ego-dystonic homosexuality was not included in the revised third edition of DSM (DSM-II-R) after a similar review.

APA does not currently have a formal position statement on treatments that attempt to change a person's sexual orientation, also known as "reparative therapy" or "conversion therapy." In 1997 APA produced a fact sheet on homosexual and bisexual issues, which states that "there is no published scientific evidence supporting the efficacy of "reparative therapy" as a treatment to change one's sexual orientation."

The potential risks of "reparative therapy" are great and include depression, anxiety, and self-destructive behavior, since therapist alignment with societal prejudices against homosexuality may reinforce self-hatred already experienced by the patient. Many patients who have undergone "reparative therapy" relate that they were inaccurately told that homosexuals are lonely, unhappy individuals who never achieve acceptance or satisfaction. The possibility that the person might achieve happiness and satisfying interpersonal relationships as a gay man or lesbian are not presented, nor are alternative approaches to dealing with the effects of societal stigmatization discussed. APA recognizes that in the course of ongoing psychiatric treatment, there may be appropriate clinical indications for attempting to change sexual behaviors.

Several major professional organizations, including the American Psychological Association, the National Association of Social Workers, and the American Academy of Pediatrics, have made statements against "reparative therapy" because of concerns for the harm caused to patients. The American Psychiatric Association has already taken clear stands against discrimination, prejudice, and unethical treatment on a variety of issues, including discrimination on the basis of sexual orientation.

Therefore, APA opposes any psychiatric treatment, such as "reparative" or "conversion" therapy, that is based on the assumption that homosexuality per se is a mental disorder or is based on the a priori assumption that the patient should change his or her homosexual orientation.

An initial version of this position statement was proposed in September 1998 by the Committee on Gay, Lesbian, and Bisexual Issues of the Council on National Affairs. It was revised and approved by the APA Assembly in November 1998. The revised version was approved by the Board of Trustees in December 1998. The committee members as of September 1998 were Lowell D. Tong, M.D. (chairperson), Leslie G. Goransson, M.D., Mark H. Townsend, M.D., Diana C. Miller, M.D., Cheryl Ann Clark, M.D., Kenneth Ashley, M.D. (consultant); corresponding members*: Stuart M. Sotsky, M.D., Howard C. Rubin, M.D., Daniel W. Hicks, M.D., Ronald L. Cowan, M.D.; Robert J. Mitchell, M.D. (Assembly liaison), Karine Igartua, M.D. (APA/Glaxo Wellcome Fellow), Steven Lee, M.D. (APA/Bristol-Myers Squibb Fellow), and Petros Levounis, M.D. (APA/Center for mental Health Services Fellow).*

APA Background Statement

Position Statement on Therapies Focused on Attempts to Change Sexual Orientation (Reparative or Conversion Therapies): SUPPLEMENT

Recommendations:

1. APA affirms its 1973 position that homosexuality per se is not a diagnosable mental disorder. Recent publicized efforts to repathologize homosexuality by claiming that it can be cured are often guided not by rigorous scientific or psychiatric research, but sometimes by religious and political forces opposed to full civil rights for gay men and lesbians. APA recommends that the APA respond quickly and appropriately as a scientific organization when claims that homosexuality is a curable illness are made by political or religious groups.

2. As a general principle, a therapist should not determine the goal of treatment either coercively or through subtle influence. Psychotherapeutic modalities to convert or "repair" homosexuality are based on developmental theories whose scientific validity is questionable. Furthermore, anecdotal reports of "cures" are counterbalanced by anecdotal claims of psychological harm. In the last four decades, "reparative" therapists have not produced any rigorous scientific research to substantiate their claims of cure. Until there is such research available, APA recommends that ethical practitioners refrain from attempts to change individuals' sexual orientation, keeping in mind the medical dictum to First, do no harm.

3. The "reparative" therapy literature uses theories that make it difficult to formulate scientific selection criteria for their treatment modality. This literature not only ignores the impact of social stigma in motivating efforts to cure homosexuality, it is a literature that actively stigmatizes homosexuality as well. "Reparative" therapy literature also tends to overstate the treatment's accomplishments while neglecting any potential risks to patients. APA encourages and supports research in the NIMH and the academic research community to further determine "reparative" therapy's risks versus its benefits.

Confidentiality of Medical Records: Does the Physician Have a Right to Privacy Concerning His or Her Own Health Records ?

POSITION STATEMENT

Approved by the Board of Trustees, December 1980
Approved by the Assembly, May 1981

"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.*

Prepared by the Task Force on the Impaired Physician[*] of the Council on Medical Education and Career Development.

It has been proposed that physicians (and students aspiring to become physicians) have a special duty to the public which can only be discharged by requiring that the physician's own health record, especially information pertaining to the physician's mental health, be exposed to the scrutiny of those who oversee the quality of medical care or the fitness of individuals to practice medicine. This supposed duty of disclosure is said to arise from the special role physicians have in society and the vulnerability of the public to potential harm from inept, malicious, or otherwise dangerous doctors. This role also places a burden on those who select physicians and scrutinize their performance so that the public interest is adequately safeguarded. This raises the general question, Does the expectation of medical confidentiality extend to the physician's own health records when the physician is a patient?

The short answer to this question is, No convincing argument has been advanced to show that a patient should be deprived of the right to the privacy of his or her medical record simply because he or she has chosen to study or practice medicine.

The traditional privacy of communications between a patient and his or her physician rests on the judgment that society benefits when sick people have unimpeded access to necessary medical treatment. This expectation of medical confidentiality is reflected in medical ethics (1), contract law (2), and the common law (3) and has been enacted into statutory law in a majority (N=36) of jurisdictions (4).[**] Recently, a federal district court found that the right to privacy of medical records has a Constitutional basis (5). We have been unable to find laws that except physicians from these protections when they become ill and seek treatment.

In attempting to balance the danger to the public from mental disorders in physicians against the rights of all patients to privacy, we believe that the reasonable protection of patients does not require the assumption that anyone who is or who has been a psychiatric patient is potentially so harmful to patients that he or she cannot practice medicine without first presenting his or her otherwise private medical record for public scrutiny. There is no evidence to suggest that the hazard is so great that normal safeguards are inadequate. Moreover, there is, in our view, a greater danger that individuals needing treatment will be barred from obtaining professional help if getting it would require them to bare their innermost secrets to public or private overseers. More likely, they would try to conceal the need and continue to practice without diagnosis and treatment for what might be curable ills.

---

[*]The Task Force (now a committee) included Robert E. Jones, M.D. (chairperson), Manuel M. Pearson, M.D., Stephen Scheiber, M.D., Douglas A. Sargent, M.D., and Robert Marvin, M.D. (Assembly liaison).

[**]As of February 1983, 42 states plus the District of Columbia had enacted psychotherapist-patient privilege statutes. The authority is the case of Zuniga v. Pierce (714 Federal Reporter 2d, 632-642, 1983).

The American Psychiatric Association is a national medical specialty society, founded in 1844, whose 36,500 physician members specialize in the diagnosis and treatment of mental and emotional illnesses and substance use disorders.

The American Psychiatric Association
1400 K Street NW • Washington, D.C. 20005
Telephone: (888) 357-7924 • Fax: (202) 682-6850 • Email: apa@psych.org

The competition for admission to medical school is severe and begins early. If it were to become generally known that potential physicians who had consulted psychiatrists or other mental health professionals would be required to disclose that fact in the medical school application process, many needing treatment either would not get it or would conceal the fact, viewing a “psychiatric history” as an impediment to acceptance. Further, as Silver and associates (6) have shown, there are no data correlating psychiatric diagnosis and treatment with performance in medical school or practice.

What is true for medical students is even more likely in the case of the practicing physician, who stands to lose his or her means of livelihood, cannot easily change a career already launched, and does not have the student's option of simply choosing not to enter medicine rather than have his or her secrets known. Recent experience with “snitch laws” in New York and elsewhere (7) suggests that this fear of disclosure is real and not merely theoretical, confirming Slovenko's suggestion (8) that mental disorder is today's “loathsome disease,” the analogue of those socially impairing conditions that first led to the development of the physician-patient privilege. Citing Eldridge's *The Law of Defamation*, Slovenko said,

Surveys indicate that the general public regards a person seeking a psychiatrist with fear, distrust, or dislike. The public generally acts differently toward a psychiatric patient. This is reflected in the law of defamation where it is provided that a statement that a person is mentally ill is an “imputation of want of ability to discharge the duties of that person's ... profession ...” and thus slander on its face.

It is no comfort to the disturbed medical student or physician that the public's prejudices may not be shared by medical school admissions committees or medical practice boards, especially since experience suggests that physicians share the public view of psychiatry and our patients. Far from protecting the public, it is likely that abolition of the confidentiality of the physician's or medical student's personal health record would simply discourage troubled people, many with treatable disorders, from finding appropriate medical help and would hamper those who try to help them. We are naturally concerned, since we believe that such an impaired individual is far more likely to endanger patients than would be the case if medical treatment were a private matter for medical practitioners as it is for others.

Medical schools, hospitals, licensure boards, and other regulatory bodies seeking to know whether a history of medical or psychiatric disorder impairs present functioning are advised to do so on a case-by-case basis, as such a history has little predictive value. A medical psychiatric evaluation by a consultant hired for the purpose of determining present competence should be obtained for evaluating applicants whose fitness is questioned and who have given voluntary, informed consent. Such evaluations should be made only for cause and should not be routinely required of all applicants.

In short, the mandatory disclosure of the physician's confidential medical or personal history is without merit.

Both tradition and public policy, as reflected in the laws of privacy, favor access to therapy for all who need it, including physicians. The supposedly heightened protections for patients sought by those who would exclude physicians from the traditional safeguards of medical confidentiality are illusions. We urge support for the traditional view and oppose forced disclosure, which seems to promise more benefit than we think it can deliver.

1. American Medical Association Judicial Council: Section 9, in Principles of Medical Ethics. Chicago, AMA, 1969
2. Horne v Patton, 287 S 2d 824 (Ala S Ct 1974)
3. Warren SD, Brandeis S: The right to privacy. Harvard Law Review 4:193, 1890
4. Slovenko R: Psychotherapist-patient testimonial privilege: a picture of misguided hope. Catholic University Law Review 23:649-673, 1974
5. Hawaiian Psychiatric Society, District Branch, American Psychiatric Association v Ariyoshi, 481 S Supt 1028, 1052 (D Hawaii 1979)
6. Silver LB, Nadelson CC, Joseph EJ, et al: Mental health of medical school applicants: the role of the admissions committee. J Med Educ 54:534-538, 1979
7. Block MA: Disabled physician: rehabilitation versus punishment. NY State J Med 79:1025-1028, 1979
8. Slovenko R: Accountability and abuse of confidentiality in the practice of psychiatry. Int J Law Psychiatry 2:431-454, 1979

The American Psychiatric Association • 1400 K Street NW • Washington, D.C. 20005
Telephone: (888) 357-7924 • Fax: (202) 682-6850 • Email: apa@psych.org

Position Statement on Homosexuality

Reaffirmed, July 2011

This position statement was proposed by the Committee on Gay, Lesbian, and Bisexual Issues of the Council on National Affairs.[1] *It was approved by the Board of Trustees in December 1992.*

Whereas homosexuality per se implies no impairment in judgment, stability, reliability, or general social or vocational capabilities, the American Psychiatric Association (APA) calls on all international health organizations, psychiatric organizations, and individual psychiatrists in other countries to urge the repeal in their own countries of legislation that penalizes homosexual acts by consenting adults in private. Further, APA calls on these organizations and individuals to do all that is possible to decrease the stigma related to homosexuality wherever and whenever it may occur.

[1]The members of the Committee on Gay, Lesbian, and Bisexual Issues are Richard A. Isay, M.D. (chairperson), Margery Sved, M.D., Rochelle L. Klinger, M.D., Debbie R. Carter, M.D., Robert M. Kertzner, M.D., Jeffrey Akman, M.D. (consultant), Daphne Lanette Atkins, M.D. (consultant), Robert P. Cabaj, M.D. (corresponding member/Assembly liaison), Mark H. Townsend, M.D. (corresponding member), and Kenneth Ashley, M.D. (APA/NIMH Fellow).

Position Statement on Issues Related to Homosexuality

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*.

While recognizing that the scientific understanding is incomplete and often distorted because of societal stigma, the American Psychiatric Association holds the following positions regarding same-sex attraction and associated issues. It is the American Psychiatric Association's position that same-sex attraction, whether expressed in action, fantasy, or identity, implies no impairment per se in judgment, stability, reliability, or general social or vocational capabilities. The American Psychiatric Association believes that the causes of sexual orientation (whether homosexual or heterosexual) are not known at this time and likely are multifactorial including biological and behavioral roots which may vary between different individuals and may even vary over time. The American Psychiatric Association does not believe that same-sex orientation should or needs to be changed, and efforts to do so represent a significant risk of harm by subjecting individuals to forms of treatment which have not been scientifically validated and by undermining self-esteem when sexual orientation fails to change. No credible evidence exists that any mental health intervention can reliably and safely change sexual orientation; nor, from a mental health perspective does sexual orientation need to be changed.

The American Psychiatric Association opposes discrimination against individuals with same-sex attraction whether it be in education, employment, military service, immigration and naturalization status, housing, income, government services, retirement benefits, ability to inherit property, rights of survivorship, spousal rights, family status, and access to health services. The American Psychiatric Association recognizes that such discriminations, as well as societal, religious, and family stigma, may adversely affect the mental health of individuals with same-sex attraction necessitating intervention by mental health professionals, for which, the American Psychiatric Association supports the provision of adequate mental health resources to provide that intervention. The American Psychiatric Association supports same-sex marriage as being advantageous to the mental health of same-sex couples and supports legal recognition of the right for same-sex couples to marry, adopt and co-parent.

Authors:
David Scasta, M.D., and Philip Bialer, M.D.

NOTE: This statement combines into one document APA policies previously expressed in twelve separate position statements adopted between 1973 and 2011.