Joint Reference Committee
American Psychiatric Association

Draft Agenda – Part One

Location: APA Headquarters, Washington, DC

June 4th, 2018 - Monday
Meeting: 9:00 am – 4:00 pm

1 Welcome, Introductions, and Verbal Disclosures of Interests & Affiliations – Bruce Schwartz, MD

2 Review and approval of draft Summary of Actions from the February 2018 Joint Reference Committee Meeting – Bruce Schwartz, MD

Will the Joint Reference Committee approve the draft summary of actions from the February 2018 meeting? (See item 2)

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

Referral Update – review and provide guidance

3.1 Enacting APA Positions: State Medical Board Licensure Queries (ASM2017A212.D/JRCFEB186.4)

Please see page 1 and 4-5 of item 3 for recommendations regarding this action paper.

This Action Paper calls for the APA to: (1) query licensing boards in each state, territory or other licensure jurisdiction about their compliance with the APA policy and with the Americans with Disabilities Act with respect to questioning about mental and physical impairment affecting current ability to practice medicine; (2) notify each licensing board in writing whether or not their medical licensure application complies with the APA's stated policy and publish a list of jurisdictions and whether or not they are congruent with the APA position on the APA's website; and (3) notify the Federation of State Medical Boards Work Group of the APA's 2015 Position Statement prior to the January 2018 meeting of that group.

The Joint Reference Committee referred the action to the CEO/Medical Director's Office – Office of the General Counsel for input and recommendations on potential implementation as well as other departments as needed.

Referral Update – review and provide guidance

3.2 APA Position Statement Strongly Recommending Twelve Weeks of Paid Parental Leave (ASM2017A2 12.I/JRCFEB186.8)

Please see page 2 and 5-6 of item 3 for recommendations regarding this action paper.
Please also see item 8.G.3 of this agenda

This Action Paper asks that the APA approve and adopt a position statement recommending twelve weeks of paid parental (i.e. both parents) leave.

The Joint Reference Committee referred action paper *APA Position Statement Strongly Recommending Twelve Weeks of Paid Parental Leave* (ASM2017A2 12.I) to the Office of the General Counsel,
Council on Healthcare Systems and Financing (LEAD), and the Council on Advocacy and Government Relations.

- Prior to review by the Councils, the Office of the General Counsel is asked to provide input on the current APA parental leave policy and how this may or may not differ with APA's policy and the laws of the District of Columbia.
- The Council on Healthcare Systems and Financing is asked to assess how such a policy may affect members in different practice settings. Council on Advocacy and Government Relations is asked to review how such a policy by be received or accepted in the political and advocacy arena.

5 Referrals from the Board of Trustees

Executive Session

5.B Report of the BOT Ad Hoc Work Group on Safe Prescribing (materials will be sent to you separately)

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

In February 2018, the JRC received the report from the Ethics Committee and referred the report back to the Committee for additional review and commentary. Their memorandum to the JRC, in response to the referral, may be found as item 4.

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

9:00 am – 9:20 am
Debra Pinals, MD – *via speakerphone*

8.K **Council on Psychiatry and Law**

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

8.K.1 Proposed Resource Document on Risk-Based Gun Removal Laws (see attachment 2 of the council's report)

Will the Joint Reference Committee approve the Resource Document on Risk-Based Gun Removal Laws?

The Council on Psychiatry and Law has developed a draft Resource Document on Risk-Based Gun Removal Laws (Attachment #2). The document is intended to provide guidance to clinicians about the existence and application of laws, including so-called "red flag" laws, which allow for removal of weapons on the basis of risk. The document highlights some areas for clinicians pertaining to these laws. After discussion in the drafting process, it was preferred that the document references these laws as "risk-based gun removal laws" for clarity.

8.K.2 Retire 1981 Position Statement: Confidentiality of Medical Records: Does the Physician have a Right to Privacy Concerning His or Her Own Health Records? (please see attachment 3 of the council's report)

Will the Joint Reference Committee recommend that the Assembly retire the 1981 Position Statement *Confidentiality of Medical Records: Does the Physician have a Right to Privacy Concerning His or Her Own Health Records?* and if retired, forward it to the Board of Trustees for consideration?

Rationale: The Council on Psychiatry and Law has determined that the 1981 Position Statement "Confidentiality of Medical Records: Does the Physician Have a Right to Privacy Concerning His or Her Own Health Records" (Attachment #3) is antiquated. In addition, the Council believes that the necessary elements of that document are sufficiently covered by the Position Statement on Inquiries about Diagnosis and Treatment of Mental Disorders in Connection with Professional Credentialing and Licensing (2015; Amended 2017) (Attachment #4). Therefore, the Council recommends that the 1981 Position Statement should be retired.

8.K.3 Retain Position Statement: 2013 Legislative Intrusion and Reproductive Choice (please see attachment 5 of the council's report)

Will the Joint Reference Committee recommend that the Assembly retain the 2013 Position Statement *Legislative Intrusion and Reproductive Choice* 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.

9:20 am – 9:40 am

Dwight Evans, MD – *via speakerphone*

8.M **Council on Research**

Please see item 8.M for the Council's report which includes a summary of current activities and information items.

8.M.1 Revised Proposed Position Statement: Mental Health Screening, Diagnosis, and Treatment During Pregnancy and Postpartum (see attachment 1 of the council's report)

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

8.M.2 Revised Resource Document on Neuroimaging (see attachment 2 of the council's report)

Will the Joint Reference Committee approve the revised Resource Document on Neuroimaging?

Referral Update – review and provide guidance

8.M.3 Providing Education and Guidance for the Use and Limitations of Pharmacogenomics in Clinical Practice (JRCJUNE176.5, ASM2017A1 12.G; JRCFEB188L1).

In response to the JRC's request for the Council on Research to re-evaluate the need to draft a resource document on the issue, the Council has concluded that the current state-of-the-art does not yet support the application of pharmacogenomics in routine clinical practice to predict treatment efficacy in psychiatric disorders.

The Council on Research would like to ensure that the Scientific Program Committee is informed of the current limitations in the empirical support for applications of pharmacogenomics in psychiatry.

The Council is concerned that companies are marketing pharmacogenomics testing in psychiatry, including at the annual meeting of the APA, in advance of adequate validation of their ability to predict outcome.

In conclusion, the Council on Research agrees with the Council on Quality Care that there is insufficient evidence to draft a Resource Document.

9:40 am – 10:00 am

Marshall Forstein, MD – *via speakerphone* – Dr. Forstein is representing Dr. Rapaport

8.I **Council on Medical Education and Lifelong Learning**

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

8.I.1 Request for Committee: Committee on Well-Being and Burnout (see the linked document for the charge and budget in the Council's report)

Will the Joint Reference Committee recommend that the Board of Trustees approve the formation of a Committee on Well-being and Burnout, under the Council on Medical Education and Lifelong Learning, as a permanent home for the efforts that were undertaken by the Board of Trustee's Ad Hoc Work Group on Wellbeing and Burnout?

Physician wellness and professional burnout and mental health vulnerability are significant concerns affecting physicians in training and practicing physicians. A committee, under the Council is needed now to continue the work of the Board of Trustees' Ad Hoc Work Group. This committee would facilitate the continuance of Dr. Everett's Presidential Initiative on Wellness and Burnout.

8.I.2 Request for Funding: Committee on Well Being and Burnout
Will the Joint Reference Committee approve a one-time, full day meeting of the Committee on Well-Being and Burnout during the September 2018 Components Meeting? The estimated cost is $9,314. This approval is predicated on the approval of the establishment of the Committee.
(The costs for the meeting in 2018 can be taken from the JRC component fund.)

8.I.3 Revised Charge: Council on Medical Education and Lifelong Learning (see linked document in the council's report)
Will the Joint Reference Committee recommend that the Board of Trustees approve the revised charge of the Council on Medical Education and Lifelong Learning?

8.I.4. Retain Position Statement: Consistent Treatment of all Applicants for State Medical Licensure (see linked document in the council's report)
Will the Joint Reference Committee recommend that the Assembly retain the Position Statement *Consistent Treatment of all Applicants for State Medical Licensure* and if retained, forward it to the Board of Trustees for consideration?

Rationale:
The Council on Medical Education believes that this position statement is still relevant and needed. The Council recommends retention of this position with a clarification of language as below.
The APA fully endorses the need for an equitable, fair and consistent treatment for state medical licensure for those applicants who graduated from medical school in the state they are applying, graduated from a school in another state or graduated from a school in another country.

8.I.5 Retain Position Statement: Residency Training Needs in Addiction Psychiatry for the General Psychiatrist (see linked document in the council's report)
Will the Joint Reference Committee recommend that the Assembly retain the Position Statement *Residency Training Needs in Addiction Psychiatry for the General Psychiatrist* and if retained, forward it to the Board of Trustees for consideration?

Rationale:
The Council reviewed the position statement. The statement meets all criteria for retention. Nothing has changed. The council recommends this position be retained.

8.I.6 Retain Position Statement: Neuroscience Training in Psychiatry Residency Training (see linked document in the council's report)

Will the Joint Reference Committee recommend that the Assembly retain the Position Statement *Neuroscience Training in Psychiatry Residency Training* and if retained, forward it to the Board of Trustees for consideration?

Rationale:
The Council reviewed the position statement. Neuroscience education varies from program to program. The Council supports the aspirational intention of this action and recommends retention.

Referral Update – action needed

8.I.7 Expanding Access to Psychiatry Subspecialty Fellowships (ASM2017A1 12.H)

This action 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. The new ACGME common requirements for fellowship programs go into effect summer 2018; there are now more opportunities available (as detailed in the Council's report).

Will the Joint Reference Committee close this action?

Referral Update – action needed

8.I.8 Addressing Physician Burnout, Depression, and Suicide — Within Psychiatry and Beyond (ASM2017A112.N)

Council has proposed a Committee under the Council as a long-term home for Wellness and Burnout initiatives. The Council requests that this action be closed.

Will the Joint Reference Committee close this action?

Referral Update – action needed

8.I.9 Recognition of Psychiatric Expertise: Efficiency and Sufficiency (ASM2017A212.E)

This action was reported previously in Fall 2017. The AMA has an existing policy that states that MOC should not be a requirement for maintenance of licensure, hospital privileges, insurance credentialing or employment. APA has been supportive of this policy. Additionally, the ABPN is developing a learning option in lieu of the 10-year exam which is scheduled to launch January 1, 2019. The Interstate Medical Licensure Compact has already released its eligibility requirements (http://www.imlcc.org/do-i-qualify/) which require, "Hold a current specialty certification or time-unlimited certification by an ABMS or AOABOS board". In order for APA to lobby for a change to this policy, the APA Board of Trustees would need to create an action which addresses this question. The Council requests this action be closed.

Will the Joint Reference Committee close this action?

Referral Update – action needed

8.I.10 Fostering Medical Student Interest and Training in Psychiatry: The Importance of Medical Student Clerkships (ASM2017A112.K).

Council reported on this in October 2017. LCME does not specify minimum lengths for clerkships; there are new models of integrated clerkships that may not suit a minimum requirement. Council is no longer working on this action; the Council *requests that this action be closed*.

Will the Joint Reference Committee close this action?

Referral Update – action needed

8.I.11 Educational Strategies to Improve Mental Illness Perceptions of Non-Mental Health Medical Professionals (ASM2017A1 12.J)

The Council and the division on Communications provided input previously; the Council *requests that this action be closed*. A list of programs from division of Communication and Division of Education is

attached. (List of Programs) Sample APA initiatives related to this action: Ongoing education programs for primary care/collaborative care Publishing/Psych News, Psychiatric Services, FOCUS, AJP, APP Communications efforts

Will the Joint Reference Committee close this action?

Referral Update – action needed

8.I.12 Educational Strategies to Improve Mental Illness Perceptions of Medical Students (ASM2017A1 12.I)

The Council provided input previously and *requests that this action be closed*. A list of programs from Division of Communication and Division of Education is attached. (List of programs) Sample APA initiatives related to this action: The Psychiatry Student Interest Group Network (PsychSIGN) APA/APAF Medical Student Programs Division of Membership Resources for Medical Students Medical Student attendance/participation in Annual Meetings Collaborative relationship with ADMSEP

Will the Joint Reference Committee close this action?

10:00 am – 10:20 am

David Gitlin, MD – *via speakerphone*

8.E **Council on Consultation-Liaison Psychiatry**

Please see item 8.E for Council's report which includes a summary of current activities and information items.

8.E.1 Resource Document: OTc Prolongation and Psychiatric Disorders (please see attachment #1 of the council's report)

Will the Joint Reference Committee approve the Resource Document entitled *OTc Prolongation and Psychiatric Disorders*?

The American Psychiatric Association (APA) Council convened a workgroup of experts, which included a representative from the American College of Cardiology to summarize the current literature and to create this set of clinical considerations for the practicing clinician. This resource document includes a summary of basic electrocardiography, psychopharmacology and drug safety, special practice settings including the intensive care unit and under-resourced clinics, special populations including children and patients with cardiac implantable electronic devices, and the approach to Torsades de Pointes risk stratification and mitigation. The document is in the process of being reviewed by ACC for endorsement.

8.E.2 Permission to Publish: Resource Document OTc Prolongation and Psychiatric Disorders

Will the Joint Reference Committee recommend that the Board of Trustees grant permission to publish the Resource *Document OTc Prolongation and Psychiatric Disorders*?

Please note that after the *American Journal of Psychiatry* has the right of first refusal.

The following disclaimer must be included in the manuscript.
"The findings, opinions, and conclusions of this report do not necessarily represent the views of the officers, trustees, or all members of the American Psychiatric Association. The views expressed are those of the authors."

10:20 am – 10:40 am
Grayson Norquist, MD – *via speakerphone*

8.L **Council on Quality Care**

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

8.L.1 Request for Funding: Committee on Quality and Performance Measurement

Will the Joint Reference Committee approve a one-time, full day meeting of the Committee on Quality and Performance Measurement during the September 2018 Components Meeting to continue the quality measurement topic prioritization process, initiated in December 2017? The estimated cost is $5,000.

(The costs for the meeting in 2018 can be taken from the JRC component fund.)

• Prioritization is an ongoing process to inform internal and external quality measure development to improve gaps in care for patients with mental and substance use disorders.
• Most of the Committee members will be present for their respective Council meetings that week.

Referral Update – no action required

8.L.2 Revised 2015 Position Statement: Use of the Concept of Recovery (JRCFEB178.M.1/ASM2017A1 4.B.20/JRCJUNE176.18)

As originally requested by the JRC in June 2017, the Council on Quality Care continued to work with several mental health patient advocacy groups to address updates to the language included in the 2015 Position Statement Action Paper: Use of the Concept of Recovery
• The patient advocacy groups were pleased by the statement but did offer some recommended edits.
• Due to the timing of the recommended edits, the Council has not yet had a chance to review and finalize the draft for JRC review.
• We respectfully request the JRC extend the deadline for response to this referral until the next JRC meeting, this fall.

8.L.3 Proposed Position Statement: Utilization of Measurement Based Care (see item 8.L addendum)

Will the Joint Reference Committee recommend that the Assembly approve the Proposed Position Statement on *Utilization of Measurement Based Care*, and if approved, forward it to the Board of Trustees for consideration?

11:00 am – 11:20 am
Andrew Saxon, MD – *via speakerphone*

8.A **Council on Addiction Psychiatry**

Please see item 8.A for the Council's report which includes a summary of current activities and information items.

8.A.1 Proposed Position Statement: Prescription Drug Monitoring Programs (see attachment A of the Council's report)

Will the Joint Reference Committee recommend that the Assembly approve the Position Statement on *Prescription Drug Monitoring Programs* and if approved, forward it to the Board of Trustees for consideration?

8.A.2 Proposed Position Statement on Physician Health Programs in the Treatment of Addiction and Substance Use Disorders in Physicians (see attachment B of the Council's report)
Will the Joint Reference Committee recommend that the Assembly approve the Position Statement on *Physician Health Programs in the Treatment of Addiction and Substance Use Disorders in Physicians* and if approved, forward it to the Board of Trustees for consideration?

8.A.3 Resource Document: Physician Health Programs in the Treatment of Addiction and Substance Use Disorders in Physicians (see attachment C of the Council's report)
Will the Joint Reference Committee approve the Resource Document on *Physician Health Programs in the Treatment of Addiction and Substance Use Disorders* in Physicians?

8.A.4 Position Statement: Addressing Health Disparities in Substance Use Disorder in the Justice System (see attachment D of the Council's report)
Will the Joint Reference Committee recommend that the Assembly approve the Position Statement on *Addressing Health Disparities in Substance Use Disorder Treatment in the Justice System* and if approved, forward it to the Board of Trustees for consideration?

Referral Update:

8.A.5 Transitional Care Services Post-Psychiatric Hospitalization (JRCFEB186.3)

The Council was asked to review the action paper and address transitional care services post-psychiatric hospitalization for person with substance use disorders and make recommendations as to the inclusion of substance use disorders in the ask. The Council noted that given that individuals with substance use disorders are at an especially high-risk for hospital readmission, the ask should include reducing barriers to accessing treatment post-discharge specifically for this patient population. The Council also highlighted that transitional care clinics based within residency associated health centers allow significant educational opportunities for resident psychiatrists, specifically in the areas of serious mental illness as well as substance use disorders. As training in the management of substance-related and addictive disorders has been disproportionately limited in psychiatric residency training programs, the transitional care clinic model should also allow programs to improve the knowledge, skills, and attitudes of trainees about substance-related disorders emphasizing the importance of access to integrated care among individuals with concurrent mental health and addiction disorders. This feedback was shared with the Council on Advocacy and Government Relations to be included in its June 2018 JRC report.

11:20 am – 11:40 am
Robert Roca, MD – *via speakerphone*

8.F **Council on Geriatric Psychiatry**

Please see item 8.F for Council's report which includes a summary of current activities and information items.

8.F.1 Proposed Position Statement: Role of Psychiatrists in Palliative Care (please see attachment #1 of the Council's report)

Will the Joint Reference Committee recommend that the Assembly approve the proposed Position Statement *Role of Psychiatrists in Palliative Care* and if approved, forward it to the Board of Trustees for consideration?

8.F.2 Revised Position Statement: Elder Abuse, Neglect and Exploitation (please see attachment #2 of the Council's report)
Will the Joint Reference Committee recommend that the Assembly approve the revised Position Statement *Elder Abuse, Neglect and Exploitation* and if approved, forward it to the Board of Trustees for consideration?

Please note: If the revised position statement is approved by both the Assembly and the Board of Trustees, the 2014 Position Statement Elder Abuse, Neglect and Exploitation will be retired.

11:40 am – 12:00 noon
Christina Mangurian, MD – *via speakerphone*

8.J **Council on Minority Mental Health and Health Disparities**
Please see item 8.J for the Council's report which includes a summary of current activities and information items.

8.J.1 Request for Task Force
Will the Joint Reference Committee recommend that the Board of Trustees consider creating a special task force to work with the scientific review committee to re-assess the scoring process for submissions for presentations at the Annual Meeting and IPS to ensure our presentations are inclusive, diverse, and prioritize various Council and Caucus-endorsed presentations?

8.J.2 Proposed Position Statement: Policy Brutality and Black Males (see document linked within the Council's report)
Will the Joint Reference Committee recommend that the Assembly approve the Position Statement on *Police Brutality and Black Males* and if approved, forward it to the Board of Trustees for consideration?

8.J.3 Proposed Position Statement: Mental Health Equity and the Social and Structural Determinants of Mental Health (see document linked within the Council's report)
Will the Joint Reference Committee recommend that the Assembly approve the Position Statement on *Mental Health Equity and the Social and Structural Determinants of Mental Health* and if approved, forward it to the Board of Trustees for consideration?

8.J.4 Proposed Position Statement on Human Trafficking (see document linked within the Council's report)
Will the Joint Reference Committee recommend that the Assembly approve the Position Statement on *Human Trafficking* and if approved, forward it to the Board of Trustees for consideration?

8.J.5 Proposed Position Statement on Conversion Therapy and LGBTQ Patients (see document linked within the Council's report)

Will the Joint Reference Committee recommend that the Assembly approve the Proposed Position Statement on *Conversion Therapy and LGBTQ Patients* and if approved, forward it to the Board of Trustees for consideration?

8.J.6 Retire Position Statement: Therapies Focused on Attempts to Change Sexual Orientation

Will the Joint Reference Committee recommend that the Assembly retire the Position Statement on Therapies Focused on Attempts to Change Sexual Orientation and if retired, forward it to the Board of Trustees for consideration?

Rationale: The proposed position statement on Conversion Therapy and LGBTQ Patients, if approved will supersede the position statement *Therapies Focused on Attempts to Change Sexual Orientation.*

1:20 pm – 1:40 pm

Gabrielle Shapiro, MD – *via speakerphone*

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

Please see item 8.C for the Council's report which includes a summary of current activities and information items.

8.C.1 Retire Position Statement: 2007 Reactive Attachment Disorder (please see attachment #4 of the council's report)

Will the Joint Reference Committee recommend that the Assembly retire the 2007 Position Statement on *Reactive Attachment Disorder*, and if retired, forward it to the Board of Trustees for consideration?

Rationale: The Council recommends that this position statement be retired as it is outdated.

8.C.2 Retain Position Statement: 2007 Family Planning (please see attachment #5 of the council's report)

Will the Joint Reference Committee recommend that the Assembly retain the 2007 Position Statement on *Family Planning*, and if retained, forward it to the Board of Trustees for consideration?

Rationale: The Council recommends that this position statement be retained as it is still relevant.

2:00 pm – 2:20 pm

Carol Bernstein, MD – *via speakerphone*

8.D **Council on Communications**

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

2:20 pm – 2:40 pm
Harsh Trivedi, MD – *via speakerphone*

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

Please see item 8.G for the Council's report which includes a summary of current activities and information items.

8.G.1 Proposed Position Statement on Core Principles for Alternative Payment Models for Behavioral Health (see attachment A of the council's report)
Will the Joint Reference Committee recommend that the Assembly approve the Position Statement on *Core Principles for Alternative Payment Models for Behavioral Health* and if approved, forward it to the Board of Trustees for consideration?

8.G.2 Background Information: Position Statement on Core Principles for Alternative Payment Models for Behavioral Health (see attachment B of the Council's report)
Will the Joint Reference Committee approve the Background Document on Position Statement on Core Principles for Alternative Payment Models for Behavioral Health?

Please note: Background information for position statements are not APA policy and do not reside on the APA website. This information is place on the APA intranet for the APA Administration.

8.G.3 Proposed Position Statement on Paid Parental Leave (see attachment C of the Council's report)
See also item 3.2 of the CEO's report.
Will the Joint Reference Committee recommend that the Assembly approve the Proposed Position Statement on *Paid Parental Leave*, and if approved, forward it to the Board of Trustees for consideration?

8.G.4 Advocacy Priorities in Telemedicine in Psychiatry (see attachment D of the Council's report)
Will the Joint Reference Committee approve the Advocacy Priorities Document on Telemedicine in Psychiatry?

Referral Update – no action required

8.G.5 Adopting an APA Position Statement Supporting Implementation of the Mental Health Parity and Addiction Equity Act (MHPAEA or parity law) (ASM2017A2 12.L/JRCFEB186.11)
See also 8.B.8
The Council finds that this paper does not consider the current work that the APA's Office of Parity Enforcement and Compliance is undertaking. The overall consensus was that an APA position paper on supporting implementation of MHPAEA should be broader in scope than the current paper. The position should state that all MHPAEA requirements be observed and that health plans, self- funded or otherwise, should re explicitly required to provide on request the documentation that evidences the regulatory rules and tests were observed and performed. The Council on Advocacy and Government Relations has also reviewed the paper and recommends, (1) inclusion of language that would identify patients as priorities; and (2) support the actions in implementation and enforcement consistent with the scope of APA's Office of Parity Enforcement and Compliance.

The Council requested that Sam Muszynski make the necessary edits and share with the Council for review. The Council will plan to submit the updated version in its October JRC report.

Referral Update – no action required

8.G.6 Position Statement on Psychologists and Other Mental Health Professionals and Hospital Privileges (JRCFEB188.B.1)

The Council agrees to work with the Council on Advocacy and Government Relations to create a workgroup charged with revising this position statement. The Council urged the work group to more explicitly include NPs, PAs, and prescribing psychologists. Dr. Thienhaus and Dr. Cole will serve as the Council's representatives to the workgroup. The Council has forwarded this recommendation to the Council on Advocacy and Government Relations to be included in its June 2018 JRC report.

Referral Update – no action required

8.G.7 Transitional Care Services Post-Psychiatric Hospitalization (JRCFEB186.3)

The Council reviewed the Action Paper on Transitional Care Services Post-Psychiatric Hospitalization as directed by the JRC. The Council members suggested that the authors integrate current APA policy that speaks to the continuum of care and the care for the uninsured, where applicable. Additionally, it suggested that the "Be it Resolved" be more focused on asking APA to lobby for better reimbursement to coordinate care. The Council has forwarded this recommendation to the Council on Advocacy and Government Relations to be included in its June 2018 JRC report.

TIME TBD

Patrick Runnels, MD – *via speakerphone*

8.B **Council on Advocacy and Government Relations**

Please see item 8.B for the Council's report which includes a summary of current activities and information items.

Referral Update – action needed

8.B.1 Designation of Psychiatry as Primary Care for Any Medical School Scholarships Requiring Primary Care Service (ASM2017A2 12.A\JRCFEB186.1)

The Council on Advocacy and Government Relations discussed at length the Action Paper on the Designation of Psychiatry as Primary Care for Any Medical School Scholarships Requiring Primary Care Service. Both the Council and the Council on Medical Education and Lifelong Learning support the premise of the Action Paper to designate psychiatry as primary care for primary care medical school scholarships. It was noted that National Health Service Corps currently encompasses general psychiatry in Medical Primary Care for eligibility to apply to the NHSC Loan Repayment Program. The Council recommends that the Action Paper be amended by the authors to incorporate language reflecting: (1) inclusion of primary care subspecialties; and (2) additional incentives for psychiatrists to practice in rural areas. The proposed language will provide opportunities for additional subspecialties to participate in scholarship programs, thus positively impacting the psychiatric physician workforce. Taking into consideration the recommendations, the Council voted to not support advancing the action paper as written.

Will the Joint Reference Committee accept the Council on Advocacy and Government Relations' recommendation to not advance the Action Paper on "Designation of Psychiatry as Primary Care for Any Medical School Scholarships Requiring Primary Care Service"?

Referral Update – action needed

8.B.2 Medical School Loan Repayment Subsidies for Psychiatrists Practicing in Community Mental Health Centers and State Psychiatric Facilities (ASM2017A2 12.B\JRCFEB186.2)

The Council on Advocacy and Government Relations discussed the Action Paper on Medical School Loan Repayment Subsidies for Psychiatrists Practicing in Community Mental Health Centers and State Psychiatric Facilities. Both the Council and the Council on Medical Education and Lifelong Learning support the resolution of the Action Paper. As an added option for providing access to underserved communities, the Council recommends that the Action Paper be amended by the authors to incorporate the practice of telemedicine. This incentive can be used as a recruiting tool for urban participation, such that individuals serving rural populations by telepsychiatry could be included in loan forgiveness programs. Taking into consideration the recommendations, the Council voted to not support advancing the action paper as written.

Will the Joint Reference Committee accept the Council on Advocacy and Government Relations' recommendation to not advance the Action Paper on "Medical School Loan Repayment Subsidies for Psychiatrists Practicing in Community Mental Health Centers and State Psychiatric Facilities"?

Referral Update – action needed

8.B.3 Transitional Care Services Post-Psychiatric Hospitalization (ASM2017A212.C\JRCFEB186.3)

See also items 8.A.5 and 8.G.7

The Council on Advocacy and Government Relations discussed the Action Paper on Transitional Care Services Post-Psychiatric Hospitalization. The Council on Advocacy and Government Relations recognizes the value of the new concept on clinical care, as described in the Action Paper, and supports the idea broadly. The Council has concerns about whether the national organization should prioritize and advocate for specific pilot programs, and instead recommends working with entities like SAMHSA to determine the best pilot programs to support. The Council on Quality Care recommends approaching the matter by providing funding to community mental health centers to engage people at discharge and then see them in their outpatient programs. At the time of this report, the Council had not received feedback from the Council on Healthcare Systems and Financing and Council on Addiction Psychiatry.

Will the Joint Reference Committee accept the Council on Advocacy and Government Relations' recommendation to not advance the Action Paper on "Transitional Care Services Post-Psychiatric Hospitalization"?

8.B.4 Resource Document: The Current State of Advocacy Teaching in Psychiatry Residency Training Programs (see attachment #4 of the Council's report)

Will the Joint Reference Committee approve the Resource Document entitled, *Advocacy Teaching in Psychiatry Residency Training Programs*?

In September 2017, a draft of a resource document illustrating the significance of incorporating advocacy training to the curriculum for psychiatric residents was presented to the Council. In spite of the parallels linking healthcare, practice and policy, many residency programs do not offer opportunities for engagement in political advocacy. This document strongly encourages medical residency programs to consider implementing advocacy curriculum that ties topics of clinical competence to the implications of relevant state and federal policy decisions for patient outcomes. At the Annual Meeting, a revised draft was presented for the Council's consideration and the Council unanimously approved the document.

8.B.5 2019 Jacob Javits Award for Public Service

Will the Joint Reference Committee recommend that the Board of Trustees approve the 2019 Jacob K. Javits Award for Public Service nominee, U.S. Representative Doris Matsui (D-CA)?

U.S. Representative Doris Matsui (D-CA) has demonstrated a commitment to the mental health community through her legislative work championing mental health issues. Due in large part to her influence on the House Energy and Commerce Subcommittee on Health, she continues to advocate in Congress for improving our nation's mental health care system. Representative Matsui exemplifies working across party lines – securing passage of landmark bipartisan legislation, the Excellence in Mental Health Act, that established a demonstration project and expanding access to mental health services to underserved communities. Through majority vote, the Council nominates Representative Doris Matsui as she embodies the spirit of the Jacob K. Javits Award and those public servants whose mission is to positively affect change for those individuals unable to speak for themselves with behavioral health needs.

Referral Update - no action needed

8.B.6 Psychologists and Other Mental Health Professionals and Hospital Privileges (formerly Hospital Privileges for Psychologists) (JRCFEB188.B.1)

The Council on Advocacy and Government Relations (CAGR) reviewed the position statement formerly titled, Hospital Privileges for Psychologists. Through JRC directive, the Council will establish a joint Council work group with the Council on Healthcare Systems and Financing to review the 2007 position statement and 2017 proposed revisions. Specifically, the work group will address concerns to which language could be misconstrued particularly in the current scope of practice environment. The work group will present a revised statement to the JRC before the October 2018 meeting.

Referral Update – no action required

8.B.7 Position Statement Strongly Recommending Twelve Weeks of Paid Parental Leave (ASM2017A2 12.I/JRCFEB186.8)

The Council on Advocacy and Government Relations (CAGR) discussed the proposed Position Statement. The Council finds the Action Paper addresses a timely matter, and the significance that psychiatrists place on maternal care. The JRC asks for the Council to consider the political and advocacy implications of an APA position. The members are in support of APA taking a position on the matter, acknowledging there could be possible resistance from local and state policymakers. The Council will forward their recommendations to the Council on Healthcare Systems and Financing to be included in the June 2018 JRC report.

Referral Update – no action required

8.B.8 Adopting an APA Position Statement Supporting Implementation of the Mental Health Parity and Addiction Equity Act (MHPAEA or parity law) (ASM2017A2 12.L/JRCFEB186.11)

See also 8.G.5

The Council on Advocacy and Government Relations (CAGR) discussed the Action Paper. The Council recognizes that APA does not currently have a position statement on the implications of the parity law on managed care utilization management. The Council supports the authors recommendation for the APA to adopt a position statement, with additional recommendations to the language. The Council recommends, (1) inclusion of language that would identify patients as priorities; and (2) support the actions in implementation and enforcement consistent with the scope of work of APA's Office of Parity Enforcement and Compliance. The Council will forward their recommendations to the Council on Healthcare Systems and Financing to be included in the June 2018 JRC report.

TIME TBD

Bernardo Ng, MD – *via speakerphone*

8.H **Council on International Psychiatry**

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

Referral Update – no action required

8.H.1 Revised Position Statement on Abuse and Misuse of Psychiatry (JRCFEB185.B)

Following a referral from the JRC and the Board of Trustees, the Council established a work group to review, update, and consolidate the following two APA position statements related to the abuse and misuse of psychiatry:

- Position Statement on Abuse and Misuse of Psychiatry (2007)
- Position Statement on Identification of Abuse of Misuse of Psychiatry (1998)

In addition to addressing the feedback provided by the Board of Trustees, the work group is also planning to connect with the expertise of the Council on Psychiatry and Law and the Council on Minority Mental Health and Health Disparities to provide input and feedback before submitting a recommendation to the JRC.

NEXT JOINT REFERENCE COMMITTEE MEETING

October 1st, 2018 - **MONDAY**
APA Headquarters
Washington, DC
Report Deadline: September 21st, 2018 @ Noon

Executive Summary
Council on Addiction Psychiatry
Andrew J. Saxon, MD, Chair

Members of the Council on Addiction Psychiatry have focused their efforts on reviewing position statements and continuing to implement their newly-approved three-year workplan. As Congress has been working on a comprehensive legislative package to address the opioid crisis, the Council has provided rapid responses to APA staff and helped guide submitted feedback to both the relevant Senate and House committees. The council has also helped staff respond to a range of regulatory activities, such as the Food and Drug Administration's Opioid Policy Steering Committee's recent request for feedback and CMS's work on Screening and Brief Intervention and Referral to Treatment (SBIRT) measures.

During the May meeting, the Council met with the leadership of National Institute on Drug Abuse, National Institute on Alcohol Abuse and Alcoholism, and SAMHSA on ways to collaborate. The conversation largely focused on the ongoing opioid crisis and the increasing rates of marijuana use and cocaine, alcohol abuse among women, and decreasing levels of data collection on tobacco use.

The Council brings the following Action Items:

Action Item 1: Will the Joint Reference Committee recommend that the Assembly approve the *Position Statement on Prescription Drug Monitoring Programs* and if approved, forward it to the Board of Trustees for consideration?
Attachment A: Proposed Statement

Background: Following a 2017 action paper from the Assembly, the Council on Addiction Psychiatry has written the proposed Position Statement on Prescription Drug Monitoring Programs. This position statement incorporates feedback from the Council on Advocacy and Government Relations, per the JRC's request.

Proposed APA Position Statement on Prescription Drug Monitoring Programs
The American Psychiatric Association believes:

1. Patient care, safety, privacy, and confidentiality must be paramount priorities.
2. The broadest implementation of PDMPs will be the most effective.
3. PDMPs should include medications prescribed and/or dispensed by substance use disorder treatment programs if the health information remains protected and confidential. PDMPs should also include a notice stating the drugs excluded from the program (such as methadone dispensed from a licensed opioid treatment program), so prescribers can better understand the limitations of the data collected.
4. PDMPs should be administered by departments of health or boards of pharmacy not law enforcement or professional licensing agencies.
5. All providers with prescriptive authority should be automatically registered with their state PDMP as part of state licensure.

6. PDMPs should be mandatory for all providers to query before prescribing controlled substances. The frequency of access and sanctions for lack of access should be determined in consultation with practicing providers to avoid onerous requirements that may not result in improved patient care or disincentives for providing quality care.
7. PDMPs should permit database access to physician-supervised delegates.
8. PDMPs should permit unsolicited notifications to providers and pharmacies regarding patients who may be obtaining controlled substances inconsistent with generally accepted standards of care.
9. PDMPs should permit release of de-identified database information to public health agencies.
10. PDMP data with protected health information should only be released to entities for purposes other than direct patient care (e.g. law enforcement, social services, and insurers) by court order.
11. PDMPs do not replace the necessity of evaluating and treating substance use disorders.

Action Item 2: Will the Joint Reference Committee recommend that the Assembly approve the *Position Statement on Physician Health Programs in the Treatment of Addiction and Substance Use Disorders in Physicians* and if approved, forward it to the Board of Trustees for consideration?
Attachment B: Proposed Statement

Background: Per JRC request, the Council on Addiction Psychiatry has reformatted and rewritten this position statement in a more concise manner. This position statement also includes feedback from the Council on Psychiatry and Law.

Proposed Position Statement on Physician Health Programs in the Treatment of Addiction and Substance Use Disorders in Physicians

The American Psychiatric Association (APA) recognizes that substance use disorders (SUDs) occur in physician populations and that these disorders can have significant impact on the physician themselves (increased risk of suicide, medical complications), their families and community, and the public. APA recognizes that physicians can benefit from access to evidence-based treatment for SUDs, including state-specific Physician Health Programs (PHP). APA commits to support and collaborate with physicians, communities, healthcare organizations, PHPs, and other relevant stakeholders in efforts to decrease stigma around SUDs by ensuring that physicians and allied healthcare providers are educated about the importance of understanding the unique risks and challenges posed by SUDs in physician populations. Furthermore, APA commits to supporting efforts to provide and standardize confidential, affordable, equitable access to evidence-based treatments for SUDs as provided through PHPs, as well as support efforts to further research the antecedents and prevention of, and the unique treatment needs of, physicians with SUDs. APA is committed to the goal of rehabilitation of physicians with SUDs in a non-disciplinary, non-discriminatory, peer-based therapeutic program environment, while also recognizing the importance of uncompromised patient care by physicians in PHPs who themselves have SUDs.

Action Item 3: Will the Joint Reference Committee recommend that the Assembly approve the *Resource Document on the Position Statement on Physician Health Programs in the Treatment of Addiction and Substance Use Disorders in Physicians* and if approved, forward it to the Board of Trustees for consideration?
Attachment C: Proposed Resource Document

Background: The Council has also reorganized the supplemental information in its initially-proposed position statement on Physician Health Programs into an accompanying resource document as the JRC had previously recommended.

Action Item 4: Will the Joint Reference Committee recommend that the Assembly approve the *Position Statement on Addressing Health Disparities in Substance Use Disorder Treatment in the Justice System* and if approved, forward it to the Board of Trustees for consideration?
Attachment D: Proposed Statement

Background: This position statement was originally drafted by the Council on Minority Mental Health and Health Disparities. The JRC referred this proposed position statement to the Council on Addiction and requested that they provide feedback, including any potential revisions. The Council had significant edits to the position statement that were largely focused on expanding the scope of the statement to include gender and sexual identity minorities, strengthening the recommendations' emphasis on evidence-based treatment, and eliminating references to disparities across various domains of SUD from the background since the position statement does not address these specifically.

Position Statement on Addressing Health Disparities in Substance Use Disorder Treatment in the Justice System
It is the position of the American Psychiatric Association that:

1. All persons should have similar access to all forms of evidence-based treatments for substance use disorder, regardless of minority status.
2. Institutions providing treatments for substance use disorders need to take an active role in ensuring that, among their patients, persons belonging to minority groups receive the same treatments as those who do not. As such, the same treatment option should be used with the same frequency across different racial, ethnic and gender groups. Institutional policies should be developed to monitor the application of this principle on a regular basis.
3. Diversion to treatment in lieu of incarceration should be offered, whenever legally appropriate for all individuals charged with non-violent drug offenses
4. Efforts should be made to ensure that minority populations have access to diversion programs in order to safeguard the equitable distribution of the benefits of such programs.
5. Access to evidence-based treatments for substance use disorders, including the use of all medications approved for the treatment of addictive disorders should become available in correctional settings and used whenever clinically appropriate, equitably among all incarcerated individuals.

6. There is a need for legislation and policies that address barriers and improve access for evidence-based substance use disorder treatment for individuals from all racial, and socioeconomic backgrounds and of all sexual orientations and gender identities who come in contact with the justice system. Further, any proposed legislation addressing SUD treatment should be evaluated for its potential impact on minority populations.
7. Given the high rates of trauma among the incarcerated population, particularly among women and transgender individuals, substance use disorder treatment programs should ensure that trauma-related disorders are adequately addressed (Wolff, Shi, Siegel 2009).
8. The effects of marijuana criminalization on exacerbating racial/ethnic disparities in arrest, incarceration, and treatment rates for substance use disorder, should be carefully considered, especially in relation to any change in marijuana-related policies and legal practices.

The Council brings the following information items to the Joint Reference Committee:

1. **JRC Referral: Action Paper on Transitional Care Services Post-Psychiatric Hospitalization**
   The Council was asked to review the action paper and address transitional care services post-psychiatric hospitalization for person with substance use disorders and make recommendations as to the inclusion of substance use disorders in the ask. The Council noted that given that individuals with substance use disorders are at an especially high-risk for hospital readmission, the ask should include reducing barriers to accessing treatment post-discharge specifically for this patient population. The Council also highlighted that transitional care clinics based within residency associated health centers allow significant educational opportunities for resident psychiatrists, specifically in the areas of serious mental illness as well as substance use disorders. As training in the management of substance-related and addictive disorders has been disproportionately limited in psychiatric residency training programs, the transitional care clinic model should also allow programs to improve the knowledge, skills, and attitudes of trainees about substance-related disorders emphasizing the importance of access to integrated care among individuals with concurrent mental health and addiction disorders. This feedback was shared with the Council on Advocacy and Government Relations to be included in its June 2018 JRC report.

2. **Creation of a Marijuana Work Group**
   Following an insightful discussion at the Council's May meeting with Nora Volkow, the director of the National Institute on Drug Abuse, the Council found that marijuana warrants member attention to ensure psychiatrists are equipped to deal with rising use among Americans. The work group's initial task will include updating position statements focused on various marijuana-related issues that are due for review this year. The work group will also consider the latest research on marijuana use, what training gaps exist for psychiatry, and weigh in on legislative proposals, when applicable.

3. Update on Tobacco Work Group

The Tobacco Work Group has been working to improve the resources available for members on tobacco use disorder, by gathering resources for a tobacco toolkit for the APA website and developing questions for the Education Department's Pulse Learning Platform. Additionally, the work group has been engaging with the Veterans Administration and will be participating in a Twitter Town Hall focused on the connection between tobacco use and mental health on International No Tobacco Day.

Council on Addiction Psychiatry
Andy Saxon, MD, Chair
May 7, 2018, 9:00 AM – 3:00 PM

Draft Minutes

Council Members: Andrew Saxon, MD; John Renner, MD; Frances Levin, MD; Robert Feder, MD; Smita Das, MD, PhD, MPH; Elie Aoun, MD; Jill Williams, MD; Jeff DeVido, MD; Shelly Greenfield, MD, MPH
Consultants: Hector Colon-Rivera, MD; Ken Stoller, MD
Fellows: Daniella Palermo, MD; Leila Vaez-Azizi, MD; Aldorian Chaney, MD, MPH
Absent: Annette Mathews, MD; Karen Drexler, MD; Oscar Bukstein, MD; Siddarth Puri, MD, MA
APA Administration: Kathy Orellana; Anita Everett

Welcome and introductions (Dr. Andrew Saxon)
Members had no new conflicts to report.

E-prescribing Update (Dr. Alan Axelson)
Dr. Axelson spoke to the group, along a representative from DrFirst on the benefits of the company's software and the ease of its PDMP and e-prescribing integration. DrFirst has been working with the New York state association and is providing the software for free and since then the system has brought about 60% of the state's doctor. The Council was not familiar with the system and pressed the vendor on how DrFirst makes authentication seamless while preventing hacking attacks and reiterated the importance of doctors understanding their limitations by knowing what is not being reported in PDMPs.

President's Update (Dr. Anita Everett)
The Council had a candid conversation with Dr. Everett that focused on how much funding is actually needed to treat the opioid crisis. The Council wants to push for more training for providers, specifically ensuring that psychiatry/medical students should be waivered by the time they graduate. The discussion also touched on the need for integrated care integration to expand treatment of SUD.

Legislative Update (Mike Troubh, APA Department of Government Relations)

- Omnibus overview
    - In March, Congress passed a $1.3 trillion omnibus package that included $1.5 billion in funding for mental health programs and a $3.6 billion set aside in funding for opioid treatment and prevention.
    - NIH saw an increase of $3 billion, including $500 million for a new initiative to research opioid addiction, development of opioid alternatives, pain management, and addiction treatment.
    - The biggest omission in the package is that it did not include funding to stabilize the markets in the Affordable Care Act.
- Legislation related to the opioid crisis
    - Congress is currently reviewing over 120 bills to address the opioid crisis. On the Senate side, the Finance and HELP Committees and on the House side, the Energy & Commerce and the Ways & Means Committees are reviewing proposals, but is still remains unclear

who what could be included in a final package. APA has responded to all four committees on upcoming legislation.
    - The bills are focused on a variety of topics including treatment, prevention, research, workforce, and law enforcement. Legislators would need to find new money or an offset for new projects given that the budget has been set.
    - Members are ambitious to have legislation passed by Memorial Day, but given that they will need bipartisan support and produce a bill with limited costs, that timeline may be unrealistic. The upcoming fall elections are likely motivating members into action and may be influencing discussions on the topic.
    - Proposals of note include:
        - NIH flexibility – both the Senate and House committees have voted to give NIH flexibility to approve non-addictive treatment.
        - Loan repayment for providers of SUD treatment – Congress recognizes the workforce shortage of treating this crisis. A proposed bill in the Senate would set aside $25 million for loan repayment assistance.
        - Expansion of MAT – Both the House and the Senate have proposed bills that would codify the 275-patient cap for waivered providers. The proposals to make permanent the ability for nurse practitioners and physician assistants to prescribe MAT have been eliminated in both chambers.
        - Lifting of the IMD exclusion – the House proposal would lift the IMD exclusion to allow Medicaid to cover residential treatment for SUD.
        - Set telepsychiatry prescribing guidelines – the House proposal would give a one-year deadline for the Attorney General and the DEA to issue final guidelines.
        - 42 CFR Part 2 – Both committees did not pass proposals to align 42 CFR Part 2 with HIPAA and strengthen protections against SUD records being used in criminal or civil proceedings, as this has become a contentious issue.
- Areas of Concern for the Council
    - VA National Centers of Excellence – how can APA engage staff at the VA to ensure that the agency not eliminate funding for this learning?
    - As we move towards more prescribing of MAT, we don't want to see cutting off treatment for other patients with co-occurring conditions.
        - Funding the training of psychiatrists is critical to protecting both SUD/MH care.
        - We can't forget that MH patients often need longer in-patient treatment.
    - Council was supportive of keeping MAT in ER settings.
    - What can APA do on a more systematic level to raise the profile of psychiatry's role in treating the crisis?
    - How are we monitoring that the workforce needs matches where the state money is going to?
    - Should we do more on safe prescription disposal?

Position Statement Review

- Physician Health Services - Dr. Devido will make the appropriate edits based on the Council's conversation.
- Equitable Treatment of Substance Use Disorders Across Racial Lines - Dr. Vaez-Aziz and Dr. Aoun will lead the edits on this position statement to include a broader range of minority patients, narrow the focus, and eliminate the marijuana references.

- Action paper: Transitional Care Services Post Psychiatric Hospitalization - The Council noted that given that individuals with substance use disorders are at an especially high-risk for hospital readmission, the ask should include reducing barriers to accessing treatment post-discharge specifically for this patient population. The Council also highlighted that transitional care clinics based within residency associated health centers allow significant educational opportunities for resident psychiatrists, specifically in the areas of serious mental illness as well as substance use disorders. As training in the management of substance-related and addictive disorders has been disproportionately limited in psychiatric residency training programs, the transitional care clinic model should also allow programs to improve the knowledge, skills, and attitudes of trainees about substance-related disorders emphasizing the importance of access to integrated care among individuals with concurrent mental health and addiction disorders.

NIAAA Update (Dr. George Koob, Director)

Dr. Koob provided an update on the NIAAA's current work. Since the last meeting with the Council, NIAAA has launched its treatment navigator tool and after lots of positive feedback, it is considering modifying the tool for providers. Dr. Koob asked the group about the core elements that would be important for providers to have access too. The audience for this version of the tool will include physicians, psychologists, and nurses as well. The Council provided feedback and offered to continue helping NIAAA work on this module.

NIAAA has also been studying women and their rising alcohol use. Despite underage drinking decreasing, there is an increase in binge drinking among those 18+, especially women. NIAAA is working with a group of sociologists and media stakeholders to understand the cultural shift to binge drinking becoming more acceptable. Dr. Koob also noted that following a new Lancet study, his team has expressed that there is a need for more research on defining what a binge is and what recovery looks like. Dr. Koob seemed particularly interested in what the Council can do to attract a more diverse workforce.

The group raised the following questions:

- Alcohol and PTSD has been studied by NIAAA. What other co-morbidities on radar?
  - Charged a subgroup of NIAAA/NIDA staff to work on the rapid decline of uneducated white men, largely due to obesity, liver disease (at least half due to alcohol), and opioid abuse.
- Women and addiction/binge drinking – we have these converging issues and their connection to sexual assault. Additionally, we know victims of sexual assault, this is a significant driver to alcoholism. How are you talking about this and are you making the connection to breast cancer?
  - Addiction is being highlighted, but we need more basic core information to providers around addiction.
  - This could be helpful to highlight in a navigator tool focused for providers
- Criminalization of binge drinking, especially for women? (e.g. Montana)
  - NIAAA putting more effort on the detection to lead to better outcomes on the intervention.
- Tobacco initiatives – as the funding shrinks across the board, how can you integrate mandated data collection for tobacco data too?

SAMHSA Update (Dr. Ellie McCance-Katz, Assistant Secretary)
Dr. McCance-Katz spoke about the many changes she is making to the SAMHSA since taking her position. She spoke about the new Policy Lab that has been formed, who's priority will be the opioid crisis and the launch of the Interdepartmental Serious Mental Illness Coordinating Committee setting new priorities to treat SMI patients.

Regarding the opioid crisis, she spoke about SAMHSA's most recent survey on BUP waivered providers. The raw data seems to reveal that after getting waivered, many providers do not go on to prescribed and that this is particularly abysmal in FQHCs. Encouragingly, this is not the trend among psychiatrists, but it is still alarming. SAMHSA will share this data with APA as soon as they can consolidate their findings. She spoke about how well the PCSS grants are going and revealed that her office has updated the funding application process for grants for states applying to Cures money. SAMHSA has also been providing TA to governors' offices across the country.

The Council raised concerns on OUD treatment reimbursement and while SAMHSA has no purview in managing reimbursement, they have raised this as an issue for CMS to take up.

NIDA Update (Dr. Nora Volkow, Director)
Dr. Volkow spoke strongly about NIDA's concern around marijuana. As states are moving to legalize the drug, more people are being exposed to it at a younger age and are turning to it for pain management, but we still don't have the full picture on its adverse effects. NIDA is prioritizing studying its impact on young adults and children through its ABCD study. It will also be looking for funding for another study that looks at younger children to try to understand the earliest trajectory of drug.

Regarding opioids, Dr. Volkow told the group that the NIH will be launching Centers of Excellence to help figure out how to manage especially difficult patient cases, especially for those patients with OUD who also need to be treated for pain. This is particularly important given that providers are dealing with severe cases whose intervention/treatment don't yet have evidence. The NIH is also working a vaccine for heroin, fentanyl, and heroin/fentanyl.

Position Statement on Prescription Drug Monitoring Programs

Issue: From 2000 to 2014 nearly half a million persons in the United States died from drug overdoses. Opioids, primarily prescription opioids and heroin, were the main drugs associated with overdose deaths. Natural and semisynthetic opioids including oxycodone and hydrocodone were involved in more overdose deaths than any other opioid type.[1] Prescription Drug Monitoring Programs (PDMPs) are state level public health efforts to improve clinical decision making, reduce controlled substance medication misuse, and identify controlled substance medication diversion. Currently, 49 states have operational PDMPs, each with its unique PDMP rules and regulations. [2] Best practices should be established for PDMPs to improve their use among states and physicians to reduce prescription drug misuse, overdose, and death.[3]

Position:
The American Psychiatric Association believes:

1. Patient care, safety, privacy, and confidentiality must be paramount priorities.
2. The broadest implementation of PDMPs will be the most effective.
3. PDMPs should include medications prescribed and/or dispensed by substance use disorder treatment programs if the health information remains protected and confidential. PDMPs should also include a notice stating the drugs excluded from the program (such as methadone dispensed from a licensed opioid treatment program), so prescribers can better understand the limitations of the data collected.
4. PDMPs should be administered by departments of health or boards of pharmacy not law enforcement or professional licensing agencies.
5. All providers with prescriptive authority should be automatically registered with their state PDMP as part of state licensure.
6. PDMPs should be mandatory for all providers to query before prescribing controlled substances. The frequency of access and sanctions for lack of access should be determined in consultation with practicing providers to avoid onerous requirements that may not result in improved patient care or disincentives for providing quality care.
7. PDMPs should permit database access to physician-supervised delegates.
8. PDMPs should permit unsolicited notifications to providers and pharmacies regarding patients who may be obtaining controlled substances inconsistent with generally accepted standards of care.
9. PDMPs should permit release of de-identified database information to public health agencies.

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[1] Center for Disease Control and Prevention. Morbidity and Mortality Weekly Report (January 1, 2016). Increases in Drug and Opioid Overdose Deaths – United States, 2000-2014. 2015/64(50);1378-82. Retrieved on Nov 18, 2016 from http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6450a3.htm.
[2] Prescription Drug Monitoring Program Center of Excellence. (2014). Briefing on PDMP Effectiveness. Heller School for Social Policy and Management, Brandeis University. Waltham, MA. Retrieved on Sept 1, 2015 from http://www.pdmpexcellence.org/sites/all/pdfs/Briefing%20on%20PDMP%20Effectiveness%203rd%20revision.pdf
[3] American Medical Association. Opioid abuse is a public health crisis. Is your state's prescription drug monitoring program up to par? The AMA Task Force to Reduce Opioid Abuse. Retrieved Sept 1, 2015 from https://download.ama-assn.org/resources/doc/washington/15-0398-opioid-one-lawmaker.pdf.

10. PDMP data with protected health information should only be released to entities for purposes other than direct patient care (e.g. law enforcement, social services, and insurers) by court order.
11. PDMPs do not replace the necessity of evaluating and treating substance use disorders.

Authors:
The Council on Addiction Psychiatry

Adoption Date:

Background:

A Prescription Drug Monitoring Program (PDMP) is a centralized database of prescribed and dispensed medications. PDMPs are state level public health efforts to improve clinical decision making, reduce controlled substance medication misuse, and identify controlled substance medication diversion.[1] Currently, 49 states have operational PDMPs.[1]

Each state has unique PDMP rules and regulations. For example, some states require every physician to register with the state PDMP. Other states do not. As another example, some states require a physician to review the PDMP prior to prescribing any federal schedule II medication. One state requires a physician to review the PDMP only if a patient is suspected of seeking a controlled substance medication for "any reason other than the treatment of an existing medical condition."[2]

Each state determines which state agency administers their PDMP. Twenty (20) boards of pharmacy, thirteen (13) departments of health, seven (7) law enforcement agencies, six (6) professional licensing boards, three (3) substance related agencies, and one (1) consumer protection agency administer PDMPs.[3]

PDMP utilization is not without controversy. PDMP data are confidential and not subject to public disclosure. But, eight states permit the forwarding of unsolicited data to law enforcement, seven states permit the forwarding of unsolicited data to licensing boards, and 20 states permit data access by law enforcement during an active investigation[3]

PDMP utilization is not without risk. Federal privacy laws prohibit the disclosure of patient identifying information of patients in opioid treatment programs (OTPs). Federal law 42CFR § 2.20 prohibits the disclosure of information regarding patients being dispensed methadone or buprenorphine by an OTP.[4] In some state jurisdictions, state privacy laws may prohibit the disclosure of protected health information and conflict with the rules and regulations of PDMPs.

From 2000 to 2014 nearly half a million persons in the United States died from drug overdoses. Opioids, primarily prescription opioids and heroin, were the main drugs associated with overdose deaths. Natural and semisynthetic opioids including oxycodone and hydrocodone were involved in more overdose deaths than any other opioid type.[5]

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 PDMPs to reduce prescription drug misuse, overdose, and death.[6]

References

1. Prescription Drug Monitoring Program Center of Excellence. (2014). Briefing on PDMP Effectiveness. Heller School for Social Policy and Management, Brandeis University. Waltham, MA. Retrieved on Sept 1, 2015 from http://www.pdmpexcellence.org/sites/all/pdfs/Briefing%20on%20PDMP%20Effectiveness%203rd%20revision.pdf.

2. Prescription Drug Monitoring Program Center of Excellence. (2014). Mandating PDMP participation by medical providers: current status and experience in selected states. Heller School for Social Policy and Management, Brandeis University. Waltham, MA. Retrieved on Sept 3, 2015 from http://www.pdmpexcellence.org/sites/all/pdfs/COE_briefing_mandates_2nd_rev.pdf.

3. Technical Assistance Guide. (2015). Implementing Best Practices: A Comparison of PDMP Changes 2010 to 2014. Prescription Drug Monitoring Program Training and Technical Assistance Center. Heller School for Social Policy and Management, Brandeis University. Waltham, MA. Retrieved on Oct 7, 2016 from http://www.pdmpassist.org/pdf/state_survey_comparisons_TAG_FINAL_20151222.pdf.

4. SAMHSA letter (2011). PMP Center of Excellence Notes from the Field, "Keeping Patients Safe: A Case Study on Using Prescription Monitoring Program Data in an Outpatient Addictions Treatment Setting." Heller School for Social Policy and Management, Brandeis University. Waltham, MA. Retrieved on Oct 7, 2016 from http://www.samhsa.gov/sites/default/files/programs_campaigns/medication_assisted/dear_colleague_letters/2011-colleague-letter-state-prescription-drug-monitoring-programs.pdf

5. Center for Disease Control and Prevention. Morbidity and Mortality Weekly Report (January 1, 2016). Increases in Drug and Opioid Overdose Deaths – United States, 2000-2014. 2015/64(50);1378-82. Retrieved on Nov 18, 2016 from http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6450a3.htm

6. American Medical Association. Opioid abuse is a public health crisis. Is your state's prescription drug monitoring program up to par? The AMA Task Force to Reduce Opioid Abuse. Retrieved Sept 1, 2015 from https://download.ama-assn.org/resources/doc/washington/15-0398-opioid-one-lawmaker.pdf.

APA Official Actions

Position Statement on Physician Health Programs in the Treatment of Addiction and Substance Use Disorders in Physicians

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

"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:

Data suggest that 10-12% of physicians develop a substance use disorder, and certain substance use disorders may actually be more common among physicians than in the general population.[1][2] In addition, physicians with substance use disorders may pose unique concerns to the public by virtue of their position as care providers. Unfortunately, compared with the general public, physicians with addictive disorders tend to enter treatment later in the course of their illness, and they may go to great lengths to conceal their illness on account of perceived negative professional consequences for seeking treatment.[3]

Encouragingly, data also suggest that relative to non-physicians, physicians may have higher rates of abstinence once engaged in formal substance use treatment programming (75% 5-year abstinence rates).[4][5] For many physicians, the entry point into substance use disorder treatment is a state-specific Physician Health Program (PHP). PHPs are peer-based monitoring, evaluation and treatment-referral centers that are often governed by state laws and administered by collaborations between state medical societies, malpractice carriers, and/or state medical boards. Notably, significant differences still exist between individual state PHPs in terms of referral processes, treatments offered, costs to physicians, second opinion processes, licensing board mandates and ongoing monitoring requirements.

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[1] Oreskovich, MR, Kaups KL, Balch CM, Hanks JB, Satele D, Sloan J, Meredith C, Buhl A, Dyrbye LN, Shanafelt TD. Prevalence of alcohol use disorders among American surgeons. Arch Surg, 2012. 147(2): p. 168-74.
[2] Cottler LB, Ajinkya S, Merlo LJ, Nixon SJ, Ben Abdallah A, Gold MS. Lifetime psychiatric and substance use disorders among impaired physicians in a physicians health program: comparison to a general treatment population: psychopathology of impaired physicians. J Addic Med. 2013 Mar-Apr;7[2]:108-12.
[3] Hughes PH, Brandenberg N, Baldwin DC Jr, Storr CL, William KM, Anthony JC, Sheehan DV. Prevalence of substance use among US Physicians. JAMA, 1992. 267(17): p. 2333-9.
[4] vi McLellan AT, Skipper GS, Campbell M, DuPont RI. Five year outcomes in a cohort study of physicians treated for substance use disorders in the United States. BMJ 2008;337:a2038.
[5] Merlo LJ, Campbell MD, Skipper GE, Shea CL, DuPont RL. Outcomes for Physicians with opioid dependence treated without agonist pharmacotherapy in physician health programs. J Subst Abuse Treat. 2016 May;64:47-54.

Position:

The American Psychiatric Association (APA) recognizes that substance use disorders (SUDs) occur in physician populations and that these disorders can have significant impact on the physician themselves (increased risk of suicide, medical complications), their families and community, and the public. APA recognizes that physicians can benefit from access to evidence-based treatment for SUDs, including state-specific Physician Health Programs (PHP). APA commits to support and collaborate with physicians, communities, healthcare organizations, PHPs, and other relevant stakeholders in efforts to decrease stigma around SUDs by ensuring that physicians and allied healthcare providers are educated about the importance of understanding the unique risks and challenges posed by SUDs in physician populations. Furthermore, APA commits to supporting efforts to provide and standardize confidential, affordable, equitable access to evidence-based treatments for SUDs as provided through PHPs, as well as support efforts to further research the antecedents and prevention of, and the unique treatment needs of, physicians with SUDs. APA is committed to the goal of rehabilitation of physicians with SUDs in a non-disciplinary, non-discriminatory, peer-based therapeutic program environment, while also recognizing the importance of uncompromised patient care by physicians in PHPs who themselves have SUDs.

Authors:

Jeffrey DeVido, M.D., Marek Hirsch, M.D., Matthew Goldenberg, D.O., Frances Levin, M.D.

Adoption Date:

Resource Document on Physician Health Programs in the Treatment of Substance Use Disorders in Physicians

In 1974, the American Medical Association (AMA) acknowledged physician impairment from alcoholism and drug dependence occurs, and recognized alcoholism and addiction as illnesses. Physician illness and impairment exist on a continuum with illness typically predating impairment, often by many years. This is a critically important distinction. Illness is the existence of a disease. Impairment is a functional classification and implies the inability of the person affected by disease to perform specific activities.

The treatment of physicians and other licensed healthcare professionals occurs with the knowledge that substance use disorders, mental health conditions, or other medical diseases and other potentially impairing conditions can be chronic, relapsing disorders; and without appropriate treatment and ongoing support, individual health and public safety may be at risk.

With this in mind and with the advice and consent of the AMA and the Federation of State Medical Boards (FSMB), plans were launched for the development of therapeutic alternatives in lieu of automatic discipline of physicians who needed assistance. By 1980, many state licensing boards and state laws supported the establishment of state-based Physicians Health Programs (PHPs). In 1985, the AMA published its Model Impaired Physician Treatment Act, and in the 1990s the FSMB had also issued its own model guidelines. Currently, 46 States, in addition to Washington D.C., have PHPs. The States not listed include California, Delaware, Wisconsin and Nebraska (although in 2016 the Governor of California signed legislation reinstituting their PHP).

PHPs are a confidential resource for physicians, other licensed healthcare professionals, or those in training suffering from addictive, psychiatric, medical, behavioral or other potentially impairing conditions. PHPs coordinate effective detection, evaluation, treatment, and continuing care monitoring of physicians with these conditions. This coordination and documentation of a participant's progress allows PHPs to provide documentation verifying a participant's compliance with treatment and/or continuing care recommendations. In 1990 the professional, educational and nonprofit corporation Federation of State Physician Health Programs (FSPHP) was established to provide consistent and objective guidance and advocacy for state PHPs and currently has a membership of 47 state PHPs.

Recommendations:

1. The diagnosis and treatment of substance use disorders is an essential part of medical and psychiatric care of physicians. Physician

patients with identified substance use disorders must be educated about the condition and offered or referred for appropriate treatment. Physician patients should be educated about the presence and value of evaluation and treatment referrals offered through PHPs.

2. Psychiatrists and other involved healthcare providers should screen for substance use and co-occurring psychiatric disorders in physicians and encourage the development of integrated treatment strategies.

3. Careful attention must be given to evaluating psychosocial stressors that may contribute to increased risk of substance use disorder in physicians (e.g., retirement, financial stressors, loneliness, medical problems, etc.).

4. Physicians must recognize that colleagues may be more vulnerable to developing substance use disorders due to their professional proximity to often misused substances (opioids, sedatives) and the unique stresses incumbent upon physicians by virtue of being care providers. Assessment of these risk factors should be considered routinely in management of physician patients, particularly when considering prescribing controlled substances or when managing substance use disorders.

5. The goal of a PHP should be the rehabilitation of physicians with substance use disorders in a non-disciplinary, non-discriminatory, peer-based therapeutic program environment. The care provided should be confidential, evidence-based, and provided by well-trained and competent clinicians, appropriate to the level of impairment.

6. PHP participant fees should be fair and equitable with full disclosure at intake.

7. PHP enrollment may be mandated by a medical board, physician employer, or voluntary. Efforts to destigmatize substance use disorders and their treatment in physicians should be supported to increase voluntary participation in PHPs.

8. When referring physicians, PHPs must have a comprehensive range of available substance use services, including medication assisted treatment, evidence-based psychotherapies for addictions (e.g., motivational enhancement, relapse prevention, cognitive behavioral therapy, twelve step facilitation, group based treatments), self-help groups (e.g., alcoholics anonymous, narcotics anonymous, SMART), medical detoxification, intensive outpatient and partial hospitalization programming and residential treatment—all based on well-established clinical referral parameters (e.g., The American Society of Addiction Medicine Placement Criteria, SAMHSA Tip 45: Detoxification and Substance Abuse Treatment). Referrals should not be onerous and should be in accord with standard clinical practice guidelines, such as VA/DoD Clinical Practice Guidelines: Management of Substance Use Disorders.[1] Recommendations regarding unique physician-specific needs in substance use treatment should continually be adjusted in light of an ever-evolving evidence-base. Treatment should not be influenced by the perceived or actual financial status of the referred physician. Because of the potential for conflicts of interest, a mechanism for routine transparent either internal or external auditing or review of the relationship between state PHPs and the treatment programs they recommend should be established. Programs should also provide concurrent assessment and treatment referrals for co-occurring psychiatric disorders.

9. The full range of evidenced-based medication assisted treatment options for substance disorders should be incorporated into evaluation and treatment planning. (Including, but not limited to, consideration of (and ability to prescribe or refer for) buprenorphine, methadone, naltrexone, acamprosate, disulfiram, nicotine agonists, varenicline, and bupropion.)

10. Treatment referral processes should be transparent to the physician client, and a formal second opinion

[1] See: http://www.healthquality.va.gov/guidelines/MH/sud/

process should be available.

11. Cognizant of the need to preserve the integrity of the profession and protect public safety (including those patients being treated by physicians who are receiving treatment through a PHP), appropriately confidential and intensive mechanisms for monitoring of physician enrollees in PHPs is imperative, with well described and transparent processes for determining the need for professional sanction should concerns about a physician's clinical status arise.

12. Training at the level of medical school, residency and fellowship must be provided to develop competency in the diagnosis, treatment, and prevention of substance use disorders in physicians.

13. More research is needed on the unique evaluation and treatment needs of physicians with substance use disorders and co-occurring psychiatric disorders, as well as research to better identify those antecedents that may predispose a physician to developing a substance use disorder in the first place.

14. Individual physician training program Graduate Medical Education (GME) offices should avail themselves of collaboration with local state PHPs to ensure effective, equitable and evidenced-based treatment of physicians-in-training with SUDs or mental health concerns.

15. Public policy efforts should help:

- Reduce the stigma of substance use disorders and substance use disorder treatment, to best optimize voluntary participation in PHPs;
- PHPs develop formal discussions and ultimately guidelines for addressing possible financial or other real or perceived conflicts of interest between the various stakeholders involved;
- Reduce legal, contractual, or regulatory requirements that impede state PHPs from implementing all FSPHP guidelines;
- Facilitate insurance coverage of PHP services;
- Streamline referral processes for enrolling physicians in PHPs, as well as standardize evaluation/treatment/appeals processes within PHPs;
- Ensure confidentiality and appropriate monitoring parameters for physicians enrolled in PHPs, with procedures and processes for managing those whose clinical status poses concerns for their ability to execute the duties of their profession, or threatens the integrity of the profession;
- Educate medical students, residents, fellows, and physicians regarding the occurrence of substance use disorders among physicians and the avenues for engaging in effective, confidential, evidence-based treatments through PHPs;
- Inform and develop effective strategies for educating the public regarding the presence of PHPs and their functioning, acknowledging the complexity of on one hand advocating for the work done in PHPs, and on the other hand managing concerns about public safety (including those patients being treated by physicians who are receiving treatment through a PHP)

Position Statement on Addressing Health Disparities in Substance Use Disorder Treatment in the Justice System~~on the Equitable Treatment of Substance Use Disorders Across Racial Lines~~

Issue:

In the United States, substance use and substance use disorders are equally prevalent across racial lines[1] and are more common in gender and sexual minorities[1*]; however, ~~blacks and Latinos~~minority groups are prosecuted and incarcerated for substance use at ~~phenomenally~~ higher rates than their ~~white~~ majority counterparts,[2, 3~~3~~] who have access to more effective legal representation and are more likely to be offered drug court or drug treatment in lieu of incarceration.[3, 4] This discrepancy in treatment as well as legal consequences does not match the demographics of drug use, drug dealing and drug related crimes.~~exists despite evidence that the majority of illegal drug users and dealers are white,[5] white youth are ⅓ times more likely to have sold illegal drugs,[6] and whites have three times as many drug-related emergency department visits.[7]~~ ~~Increased levels of imprisonment~~~~Criminal justice~~ Justice involvement leads to difficulties in~~y~~ obtaining housing, ~~difficulty obtaining~~ social services, ~~discrimination from~~ employment, and higher rates of criminal recidivism.[8] While substance use disorders (SUDs) are overrepresented among the ~~inmate~~incarcerated population, SUD treatment in U.S. correctional facilities is scant and frequently not evidence-based, further exacerbating treatment disparities (Compton 2010, Wakeman 2015).

~~Furthermore, restricting~~Restricting access to ~~appropriate~~ appropriate, evidence-based SUD ~~substance use~~ treatment both within and outside of the criminal justice system leads to higher rates of relapse, lost productivity, crime, and other adverse health outcomes including overdose

[1] Hedden, S. L., Kennet, J., Lipari, R., Medley, G., Tice, P., Copello, E., & Kroutil, L. (n.d.). Behavioral health trends in the United States: results from the 2014 National Survey on Drug Use and Health (pp. 1-37) (USA, Department of Health and Human Services).

[1*] Medley, G., Lipari, R. N., Bose, J., Cribb, D. S., Kroutil, L. A., & McHenry, G. (2016, October). Sexual orientation and estimates of adult substance use and mental health: Results from the 2015 National Survey on Drug Use and Health. NSDUH Data Review.

[2] Human Rights Watch, *Punishment and Prejudice: Racial Disparities in the War on Drugs*, HRW Reports, vol. 12, no. 2 (May 2000)

[3] Csete, J., Cohen, J. Health Benefits of Legal Services for Criminalized Populations: The Case of People Who Use Drugs, Sex Workers and Sexual and Gender Minorities. J Law Med Ethics. 2010 Winter;38(4):816-31.

~~[3] Human Rights Watch, *Punishment and Prejudice: Racial Disparities in the War on Drugs*, HRW Reports, vol. 12, no. 2 (May 2000)~~

[4] Marc Mauer, *Race to Incarcerate,* rev. ed. (New York: The New Press, 2006).

[5] Alexander, M. (2012). The New Jim Crow: Mass Incarceration in the Age of Colorblindness. New York, NY: New Press.

[6] U.S. Department of Health, *National Household Survey on Drug Abuse*, *1999* (Washington, DC: Substance Abuse and Mental Health Services Administration, Office of Applied Studies, 2000), table G, p. 71, www.samhsa.gov/statistics/statistics.html

[7] Bruce Western, *Punishment and Inequality* (New York: Russel Sage Foundation, 2006), 47.

[8] Alexander, M. (2012). The New Jim Crow: Mass Incarceration in the Age of Colorblindness. New York, NY: New Press.

Commented [EA1]: I would suggest expanding the PS to include all minority groups, based on race, ethnicity as well as gender and sexual identity. Also, we are talking mostly about the CJS, but there is an argument to be made that SUD treatment is provided inequitably both on the CJS and in the private and public sector as well, so I would advocate to keep the PS more general I would suggest an alternative title such as:
Position statement on addressing disparities in SUD treatment for minority populations.

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and death.[9] Completion of treatment allows for better health, fewer rela__pses, fewer readmissions, ~~less future criminal involvement,~~reduced criminal recidivism, improved employment, and longer term abstinence.[10] Despite the ~~multitude of positive effects~~ many individual and societal benefits of providing ~~substance use~~SUD treatment, ~~racial~~ disparities persist in the available resources for treatment, referral to treatment, treatment completion, and quality of treatment. Offering ~~substance use~~SUD treatment as ~~the primary response~~ an alternative to incarceration for ~~to~~ ~~a~~ non-violent drug related crimes, as well as allocating public funding for substance use treatment, can help mitigate the effects of ~~racial~~ disparia~~a~~ties ~~discrimination~~ in the criminal justice system, alongside the positive benefits from successful societal re-entry.

Position:

It is the position of t~~T~~he American Psychiatric Association that:

1. All persons should have similar access to all forms of evidence-~~-~~based treatments for substance use disorder, regardless of minority status.

2. Institutions providing treatments for substance use disorders need to take an active role in ensuring that, among their patients, persons belonging to minority groups receive the same treatments as those who do not. As such, the same treatment option should be used with the same frequency across different racial, ethnic and gender groups. Institutional policies should be developed to monitor the application of this principle on a regular basis.~~Advocates that racial minorities should be offered substance use treatment in an equitable fashion and that efforts should be made to address barriers that lead to lower uptake of substance use disorder treatment among racial/ethnic minorities.~~
~~1.~~

3. Diversion to treatment in lieu of incarceration should be offered, whenever legally appropriate for all individuals charged with non-violent drug offenses

4. Efforts should be made to ensure that minority populations have access to diversion programs in order to safeguard the equitable distribution of the benefits of such

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[9] Position Statement on Treatment of Substance Use Disorders in the Criminal Justice System
[10]Mennis, J., & Stahler, G. J. (2016). Racial and Ethnic Disparities in Outpatient Substance Use Disorder Treatment Episode Completion for Different Substances. Journal of Substance Abuse Treatment, 63, 25-33.

10. WILSON M. COMPTON, DEBORAH DAWSON, SARAH Q. DUFFY, BRIDGET F. GRANT. The Effect of Inmate Populations on Estimates of DSM-IV Alcohol and Drug Use Disorders in the United States, American Journal of Psychiatry 2010: 167: 473-474.

11. Sarah E. Wakeman & Josiah D. Rich (2015) Addiction Treatment Within U.S. Correctional Facilities: Bridging the Gap Between Current Practice and Evidence-Based Care, Journal of Addictive Diseases, 34:2-3, 220-225

~~1. WILSON M. COMPTON, DEBORAH DAWSON, SARAH Q. DUFFY, BRIDGET F. GRANT. The Effect of Inmate Populations on Estimates of DSM-IV Alcohol and Drug Use Disorders in the United States, American Journal of Psychiatry 2010: 167: 473-474.~~

programs.~~Believes that individuals charged with a non-violent drug related offense, regardless of race, should be offered evidence-based substance use disorder treatment as a primary response.as an alternative to incarceration.~~

~~2.~~

5. Access to evidence--based treatments for substance use disorders, including the use of all medications approved for the treatment of addictive disorders should become available in correctional settings and used whenever clinically appropriate, equitably among all incarcerated individuals.

~~Advocates that racial minorities should be offered substance use treatment in an equitable fashion and that efforts should be made to address barriers that lead to lower uptake of substance use disorder treatment among racial/ethnic minorities.~~

~~3. Advocates that all individuals who are currently in treatment for a substance use disorder in the community (e.g., on methadon or buprenorphine for an opioid use disorder), should be evaluated for continued medical and SUD treatment, and continued on medication while they are incarcerated, wherever possible.~~

6. ~~Supports~~ There is a ~~-~~need for l~~l~~egislation and policies that address barriers and improve access for evidence-based substance use disorder treatment for individuals from all racial, ~~-~~and socioeconomic backgrounds and of all sexual orientations and gender identities who come in contact with the justice system. Further, any proposed legislation addressing SUD treatment should be evaluated for its potential ~~, including access to methadone and buprenorphine, for people from all racial and socioeconomic backgrounds~~and which consider how any proposed legislation is likely to impact on minority populations.~~racial/ethnic disparities in SUD treatment.~~
7. Given the high rates of trauma among the incarcerated population, particularly among women and transgender individuals, substance use disorder treatment programs should ensure that trauma-related disorders are adequately addressed.

8. The effects of marijuana criminalization on exacerbating racial/ethnic disparities in arrest, incarceration, and treatment rates for substance use disorder, should be carefully considered, especially in relation to any change in marijuana-related policies and legal practices.

Commented [EA2]: I suggest dividing the first position in two. This way, we advocate for treatment in lieu of punishment for all, as a means of limiting the impact of the criminalization of drugs, and the second point focuses on the disparate allocation of resources for minority groups

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Background Information

Beginning with the Harrison Act of 1914, leading into the War on Drugs ~~in~~ launched in 1971, the laws and policies regulating drug use in the United States have disparately impacted minority populations. ~~In 1971~~82, ~~President Nixon launched the War on Drugs, which was later revitalized under~~ President Reagan ~~in the 1980s, and which has led to the United States to have the highest incarceration rate in the world along with enormous racial inequities.~~ ~~announced his administration's War on Drugs; l~~In 1985, after crack cocaine emerged as a cheaper alternative to powder cocaine, leading to increased crack use by the poor, t~~.~~ The Anti-Drug Abuse Act passed in~~of~~ 1986. It led to a framework for mandatory minimum sentences in which one gram of crack cocaine was legally considered to be the equivalent of one hundred grams of powder cocaine~~,~~ and expanded the use of the death penalty for serious drug related offenses.[11] Those convicted of drug related offenses were further marginalized by the Personal Responsibility and Work Opportunity Reconciliation Act which created Temporary Assistance to Needy Families (TANF). This legislation ~~which~~ placed a lifetime ban on eligibility for welfare and food stamps for anyone convicted of a felony drug offense, leaving many impoverished individuals with substance use disorders with even fewer sources of income and social supports.

~~Two thirds of crack users are white or Hispanic, yet in 1994, 84.5% of those convicted of crack possession were black. Bill Clinton signed the Personal Responsibility and Work Opportunity Reconciliation Act which created Temporary Assistance to Needy Families (TANF) which placed a lifetime ban on eligibility for welfare and food stamps for anyone convicted of a felony drug offense, rendering many impoverished individuals with substance use disorders with even fewer sources of income and social supports. .~~

~~This information sets the stage~~These legislative changes set the stage for the ~~incredible~~ destructive impact the War on Drugs has had upon black communities. Human Rights Watch reported in 2000 that in seven states blacks constituted 80 to 90 percent of all drug offenders sent to prison; in fifteen states, blacks are admitted to prison on drug charges at a rate from twenty to fifty seven times greater than that of white men. This is despite government data that has demonstrated blacks were no more likely to be guilty of drug crimes than whites. In fact, data has demonstrated that white youth, aged 12-17, are ⅓ times more likely to have sold illegal drugs, and whites are three times more likely to visit the emergency department related to drug use. Yet, black men have been admitted to state prison on drug charges at a rate that is more than thirteen times higher than white men.

The racial bias, if not inherent in the grossly disproportionate numbers presented above, is evident in multiple studies examining approaches and beliefs regarding drug use. In 1995, a survey examined participant's notions of the "drug user;" 95% of respondents pictured ~~-~~a black drug user, in stark contrast to the reality of blacks constituting only 15% of total drug users in 1995. In 2002, a study conducted by the University of Washington found that high arrest rates of blacks was related to the police department's focus on crack, a drug more likely to be sold by

[11] Provine, Unequal Under Law: Race in the War on Drugs

blacks, and on outdoor drug markets that targeted black neighborhoods. These findings suggest a societal construction of drug use as a "black" problem with greater levels of policing in minority communities, despite data suggesting showing thatotherwise. drug use prevalence is equal across racial lines.

This is made particularly clear by the following figures: 98.4% of those serving a life sentence under the "two strikes and you're out" sentencing scheme in Georgia were black. This provision allowed for life imprisonment after a second drug offense; this provision was invoked for 16% of black defendants, but only for 1% of white defendants. In Florida, 1,000 highway stops by state troopers captured on video found more than 80% of the people stopped and searched were minorities, despite African Americans or Latinos constituting only 5% of drivers. In Illinois, Latinos comprised 30% of motorists stopped by drug officers, despite making fewer than 3% of personal vehicle trips.

This These data, alongside the differential treatment of whites for alcohol use related behaviors, including drunk driving, suggest a clear pattern ofillustrates a pattern of racial discrimination in reference to substance useunequal application of law enforcement related to substance use disorders, and the rippling significant deleterious effects of discrimination of racial discrimination in arrest rates, including imprisonment, fewer including the imprisonment and marginalization of blacks across the country.

Beyond the racial discrimination demonstrated within the criminal justice system, racial disparities exist across multiple domains of substance use treatment. Evidence demonstrates that engagement in substance use treatment is associated with improved substance use, employment, and criminal justice outcomes,[12] and completion of treatment leads to better health, fewer relapses, fewer readmissions, less future criminal involvement, higher levels of employment and wages, and longer term abstinence.[13] Given these findings, the data on racial disparities across domains of substance use treatment are appalling.

Blacks and Latinos are significantly less likely than whites to receive substance use treatment in the context of a criminal history; this disparity compounds further when controlling for socioeconomic status.[14] Substance use treatment for youth is incredibly important, and has been found to significantly lower likelihood of future substance use, yet black adolescents

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[12] Acevedo, A., Garnick, D., Dunigan, R., Horgan, C., Ritter, G., Lee, M., . . . Wright, D. (2015). Performance Measures and Racial/Ethnic Disparities in the Treatment of Substance Use Disorders. Journal of Studies on Alcohol and Drugs, 76, 57-67.

[13] Mennis, J., & Stahler, G. J. (2016). Racial and Ethnic Disparities in Outpatient Substance Use Disorder Treatment Episode Completion for Different Substances. Journal of Substance Abuse Treatment, 63, 25-33.

[14] Cook, B. L., & Alegría, M. (2011). Racial-Ethnic Disparities in Substance Abuse Treatment: The Role of Criminal History and Socioeconomic Status. Psychiatric Services, 62(11), 1273-1281.

receive less specialty care for substance use than their white counterparts.[15] Blacks and Latinos experience significant disparities in ~~diversion to treatment~~diversion to drug courts and SUD treatment as an alternative to incarceration.[16] Despite attempts to minimize the role of race in ~~substance use~~SUD treatment referral, through standardizing measures such as Proposition 36 in California, blacks with criminal histories continue to remain less likely to receive referral to treatment from court than their white counterparts.[17]

~~In addition to the disparities in the reception of substance use treatment, disparities persist in the completion of treatment once engaged. Blacks are significantly less likely to complete an episode of treatment than their white counterparts, a disparity that persists across substances.[18] This is particularly important as differing substances have differing levels of treatment completion, yet blacks remain significantly less likely to complete treatment regardless of substance. These disparities in completion rates persist, frequently but not universally, across state lines.[19]~~

~~In the context of the more recent opioid epidemic, racial disparities in the context of access to appropriate pharmacological treatment highlight disparities in access. The Drug Addiction Treatment Act of 2000 did not improve access to methadone while simultaneously restricting access to buprenorphine through a variety of bureaucratic measures; these intentional measures have inhibited minorities from receiving equal access to opiate substitution treatments.[20] Data also suggests despite the utility of substance use treatment, blacks still remain more likely to be rearrested.[21]~~

The ~~etiology of these detrimental disparities is unclear, and~~presence of these well-documented health inequities for individuals who are justice system-involved demands addressing legal structures that may exacerbate disparities (e.g., racial/ethnic differences in rates of diversion to drug courts), as well as improving ~~access, referral, and completion of substance use treatment across racial lines,~~access to substance use disorder treatment and

[15]Alegria, M., Carson, N. J., Goncalves, M., & Keefe, K. (2011). Disparities in Treatment for Substance Use Disorders and Co-Occurring Disorders for Ethnic/Racial Minority Youth. Journal of the American Academy of Child & Adolescent Psychiatry, 50(1), 22-31.

[16] Nicosia, N., Macdonald, J. M., & Arkes, J. (2013). Disparities in Criminal Court Referrals to Drug Treatment and Prison for Minority Men. American Journal of Public Health, 103(6).

[17]Macdonald, J., Arkes, J., Nicosia, N., & Pacula, R. L. (2014). Decomposing Racial Disparities in Prison and Drug Treatment Commitments for Criminal Offenders in California. The Journal of Legal Studies, 43(1), 155-187.

~~[18]Mennis, J., & Stahler, G. J. (2016). Racial and Ethnic Disparities in Outpatient Substance Use Disorder Treatment Episode Completion for Different Substances. Journal of Substance Abuse Treatment, 63, 25-33.~~

~~[19] Arndt, S., Acion, L., & White, K. (2013). How the states stack up: Disparities in substance abuse outpatient treatment completion rates for minorities. Drug and Alcohol Dependence, 132(3), 547-554.~~

~~[20] Netherland, J., & Hansen, H. (2017). White opioids: Pharmaceutical race and the war on drugs that wasn't. BioSocieties, 12(2), 217-238.~~

~~[21]Acevedo, A., Garnick, D., Dunigan, R., Horgan, C., Ritter, G., Lee, M., . . . Wright, D. (2015). Performance Measures and Racial/Ethnic Disparities in the Treatment of Substance Use Disorders. Journal of Studies on Alcohol and Drugs, 76, 57-67.~~

addressing barriers to treatment entry. ~~as well as the funding of A~~additional research is clearly needed to understand and adequately address the~~and investigation into the possible racial component~~ drivers of health disparities in SUD treatment for individuals who are justice system involved. ~~driving these findings.~~

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COUNCIL ON ADVOCACY AND GOVERNMENT RELATIONS

EXECUTIVE SUMMARY:
The Council on Advocacy and Government Relations (CAGR) met Monday, May 7, during the American Psychiatric Association's Annual Meeting in New York, NY. The Council received updates from the APA Administration on major federal and state legislative activity, discussed JRC directives for the Council, APA partnership and collaborative efforts, and received an update from the APA*PAC*.

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The Council discussed several key issues including:

- Congressional Response to Nationwide Opioid Epidemic
- Broadening Efforts to Address State Scope of Practice
- Council Advocacy Work Products
- APA Federal and State Legislative Priorities
- Increasing APA Membership Participation in Grassroots Advocacy

The approved minutes from March 18 conference call **(Attachment #1)**, approved minutes from April 24 conference call **(Attachment #2)**, and draft minutes from the Annual Meeting **(Attachment #3)** are attached.

The Council brings the following action items to the Joint Reference Committee:

1. **JRC REFERRAL: Action Paper on Designation of Psychiatry as Primary Care for Any Medical School Scholarships Requiring Primary Care Service**
   As directed by the JRC, The Council on Advocacy and Government Relations discussed at length the Action Paper on the Designation of Psychiatry as Primary Care for Any Medical School Scholarships Requiring Primary Care Service. Both the Council and the Council on Medical Education and Lifelong Learning support the premise of the Action Paper to designate psychiatry as primary care for primary care medical school scholarships. It was noted that National Health Service Corps currently encompasses general psychiatry in Medical Primary Care for eligibility to apply to the NHSC Loan Repayment Program. The Council recommends that the Action Paper be amended by the authors to incorporate language reflecting: (1) inclusion of primary care subspecialties; and (2) additional incentives for psychiatrists to practice in rural areas. The proposed language will provide opportunities for additional subspecialties to participate in scholarship programs, thus positively impacting the psychiatric physician workforce. Taking into consideration the recommendations, the Council voted to not support advancing the action paper as written.

   ACTION: Will the Joint Reference Committee accept the Council on Advocacy and Government Relations' recommendation to not advance the Action Paper on "Designation of Psychiatry as Primary Care for Any Medical School Scholarships Requiring Primary Care Service"?

2. **JRC REFERRAL: Action Paper on Medical School Loan Repayment Subsidies for Psychiatrists Practicing in Community Mental Health Centers and State Psychiatric Facilities**

As directed by the JRC, the Council on Advocacy and Government Relations discussed the Action Paper on Medical School Loan Repayment Subsidies for Psychiatrists Practicing in Community Mental Health Centers and State Psychiatric Facilities. Both the Council and the Council on Medical Education and Lifelong Learning support the resolution of the Action Paper. As an added option for providing access to underserved communities, the Council recommends that the Action Paper be amended by the authors to incorporate the practice of telemedicine. This incentive can be used as a recruiting tool for urban participation, such that individuals serving rural populations by telepsychiatry could be included in loan forgiveness programs. Taking into consideration the recommendations, the Council voted to not support advancing the action paper as written.

ACTION: Will the Joint Reference Committee accept the Council on Advocacy and Government Relations' recommendation to not advance the Action Paper on "Medical School Loan Repayment Subsidies for Psychiatrists Practicing in Community Mental Health Centers and State Psychiatric Facilities"?

3. **JRC REFERRAL: Action Paper on Transitional Care Services Post-Psychiatric Hospitalization**

As directed by the JRC, the Council on Advocacy and Government Relations discussed the Action Paper on Transitional Care Services Post-Psychiatric Hospitalization. The Council on Advocacy and Government Relations recognizes the value of the new concept on clinical care, as described in the Action Paper, and supports the idea broadly. The Council has concerns about whether the national organization should prioritize and advocate for specific pilot programs, and instead recommends working with entities like SAMHSA to determine the best pilot programs to support. The Council on Quality Care recommends approaching the matter by providing funding to community mental health centers to engage people at discharge and then see them in their outpatient programs. At the time of this report, the Council had not received feedback from the Council on Healthcare Systems and Financing and Council on Addiction Psychiatry.

ACTION: Will the Joint Reference Committee accept the Council on Advocacy and Government Relations' recommendation to not advance the Action Paper on "Transitional Care Services Post-Psychiatric Hospitalization"?

4. **RESOURCE DOCUMENT: The Current State of Advocacy Teaching in Psychiatry Residency Training Programs**

In September 2017, Council members Drs. Katherine Kennedy and Mary Vance presented a draft of a resource document illustrating the significance of incorporating advocacy training to the curriculum for psychiatric residents. In spite of the parallels linking healthcare, practice and policy, many residency programs do not offer opportunities for engagement in political advocacy. This document strongly encourages medical residency programs to consider implementing advocacy curriculum that ties topics of clinical competence to the implications of relevant state and federal policy decisions for patient outcomes. At the Annual Meeting, Drs. Kennedy and Vance presented a revised draft for the Council to reconsider, to which the Council unanimously approved.

ACTION: Will the Joint Reference Committee accept the Council on Advocacy and Government Relations' recommendation to approve the Resource Document entitled, "Advocacy Teaching in Psychiatry Residency Training Programs"? **(Attachment #4)**

5. **JACOB K. JAVITS AWARD FOR PUBLIC SERVANT**

U.S. Representative Doris Matsui (D-CA) has demonstrated a commitment to the mental health community through her legislative work championing mental health issues. Due in large part to her influence on the House Energy and Commerce Subcommittee on Health, she continues to advocate in Congress for improving our nation's mental health care system. Representative Matsui exemplifies

working across party lines – securing passage of landmark bipartisan legislation, the Excellence in Mental Health Act, that established a demonstration project and expanding access to mental health services to underserved communities. Through majority vote, the Council nominates Representative Doris Matsui as she embodies the spirit of the Jacob K. Javits Award and those public servants whose mission is to positively affect change for those individuals unable to speak for themselves with behavioral health needs.

ACTION: Will the Joint Reference Committee recommend that the Board of Trustees vote to approve the Council's recommendation to award the 2019 Jacob K. Javits Award for Public Service to U.S. Representative Doris Matsui of California?

The Council brings the following informational items to the Joint Reference Committee:

1. **JRC REFERRAL: Psychologists and Other Mental Health Professionals and Hospital Privileges** *(formerly Hospital Privileges for Psychologists)*
   The Council on Advocacy and Government Relations (CAGR) reviewed the position statement formerly titled, *Hospital Privileges for Psychologists*. Through JRC directive, the Council will establish a joint Council work group with the Council on Healthcare Systems and Financing to review the 2007 position statement and 2017 proposed revisions. Specifically, the work group will address concerns to which language could be misconstrued particularly in the current scope of practice environment. The work group will present a revised statement to the JRC before the October 2018 meeting.

2. **JRC REFERRAL: APA Position Statement Strongly Recommending Twelve Weeks of Paid Parental Leave**
   The Council on Advocacy and Government Relations (CAGR) discussed the APA Position Statement Strongly Recommending Twelve Weeks of Paid Parental Leave, as directed by the JRC. The Council finds the Action Paper addresses a timely matter, and the significance that psychiatrists place on maternal care. The JRC asks for the Council to consider the political and advocacy implications of an APA position. The members are in support of APA taking a position on the matter, acknowledging there could be possible resistance from local and state policymakers. The Council will forward their recommendations to the Council on Healthcare Systems and Financing to be included in the June 2018 JRC report.

3. **JRC REFERRAL: Action Paper on Adopting an APA Position Statement Supporting Implementation of the Mental Health Parity and Addiction Equity Act (MHPAEA or parity law)**
   The Council on Advocacy and Government Relations (CAGR) discussed the Action Paper on Adopting an APA Position Statement Supporting Implementation of the Mental Health Parity and Addiction Equity Act, as directed by the JRC. The Council recognizes that APA does not currently have a position statement on the implications of the parity law on managed care utilization management. The Council supports the authors recommendation for the APA to adopt a position statement, with additional recommendations to the language. The Council recommends, (1) inclusion of language that would identify patients as priorities; and (2) support the actions in implementation and enforcement consistent with the scope of work of APA's Office of Parity Enforcement and Compliance. The Council will forward their recommendations to the Council on Healthcare Systems and Financing to be included in the June 2018 JRC report.

Attachment #1

COUNCIL ON ADVOCACY & GOVERNMENT RELATIONS

CONFERENCE CALL
MARCH 8, 2018
CALL MINUTES

MEMBERS IN ATTENDANCE

Patrick Runnels, MD
Matthew Erlich, MD
Katherine Kennedy, MD
Debra Koss, MD
David Lowenthal, MD
Cassandra Newkirk, MD, PC
Craig Zarling, MD (ASM)
Andrian Jacques Ambrose, MD
Taiwo Babatope, MD, MPH, MBA
Sabina Bera, MD
John Chaves, MD
Rachel Talley, MD
Mary C. Vance, MD
Larry Gross, MD

MEMBERS ABSENT

David Diaz, MD
Jenny Boyer, MD, PhD, JD
Michelle Durham, MD, MPH
Napoleon Higgins, MD
Steve Hyun Koh, MD
Barry Perlman, MD
Jessica Lynn Thackaberry, MD (ECP)
Charles Price, MD
Dakota Carter, MD
Katherine Koh, MD, MSc
Natalie Ramirez, MD
Alan Rodriguez Penney, MD
Onyinye Ugorji, MD, MBA
Wilsa Charles Malveaux, MD

WELCOME, AGENDA OVER, ROLLCALL

Dr. Runnels went over the agenda for the call and asked for Deana to check attendance for the call.

Ashley Mild, interim Chief for the Department, introduced DGR's new hires co-Directors of Federal Affairs Megan Marcinko and Mike Troubh and shared that the Department has hired a new State Director, Erin Philp.

Colleen Coyle, APA's General Counsel joined the conference call to discuss the Secret Shopper project:

- Purpose would be to look through directories and see if they are accurate and see if providers are actually seeing patients
- 80-85% are either deceased, have quit the network, include the wrong information, or are over-listed
- This is often done at the request of district branches and state associations
- Most providers cannot take new patients for 4-6 weeks
- Misrepresentation of product by insurance companies
- Speaking with Attorney General, this encourages and investigation
- Look at the out-of-network research for psychiatrists and use this data
- Not an issue of shortage, an issue with network
- People see psychiatrists outside of network

    - This can be used to discuss rates, why psychiatrists are paid less
    - Incentive for insurance commissioners to work on pressing issue for accurate directories
- Dr. Koss: New Jersey mental health association did a similar secret shopper project, with the intention of highlighting problems with insurance networks.
    - The message was that there are not enough psychiatrists and they don't accept insurance.
    - Led to awful headlines bashing psychiatrists and psychologists took advantage of this
    - As state DB, we decided not to because we are facing scope bills in NJ. We want to let others know that there are concerns related to this.
- Colleen: We originally worked with MHA and they did not have a plan. Unlike them, we would be careful on sharing information and speaking to the press.
- Dr. Zarling: When we see our patients in the office, they mention how they have experienced a long process in outpatient visits.
    - Some say that seeing a psychologist is the answer to that
    - This is a widely accepted sentiment
    - It would beneficial to shed some light on how bad access is
- Dr Kennedy: Not aware of 80-85%.
    - In 2017, we worked to get a bill passed to address network adequacy. It is still being implements, so we're not yet sure of the implications.
    - Needs to be a signal to inform patients whether or not their providers are accepting patients
- Dr. Zarling: For the average psychiatrist, uniform access is a huge issue and will resonate with their membership concerns.
- Dr. Runnels: Were there any thoughts from the NJ group regarding how the state could have done things differently?
- Dr. Koss: Data is always hopeful, and the politics are local.
    - What happens in states is contingent on what the matters are in the state
    - There was a sense of concern regarding this matter
    - Weigh the risks and concerns of using this data, based on local issues
- Dr. Runnels: Willing to go back to the staff to see how message can be better communicated
- Glenn: Access is important, but reimbursement really drives the message home. A lot of it also depends on the audience (policymakers v. general public)

Ms. Marcinko and Mr. Troubh provided a federal legislative update

- CHIP- Budget Deal
    - The bipartisan budget agreement in Congress passed last month
    - Provides for important mental health initiatives for which APA lobbied, including earmarking $6 billion to confront the opioid epidemic, as well as extending the state Children's Health Insurance Program (CHIP)
    - Following a four-month lapse in federal funding, Congress passed a six year reauthorization of CHIP in January, as part of a short term continuing resolution to maintain funding for the federal government
    - The bipartisan budget deal in February provided an additional four year funding extension, accumulating to a full decade of federal support, for CHIP

- The $14 billion program provides health insurance to nearly nine million children and adolescents from low-income families, who do not qualify for their state's Medicaid program
- Also provides access to quality, evidence-based mental health care services for the estimated 850,000 CHIP beneficiaries experiencing serious behavioral or emotional disorders
- APA administration collaborated with DBs to engage members through the APA Action Center, most recently via a member-wide grassroots effort to encourage lawmakers to support timely CHIP reauthorization
- As a result, Council members and APA advocates sent over 1,400 letters to their respective federal lawmakers and governors, phoned congressional offices, or urged action through social media

- Opioids
  - House and Senate committees will convene on opioid-related hearings in the coming weeks. DGR staff will attend these hearings and weigh in on legislation, where appropriate
  - The House Energy and Commerce Health Subcommittee will focus on opioid-related coverage and payment issues in the Medicare and Medicaid programs. More than two dozen bills are slated for consideration
  - The Senate HELP Committee's bipartisan hearings on the subject with FDA, NIG, CDC, SAMHSA, governors, health experts and impacted families. The proposals in the Senate HELP bill includes, but are not limited to:
    - FDA: The bill would give the FDA authority to require manufacturers to package certain drugs for set durations of treatment, for instance, in three-day blister packs. Through the bill, the FDA would receive additional funding to improve coordination with the U.S. Customs and Border Patrol, and would allow for the FDA to clarify its development and regulatory pathways to spur development of non-addictive and non-opioid pain products through feedback from public meetings.
    - CDC and PDMPs: The bill authorizes the Centers for Disease Control and Prevention (CDC) to undertake prevention activities related to prescription drug monitoring programs (PDMDs), including enhancing interoperability between the program and health information technology and facilitating data exchange among state PDMPs.
    - Privacy issues: The bill directs HHS to establish model programs and materials for training health care providers on the privacy and security regulations governing patient records, as well as "Jessie's Law," which would direct HHS to develop best practices for how, at a patient's request, said patient's history of opioid use disorder can be "prominently displayed in the medical records."
  - Meanwhile, FDA Commissioner Scott Gottlieb delivered remarks to the National Rx Drug Abuse and Heroin Summit last week, in which he discussed the FDA's analysis of prescribing patterns. Commissioner Gottlieb noted a lack of evidence-based guidelines to inform clinical practice for opioid use, and expressed support for Congress' efforts to pass legislation that would create a uniform system of electronic prescriptions for controlled substances and integration of Electronic Health Records (EHR) and PDMPs, as well as data sharing across PDMPs.
- Guns

- Discussion of potential gun control legislation continued last week, including at a bipartisan White House meeting hosted by President Trump. Similarly, to immigration, the President expressed openness to the Democratic position on the issue, saying that he preferred a "comprehensive" measure, even suggesting that the government should be able to confiscate guns prior to individuals receiving their due process rights. However, those policies are likely to be opposed by many rand-and-file Republicans and lawmakers appear no closer to an agreement on a comprehensive bill addressing gun violence.
- I will ask Deana to share the press release/statement APA put out, which read: "Our organizations include 450,000 physicians and medical student members. Gun violence is a public health epidemic that is growing in frequency and lethality, and it is taking a toll on our patients. We urge our national leaders to recognize in this moment what the medical community has long understood: we must treat this epidemic no differently than we would any other pervasive threat to public health. We must identify the causes and take evidence-based approaches to prevent future suffering. Our organizations call on the President and the United States Congress to help prevent gun violence in the following ways: (1) Label this violence, caused by the use of guns, a national public health epidemic. (2) Fund appropriate research at the Center for Disease Control and Prevention (CDC) as part of the FY 2018 omnibus spending package. (3) Establish constitutionally appropriate restrictions on the manufacturing and sale, for civilian use, of large-capacity magazines and firearms with features designed to increase their rapid and extended killing capacity."
- Additionally, APA called for there to be an open dialogue on mental illness, identifying three points: (1) Enforce the Mental Health Parity and Addiction Equity Act, to ensure that health insurance coverage provides timely access to a full range of mental health and substance use disorder providers and services. These efforts must explicitly remedy/redress the discrimination against mental health providers and their patients that has resulted in the documented shortages of these providers participating in health insurance plans, which is a significant barrier to consumers accessing their coverage. (2) Improve access to quality mental health and substance use services by addressing workforce shortages; implementing evidence-based, innovative health care delivery models; and ensuring adequate funding so that communities have available a continuum of outpatient and inpatient services, including treatment options for people in crisis. (3) Invest in research to improve early detection and intervention for mental illnesses through translational studies, which will help us turn preclinical and clinical research insights and discoveries into new diagnostics and therapeutics that meaningfully impact patients' lives.

- Omnibus
    - As high-level negotiations on an omnibus spending bill continue off the floor, both the House and the Senate met last week and advanced financial services bills and judicial nominations, respectively. The House held their last votes on Tuesday, in order to provide for Evangelical preacher and Presidential adviser Billy Graham to lie in honor in the Capitol Rotunda on Wednesday and Thursday. We anticipate the larger package will pass through both chambers by the month's end.

- Questions/Discussion:
    - Dr. Zarling asked about APA and Ligature Risks

- Dr. Runnels: Working with staff to have Addiction Psych Council join a conversation at the Annual Meeting.
- Dr Runnels: On gun issue, there is not a response from organized groups on the issue regarding detaining people indefinitely because they are thought to be a risk. There is an argument that has not been challenged.
- Dr. Erlich: APA as nonpartisan, the use of mental health in articles on President's Trump's suggestion on re-institutionalizing. This puts APA in a tricky position and at some point, APA will want to lobby on more funding, which will be hard to navigate.
- Dr. Runnels: Want to ignore the gun issue and focus on the mental health issue.
- Dr. Erlich: Reaching out to both sides of the aisle.
- Would be interested to know how APA navigates this, without leaning one way or the other.
- Ashley: Deana will share the APA paper and the current activity for APA staff.
- Dr. Zarling: This is an opportunity for APA to lead the discussion with legislators and policymakers.
- Dr. Runnels: Maybe we can circle back to May.

APA regional directors provided an abbreviated state legislative update

- Involuntary Commitment with Substance Use Disorder (SUD)
    - We are going to wait until May to develop products and actions on this issue
- Questions
    - Dr. Runnels requested some examples providing more details

Dr. Koss specifically asked for the Council to discuss recent activity concerning medical licensure

- Referenced an article
    - Can we offer support on this pertinent issue?
    - Dr. Zarling: This is a focusable concern on which our members would be interested. It creates a problem with access. We could address this at the national policy conferences and someone could champion this to the state boards. Must be cautious, as APA is a national organization,
    - Dr. Runnels: We should circle back to Ashley and see what we can do. Push action maybe set up a small group with an interest in this matter.

Considering the time, Dr. Runnels wrapped the conference call, sharing the next call – set for April will focus only on JRC directives

Ms. Mild announced the State Advocacy Conference is slated for August.

Council on Advocacy & Government Relations
Conference Call
April 24, 2018
Meeting Minutes

ATTENDANCE

Members Present:

Patrick Runnels - *Chair*
David Diaz – *Vice Chair*
Jenny Boyer
Napoleon Higgins
Katherine Kennedy
Debra Koss
David Lowenthal
Craig Zarling (AMS)
Larry Gross – *consultant*
Wilsa Charles Malveaux – *consultant*
Sabrina Bera -*Spurlock Congressional Fellow*
Dakota Carter -*SAMHSA Fellow*
Alan Rodriguez Penney – *SAMHSA Fellow*
Mary Vance – *Public Psychiatry Fellow*

Members Absent:

Michelle Durham
Matthew Erlich
Steve Koh
Cassandra Newkirk
Barry Perlman
Charles Price
Jessica Thackaberry
Adrian Jacques Ambrose
Taiwo Babatope
John Chaves
Katherine Koh
Natalie Ramierz
Rachel Talley
Onyinye Ugori

WELCOME AND AGENDA OVERVIEW

Dr. Runnels opened the meeting with rollcall.
And proceed to explain that the Council received several JRC directives of Action Papers and Position Statements for the Council to review. This conference call will be dedicated to completing these directives in advance of the Annual Meeting in a couple of weeks.

JRC DIRECTIVES

Action Paper: *Designation of Psychiatry as Primary Care for Any Medical School Scholarships Requiring Primary Care Service (ASM2017A2 12.A)*
Dr. Runnels allotted time for the members to read the Action Paper.

- Zarling: The action paper adds an additional incentive and loans for psychiatrists to work/practice in rural communities.
- Runnels: The paper provides good intention to advocate for access to services and treatment
- Diaz: The action paper is fairly straightforward
- Koss: One addition to be recommended to the author is to include applying this paper to psychiatry subspecialties. Sometimes the wording for loan programs excludes subspecialties.
- Boyer: Agreed to expand the scope, the action paper should include language that focuses on subspecialties.
- Runnels: The Council agrees the author should revise the language to include subspecialties.

Action Paper: *Medical School Loan Repayment Subsidies for Psychiatrists Practicing in Community Mental Health Centers and State Psychiatric Facilities (ASM2017A2 12.B)*
Dr. Runnels allotted time for the members to read the Action Paper.

- Runnels: The action paper addresses public health service loan forgiveness programs.
- Lowenthal: Concurred, including general medical school loans.
- Bera: The action paper should also add language specific to subspecialties.
- Runnels: There should be an ask for an increase of funding for these programs. There current funding is already inadequate.
- Koss: Laon repayment programs are often two parts: (1) where psychiatry is included, keeping with federal standards; (2) the appropriation of funds. In this aspect, APA could collaborate with AACAP to advocate and promote loan forgiveness. The action paper resolves are actionable but may be a heavier lift for just the APA.
- Boyer: To expand the scope of the paper, would it be possible to encompass telemedicine. There are rural facilities that only offer telemedicine.
- Runnels: Agreed the recommendation of including telemedicine can be used as a mechanism for recruiting practitioners from urban setting that car practice telesychiatry, expanding provide access in the hard to reach communities.

Action Paper: *Transitional Care Services Post-Psychiatric Hospitalization (ASM2017A2 12.C)*
Dr. Runnels allotted time for members to review the Action Paper.

- Zarling: The action paper doesn't look to be controversial. The program described looks at systems approach.
- Runnels: The program, described, is a new clinical concept not implemented nationally.
- Boyer: Familiar with the concept, the services are not provided through a hospital, but similar to a day facility. There are PAC teams that go out to visit patients in their homes, meet with family members, and this is all provided through public health systems. Unfortunately, there is not enough money in other state systems to provide transitional care.
- Runnels: The larger question is, whether the Council is responsible for deciding if APA should be advocating for pilot programs.
- Koss: Agreed. Who at APA prioritizes these asks?
- Runnels: My suggestion would be for APA to speak to SAMHSA about this program.
- Zarling: APA should approach the concept in general, but agreed that APA should not advocate for a specific program. Reiterating, the Council should support the concept in general. And recommends the Council defer to APA leadership to determine if we advocate for specific programs.
- Runnels: Agreed. APA leadership should develop an overview list of priorities and initiatives that we should advocate for funding.

Action Paper: *APA Position Statement Strongly Recommending Twelve Weeks of Paid Parental Leave (ASM2017A2 12.I)*
Dr. Runnels allotted time for members to review the Action Paper.

- Zarling: Thought the action paper is timely, given the recent news stories, and the significance that psychiatrists place on maternal care. The recent debate in the Assembly, suggested this is a contentious topic for some APA members.
- Runnels: Suggested that the Council shared a lot of agreement and consensus on the intent of the action paper. And asked if anyone has an opinion about the political wisdom.

- Runnels: Thought the action paper is a little prescriptive. And there is some momentum from both sides of the political aisle. Presumes there aren't strong political concerns.
- Boyer: In disagreement, it was implied there could be some push back in the Southern region. Many state legislatures in the South have more of a conservative view point.
- Runnels: Posed the question, do you see this action paper as toxic or politically dangerous?
- Boyer: In the end, APA needs to stand for something. But, yes, there is potential for push back.
- Lowenthal: Agreed, that with any position APA takes, it may be a position that members don't agree.
- Charles Malveaux: Reiterated that APA should take a stand. Speaking in support of the matter, recommended the Council to suggest to APA to no worry about the political views.
- Zarling: Agreed, this is a primary issue and the Council should support the action paper. APA should also understand there will potentially be blow back and then should be willing to address it.

Action Paper: *Adopting an APA Position Statement Supporting Implementation of the Mental Health Parity and Addiction Equity Act (MHPAEA or parity law) (ASM2017A2 12.L)*
Dr. Runnels allotted time for the members to review the Action Paper.

- Zarling: Posed the question, if this paper is different than what APA is currently doing?
- Kennedy: The action paper addresses a medical necessity criteria without individuals trained as psychiatry. The criteria is a way to get around MHPEA; and this is a way for the APA to indicate that they support the utilization of psychiatrists in developing medical necessity criteria. This looks at the many ways insurance companies try to get around MHPEA.
- Runnels: Quoted the paper, "Whereas the APA has no current position statement on the implications of the parity law," is it true that there is a gap in APA policy?
- Zarling: If this is the case, this puts a flag in the ground, filling that gap where APA does not have policy. The action paper advocates for a less dense criteria.
- Boyer: The language is unclear in addressing chronic illness.
- Runnels: Agreed, the language is dense. Asked if it would be helpful for APA staff/author to help identify the key points of the action paper, because it is so dense.
- Zarling: My read is the ask for APA is to develop a position statement; and assume the Council would be in support of this.
- Kennedy: Many states are actively advocating for states to pass legislation that will to enforce MHPEA.
- Boyer: Most importantly, we need to focus on the patients.
- Zarling: Agreed, the priority should the patients, insurance policies, and managing them.
- Zarling: The Council should recommend, when the position statement is written, it should be framed from the access to care for patients.
- Runnels: Agreed, the Council will recommend support of the action paper with inclusion of patient-oriented language. And APA staff will follow-up to the Council clarifying the dense language of the action paper.

Position Statement: *Psychologists and Other Mental Health Professionals and Hospital Privileges (formerly Hospital Privileges for Psychologists)*
Dr. Runnels expanded that the revised position statement was returned to the Council for more reworking. Taking in consideration the JRC directive, CAGR will reestablish a joint Council work group with the Council on Healthcare Systems and Financing. The members agreed.

Attachment #3

COUNCIL ON ADVOCACY & GOVERNMENT RELATIONS

ANNUAL MEETING
NEW YORK, NY
MAY 7, 2018
MEETING MINUTES

MEMBERS IN ATTENDANCE

Patrick Runnels, M.D. – Chair
David Diaz, M.D. – Vice Chair
Jenny Boyer, M.D., Ph.D., J.D.
Michelle Durham, M.D., M.P.H.
Matthew Erlich, M.D.
Napoleon Higgins, M.D.
Katherine Kennedy, M.D.
Steve Koh, M.D.
Debra Koss, M.D.
David Lowenthal, M.D.
Cassandra Newkirk, M.D., P.C.
Craig Zarling, M.D. (ASM)
Charles S. Price, M.D.
Adrian Jacques Ambrose –Leadership Fellow
Taiwo Babatope –Child & Adolescent Psychiatry
Sabrina Bera – Spurlock Congressional Fellow
Dakota Carter – SAMHSA Fellow
John Chaves – Public Psychiatry Fellow
Alan Rodriguez Penney – SAMHSA Fellow
Rachel Talley – Public Psychiatry Fellow
Mary C. Vance –Public Psychiatry Fellow
Larry Gross, M.D.

MEMBERS ABSENT

Barry Perlman, M.D.
Jessica Lynn Thackaberry, M.D. (ECP)
Katherine Koh – SAMHSA Fellow
Natalie Ramirez – Diversity Leadership Fellow
Onyinye Ugorji – Public Psychiatry Fellow
Wilsa Charles Malveaux, M.D.

GUEST IN ATTENDANCE

Anita Everett, M.D., APA President
Saul Levin, M.D., M.P.A., APA Medical Director and CEO
Kristin Kroeger, APA Chief of Policy, Programs, and Partnerships

APA STAFF IN ATTENDANCE

Craig Obey
Ashley Mild
Megan Marcinko
Mikael Troubh
Kaileen Dougherty
Erin Philp
Marsi Thrash
Tim Miller
Deana McRae

WELCOME

Dr. Runnels called the meeting to order. Welcoming the Council, before introducing APA President Dr. Anita Everett.

GREETINGS FROM APA PRESIDENT DR. ANITA EVERETT

APA President Dr. Anita Everett visited the Council during their 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 thanked the Council for implementing her platform while in office as APA President, suggesting there will continue to be opportunities to incorporate strategies to our advocacy efforts on matters, such as: access to behavioral health for all Americans; innovation in mental health care delivery; and supporting physician wellness and resilience.

COUNCIL DISCUSSION ON COLLABORATION WITH OTHER APA COMPONENTS

Dr. John Renner from the Council on Addiction Psychiatry joined the Council to discuss the Council current work and activity, particularly around the opioid epidemic. The Council continues to work on medication-assisted treatment, and recently has worked with the DGR staff to assist in reviewing legislation and advocacy efforts to policymakers. The Council is also working on the Pulse Learning project. The Council is aiding APA staff in applying for a SAMHSA grant, targeting specific physicians to train members through the district branches. The Council is also involved in APA's effort to "train-the-trainer" with an upcoming meeting of 25 physicians in Washington, DC this July for Buprenorphine courses.

Dr. Harsh Trivedi, Chair of the Council on Healthcare Systems and Financing, shared their current activity and projects – suggesting there are opportunities for the two components to collaborate on projects. There are plenty of crossover issues, such as how HCSF can help CAGR in terms of addressing health care reform; enforcement of parity at the state level; and IMD exclusion. The Council also works in collaboration with Council on Quality Care and the Council on Research; and recently advised the APA administration in developing a best practices guideline with the ATA.

APA COALITIONS AND PARTNERSHIPS

Kristin Kroeger spoke to the collaborations the APA administration has established and sustained when working on behalf of APA membership. APA established the Policy, Programs, and Partnership Division specific to working with other like-minded stakeholders to purse advocate on mental health issues, citing stronger force with more voices. She informed the Council, DGR works closely with PPP in pursing these efforts and shared the list of priorities set by Division.

Priorities include:

- Telepsychiatry legislation, and working with DEA (Ryan Haight)
- Religious protections
- APA is in the fourth year in the SANs grant: CMS approved CPT codes for collaborative care. State legislation to get states to pay to improve access

Partnerships, include:

- Mental Health Liaison Group and Group of 6
- New collaborations: LGBTQ and FedWatch
- Specific issue collaborations: AAMC workforce coalition

Questions:

- Dr. Runnels: How does it get prioritized. Is there a dashboard?
- Dr. Runnels: How often do we disagree with these coalitions?
- Kristin: It is good to know where each respective organization stands for future collaborations.
- Dr. Runnels: How can CAGR get involved?
- We send to individuals and relevant councils and we can do that for CAGR.

- Kristin: Particularly working on the same issue, we hope to have some synergy. Possibly meet during the September component meeting to discuss.

Members requested Ms. Kroeger's slides to be shared with the Council.

COUNCIL'S RESPONSE TO THE JRC ACTION ITEMS

Dr. Runnels reminded the Council that these papers had already been reviewed and discussed during the last conference call in April. However, seeing that not every member was able to participate during the call, we wanted to give everyone the opportunity to review the papers, and provider feedback. And for those who had already provided feedback, we ask for you to review the drafted comments to the JRC and revise as necessary.

POSITION STATEMENT: ***Psychologists and Other Mental Health Professionals and Hospital Privileges*** *(formerly Hospital Privileges for Psychologists)*

The first position statement, *Psychologists and Other Mental Health Professionals and Hospital Privileges (formerly Hospital Privileges for Psychologists)* is one the JRC returned to the Council for some tweaking. Specifically, the work group was asked to address concerns to language that may be misconstrued, this is of particular importance in the current legislative and policy environment. Since we have previously reviewed the position statement, would the Council agree to reestablish the Council work group – utilizing the same participants to join the Council on Healthcare Systems and Financing to review the 2007 position statement and 2017 proposed revisions. The hope is to review the product during the September component meeting to present a revised statement to the JRC in October.

ACTION PAPER: ***Designation of Psychiatry as Primary Care for Any Medical School Scholarships Requiring Primary Care Service***

Dr. Runnels provided an overview of the discussion had on the April conference call. And referred to the compiled comments for the Council to, either, expand on or revise. He suggested the Council to take in consideration the comments received from the Council on Medical Education and Lifelong Learning. Dr. Koss advised the Council, the National Health Service Corps loan repayment program does not encompass child psychiatry, addiction, and geriatric – and thus reiterated the program includes only general psychiatry. She suggested to revise the language to include these subspecialties. Both Drs. Koh and Gross disagreed, suggested keeping the language general, hoping to prevent confusion. Dr. Newkirk asked if listing the subspecialties would make a difference. In response, Dr. Koss suggested it does matter, when applying after residency when psychiatrists with specialists are no longer eligible, according to NHSC language. Dr. Boyer rescinded her objection to the language. Dr. Higgins suggested there is not a decreasing population in rural areas. A psychiatrist in a subspecialty does not define their practice; doctors with specialties will often see patients outside of their specialty. It was recommended to strike the drafted comment, and include "expanding language", adding a sentence to identify subspecialties and telepsychiatry. This motion was not approved. Albeit the Council supports the premise of the Action Paper to designate psychiatry as primary care for primary care medical school scholarships. The Council vote to include n the report, the following recommendation – that the Action Paper be amended by the authors to incorporate language reflecting: (1) inclusion of primary care subspecialties; and (2) additional incentives for psychiatrists to practice in rural areas. The proposed language will provide opportunities for additional subspecialties to participate in scholarship programs, thus positively impacting the psychiatric physician workforce. Taking into consideration the recommendations, the Council voted to not support advancing the action paper as written.

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

Having discussed the Action Paper previously, the Council did not have further recommendations or revisions to the drafted comments. Taking in consideration the comments received from the Council on Medical Education and Lifelong Learning in support of the resolution of the Action Paper, CAGR agreed it action is an acceptable ask. As an added option for providing access to underserved communities, the Council recommends that the Action Paper be amended by the authors to incorporate the practice of telemedicine. This incentive can be used as a recruiting tool for urban participation, such that individuals serving rural populations by telepsychiatry could be included in loan forgiveness programs. The Council voted to not support advancing the action paper as written.

ACTION PAPER: ***Transitional Care Services Post-Psychiatric Hospitalization***

The action paper was previously discussed during the April conference call. At that time, the Council requested for further clarification from APA staff on the legislative activity or current funding mechanisms. Dr. Runnels asked of the Council, if it is there responsibility to determine which pilot programs to place as a priority for the organization. The Council recognized the value of the new concept on clinical care, as described in the Action Paper, and supported the idea broadly. The Council has concerns about whether the national organization should prioritize and advocate for specific pilot programs, and instead recommends working with entities like SAMHSA to determine the best pilot programs to support. In advance of the meeting, the Council had not received feedback from the Council on Quality Care, Council on Healthcare Systems and Financing or Council on Addiction Psychiatry.

ACTION PAPER: ***APA Position Statement Strongly Recommending Twelve Weeks of Paid Parental Leave***

Having previously discussed the action paper during the April conference call, the Council was largely in agreement with the drafted comments for the JRC. The Council finds the action paper addresses a timely matter, and the significance that psychiatrists place on maternal care. While the JRC asks for the Council to speculate whether there would be political or advocacy implications, the members were in full support of APA taking a position on the matter. However, the Council acknowledged there could be possible resistance from local and state policymakers in some states. The Council will forward their recommendations to the Council on Healthcare Systems and Financing to be included in their June JRC report.

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

Having discussed previously, the Council asked for APA administration to clarify APA's position on mental health parity implementation and enforcement, specifically in the states. The Council discussed further, in drafting the position statement, APA should place patients as the priority. It was recommended for a joint Council work group to be established lead by the Council on Healthcare Systems and Financing, to draft the position statement, working with Sam Muszynski and staff. The Council recognized that APA does not currently have a position statement on the implications of the parity law on managed care utilization management, as indicated in the action paper. The Council supports the authors recommendation for the APA to adopt a position statement, with additional recommendations to the language. The Council recommends, (1) inclusion of language that would identify patients as priorities; and (2) support the actions in implementation and enforcement consistent with the scope of work of APA's Office of Parity Enforcement and Compliance. The Council will forward their recommendations to the Council on Healthcare Systems and Financing to be included in their June JRC report.

COUNCIL REVIEW OF ADVOCACY WORK PRODUCTS

Joining via conference call, Dr. Vance provided the Council will an abbreviated background and progress of *The Current State of Advocacy Teaching in Psychiatry Residency Training Programs* resource document, before the Council for consideration. In September 2017, Council members Drs. Katherine Kennedy and Mary Vance presented a draft of a resource document illustrating the significance of incorporating advocacy training to the curriculum for psychiatric residents. In spite of the parallels linking healthcare, practice and policy, many residency programs do not offer opportunities for engagement in political advocacy. This document strongly encourages medical residency programs to consider implementing advocacy curriculum that ties topics of clinical competence to the implications of relevant state and federal policy decisions for patient outcomes. Dr. Kennedy informed the Council, recommendations received from the Council on Medical Education and Lifelong Learning had been incorporated. And thanked CMELL for their assistance in connecting with 7 additional residency programs. The question was posed if, authors have the ability to update the resource document over a period of time. Staff responded with a request to follow back with a response. Members reiterated their initial objection to the resource document, citing the language required programs to instate advocacy training. Dr. Kennedy responded that the language has been revised. Dr. Koh applauded their commitment and efforts to encourage advocacy in the early phases of psychiatric physicians training. The vote was called, to which the Council unanimously approved.

DB SURVEY RESULTS OF ADVOCACY WORK GROUP: ENGAGE OUR GRASSROOTS IN LOCAL EFFORTS

Dr. Koss spoke to the product of the Council advocacy work group on engaging grassroots at the ocal level. She presented the results from a recent survey administered by APA DGR staff to the executive directors and presidents of the District Branches and State Associations. The Council was impressed with the feedback from the survey and inquired if staff would develop resources documents (i.e. fact sheets) to be used by states. The Council asked for DGR staff to provide a link to the survey results to be shared to a larger audience. The information obtained can be utilized by DGR to assist states in building advocacy alerts and expanding grassroots/engagement avenues.

Questions:

- Dr. Koh: There are inefficiencies in how we advocate. How do we break the cycle without repeating ourselves every few years? Does any member have any suggestions?
- Dr. Koss: We respect the independence of local level branches. We would advise them to develop strategy and then use a uniformed message. We hope to get all APA members involved.
- Dr. Kennedy: Members have expressed concerns about asking for money. Unfortunately, we have DBs that don't have strong executive staff at the local level. This survey is a means to educate all APA members about best practices, especially for those states that don't have strong district branches.
- Dr. Lowenthal: Heading up the other advocacy on scope and developing an updated toolkit, unfortunately did not get this type of traction. We contemplated if was the group participants, or the objective that led to the lack of participation. Should we revisit the objectives?
- Dr. Erlich: Applauded Dr. Koss for her strong leadership, and her ability to jump out there on task. Would it be possible for the fellows be establish a specific work group, that functions in this way? These objectives on advocacy have some zeal.
- Dr. Runnels: Take the summer, as the larger group works through.

ESTABLISHING WORK GROUP TO UPDATE OPERATION ACTIVITIES AND CHARGE FOR THE COUNCIL

Dr. Runnels shared his approach to establishing a Council work group to revamp current charge. He listed the Council members already invited to participate: Deb Koss, Matt Erlich, Steve Koh, Rachel Talley, Mary Vance, and Patrick Runnels. The purpose of the revamping is to reflect the mission of we would like to see of the Council. The Council agreed this was an appropriate task. Dr. Runnels informed the Council he hoped to have developments by the component meeting in September.

DGR Legislative Update

APA staff provided relevant and current federal legislative activity, presented by Megan Marcinko and Mike Troubh.

APA staff provided relevant and current state legislative and regulatory activity, presented by Erin Philp.

GREETINGS FROM APA CEO AND MEDICAL DIRECTOR DR. SAUL LEVIN

Dr. Levin welcomed Craig Obey, new DGR Chief. Thanked Ashley Mild for her role as Interim Chief. And the entire of the Council for their continued commitment to be being the face of advocacy for APA.

NOMINATION OF JACOB JAVITS AWARD FOR PUBLIC SERVANT

DGR staff provided three names for consideration by the Council for the Javits award recipient. The Council discussed at length the nominations, with the majority voting (9 members) in favor of U.S. Representative Doris Matsui (D-CA). has demonstrated a commitment to the mental health community through her legislative work championing mental health issues. Due in large part to her influence on the House Energy and Commerce Subcommittee on Health, she continues to advocate in Congress for improving our nation's mental health care system. Representative Matsui exemplifies working across party lines – securing passage of landmark bipartisan legislation, the Excellence in Mental Health Act, that established a demonstration project and expanding access to mental health services to underserved communities. Through majority vote, the Council nominates Representative Doris Matsui as she embodies the spirit of the Jacob K. Javits Award and those public servants whose mission is to positively affect change for those individuals unable to speak for themselves with behavioral health needs.

Resource Document:
Advocacy Teaching in Psychiatry Residency Training Programs

Council on Advocacy and Government Relations

Katherine G. Kennedy, M.D.; Mary C. Vance, M.D. [1]

Background

Advocacy, generically defined as the active support for a particular cause, policy, or issue, is applicable to medicine and psychiatry as physicians' responsible use of "their expertise and influence to advance the health and well-being of individual patients, communities, and populations" (Frank, 2005). Advocacy can be undertaken from within an organization or as an outside stakeholder, and it can focus on a single theme (e.g., Barber, 2008) or more generally on issues that relate to patient needs, including the social determinants of health (e.g., Chin, 2017). Although the concept of advocacy is commonly linked to legislative advocacy, a specific arena of advocacy that seeks to influence policy and politics, it is also applicable more broadly to other activities that physicians undertake to support specific causes (e.g., community-level advocacy to avert the shutdown of a homeless shelter, interviews with the lay media as advocacy to inform public opinion).

Participation in advocacy is increasingly recognized as an integral part of a physician's professional role. In June 2002, the American Psychiatric Association (APA) Board of Trustees voted to support the American Medical Association's (AMA) "Declaration of Professional Responsibility," which includes the assertion that "physicians commit themselves to … advocate for social, economic, educational, and political changes that ameliorate suffering and contribute to human well-being" (AMA, 2001). The primary goal of advocacy as a professional responsibility is further underscored by its inclusion in the physician competency frameworks of multiple medical regulatory bodies, among them the Accreditation Council for Graduate Medical Education (ACGME) (ACGME, 2017, "Psychiatry") and the Royal College of Physicians and Surgeons of Canada (Frank, 2005). These positions highlight that the scope of a physician's practice includes not only understanding the impacts of the greater environment—e.g., families, communities, and healthcare systems—on the health and well-being of his or her patients, but also the will to act on that understanding to improve patient experiences and outcomes.

While advocacy is not unique to psychiatry, it is an important component of

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[1] Workgroup Members: Katherine G. Kennedy, M.D.; Mary C. Vance, M.D.; Debra A. Pinals, M.D.; Rachel Tally, M.D.

ensuring that both persons in mental health treatment and the psychiatrists who treat them are equipped with the resources and policies they need to maximize positive impact and treatment outcomes. As medical doctors with additional extensive training and human psychology and behavior, psychiatrists are uniquely positioned to appreciate that behavioral illness occurs in a systems context and that a complex array of biopsychosocial factors impact patients' lives. Psychiatrists are well-equipped to treat their patients by making biological and psychological changes, via pharmacotherapy and psychotherapy, to alleviate the suffering of mental illness. Moreover, they are well-suited to better shape the systems of care that their patients navigate by partnering with professional and community organizations in group advocacy efforts. Finally, they are well-positioned to work within the profession of medicine to foster an effective physician workforce that would further optimize patient health and well-being.

The Role of Advocacy Training for Psychiatric Residents

Because understanding how to advocate is not necessarily intuitive, formalized training in advocacy can be helpful in achieving greater impact. However, formalized methods to teach advocacy skills have not historically been widely available in psychiatry. Learning how to advocate for patients and for the profession requires the development of multiple specific, complex skills, such as public speaking, expository writing, legislative and media outreach, and coalition-building. These skills should be taught in a thoughtful and considered manner, as it cannot be assumed that advocacy will be learned by simple exposure or passive observation. Advocacy also requires a solid knowledge base of multiple topics outside of the strict biomedical realm, including how healthcare systems operate; how mental health services are financed; the social determinants of health; and how the legislative process functions at local, state, and federal levels. In order to acquire these skills and knowledge, the APA Council on Advocacy and Government Relations (CAGR) recommends that psychiatry residents be offered both didactic and experiential learning opportunities in advocacy during their training years (see below, "The Role of APA Governance in Promoting Advocacy," for more information on CAGR).

Training in advocacy techniques during residency increases advocacy behaviors beyond residency. A *Pediatrics* study (Minkovitz, Goldshore, Solomon, Guyer, & Grason, 2014) examined pediatric residents who received specialized advocacy training during their residency. Five years after residency, these pediatricians experienced "greater participation in community activities and greater related skills than their peers nationally" (Minkovitz, Goldshore, Solomon, Guyer, & Grason, 2014, p. 83). This study suggests that when advocacy is taught during residency, the positive effects persist post-residency and "may lead to a more engaged pediatrician workforce" (Minkovitz, Goldshore, Solomon, Guyer, & Grason, 2014, p. 83).

In addition, although a number of medical schools support both an advocacy

curriculum and advocacy opportunities for their medical students (e.g., the Boston University Advocacy Training Program at Boston University School of Medicine) (BUATP, 2017), the advocacy skill set may decline during residency and post-residency unless advocacy training is reinforced during residency. For example, one study (Stafford, Sedlak, Fok, & Wong, 2010) examining advocacy attitudes and participation in internal medicine residents found that, although advocacy participation was relatively higher among respondents during high school, undergraduate studies, and medical school, a sharp drop-off occurred during residency. Furthermore, 45% and 34% of respondents were unsure as to whether they planned to participate in advocacy during fellowship and post-fellowship, respectively. Therefore, formalized advocacy teaching during residency could be used as a tool to combat this trend of declining advocacy participation.

Of note, when teaching advocacy, CAGR also recommends that the emphasis should be on teaching techniques for advocacy rather than on teaching about specific viewpoints or topics to advocate for. Our profession does not share a monolithic perspective, and CAGR recognizes that what is learned in advocacy training will be used to advocate on behalf of multiple perspectives.

A Survey of Advocacy Curricula in Psychiatric Residencies

Recognizing the importance of advocacy to the profession of psychiatry, psychiatric educators and trainees across the country have begun to incorporate advocacy teaching into the curricula of psychiatric residencies over the past 4-5 years. The current paper began as an effort to document examples of the advocacy curricula of the U.S. psychiatry residency training programs currently teaching advocacy, with the intent to create a resource document that will enable more training programs to do the same and to foster the development of a "best practice guideline" for advocacy teaching.

To identify psychiatry residency programs teaching advocacy, responses from a blast email to the American Association of Directors of Psychiatric Residency Training (AADPRT) inquiring about advocacy curricula were first utilized to identify potential programs. The authors' personal knowledge of advocacy curricula either in development or already in place was used to further identify pertinent programs. Finally, a request to CAGR members was made, both in person and via email, to name additional programs. These efforts yielded a total of seven programs with advocacy curricula either in development or in place. Phone interviews were then conducted in Fall 2017 with the program directors, faculty members, and/or resident leaders at each program who had specific knowledge of their advocacy curricula in order to more collect detailed information. Summaries of these advocacy curricula were emailed to each program director for updates and final approval in January 2018. These seven programs, therefore, are highlighted in this resource document and offer a beginning outline of advocacy training elements (see Table 1 and Appendix A for further details). Other programs may

be in effect or in development, and these are meant to serve only as initial representative models.

Many of these programs began their forays into advocacy either in response to grassroots pressure by current residents in their program or following queries by prospective residents during recruitment season. Some began as a result of the activities of advocacy-oriented faculty. These common patterns of introduction are key differentiators between advocacy teaching and the teaching of other topics during residency. Many topics taught in residency adhere to a top-down flow of information, in which accreditation requirements activate residency programs to teach certain topics, which then activates trainees to learn them. In contrast, the teaching of advocacy has tended to start with a bottom-up flow of information, in which trainees or faculty activate their programs to teach a topic of interest and importance to them—as, indeed, advocacy training is not currently mandated by the ACGME as a standalone competency for psychiatry (see below, "The Role of the Accreditation Council for Graduate Medical Education"). One could argue that this trend in advocacy teaching is emblematic of advocacy itself, wherein grassroots movements often play a significant role in bringing the needs of stakeholders and constituents to the attention of leaders and policymakers.

Of the seven advocacy educational initiatives identified, four are part of the residency program's formal curriculum, one is offered in part as an elective with three sessions as part of the formal curriculum, and two were in the development phase at the time of this resource document's writing. Table 1 provides a summary of the general elements of each program, and further information on the specific contents of each program's advocacy curriculum is listed in Appendix A.

Table 1. Key elements of advocacy curricula within seven sample residency programs, as of January 2018.

Program	Initiated	Protected Time?	Didactic	Experiential
UCSF	9/2017	Yes	Curriculum teaches physician advocacy, structural competency, policy and stakeholder engagement, and writing for a public audience	Longitudinal advocacy project completed with faculty mentorship
Yale	9/2016	Not advocacy-specific	Coordinates with Yale Policy Initiative and other Yale-based groups and programs to provide didactics (e.g., seminars,	Group Legislative Project: advocate for legislation during Connecticut General Assembly via public hearing testimony,

			conferences, grand rounds); 3 sessions added as part of core curriculum to begin in April 2018	media outreach, and coalition-building
Univ. Illinois	9/2013	Yes	Two-part lecture series (didactics and special speaker)	Advocacy Day: full day at State Capitol, learning advocacy skills and speaking with legislators
Harvard	2015	Yes	Three-issue lecture series (advocacy, racism, and structural competency); informal "resident reflection" sessions to discuss sociopolitical issues	Community project competition; ad hoc experiential opportunities; staffing an asylum clinic; Advocacy Day in development
Univ. Mich	2016	Yes	Lectures for PGY-2s on psychiatry within the larger social context and for PGY-3s on social determinants, healthcare systems and financing, and laws/regulations on psychiatric practice across states	Elective in mental health policy/legal regulation of psychiatric practice allows residents to shadow state psychiatric health policy leadership and learn about internal advocacy; also have opportunities to meet with leadership from the state's executive, judicial, and legislative branches
HCMC	2015	Yes	Uses APA publication *Social Determinants of Mental Health* for resident-led discussions	Legislative Retreat: full day at State Capitol, learning advocacy skills and speaking with legislators; annual service project with scholarly component and group community project; administrative elective
Univ. Texas	9/2015	Yes	Three four-hour meetings per year on advocacy topics, with initial didactic followed by	Mental Health Day at State Capitol to meet with legislators and attend structured sessions on mental health

			special speakers' panel and breakout groups	

Legend: UCSF = University of California, San Francisco; Yale = Yale University; Univ. Illinois = University of Illinois, Peoria; Harvard = Harvard/Massachusetts General Hospital/McLean Hospital; Univ. Michigan = University of Michigan, Ann Arbor; HCMC = Hennepin County Medical Center; Univ. Texas = University of Texas, Southwestern; PGY = postgraduate year

These seven programs span a wide geographic range, including the Northeast (Connecticut, Massachusetts), the Southwest (Texas), the Midwest (Illinois, Michigan, Minnesota), and California. Some begin advocacy teaching in the PGY-I training year, but most focus their teaching during the PGY-II and PGY-III years. Each program's approach to advocacy varies, although most contain both didactic and experiential components.

As far as the didactic component, many programs focus their didactics on the explication and analysis of the social determinants of health, such as race, gender, and socioeconomic status. Didactics are often resident-led or tailored to the expressed interest of the current group of residents. Most programs invite special speakers, including legislators, community activists, journalists, to offer perspectives and answer questions.

As far as the experiential component, many programs have an annual experiential session, termed either "Advocacy Day" or "Legislative Retreat," during which psychiatry residents travel to their state's capitol and have the opportunity to meet state legislators and attend committee meetings. Some formal training in public speaking and written expression may occur during these events.

Even when advocacy training is an explicit goal for a residency program, multiple barriers to the creation, implementation, and longevity of these programs were identified during our survey. These include 1) the lack of a clear faculty internal champion/leader for advocacy; 2) limited time available for advocacy training; 3) the lack of a well-developed curriculum, and 4) the lack of faculty with advocacy experience. Figure 1 identifies potential action items to address these barriers.

All seven programs are still in the process of defining and refining their curricula, demonstrating that this is an evolving area for educational leaders. Compiling their

Figure 1. Approaches to enhance advocacy education in residency.

1) Prioritize advocacy at the level of program leadership
2) Identify blocks of time in which advocacy teaching can be incorporated
3) Develop or utilize a clear curriculum according to the best practices currently available
4) Identify faculty with advocacy experience to teach, or select from those who are enthusiastic about advocacy and help them gain the relevant experience

approaches here is a first step to identifying a "best practice approach" to advocacy training. It is our hope that offering these details as ideas will help programs that are contemplating this type of training augmentation.

The Role of the Accreditation Council for Graduate Medical Education (ACGME) in Promoting Advocacy

The Accreditation Council for Graduate Medical Education (ACGME), which is responsible for accrediting graduate medical training programs, including psychiatric residency programs, endorses advocacy within its competency framework for psychiatry: specifically, the ability to "advocate for quality patient care and optimal patient care systems" falls as a subheading under the competency of "systems-based practice" (ACGME, 2017, "Psychiatry"). Furthermore, the Psychiatry Milestone Project, developed jointly by the ACGME and the American Board of Psychiatry and Neurology (ABPN), evaluates residents' advocacy competency under multiple domains, including "medical knowledge," "systems-based practice," and "professionalism" (ACGME & ABPN, 2015). However, in the Psychiatry Milestone Project, the ability to advocate is generally considered an "aspirational" skill that "only a few exceptional residents will reach"; and neither competency framework elevates advocacy to the level of a core competency, as the Canadian CanMEDS framework does (Frank, 2005).

The ACGME's current stance on advocacy likely factors into the limited time generally devoted to teaching advocacy in psychiatric training programs. Although the skills and knowledge related to advocacy may be embedded in other topics areas, there is no specified time or educational unit expectation explicitly geared toward advocacy training. This could cause psychiatry residencies to consider advocacy a lower-priority teaching topic, if it is even considered a teaching topic at all. Given the multiple competing demands of residency, and the need to offer rigorous basic psychiatry training on numerous core elements, the addition of an advocacy curriculum to an already packed educational agenda could understandably be perceived as excessively burdensome and/or unrealistic. In counterpoint, however, it is notable that the ACGME's advocacy program requirements for psychiatry differ from those for pediatrics: in the latter, the ACGME specifies that at least five educational units, or five months, of ambulatory experience is required and should include "elements of community pediatrics and child advocacy" (ACGME, 2017, "Pediatrics"). This requirement may in part account for the more robust advocacy curricula currently available in pediatric residencies as compared to psychiatry residencies (e.g., Chamberlain et al., 2013), and suggests that a stronger emphasis on advocacy from the ACGME could galvanize psychiatry residency programs to develop advocacy curricula and engage faculty members as teachers of advocacy.

The Role of APA Governance in Promoting Advocacy

Advocacy is one of the APA's core goals, as it strives to represent the best

interests and wishes of both patients with mental illness and the psychiatric profession. A discussion of advocacy teaching would, therefore, be incomplete without mentioning the advocacy resources and services that the APA provides for its members, and how these can foster the education of future psychiatrist-advocates.

There are multiple individuals and groups within the APA's national and regional networks that perform key advocacy functions, but two main arms within the APA's national network focus directly on advocacy: the Council on Advocacy and Government Relations (CAGR), comprised of appointed APA members, and the Department of Government Relations (DGR), comprised of APA staff. As a permanent council of the APA, the role of CAGR is to provide policy guidance and grassroots advocacy to APA leadership, using the group's collective experience to inform the organization's positioning in political arenas. CAGR also reviews action papers, position statements, and other drafted APA documents and receives regular reports from the DGR to stay current on mental health issues on Capitol Hill as well as within state legislatures. The DGR, on the other hand, helps both APA members and staff stay attuned to legislative, regulatory, and governmental developments and provides resources to advocate on behalf of the APA on Capitol Hill and at the district branch level.

In its role as an advisory body on advocacy representing APA members across the country, CAGR is well-positioned, in consultation with other relevant councils, to serve as an in-house "think tank" to analyze, make recommendations, and distribute information about approaches to advocacy teaching in psychiatric residencies. The current resource document is one example of CAGR's work in this arena. To further assist APA members in learning and teaching about advocacy during training and beyond, CAGR is also in the process of developing an online module, entitled "Advocacy 101." This interactive tool will inform users about ways in which psychiatrists can advocate in a variety of settings, offer an outline of the legislative process at the state and federal levels, and introduce the range of resources that APA can provide in support of advocacy efforts. Members who seek to become more involved with advocacy efforts or who have questions, comments, or suggestions for the APA's advocacy arms are encouraged to reach out to CAGR, as the APA's advocacy efforts are informed by the voices of its members.

Summary

Advocacy is increasingly recognized as an integral part of a physician's professional role. Research suggests that advocacy skills and values, when acquired during residency, are likely to continue post-residency. Introducing advocacy curricula to psychiatric residencies is a potential way to encourage psychiatrists to participate in advocacy efforts throughout their careers. Over the past several years, largely in response to grassroots pressure from trainees or faculty active in advocacy, a number of psychiatry residency programs have started to train their residents to engage in advocacy in the

community and at all levels of government. This resource document highlights seven programs that currently have advocacy curricula available to their residents, and, although not exhaustive, provides a potential roadmap for psychiatric educators who are considering methods that might be effective to foster training and experience in this important area of psychiatric development. Regulatory and policy changes, including within the ACGME's training requirements for psychiatry, may encourage even more programs to adopt advocacy curricula. The APA plays an important role in ensuring that all psychiatry residents receive optimal advocacy education during their training years, and serves as a resource for educators and trainees interested in becoming more involved with advocacy teaching and with other advocacy efforts.

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Appendix A. Details of advocacy curricula within seven sample residency programs, as of January 2018.

This appendix details the advocacy curricula of the seven psychiatry residency programs sampled in the survey for this resource document. It has been reviewed and approved by all program directors as of January 2018, but because curricula are subject to change, the most up-to-date information can be obtained by contacting the programs directly.

1. California: University of California, San Francisco - Colin Buzza, M.D., Erick Hung, M.D. (Program Director)

Advocacy Curriculum Overview

- The UCSF Adult Psychiatry Residency Program features a new, two-year advocacy curriculum.
- Seven hours of protected educational time are included and provide a framework for physician advocacy as well as background on structural competency, policy and stakeholder engagement, and writing for a public audience.
- The curriculum culminates with a longitudinal advocacy project selected by residents and completed with faculty mentorship.

Other Advocacy Initiatives

- UCSF also has a "STEP UP" initiative (Zuckerberg San Francisco General Training and Education Programs for Underserved Populations).
    - Website at http://stepup.ucsf.edu
    - Interdisciplinary program available to any resident rotating at Zuckerberg San Francisco General Hospital
    - Curriculum includes educational strategies to provide background on policy, structural competency, leadership, and advocacy
    - Can obtain a Certificate in Health Equity by completing this initiative
- Other advocacy efforts involving UCSF psychiatry residents have included:
    - Working with residents from across disciplines to advocate for preserving the Affordable Care Act and Medicaid coverage via rallies, op-eds, and a social media campaign
    - Working with the residents' union (Service Employees International Union, SEIU) to advocate for increasing the availability of psychiatric beds and addressing homelessness via direct stakeholder engagement, op-eds, and social media

2. Connecticut: Yale University - Katherine G. Kennedy, M.D., Robert Rohrbaugh, M.D. (Program Director)

Advocacy Curriculum Overview

- An advocacy component was added to the PGY-II core curriculum in April 2018.
    - Consists of 4.5 hours over three sessions as part of a new teaching initiative on social justice and health inequity
    - One session focuses on community advocacy, and the remaining two sessions focus on legislative advocacy skills
- A pilot advocacy elective was started in September 2016 with the following rationale: "Our mental health care system is in the process of undergoing enormous transformation. The decisions made in the next few years will impact the way health care is organized and delivered for the next generation. Understanding how to advocate for a better mental health care delivery system is critical to ensuring that patents have access to quality mental health services."
    - A hands-on experience designed to help Yale psychiatry residents understand how the legislative process works in the Connecticut General Assembly (CGA) and how advocates can work within that system to support or oppose legislation
    - Includes opportunities to tour the State Capitol, meet with state senators and representatives, provide oral and written testimonies to CGA committee hearings, and network with other advocates and organizations
    - For the elective's didactic component, leaders of the elective coordinate with the Yale Policy Initiative and other Yale-based groups to host special speakers for seminars, conferences, and grand rounds
    - Open to PGY-IIIs and PGY-IVs at Yale, in addition to fellows and faculty members
- Five hours of protected time is set aside during the PGY-III and PGY-IV schedules for elective experiences. Yale offers a wide variety of electives from which residents may choose; residents often select one or more electives.

Advocacy Curriculum Details

Educational Goals and Objectives

- At the end of this elective, trainees should be able to:
    - Discuss the legislative process in the Connecticut General Assembly
    - Recognize current issues of national concern in the mental health care delivery system, including access to treatment, parity, and scope of practice issues

- Understand how advocates can work with state legislators to improve mental health services
- Apply the principles of effective oral and written testimony at public hearings
- Develop an approach for coalition-building with other advocates and advocacy organizations
- Appreciate how stigma against mental illness can impact advocacy efforts
- Appreciate how the psychiatrist's perspective can assist journalists and other media producers

Group Legislative Project

- Each resident will participate in a group legislative project during this elective. The number of projects will be entirely determined by resident interest.
- In this project, residents will:
  - Work together to identify an area of interest
  - Research the history of state and federal policies for that interest
  - Work with key state lawmakers to develop a legislative solution
  - Advocate for that legislation throughout the CGA 2017 session, using methods such as public speaking, media outreach, coalition-building, and community organizing
- Timeline for the legislative project:
  - September-November: Identify an issue of concern; research the history of legislation for that issue in Connecticut and other states; propose a legislative solution
  - November-January: meet with legislators about the proposed legislation; facilitate submission of that legislation
  - February-March: each resident will submit written testimony and, depending on work schedules, also provide oral testimony at a public hearing at the State Capitol
  - March-June: follow the bill in CGA; set up letter, phone, and email campaigns to legislators; work with media to increase awareness and further grassroots efforts

<u>3. Illinois: University of Illinois, Peoria - Ryan Finkenbine, M.D. (Program Director)</u>

Advocacy Curriculum Overview

- A four-year advocacy curriculum began in Fall 2014.
- The curriculum is divided into three parts. All residents attend Parts I (advocacy basics) and II (special speaker), while Part III (advocacy day) is for PGY-IIIs

only.

Advocacy Curriculum Details

Three-Part Curriculum

- Part I consists of a two-lecture series, each lecture being 1.5-2 hours in length.
    - Lecture 1: how laws are passed, and what physicians can do
    - Lecture 2: overview of current issues facing psychiatry—issues are gleaned from the APA, the Illinois Psychiatric Society (IPS), and a literature and media review
- Part II consists of a special speaker's presentation (e.g., a local, state, or federal legislator). In the past, the program has had state representatives and U.S. Representative Darin Lahood speak. In the future, it may bring in leaders from mental health organizations or the Director of the Illinois Department of Human Services (DHS).
    - In addition to residents, faculty, hospital administrators, and media can attend
    - Residents invited to submit questions in advance of the speaking program
- Part III is entitled "Advocacy Day" and consists of a full day spent at the Illinois State Capitol. Residents prepare for this experience by developing a one-page memo that outlines current issues and concerns, usually based on IPS issues. Residents fill out a pre and post assessment form for this section of the course. The Advocacy Day schedule is as follows:
    - AM: orientation to the APA and political action committees, with emphasis on APA and IPS priorities; overview of the Illinois General Assembly and mental health care rules/laws/issues; learning about consumer groups and professional interest groups and how they may impact patient care
    - PM: each resident paired with a legislator; resident discusses with the legislator his or her one-page memo
    - Full group of legislators and residents meet to discuss the memos/IPS issues
    - Photo opportunities

<u>4. Massachusetts: Harvard/Massachusetts General Hospital/McLean Hospital - Mary C. Vance, M.D., Derri Shtasel, M.D., M.P.H., Scott Beach, M.D. (Program Director)</u>

Advocacy Curriculum Overview

- In 2015, an advocacy group called the Resident Advocacy Committee (RAC) was

formed by psychiatry residents, with a focus on "improving care for patients with mental illness through education, community outreach, and legislative efforts."
    - Website at http://mghmcleanpsychiatry.partners.org/advocacy/home/
- The group's first effort was to translate general interest in advocacy into specific actions. The group chose to use education as a vehicle, to create core curricular material that aligned with priorities of the Division of Public and Community Psychiatry. Two areas were selected: 1) advocacy fundamentals and 2) racism as a social determinant of mental health. These areas would be embedded in the residency curriculum and span four years of training.
- This curriculum is now integrated into the residency training program formally, with funding support and website visibility (to facilitate awareness, promote a cultural shift to include advocacy efforts, and assist in prospective resident recruitment).
- An "Advocacy Day" to the Massachusetts State House is in planning but not fully implemented.
- Multiple ad hoc experiential opportunities are also available for all residents to attend—National Alliance on Mental Illness (NAMI) walks, protest marches, homeless census, etc. These are publicized through the RAC's listserv.

Advocacy Curriculum Details

Three-Issue Lecture Series

- The first lecture series addresses advocacy fundamentals and consists of four lecture hours over two years (a one-hour lecture during PGY-II and a three-hour panel during PGY-III).
    - PGY-II lecture: "Introduction to Advocacy" – focus on bringing in an engaging speaker who can act as an inspiring role model for advocacy; most recently Ken Duckworth, M.D., Medical Director of NAMI
    - PGY-III panel: "Advocacy in Psychiatry" – focus on either an issue of interest or on more granular discussion of aspects of advocacy; panel usually includes local community health care advocates
- The second lecture series addresses racism as a social determinant of health and consists of four lecture hours over four years (a one-hour lecture for each PGY class). Its purpose is to bring awareness to racism as a unique determinant of mental health; provide historical context; and focus on the impact of racism on psychiatric evaluation, diagnosis and treatment.
    - PGY-I through PGY-III lectures presented by residents, each focusing on one level of racism and its impact: structural racism (how racism is imbedded within the makeup of neighborhoods), personally mediated racism (the role of bias in diagnosis and treatment), and internalized

racism (consequences of implicit bias and microaggressions)
    - PGY-IV lecture varies each year, with an emphasis on using advocacy to address the impact of structural racism
- The third lecture series addresses structural competency: i.e., learning to identify, address, and engage with structural factors affecting patient care. This lecture series is in development.

Funding Support

- A community project competition is hosted yearly by the RAC, awarding $1500 in funding to the best advocacy project pitch.
- RAC members can also request funds from the program director for advocacy-related events/projects (e.g., defraying costs of food and travel to advocacy events, providing refreshments at RAC meetings, ordering RAC pins).

Research and Education

- The RAC also prioritizes quality improvement for the advocacy curriculum, preserving and disseminating the curriculum for other audiences, and research into advocacy best practices. As such, the following efforts towards these goals have been made:
    - Pre and post surveys conducted for both the advocacy lecture series and the racism lecture series
    - Advocacy and racism lectures and concepts presented at national meetings:
        - Medlock MM, Weissman A, Carlo A, Zeng MC, Shtasel D, Rosenbaum J. Residents teaching about racism: a novel educational approach to combating racial discrimination in mental health care (workshop). American Psychiatric Association Annual Meeting, Atlanta, Georgia, May 2016
        - Shtasel D, Weissman A, Carlo A, Beckmann D, Medlock MM. Teaching residents about racism: prevention? Institute for Psychiatric Services, Washington DC, October 2016
        - Publishing the racism curriculum :Medlock MM, Weissman A, Wong SS, Carlo, A. Addressing the legacy of racism in psychiatric training. *Am J Psych Residents' Journal* 2016; 11(2):13
        - Medlock MM, Weissman A, Wong SS, Carlo A, Zeng MC, Borba C, Curry M, and Shtasel D. Racism as a unique social determinant of mental health: development of a didactic curriculum for psychiatry residents. *MedEdPORTAL Publications* 2017;13:10618 https://doi.org/10.15766/mep_2374-8265.10618

Other Advocacy Initiatives

- The internal medicine and pediatrics residencies at the Massachusetts General Hospital also have active resident advocacy groups, with which the RAC is in the process of developing collaborations.
- Multiple advocacy organizations also exist locally in Boston, and residents occasionally attend these groups' events and/or invite them as speakers. These include:
    - The Boston University Advocacy Training Program (BUATP), out of the Boston University School of Medicine, which has a robust advocacy training curriculum and hosts an annual Boston Student Health Activist Summit (BSHAC) (website at http://blogs.bu.edu/buatp/)
    - The Student Coalition on Addiction (SCA), "a group of health care students … working to advocate for residents with and at risk for substance use disorders, including those disadvantaged by homelessness, poverty, racism, and other systemic forces" (website at https://ma-sca.org)
    - Right Care Alliance, a national organization with an active Boston chapter, focused on improving the health care system in general by combating wasteful overuse and underuse; interested in input from psychiatrists (https://rightcarealliance.org/)
- Asylum clinic: The RAC has been working with internal medicine to help staff a new MGH asylum clinic started in Fall 2017, which offers medical and psychological evaluations to people seeking asylum. These evaluations can be presented in court to support the need for asylum.
- Resident reflections: The RAC has held informal gatherings amongst residents to meet and discuss current sociopolitical topics.

5. Michigan: University of Michigan, Ann Arbor - Debra A. Pinals, M.D., Michelle Riba, M.D., Michael Jibson, M.D., Ph.D. (Program Director)

Advocacy Curriculum Overview

- A didactic curriculum spans the four years of residency.
- An experiential elective has also been established to allow for exposure to internal advocacy related to mental health policy and the legal regulation of psychiatric practice.

Advocacy Curriculum Details

Didactic Component

- In PGY-I and PGY-II, there is a didactic review of psychiatry in the social context.
- In PGY-III and PGY-IV, there is a didactic related to healthcare systems and financing as well as a didactic examining the legal regulation of psychiatric practice across states.
- Residents participating in the experiential elective are expected to develop a brief overview of lessons learned and to provide training for their resident colleagues about one health policy area to which they were exposed.

Experiential Elective Component

- This experiential component includes shadowing the State Medical Director for Behavioral Health within Michigan and participating in activities such as:
    - Legislative development
    - Policy development
    - Attendance at meetings
    - Attendance on tours of programs
- Another available experiential route involves participation with faculty leaders in activities such as:
    - Attendance at university-level administrative meetings

Discussing advocacy with faculty that have served in major psychiatric leadership roles (including a past president of the APA and past presidents of other allied psychiatric organizations) in a mentoring elective

6. Minnesota: Hennepin County Medical Center - Scott Oakman, M.D. (Program Director)

Advocacy Curriculum Overview

- HCMC's advocacy curriculum consists of both didactic and experiential components.
- Experiential components include an annual service project, an administrative elective, and a one-day legislative retreat.
- The curriculum uses *Social Determinants of Mental Health*, an APA publication, (2015, editors Michael T. Compton and Ruth S. Shim) as a resource. This book "provides a foundation of knowledge on the social and environmental underpinnings of mental health and mental illnesses for clinical and policy decision making, with a goal to improve the mental health of individuals across diverse communities and the mental health of the nation as a whole."

Advocacy Curriculum Details

Didactic Component

- PGY-II: resident-led discussions use *Social Determinants of Mental Health* as their source text.
    - For each class, one resident takes charge of a chapter to summarize
    - Discusses case(s) from his or her own practice/experience
    - Provides community examples
    - Leads discussion on ideas for interventions and actions

Experiential Component

- PGY-II: residents engage in an annual service project.
    - Needs to have a component of scholarly activity
    - Are group projects in which residents connect with a hospital-sponsored service activity (e.g., patient education projects, presentations in schools, NAMI, anti-stigma campaigns like MakeItOK.org)
- PGY-IV: there is an opportunity for an administrative elective, in which the resident shadows the Psychiatry Chair and other administrative leaders.
- PGY I-IV: a one-day legislative retreat is available for all levels of residents. The retreat schedule is as follows:
    - AM: advocacy training with APA/CAGR (discussion of the legislative process, state and federal issues, and how to effectively communicate with legislators), NAMI Minnesota (state legislative issues and the role of NAMI in advocacy), the Minnesota Psychiatric Society, and the Minnesota Medical Association
    - PM: experience at the Capitol, in which residents meet with legislators and legislative staff and attend committee meetings; focus on educating legislators, fielding questions, and gaining a better understanding of the political process

<u>7. Texas: University of Texas, Southwestern - Lindsey Pershern, M.D., Adam Brenner, M.D. (Program Director)</u>

Advocacy Curriculum Overview

- In the past, the program's only advocacy focus was on "Mental Health Day," during which residents were bussed to the State Capitol (Austin, Texas) to meet legislators and had structured events to discuss mental health.
- A new advocacy curriculum was started in Fall 2015, geared for all years of psychiatric residency.
- An afternoon workshop occurs every four years, with three meetings on a special topic and four hours allotted per meeting.

    - Residents have input on selecting the special topic, which allows topics to be tailored to that group's interests and fosters a more collaborative effort with them.
    - Meetings are focused on hands-on learning, not simply didactics—more of a workshop than a lecture, since residents prefer this.
- All residents have protected time for these workshops.

Advocacy Curriculum Details

Special Session - Afternoon Advocacy Workshop (occurs once every four years)

- Each workshop begins with a didactic piece—i.e., what advocacy is at different levels, from patient to political.
- This is followed by a panel, in which each panelist responds to the question, "How do you define advocacy?" Past panelists include:
    - State Representative
    - mental health journalist
    - president of NAMI Texas
    - representative from a mental health policy institute
    - representative from an advocacy institute in Texas
- The panelist question-and-answer session is followed by a breakout session. There are eight groups and eight residents per group, each with a facilitator leading a case-based discussion.
- Finally, all breakout groups return to the large group to discuss.
- In addition to the special session, components of the workshop are integrated yearly into two hours of PGY-1 lecture/discussion sessions. The content of these sessions is dynamic and target the needs of the incoming resident class.

Item 8.C
Joint Reference Committee
June 2018

EXECUTIVE SUMMARY

Council on Children, Adolescents, and Their Families

Council Overview

The work of the Council is directed toward maximizing the effectiveness of APA in addressing the mental health needs of children, adolescents, and their families. Its charge is primarily carried out through APA meetings workshops, position statements, and collaborations with APA Councils and allied children and adolescent's organizations.

The Council met via conference call on April 11, 2018 at 7:00PM EST and in-person on May 7, 2018 at the 2018 APA Annual Meeting. The following action items stemmed from previous meetings:

Action Items

ACTION: Will the Joint Reference Committee recommend that the Board of Trustees vote to retire the APA Position Statement on Reactive Attachment Disorder (2007)? See attachment 4

ACTION: Will the Joint Reference Committee recommend that the Board of Trustees vote to retain the APA Position Statement on Family Planning (2007)? See attachment 5

Information Items

1. As a request from the Council on Quality Care, the Council reviewed and provided feedback on the importance and relevance of the CMS measure *Screening for Pregnancy*.
2. The Council is interested in developing a toolkit on transitional age youth in collaboration with the Caucus on College Mental Health.
3. The Council plans to explore a potential position statement involving the impact of forced separation of children and infants from their parents as it relates to the immigrant population.
4. The following interest groups continue to develop educational resources and policies to further address the needs of children, adolescents, and their families: Integrated Care, Juvenile Justice/Corrections, Social Media, TAY/Adult Psychiatrists, Gender Dysphoria/Transgender Mental Health, Immigrant and Refugees, First Break Psychosis

Attachments

1. April 2018 Minutes
2. May 2018 Agenda
3. May 2018 Minutes
4. APA Position Statement on Reactive Attachment Disorder
5. APA Position Statement on Family Planning

MINUTES

Council on Children, Adolescents and Their Families
April 11, 2018, 7PM-8PM ET

Present
Jospeh Penn, M.D – Chair
Azeesat Babjide, M.D
Cailtin Costello, M.D.
Tresha Gibbs, M.D.
Warren Ng, M.D.
Mary Ann Schaepper, M.D. (ASM)
Gabrielle Shapiro, M.D.
Carlos Fernandez, M.D. – SAMHSA Fellow
Haoyu Lee, M.D. – SAMHSA Fellow
Thien Chuong Richard Ly, M.B.B.S. – APA/APAF Child and Adolescent Psychiatry Fellow
Ferdnand Osuagwu, M.D. – Diversity Leadership Fellow
Colby Tyson, M.D. – SAMHSA Fellow
Mark Chenven, M.D.

Excused
Steven Adelsheim, M.D.
Kimberly Gordon, M.D. (ECP)
Samina Aziz, M.D.
Lisa Cullins, M.D. – AACAP Liaison
Lorena Reyna, M.D. – Diversity Leadership Fellow
Cindy Vargas-Cruz, M.D. – SAMHSA Fellow

Absent
Michael Houston, M.D.
Ricardo Vela, M.D.
Krystal Clark, M.D., M.Sc.
Christina Cruz, M.D. – SAMHSA Fellow
Qortni Lang, M.D., M.S. – APA/APAF Child and Adolescent Psychiatry Fellow
David Saunders, M.D., Ph.D. – APA/APAF Leadership Fellow
Michael Morse, M.D.

Meeting Minutes

1. Welcome/approval of minutes
    a. Dr. Penn began the call with welcoming remarks
2. Update from First-Episode Psychosis Interest Group
    a. Dr. Gibbs gave an update on the first break psychosis workgroup.
    b. The workgroup reached out to Dr. Anita Everett and are looking to focus on billing/coding and a potential collaboration with the Council on Healthcare Systems and Financing.
    c. Members voice their support of the workgroup and also questioned how programs could be sustained.
    d. Potential collaboration with AACAP and systems of care.
    e. An action paper on early onset psychosis would be practical and timely.
    f. The group plans to meet in-person at the Annual Meeting.
3. Agenda item request for the Annual Meeting
    a. Updates will be given by:
        i. APA Division of Government Relations
        ii. AACAP - Parent Guide

   iii. Caucus on College MH
   iv. Minority MH Council (?)
b. Members requested an update on Typical or Troubled, first break psychosis, marijuana use, impact of forced separation

4. Members' Annual Meeting presentations cover a wide range of subjects including but not limited to transition aged youth (Babajide), social media (Costello), HIV (Ng), and Latino mental health (Fernandez).
5. Lastly, Dr. Shapiro mentioned support of the APA Foundation Benefit, which will take place on Saturday, May 5 at the Marriott Marquis.

AMERICAN PSYCHIATRIC ASSOCIATION

AGENDA

2018 Annual Meeting – Council on Children, Adolescents and Their Families
Monday, May 7, 2018
2:30 p.m. – 5:00 p.m. ET
Sheraton New York Times Square Hotel, Empire East, 2nd Floor

Agenda Item	Presenter
Opening Remarks/Welcome	Joseph Penn, M.D., Council Chair Saul Levin, M.D., M.P.A., APA CEO and Medical Director
Update from APA Caucus on College Mental Health	Amy Alexander, M.D. Ludmila DeFaria, M.D.
AACAP Update	Karen Wagner, M.D., Ph.D, President, AACAP Heidi Fordi, CAE, Executive Director, AACAP Carmen Head, MPH, Director of Research, Training and Education, AACAP Rob Grant, Communications Director, AACAP
Update on APA Foundation's Typical or Troubled®	Christopher Seeley, Program Director of School and Justice Initiatives, APA Foundation
Update on APA/APAF Child and Adolescent Psychiatry Fellowship	Cathryn Galanter, M.D., Chair of the APA/APAF Child and Adolescent Psychiatry Fellowship Selection and Advisory Committee

Breakout Groups or Break	
Update from APA Division of Government Relations	Megan Morino, Director of Federal Relations, APA Mikael Troubh, Director of Federal Relations, APA
Council Member Recognitions	Joseph Penn M.D.
Closing Remarks	Joseph Penn, M.D.

AMERICAN PSYCHIATRIC ASSOCIATION

MINUTES

2018 Annual Meeting – Council on Children, Adolescents and Their Families

Monday, May 7, 2018

2:30 p.m. – 5:00 p.m. ET

Sheraton New York Times Square Hotel, Empire East, 2nd Floor

Attendance

Present:
Gabrielle Shapiro, M.D. – Acting Chair
Steven Adelsheim, M.D.
Azeesat Babjide, M.D
Cailtin Costello, M.D.
Tresha Gibbs, M.D.
Kimberly Gordon, M.D. (ECP)
Warren Ng, M.D.
Mary Ann Schaepper, M.D. (ASM)
Mark Chenven, M.D.
Christina Cruz, M.D. – SAMHSA Fellow
Carlos Fernandez, M.D. – SAMHSA Fellow
Qortni Lang, M.D., M.S. – APA/APAF Child and Adolescent Psychiatry Fellow
Haoyu Lee, M.D. – SAMHSA Fellow
Thien Chuong Richard Ly, M.B.B.S. – APA/APAF Child and Adolescent Psychiatry Fellow
Ferdnand Osuagwu, M.D. – Diversity Leadership Fellow
Lorena Reyna, M.D. – Diversity Leadership Fellow
David Saunders, M.D., Ph.D. – APA/APAF Leadership Fellow
Colby Tyson, M.D. – SAMHSA Fellow
Lisa Cullins, M.D. – AACAP Ex Afficio

Absent:
Michael Houston, M.D.
Ricardo Vela, M.D.
Krystal Clark, M.D., M.Sc.
Michael Morse, M.D.

Excused:
Joseph Penn, M.D – Chair
Samina Aziz, M.D.
Cindy Vargas-Cruz, M.D. – SAMHSA Fellow

Guests:
Tim Van Deusen, M.D.
Rob Grant, AACAP
Carmen J. Head, AACAP
Karen Wagner, AACAP
Heidi Fordi, AACAP
Cathryn Galanter, M.D.
Amy Alexander (formerly Amy Poon), M.D.
Ludmila DeFaria, M.D.

APA Administration:
Tatiana Claridad, Staff Liaison
Saul Levin, M.D., M.P.A.
Yoshie Davison, APA MDO
Judson Wood, APA MDO
Megan Marcino, APA DGR
Mikael Troubh, APA DGR
Christopher Seeley, APA Foundation
Harsha Amaravadi, APA Foundation

Opening Remarks/Welcome

- Dr. Shapiro started the meeting with introductions in Dr. Penn's excused absence

AACAP Updates

- Karen Wagner, M.D., AACAP President gave an update on her initiatives for her presidential term
- AACAP touched on updating the Parents Medication Guide, Facts for families, AACAP News, and screening tools for youth
- AACAP looks forward to collaborating with APA, American Pediatric Association, and SAMHSA
- AACAP's Annual Meeting is in Seattle from October 22-27, 2018. It will focus on depression and suicide and will also cover research issues and recruitment
- Carmen Head updated the group that the new Research Poster deadline is June 15, 2018

Caucus on College Mental Health

- Amy Alexander, M.D. and Ludmila DeFaria, M.D. gave an update on the work of the Caucus on College Mental Health. 40-50 members attended the 2018 Annual Meeting Caucus meeting in NYC. The Caucus plans to address emotional support animals in the future. They thanked the Council for their contributions to the HEMHA guide in such short notice.

APA/APAF Child and Adolescent Psychiatry Fellowship Update

- Cathryn Galanter, M.D., Chair of the Child and Adolescent Psychiatry Fellowship Selection and Advisory Committee gave an update on the Council on Children, Adolescents, and Their Families. She announced the selection of five new incoming Fellows; they will begin their Fellowship in July 2018.
- The Council hopes to see the Fellowship grow to accept more Fellows in the future.

Remarks from APA CEO and Medical Director (Saul Levin, M.D., M.P.A.)

- Dr. Levin gave visited the Council midway during the meeting and thanked everyone for their contributions to the Council. He emphasized AACAP and APA will be discussing further on collaborations.

APA Foundation (APAF) – Typical or Troubled Update

- Christopher Seeley, Program Director, School and Justice Initiatives, along with Harsha Amaravadi, gave an update on the developmental status of Typical or Troubled
- Questions that came up during the conversation: What can the Child Council do? What can the Child psychiatrists do?
- APAF plans to leverage all the resources that exist and be strategic knowing the uniqueness of their voice
- Council members commented that if APA and APAF partnered with NAMI we will play a different role

DGR Update

- Megan Marcino and Mikael Troubh, APA Directors of Federal Relations gave a broad overview of the legislative matters within the house of medicine

- The Council was interested in learning about the following topics: Eligibility for National Health Service Corp, Dreamers, Immigrants, Youth Coalitions

The meeting concluded with feedback from Fellows and members. Fellows recommended that staff provide a broad overview of current Council initiatives and bios of council members. Dr. Shapiro acknowledged those who would be rotating off after the 2018 Annual Meeting and thanked them for their service.

Position Statement on Reactive Attachment Disorder

Approved by the Board of Trustees, June 2002
Approved by the Assembly, May 2002
Reaffirmed, 2007

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

Reactive Attachment Disorder (RAD) is a complex psychiatric condition that affects a small number of children. It is characterized by problems with the formation of emotional attachments to others that are present before age 5. A parent or a physician may first notice problems in attachment with the caregiver that ordinarily forms in the latter part of the first year of the child's life. The child with RAD may appear detached, unresponsive, inhibited or reluctant to engage in age-appropriate social interactions. Alternatively, some children with RAD may be overly and inappropriately social or familiar, even with strangers. The social and emotional problems associated with RAD may persist as the child grows older.

Children with RAD have had problems or severe disruptions in their early relationships. Many have been physically, emotionally or sexually abused. Others have experienced episodes of prolonged isolation or neglect. Some have had multiple or traumatic losses or changes in their primary caregiver.

Children who exhibit signs of RAD need a comprehensive psychiatric assessment. Particular care must be taken to distinguish RAD from one of the Pervasive Development Disorders, such as Autistic Disorder. These conditions are known to be neurodevelopmental in origin and are not caused by problems in early parenting.

Children with RAD will benefit most from an individualized treatment plan that will usually include work with the child's family to help them foster an attachment to their child. Except when complicating factors arise, hospitalization is generally contraindicated since the treatment goal is fostering an attachment between child and parent.

While some therapists have advocated the use of so-called coercive holding therapies and/or "re-birthing techniques", there is no scientific evidence to support the effectiveness of such interventions. In fact, there is a strong clinical consensus that coercive therapies are contra-indicated in this disorder. And unfortunately, as recent events attest, such unproven and unconventional therapies can also have tragic consequences.

Parents and caregivers of children who show signs or symptoms of RAD should:

- seek a comprehensive evaluation by an appropriately trained, qualified and experienced mental health professional prior to the initiation of any treatment plan,
- ask questions about the results of the evaluation,
- make sure they understand in detail the risks as well as the potential benefits of any intervention, and
- feel free to seek a second opinion if they have questions or concerns.

Evaluating and treating children with complex child psychiatric conditions such as Reactive Attachment Disorder is challenging. There are no simple solutions or magic answers. However, close and ongoing collaboration between the child's family and the treatment team will increase the likelihood of a successful outcome.

Reaffirmed, 2007

Position Statement on Family Planning

"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.*

Approved by the Board of Trustees, December 1973
Endorsed by the Assembly, November 1973

This statement was prepared by the Task Force on Family Planning and Population.[1]

INDIVIDUAL CHOICE as to whether and when to become a parent and the prevention of unwanted pregnancy or birth is an important way to promote and safeguard the health and welfare of Individuals, families, and communities. Birth control, including contraception, medically safe abortion, and voluntary sterilization should therefore be available universally to every individual on request to prevent unwanted pregnancy or parenthood as a part of standard health care and medical services.

[1]The task force included: Eugene B. Brody, M.D., chairman, Robert Cancro, M.D., Stephen Fleck, M.D., and E. James Lieberman, M.D.; Henry P. David, Ph.D., Cornelia Friedman, M.D., Zigmond M. Lebensohn, M.D., Warren Miller, M.D., Lucile Newman, Ph.D., and M.D. Shelesnyak, Ph.D., consultants; Richard Barthel, M.D., Falk Fellow; John Cawte, M.D., and James Fawcett, Ph.D., corresponding consultants; and Lane Ameen, M.D., liaison with the Council on Emerging Issues.

(*American Journal of Psychiatry* 131:4, 498)

The American Psychiatric Association
1000 Wilson Boulevard, Suite 1825 • Arlington, VA 22209
Telephone: (703) 907-7300 • Email: apa@psych.org

Item #8.D
Joint Reference Committee
June 2018

Council on Communications Report to the JRC

Link to attachment:

APA Resources for improving perceptions of Psychiatrists among non-medical Mental Health Professionals and Medical Students

Action Items:

The Council on Communications has no action items for the JRC to review.

Referral Updates:

The Department of Communications and Public Affairs was asked by the Department of Education to provide a list of resources that cover the actions laid out in Action Item ASM2017A1 12.I, titled *Educational Strategies to Improve Mental Illness Perceptions of Medical Students.*

This feedback was shared with Tristan Gorrindo, Director of APA's Department of Education, who was listed as the primary reviewer of this action item and is attached to this report.

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Other Council Business:

The Council discussed revisions to APA's Mission and Vision Statements at the request of Dr. Levin. Dr. Drew Ramsey presented a first draft for changes to the Mission and Vision Statements to the council, who offered feedback. Dr. Ramsey is incorporating that feedback into a draft that will be sent to Dr. Levin for review at a later date. If approved, it will be sent to the JRC for consideration.

The Council hosted a discussion on working with the media as a psychiatrist led by guest speaker Dr. Christy Duan, who is an APA member who had an internship rotation with ABC News. The discussion centered on the challenges in covering a subject like mental health and substance use disorders, and best practices for finding an outlet or publisher to disseminate one's works.

The Council discussed prospective APA involvement in film and television projects. Council discussion in this instance focused on two film projects: "Far From the Tree," a documentary based on the book of the same name by Andrew Solomon, and "Do No Harm," an independently produced documentary on physician suicide.

"Far From the Tree" received a positive reaction from council members, who praised its accurate and compassionate portrayal of people coping with and receiving treatment for mental illness and substance

use disorders. Council members agreed that if APA is going to partner with or promote a film in the near term, Far From the Tree would be an excellent candidate.

Conversely, “Do No Harm” was thought to be overly sensational and possibly misleading. Dr. Carol Bernstein suggested that Directors of Medical Student Education and PsychSIGN groups become involved in prospective screenings at medical schools, which the filmmaker has used to promote the film.

There was additional discussion about the larger question of when and how the APA should become involved with projects. Council members agreed that the APA should develop a formal protocol for fielding requests for collaboration or partnership from filmmakers and other figures in the world of entertainment media.

APA Resources for improving perceptions of Psychiatrists among non-medical Mental Health Professionals and Medical Students

Many of the day-to-day operations of the APA and its staff result in programs, activities, and other resources designed to promote the role of psychiatrists as medical leaders for the mind, brain and body, and fight against persistent problems such as stigma and misinformation around the diagnosis and treatment of mental illness and substance use disorders.

The most basic of these resources is a webpage on psychiatry.org that answers the question: "What is Psychiatry?" The page defines the practice of psychiatry, discusses the diagnosis and treatment of patients that the average psychiatrist engages in, and explores the medical training required to become a psychiatrist. The page also makes clear the difference between psychiatrists and psychologists, something that is often a source of confusion among the public and even at times the media.

Many other similar resources, such as "What is Mental Illness?," "What is ECT?" and "What is Telepsychiatry?," are part of the "Patients & Families" section on Psychiatry.org and exist to correct common misconceptions about the nature, diagnosis and treatment of mental illness and substance use disorders, inform members of the public and media, and reassure patients who may be apprehensive about undergoing these treatments or even seeking treatment at all.

The Patients & Families section is also home to a number of webpages dedicated to many specific mental disorders, such as depression, gender dysphoria, and addiction and substance use disorders. Each of these pages hosts a basic definition of a given disorder, blog posts and news items related to that disorder, frequently asked questions answered by experts in the field, additional resources hosted by APA and allied groups, upcoming events, and patient stories from actual patients sharing their personal experiences coping with a given disorder. New pages are added on a rolling basis, and each one is reviewed by a physician on a regular basis to ensure that the information it contains is accurate, easy to understand and medically correct.

One of the ways that APA lives up to its motto of "medical leadership for mind, brain and body is by serving as the go-to source for accurate, medically correct information on issues related to mental health and substance use disorders. The "Newsroom" section of psychiatry.org is full of APA's statements from APA leadership and spokespeople, and makes clear where our organization and members stand on the important issues of the day as they pertain to psychiatry. The news releases hosted on this site cover everything from APA organizational news like election results and APA partnerships with allied groups, to the release of cutting edge medical research.

Also included in the Newsroom section are APA's Blogs, which cover a similarly expansive array of topics. Many of these blogs are written with a lay-audience in mind, but others are aimed at medical professionals both in and outside the organization. The "What APA is Doing for You" section is designed to keep members informed about important initiatives being undertaken by the APA on behalf of its membership, including lobbying efforts by APA's Department of Government Relations at both the State and Federal level.

APA engages in extensive outreach to doctors and medical students at home and abroad with the goal of building partnerships to support APA's broader mission and help end the stigma against mental illness and substance use disorders among the general public. Full pages are dedicated to international

psychiatry, where APA is actively engaged in building a global network of psychiatrists, and resources for psychiatry residents and early-career psychiatrists. The Med Students page on Psychiatry.org has a wealth of information and resources designed with students considering a career in psychiatry in mind. In addition, APA offers free membership for medical students, who receive the full range of benefits available to members, including mentoring career development, and free subscriptions to the American Journal of Psychiatry and Psychiatric News.

APA maintains an active presence on all major social media platforms, including Facebook, Twitter, LinkedIn and Instagram. These channels offer APA a way to foster conversations directly with members and the public, and give APA messaging astounding reach. Social media also allows us to collaborate with allied groups on events like Twitter Chats, which are fantastic for gauging public thinking around a given subject, such as depression, and promoting APA resources on that topic.

All of the resources listed above are designed to place APA, its members, and the profession of psychiatry in general in a place of confident leadership where matters of the mind and brain health are concerned. They are the online component of a larger network of that extends from every employee to all 37,000+ members of the APA and their respective district branches, the work of the APA Foundation and the numerous publications of American Psychiatric Publishing.

Item #8.E
Joint Reference Committee
June 2018

Executive Summary

The Council on Consultation-Liaison Psychiatry 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.

Since the JRC report in February, the Council has focused on the following issues:

- **Member Education Activities:** Since the Board approved the name change last spring, the Council is identifying opportunities to communicate the new name change to APA members, other professional groups, and the public through *Psychiatric News*, the Annual Meeting, and shareable resources to illustrate the breadth and depth of Consultation-Liaison (C-L) Psychiatry. Below are specific activities:
    - A series of articles promoting C-L Psychiatry in *Psychiatric News* will include topics such as women's perinatal health, HIV, neurology, oncology, transplant surgery, and cardiology. The first article released at the Annual Meeting focused on the name change. (https://psychnews.psychiatryonline.org/doi/full/10.1176/appi.pn.2018.5a5)
    - A Prezi video is being modified to help recruit medical students into the sub-specialty and the group is expanding into other communications and social media.
    - Sessions were included at the Annual Meeting showing the breadth and depth of C-L Psychiatry. In total there were 34 sessions specifically dedicated to C-L topics.

- **Resource Documents:** The Council has a number of workgroups underway focused on the following:
    - "The Assessment of Capacity for Medical Decision Making"
    - "QTc Prolongation and Psychiatric Disorders"
    - "Emergency Department Boarding of Individuals with Acute Mental Illness"
    - "Psychiatric Issues in Infertility"

The Resource Document on "QTc Prolongation and Psychiatric Disorders" is ready for JRC approval as noted below.

- **HIV Steering Committee:** The Committee developed a Position Statement and accompanying resource document on Pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) for HIV prevention. Given that antiretroviral-based therapy is relatively new, they have received questions on the topic and want to provide guidance through a Position Statement. The Committee will have the position statement and resource document ready for the next JRC meeting.

  The committee reviewed 10 position statements and is considering 8 to be retired because the information is included in more recent position statements or the information is no longer needed (see bullets). Of the others, one is being updated and one will be included in a broader substance use position statement and then will be retired. The Committee hopes to make its recommendations including any new or updated position statements at the next JRC meeting.

In September 2017, SAMHSA funding for the five-year HIV/AIDS Training Grant ended due to lack of funds. The Committee will continue to do trainings, both in-person and virtually via webinars.

Action requested.

1) **Will the JRC approve the Resource Document on "QTc Prolongation and Psychiatric Disorders"?**
   The American Psychiatric Association (APA) Council convened a workgroup of experts, which included a representative from the American College of Cardiology to summarize the current literature and to create this set of clinical considerations for the practicing clinician. This resource document includes a summary of basic electrocardiography, psychopharmacology and drug safety, special practice settings including the intensive care unit and under-resourced clinics, special populations including children and patients with cardiac implantable electronic devices, and the approach to Torsades de Pointes risk stratification and mitigation.

   The document is in the process of being reviewed by ACC for endorsement. The Council would also like to seek publishing approval by AJP.
   - Attachment 1 (resource document)

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American Psychiatric Association (APA) Resource Document on QTc Prolongation and Psychotropic Medications

Margo C. Funk, M.D., M.A.,[1] Scott R. Beach, M.D.,[2,3] Jolene R. Bostwick, PharmD, BCPS, BCPP,[4] Christopher M. Celano, M.D.,[2,3] Mehrul Hasnain, M.D.,[5] Ananda Pandurangi, M.B.B.S., M.D.,[6] Abhisek C. Khandai, M.D., M.S.,[7] Adrienne Taylor, M.D.,[7] James L. Levenson, M.D.,[6] Michelle Riba, M.D.,[8] and Richard J. Kovacs, M.D.[9]

[1]Mental Health Service Line, Veterans Affairs Southern Oregon Rehabilitation Center and Clinics, White City, OR; [2]Department of Psychiatry, Massachusetts General Hospital, Boston, MA; [3]Harvard Medical School, Boston, MA; [4]Department of Clinical Pharmacy, University of Michigan College of Pharmacy, Ann Arbor, MI; [5]Mount Pearl, Newfoundland, Canada; [6]Department of Psychiatry, Virginia Commonwealth University, Richmond, VA; [7]Department of Psychiatry and Behavioral Sciences, Northwestern Feinberg School of Medicine, Chicago, IL; [8]Department of Psychiatry, University of Michigan Medical School, Ann Arbor, MI; [9]Krannert Institute of Cardiology, Indiana University School of Medicine, Indianapolis, IN

Corresponding Author: Margo C. Funk, M.D., M.A., 8495 Crater Lake Avenue, White City, OR, 97503. Phone: (541) 826-2111 ext.3394. Email: margo.funk@va.gov

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Pandurangi, Khandai, Taylor, Levenson, Riba, and Kovacs report no competing interests.

ABSTRACT

OBJECTIVE: Psychiatrists and other clinicians frequently prescribe psychotropic drugs that may prolong cardiac repolarization, thereby increasing the risk for torsades de pointes (TdP). The corrected QT interval (QTc) is the most widely used and accepted marker of TdP risk. This resource document was created in response to the paucity of strong evidence to guide clinicians in best practice prescription and monitoring of psychotropic medications that may increase risk of TdP.

METHOD: The American Psychiatric Association (APA) Council on Consultation-Liaison Psychiatry, in collaboration with the American College of Cardiology (ACC), convened a workgroup of experts to summarize the current literature and to create this set of clinical considerations for the practicing clinician.

RESULTS: This resource document includes a summary of basic electrocardiography, psychopharmacology and drug safety, special practice settings including the intensive care unit and under-resourced clinics, special populations including children and patients with cardiac implantable electronic devices, and the approach to TdP risk stratification and mitigation.

CONCLUSIONS: There is no absolute QTc interval at which a psychotropic should not be used, rather a comprehensive risk-benefit analysis should include assessment of pharmacologic and non-pharmacologic risks for TdP versus the risk of failure to control high-risk psychopathology or of psychiatric decompensation.

INTRODUCTION

Psychiatrists frequently prescribe psychotropic drugs that may prolong cardiac repolarization, thereby increasing the risk for torsades de pointes (TdP). The heart-rate corrected QT interval (QTc) on the electrocardiogram (ECG) is the most widely used and accepted marker of TdP risk by drug safety boards. Over the past decade, there has been increased attention by the medical community about the role of QTc interval monitoring in the prescription of psychotropic medications.

The incidence of TdP is difficult to study in a systematic way. Although rigorous testing of new drugs for the tendency to prolong the QTc interval has been in place for more than 10 years, classification systems that catalogue medications according to 'level of risk' are based on variable levels of evidence, including case reports or retrospective cohorts, which cannot be used to compare drugs and are difficult to generalize into clinical practice. Though TdP is thought to be a fairly rare event, active surveillance systems suggest the incidence of TdP may be 10 to 100-fold higher than estimated by spontaneous report (1). Furthermore, most studies use the Bazett correction; though it is the most widely used correction formula, it is well established that Bazett overestimates the QTc interval at high heart rates, underestimates the QTc interval at low heart rates, and is consistently cited to be the least reliable method of correction.

Given the paucity of strong evidence to guide clinicians in best practice prescription and monitoring of psychotropic medications that may increase risk of TdP, to date there are no practice guidelines endorsed by the American Psychiatric Association (APA) or the American College of Cardiology (ACC). The APA Council on Psychosomatic Medicine, in collaboration with the ACC, convened this workgroup of experts in the field to summarize the current literature and to create a set of clinical considerations for the practicing clinician. This resource document is not intended to be a practice guideline, rather an educational tool for clinicians to use when prescribing psychotropic medications.

QTc INTERVAL AND TORSADES DE POINTES

Drug-Induced TdP and the Association with QTc Interval

TdP (literally meaning twisting of points) is a very rare form of polymorphic ventricular tachycardia characterized by the twisting of QRS complexes around the isoelectric line. The phenomenon was described by Desertennes and colleagues in 1966 in a group of patients that exhibited a long QT interval, a long cycle/short cycle sequence prior to the arrhythmia and macroscopic T wave alternans (2). The clinical arrhythmia had also been described in a series of patients exposed to the antiarrhythmic drug quinidine (3). TdP usually occurs in unsustained bursts that terminate spontaneously. These bursts can recur and may progress to a fatal ventricular arrhythmia. When not quickly fatal, it is clinically characterized by palpitation, dizziness and syncope. Chest pain, shortness of breath and sweating may be present as non-specific symptoms.

The burst-pattern of drug-induced TdP makes it very difficult to capture on a standard 10 second ECG. Pre-mortem diagnosis by ECG requires prolonged monitoring and sometimes a bit of luck. Sudden cardiac death attributable to drug-induced TdP is likewise difficult to adjudicate without concomitant ECG evidence of the arrhythmia. Therefore, surrogate markers and risk models have been used to inform prescribers of drugs that might produce TdP in an individual patient. Since TdP is characterized by a prolonged QTc interval by definition, QTc interval prolongation has been the major surrogate marker for the clinical arrhythmia. In a major Rotterdam prospective population-based cohort study, prolonged QTc interval (as defined in Table 1) was associated with a three-fold (8-fold for those ≥68 years age) increased risk of sudden cardiac death over a 6.7-year follow-up period (4). The link between drug-induced QTc interval prolongation and TdP is so strong that regulatory agencies responsible for drug approval worldwide have mandated that every new drug with significant systemic bioavailability be thoroughly tested for the possibility of drug-induced QTc interval prolongation (www.ich.org, product guidelines)

(5). The American Heart Association, the American College of Cardiology and other organizations have published strategies to reduce TdP risk in hospitalized patients based on QTc interval prolongation as a surrogate marker for arrhythmia risk (6). These and other similar data have contributed to using QTc interval primarily as the most important (but imprecise) surrogate marker for TdP. Other less researched and less often used surrogate markers include T-wave shape and morphology and J-T interval.

The Genesis of the QTc Interval

Mechanical activity of the heart is linked to electrical activity in a complex interplay between the depolarization and repolarization of excitable tissue and contraction and relaxation of the myocardium. The ECG represents the body surface findings of the sum of the cardiac cycle of depolarization and repolarization. Figure 1.A shows an ECG lead II waveform with descriptions of ECG intervals and the electrophysiological events represented.

Figure 1.B-C provides a simplified description of ionic events occurring at a cellular level. Sodium (Na^+), calcium (Ca^{2+}), and potassium (K^+) ionic movements underlie the processes of depolarization and repolarization. A resting potential is maintained by sodium-potassium pump and other mechanisms resulting in uneven distribution of ions between the interstitium and interior of the cardiac myocyte (7). Cellular depolarization (QRS interval on the surface ECG; Figure 1) derives mostly from a net inward flux of sodium and then calcium ions. Cell repolarization (JT/QT interval on the surface ECG; Figure 1) derives from a net outward flux of potassium ions. Ventricular tissue is vulnerable to polymorphic ventricular tachycardia (e.g., TdP) during the latter part of the repolarization phase and the risk increases if ventricular repolarization is prolonged. The majority of drugs associated with QTc interval prolongation and TdP are linked to pharmacological blockade of hERG (human-Ether-a-go-Related Gene) potassium channels (Figure 1.D), which produce a repolarizing current termed the delayed rectifier current (IKr) (8). The role of magnesium (Mg^{2+}), known to be a first line intervention for acute TdP, is unclear

mechanistically, but may serve to stabilize the cardiac myocyte membrane potential via interaction with calcium and potassium channels (Figure 1.C).

Correcting QT Interval for Heart Rate

The duration of QT interval varies depending upon the heart rate, and the QT interval needs to be "corrected" (QTc) for heart rate to make it more consistent and clinically meaningful. A number of different formulae, each with its own set of limitations, exist to correct the QT interval for heart rate. It is important to recognize there is a lack of consensus as to which technique is optimal, and none are perfect. When doing serial comparisons of QTc interval, the same correction technique should be used throughout.

Bazett's formula ($QTcB = QT/\sqrt{RR}(Sec.)$) (9) is the most common method used to correct QT interval for heart rate, and is programmed into most ECG machines in clinical use. The RR interval, which is a proxy for heart rate, is input into the formula in seconds. The standard "normal" and "at risk" values for QTc interval are studied and based on this formula as well (10) (Table 1). A major limitation of Bazett's formula is that it overestimates QTc interval at any heart rate much higher than 60 beats per minute (bpm) and underestimates QTc interval at rates lower than 60 bpm (11). As many patients who are being treated with potentially QTc-prolonging medications in the hospital setting are tachycardic due to agitation or systemic medical conditions, this overcorrection becomes clinically meaningful. Bazett's formula was a standard for pharmaceutical research but the International Council for Harmonization of Technical Requirements for Pharmaceuticals for Human Use (ICH) recently identified it as "an inferior method" and recommended using Fridericia's formula (or another suitable method) instead (www.ich.org). Fridericia's formula uses a cube root (instead of square root) of HR ($QTcF = QT/\sqrt[3]{RR}$) and is less influenced by extremes of HR. Other formulas (e.g., Framingham's and Hodges') or statistical methods (population- or

individual-corrected QTc interval) are also available but are used less frequently. In some cases of drug-induced QTc interval prolongation, the uncorrected QT interval may be a better predictor of clinical events (12).

Table 1. Bazett-corrected QTc interval measurements (6, 10).

Rating	Adult men (ms)	Adult women (ms)
Normal	< 430	< 450
Borderline	431-470	451-480
Prolonged	> 470	> 480

Technical Aspects of Recording and Measuring QT interval on the ECG

Since the QT interval is, by definition, an ECG measurement, a properly recorded and measured ECG must be the basis for clinical decision making regarding QTc interval prolonging drugs. Interpretation of the ECG, including quantitation of the electrocardiographic intervals, should be performed according to the local institutional standards. In most hospital settings, board-certified cardiologists provide the interpretations, but in many practice settings this may not be feasible. ECG interpretation should be available by a person qualified by experience or training to interpret the ECG. Most modern ECG machines provide computer-derived interval measurements, as well as interpretive statements. These automated measures differ from machine to machine, but most often are derived from "representative complexes" or "median complexes" that take advantage of signal averaging techniques and automated threshold detection. Prescribers need to be aware of the limitations of machine-derived intervals, as well as the difference of measurements from machine to machine (13). In general, if the patient's ECG pattern is normal and free of artifact, the computer-derived intervals, including QTc interval, are reliable. If the patient's ECG is abnormal the computer-derived intervals are less reliable, and prescribers should consider performing manual measurement. Widening of the QRS complex is a common abnormality seen with bundle branch block, ventricular pacing or use of certain medications (e.g. tricyclic antidepressants)

and leads to prolongation of the QT interval without perturbation of repolarization. In such cases clinicians should not only perform manual measurements, but also consider alternative methods to assess for TdP risk. In all cases, manual measurement remains the best approach, and is a skill that should be encouraged among all clinicians involved in caring for patients who may receive ECGs in the course of their clinical care (14).

How to measure the QT interval

The QT interval is defined as the distance from the beginning of the QRS complex to the end of the T-wave. A standardized approach to define the end of the T-wave is the intersection of the tangent to the steepest downward slope of the T-wave with the isoelectric baseline (Figure 2A). When using Bazett's or Fridericia's formulae to correct for heart-rate, the RR interval from the preceding cycle length is used (14).

The recommendations above apply to the standard 12 lead ECG, which by definition, is a 10 second recording of cardiac electrical activity. Many other techniques capture ECG information in other formats and may have utility in monitoring the QTc interval. Hospital telemetry systems record single or multi-lead ECG data continuously from patients. Many of these systems have automated QTc interval measurement algorithms, some even providing real time assessment of the QTc interval. The AHA has published standards regarding these systems, and the practitioner should be familiar with the local systems if they are used to make clinical decisions (15). Ambulatory monitors (e.g., Holter, event, and implanted loop) can also provide measurements of the QTc interval, but similar to the 12 lead ECG, require noise-free signals and are more reliable in patients with normal ECGs. The use of ambulatory monitors for measurement of the QTc interval is discouraged because of the difficulty obtaining a noise-free signal in the ambulatory patient. Similarly, single-lead measurement with a mobile device is not a substitute for a 12-lead ECG. Ambulatory monitors and single-lead mobile devices may be useful for monitoring/screening at-risk patients for arrhythmias, however.

Non-drug risk factors for QTc interval prolongation and TdP

Medications are only one of the several possible risk factors for QTc interval prolongation and these increase the risk of TdP independently. Well-established non-drug risk factors based on literature are included in Table 2.

Table 2. Risk for TdP (16-18)

Non-modifiable risk factors	Modifiable risk factors
● Female sex	● Concurrent use of more than one QTc interval prolonging drug
● Advanced age	● Pharmacokinetic drug-drug interactions
● Congenital long QT syndrome	● Drug toxicity
● Personal history of drug-induced QTc interval prolongation	● Rapid intravenous infusion of QTc interval prolonging drugs
● Personal history of structural or functional cardiac disease (e.g. heart failure with reduced ejection fraction)	● Severe acute illness
● Metabolizer status	● Bradycardia
● Family history of sudden cardiac death	● Starvation
	● Inadequate dose adjustment of hepatically-metabolized drugs in patients with hepatic cirrhosis
	● Inadequate dose adjustment of renally-eliminated drugs in patients with acute kidney injury or chronic kidney disease
	● Risk or presence of hypokalemia, hypomagnesemia or hypocalcemia

Combinations of these risk factors have been shown to correlate with subsequent prolongation of the QTc interval in at-risk patients (19); therefore, potential cumulative effects must be seriously considered. The odds of provoking TdP with a non-cardiac drug alone are very low, but co-existing risk factors can increase the odds dramatically (20, 21). It is essential to be aware of these risk factors to assess and monitor patients accordingly if a drug with a risk to prolong QTc interval is being considered or prescribed.

Most of the non-modifiable risk factors are self-explanatory and can be documented through clinical interview or past clinical records. Prior unexplained syncope should be investigated thoroughly as to the cause. While abnormal QT behavior in the absence of other risk factors may suggest congenital LQTS, it is important to recognize that some patients will show no evidence of LQTS until exposed to a QTc interval prolonging agent or clinical situation (22). If in doubt, a cardiologist can be consulted.

Pharmacodynamic and pharmacokinetic drug-drug interactions are probably the most common risk factors that can be easily modified (or prevented) in many instances. The pharmacodynamic interaction would result when drugs with a potential to prolong QTc interval are prescribed concurrently. A pharmacokinetic interaction would occur if a drug or a substance (e.g., nicotine, drug of abuse) is added or removed resulting in a metabolic interaction that results in slow or inhibited metabolism and consequent higher plasma concentrations of the drug associated with QTc interval prolongation. Given the vastness of possible drug-drug interactions, the best clinical approach would be to consult with a pharmacist.

Toxic drug plasma concentrations can result from a slow (or rapid, i.e., if a parent drug requires activation via CYP enzymes to an active drug) metabolizer status, pharmacokinetic drug-drug interaction, or from an intentional or accidental overdose. Patients in such a situation will need to be monitored depending upon the level of toxicity and extent of other risk factors for QTc interval prolongation. Dose-related QTc interval prolongation is an important consideration, so medications administered intravenously that

achieve higher plasma concentrations more rapidly, may increase this risk compared with oral administration. Presence of hepatic cirrhosis and/or renal insufficiency will add to the QTc interval prolonging effect of the drug by impairing its metabolism and/or excretion, resulting in higher than usual (or toxic) drug plasma concentrations. In states of mild insufficiency, the effect may be negligible for one drug, but the risk will be cumulative if more than one drug associated with QTc interval prolongation are prescribed concurrently.

Hypokalemia, hypomagnesemia and hypocalcemia can add to the risk of TdP. Several medications and/or procedures (e.g., diuretics and dialysis) can potentially disrupt electrolyte balance, and patients taking them will need to be monitored in this regard (23). Maintaining communication with the physician prescribing such drugs and establishing responsibility about electrolyte monitoring will facilitate the process and minimize duplication. Acute medical conditions (e.g., gastroenteritis, endocrinopathies), physiological conditions (e.g., gravida emesis, strenuous exercise), or fasting can also cause electrolyte disruption. Furthermore, certain diagnoses can be accompanied by behaviors (e.g., purging and/or dietary restriction in eating disorders, binge drinking in alcohol use disorder, use of dietary supplements) that would pose a risk for electrolyte derangement; these need to be considered during risk stratification.

PSYCHOPHARMACOLOGY

It is worth noting the following discussion of psychotropic medication classes, and in some cases, individual medications, is meant to highlight the importance of performing a comprehensive risk-benefit evaluation through the application of current data, knowledge of the clinical relevance of absolute QTc interval calculations and consideration of historical regulatory recommendations in the context of other non-medication risk factors.

CredibleMeds publishes a widely used, freely available online list of drugs known to prolong the QTc interval, divided into four categories (https://crediblemeds.org/) (24): drugs with known risk of TdP;

drugs with possible risk of TdP; drugs with conditional risk of TdP (i.e., can cause TdP under certain conditions); and drugs to be avoided by patients with congenital long QT. The lists are produced by consensus of a board of experts who utilize available data from product labeling, the FDA, published literature, and other sources. A link to the website is included in many guidelines of the American Heart Association and American College of Cardiology. However, the inclusion and classification are not systematic, as it is based on evidence of quite variable quality, ranging from double blind, randomized placebo-controlled trials with intensive ECG monitoring to single case reports that often include other risks that may account for the reported association. In some cases, supporting citations provide no actual evidence of the association. In our opinion, the classification on crediblemeds.org should not be accepted uncritically, but considered as a general list of drugs with possible potential for causing TdP. For all drugs that have a potential to prolong QTc interval, the risk of QTc interval prolongation and TdP increases when other risk factors for QTc interval prolongation are also present.

Several other points are important to remember when reviewing studies related to QTc interval prolongation. First, it is critical to understand the population being studied (e.g., healthy vs. medically or psychiatrically ill), the method of QTc interval measurement used (e.g., Bazett, Fridericia, use of a nomogram), the timing of QTc interval measurement (e.g., following a single dose of a medication vs. at steady-state), the dose of the medication, and the presence of other medications that might alter the metabolism of the medication being studied. These vary widely among studies and can impact the degree of QTc interval prolongation reported. Second, while most studies report mean QTc interval prolongation, this arguably is less important than the percentage of participants who experience clinically meaningful QTc interval prolongation, since, in these instances, a change in medication can make a substantial impact on QTc interval. Finally, it is important to recognize the strengths and weaknesses of different study types. Case reports, for example, are important for identifying potentially important side effects, but they often are fraught with confounders and may be in the setting of overdose, which limits

their utility. Thorough QTc interval studies, in contrast, can clearly illustrate causal relationships between medications and QTc interval prolongation; however, these are performed in healthy adults with minimal QTc interval risk factors and so have limited generalizability. Given the wide variability in methodology and study samples, we have chosen to refrain from providing mean QTc interval prolongation for specific medications in table form. Instead, we hope to highlight relevant studies that provide guidance for making recommendations regarding medication selection in patients at risk for QTc interval prolongation. It is important clinicians understand the inherent limitations of available data and how this applies to their own practice as well as how this may impact guidance provided by regulatory agencies.

Regulatory Agencies and Drug Safety Monitoring

Agencies in many countries regulate the drug (and therapeutic devices) approval process through establishing efficacy and safety of the drug (device) and monitoring them for any potential concerns after they become available for use. A few examples of such agencies include the Food and Drug Administration (FDA) in the USA, Medicines and Healthcare Products Regulatory Agency (MHRA) of the United Kingdom, Health Canada, and the Therapeutic Goods Administration (TGA) of Australia. Over the last decade, these agencies have issued safety warnings related to the risk of QTc interval prolongation and TdP associated with some psychotropic drugs. In some cases, the warnings followed data based on thorough QTc interval studies and in other instances warnings were based on data from post-marketing reports and surveillance. While some degree of general consensus exists between various agencies, they tend to differ in fine details and occasionally more dramatically. The differences stand out more noticeably when data are limited and/or difficult to interpret reliably. This is the case with regards to the risk of QTc interval prolongation and TdP associated with psychotropic drugs, as we highlight with a few examples below.

Citalopram and escitalopram underwent a thorough QTc interval study after post-marketing reports of

QTc interval prolongation and TdP associated with citalopram emerged (25, 26). A dose-dependent QTc interval prolongation was observed both for citalopram (mean 8.5 ms with 20 mg/day dose and mean 18.5 mg with 60mg/day dose) and escitalopram (mean 4.5 ms with 10 mg/day dose and mean 10.7 mg with 30mg/day dose). The increase, based on predefined terms, was significant for citalopram but not for escitalopram. Following these data, all four regulatory agencies mentioned above issued a safety warning for citalopram. The MHRA considered the data for escitalopram concerning enough to issue a safety warning for escitalopram as well. This highlights that safety of psychotropics (or lack thereof) is not a dichotomous matter (21). Interestingly, in the aforementioned thorough QTc interval study (25) QTc interval was calculated using Bazett's method, which now is considered an "inferior method" and Fridericia's method (or another suitable method) is recommended for use in such studies (27).

The FDA and the TGA both have issued safety warning about quetiapine based on post-marketing data. The evidence was not strong or clear enough for the FDA to issue a "boxed" safety warning, however, a warning is included within the text of the FDA label for quetiapine. The FDA label notes "there were cases reported of QTc interval prolongation in patients who overdosed on quetiapine, in patients with concomitant illness, and in patients taking medicines known to cause electrolyte imbalance or increase QTc interval" (28). The TGA safety warning is based on a very similar observation and notes "Post-marketing reports of QTc interval prolongation associated with quetiapine treatment have occurred not only in the context of overdose, but also with concomitant illness and in patients taking other drugs known to cause electrolyte imbalances or increase the QTc interval" (29). A recent comprehensive review has substantiated these concerns noticing that while quetiapine toxicity is associated with QTc interval prolongation, all three cases of TdP (out of 16 case reports of QTc interval prolongation) reported up till 2013 had occurred at therapeutic doses of quetiapine (21)

This document does not specifically cover safety warnings issued by various regulatory agencies. Above we have only provided a few examples to draw attention to this matter. Our understanding of

psychotropic drug associated QTc interval prolongation and TdP is evolving. Further safety warnings and/or modification of existing warnings is expected as data emerge. We advise clinicians to stay informed and follow the safety warnings pertinent to their country of practice.

Selective Serotonin Reuptake Inhibitors (SSRIs)

For many years, SSRI antidepressants were considered safe from a QTc interval prolongation perspective, despite occasional case reports of QTc interval prolongation for all agents in this class. To date, studies examining QTc interval prolongation effect for fluoxetine, fluvoxamine and paroxetine have provided no compelling evidence of QTc interval prolongation (30). Sertraline remains the agent with the best-established track record in cardiac populations (31, 32)

As previously stated, on August 2011, the United States Food and Drug Administration (FDA) issued a warning for QTc interval prolongation with citalopram based on a thorough QTc interval study demonstrating prolongation of 8.5ms at doses of 20mg and 18.5ms at doses of 60mg (25). Subsequent studies, including a meta-analysis, a large retrospective study of an ECG database, and a randomized placebo-controlled study, have suggested that citalopram may be more likely than other SSRIs to cause QTc interval prolongation, and may prolong the QTc interval at a similar magnitude to that demonstrated in the FDA study (33-36). The FDA currently advises practitioners to not utilize doses of citalopram greater 40mg in all patients, and to use doses of 20mg or lower in patients over the age of 65 years or with liver dysfunction. Though most studies suggest that the risk of QTc interval prolongation and TdP increases with higher doses, at least one large study found higher doses to be associated with fewer adverse outcomes, though QTc interval was not specifically examined and the authors did not control for other known risk factors (37).

Several studies have suggested that escitalopram may have QTc interval prolonging properties, with a

thorough QTc interval study estimating prolongation of 4.5ms at 10mg and 10.7ms at 30mg daily (30). However, a large meta-analysis of nearly 3300 patients demonstrated a mean prolongation of only 3.5ms for all doses (38).

When applying these results to real-life clinical practice, it is essential to consider that QTc interval changes in the range of 10-20ms, as found in the citalopram studies, are below the limits of detection on an individual ECG and may only yield a signal in large samples. QTc interval changes in the range of 30-60ms would be considered potential signals; changes >60ms should be considered unusual and signals of concern. Hence, though the QTc interval changes with citalopram separate out from the other SSRIs, the clinical impact in isolation of other risk factors is insignificant.

It is also important to keep in mind that, for some patients, the risk of QTc interval prolongation with 60mg of citalopram is not as significant as the risk of psychiatric decompensation with a lower dose. There is evidence to suggest that the FDA warning has not reduced all-cause or cardiac mortality, but has led to increased rates of psychiatric hospitalizations for patients whose dose was reduced reflexively (39). Another study found that patients who had their dose of citalopram reflexively reduced were more likely to be prescribed sedatives or anxiolytics and had higher healthcare utilization (40). These studies highlight the importance of comprehensively considering all factors contributing to the risk-benefit ratio when prescribing “at-risk” medications.

Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)

Among SNRIs, venlafaxine, the oldest agent in this class, has the most evidence to support concerns with the risk for dose-related QTc interval prolongation, in both therapeutic doses (150 mg or 300 mg daily) and in overdose situations (41-44), some of which have proven fatal (45, 46). With that stated, the overall risk of QTc interval prolongation and TdP at therapeutic doses and in overdose situations is low (47),

though elderly patients may be at greater risk (48). One study comparing the risk of sudden cardiac death or near death when venlafaxine was compared to other antidepressants found no increase in risk with the use of venlafaxine (49).

The paucity of data on the remaining available SNRIs, including duloxetine, desvenlafaxine, and levomilnacipran, limit any conclusions regarding the QTc interval prolongation risk among these agents (41). Duloxetine's effects on the QTc interval have been studied in therapeutic and supratherapeutic doses. Overall, studies have found a decrease in the QTc interval when studied in healthy adults (50, 51). When corrected for heart rate, there is a slight increase in QTc interval values, however, study authors deemed this is not clinically significant (51).

One published study, reviewing overdoses of desvenlafaxine identified no cases of QTc interval prolongation in doses up to 3500 mg (52). In a systematic review and meta-analysis of levomilnacipran, this agent was found to increase QTc interval compared to placebo when Bazett's formula, but not when Fridericia's formula, was used (53), suggesting these findings may have been driven by increases in heart rate. Among users of levomilnacipran, no patients experienced a QTc interval greater than 500 ms (53). Notably, some studies evaluating the QTc interval risk of levomilnacipran were further limited by the exclusion of patients with a baseline abnormal ECG (54, 55).

Tricyclic and Tetracyclic Antidepressants (TCAs)

TCAs are known to prolong the QTc interval via blockade of sodium channels leading to QRS widening, in addition to effects on the delayed potassium rectifier current. Clinically significant QTc interval prolongation tends to occur at therapeutic doses only in the setting of pre-existing cardiac disease, or in overdose (56). A meta-analysis suggested the average QTc interval prolongation associated with TCAs is 13 ms compared to placebo (31). Among TCAs, amitriptyline and maprotiline have been most commonly associated with TdP in case reports (57).

Other Antidepressants

At therapeutic doses, the use of bupropion has demonstrated a reduction in QTc interval (33, 58, 59) and may be considered a reasonable option in patients at high risk for ventricular arrhythmias (60). On the other hand, similar to venlafaxine, bupropion has been linked to QTc interval prolongation, particularly in overdoses (61-64). Reports of QTc interval prolongation with bupropion may be confounded by tachycardia and reported concomitant medications or substances (41). Importantly, in one key study, none of the patients that exhibited prolonged QTc interval experienced any type of arrhythmia (62).

Evaluating the risk of QTc interval prolongation with mirtazapine, studies have demonstrated a greater risk of mirtazapine for cardiac sudden death and ventricular arrhythmias in elderly patients when compared with paroxetine or citalopram (65, 66). However, other studies demonstrate low risk of mirtazapine for cardiovascular adverse drug reactions, including arrhythmia, when compared to other antidepressants (60, 67) or in overdose (68, 69). Given these conflicting results, mirtazapine should be used cautiously in patients at risk for QTc interval prolongation, which is in alignment with the FDA warning in product labeling.

Continuing on with newer antidepressants, data on the risk of QTc interval prolongation with use of vilazodone is very limited, however initial data does not support an increase in risk (41, 70, 71). With regard to vortioxetine, data fail to demonstrate a risk associated with therapeutic and supratherapeutic doses in healthy adult males (72). Further, in short-term studies of adults with major depressive disorder treated with vortioxetine, changes in QTc interval (Fridericia) were similar to that of placebo (73). It is important to keep in mind that broader exposure is limited due to the novelty of these two agents.

Antipsychotic Medications

Both typical and atypical antipsychotic medications also have been associated with QTc interval prolongation and its sequelae of TdP and sudden cardiac death (SCD). Among the typical antipsychotics, low-potency phenothiazines--especially thioridazine--lead to the greatest risk of QTc interval prolongation and sudden cardiac death (74-76). In a randomized trial of six antipsychotic medications, thioridazine led to 30.1 ms of QTc interval prolongation, which was numerically greater than the prolongation associated with haloperidol (7.1 ms), ziprasidone (15.9 ms), quetiapine (5.7 ms), olanzapine (1.7 ms), or risperidone (3.6 to 3.9 ms) (74).

Aside from thioridazine, haloperidol's QTc interval prolonging properties have received the most attention. Haloperidol is available in oral, intramuscular, and intravenous formulations, and each formulation is typically used in different clinical situations. While oral and intramuscular haloperidol are typically used for the management of psychosis or agitation in medically stable patients, intravenous haloperidol is often used for the management of delirium in medically ill patients. As noted above, in individuals without significant medical illness, orally administered haloperidol 15mg daily is associated with a mild (~7 ms) increase in QTc interval at steady state (34). Intravenous haloperidol may cause a greater degree of QTc interval prolongation and confer a greater risk for TdP than orally administered haloperidol (77), though the difference between these medications may be explained--at least in part--by their uses in different clinical populations, as noted above (78). Due to its links to QTc interval prolongation and TdP, the FDA recommends cardiac monitoring of patients in the setting of intravenous haloperidol use (79).

Other typical antipsychotic medications also prolong the QTc interval. Both chlorpromazine and pimozide are associated with clinically significant QTc interval prolongation (77, 80, 81), and pimozide has been linked to TdP in overdose (82). Loxapine appears to be less likely to cause significant QTc interval prolongation, as two recent thorough QTc interval studies found that inhaled loxapine leads to

mild (~5ms) increases in the QTc interval (83, 84). Finally, while the effects of perphenazine on QTc interval have not been studied, a retrospective cohort study found that perphenazine was associated with a similar risk of sudden death / ventricular arrhythmia and a lower risk of all-cause mortality compared to olanzapine (85).

Like the typical antipsychotics, nearly all atypical antipsychotic medications have been associated with QTc interval prolongation to some degree. While it is difficult to rank atypical antipsychotic medications based on QTc interval risk due to differing study methodologies (21), ziprasidone appears to carry a particularly high risk of QTc interval prolongation (86). Thorough QTc interval studies suggest that ziprasidone leads to 10-21 ms increases in the QTc interval on average (74, 87), with over 20% of individuals experiencing a >60 ms increases in QTc interval, a substantial and clinically meaningful increase (88).

The remaining atypical antipsychotic medications prolong QTc interval to a lesser degree. Iloperidone has been linked to Fridericia-corrected QTc interval increases of 8.5 ms (at a dose of 8mg BID) to 15.4 ms (at a dose of 24mg daily) in cardiovascular healthy adults (87). As previously highlighted, thorough QTc interval studies suggest that quetiapine leads to small to moderate (1.3-14.5 ms) increases in QTc interval at doses of up to 750mg daily, and the FDA has issued a warning due to quetiapine's propensity to prolong QTc interval (74, 87-90). These same trials found olanzapine to prolong QTc interval by 1.7-6.8 ms at up to 20mg/day and risperidone to prolong QTc interval by 3.6-11.6 ms at doses of 6-16mg/day (74, 88). QTc interval prolongation from paliperidone, lurasidone, and asenapine range from 4.5 ms (asenapine) to 12.3ms (paliperidone) (91), and a recent meta-analysis found that these three medications did not cause significant QTc interval prolongation compared to placebo (86). Though the effect of clozapine on QTc interval has been studied rarely, a retrospective review of patients who had switched treatment from another antipsychotic (>80% were atypical antipsychotics) to clozapine found no

significant changes in QTc interval following the switch, suggesting that the risk of QTc interval prolongation between clozapine and other atypical antipsychotic medications is similar (92). Finally, aripiprazole appears to be the least likely atypical antipsychotic medication to cause QTc interval prolongation, with a recent meta-analysis finding that aripiprazole led to significant reductions in QTc interval compared to both placebo and active controls (93).

The link between atypical antipsychotics and TdP is less clear. While these medications have only been linked to TdP in case reports and FDA adverse events reports (21, 94), atypical antipsychotics have been associated with an increased risk of sudden death in population-based studies (95, 96), which may be explained by the association between these medications and ventricular arrhythmias. Furthermore, in elderly patients with dementia, they have been associated with mortality related to cardiac events, which has led the FDA to issue a boxed warning related to this complication.

Other Psychotropics

Lithium

There have been conflicting reports concerning lithium's effect on QTc interval prolongation. A retrospective study showed lithium had no significant association with QTc interval prolongation (97). However, another report showed lithium in concentrations above 1.2 mmol/L can markedly prolonged the QTc interval (98). Multiple regression analysis revealed that sex, lower serum potassium concentration, and especially, higher serum lithium concentration were determinants for the prolongation of the QTc interval (99).

Antiepileptic Drugs

Major antiepileptic drugs have not been found to significantly precipitate prolongation of QTc interval. Valproate was found to lower QTc interval dispersion, which might indicate that valproate may have

some preventative effects and stabilization in cardiac conduction (100). Studies with lamotrigine or topiramate have not shown any clinically significant changes on individual QTc interval, except for slight decreases in QTc intervals with lamotrigine (101, 102). Though carbamazepine has sodium-channel blocking properties, at least one study suggests decreasing QTc interval with increasing carbamazepine concentrations (103). In a double-blind, placebo- and active-controlled trial, gabapentin enacarbil, a transported prodrug of gabapentin, was not associated with QTc interval prolongation in healthy adults (104).

Stimulants

Stimulants have multifactorial potential in addition to just QTc interval prolongation. The increase of catecholamines by CNS stimulants results in a rise in heart rate (HR) and blood pressure (BP), which would be expected to increase the risk of ventricular arrhythmia or sudden cardiac death (105). Clinical trials have found no statistically or clinically significant changes to the QTc interval over short and long-term treatment with methylphenidate and amphetamine drugs (106, 107). Atomoxetine has been shown to be associated with life-threatening long QT syndrome (108). Evidence shows that atomoxetine inhibits cardiac potassium channel currents causing action potential prolongation and increasing risk of acquired long-= QT syndrome (109). However, a pooled analysis of five randomized double-blind trials showed no clinically significant increase in QTc interval prolongation (110).

Modafinil has been shown to cause infrequent significant increases in BP and HR. However, there has been no evidence that it has any clinically significant effect on QTc interval prolongation (111). While not considered stimulants, it is worth noting there are also no statistically or clinically significant increases in QTc interval associated with clonidine and guanfacine (112).

Although the cardiovascular impact of stimulant use is minimal in healthy patients, prescribers should use

caution in patients with underlying heart disease, other atrial or ventricular arrhythmias, symptoms of undiagnosed disease (e.g. syncope), or prescription of other like cardiac medications. Given their effects on the sympathetic nervous system, patients receiving stimulants should have routine monitoring of HR and BP.

Trazodone

Trazodone has rarely been associated with QTc interval prolongation (113). However, there have been a few case reports highlighting risk of transient QTc interval prolongation in the setting of trazodone overdose, especially in patients taking other QTc interval prolonging agents or with underlying cardiovascular disease (113, 114).

Benzodiazepines and Buspirone

Although there may be effects on other cardiac parameters, there appears to be little effect on QTc interval from benzodiazepines and none reported with buspirone (115).

Acetylcholinesterase Inhibitors and Amantadine

Medications commonly used in dementias also have a relationship with prolonged QTc interval. Acetylcholinesterase inhibitors, such as donepezil, have cholinergic effects which may lead to adverse reactions in the cardiovascular system. Cardiac arrhythmias, QTc interval prolongation and TdP in patients prescribed donepezil have been highlighted in case reports (116). However, these case reports include patients of age 80 years or older, with several medical comorbidities. The dopaminergic activity of amantadine has potential for induction of malignant arrhythmias resulting in amantadine-induced TdP in the setting of overdose and co-ingestions (117, 118).

Methadone

Methadone is well-known to be strongly associated with both QTc interval prolongation and TdP (119-121). TdP associated with methadone use was first reported in a retrospective case series of 17 patients receiving high dose treatment (119). Several case-control, cross-sectional, and prospective cohort studies have assessed the incidence of methadone-associated QTc interval prolongation and shown significant effects on the QTc interval (120). Unfortunately, the prevalence of QTc interval prolongation and TdP in methadone-treated patients is not clear; this gap in knowledge represents a major public health concern, especially in light of the burgeoning opioid epidemic. As highlighted previously, guidelines from the American Pain Society can be helpful in identifying approaches to mitigating the risk of QTc interval prolongation associated with methadone, which may include dose reduction and discontinuation of other agents that may prolong the QTc interval (122). Concomitant use with other medications with known risk for prolonging the QTc interval (e.g., citalopram) or in the context of electrolyte disturbances warrants cautious consideration of augmented risk for TdP (123). Further, as newer agents are developed in the management of opioid addiction, risks associated with these medications and how they compare with the QTc interval prolongation risks of methadone will be important.

Buprenorphine

In general, QTc interval prolongation is not considered a consequence of the use of other narcotics. Buprenorphine has been found to be less likely to cause QTc interval prolongation than methadone (124). However, some studies have shown that induction with buprenorphine was still followed by an increase in QTc interval (125).

Special Population: Children and Adolescents

Our workgroup has chosen to limit our review to studies involving adults over the age of 18. While psychotropic medications can cause QTc interval prolongation in children and adolescents, there are few

studies evaluating these effects. Importantly, additional research is necessary within this population to guide clinical decision-making and avoid "overcautious interpretation" of ECGs among children and adolescents, which may lead to non-treatment (126). Further, extrapolation of adult data is not appropriate. One example includes data surrounding the use of methadone among pediatric patients and young adults, which suggest methadone may be safe, though additional prospective data are needed (127, 128). Antipsychotic medications have received the greatest attention in the pediatric population, where a systematic review found ziprasidone to be linked to the greatest degree of QTc interval prolongation and aripiprazole to lead to a significant reduction in QTc interval, consistent with studies in adults (129). Use of antipsychotic medications or other medications that may prolong the QTc interval in the context of eating disorders within this population requires specific consideration. One article highlights the importance of additive risk in the context of anorexia related to bradycardia and/or electrolyte abnormalities and the impact correction equations may have on normalizing the QTc interval, thereby underestimating the true severity of the repolarization abnormality (130). Additional monitoring is recommended in this population as well as those with bulimia who may purge and be pre-disposed to electrolyte abnormalities. Caution and repeat ECGs are advised as medications posing risk for QTc interval prolongation are added or doses are adjusted, or additional risk factors for QTc interval prolongation arise over the course of treatment.

In contrast, there are very few studies evaluating the effects of antidepressants or mood stabilizers on QTc interval in pediatric populations (101, 131). Pediatric patients represent a special challenge to the measurement and correction of the QTc interval. Pediatric patients may not be able to maintain the quiet supine posture needed for good quality ECG recording, The QTc interval varies with age, and sex, and there is a sharp inflection in the relationship between age and QTc interval around puberty. Heart rate and the effect of heart rate on the performance of QT correction factors is more variable in the pediatric age range, and published reference ranges for QTc interval values have been developed in populations

that may not reflect modern society's mix of races (132). For these reasons, the practitioner caring for pediatric patients may wish to consult with a local cardiologist with the experience and/or training to deal with the complex issues present in the pediatric population. Given the limitations in the literature, as well as complexities related to categorizing risk in children and adolescents of different age, making broad recommendations regarding the assessment and minimization of QTc interval prolongation in pediatric populations is difficult and beyond the scope of this resource document.

Non-Psychiatric Medications and QTc prolongation

While this resource document is focused on psychotropics, these represent only a subset of QTc interval prolonging medications. Over 100 non-psychotropic medications have also been shown to prolong the QTc interval and/or be associated with TdP, particularly anti-arrhythmics, certain antibiotics (e.g., macrolides and fluoroquinolones), antivirals (HIV medications), anti-emetics (e.g., ondansetron), acid blockers, antihistamines (e.g., hydroxyzine and diphenhydramine) and some anti-cancer medications. While a full discussion of QTc interval prolongation risk of all these medications is well outside the scope of this document, a few salient points are made below.

It is important to note that non-psychotropic QTc interval prolonging medications are frequently administered or prescribed in a variety of settings, often more so than psychotropics. In the intensive care population, 3-30% of patients received QTc interval prolonging medications, the most frequently administered being amiodarone, along with high use of fluoroquinolones (levofloxacin) and macrolides (azithromycin) (133, 134). A study in emergency departments found the top nine administered or prescribed QTc interval prolonging medications as non-psychotropic, particularly diphenhydramine, azithromycin, and ondansetron; ondansetron alone was prescribed in almost 10% of ED visits, despite being officially FDA-approved only for post-operative and chemotherapy-associated nausea and vomiting (135). In outpatients, a study of a national pharmaceutical claims database found almost a quarter of

prescriptions involving QTc interval prolonging medications, the top three being clarithromycin, erythromycin, and levofloxacin (66).

Of particular concern is the co-administration of two or more QTc interval prolonging medications, as this significantly increases the risk of QTc interval prolongation (136-138). This is particularly salient given the often-significant medical co-morbidity of the psychiatric population, and the resultant comingling of psychotropics and QTc interval prolonging non-psychotropics. In intensive care, almost one in five patients were co-administered two or more QTc interval prolonging medications; particularly frequent combinations included amiodarone and haloperidol, as well as amiodarone or haloperidol with macrolides or fluoroquinolones (133). In outpatients, close to 10% of patients received 2 or more QTc interval prolonging medications concurrently, particularly antidepressants such as fluoxetine and amitriptyline with macrolides or fluoroquinolones (139). Clinicians should also take care to inquire about over-the-counter medications, supplements, and imported drugs not approved in the U.S. Many useful tools exist online for the clinician to track potential drug-drug interactions prolonging the QTc interval, such as the Medscape Multi-Drug Interaction Checker (http://reference.medscape.com/drug-interactionchecker).

Minimization of QTc prolongation risk must involve a thorough assessment of the entire medication list, as well as the balancing risks/benefits of psychotropics against those of other medications, and potential drug-drug interactions using appropriate reference tools.

CLINICAL CONSIDERATIONS

When to Obtain an ECG?

A wide variety of physiologic and pharmacologic factors can influence the QTc interval; it is therefore recommended that QTc interval measurement should be no more than one month prior to the decision point, and no substantial changes in medications, electrolytes or cardiovascular status (e.g. an episode of

heart failure or an acute MI) should have occurred subsequent to the measurement. ECGs are noninvasive, inexpensive and readily available in most clinical settings, so if there is uncertainty on the patient's status an ECG should be considered. Clinicians should consult any guidelines surrounding the ECG monitoring for specific medications. For example, the methadone safety guidelines published by the American Pain Society provides detailed information regarding recommendations for baseline and follow-up ECG monitoring, when to avoid methadone use, and alternative medications to consider for patients at high risk for QTc interval prolongation or TdP (122).

In resource-poor settings ECGs may not be easily accessible. Practitioners should not let the absence of an ECG preclude the prescription of a psychotropic medication; rather they must carefully consider known risks vs. benefit of prescribing the medication. In settings where clinicians have access to an ECG machine in the absence of a cardiology overread, clinicians of any medical specialty should feel comfortable with measurement, calculation, and documentation of the QTc interval.

Additional Monitoring

It is important to monitor electrolytes in patients that may have risk of electrolyte dysfunction, specifically hypokalemia or hypomagnesemia. Electrolyte monitoring is particularly indicated in patients with severe diarrhea or vomiting, alcohol use disorder, susceptible to rapid fluid shifts as in dialysis, and in individuals receiving certain medications such as loop and thiazide diuretics, amphotericin B, and proton-pump inhibitors. Empiric supplementation with a bio-available magnesium preparation may be considered in patients at risk of chronic electrolyte deficiency. Renal and/or liver function, depending on the medication utilized and the patient's status, should be monitored to determine if renal or hepatic impairment may increase the risk for dose-dependent QTc interval prolongation. As always, monitoring for the addition or removal of specific medications which may affect drug concentrations of any offending medication(s) should also occur.

Intensive Care Unit (ICU)

Patients in the ICU setting are at increased risk of TdP given the very nature of having severe medical/surgical illness. In one survey, 18.2 % of patients admitted to a coronary care unit had a QTc interval > 500 ms (134). Patients are more likely to have multiple risk factors for QTc interval prolongation, including concurrent use of medications associated with QTc interval prolongation, parenteral administration of such medications, electrolyte disturbance, hepatic/renal dysfunction, older age and underlying cardiac illness.

It is essential for all members of the ICU team, psychiatry, cardiology and other specialty services to work collaboratively and broadly to approach risk stratification and risk mitigation in ICU patients. Clinical conversations about risk stratification in the ICU may superficially focus on the question: "does the patient have a QTc interval > 500 ms?" often stopping short of an all-inclusive evaluation of all pertinent risks, benefits and risk-mitigation strategies. There is no absolute QTc interval at which a psychotropic should not be used. The decision of where to draw the line requires a comprehensive risk-benefit assessment.

An important risk/benefit consideration is the risk of not appropriately controlling agitation which may result in harm to patient via self-removal of external devices including vascular access, monitoring devices, temporary pacing wires, endotracheal tubes, etc. It is critical that antipsychotics are not inappropriately under dosed for agitation out of concern for QTc interval prolongation. The intensive care unit should be considered the "safest" place in the hospital where patients are closely monitored and staff are equipped to rapidly manage arrhythmias. In very high-risk cases (e.g. patient with history of past TdP, on high-risk antiarrhythmic medication and severe agitation requiring parenteral haloperidol) the team may consult cardiology for temporary over-drive pacing to prevent bradycardia. Re-intubation may be

considered in patients with uncontrollable agitation.

When to Consult Cardiology

Routine cardiology consultation is not indicated when prescribing QTc interval prolonging medications to a patient without cardiac risk factors; however, many higher-risk clinical scenarios are best approached with cardiology input. In patients with known heart disease and one or more risk factors for drug-induced Torsades, the clinician may consider consulting with the existing cardiologist when starting a medication with liability. In higher risk scenarios including: co-administration of high-risk medications (e.g. amiodarone and parenteral haloperidol), marked QTc interval prolongation (>500ms), or a sudden increase of QTc interval (>60 ms from baseline), referral to cardiology is appropriate. Patients on a known offending drug who experience cardiac symptoms such as syncope, dizziness, and palpitations should immediately be referred to cardiology. Again, a team-based care approach with open communication between specialties is paramount.

Approach to the Patient with a Pacemaker or Implantable Cardioverter Defibrillator

Practitioners commonly assume that the presence of a pacemaker (PPM), implantable cardioverter defibrillator (ICD), or cardiac resynchronization therapy (CRT) device is protective against TdP, regardless of QTc interval prolongation. Specifically, clinicians may suppose that such devices will prevent TdP by pacing, or that a single appropriate shock could terminate a ventricular arrhythmia without complication.

It should be first considered that patients with a cardiovascular implantable electronic device (CIED) are already at increased risk for TdP by the mere nature of having pre-existing cardiac disease. It is important to remember that all CIEDs have intrinsic pacing function, however to prevent accelerated PPM battery depletion and unnecessary ventricular strain, most pacemakers are not set to pace until the heart rate drops

below 40-50 beats/minute. A review of all published case reports of TdP in patients with PPMs over a 24 year period found a pacing rate of 55+/-11 beats/min when TdP occurred (140). Hence, typical pacing parameters will not prevent TdP. Tachycardia pacing (>70 beats/min) is an accepted approach that may effectively prevent TdP and may be strategically used, in collaboration with cardiology colleagues, in the setting of acute medical/surgical illness requiring higher-risk psychotropic medication (e.g. parenteral haloperidol for delirium in the cardiac intensive-care unit).

ICDs and CRTs both have the capability to recognize TdP and deliver appropriate shock therapy. Though the goal of defibrillation is to terminate the ventricular arrhythmia, in most settings a single shock is not enough to stabilize the patient. Recalling that TdP typically occurs in a milieu of multiple risk factors, often including hypokalemia, hypomagnesemia and medications that prolong ventricular repolarization, TdP may continue, despite repeated defibrillation, until the underlying milieu is corrected. Patients may experience a phenomenon known as "ICD storm" in which the ICD/CRT delivers repeated shocks in an attempt to abort the arrhythmia. ICD storm can result in additional comorbidity, including post-traumatic stress disorder (PTSD), increased anxiety and reduced quality of life (141, 142). When prescribing medications known to increase risk of TdP to patients with a CIED, the clinician should not assume that the patient is "protected," rather the presence of a cardiac device should trigger increased vigilance (143).

CONCLUSIONS

▪ The most widely used correction formula (Bazett), programmed into most ECG machines, is not a consistently reliable method of correction. It overestimates QTc interval at high heart rates and underestimates it in bradycardia. Manual measurement with heart-rate correction using Fridericia or an alternative population-based nomogram is more consistently reliable across a range of clinical scenarios.

▪ Currently available sources that classify drugs according to 'level of risk' are based on evidence of very variable quality and validity.

▪ Medications are only one of the several possible risk factors for QTc interval prolongation, each of which can increase the risk of TdP independently. Combinations of these risk factors can create cumulative risk. The co-administration of two or more QTc interval prolonging medications is of particular concern.

▪ There is not unanimity in the guidelines and warnings among the Food and Drug Administration (FDA) in the USA and analogous bodies in other countries.

▪ In patients with significant cardiac risk factors, psychotropic drugs with a known risk to prolong QTc interval or those with a regulatory warning in this regard should be avoided when relatively safer alternatives are available.

▪ Though there is no absolute QTc interval at which a psychotropic drug should not be used, the risk-benefit ratio in patients with pretreatment QTc intervals >500ms must be assessed comprehensively with careful attention to risk mitigation strategies. The treatment team must consider risk of failure to control high risk psychopathology or of psychiatric decompensation.

▪Routine cardiology consultation is not indicated when prescribing QTc interval prolonging medications to a patient without cardiac risk factors. When significant cardiac disease is present and/or when other risk factors for QTc interval prolongation are present, cardiology input should be considered.

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FIGURES

Figure 1. Torsades de Pointes and Use of the Tangent Method for Reliable QT-Interval Measurement[a]

[a]Panel A shows an example of torsades de points from surface telemetry monitoring. Panel B shows ECG intervals relevant for QT interval measurement and heart-rate correction. The dotted red lines represent the intersection of the tangent to the steepest downward slope of the T-wave and the isoelectric baseline. Use of this intersection to define the end of the T-wave is a reliable and well-accepted method for QT interval measurement.

Figure 2. Electrocardiogram (ECG) Waveforms and Intervals Corresponding to Ionic Activity During Cardiac Depolarization and Repolarization[b]

[b]Panel A shows a surface ECG waveform with intervals relevant to monitoring for TdP. The dotted line demonstrates delayed repolarization manifesting as a prolonged T-wave/U-wave, represented on the ECG as QT prolongation. The solid line shows the tangent to the steepest downward slope of the T-wave,

defining the end of the T-wave by the intersection of the tangent with the baseline. Panel B shows the relationship of sodium (Na^+), calcium (Ca^{2+}) and potassium (K^+) action potentials to the surface ECG (panel A). Panel C demonstrates the net influx of sodium (Na^+) and calcium (Ca^{2+}) into the cardiac myocyte during depolarization and the net efflux of potassium (K^+) during both normal and delayed repolarization. The role of magnesium (Mg^{2+}) is unclear, however it may promote stabilization of the membrane potential during repolarization via interactions with calcium and potassium channels. Panel D compares the rate of potassium efflux through various potassium channels during normal repolarization versus in the presence of a hERG channel blocking drug.

Figure 1

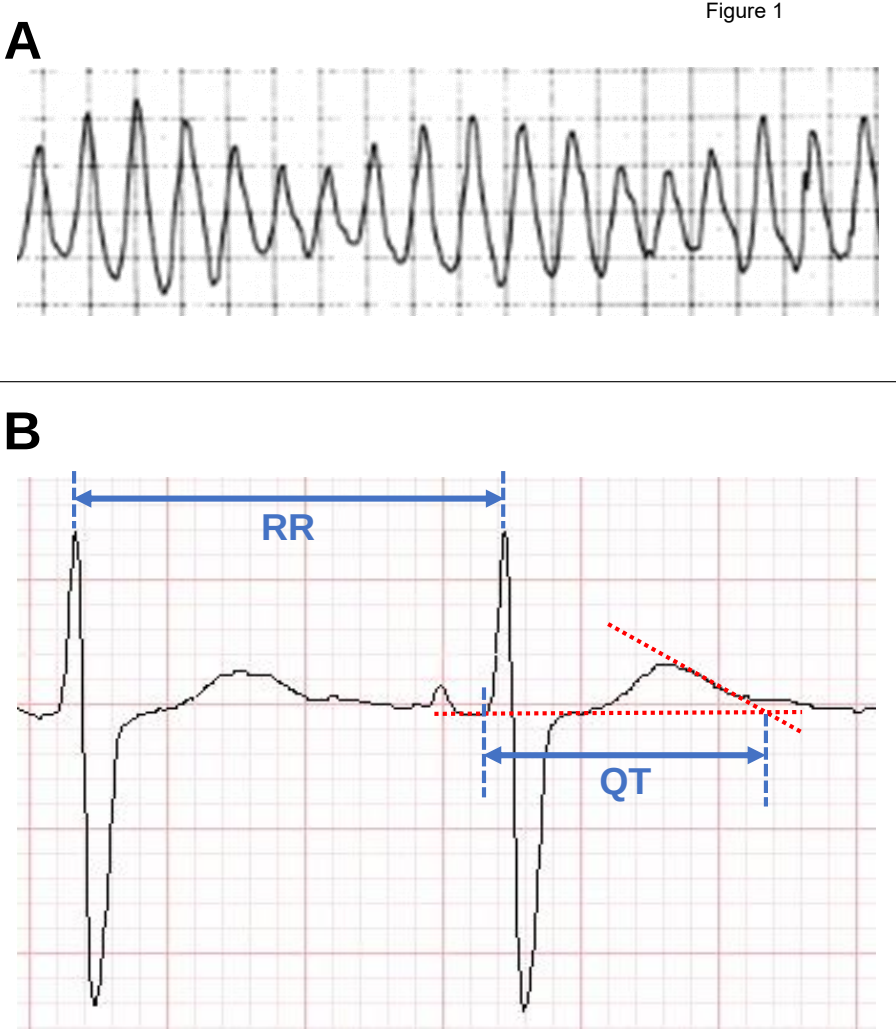
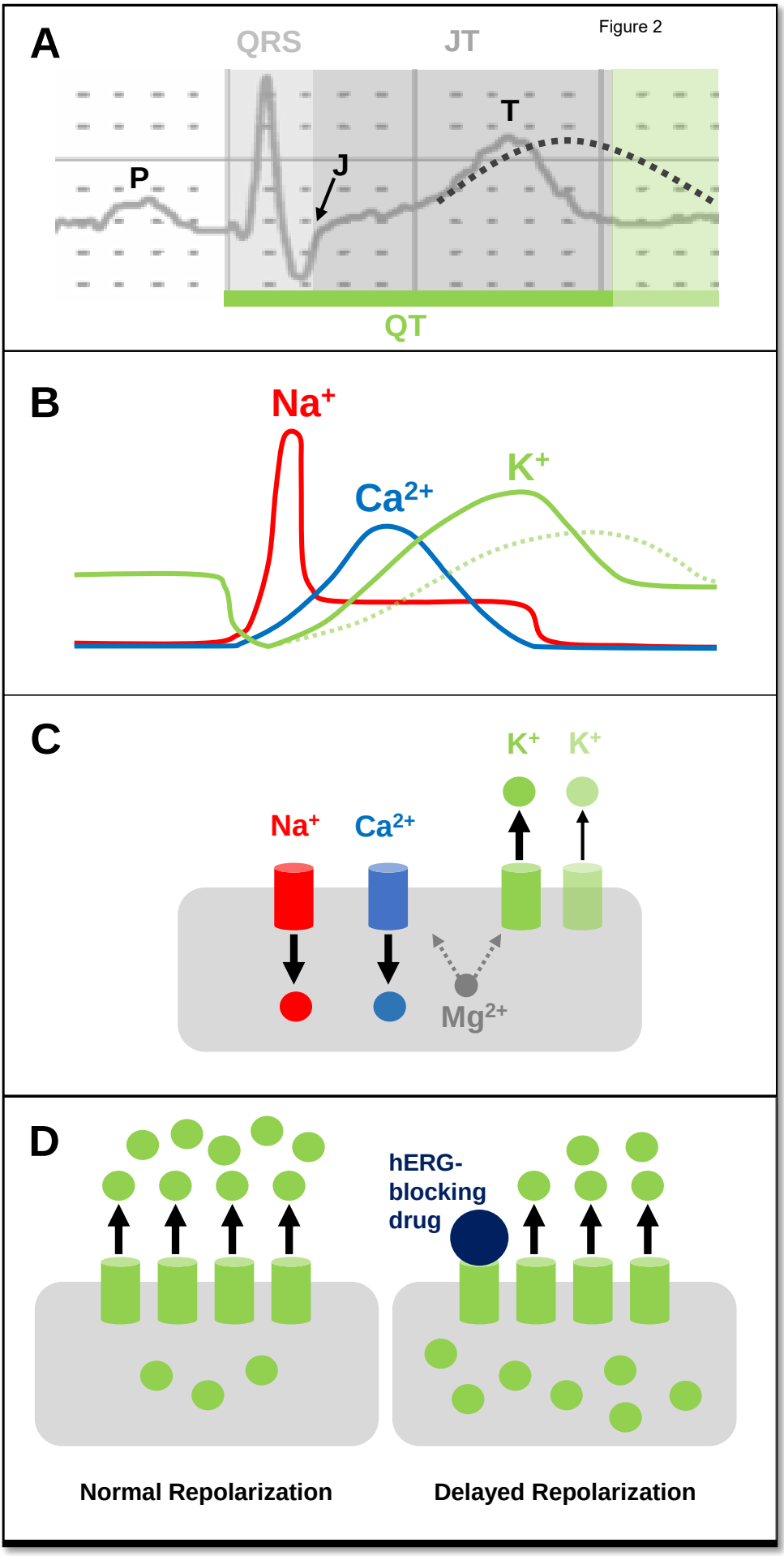


Figure 2


A
QRS
JT
T
P
J
QT
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Na+
Ca2+
K+
C
K+
K+
Na+
Ca2+
Mg2+
D
hERG-blocking drug
Normal Repolarization
Delayed Repolarization

Executive Summary

Council on Geriatric Psychiatry

Description of the Council:

The Council supports APA in its work on behalf of older adults and the psychiatrists who care for them. To this end, the Council develops Position Statements and Resource Documents on important issues in geriatric psychiatry, thereby providing APA with background information essential for advocacy efforts and interactions with the media. The Council also works collaboratively with other professional groups to develop best practices in geriatric psychiatry, to promote research, and to provide education and training to psychiatrists, other physicians, residents, medical students, and allied mental health professionals.

Information Items:

- The Council is revising the position statement entitled "HIV Infection in People over 50".
- The Council discussed the progress of the *Cultural Competency Guide for the Treatment of Elderly Adults*. It is due for publication in the fall.
- In the next meeting, the Council will discuss the implications of the use of technology by older adults.
- The Council collaborated with the Council on Quality Care and AAGP to advocate for issues pertaining to CMS's stand on ligature-free environment.

Action Items:

- Will the JRC approve the Position Statement on the "Role of Psychiatrists in Palliative Care"?
- Will the JRC approve the revised Position Statement on "Elder Abuse, Neglect and Exploitation"? (Red-lined version and clean copy attached)

Council on Geriatric Psychiatry – Minutes of the Meeting
Council Members Present:

1. Robert Paul Roca, MD (Chair)
2. Brent Forester, MD
3. Maria Llorente, MD
4. EJ Santos, MD
5. Marilyn Price, MD
6. Susan Lehmann, MD
7. Micheline Dugue, MD
8. Marsden McGuire, MD
9. Olivia Okereke, MD
10. Ipsit Vahia, MD
11. Juliet Glover, MD
12. Ebony Dix, MD (RFM)
13. Rebecca Radue, MD (RFM)
14. Daniel Shalev, MD (RFM)
15. Daniel Dahl, MD
16. Melinda Lantz, MD (Ex-officio, American Association of Geriatric Psychiatrists (AAGP))

Staff in Attendance:

- Sejal Patel (Staff), APA

Council Members Absent with excused absence:

1. Susan Schultz, MD
2. Paul Kirwin, MD
3. Maureen Nash, MD

Council Members Absent with unexcused absence:

1. Anand Kumar, MD (Vice-chair)

Guests in Attendance:

1. Samantha Shugarman, Deputy Director of Quality, Department of Reimbursement Policy
2. Megan Marcinko, Co-Director, Federal Affairs, Division of Government Relations
3. Diana Clarke, PhD, Deputy Director, APA Research

Minutes of the Meeting

Introductions

The meeting began with introductions of all participants and review of the agenda for the meeting.

The topics discussed in the meeting included the following:

Position Statements:

Role of Psychiatrists in Palliative Care: A workgroup consisting of volunteers from the Council on Geriatric Psychiatry and the Council on Consultation Liaison Psychiatry has developed the Position Statement on Role of Psychiatrists in Palliative Care. After several rounds of review and edits, the Council is submitting the document to the JRC for approval.

Elder Abuse, Neglect, and Exploitation (2008): The Council reviewed the old statement and agreed that it needs to be updated. A workgroup consisting of three volunteers revised the position statement. The statement was reviewed and revised at this meeting. The Council is submitting the statement to the JRC for approval.

HIV Infection in People Over 50 (2008): During the fall Component Meeting, the Council agreed that the statement needs revision and has formed a workgroup. The new statement will address sexually transmitted illnesses more broadly. The workgroup presented the first draft of the statement to the Council for review. Work will continue during upcoming conference call meetings.

The Council also discussed the progress on the position statement on "Role of Psychiatrists in Long-term Care Settings."

Update from American Association of Geriatric Psychiatrists (AAGP)

Dr. Melinda Lantz, President, AAGP provided an update on the AAGP's current activities and priorities. Dr. Lantz informed the Council that next AAGP Meeting will be held in Atlanta from March 1-4, 2019 and will focus on Advocacy. She talked about AAGP's upcoming meeting with the Substance Abuse and Mental Health Services Administration (SAMHSA) to discuss workforce issues in geriatric psychiatry. SAMHSA wants to increase its knowledge of important workforce issues for this population, such as training needs for suicide prevention, potential use of the peer workforce, and financing models to address workforce shortages, among other topics. The focus of the meeting will be on the potential development of a guidance document to identify next steps to develop the workforce serving older adults with SMI. She mentioned that AAGP is very appreciative of this collaboration with the Council and would like to continue working with the Council on issues that are important to geriatric psychiatrists.

Update from APA Division of Government Relations

Staff from the APA's Department of Government Relations attended the Council on Geriatric Psychiatry meeting to provide an update on current legislative, political, and grassroots initiatives. The update included an outline of the current "state of play" or political environment on Capitol Hill, a review and update of legislation such as Budget Agreement, Omnibus, and opioid-related legislation. DGR staff also indicated a desire to work more closely with the Council and will work with the staff liaison to identify opportunities for collaboration.

APA Registry Update from Research Division

Dr. Diana Clarke, Deputy Director of APA Research provided an update on APA Registry, PsychPRO. She mentioned that membership in PsychPRO has grown continuously since its inception in 2016, with over 300 psychiatrists and mental health professionals enrolled. She noted that the registry helps psychiatrists and other mental health professionals meet CMS's new Merit-based Incentive Payment System (MIPS) quality reporting requirements. The registry is certified as a Qualified Clinical Data Registry by the Centers for Medicare and Medicaid Services. It will help those clinicians who qualify to meet reporting requirements to avoid reimbursement penalties and potentially achieve bonuses from the MIPS program, as well as automatically meet their requirements for Maintenance of Certification Part IV. As APA continues to build the PsychPRO, the idea is to implement the platform as a complete tool that provides not only data collection and measurement with user-friendly feedback mechanisms—such as a dashboard with benchmarks—but also patient engagement tools, decision support, and other educational and training information and resources.

Update on APA efforts in Quality Care:

Samantha Shugarman, Deputy Director of Quality, provided an update on APA's efforts to address issues relevant to Quality Care. Samantha talked about what APA has been doing about the issues surrounding ligature risk, suicides and self-harm. She informed the Council about the survey APA has recently circulated to members to collect data on this issue that can be synthesized and sent to CMS for consideration. She encouraged members to fill out the survey and circulate it to the other responsible people in their facility.

Samantha also informed the Council about the surveys on the Joint Commission's National Patient Safety Goal (NPSG) on suicide risk reduction for the Hospital Accreditation Program (HAP) and the Behavioral Health Care (BHC) accreditation programs. The revision of this NPSG is intended to assist health care organizations to better identify and treat individuals with behavioral health diagnoses who are potentially at risk for suicide. It addresses screening, assessing level of risk, taking care of at-risk individuals, and providing resources for follow-up care at discharge. She encouraged the members to take the survey and circulate it to their networks.

She also mentioned that issues around psychotropic drug use in the elderly are on APA's agenda. APA will reach out to members to collect data on this matter soon. The collected data will be shared with the CMS with the goal of facilitating the development of policies to promote appropriate and safe care for patients. Lastly, she also provided a general overview and update on the Merit Based Incentive Program (MIPS).

APPI Book: Culture, Heritage, and Diversity in Older Adult Mental Health Care

Last year the Council took up the task of updating the curriculum on the treatment of ethnic minority elderly that was developed in 2004 by the Council on Aging. A task group consisting of members of the current Council, other APA members, and APA/APAF Fellows worked to develop a comprehensive, 11-chapter expansion of the original curriculum. In light of its quality, the Council explored the idea of publishing their work product as a book. The manuscript was submitted to APA Publishing and was accepted for publication. Dr. Maria Llorente, a member of the Council and the editor of the book, informed the Council that the book will be released in September 2018.

Experiences of APA/APAF Fellows on Council:

Three APA/APAF Fellows are currently assigned to the Council, two of whom are completing their tenure. One of these two fellows, Dr. Ebony Dix, was present at the meeting. She was asked to reflect on her time on the Council, Dr. Dix reported that it was a wonderful experience. The Chair and other Council members were very receptive to fellows' ideas and actively solicited their participation. She 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.

Attachments:

- Position Statement on the "Role of Psychiatrists in Palliative Care"
- Position Statement on "Elder Abuse, Neglect and Exploitation"
- Council Meeting Agenda
- Minutes of the Conference Call Meetings

Council on Geriatric Psychiatry

Monday, May 7, 2018, 9:AM-1:00PM

Bowery, Lower Lobby, Sheraton New York Times Square Hotel

Agenda

- Introductions
- Review minutes of the past meeting
- Summary of events since last meeting
    - Input to CMS regarding two-midnight rule and antipsychotics in nursing homes (see Appendix)
    - Input to CCLP regarding resource document on determining decisional capacity (see Appendix)
    - Other input (see Appendix)
- Council work plan review
- Work in progress
    - Book on culturally competent care (Maria Llorente, MD)
    - Position Statements
        - Long Term Care (in revision)
        - Palliative Care (in revision)
        - Elder Abuse (old statement being updated)
        - HIV in persons over 50 (old statement being updated)
        - Disaster response (proposed new statement)
- Update from American Association of Geriatric Psychiatrists. (Melinda Lantz, MD)
- Update from Department of Reimbursement Policy (Samantha Shugarman, Deputy Director of Quality)
- Update from APA Research Division on Registry (Diana Clarke, PhD, Deputy Director and Debbie Gibson, Registry Manager)
- Update from Department of Government Relations (Megan Marcinko, Co-Director of Federal Affairs)
- Technology for Aging Adults (Ipsit Vahia, MD)
- Annual Meeting submissions: Old and Potential (2019)
- Soliciting nominations for Weinberg and Hartford-Jeste Awards
- Experience of Fellows on Council (Ebony Dix, MD and Rebecca Radue, MD)

Council on Geriatric Psychiatry

Wednesday, February 14, 2018

1) Palliative care position statement: Maureen Nash has been working on a revision of this position statement with colleagues from the Council on Psychosomatic Medicine. The group was in agreement that the most recent draft is excellent. It was suggested that the statement include language pointing out the value of having psychiatrists on palliative care teams, particularly for patients with serious mental illnesses, including major neurocognitive disorders.
2) Feedback to NQF about proposed measure regarding antipsychotic use in non-psychiatric hospital inpatient settings: This measure, currently before the National Quality Forum for possible endorsement, is based on the premise that patients started on antipsychotics in medical-surgical settings for delirium or dementia-related behavioral disturbance are at risk of being discharged on these meds and harmed by them. The group appreciated the fact that patients on psychiatric units are excluded from the denominator, as are patients with schizophrenia, bipolar disorder, Huntington's, and Tourette's; it was suggested that patients with schizoaffective disorder should also be excluded from the denominator. It was appreciated that patients started on antipsychotics because they are dangerous to self or others are excluded from the numerator; it was suggested that patients with documented psychotic symptoms (e.g., delusions and hallucinations), whatever the cause, should also be excluded from the numerator.
3) Feedback to the AHRQ about their proposed key questions regarding treatment of clinical Alzheimer's type dementia (CATD) and the diagnosis of CATD and Mild Cognitive Impairment: It was suggested that question 1a look at comparative effectiveness and harms of interventions to slow **functional** as well as cognitive decline. It was also suggested that effectiveness be measured in terms of impact on cost of care, use of services, and caregiver well-being as well as on cognition and function. With respect to 1b, it was suggested that the patient characteristics considered include frailty, comorbidities, level of function, and type of insurance as well as the characteristics already listed. With respect to question 2, it was suggested that the benefits and harms of interventions for agitation/aggression be looked at as a function of patient characteristics (in the same manner as proposed in question 1b). It was also suggested that the AHRQ look into the harms of **nontreatment** of agitation/aggression among these patients. With respect to question 3, it was suggested that the AHRQ look into the evidence that early diagnosis of Alzheimer's disease or identification of genetic risk for Alzheimer's disease might be emotionally harmful to patients.

October 18, 2017

1) Position statement on the role of psychiatrists in nursing facilities: We reviewed revisions prepared by Maureen Nash (thank you Maureen). Marsden McGuire offered to do some additional work on it prior to our next meeting.
2) Position statement on Elder Abuse, Neglect, and Exploitation: Marilyn Price, Ebony Dix, Juliet Glover, and E.J. Santos have volunteered to revise this position statement and will get back to the Council soon with a target date for a first draft.

3) Position statement on HIV infection in people over 50: Ebony Dix, Rebecca Radue, and E.J. Santos have volunteered to revise this position statement and will get back to the Council soon with a target date for a first draft.
4) Position statement on disaster preparedness and response: Ebony Dix, Paul Kirwin, and Maria Llorente have volunteered to develop a position statement on this topic (as it relates to older adults) and will get back to the Council soon with a target date for a first draft.

November 8, 2017

1) The position statement on the role of psychiatrists in palliative care was presented to the JRC in October. The paper was well received in terms of content but the JRC is now asking that position statements be formatted differently. They are looking for a brief "issue statement" followed by a simple narrative position statement. Attached to this can be a more expansive background document. They are inviting us to submit a revised version in time for consideration at the February JRC; this would require that we submit it by the end of January. In the next few days we will confirm our understanding of the formatting expectations with APA staff and JRC leadership. We will then work on the next revision. I think it is very realistic to have it ready for the February meeting
2) As you recall, the Board asked us to revise the PS (already passed by the Assembly) on the role of the psychiatrist in nursing homes. Drs. Nash and McGuire worked on this over the last few weeks. Sejal is going to show the revised draft to JRC leadership and APA staff in the next few days to see if the JRC would accept it in its current format. If not, we will proceed with reformatting it before sending it to the JRC for approval.
3) Groups of Council members have agreed to work together on updating or developing statements on (1) elder abuse and neglect, (2) HIV in persons over 50, and (3) disaster preparedness and response. Sejal will begin right away to arrange conference calls of Council members who volunteered to help with these. In the meantime, we will settle the formatting questions so that the first drafts of these statement are developed along the required lines.
4) Susan Lehmann and Brent Forester have volunteered to help compose a letter from the APA to CMS asking that the nursing home quality measure looking at the percentage of patients on antipsychotics exclude patients with bipolar and schizoaffective disorder as well as patients with schizophrenia. Thanks so much to both of you for volunteering to do this.

5) The book on the culturally competent care of older adults is nearly complete. As you know, American Psychiatric Press will be publishing it. Congratulations to Maria Llorente and her team for this fabulous accomplishment!

August 8, 2017/ Conference Call Meeting
Minutes:
Thanks to everyone who participated in tonight's conference call. Below is a summary of what transpired.
1) We welcomed new members, Daniel Shalev (Leadership Fellow) and Juliet Glover (Consultant).
2) We discussed the status of two position statements. The statement on the role of the psychiatrist in palliative care is currently in the hands of the APA Joint Reference Committee. I anticipate that we may need to reformat it but have not yet gotten formal feedback. Sejal will circulate the draft we submitted to the JRC. The statement on the role of the psychiatrist in

long-term care was returned to us by the Board of Trustees with a request for revisions. I invited members of the Council to volunteer to help us revise the document. Sejal will circulate the draft we submitted to the Board for everyone's review.
3) We discussed the work of Maria Llorente and her group on the curriculum for the culturally competent care of older adults. Springer has an interest in publishing it. The American Psychiatric Press may also be interested. Several members of the Council shared their experience working with Springer as a publisher. We will take this up at our September meeting.
4) Sejal and Dr. Roca reminded members of the Council of the upcoming deadline for nominations for the Weinberg and Hartford-Jeste awards.
5) We discussed potential agenda items for the September meeting. In addition to the working on the position statements and reviewing the status of the cultural competency guide, we decided to review existing position statements relating to geriatric psychiatry to determine if they need updating. Sejal will make these available for review at the September meeting. We talked about how to increase the prevalence of programs relating to geriatric psychiatry at the Annual meeting. Dr. Roca will contact Dilip Jeste to find out if he did anything special during his presidential year to accomplish this. We also talked about creating educational content for the APA website and heard about resources that are available on the SAMHSA website that we might leverage or use as a model.

Title: Role of Psychiatrists in Palliative Care

Issue statement: Palliative care is a comprehensive, multidisciplinary approach to the treatment of persons with serious illness. Its focus includes both life-limiting and life-threatening conditions, many of which are frequently complicated by psychiatric disorders or symptoms. Palliative care places special emphasis on early identification, assessment, and treatment of pain and other physical symptoms. It also addresses social, cultural, ethical, legal, and spiritual considerations in patient care with the goals of preventing and relieving suffering and distress as well as enhancing quality of life. Palliative care physicians have expertise in the management of distressing symptoms such as dyspnea, nausea, and constipation. Their training in advanced disease trajectories and communication skills prepares them to engage in productive ongoing dialogues about prognosis and treatment options with patients and their families. They have expertise in the ongoing assessment of patients' goals of care to ensure that medical choices are consistent with patients' preferences. They remain engaged with patients throughout the course of illness. The American Board of Psychiatry and Neurology is a founding board of the ACGME approved fellowship in Hospice and Palliative Care. Patients with serious mental illness, major neurocognitive disorder with behavioral disturbance, and other psychiatric comorbidities are best served when specialized psychiatric care is integrated into palliative care services.

Position statement: Patients with psychiatric illness would benefit from greater access to palliative care, and many patients receiving palliative care develop serious psychiatric comorbidities requiring expert psychiatric management. The APA supports efforts to increase training in palliative care during psychiatric residency and encourages practicing psychiatrists to expand their knowledge of palliative care.

Authors: Council on Geriatric Psychiatry (Lead) and Council on Consultation Liaison Psychiatry

Current Position Statement on Elder Abuse, Neglect and Exploitation:

Approved by the Board of Trustees, July 2008
Approved by the Assembly, May 2008
Reaffirmed, December 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.

Issue

Elder abuse, neglect, and exploitation have been identified as major public health problems. All 50 states have adopted either mandatory or voluntary reporting laws. Abuse may be physical, emotional, and/or sexual, and may include threats, insults, harassment, harsh orders, infantilization, restriction of social and religious activity, financial exploitation, and failure to provide a safe environment. Older adults who suffer abuse, neglect and/or exploitation may be located in caregiving settings ranging from home to skilled nursing facilities. They may experience significant shame and ambivalence about prosecuting the perpetrators, especially when they are family members. Those with common geriatric syndromes such as cognitive impairment, delirium, falls, stroke, incontinence and overall decreased mobility are particularly vulnerable to victimization. Psychiatric symptoms seen in abused elderly persons include, but to limited to, resignation, ambivalence, fear, anger, cognitive impairment, depressed mood, insomnia, substance abuse, delirium, agitation, lethargy and self-neglect.

Depression and anxiety may result from abuse, and may also increase risk of abuse as vulnerable older adults become more socially isolated. Perpetrators of abuse may also have substance use and/or psychiatric disorders, including dementia, and may themselves require treatment. Elder abuse, neglect and financial exploitation are crimes. Psychiatrists may be called upon to participate in legal proceedings associated with elder abuse and may be in position to advocate for and help empower older adults to participate in this process when appropriate. All these activities are consistent with the APA's vision of ensuring humane care and effective treatment for all persons with mental disorders and its mission to promote the highest quality of psychiatric care.

Position Statement

The American Psychiatric Association (APA) recommends a comprehensive and culturally competent biopsychosocial assessment of older adult victims, and when clinically indicated, their perpetrators in order to facilitate effective interventions, including the utilization of legal, social and financial resources. Psychiatrists play a pivotal role in the identification and reporting of abuse, mitigation of risk, and treatment of the mental health sequelae of abuse.

Authors: Council on Geriatric Psychiatry

Deleted: Emotional abuse is often linked with physical abuse and both types of abuse can result in stress-related disorders.

Deleted: the following:

Deleted: These psychiatric symptoms are often the result of varied types of emotional and physical abuse, including threats, insults, harassment, lack of safe environment, harsh orders, infantilization, restriction of social and religious activity, and financial exploitation. Caregiver burden should be considered as an important risk factor for abuse, neglect, and exploitation, and appropriate interventions can be developed. This is particularly relevant in addressing

Deleted: victimized elderly persons

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Proposed revision of the Position Statement on Elder Abuse, Neglect and Exploitation:

Issue

Elder abuse, neglect, and exploitation have been identified as major public health problems. All 50 states have adopted either mandatory or voluntary reporting laws. Abuse may be physical, emotional, and/or sexual, and may include threats, insults, harassment, harsh orders, infantilization, restriction of social and religious activity, financial exploitation, and failure to provide a safe environment. Older adults who suffer abuse, neglect and/or exploitation may be located in caregiving settings ranging from home to skilled nursing facilities. They may experience significant shame and ambivalence about prosecuting the perpetrators, especially when they are family members. Those with common geriatric syndromes such as cognitive impairment, delirium, falls, stroke, incontinence and overall decreased mobility are particularly vulnerable to victimization. Psychiatric symptoms seen in abused elderly persons may include, but are not limited to, resignation, ambivalence, fear, anger, cognitive impairment, insomnia, substance abuse, delirium, agitation, lethargy, and self-neglect. Depression and anxiety may result from abuse, and may also increase risk of abuse as vulnerable older adults become more socially isolated. Perpetrators of abuse may also have substance use and/or psychiatric disorders, including dementia, and may themselves require treatment. Elder abuse, neglect and financial exploitation are crimes. Psychiatrists may be called upon to participate in legal proceedings associated with elder abuse and may be in position to advocate for and help empower older adults to participate in this process when appropriate. All of these activities are consistent with the APA's vision of ensuring humane care and effective treatment for all persons with mental disorders and its mission to promote the highest quality of psychiatric care.

Position Statement

The American Psychiatric Association recommends completion of a comprehensive and culturally competent biopsychosocial assessment of older adult victims and, when clinically indicated, their perpetrators in order to facilitate effective interventions, including the utilization of legal, social and financial resources. Psychiatrists play a pivotal role in the identification and reporting of abuse, mitigation of risk, and treatment of the mental health sequelae of abuse.

Authors: Council on Geriatric Psychiatry

Item 8.G
Joint Reference Committee
June 2018

Executive Summary
Council on Healthcare Systems and Financing
Harsh Trivedi, MD, MBA, Chair

Members of the Council on Healthcare Systems and Financing have focused their efforts on reviewing position statements and responding to action papers presented to the Committee in the past months. The Council has continued to provide feedback to the Administration on health reform, quality and payment reform, parity, and alternative payment methods. Our May meeting focused on the current Congressional landscape, ways to support the APA Foundation's work with the National Alliance of Health Care Purchaser Coalition, and outstanding position statement edits. We continue to monitor APA activities on parity implementation and regulatory issues, as well as the Trump Administration's efforts to combat the opioid crisis.

The Council brings the following Action Items:

Action Item 1: Will the Joint Reference Committee recommend that the Assembly approve the *Position Statement on Core Principles for Alternative Payment Models for Behavioral Health* and if approved, forward it to the Board of Trustees for consideration?
Attachment A: Proposed Statement

Background: The Committee on Reimbursement for Psychiatric Care drafted the attached proposed position statement. This has been approved by the Council on Healthcare Systems and Financing.

Proposed APA Position on Core Principles for Alternative Payment Models for Behavioral Health:
The APA urges future alternative payment models (APMs) for behavioral health to follow a core set of general principles to avoid unintended consequences that could harm patients, psychiatrists, and other mental health professionals and providers.

- The predominant goals for behavioral health APMs should be defined as increasing access and improving quality of care for individuals with mental health and substance use disorders (MH/SUDs), in order to improve outcomes.
- Mental health and substance use treatment has suffered from decades of inadequate funding and reimbursement.
- Current payments for psychiatric services do not cover the costs of providing the services and APMs must reflect the true costs of care. Therefore, APMs cannot be expected to reduce expenditures for the care of the population with these disorders.
- APMs should incentivize the care of underserved populations, with the use of evidence-based treatments, efficient use of resources, and tracking of outcomes using validated measures.
- Behavioral Health APMs must be designed specifically for the care of individuals with MH/SUDs and tailored to support individual treatment options, with flexibility in care delivery, to meet the diverse needs of this heterogeneous patient population.
- Behavioral Health APMs must be developed with substantive input from practicing psychiatrists and other mental health providers.
- Participation in Behavioral Health APMs should be voluntary, not mandatory.
- Behavioral Health APMs must provide improved reimbursement to psychiatrists, other mental health professionals, and systems of care, utilizing value-based payment.

- Behavioral Health APMs should take into account the lack of access for many psychiatrists to appropriate certified electronic health record technology (CEHRT); the expense and administrative burden of data reporting; and the limited availability of well validated behavioral quality measures.
- Behavioral Health APMs should support the delivery of services via telepsychiatry.

Action Item 2: Will the Joint Reference Committee approve the *Background Document on Position Statement on Core Principles for Alternative Payment Models for Behavioral Health* and if approved, forward it to the Board of Trustees for consideration?
Attachment B : Proposed background document

Background: The Committee on Reimbursement for Psychiatric Care drafted this background document to supplement their *Position Statement on Core Principles for Alternative Payment Models for Behavioral Health*. This has been approved by the Council on Healthcare Systems and Financing.

Action Item 3: Will the Joint Reference Committee approve the Position Statement Strongly Recommending Twelve Weeks of Paid Parental Leave and if approved, forward it to the Board of Trustees for consideration?
Attachment C: Proposed Statement

Background: The Council on Healthcare Systems and Financing reviewed the Position Statement Strongly Recommending Twelve Weeks of Paid Parental Leave, as directed by the JRC. The Council voted to approve it without changes. The Council on Advocacy and Government Relations was also asked to review this position statement and consider the political and advocacy implications. It supported the paper finding that it addresses a timely matter, and the significance that psychiatrists place on maternal care, while acknowledging that there could be possible resistance from policymakers.

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

Action Item 4: Will the Joint Reference Committee approve the Advocacy Priorities Document on Telemedicine in Psychiatry?
Attachment D: Proposed Advocacy Priorities Document

Background: The JRC approved the updated telepsychiatry position statement included in the Council's January report. This document provides additional context to the position statement submitted and outlines internal recommendations to guide advocacy efforts.

Proposed APA Advocacy Priorities on Telemedicine in Psychiatry
The APA will advocate for:

1. Increasing telemedicine and telepsychiatry research.
2. Developing and promoting telepsychiatry best practices.

3. Promoting telepsychiatry experiential learning during psychiatry residency.
4. Promoting telepsychiatry training opportunities for all psychiatrists.
5. Reducing regulatory barriers for the use of telepsychiatry.
6. Removing barriers preventing federal medical providers from evaluating, treating and consulting on any federal patient regardless of patient location.
7. Reimbursement parity of synchronous video-conferencing and in-person services where synchronous video-conferencing has demonstrated that quality of care is preserved.
8. Streamlining CPT coding.
9. Removing Medicare synchronous video-conferencing originating site restrictions in geographic areas with inadequate access to care but not classified as health profession shortage areas (HPSAs) by the Health Resource & Services Administration.
10. Including telemedicine and telepsychiatry in integrated care payment systems.

The Council brings the following informational items to the Joint Reference Committee:

1. **JRC Referral: Action Paper on Adopting an APA Position Statement Supporting Implementation of the Mental Health Parity and Addiction Equity Act (MHPAEA or parity law)**
   The Council finds that this paper does not consider the current work that the APA's Office of Parity Enforcement and Compliance is undertaking. The overall consensus was that an APA position paper on supporting implementation of MHPAEA should be broader in scope than the current paper. The position should state that all MHPAEA requirements be observed and that health plans, self- funded or otherwise, should re explicitly required to provide on request the documentation that evidences the regulatory rules and tests were observed and performed. The Council on Advocacy and Government Relations has also reviewed the paper and recommends, (1) inclusion of language that would identify patients as priorities; and (2) support the actions in implementation and enforcement consistent with the scope of APA's Office of Parity Enforcement and Compliance.

   The Council requested that Sam Muszynski make the necessary edits and share with the Council for review. The Council will plan to submit the updated version in its October JRC report.

2. **JRC Referral: Position Statement on Psychologists and Other Mental Health Professionals and Hospital Privileges**
   The Council agrees to work with the Council on Advocacy and Government Relations to create a workgroup charged with revising this position statement. The Council urged the work group to more explicitly include NPs, PAs, and prescribing psychologists. Dr. Thienhaus and Dr. Cole will serve as the Council's representatives to the workgroup. The Council has forwarded this recommendation to the Council on Advocacy and Government Relations to be included in its June 2018 JRC report.

3. **JRC Referral: Action Paper on Transitional Care Services Post-Psychiatric Hospitalization**
   The Council reviewed the Action Paper on Transitional Care Services Post-Psychiatric Hospitalization as directed by the JRC. The Council members suggested that the authors integrate current APA policy that speaks to the continuum of care and the care for the uninsured, where applicable. Additionally, it suggested that the "Be it Resolved" be more focused on asking APA to lobby for better reimbursement to coordinate care. The Council has

forwarded this recommendation to the Council on Advocacy and Government Relations to be included in its June 2018 JRC report.

4. **Creation of a Serious Mental Illness Work Group**
   After the release of the Committee on Integrated Care's white paper, "Psychiatry's Role in Improving the Physical Health of Patients with Serious Mental Illness," in December 2017, the Council discussed that care for patients with SMI does not have a home within any of the Councils. To better coordinate APA's work in the area and think strategically about how to support the implementation of the federal Interagency Serious Mental Illness Coordinating Committee's report recommendations, the Council will form a work group focused on this issue.

5. **Level of Care Work Group Update**
   The Council, along with the Council on Research and the Council on Quality Care, has formed a work group consisting of six members from across all three councils. Per the JRC's request, it is expected that that work group will evaluate the pros and cons of the development of a level of service instrument, the potential avenues and funding for such development and make a recommendation to the JRC. Members will submit a report in October 2018 on the group's progress.

Council on Healthcare Systems and Financing
Harsh Trivedi, MD, MBA, Chair
May 8, 2017, 9:00 AM – 3:00 PM EST

Draft Minutes

Council Members: Harsh Trivedi, MD, MBA, Chair; Ann Sullivan, Vice Chair; Eileen McGee, MD; Mark Bradshaw, MD; Robert Cabaj, MD; Vikram Kambampati, MD; Joseph Mawhinney, MD; Lori Raney, MD; Ole Thienhaus, MD
Fellows: Alexander G Cole, MD; Matthew Goldman, MD, MS; Kathryn Skimming, MD, MS; Adjoa Smalls-Mantey, MD; Kevin Mauclair Simon, MD; Luming Li, MD
Corresponding Member: Sosunmolu Shoyinka, MD
Consultant: Elias Karim Shaya, MD; Bradley Stein, MD
Committee Chairs: Greg Harris, MD; Larry Miller, MD
Incoming Members: Clarence Chou, MD; Robert Trestman, MD
Excused Absence: Naakeesh Dewan, MD; Eliot Sorel, MD; Ripal Shah, MPH, MD
Unexcused Absence: Ranota Delores Hall, MD
APA Administration: Kathy Orellana; Kristin Kroeger; Becky Yowell; Sam Muszynski

Welcome and Introductions (Dr. Trivedi)
Members were introduced and presented no new conflicts.

DGR Legislative Update (Mike Troubh)

- Omnibus overview
    - In March, Congress passed a $1.3 trillion omnibus package that included $1.5 billion in funding for mental health programs and a $3.6 billion set aside in funding for opioid treatment and prevention.
    - NIH saw an increase of $3 billion, including $500 million for a new initiative to research opioid addiction, development of opioid alternatives, pain management, and addiction treatment.
    - The biggest omission in the package is that it did not include funding to stabilize the markets in the Affordable Care Act.
- Legislation related to the opioid crisis
    - Congress is currently reviewing over 120 bills to address the opioid crisis. On the Senate side, the Finance and HELP Committees and on the House side, the Energy & Commerce and the Ways & Means Committees are reviewing proposals, but is still remains unclear who what could be included in a final package. APA has responded to all four committees on upcoming legislation.
    - The bills are focused on a variety of topics including treatment, prevention, research, workforce, and law enforcement. Legislators would need to find new money or an offset for new projects given that the budget has been set.
    - Members are ambitious to have legislation passed by Memorial Day, but given that they will need bipartisan support and produce a bill with limited costs, that timeline may be unrealistic. The upcoming fall elections are likely motivating members into action and may be influencing discussions on the topic.
    - Proposals of note include:

- NIH flexibility – both the Senate and House committees have voted to give NIH flexibility to approve non-addictive treatment.
- Loan repayment for providers of SUD treatment – Congress recognizes the workforce shortage of treating this crisis. A proposed bill in the Senate would set aside $25 million for loan repayment assistance.
- Expansion of MAT – Both the House and the Senate have proposed bills that would codify the 275-patient cap for waivered providers. The proposals to make permanent the ability for nurse practitioners and physician assistants to prescribe MAT have been eliminated in both chambers.
- Lifting of the IMD exclusion – the House proposal would lift the IMD exclusion to allow Medicaid to cover residential treatment for SUD.
- Set telepsychiatry prescribing guidelines – the House proposal would give a one-year deadline for the Attorney General and the DEA to issue final guidelines.
- 42 CFR Part 2 – Both committees did not pass proposals to align 42 CFR Part 2 with HIPAA and strengthen protections against SUD records being used in criminal or civil proceedings, as this has become a contentious issue.

Background on Paid Leave Position Statement (Dr. Maureen Niel)

- Dr. Maureen Van Niel, the president of the APA's Women's Caucus, came to speak to the Council about the position paper and answer any outstanding questions.
- She covered the mental health impacts of providing parents with up to twelve weeks paid leave when birthing, adopting, or fostering a child, as well as the financial implications of the policy.
- Upon hearing her responses, the Council moved to approve the position statement.

Overview of the American Academy of Physician Assistants' Optimal Team Practice (Phyllis Peterson)

- Phyllis Peterson presented to the Council about the PAs proposed Optimal Team Practice model to work collaboratively with physicians.
- She spoke about concerns that had been raised at an AMA meeting about PAs focused on practicing solo and wanted to set the record straight that they want to work as part of the medical team.
- While the Council expressed their concerns, she relayed that the AAPA is actively pursuing psychiatrist to be preceptors to PAs and asked how PAs and psychiatrists can work together to develop best practices for care.

Update from the National Alliance of Health Care Purchaser Coalition (Mike Thompson)

- Mike gave an overview of the Coalition's work on mental health and its partnership with the APA Foundation's Center for Workplace Mental Health.
- Among the Coalition's priorities is expanding the reach of the Collaborative Care Model. The primary problem he noted is that since the CoCM codes have been turned on, the number of claims coming through are low.
- He also spoke of the Coalition's upcoming Evalue8 Report coming out in June and a new action brief on parity being released in May.
- Questions raised by the Council focused on how employers are dealing with stigma, how they are measuring the benefits of expanding mental health care, how they can push to expand the pool of providers accepted into the payer networks, and what is being done on first episode psychosis.

- The Council expressed enthusiasm for having APA members take action on addressing the issue of individual providers joining payer networks more easily.
    - One suggestion was to have the Coalition present to the Assembly and encourage them to take this issue up at the state level by engaging their state associations.
    - The Council also suggested created an APA goal to have a certain percentage of psychiatrist be in-network in the next few years.
    - Additionally, how could the organization make a bigger push to expand the Collaborative Care Model? Members considered what it would take to get 30% of primary care physicians practicing the model.

Position Statement Review

- Action paper: Transitional Care Services Post Psychiatric Hospitalization
    - The Council votes to pass on the following recommendations to CAGR:
        - The authors should pull from existing position statements that speak to the continuum of care and the care of the uninsured.
        - The action should be more focused on asking APA to lobby for better reimbursement to coordinate care.
- Action paper: Adopting an APA Position Statement Supporting Implementation of the Mental Health Parity and Addiction Equity Act
    - The Council finds that this paper does not consider the current status of the parity work APA is doing. The Council recommends that Sam Muszynski make the necessary edits and share with the Council for review by the October JRC report deadline.
- Position Statement on Psychologists and Other Mental Health Professionals and Hospital Privileges
    - The Councils recommends that the Council on Advocacy and Government Relations create a workgroup with its members to revise this position statement to include NPs, PAs, and prescribing psychologists.
    - Dr. Thienhaus and Dr. Cole will serve as the Council's representatives to the workgroup.
- Position Statement Strongly Recommending Twelve Weeks of Paid Parental Leave
    - This statement has been approved.

Council Chair Updates

- Dr. Trivedi spoke about the shifts in committee chair positions for the next year and expressed that he will be asking for more transparency on future appointments and that future committee chairs be members of the Council.

APA Updates

- Parity
    - Sam Muszynski began his report by noting that this fall will mark the 10th anniversary of the enactment of the Mental health parity and Addiction Equity Act of 2008. While there has been considerable progress in eliminating disparities in financial requirements and quantitative treatment limitations for MH/SUD services over this span the progress on ensuring compliance with the law's requirements respecting non-quantitative treatment limitations (NQTLs); e.g., medical management protocols, reimbursement rates, has not been as robust.

    - APA undertook a number of exploratory efforts with those responsible for enforcement at the federal level (DOL and CCIIO) and the state level (Insurance Commissioners and several Attorneys General) and entities which subcontract with these entities to conduct market examinations of health plans to better inform its efforts.
        - Most state and federal regulators are ready, willing, and able to move on parity compliance, but face a number of practical hurdles: filing systems, forms and procedures that do not facilitate in-depth reviews at the pre-market stage; limited understanding as to how to apply the parity regulatory tests, insufficient resources for comprehensive reviews; limited clinical expertise; and wariness of instructing issuers to amend their plans for fear of legal challenges, among others.
- Our key interest is in better evaluation of health plan justifications for these especially for matters such as reimbursement rates. APA staff is working on the development of an NQTL audit tool to facilitate improved review of these issues.
- Other essential components of APA's efforts have been trainings and consultations with numerous state insurance entities and market exam subcontractors, webinars, formulation of a new MHPAEA chapter for the NAIC Market regulation handbook and contractual arrangements with states in collaboration with Milliman to redesign their parity review and evaluation protocols. APA will also be providing training and technical assistance sessions for federal regulatory staff on evaluation plan justifications for NQTLs which are applied to MH/SUD services. These efforts have been well received and APA.
- Collaborations and Partnerships
    - Kristin Kroeger presented on the work that the Policy, Programs, and Partnership department is doing with other departments and on behalf of the APA with other external partners and coalitions.
    - She also spoke about the newly updated MACRA toolkit and the Patient Safety Risk Assessment staff is working on to solicit feedback on the ligature issue. Staff is aware of facility closures in Washington, Idaho, Ohio, and Pennsylvania. The survey will give APA staff numbers to present to CMS staff.
    - Staff also continues to work on Collaborative Care Model trainings and has created a Medicaid toolkit for members to use for advocacy at the state level. In states where APA is combating psychologists prescribing, CoCM is being used as an alternative solution – sample legislative language has been helpful. Based on RUC data, staff believe that as people get more comfortable with the codes, we will see more claims.
    - APA also met with SAMHSA to discuss its Interdepartmental Serious Mental Illness Coordinating Committee. APA will provide TA on continuum of care, population health, parity/enforcement, and paying for psychiatric services at the same rate as medical services.
- Leavitt Partners Case Study/Level of Care Work Group
    - Staff worked with Leavitt Partners to create a case study on leveraging technology to lessen the administrative burden on case management within the CoCM. APA will be working with Leavitt Partners and Montefiore to promote the case study.
    - The Level of Care Work Group has recruited six members and will be chaired by Dr. Dewan of the Council on Healthcare Systems and Financing. The JRC requests a report in October 2018 on the work group's progress. It is expected that that work group will evaluate the pros and cons of the development of a level of service instrument, the

potential avenues and funding for such development and make a recommendation to the JRC.

- Coding/Reimbursement
  - Becky Yowell noted that there are now CPT codes that can be used by primary care physicians to report psychiatric collaborative care management services. Recent Medicare data showed that slightly over 700 claims were billed for the initial month of care so we anticipate a slow but hopefully steady increase in billings over time.
  - Gregory Harris, MD, updated the group on the activities of the Committee on RBRVS, Codes and Reimbursements. CMS is soliciting feedback regarding potential changes to the E/M documentation guidelines. They appear to want to simplify while also addressing concerns they have about upcoding as a result of the ability to "copy and paste" documentation elements from previous visits into the record. We anticipate seeing their proposal in the July proposed rule on the 2019 Physician Fee Schedule. Ron Burd, MD has retired as the APA RUC Representative; Allan Anderson is now the RUC Representative and Dr. Harris replaces Dr. Anderson as the RUC Alternate Rep. The committee held a well-attended (175+) CPT coding and documentation workshop at the Annual Meeting in NYC. He went on to report that the committee strongly believes that this sort of workshop is a must-have at any annual meeting and noted problems in ensuring it remained on the program.
  - Laurence Miller, MD, updated the group on the activities of the Committee on Reimbursement for Psychiatric Services. He thanked the council for their support in approving the principles the committee developed on Alternative Payment Models. Members of the committee met during the APA Annual Meeting and began a discussion to identify potential models for psychiatry. Coordinated Specialty Care for patients experiencing their first episode of psychosis is one area that is being considered. The committee will be developing a strategic plan over the next few months to identify, prioritize and move projects forward. He noted that it was nice to have the involvement (as members of the committee) of heads of other mental health organizations (Joe Parks, National Council, and Brian Hepburn, NASMHPD). He also noted that there is no specific committee/council within the APA that addresses the needs of the seriously mentally ill population. The Council resolved to form a work group to focus on patients with Serious Mental Illness.

APA Official Actions

Position Statement on Core Principles for Alternative Payment Models for Behavioral Health

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: The APA supports the development of new models of care that will improve access, quality of care, and patient outcomes for the millions of individuals with mental health and substance use disorders. We strongly recommend including the Collaborative Care Model in alternative payment models. We have also advocated for new models of care that address mental health and substance use benefits for children, adolescents, and young adults—particularly new models addressing the onset of psychosis in adolescents and young adults. However, we also have concerns that the current approach and prevailing requirements for new models of care, especially under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), and the development of models without input from psychiatry, could lead to decreases in patient access and quality of care, as well as insufficient reimbursement for psychiatrists and other mental health providers. Consequently, we advise a cautious approach consistent with general principles that will avoid harming patients or providers.

POSITION:
The APA urges future alternative payment models (APMs) for behavioral health to follow a core set of general principles to avoid unintended consequences that could harm patients, psychiatrists, and other mental health professionals and providers.

- The predominant goals for behavioral health APMs should be defined as increasing access and improving quality of care for individuals with mental health and substance use disorders (MH/SUDs), in order to improve outcomes.
- Mental health and substance use treatment has suffered from decades of inadequate funding and reimbursement.
- Current payments for psychiatric services do not cover the costs of providing the services and APMs must reflect the true costs of care. Therefore, APMs cannot be expected to reduce expenditures for the care of the population with these disorders.
- APMs should incentivize the care of underserved populations, with the use of evidence-based treatments, efficient use of resources, and tracking of outcomes using validated measures.
- Behavioral Health APMs must be designed specifically for the care of individuals with MH/SUDs and tailored to support individual treatment options, with flexibility in care delivery, to meet the diverse needs of this heterogeneous patient population.
- Behavioral Health APMs must be developed with substantive input from practicing psychiatrists and other mental health providers.
- Participation in Behavioral Health APMs should be voluntary, not mandatory.
- Behavioral Health APMs must provide improved reimbursement to psychiatrists, other mental health professionals, and systems of care, utilizing value-based payment.

- Behavioral Health APMs should take into account the lack of access for many psychiatrists to appropriate certified electronic health record technology (CEHRT); the expense and administrative burden of data reporting; and the limited availability of well validated behavioral quality measures.
- Behavioral Health APMs should support the delivery of services via telepsychiatry.

Authors:
Committee on Reimbursement for Psychiatric Care

Background Document for
Draft Position Statement on Core Principles for Alternative Payment Models for Behavioral Health

The APA's Position Statement enunciates 10 principles. These are presented below along with their supporting background information.

- The first principle declares that the predominant goals for behavioral health APMs should be defined as increasing access and improving quality of care for individuals with mental health and substance use disorders (MH/SUDs), in order to improve outcomes.

From the outset, there needs to be a fresh, new approach for developing and evaluating alternative payment models for individuals with mental health and substance use disorders (MH/SUDs). Behavioral health APMs should be required to meet the fundamental goals of improving access to care, and ensuring high standards of care, for individuals with MH/SUDs. Reining in costs is a laudable goal, but models that only do this are not meeting the needs of this population.

- The second principle notes that mental health and substance use treatment has suffered from decades of inadequate funding and reimbursement.
- The third principle emphasizes that current payments for psychiatric services do not cover the costs of providing the services and APMs must reflect the true costs of care. Therefore, APMs cannot be expected to reduce expenditures for the care of the population with these disorders.

For psychiatric services, the current rates from many payors do not cover the costs of providing the services. Healthcare organizations lose money on psychiatric services and have to cover the loss from other service lines. This creates an inappropriate business incentive which restricts access. The base payment rate of any APM must be adequate to cover the costs of providing the services. (The prospective payment system (PPS) for Certified Community Mental Health Centers is an excellent example an APM consistent with this principle.) The general rationale behind implementation of APMs does not apply to patients with mental illness. Much of the impetus for new models of care stems from data showing that the high spending in American health care does not translate to better patient outcomes. The vast majority of existing APMs address either primary care – to incentivize primary care providers to serve as gatekeeper and care coordinator to decrease unnecessary procedures and hospitalizations — or are built around very costly procedures or conditions. The primary goal is often to reduce the overall costs for the entire course of care for such patients.

The circumstances are very different for patients with mental illness, including substance use, and the psychiatrists who treat them — if those patients are even able to see a psychiatrist. Unlike the overwhelming preponderance of physical health issues, mental health issues are generally regarded to be under-treated, with persistent disparities in treatment for substance use disorders, as well as racial and ethnic disparities.

- The fourth principles states that APMs should incentivize the care of underserved populations, with the use of evidence-based treatments, efficient use of resources, and tracking of outcomes using validated measures.

In 2014, about 18 percent, or 43.6 million, of American adults had a mental illness. The percentage of children and adolescents with a mental illness was a staggering 13 to 20 percent. In 2014, 8 percent, or 20.2 million, of individuals age 12 and older had a substance use disorder.[i] Yet only 40 percent of adults, and only 50.6 percent of children ages 8-15, with a *diagnosed* mental illness received treatment. Furthermore, only 59 percent of those with a *serious* mental illness received treatment.[ii]

Individuals with mental illness often have extensive non-psychiatric medical needs. Depression, anxiety, substance use disorders, and other common psychiatric disorders frequently are comorbid with cardiovascular disease, diabetes, obesity, pain disorders, and other costly and potentially disabling physical conditions.[iii] Indeed, the rate of mortality among persons with mental disorders in comparison to those without is startlingly high.[iv] Many chronic medical conditions require a self-care regimen in order to manage symptoms and prevent further disease progression, which may be hampered by comorbid mental conditions. A recent study found that 68 percent of adults who have a mental disorder also suffer from a medical comorbidity.[v] Furthermore, most early mortality in patients with mental disorders is associated with chronic comorbid conditions, which are exacerbated by mental illness. A meta-analysis of worldwide mortality estimates found that the risk of mortality for individuals with psychiatric disorders was 2.2 times higher than for persons without mental disorders.[vi] A majority (67%) of deaths was attributed to natural causes such as cardiovascular disease, lung disease, and diabetes and the reduction in life expectancy ranged widely from 1.4 to 32 years. Co-occurring mental disorders in persons with medical conditions also contribute to unemployment, absence from work, and decreased productivity at work. [vii]

Increasing patient access and quality of care for individuals with MH/SUDs can often lead to savings over the long-term, particularly through improvements in overall health. But capturing those savings requires looking at the whole health of an individual, over a period of years. Most APMs are required to demonstrate savings during a snapshot period (typically a year). The bar is often raised each year due to shifting benchmarks. CMS often places limitations on what costs can be considered in that equation, for example, only comparing savings in Part B. If behavioral health APMs are subjected to this approach, most (if not all) are doomed to failure.

- The fifth principle states that Behavioral Health APMs must be designed specifically for the care of individuals with MH/SUDs and tailored to support individual treatment options to meet the diverse needs of this heterogenous population.

Ultimately, all the emerging payment methodologies have a central commonality – holding providers accountable for the costs of care. We agree in principle that this is a proper objective. However, it is essential that any chosen methodology be properly constructed in a manner that is fair to the accountable provider and does not provide undue incentives which may jeopardize essential clinical care appropriate to any given patient's condition. This is a complex undertaking when dealing with psychiatric patients and thoughtful caution should be a primary precept.

First, the acuity or chronicity of a patient's status for any given psychiatric diagnosis is highly heterogeneous. Moreover, treatment options and the treatment of choice and how many or which providers may be involved can be highly variable as well. This greatly complicates the task of defining an episode of care where the baseline denominator is a particular diagnosis. The idiosyncrasies of this population do not lend themselves well to the one-size-fits-all approach of most existing models.

Second, the difficulties noted above have multiple implications for calculating baseline costs for any defined episodes. For example, what is the duration of the episode and what costs should be included in the bundle. Should it include prescription medicines? Which providers should be paid out of the bundle? How will baseline costs or payment be adjusted for quality of care and patient health status? Will costs be reconciled retrospectively or are they to be truly prospective? These calculations must take these issues into consideration if incentives to skimp on care and/or avoid high-risk patients are to be minimized. Claims data can be useful in constructing preliminary answers to these questions, but extant data must also take into consideration that reimbursement for psychiatric services has been consistently underfunded and available data probably do not reflect actual costs. This can easily produce inequities for the provider deemed accountable for the bundle and increase the risk of the negative incentives noted. In any case, how baseline costs are established and adjusted

is a threshold consideration in as much as the assumption of risk by the provider is inherent in any bundled-like payment arrangement and will be determinative of how service delivery is operationalized for patients.

Third, how will the accountable provider(s) be determined and how will any services subject to the payment be apportioned? Who is responsible for the initial evaluation and treatment plan and accountable for the episode? This goes to the heart of the provider risk assumption question and also involves detailed policy deliberation. There are desirable and positive care coordination and management incentives built into these approaches. However, payment policy must take into account that the psychiatric service system has been more fragmented than not, and new approaches will require a culture change as much as optimal payment design to work toward optimizing care for patients. Phasing in any new payment model may be essential.

There are many other essential issues that require resolution regarding the design of alternative payment approaches for psychiatric services. Another concern involves whether adequate evidence supports developing new delivery models that may incentivize particular treatment modalities, and what constitutes adequate evidence. These and those noted above should be essential filters for advancing concepts to CMS. If the foregoing questions cannot be resolved, then the feasibility of any concept or idea, no matter how good in principle it appears, must be questioned. The unintended, and likely negative, consequences of poorly constructed approaches are difficult to project but will be consequential for patients and clinical outcomes.

It is also worth noting that patients with MH/SUDs can also benefit greatly from receiving support and assistance in areas that impact their health, but are not typically reimbursed by payors. For example, SAMHSA has provided grants to support health improvement interventions such as smoking cessation, weight reduction, exercise classes, cooking advice, appointment reminders, etc. These can greatly improve clinical care and patient outcomes.

- The sixth principle states that Behavioral Health APMs must be developed with substantive input from practicing psychiatrists and other mental health providers.

No behavioral health APM should be designed without involvement and input from practicing psychiatrists and other mental health providers – from the very start. As the model evolves, there must be additional opportunities for frequent input from psychiatrists and other mental health professionals who have substantial clinical experience and expertise in treating individuals experiencing various mental health and substance use disorders. It is crucial to gain input and buy-in from providers from across the country, who practice in a variety of health care settings, and treat patients from diverse ethnic and socio-economic backgrounds.

Psychiatrists should be involved from the very beginning of that process in order to avoid building upon ideas that look good in theory, but are not effective in practice. Psychiatrists have years of training in the biological, psychological, and social aspects of mental health and substance use disorders. Psychiatrists are uniquely positioned to determine appropriate medications and other treatments for individual patients, particularly those with comorbid medical conditions, severe mental illness, and multiple mental health issues. Decisions regarding diagnosis and treatment require extensive knowledge and experience regarding the pharmacological effects of particular medications, as well as how they interact with the patient's own particular mental health and other conditions.

New behavioral health APMs can also benefit from experience that psychiatrists and other mental health clinicians have gained with existing models. For example, lessons can be learned from the Arkansas Medicaid episodes of care models for children and adolescents with ADHD (attention deficit hyperactivity disorder) and ODD (oppositional defiance disorder). Some APA members have expressed concerns that certain behavioral health models may result in decreased quality, because the main goal was cost containment. Other concerns include that existing APMs may be too narrowly drawn for treating only particular diagnoses and/or treatments, which creates disincentives for accurate diagnosis and treatment, simply to keep an individual in that model.

It is also important to consult and seek the input of professional societies representing the interests of psychiatrists and other mental health professionals. Virtually all APMs are built upon some aspect of fee-for-service and developing an APM requires substantial knowledge of current payment structures and policies. Professional societies spend significant time and resources gaining this knowledge, so their members don't have to, and also because the intricacies of existing payment policies often benefit some clinicians, while harming others.

The APA is not aware of current ideas for behavioral health APMs that are widely supported by psychiatrists and other practicing mental health professionals, although we know of recent discussions among professional societies around possible APMs for dementia care and substance use disorders. APA members have expressed concerns that private entities may be developing and marketing an array of new models of care for MH/SUDs which were designed without consulting practicing psychiatrists and other mental health professionals.

- The seventh principle declares that participation in Behavioral Health APMs should be voluntary, not mandatory.

The APA opposes any behavioral health APM mandating participation by psychiatrists or their patients, or imposing penalties or other negative consequences for their failure to participate. Psychiatrists work in a wide array of practices and settings, and many individual psychiatrists work in more than one setting. These include academic health centers, hospitals, clinics, nursing homes, and private practices. As a result, a particular APM may work for one psychiatrist or even one of their practice settings, but not others.

Psychiatrists account for the largest percentage (42%) of physicians in clinical practice that have formally opted out of Medicare.[viii] Medicare policies need to encourage and support the ability of psychiatrists to participate in Medicare, continue to see their current Medicare patients, and accept new patients. Since 2006, less than half of the available geriatric psychiatry fellowships have been filled.[ix]

- The eighth principle is designed to ensure that Behavioral Health APMs provide adequate reimbursement to psychiatrists and other mental health professionals.

A fundamental obstacle to creating behavioral health APMs involving psychiatrists is the general requirement that an APM must generate savings, in comparison with fee-for-service. While psychiatric care can lead to cost savings for patients overall, there is a widespread view within psychiatry that the prevailing Medicare fee-for-service rates are insufficient. This contributes to the high percentage of psychiatrists who opt of Medicare. It also poses a major obstacle for creating APMs that would require demonstrated savings based solely on the reimbursement of psychiatrists.

To achieve successful and widespread acceptance and adoption, any behavioral health APM must be built upon a framework of adequate reimbursement for psychiatrists and other health providers. Unfortunately, reimbursement for psychiatrists has simply not kept pace with the rising costs of delivering care. Many psychiatrists in small and solo practices would like to be able to hire clinical staff and invest in electronic health record (EHR) systems, but they simply cannot afford it. As a result, many psychiatrists have left clinical practice for more lucrative opportunities, and this contributes to the shortage of psychiatrists in this country.

Even the recently issued Medicare reimbursement rates for collaborative care services may not be sufficient to cover the costs of primary care providers contracting with psychiatric consultants. While the APA strongly supports the inclusion of the Collaborative Care Model in APMs, that endorsement comes with the caveat that those models must ensure adequate reimbursement for the consulting psychiatrist's services – either by allowing separate billing for collaborative care services (under the Physician Fee Schedule) or by refraining from requiring savings generated from "ratcheting down" those rates.

- The ninth principle states that Behavioral Health APMs should take into account the lack of appropriate EHR systems for mental health care and the lack of access to CEHRT for many psychiatrists.

Under the MACRA, "Advanced" APMs must employ Certified Electronic Health Record Technology (CEHRT). In MACRA policies for the 2017 participation year, CMS has interpreted this as requiring such APMs to certify that at least half their participants use CEHRT. The APA understands that the need for greater integration and use of EHRs within health care delivery is paramount toward the goal of improving health outcomes of individuals and of the population as a whole. However, psychiatrists have struggled to meet the CEHRT requirements of the EHR Meaningful Use (MU) Incentive Program. Very few psychiatrists have been successful in meeting these standards. This may pose a significant barrier in the widespread adoption of behavioral health APMs for psychiatrists, unless allowances are made.

Many psychiatrists have been slow to adopt EHRs into their practice, particularly those who have their own small or solo practices. This due to multiple reasons, including cost, a lack of high-quality EHRs tailored to the practice of psychiatry, and concerns regarding the safety and security of highly sensitive data about individual patient's MH/SUDs. Despite the proliferation of EHR systems over the past decade, including some that purport to cater to mental health specialists, these generally do not have psychiatry-specific outcome measures integrated into their systems. Systems must custom build them into the base EHR design, at the clinician's expense. This further increases the financial burden that solo practitioners and small-group practices already shoulder when bringing an EHR online in their practice.

Some APA members, especially those practicing in solo or small group settings, have also indicated that the adoption and maintenance of a complete EHR system has resulted in decreased efficiency for their practices. Even more disturbing, some say it has shifted their focus away from the patient, and poses a serious obstacle in the therapeutic relationship central to the psychotherapeutic process. Because of this, many psychiatrists have elected not to integrate an EHR system into their practice. Another issue is that many consulting psychiatrists who care for patients in hospitals and other facility settings do not have access to the hospital EHRs for those patients, or their own practice's EHR system is not compatible with the systems for those facilities. This prevents them from using EHRs to keep comprehensive data on those patients.

- The tenth principle declares that Behavioral Health APMs should support the delivery of services via telepsychiatry.

The APA is a strong proponent of telehealth as practiced by psychiatrists, known as "telepsychiatry," and has developed a "Telepsychiatry Toolkit" with videos and other materials to educate psychiatrists on this treatment option.[x] Telepsychiatry services, particularly in rural and remote areas, can make a real difference in the ability of patients with MH/SUDs to access the care they need, both long-term for those with chronic conditions and short-term for those facing a crisis. Telepsychiatry has been employed in therapeutic settings since the 1950s. Recent advances in video technology coupled with widespread, broadband internet access have resulted in a rapid expansion in the number of psychiatrists who regularly engage in telepsychiatry. Early and more recent research indicates that psychiatry as a medical discipline appears to be an ideal fit with videoconferencing as a treatment modality. Many psychiatric treatments can be translated to telepsychiatry. Furthermore, case studies and empirical data have revealed no known absolute exclusion criteria, nor contraindications for any specific psychiatric diagnoses, treatments, or populations. Given the current shortage of psychiatrists practicing in the United States, the use of telepsychiatry is a helpful tool that can increase access to care for an already vulnerable mental health population.[xi]

Access to psychiatric care is fundamental to address the whole health of patients utilizing health care services. Patients with acute and chronic mental health problems are at increased risk for suicide, homicide, and

accidents. The risk of suicide is especially pronounced within rural populations, which typically demonstrate higher suicide rates, particularly for men, when compared with urban populations. Telepsychiatry increases access to critical services to patients within rural, remote, and isolated settings, and has the potential to address these public health concerns.[xii]

Medicare currently reimburses telepsychiatry services only in rural or designated underserved areas. Allowing it to be reimbursed in other areas would greatly allow expansion of those services.

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

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

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

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

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

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

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

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

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

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

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

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

Health disparities exist among different socioeconomic groups associated with the lack of paid parental leave. Many women with a higher family income can afford to take unpaid leave for months and stay home with their infants, but millions of women in lower socioeconomic groups with low-paying or part-time jobs do not take leave because they cannot afford to live without the income they provide for their families. In almost half of all two-parent households, both parents now work full time; in 40 percent of

all families with children, the mother is a primary breadwinner. A paid parental leave would address health disparities, a core principle of the APA.

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

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

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

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

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

Susan Gerretson M.D. APA Member
D. Scott Allen M.D. APA Member
Linda Addante M.D. APA Member

ESTIMATED COST:
Author: $0
APA: $154

ESTIMATED SAVINGS:

ESTIMATED REVENUE GENERATED:

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

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

APA STRATEGIC PRIORITIES: Advancing Psychiatry, Diversity

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

Attachment:

APA Official Actions

APA Position Statement on Paid Parental Leave

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

POSITION

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

Authors:

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

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Telemedicine in Psychiatry
--- Advocacy Priorities ---

The APA will advocate for:

1. Increasing telemedicine and telepsychiatry research.
2. Developing and promoting telepsychiatry best practices.
3. Promoting telepsychiatry experiential learning during psychiatry residency.
4. Promoting telepsychiatry training opportunities for all psychiatrists.
5. Reducing regulatory barriers for the use of telepsychiatry.
6. Removing barriers preventing federal medical providers from evaluating, treating and consulting on any federal patient regardless of patient location.
7. Reimbursement parity of synchronous video-conferencing and in-person services where synchronous video-conferencing has demonstrated that quality of care is preserved.
8. Streamlining CPT coding.
9. Removing Medicare synchronous video-conferencing originating site restrictions in geographic areas with inadequate access to care but not classified as health profession shortage areas (HPSAs) by the Health Resource & Services Administration.
10. Including telemedicine and telepsychiatry in integrated care payment systems.

Committee on Telepsychiatry
Council on Healthcare Systems and Financing

Item 8.H
Joint Reference Committee
June 2018

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. The Council has two reporting components, including the Chester M. Pierce Human Rights Award Nominating Committee and the Caucus on Global Mental Health and Psychiatry. The Council also liaises with the World Psychiatric Association and the United Nations through respective APA representatives.

Joint Reference Committee Referral Updates

- **Position Statement on the Abuse and Misuse of Psychiatry:** Following a referral from the JRC and the Board of Trustees, the Council established a work group to review, update, and consolidate the following two APA position statements related to the abuse and misuse of psychiatry:

  - Position Statement on Abuse and Misuse of Psychiatry (2007)
  - Position Statement on Identification of Abuse of Misuse of Psychiatry (1998)

  The work group is comprised of the following Council members and includes consultants with expertise in the topic:

  - Sherifa Iqbal
  - Khurshid Khurshid
  - Jack McIntyre
  - Angela Shrestha
  - Mary Kay Smith
  - Paul Summergrad

  In addition to addressing the feedback provided by the Board of Trustees, the work group is also planning to connect with the expertise of the Council on Psychiatry and Law and the Council on Minority Mental Health and Health Disparities to provide input and feedback before submitting a recommendation to the JRC.

International Development and Engagement

- **Caucus on Global Mental Health and Psychiatry:** Under the leadership of the former Caucus Chair, Khurshid Khurshid, the Caucus established an executive committee structure comprised of candidates not elected to the Caucus Chair position in the previous election. This included Richa Bhatia and Gabriel Ivbijaro who facilitated the coordination of submissions for the 2018 APA Annual Meeting and provided guidance and mentorship to Caucus members interested in submitting. During the 2018 APA Annual Meeting, the Caucus established connections with the American Association of Directors of Residency Training (AADPRT) Caucus on Global Psychiatry, the National Institute of Mental Health (NIMH), and the World Psychiatric Association.

  From March to April 2018, the Caucus solicited candidates for nomination and conducted an online election for the 2018-2019 Caucus Chair position. Four candidates were identified as follows:

  - Richa Bhatia
  - Josepha Immanuel
  - Gabriel Ivbijaro
  - Nubia Lluberes

Gabriel Ivbijaro received the majority of votes to become the 2018-2019 Caucus Chair. The Caucus Chair plans to continue involving the other candidates, through the established executive committee structure, and work with past Caucus Chairs, which includes Milton Wainberg, Eliot Sorel, Vincenzo Di Nicola, and Khurshid Khurshid, as an advisory group.

Caucus membership has increased to over 800 APA members, established with only 50 members in 2014, which may reflect the growing interest in the area of global mental health and the benefit of the Caucus and its activities to APA members.

- **International Poster Engagement Program:** Following the approval by the APA Board of Trustees to incorporate the International Poster Engagement Program into the charge of the Council on International Psychiatry, the Council, under the leadership of Council Chair, Bernardo Ng, and U.K. Quang-Dang, managed the program for the 2018 APA Annual Meeting.

  Participants were identified through an opt-in notification sent to individuals whose international poster submissions were accepted by the Scientific Program Committee for the 2018 APA Annual Meeting. The following 11 individuals are the 2018 International Poster Engagement participants:

  - Reinhard Dolp (Canada)
  - Edith Serfaty (Argentina)
  - Juan Cano (Colombia)
  - Weeranee Charoenwongsak (Thailand)
  - Han Yang Khiew (Singapore)
  - Sergio D. Apfelbaum (Argentina)
  - Nicolaas Bouman (Netherlands)
  - Raul Ricardo Quiroga (Spain)
  - Penchaya Atiwannapat (Thailand)
  - Ana Paula Souto Melo (Brazil)
  - Jaime Valero (Colombia)

  Identified reviewers were then paired up to connect with participants to meet in-person during their respective poster presentations at the APA Annual Meeting. Reviewers and participants engaged in dialogue and shared opportunities for participants to connect with APA through member activities and benefits. Reviewers also provided feedback regarding the participants' research posters on format and layout, language and terminology, method and analysis, and presentation and communication, upon request by participants.

  The following individuals, consisting of Council and Caucus members, were identified as reviewers:

  - Mark Messih
  - Yanbo Zhang
  - Winfield Tan
  - Angela Shrestha
  - Gordon Donnir
  - Shannon Kinnan
  - Saeed Ahmed
  - Uyen-Khanh Quang-Dang
  - Jack McIntyre
  - Mary Kay Smith
  - Vikas Gupta
  - Roopma Wadhwa
  - Josepha Immanuel
  - Khurshid Khurshid
  - Jennifer Severe
  - Nubia Lluberes
  - Zohaib Haque

  The overall feedback from participants of the 2018 International Poster Engagement Program was positive, with participants expressing great appreciation for the opportunity to engage with APA members and to also receive feedback on their research posters. The Council noted that the next step to engagement may be to follow up with participants to invite them to join the APA Caucus on Global Mental Health and Psychiatry, which coordinates the development and submission of abstracts for the APA Annual Meeting and meets in-person annually at the Annual Meeting. Any

non-members would be provided with information to join APA in order to become part of the Caucus. The expectation is that through this connection with the Caucus the opportunity for mentorship of participants from the International Poster Engagement Program can continue.

- **International Medical Graduate Psychiatrists:** The Council continues to discuss opportunities for collaboration with the APA International Medical Graduate (IMG) Psychiatrists Caucus, including meeting with the Caucus President, Raj Tampi, during the 2018 APA Annual Meeting. Dr. Tampi provided the Council with an overview of Caucus activities noting several areas where the Council may be able to collaborate with the Caucus, including addressing challenges faced by IMG psychiatrists trying to get into residency training programs through continued professional development and skill building, fostering growth of resident and mid-career members in the IMG Caucus, and other issues and challenges faced by IMGs. The Council and the IMG Caucus will continue to discuss intersecting opportunities for collaboration.

International Education and Awareness

- **Chester M. Pierce Human Rights Award Nominating Committee:** The Validity Foundation was awarded the 2018 APA Chester M. Pierce Human Rights Award during the 2018 APA Annual Meeting. The award was presented to the executive director of the Validity Foundation, Janos Fiala-Butora, S.J.D., and Validity Foundation board members, Ed Rekosh and Mike Bienenfeld, during the session "Emerging Ethical Considerations in a Globalized Psychiatry." The Validity Foundation was featured in an article in the *APA Daily* highlighting their work and quoting the executive director as saying "We are very honored and grateful to APA recognizing our advocacy work."

  The Chester M. Pierce Human Rights Award recognizes the extraordinary efforts of individuals and organizations to promote the human rights of populations with mental health needs by bringing attention to their work. The Validity Foundation, formerly known as the Mental Disability Advocacy Center, is an international human rights organization that uses the law to secure equality, inclusion and justice for people with mental disabilities worldwide. Validity is headquartered in Budapest, Hungary, has participatory status with the Council of Europe, and maintains special consultative status with the United Nations Economic and Social Council.

  The Chester M. Pierce Human Rights Award Nominating Committee met during the 2018 APA Annual Meeting to discuss the nomination and selection process for the 2019 awardee. The current Nominating Committee is comprised of the following APA members from multiple APA components:

  - James Griffith, Brandon Kohrt (Council on International Psychiatry)
  - Eric Yarbrough, Farha Abbasi (Council on Minority Mental Health and Health Disparities)
  - Francis Sanchez (Assembly Committee of Representatives of Minority/Under-Represented Groups)
  - Samuel Okpaku (Black Psychiatrists of America, Inc.)

- **Global Mental Health and International Psychiatry Sessions:** The Council and the Caucus developed several submissions accepted for presentation at the 2018 APA Annual Meeting including those listed in **Attachment 1**. Accepted sessions were listed under the topic tracks "Global, Political, and

Social Issues" and "International Collaborations." The International Poster Engagement Program was incorporated in to each of the four scheduled International Poster Sessions. It was identified that there may be a gap in topics not covered in the scientific program including those addressing system and infrastructure issues in developing countries and international humanitarian opportunities. The Council and the Caucus are coordinating the development of submissions for the 2019 APA Annual Meeting, as well as upcoming meetings sponsored by other national psychiatric organizations, including the World Psychiatric Association World Congress of Psychiatry scheduled for September 27-30, 2018 in Mexico City, Mexico.

- **Global Mental Health Model Curriculum**: The Council established a work group to begin discussions around developing a model global mental health curriculum to serve as a "roadmap" for U.S. residency training programs. The work group is expected to review existing global mental health curriculums at multiple residency training programs and address several issues, including needs based assessments, cultural and technical aspects of implementation, training challenges, and perspectives in the definition and meaning of "global mental health." The work group is comprised of the following Council and Caucus members:

  - Bibhav Acharya
  - Ken Busch
  - Vincenzo Di Nicola
  - James Griffith
  - Sherifa Iqbal
  - Gabriel Ivbijaro
  - Geetha Jayaram
  - Sam Okpaku
  - Angela Shrestha
  - Mary Kay Smith
  - Winfield Tan
  - Alan Tasman

  The work group is also planning to connect with the expertise of the Council on Medical Education and Lifelong Learning and AADPRT to provide input and feedback before submitting a recommendation to the JRC. Meanwhile, the Council welcomes any preliminary feedback from the JRC.

- **Position Statement on Mental Health of Foreign Nationals on TPS (Temporary Protected Status):** The Council established a work group to review a proposal for a position statement, submitted by APA members Jennifer Severe, Ralph De Simlien, and Josepha Immanuel, focused on the mental health of foreign nationals on TPS (Temporary Protected Status) (**see Attachment 2**). The work group is comprised of the following Council members:

  - Ken Busch
  - Nikki Goodsmith
  - James Griffith
  - Sherifa Iqbal
  - Terriann Nicholson
  - Samuel Okpaku
  - Jennifer Severe
  - Angela Shrestha

  The work group is also planning to connect with the expertise of the Council on Psychiatry and Law and the Council on Minority Mental Health and Health Disparities to provide input and feedback before submitting a recommendation to the JRC. Meanwhile, the Council welcomes any preliminary feedback from the JRC.

2018 APA Annual Meeting: Global Mental Health Sessions

Sessions listed are included in the following tracks on the APA Meetings App:

- **Global, Political, and Social Issues**
- **International Collaborations**

APA international component meetings and activities can also be found on the app.

Online listing available on the following webpage: www.psychiatry.org/psychiatrists/international/annual-meeting-sessions

SATURDAY, MAY 5

IMG: I Care and Need to be Cared
8:00 a.m. – 9:30 a.m.
Javits Convention Center, Rooms 1D05/06
Chair(s): Kishan Nallapula
Presenter(s): Jenifer Severe, Maria Mirabela Bodic, Sasidhar Gunturu

Children of Syria, Waves of Hope: Two View of Trauma and Posttraumatic Stress Among the Syrian Refugees
8:00 a.m. – 11:00 a.m.
Javits Convention Center, Empire/Hudson/Chelsea
Chair(s): Balkozar Seif Eldin Adam
Presenters: Fatten Elkomy, Cheryl Lea Green, Magdoline Daas

Cultural Issues of Suicide, Sociopathy, and Opioids: An International Latino Perspective
8:00 a.m. – 11:00 a.m.
Javits Convention Center, Shubert/Uris/Plymouth
Chair(s): Bernardo Ng
Presenter(s): Pedro Ruiz, Maria Oquendo, Nicolas Martinez, Alvaro Camacho

Hikikomori: Recent Findings and Their Relevance to American Psychiatry
8:00 a.m. – 11:00 a.m.
Javits Convention Center, Times Square
Chair(s): Tsuyoshi Akiyama, Takahiro Kato
Presenter(s): Takahiro Kato, Tsuyoshi Akiyama, Alan R. Teo, Michael B. First, Tae Young Choi

IMGs as Psychiatrists: Training Director and Resident Perspectives
10:00 a.m. – 11:30 a.m.
Javits Convention Center, Rooms 1A19/20
Chair(s): Vikas Gupta, Roopma Wadhwa,
Presenter(s): Rajesh R. Tampi, Vineeth John

International Poster Session
APA International Poster Engagement Program
10:00 a.m. – 12:00 p.m.
Javits Convention Center, Exhibit Hall
See list of presenters in Program Guide/Meetings App

APA Chester M. Pierce Human Rights Award Nominating Committee
11:00 a.m. – 12:00 p.m.
Sheraton New York Times Square, Madison 1
Chair(s): James Griffith

Failure to Identify a Human Trafficking Victim
AJP Global Mental Health Discussion
1:00 p.m. – 2:00 p.m.
Javits Convention Center, Exhibit Hall, APA Central, Resident/ECP Hub
Facilitator(s): Mollie Gordon (Open to Attendees)

Social Discrimination and Mental Illness Around the Globe
1:00 p.m. – 2:30 p.m.
Javits Convention Center, Room 1E08
Chair(s): Nancy Diazgranados
Lecturer(s): Dinesh Bhugra

The IMG and a Successful Career in Psychiatry
1:00 p.m. – 4:00 p.m.
Javits Convention Center, Rooms 1A19/20
Chair(s): Rajesh R. Tampi
Presenter(s): Antony Fernandez, Juan Joseph Young, Sila Balachandran

International Poster Session
APA International Poster Engagement Program
2:00 p.m. – 4:00 p.m.
Javits Convention Center, Exhibit Hall
See list of presenters in Program Guide/Meetings App

Africa Discussion Group
4:00 p.m. - 5:00 p.m.
Sheraton New York Times Square, Carnegie East
Facilitator(s): Samuel Okpaku (Open to Attendees)

SUNDAY, MAY 6

Beyond Borders: Innovative Medical-Legal Partnerships to Assist Refugees and Asylum-Seekers
8:00 a.m. – 9:30 a.m.
Javits Convention Center, Room 1E09
Chair(s): Maya Prabhu
Presenter(s): Howard V. Zonana, Chinmoy Gulrajani, Wendy Parmet, Linus Chan

2018 APA Annual Meeting: Global Mental Health Sessions

Human Trafficking: Focused Evaluation of the Problem and Response in Southern California
8:00 a.m. – 9:30 a.m.
Javits Convention Center, Rooms 1A01/02
Chair(s): Eric Rafla-Yuan
Presenter(s): Stephanie Martinez, Lawrence Malak,Priti Ojha, Steve Hyun Koh, Eric Rafla-Yuan

APA Caucus on Global Mental Health and Psychiatry
8:00 a.m. – 10:00 a.m.
Sheraton New York Times Square, Riverside Ballroom
Chair(s): Khurshid Khurshid (Open to Attendees)

Mental Health Challenges Facing Patients and Providers of African Descent
10:00 a.m. – 11:30 a.m.
Javits Convention Center, Cantor/Jolson
Presenter(s): Patricia Newton

International Poster Session
APA International Poster Engagement Program
10:00 a.m. – 12:00 p.m.
Javits Convention Center, Exhibit Hall
See list of presenters in Program Guide/Meetings App

Cooperation Between American Psychiatrists and Colleagues in Developing and Emerging Countries
1:00 p.m. - 4:00 p.m.
Javits Convention Center, Shubert/Uris/Plymouth
Chair(s): Uriel Halbreich
Presenter(s): Eliot Sorel, Dinesh Bhugra, Helen E. Herrman

Promoting Sustainable Mental Health Systems After Humanitarian Disasters: "Building Back Better" Strategies in Global Mental Health
1:00 p.m. – 4:00 p.m.
Javits Convention Center, Rooms 2D04/05
Chair(s): Brandon Kohrt
Presenter(s): Suzan Song, Amir Arsalan Afkhami, James Griffith, Brandon Kohrt, Allen Dyer

Shelter From the Storm: Understanding and Treating the Refugee Patient
1:00 p.m. – 4:00 p.m.
Javits Convention Center, Lyceum/Carnegie
Chair(s): Eugenio M. Rothe, Aidaspahic S. Mihajlovic
Presenter(s): Holly Ackerman, Catherine Stuart May, Andres Julio Pumariega, Eugenio M. Rothe, Pedro Ruiz

Toward Hispanic-American Well-Being: Understanding Cultural Concepts of Distress Responses to Stress/Trauma, and Adaptation of Services
1:00 p.m. – 4:00 p.m.
Javits Convention Center, Rooms 1A04/05
Chair(s): Esperanza Diaz, Jose E. De La Gandara
Presenter(s): Alvaro Camacho, Ruby C. Castilla Puentes, Carlos Fernandez, Pamela Carolina Montano
Discussant(s): Bernardo Ng

International Poster Session
APA International Poster Engagement Program
2:00 p.m. – 4:00 p.m.
Javits Convention Center, Exhibit Hall
See list of presenters in Program Guide/Meetings App

MONDAY, MAY 7

APA International Member Welcome
for new APA International Members
7:00 a.m. – 9:00 a.m.
Sheraton New York Times Square, Metropolitan Ballroom West Large, Second Floor
Speaker(s): Anita Everett, Rahn K. Bailey, Saul Levin
Presenter(s): Andres Mega (AR), Ahmed Mubarak (EG), David Ndetei (KY), Julian Beezhold (UK)

At Risk: Undocumented Immigrant Mental Health in the Current Political Climate
8:00 a.m. – 11:00 a.m.
Javits Convention Center, Rooms 1A01/02
Chair(s): Pamela Carolina Montana, Divya Chhabra
Presenter(s): Victor M. Fornari, Ateaya Ali Lima, Andres Julio Pumariega, Tahia Haque, Pamela Carolina Montano, Alma Valverde Campos, Francis G. Lu, Esperanza Diaz

Emerging Ethical Considerations in a Globalized Psychiatry
2018 APA Chester M. Pierce Human Rights Award Presentation to Validity Foundation
8:00 a.m. – 11:00 a.m.
Javits Convention Center, Marquis Ballroom B/C
Chair(s): Anish Ranjan Dube
Presenter(s): Allen Ralph Dyer, Samuel Okpaku, Christopher Cho, Michael Liebrenz

Innovative Quality Improvement Initiatives: International Perspectives
8:00 a.m. – 11:00 a.m.
Javits Convention Center, Odets
Chair(s): John S. McIntyre
Presenter(s): Wolfgang Gaebel, Michelle B. Riba, J. Richard Ciccone

2018 APA Annual Meeting: Global Mental Health Sessions

Middle Eastern Arab Psychiatry: Innovative Initiatives in Clinical Service, Policy, Education, and Research
8:00 a.m. – 11:00 a.m.
Javits Convention Center, Room 1A03
Chair(s): Ossama Tawakol Osman, Abdel F. Amin
Presenter(s): Ammar Albanna, Ossama Tawakol Osman, Hisham Ramy, Ahmed Elkashef, Ghanem Ali Al Hassani, David V. Sheehan

APA Caucus of International Medical Graduate (IMG) Psychiatrists
11:00 a.m. – 12:00 p.m.
Sheraton New York Times Square, New York West
Chair(s): Antony Fernandez

Innovations in Global Psychiatric Education
1:00 p.m. – 4:00 p.m.
Javits Convention Center, Rooms 1D03/04
Chair(s): Roger Man Kin Ng
Presenter(s): Nada Logan Stotland, Dinesh Bhugra, Marc H. M. Hermans, Mahesh Jayaram

The Fourth Industrial Revolution and Telepsychiatry in the UK
3:00 p.m. – 4:30 p.m.
Javits Convention Center, Room 1E17
Chair(s): Cyrus A. Abbasian, Zainab Kikelomo Imam
Presenter(s): David Robert Bickerton, Wiktor Lucjan Kulik

Trauma, Culture, and Complex PTSD: Cambodian Genocide Survivors
3:00 p.m. – 4:30 p.m.
Javits Convention Center, Rooms 1D05/06
Chair(s): Dora-Linda Wang, Jesus Salvador Ligot
Lecturer(s): Devon E. Hinton

TUESDAY, MAY 8

APA Council on International Psychiatry
8:00 a.m. – 12:00 p.m.
Sheraton New York Times Square, New York West
Chair(s): Bernardo Ng

Global Mental Health Research and the Fogarty International Center's 50th Anniversary
8:00 a.m. – 11:00 a.m.
Javits Convention Center, Rooms 1D03/04
Chair(s): Beverly Pringle, Kathleen Michels
Presenter(s): Milton Leonard Wainberg, Vishwajit Mingaonkar, Mary McKay, Lauren Haack, Muthoni Anna Mathai, Brandon Kohrt,
Discussant(s): Joshua A. Gordon, Roger I. Glass

Edutour: The International UN Headquarters
8:30 a.m. – 12:00 p.m.

How to Improve Access and Effectiveness of Treatment of Borderline Personality Disorders: A Nation-Wide Service Reform in the Netherlands
10:00 a.m. – 11:30 a.m.
Javits Convention Center, Room 1E08
Chair(s): Ellen Willemsen, Joost Hutsebaut
Presenter(s): Miep Koch, Helga Aalders, Marlies Soleman

Cannabis Use in Europe and the U.S.
1:00 p.m. – 4:00 p.m.
Javits Convention Center, Liberty
Chair(s): Francoise C. Petitjean, John A. Talbott
Presenter(s): Alain Dervaux, Amine Benyamina, Georges Brousse, Frances Rudnick Levin, Meg Haney, Gregory Blunt
Discussant(s): Richard Joseph Frances

Positive Psychiatry International
1:00 p.m. – 4:00 p.m.
Javits Convention Center, Room 1A08
Chair(s): Dilip V. Jeste, Keri-Leigh Cassidy
Presenter(s): Nina Timmerby, Vihang Nalinkant Vahia, Orestes Forlenza, Dinesh Bhugra

Conversations on Diversity
3:00 p.m. – 4:30 p.m.
Javits Convention Center, Room 1E08
Chair(s): Vabren Watts, Ranna I. Parekh
Presenter(s): Saul Levin, Anita Everett, Altha Stewart, Eric Yarbrough, Ruth S. Shim

WEDNESDAY, MAY 9

Iraq on the Ground (Part II): Mental Health in Conflict Zones
8:00 a.m. – 11:00 a.m.
Javits Convention Center, Room 1A03
Chair(s): Allen Ralph Dyer
Presenter(s): Anita Smith Everett, Amir Arsalan Afkhami, Catherine Stuart May, Mohammed Al-Uzri

Stress Among Medical Students, Residents, and Physicians: A Global Perspective
8:00 a.m. – 11:00 a.m.
Javits Convention Center, Rooms 1A06/07
Chair(s): Fahad Dakheel Alosaimi
Presenter(s): Ahmad N. Alhadi
Discussant(s): Sanjeev Sockalingam

Hidden in Plain Sight: Human Trafficking and the Role of Psychiatry Training
1:00 p.m. – 2:30 p.m.
Javits Convention Center, Broadway in South
Chair(s): Leigh Meldrum
Presenter(s): Amy Fehrmann, Christopher Scovell, Mariam Faris

2018 APA Annual Meeting: Global Mental Health Sessions

Mental Health, Human Rights, and Striving for Peace During Conflict
1:00 p.m. – 2:30 p.m.
Javits Convention Center, Rooms 1D03/04
Chair(s): Ricardo Restrepo
Presenter(s): Homer Venters, Adriana Valderrama, Ricardo Restrepo

Coming to America: Examining Psychosis in Migrant Populations in the Forensic Setting
3:00 p.m. – 4:30 p.m.
Javits Convention Center, Rooms 1D05/06
Chair(s): Davide Christopher Mancini, Ann L. Hackman
Presenter(s): Danae Nicole DiRocco, Avinash Ramprashad, Lauren Evans

Title: *Position Statement on Mental Health of Foreign Nationals on Temporary Protected Status*

Author(s): Jennifer Severe MD, Ralph de Similien, MD, Josepha Immanuel MD

The issue: Congress created the Temporary Protected Status (TPS) as part of the Immigration Act of 1990 to provide a temporary blanket relief to eligible foreign nationals who are unable to safely return to their home country because of extenuating circumstances such as war or natural disasters.[1,2,4] With their granted status, TPS holders have made significant contributions to the American social, economic and civic fabric for several years and their contributions cannot be ignored.[1,2] As of October 2017, approximately 437,000 foreign nationals from 10 countries are part of the TPS program with 93% from El Salvador, Honduras and Haiti and the remaining from Nepal, Syria, Nicaragua, Yemen, Sudan, Somalia and South Sudan. At the risk of separation from their families established in the United States or returning back to their native country which might still be unsafe, they are desperately trying to avoid deportation by seeking an extension of their TPS or obtaining permanent residence in the United States. The process of obtaining a TPS extension or permanent legal residence can be an arduous and psychologically demoralizing ordeal given the lingering possibility of TPS revocation.[1,2]

The Department of Homeland Security holds the power to issue, renew and terminate a country's TPS designation at their discretion but at times, the nuances of the lingering emotional response to trauma and chaos that some of the TPS holders have experienced in their native country may not be accounted for in their decision for TPS termination. It is up to the APA to take stand on providing assistance for such individuals as navigate this complexity.

APA Position Statement:

1. The APA calls for a collective awareness of healthcare provider on the potential fear anxiety, demoralization, re-traumatization and suicidal state that many individuals on Temporary Protected Status are prone to or may be going through as they await a decision on their immigration status.
2. The APA advocates for active mental health screening and evaluation of individuals on TPS to mitigate the psychological repercussions as much as possible. The APA calls for a conscious effort to deliver, or refer for, appropriate mental health services.
3. The APA understands the ethical responsibility of mental health providers caring for individuals on a Temporary Protected Status to maintain treatment regardless of the individual's fate in the United States to the extent possible.
4. The APA creates a personalized framework for safe and timely transition in care, across settings and countries for TPS holders who may lose their health insurance or transition to another country
5. The APA counts on mental health institutions to support, guide and empower individuals on Temporary Protected Status as they seek information and assistance in their period of crisis.

6. The APA calls federal policy makers' attention on the major psychological repercussion of extenuating circumstances such as war or natural disasters on individuals with Temporary Protected Status (TPS) who had to move out of their home countries. TPS holders' mental health status should be taken into consideration as they seek to transfer to permanent residence.

Reference:

1. Jill H. Wilson. Temporary Protected Status: Overview and Current Issues. Analyst in Immigration Policy. Congressional Research Service. January 17, 2018
2. United States Citizenship and Immigration Services (USCIS). https://www.uscis.gov/humanitarian/temporary-protected-status/temporary-protected-status-designated-country-haiti
3. https://www.uscis.gov/humanitarian/temporary-protected-status
4. Robert W, Donald K. Center of Migration Studies. A Statistical and Demographic Profile of the US Temporary Protected Status Populations from El Salvador, Honduras, and Haiti. J of Migr and Hum Sec.
5. George Bush: Statement on Signing the Immigration Act of 1990. November 29, 1990. http://www.presidency.ucsb.edu/ws/?pid=19117
6. Challenges and good practices in the return and reintegration of irregular migrants to Western Africa. International
7. Battistella, Graziano. 2004. "Return Migration in the Philippines: Issues and Policies." In International Migration: Prospects and Policies in a Global Market, edited by J. Edward Taylor and Douglas S. Massey, 212-29. Oxford: Oxford University Press.
8. Graziano Battistella. Return Migration: A Conceptual and Policy Framework. Scalabrini Migration Center. March 8, 2018.

ATTACHMENT 3: COUNCIL MINUTES - JANUARY

Council Name: Council on International Psychiatry
Date: January 18, 2017
Time: 8:00 PM – 9:00 PM
Location: Conference Call

Council Members Present: B. Ng, J. Griffith, S. Okpaku, U.K. Quang-Dang, M. Riba, S. Iqbal, J. McIntyre, E. Sorel, M. K. Smith, M. Komrad, R. De Similien, J. Winfield Tan, N. Goodsmith, N. Karingula, A. Shrestha

Council Members with Excused Absences: B. Acharya, G. Jayaram, K. Busch, V. Di Nicola, B. Kohrt, E. Pi, A. Tasman, G. Raviola, A. Vahabzadeh, C. Buzza, L. McIntyre, T. Nicholson

Council Members with Unexcused Absences: None

Guests in Attendance: Khurshid Khurshid, MD

Staff in Attendance: R. Juarez

Council Minutes

The Council approved the minutes of the December 14 conference call.

Position Statements

Healthcare as a Human Right: Dr. Sorel thanked the Council for supporting the Position Statement on Health Care, Including Mental Health Care, is A Human Right and thanked Dr. Iqbal for chairing the Assembly Reference Committee during the November Assembly. Dr. Sorel shared that the Council may take into consideration finding ways to include other medical specialty organizations to support the position statement as well. Dr. McIntyre noted that while it may not be a high priority item for the American Medical Association, there will most likely be support for the position statement. Dr. Iqpal shared that the goal of the Assembly Action Paper becoming a Position Statement opened the door to other ideas for APA, both nationally and internationally, which can support other future Assembly Action Papers.

Mental Health Needs of Undocumented Immigrants: The Council on Minority Mental Health and Health Disparities shared the draft of a Position Statement on the Mental Health Needs of Undocumented Immigrants with the Council on International Psychiatry for feedback. Drs. Shrestha and Goodsmith reviewed the document and noted that it was well written. Dr. Khurshid shared that including a statement that the positive impact of healthcare education in the United States may be taken into consideration as some places have dedicated medical students, residents, and faculty working in this area which serves as an important learning experience. Dr. Goodsmith agreed that it would be good to increase resident training to prepare psychiatrists to have the skills to work with these populations. Dr. Quang-Dang noted that the statement may be enhanced by clarifying the audience and intent to include policy makers and psychiatrists to advocate for the mental health of this population. Overall, the Council supported the position statement, noting that it may be a better resource if it were paired with the

existing *Position Statement on Role of Psychiatrists in Addressing Care for People Affected by Forced Displacement*.

2018 Chester M. Pierce Human Rights Award Nominating Committee: It was discussed that it can be challenging to have a full audience during the presentation of an award at a session held at the Annual Meeting, but noted that there was a good turnout the previous year. It was also shared that the Executive Director of the Validity Foundation (formerly Mental Health Advocacy Center), Steven Allen, may be available to accept the award, so having it presented during a session with a sizable audience would be best. The session "Emerging Ethical Considerations in a Globalized Psychiatry", the session "Promoting Sustainable Mental Health Systems After Humanitarian Disasters", and the New International Member Welcome event, were mentioned as potential places to present the award. After Council members shared the dates of their respective sessions, it was noted that there were several conflicts with the Council meeting on Monday morning, so it was discussed that it may be best to perhaps move the Council meeting to Tuesday morning.

APA Caucus on Global Mental Health Update: Dr. Khurshid provided an update on the Caucus meeting for New York, sharing that invitations to speak are planned to go to Dr. Mary Kay Smith and a representative of the National Institute on Mental Health. It was also shared that the ongoing structure of the Caucus moving forward will be discussed with the past Chairs.

International Poster Engagement Program Work Group: Dr. Quang-Dang thanked everyone on the Council who volunteered to participate in the engagement program including Drs. Khurshid, Smith, Shresta, Ng, Di Nicola, McIntyre, and Tan as well as the members of the Caucus on Global Mental Health, who also previously served as Fellows on the Council, Drs. Josepha Immanuel and Jennifer Severe. Dr. Quang-Dang shared that she is also on the APA Scientific Program Committee for posters which was finalizing the list of accepted submissions for New York. It was noted that the names of the participants should be available by March. Each reviewer is expected to have about 2-3 participants to connect and meet with during the Annual Meeting and the goal is to get as many participants as possible. If necessary, the Council may connect with the members of the Caucus on Global Mental Health to identify additional reviewers.

Global Integrated Care Survey Update: Dr. Sorel thanked Drs. De Similen and Winfield for their efforts in coordinating the responses to the survey and noted that a couple of dozen countries have participated. Appreciated was expressed to all those Council members who have provided information to help complete the survey. It was also shared that there is a sessions scheduled for the APA Annual Meeting where the data collected will be shared with. Dr. Smith suggested that the Caucus on Global Mental Health on Psychiatry may be a good place to make connections for participation in the survey as well.

World Psychiatric Association Update: Dr. Ng shared that the deadline for WPA Mexico Congress is approaching that Council members are encouraged to plan to attend the meeting as the convention center will be in a beautiful part of Mexico City. Any Council members who submit an abstract are encouraged to notify Dr. Ng of their submission for follow up.

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Climate Change and Mental Health Discussion: Following the previous call with Drs. David Pollack and Robin Cooper, regarding the establishment of an APA Caucus on Climate Change and Mental Health, the he Council discussed whether the Council supports the establishment of the Caucus in the APA and if the Caucus should be housed under the Council on International Psychiatry. Overall, the Council expressed strong support for the establishment of the Caucus in the APA, but were unsure if the Council on International Psychiatry or any of the other Councils were a good fit for the Caucus following the feedback from Drs. Pollack and Cooper. It was shared that an APA Caucus can serve as a good place for people to come together to work together and share their perspectives on a certain issue, noting the value of APA caucuses as bringing groups of members into the APA. It was shared that there was also an Assembly group focused on looking at the impact of environmental toxins and that the Caucus on Global Mental Health and Psychiatry may take into consideration incorporating this group of APA members into their structure. The Council shared that it would express their support for the establishment of the Caucus to the JRC and request guidance from the JRC regarding next steps.

ATTACHMENT 4: COUNCIL MINUTES – FEBRUARY

Council Name: Council on International Psychiatry
Date: February 15, 2018
Time: 8:00 PM – 9:00 PM
Location: Conference Call

Council Members Present: B. Ng, K. Busch, V. Di Nicola, J. Griffith, S. Okpaku, U.K. Quang-Dang, M. Riba, S. Iqbal, M. K. Smith, J. Winfield Tan, N. Goodsmith, N. Karingula, A. Shrestha

Council Members with Excused Absences: B. Acharya, G. Jayaram, B. Kohrt, E. Pi, A. Tasman, G. Raviola, J. McIntyre, E. Sorel, A. Vahabzadeh, C. Buzza, M. Komrad, R. De Similien, L. McIntyre, T. Nicholson

Council Members with Unexcused Absences: None

Guests in Attendance: Khurshid Khurshid, MD

Staff in Attendance: R. Juarez

Council Minutes

The Council approved the minutes of the January 18 conference call.

JRC Update

The JRC forwarded the Position Statement on the Misuse and Abuse of Psychiatry to the Council to review and update by the June JRC meeting. The Council will identify a work group of Council members to work with APA staff and any other necessary Councils to develop the updated position statement for review by the JRC on their June conference call. The JRC also shared that the establishment of the Caucus on Climate Change and Mental Health was set to be assigned to another APA component to be announced at a later date.

Chester M. Pierce Human Rights Award Nominating Committee

It was shared that the 2018 APA Chester M. Pierce Human Rights Award will be awarded to the Validity Foundation during the session "Ethical Considerations in a Globalized Psychiatry" at the upcoming 2018 APA Annual Meeting in New York City. More information will be available to Council members as the details are confirmed.

Caucus on Global Mental Health and Psychiatry

It was shared that the Caucus is scheduled to meet during the upcoming 2018 APA Annual Meeting on Sunday, May 6, 8:00 am - 10:00 am. The chair, Dr. Khurshid, noted that they are working on finalizing the agenda for the meeting which should include a discussion of lessons learned in the past year, structuring the Caucus into regions and areas, identifying Caucus members to coordinate the development of session proposals for APA meetings, including reviewing and guiding research before submission, encouraging networking, and identifying opportunities to work with the National Institutes of Health, the American Association of Directors of Psychiatric Residency Training (AADPRT) Global

Psychiatry Group, and other APA Caucuses. Council members shared that it may be good to utilize the good turnout at the annual in-person Caucus meeting for feedback as well as utilizing the listserv throughout the year. Dr. Richa Bhatia, a member of the Caucus Executive Committee, shared that given the large number of Caucus members that it may be good for the Caucus to become more organized to become more productive. It was also announced that the Caucus is in the process of soliciting nominations for the Caucus election for the 2018-2019 chairperson.

International Poster Engagement Program

Dr. Quang-Dang shared that 800 to 900 posters were accepted for the 2018 APA Annual Meeting, including 113 international posters which equates to about 160+ international poster presenters as many of the international poster submissions included more than one author. It was noted that acceptance letters were sent to poster presenters last week. The Council hopes to incorporate the announcement for participation in the International Poster Engagement Program in the next year's APA Annual Meeting poster submission cycle. The participant submission form will include, in addition to the uploaded PDF of the poster being presented, the date and time of the presenters' poster presentation and if they will require a English translator. The group of Council and Caucus members identified to engage with poster presenters are also planning to use the same evaluation form as last year to provide feedback to the Council.

Society for the Study of Psychiatry and Culture

Several Council members noted that they were planning to attend the Annual Meeting for the Society for the Study of Psychiatry and Culture, scheduled for April 19-21, in San Diego, CA. Drs. Griffith, Okpaku, and Di Nicola noted that they were planning to attend and participate as presenters.

ATTACHMENT 4: COUNCIL MINUTES – APRIL

Council Name: Council on International Psychiatry
Date: April 12, 2018
Time: 8:00 PM – 9:00 PM
Location: Conference Call

Council Members Present: B. Ng, K. Busch, G. Jayaram, B. Kohrt, E. Pi, J. Griffith, S. Okpaku, U.K. Quang-Dang, M. Riba, J. McIntyre, E. Sorel, S. Iqbal, M. K. Smith, J. Winfield Tan, N. Karingula, A. Shrestha

Council Members with Excused Absences: B. Acharya, V. Di Nicola, A. Tasman, G. Raviola, A. Vahabzadeh, C. Buzza, M. Komrad, R. De Similien, N. Goodsmith, L. McIntyre, T. Nicholson

Council Members with Unexcused Absences: None

Guests in Attendance: Khurshid Khurshid, MD, Jennifer Severe, MD

Staff in Attendance: R. Juarez

APA Position Statement on Abuse and Misuse of Psychiatry

Dr. Ng shared that the JRC forwarded the Position Statement on the Misuse and Abuse of Psychiatry to the Council to review and update. Several Council members expressed that they would be interested in working on the review and update of the position statement, including Drs. Smith, McIntyre, and Khurshid. APA staff will circulate the position statement to the entire Council to determine if any other Council members may be interested in working on it as well.

Caucus on Global Mental Health and Psychiatry

Dr. Khurshid shared that the Caucus has a good slate of candidates for the Caucus Chair position and noted that the online ballot has been distributed to Caucus members to cast their vote. Dr. Khurshid also noted that he is planning to circulate a preliminary agenda for the Caucus meeting for feedback which includes Dr. Andrea Horvath to provide an update on activities from the Fogarty International Center. It was noted that it may be possible to incorporate Dr. Jennifer Severe on the agenda regarding her work on the mental health needs of foreign nationals on temporary protected status (TPS). It was also clarified that the new Caucus Chair will be announced at the Caucus meeting.

International Poster Engagement Program

Dr. Quang-Dang shared that there are 20-25 identified reviewers, with many being from the Caucus on Global Mental Health and Psychiatry and outside the United States, and that there are 11 participants in the International Poster Engagement Program including participants from Argentina, Canada, Colombia, Thailand, Singapore, the Netherlands, Spain, and Brazil. This composition should allow there to be two reviewers assigned for each participant. It was noted that in the future, there may be an opportunity to include the invitation for participation in the poster submission acceptance notification. There will also be an opportunity to collect feedback from participants similar to the previous year. Council members shared that it would be great if a social gathering could be organized and Dr. Kohrt shared that if it was

possible to share information for international research opportunities with the Fogarty International Center, he could pass that along.

World Psychiatric Association

Dr. Pi shared that the abstract deadline for the World Congress of Psychiatry scheduled for September 27-30, 2018 in Mexico City has been extended to April 23rd. Also, the WPA ECP Fellowship for this meeting was included in the latest alert from *Psychiatric News* which has a deadline of May 15. Dr. Okpaku shared that he was planning to submit, but noted that there was no option for topics on ethics and global mental health. Dr. McIntyre noted that he would be interested in presenting on the topic of ethics if necessary.

Mental Health Needs of Foreign Nationals on Temporary Protected Status

Dr. Jennifer Severe, a former APA/APAF Fellow and Council member, shared that she is planning to have an exhibit booth at the upcoming APA Annual Meeting to address the issue of the mental health needs of foreign nationals on temporary protected status (TPS). This includes people who have moved to the United States following a major disaster, since 1998, who are now being required to move back to their home country. This impacts individuals from Haiti, El Salvador, Nicaragua, Sudan, and others, to name a few, who do not qualify for residency status in the United States. In a recent meeting with the Haitian Ambassador, Dr. Severe shared the mental health component of individuals with TPS, which was new information for consideration by the Ambassador. Dr. Severe noted that if Council members are interested in volunteering their time at the exhibit booth to please contact her. It was shared that this volunteer opportunity was shared with the AADPRT Global Psychiatry Caucus as well. Council members shared their experiences including Dr. Jayaram who noted an increase in foreign nationals being admitted and Dr. Griffith noting that they consult with immigration law firms and that a potential focus on this matter could be on the impact on kids – family comorbidity. Dr. Kohrt shared that Dr. Severe may consider connecting with the Group for the Advancement of Psychiatry (GAP) Cultural Psychiatry group who recently wrote a piece for *Psychiatric Times* on this using evidence based practices regarding the impact of family separation. Dr. Severe noted that it would also be beneficial to receive statements from psychiatrists about this issue to project on a screen at their exhibit booth. This opportunity can also be circulated to the Council and the Caucus on Global Mental Health and Psychiatry.

World Bank "Brain Bond" Initiative

Dr. Sorel provided an update on the World Bank "Brain Bond" initiative which noted a meeting by the World Bank in late February to discuss developing a "social bond" that would be placed on the market to raise $10 billion dollars to support the development of brain research and access to mental health services. The idea was generated by two parents whose son had a psychotic break, but is now well-adjusted, seeking out opportunities for breakthroughs in the understanding of mental disorders. Several psychiatrists are involved in this discussion including Dr. Vikram Patel and Dr. Pamela Collins.

ATTACHMENT 5: COUNCIL ROSTER

Item 8.H
Joint Reference Committee
June 2018

Council on International Psychiatry — 2018-19 Roster

Position	Name	State	Email	Term
Chairperson	Bernardo Ng, MD	CA	bng@sunvalleyb.com	2016-19
Vice Chairperson	U.K. Quang-Dang, MD, MS	CA	ukqd@post.harvard.edu	2014-20
Member	Bibhav Acharya, MD	CA	bibhav.acharya@ucsf.edu	2016-19
Member	Geetha Jayaram, MBA, MD	MD	gjayara1@jhmi.edu	2017-20
Member (ASM Liaison)	Ken Busch, MD	IL	kgbusch@sbcglobal.net	2014-19
Member	James Griffith, MD	DC	jgriffith@mfa.gwu.edu	2014-21
Member	Vincenzo Di Nicola, MD, PhD	QC	dinicolav@hotmail.com	2017-20
Member	Brandon Kohrt, MD, PhD	NC	brandon.kohrt@duke.edu	2017-20
Member	Samuel Okpaku, MD, PhD	TN	sam.okpaku@gmail.com	2014-21
Member	Edmond Pi, MD	CA	ehpi@usc.edu	2015-21
Member	Paul Summergrad, MD	MA	psummergrad@tuftsmedicalcenter.org	2018-21
Member	Allan Tasman, MD	KY	allan.tasman@louisville.edu	2014-19
Corresponding Member	Sherifa Iqbal, MD	MO	sfmi2000@yahoo.com	2017-18
Corresponding Member	Juan Gallego, MD , MS	NY	jug9069@med.cornell.edu	2018-19
Corresponding Member	Mary Kay Smith, MD	OH	marykay.smith561@gmail.com	2018-19
Corresponding Member	Milton Wainberg, MD	NY	mlw35@cumc.columbia.edu	2018-19
Consultant	Eliot Sorel, MD	DC	esorel@gmail.com	2018-19
Consultant	Jennifer Severe, MD	NY	jennifer.severe@hotmail.com	2018-19
Fellow (PUB-2nd year)	Colin Buzza, MD, MPH, MSc	CA	colin.buzza@ucsf.edu	2016-18
Fellow (PUB-2nd year)	Ralph H. de Similien, MD, MS, MEd	DC	rhdesimilien@gmail.com	2016-18
Fellow (CHL-2nd year)	J. Winfield Tan, MD	NC	winfield.tan@gmail.com	2016-18
Fellow (PUB-1st year)	Nicole Goodsmith, MD, PhD	CA	nikki.goodsmith@gmail.com	2017-19
Fellow (SAM-1st year)	Nidhi Shree Karingula, MD, MPH	NJ	nidhishree.karingula@gmail.com	2017-19
Fellow (PUB-1st year)	Lucas McIntyre, MD	WA	mcintyl@uw.edu	2017-19
Fellow (DIV-1st year)	Terriann Nicholson, MA, MD	NY	nichols@nyspi.columbia.edu	2017-19
Fellow (SAM-1st year)	Angela Shrestha, MD	IL	ashrestha@psych.uic.edu	2017-19

APA Pierce Human Rights Award Nominating Committee Chair:	James Griffith, MD	DC	jgriffith@mfa.gwu.edu
APA Caucus on Global Mental Health and Psychiatry Chair:	Gabriel Ivbijaro, MD	UK	gabriel.ivbijaro@gmail.com
APA United Nations Special Advisors Liaison:	Vivian B. Pender, MD	NY	vp52@columbia.edu
World Psychiatric Association Zone 1 (United States) Rep:	Edmond Pi, MD	CA	ehpi@usc.edu

DIV = Diversity Leadership Fellow | SAM = SAMHSA Fellow | PUB = Public Psychiatry Fellow | CHL = Child/Adolescent Psychiatry Fellow

COUNCIL ON MEDICAL EDUCATION AND LIFELONG LEARNING
Report to the Joint Reference Committee

The Council's purview covers issues affecting the continuum of medical education in psychiatry – from undergraduate medical education to the lifelong learning and professional development of practicing physicians. The Council is a convening body for the allied educational organizations including AADPRT, ADMSEP, AACDP, AAP and ABPN.

Executive Summary
The Council Met by phone April 12, 2018; the Council met at the Annual Meeting on May 5, 2018. Minutes of those meetings are attached. (May 5 minutes) (April 12 minutes)

The Council presents several actions and referral updates.

Action items

1. ***Will the Joint Reference Committee recommend that the Board of Trustees approve the formation of a Committee on Well-being and Burnout, under the Council on Medical Education and Lifelong Learning, as a permanent home for the efforts that were undertaken by the 2017 Wellbeing and Burnout Workgroup?***

   Physician wellness and professional burnout and mental health vulnerability are significant concerns affecting physicians in training and practicing physicians. A committee, under the Council is needed now to continue the work of the Ad-hoc Workgroup. This committee would facilitate the continuance of Anita Everett's Presidential Initiative on Wellness and Burnout. (Relates to action ASM2017A1 12.N) (Attachment: Charge and Budget)

2. ***Will the Joint Reference Committee recommend that the Board of Trustees approve the revised charge of the Council on Medical Education and Lifelong Learning?***

   The Council on Medical Education and Lifelong Learning has revised its charge, eliminating items that are no longer part of the work of the Council and making additional text revisions. (Attachment Revised Charge)

3. ***Will the Joint Reference Committee recommend that the Board of Trustees retain, with one text clarification, the Position Statement "Consistent Treatment of all Applicants for State Medical Licensure" ?***

   The Council on Medical Education believes that this position statement is still relevant and needed. The Council recommends retention of this position with a clarification of language as below.

   Position Statement
   Consistent Treatment of all Applicants for State Medical Licensure
   "The APA fully endorses the need for an equitable, fair and consistent treatment for state medical licensure for those applicants who graduated from medical school in the state they are

applying, graduated from a school in another state or graduated from a school in another country." (Attachment: Position Statement)

4. ***Will the Joint Reference Committee recommend that the Board of Trustees retain the position statement "Residency Training Needs in Addiction Psychiatry for the General Psychiatrist"?***

   The Council reviewed the position statement. The statement meets all criteria for retention. Nothing has changed. The council recommends this position be retained. (Attachment: Position Statement)

5. ***Will the Joint Reference Committee recommend that the Board of Trustees retain the position statement "Neuroscience Training in Psychiatry Residency Training" ?***

   The Council reviewed the position statement. Neuroscience education varies from program to program. The Council supports the aspirational intention of this action and recommends retention. (Attachment: position statement) (Attachment: details of the Council review)

Referral Updates

6. **Expanding Access to Psychiatry Subspecialty Fellowships (ASM2017A1 12.H)**
   This action 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.
   The new ACGME common requirements for fellowship programs go into effect summer 2018; there are now more opportunities available (as copied below from the new requirements). The Council requests that this action be closed.

   Residency review committees choose from two options:
   Option 1: All required clinical education for entry into ACGME-accredited fellowship programs must be completed in an ACGME-accredited residency program, an AOA-accredited residency program, in a program with ACGME International (ACGME-I) Advanced Specialty Accreditation, or in a Royal College of Physicians and Surgeons of Canada (RCPSC)- accredited or a College of Family Physicians of Canada (CFPC)- accredited residency program located in Canada. (Core)

   Option 2: All required clinical education for entry into ACGME-accredited fellowship programs must be completed in an ACGME-accredited residency program, or an AOA-accredited residency program. (Core)

   Background and Intent: Eligibility for ABMS or AOA Board certification may not be satisfied by fellowship training. Applicants must be notified of this at the time of application, as required in II.A.4.a).(9).
   III.A.1.b) Fellow Eligibility Exception
   The Review Committee for _____ will allow the following exception to the fellowship eligibility requirements:
   [Note: The Review Committee will decide whether or not to allow this exception. This section will be deleted for Review Committees that do not allow the exception.]

III.A.1.b).(1) An ACGME-accredited fellowship program may accept an exceptionally qualified international graduate applicant who does not satisfy the eligibility requirements listed in III.A.1.

http://www.acgme.org/What-We-Do/Accreditation/Common-Program-Requirements/In-Revision

7. **Addressing Physician Burnout, Depression, and Suicide — Within Psychiatry and Beyond (ASM2017A1 12.N)**
   Council has proposed a Committee under the Council as a long-term home for Wellness and Burnout initiatives. The Council requests that this action be closed.

8. **Recognition of Psychiatric Expertise: Efficiency and Sufficiency (ASM2017A2 12.E)**
   This action was reported previously in Fall 2017. The AMA has an existing policy that states that MOC should not be a requirement for maintenance of licensure, hospital privileges, insurance credentialing or employment. APA has been supportive of this policy. Additionally, the ABPN is developing a learning option in lieu of the 10-year exam which is scheduled to launch January 1, 2019. The Interstate Medical Licensure Compact has already released its eligibility requirements (http://www.**imlcc**.org/do-i-qualify/) which require, "Hold a current specialty certification or time-unlimited certification by an ABMS or AOABOS board". In order for APA to lobby for a change to this policy, the APA Board of Trustees would need to create an action which addresses this question. The Council requests this action be closed.

9. **Fostering Medical Student Interest and Training in Psychiatry: The Importance of Medical Student Clerkships (ASM2017A1** 12.K).
   Council reported on this in October 2017. LCME does not specify minimum lengths for clerkships; there are new models of integrated clerkships that may not suit a minimum requirement. Council is no longer working on this action; the Council requests that this action be closed.

10. **Educational Strategies to Improve Mental Illness Perceptions of Non-Mental Health Medical Professionals** (ASM2017A1 12.J) The Council and the division on Communications provided input previously; the Council requests that this action be closed. A list of programs from division of Communication and Division of Education is attached. (List of Programs)
    Sample APA initiatives related to this action:
    Ongoing education programs for primary care/collaborative care
    Publishing/Psych News, Psychiatric Services, FOCUS, AJP, APP
    Communications efforts

11. **Educational Strategies to Improve Mental Illness Perceptions of Medical Students**
    (ASM2017A1 12.I). The Council provided input previously and requests that this action be closed. A list of programs from Division of Communication and Division of Education is attached. (List of programs)
    Sample APA initiatives related to this action:
    The Psychiatry Student Interest Group Network (PsychSIGN)
    APA/APAF Medical Student Programs
    Division of Membership Resources for Medical Students
    Medical Student attendance/participation in Annual Meetings
    Collaborative relationship with ADMSEP

Information items

12. Lifelong Learning and – Maintenance of Certification (MOC) - A report from American Board of Psychiatry and Neurology is included in the May 5 Council minutes. (Attachment) The Chair of the APA member caucus on Maintenance of Certification attended the May 5 Council meeting and addressed the Council.
    The ABPN pilot program to provide an alternative to the 10-year exam begins in 2019. Participants in the pilot program will read and answer questions on 30-40 journal articles selected by the ABPN Pilot Project Test Writing Committees. Link to ABPN for more detail https://www.abpn.com/maintain-certification/moc-part-iii-pilot-project/
    Iowa Psychiatric Society application to join the APA Subcommittee on Joint Sponsorship was approved.

Attachments:
Charge of the council/clean copy
Charge of the council/ revisions marked
Minutes, May 5, 2018
    Review Notes - Neuroscience training
    AADPRT Report
    ABPN Report
    AAP Report
Position statement: ***Residency Training Needs in Addiction Psychiatry for the General Psychiatrist***
Position statement: ***Consistent Treatment of all Applicants for State Medical Licensure***
Position statement: ***Neuroscience Training in Psychiatry Residency Training***
List of Programs that address:
    (ASM2017A1 12.J) "Mental Illness Perceptions of Non-Mental Health Medical Professionals"
    (ASM2017A1 12.I) "Educational Strategies to Improve Mental Illness Perceptions of Medical Students"
Minutes, April 12, 2018
Committee on Well-Being and Burnout: Charge and Budget

CHARGE OF THE COUNCIL ON MEDICAL EDUCATION AND LIFELONG LEARNING REVISED FROM THE OPERATIONS MANUAL OF THE BOARD OF TRUSTEES AND ASSEMBLY OF THE AMERICAN PSYCHIATRIC ASSOCIATION

8. Council on Medical Education and Lifelong Learning

The Council on Medical Education and Lifelong Learning is charged with the following:

Charge: The Council monitors emerging issues and facilitates the development of resources and programs for psychiatric education at every level in the United States and globally. It includes premedical education, medical education, and graduate medical education for residents and fellows in psychiatry (both basic education and subspecialty areas), psychiatric aspects of graduate medical education for other medical specialists and post-graduate continuing medical education and lifelong learning.

The Council advises and assists the APA Division of Education in the development, implementation, and promotion of its education programs and initiatives.

1. The Council acts as advisors for continuing medical education efforts and activities of the Association, meeting the requirements for Category 1 CME credit. (The Annual Meeting Scientific Program Committee has responsibility for CME programming at the Annual Meetings.)

• recommend general policy and standards for continuing education of the APA including the CME and Maintenance of Certification (MOC) mission of the Association;

• through a variety of processes, assess the educational needs of APA members; identify the key learning gaps for psychiatry; and assist in identifying appropriate quality measures and topics for educational programming;

• act in an advisory capacity in the assessment of the overall CME program of the APA.

• promote the development and distribution of new types of continuing medical education products; and

• work closely with the Division of Education to create educational programs that are relevant, and demonstrate outcomes that add to members' foundation of knowledge in a rapidly changing field and positively impact~~s~~ professional practice.

2. The Council identifies emerging issues related to undergraduate medical education and assists in developing effective, appropriate psychiatric education for all future physicians. The Council also facilitates and supports medical student recruitment into psychiatry.

3. The Council reviews and develops recommendations regarding all aspects of graduate medical education in psychiatry, including but not limited to development and maintenance of the highest quality psychiatric training program planning, curriculum development, career development, residency teaching, interface with medical student education, primary care and other medical specialty education and post residency fellowship training. The Council is charged with facilitating the APA’s response to proposed changes in the ACGME Essentials and the Special Requirements for Psychiatry and subspecialty programs.

4. The Council works with other APA components and Divisions to advise and assist on issues related to psychiatric education.

5. The Council maintains effective communication and collaboration with other relevant associations and organizations: the American Board of Psychiatry and Neurology (ABPN) and its subspecialties; the Liaison Committee on Medical Education (LCME); the Accreditation Council for Graduate Medical Education and Continuing Medical Education (ACGME) and the Residency Review Committee for Psychiatry (RRC); the Accreditation Council for Continuing Medical Education (ACCME); the American Medical Association (AMA); the Council of Medical Specialty Societies (CMSS); the American Board of Medical Specialties (ABMS); the Association of American Medical Colleges (AAMC); the American Association of Directors of Psychiatric Residency Training (AADPRT); the Association for Academic Psychiatry (AAP); American Association of Chairmen of Departments of Psychiatry (AACDP); the Association of Directors of Medical Student Education in Psychiatry (ADMSEP); the American Medical Student Association (AMSA); the Student National Medical Association (SNMA); as well as other medical specialty and medical student organizations.

7. The Council will disseminate relevant education information to all members of the APA.

8. Finally, the Council is charged with oversight of various APA awards and components that fall within its purview.

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Development, March 1999; restructured under Council on Medical Education and Lifelong Learning May 2002.

Caucus ~~of~~ on Maintenance of Certification (MOC)

Committee on Wellness and Burnout [pending Board approval]

Subcommittee on Joint Sponsorship of Continuing Medical Education (CME): The subcommittee is charged to implement an effective linkage between the accredited organization (APA) and ~~the~~ its nonaccredited organization partners. Subcommittee members plan, implement, and evaluate district branch and allied organization programs in compliance with APA's policies and procedures. **Composition:** Members are selected directly by the district branches. An APA member from the applying organization commits to serving on the APA Subcommittee on Joint Sponsorship, and must attend annual Joint Sponsorship meeting/webinars. Allied groups name a representative to participate in this group. Each DB/Chapter or allied organization interested in joining the subcommittee and participating in APA's CME credit partnership must submit an application for membership. The application is reviewed by the Council on Medical Education Chair, who provides final approval for membership. Members serve for at least one year. This committee is not authorized to meet in person except at the APA Annual Meeting. **History:** Established September 1992, to facilitate APA's joint sponsorship of district branch and chapter programs and to comply with ACCME essentials. In September 1992, the Board established a policy on APA joint sponsorship of CME activities such that APA will consider joint sponsorship of only district branch and chapter CME activities. In September 2002, the Board determined that APA could also jointly sponsor meetings with international psychiatric associations on a case-by-case basis. In 2016 Joint sponsorship was opened to allied organizations on a limited basis by the APA Board. Restructured as corresponding subcommittee May 2002; composition clarified March 2003.

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	Administration, including the CME Conference Manager. The Director of the Meetings and Conventions Department oversees the staff support for logistics, registration, and exhibits, which includes a Senior Meeting Planner, Associate Director for Registration, the Associate Director for Exhibits, and the Meetings Assistant. **Composition:** Twelve members (no less than 50% of the entire IPS Scientific Program Committee shall have attended three IPS Meetings) and 2 consultants (including advocacy representative and a local member), three liaisons (for example, an APA Fellow, a representative from Psychiatric Services Journal, and the chair or a member of the Annual Meeting Scientific Program Committee.) Each member serves three years and may be reappointed for an additional three-year term, not to exceed a total of six years. Each consultant and liaison serve one-year terms and are appointed annually. The composition of the Committee should include diverse members who work in various practice settings, including, but not limited to, community-based, collaborative/integrated care practices, administration, and/or public funded systems and centers. New members are appointed no later than September 1 of each year, by the President-elect (who will be President at the time of the Meeting for which those appointments will serve), beginning his/her term in the October of the President-elect's year and serving a three-year term. The chair of the Committee will be appointed or reappointed annually by the President-elect. **History:** Established 1949; name changed 1994 and 1999; restructured May 2002; composition revised December 2004. **Vestermark Award Committee:** The Committee administers the Vestermark Psychiatry Educator Award. **Composition:** Three members, one of whom is traditionally the director of NIMH and/or his/her designee. The committee is not authorized to meet in person except at the APA Annual Meeting. **History:** Restructured as corresponding committee, May 2002.
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CHARGE OF THE COUNCIL ON MEDICAL EDUCATION AND LIFELONG LEARNING REVISED FROM THE OPERATIONS MANUAL OF THE BOARD OF TRUSTEES AND ASSEMBLY OF THE AMERICAN PSYCHIATRIC ASSOCIATION

8. Council on Medical Education and Lifelong Learning

The Council on Medical Education and Lifelong Learning is charged with the following:

Charge: The Council monitors emerging issues and facilitates the development of resources and programs for psychiatric education at every level in the United States and globally. It includes premedical education, medical education, and graduate medical education for residents and fellows in psychiatry (both basic education and subspecialty areas), psychiatric aspects of graduate medical education for other medical specialists and post-graduate continuing medical education and lifelong learning.

The Council advises and assists the APA Division of Education in the development, implementation, and promotion of its education programs and initiatives.

1. The Council ~~has oversight for planning, coordinating, directing, and evaluating all~~ acts as advisors for continuing medical education efforts and activities of the Association, meeting the requirements for Category 1 CME credit. (The Annual Meeting Scientific Program Committee has responsibility for CME programming at the Annual Meetings.)

• recommend general policy and standards for continuing education of the APA including the CME and Maintenance of Certification (MOC) mission of the Association;

• through a variety of processes, assess the educational needs of APA members; identify the key learning gaps for psychiatry; and assist in identifying appropriate quality measures and topics for educational programming;

• act in an advisory capacity in the assessment of the overall CME program of the APA. ~~review and evaluate all CME programs of the APA including APA meetings, books and journals, online programs, etc.;~~

• promote the development and distribution of new types of ~~effective~~ continuing medical education products; and

• work closely with the Division of Education to create ~~provide~~ educational programs that are relevant, and ~~that~~ demonstrate ~~an~~ outcomes that add to members' foundation of knowledge in a rapidly changing field and positively impact~~s~~ professional practice. ~~and adds to members' foundation of knowledge in a rapidly changing field.~~

2. The Council identifies emerging issues related to undergraduate medical education and assists in developing effective, appropriate psychiatric education for all future physicians, ~~as well as facilitating and supporting medical student recruitment into psychiatry.~~ The Council also facilitates and supports medical student recruitment into psychiatry.

3. The Council reviews and develops recommendations regarding all aspects of graduate medical education in psychiatry, including but not limited to development and maintenance of the highest quality psychiatric training program planning, curriculum development, career development, residency

teaching, interface with medical student education, primary care and other medical specialty education and post residency fellowship training. The Council is charged with facilitating the APA's response to proposed changes in the ACGME Essentials and the Special Requirements for Psychiatry and subspecialty programs.

4. The Council works with other APA components and Divisions to advise and assist on issues related to ~~all levels of~~ psychiatric education.

5. The Council maintains effective communication and collaboration with other relevant associations and organizations ~~such as~~: the American Board of Psychiatry and Neurology (ABPN) and its subspecialties; the Liaison Committee on Medical Education (LCME); the Accreditation Council for Graduate Medical Education and Continuing Medical Education (ACGME) and the Residency Review Committee for Psychiatry (RRC); the Accreditation Council for Continuing Medical Education (ACCME); the American Medical Association (AMA); the Council of Medical Specialty Societies (CMSS); the American Board of Medical Specialties (ABMS); the Association of American Medical Colleges (AAMC); the American Association of Directors of Psychiatric Residency Training (AADPRT); the Association for Academic Psychiatry (AAP); American Association of Chairmen of Departments of Psychiatry (AACDP); the Association of Directors of Medical Student Education in Psychiatry (ADMSEP); the American Medical Student Association (AMSA); the Student National Medical Association (SNMA); as well as other medical specialty and medical student organizations.

~~6. The Council will serve as advisors and mentors to the student leaders of PsychSIGN, the Psychiatry Student Interest Group Network.~~

7. The Council will disseminate relevant education information to all members of the APA.

8. Finally, the Council is charged with oversight of various APA awards, ~~fellowships,~~ and components that fall within its purview.

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Caucus ~~of~~ on Maintenance of Certification (MOC)

Committee on Wellness and Burnout [pending Board approval]

~~**Caucus of Resident-Fellow Members**~~

~~**Committee of Resident-Fellow Members(CoRFM):** CoRFM relays information from Resident-Fellow Members to the Board of Trustees. Increase collaboration between RFM leadership programs and groups within the APA. Efforts to minimize scheduling conflicts will be facilitated by APA staff. The CoRFM will meet via monthly conference calls (and/or Skype) and communicate primarily via email. The CoRFM will only meet in person at the annual meeting. This structure will allow a wide representation of RFMs in a cost neutral manner. All proposed individuals receive funding to the annual meeting from other sources. Although other RFM groups exist within the current structure of the APA, this group will facilitate communication between groups and allow for collaborative efforts. The Chairperson will prepare reports to the Council on Medical Education and Lifelong Learning with the assistance of the RFMTE. Composition: CoRFM will be composed of the RFMT, RFMTE, ACOM representative from each geographic area (7), the RRC RFM liaison (1), the AMA liaison (1), and one RFM representative from each council. The RFMs on each council will elect one RFM amongst themselves to serve on CoRFM. The RFMT will chair the CoRFM. A member of the BOT will serve as mentor to the CoRFM. History: Established 2010~~

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Council on Medical Education and Lifelong Learning

MAY 5, 2018, 1:30 – 4:00k

Central Park West Room, Second Floor, Sheraton Times Square, NY

Minutes

Attending the Call: Mark Rapaport MD Chair, Marshall Forstein, MD, Vice Chair, Benoit Dube MD, Edward Silberman MD, Steven Fischel MD, PhD, Justin Hunt MD (ASM), Eitan Kimchi MD, Rashi Aggarwal MD, Jose Vito MD, Julie Chilton MD (ECP), Erick Hung MD, Chris Thomas MD, Paul Nestadt MD, Tony Hu DO, Marcy Verduin MD, (AAP), John Spollen MD, (ADMSEP), Rick Summers MD, Larry Faulkner MD (ABPN), Claudine Jones-Bourne MD RFM, Ian Hsu MD, M.Phil. RFM, Erica Lubliner MD RFM, Linda Drozdowicz, MD, RFM, Laura Pientka DO, RFM, Albert Ning Zhou MD, RFM, Muhammed Zeshan MD RFM, Tristan Gorrindo, MD, Kristen Moeller

Guests: Ranga Ram, MD, Chair, Maintenance of Certification Caucus, Anita Everett, APA President, Avni Kapadia, M.D., ABPN Administrative Fellow

Not attending: Venkata Kolli MD, Phil Luber MD, Donna Sudak, MD (AADPRT), Jessica Merritt MD RFM, Leon Cushenberry MD, RFM, J. Corey Williams MD RFM

Welcome, Introductions, Acknowledgements and Minutes

Mark Rapaport, M.D., Chair of the Council, welcomed the members, followed by introductions and acknowledgement of members leaving the Council. Minutes of April 12, 2018 were approved.

APA Caucus on Maintenance of Certification (MOC)

Ranga Ram, M.D. attended the Council as the new Chair of the Caucus on MOC (meets Sunday May 6, 2018). Dr. Ram noted that his role as Chair of the Caucus is to speak for members. Having been involved in recent meetings, Dr. Ram has a broadened perspective on what APA and ABPN are doing and can do to achieve MOC reform. There are members with strong opinions who perceive inaction on MOC, and are considering whether there may be other less regulated or less costly paths to a recertification process. Larry Faulkner offered information that MOC has not driven people to leave practice. That ABPN loses money on 13 MOC examinations. That fees have decreased in the last year; as counterpoint to lack of evidence to support the value of MOC, Dr Faulkner noted that evidence that education works is hard to come by for any level of education.

Personal Learning Project (PLP) and Feedback Survey

Chris Thomas reported on PLP progress and next steps. Refinements to PLP will be made as the result of the beta-test suggestions: more flexibility in the format; linking with resources; could be coded into a standard share code. Eric Hung, Chris Thomas, and Ian Hsu offered to be involved in the next steps. PLP could provide self-directed point-of-care learning, AMA PRA category 1, and might provide meaningful MOC part 2 self-assessment. Marshall Forstein reported on the Survey on Feedback project. it would be beneficial if feedback had common language and processes that are reproducible. What is the field

doing in supervision to expand the knowledge base? Mark suggested that the Academic Chairs might be used to facilitate the survey. AADPRT is not available to collaborate on this survey at present.

Initiative to Promote the Creation of New Residency Programs in Psychiatry.
Rick Summers proposed that APA encourage the development of new ACGME resident training programs. At present, it is not possible to add to existing training programs but new programs can be started. Through collaboration, knowledge and information would be shared regarding new pathways to create ACGME programs. It would be useful to document the facts and payment factors. Other organizations could be invited to collaborate and share information; AADPRT has a caucus for new programs with mentoring available. AAMC is looking at ideas re the physician workforce. The council voted to take this on as a new project.

Charge of the Council
The charge and revisions to the charge were reviewed; additional revisions were suggested. The revised charge was approved by the council.

Allied Education Groups
Association of Directors of Medical Student Education in Psychiatry (ADMSEP) John Spollen, ADMSEP President, reported on initiatives including the upcoming Annual Meeting in Minneapolis, MN, and medical student recruitment and matching. Many medical students are applying to 40 ± programs.

Association for Academic Psychiatry (AAP) Marcy Verduin, current president, reported on AAP initiatives (Attachment)

American Board of Psychiatry and Neurology (ABPN) Larry Faulkner provided a detailed written report regarding status of ABPN. ABPN is reducing fees in 2018; More than 14,000 physicians participating in MOC (= 60% of those eligible) have registered for the ABPN pilot program. (Attachment)

American Association of Chairs of Departments of Psychiatry (AACDP) Mark Rapaport, President of the Chairs group reported on AACDP plans to increase involvement and communication of the group in national issues and common education concerns.

American Association of Directors of Psychiatric Residency Training (AADPRT) Donna Sudak provided a written update (Attachment)

Three APA Position statements assigned to the Council were reviewed and recommended for retention

Neuroscience Training in Psychiatry Residency Training
Venkatta Kolli led a preliminary review. (Attachment) Neuroscience education varies from program to program. The Council supports the aspirational intention of this action and recommends retention. (Attachment)

Consistent Treatment of All Applicants for State Medical Licensure
The group discussed the need to retain this position. The council recommends retention of this position with a clarification of language as below.

"The APA fully endorses the need for an equitable, fair and consistent treatment for state and medical licensure for those applicants who graduated from medical school in the state they are applying, graduated from a school in another state or graduated from a school in another country."

Residency Training Needs in Addiction Psychiatry for the General Psychiatrist
Rashi Aggarwal led discussion of this position. The statement meets all criteria for retention. Nothing has changed. The council recommends this position continue.

Proposal for new standing committee –
Discussion and vote

Proposed Action - *Will the Joint Reference Committee recommend that the Board of Trustees approve the formation of a standing committee on Wellness and Resiliency or Burnout, under the Council on Medical Education and Lifelong Learning as a permanent home for the wellness efforts that were undertaken by the 2017 Wellbeing and Burnout Workgroup?*

Relates to (ASM2017A1 12.N) Addressing Physician Burnout, Depression, and Suicide — Within Psychiatry and Beyond. The Council requests that their role in assembly action ASM2017A1 12.N be closed.

APA Division of Education Initiatives
Tristan Gorrindo provided an overview of APA's continuing medical education activities. In 2017 APA provided 1,812 hours of CME credit to over 50,000 participants (online, journal-based, and live programs). The Annual Meeting in NY had a registration of over 13,000 professional attendees. The IPS meeting is considering its role and goals in psychiatry education. Current major initiatives include program that support education in substance use disorder, buprenorphine training and mentoring, and integrated care. Mark Rapaport noted the FOCUS program of lifelong learning and the Spring issue guest editor, A. John Rush, Biomarkers in Psychiatry.

Update on Awards
Due date for educator awards is June 1, 2018. Vestermark Psychiatry Educator Award. Nancy CA Roeske Certificate. Irma Bland Award for Excellence in Teaching Residents. .

Update to the Council on Past Referrals from the JRC
Expanding Access to Psychiatry Subspecialty Fellowships (ASM2017A1 12.H) The summer 2018 ACGME revised program requirements offer increased opportunities for fellowships. (A disconnect remains regarding certification) (see minutes April 12).
The council will report the increased opportunities in the common program requirements and ask that this action be closed.

Fostering Medical Student Interest and Training in Psychiatry: The Importance of Medical Student Clerkships (ASM2017A1 12.K). Council will ask that this action be closed.

Educational Strategies to Improve Mental Illness Perceptions of Non-Mental Health Medical Professionals (ASM2017A1 12.J) and Educational Strategies to Improve Mental Illness Perceptions of Medical Students (ASM2017A1 12.I). the divisions of education and communication were tasked with providing a list of what is currently being accomplished in this area through ongoing activities. The Council will ask that these actions be closed.

Recognition of Psychiatric Expertise: Efficiency and Sufficiency (ASM2017A2 12.E) – The Council will provide an update and ask that this action be closed.

Other Issues

Meet During Fall Component Meeting
Thursday September 13, 2018.
Renaissance Arlington Capital View.

Attachments

- Details about Neuroscience Training (Relates to action item)
- Report from AACAP
- Report from ABPN
- Report from AAP

Position Statement on Neuroscience Training in Psychiatric Residency Training
Venkata Kolli

NNCI has done a lot of work done on incorporating neurosciences into residency education. The APA, AADPRT, American College of Psychiatrists and the ABPN have supported neuroscience education in residency. 2014 April issue of Academic Psychiatry focused on the state of neuroscience education and gaps.

There seems to be a gradual uptake of neuroscience education among psychiatric residencies, but further work is required. However, there is a lack of published data on the precise impact of the recent initiatives on neuroscience education.
I feel this position statement is still relevant and should be retained.

I think it is not required, but I wondered around adding a line on 'partnering with organizations like AADPRT, ABPN, and ACP'. The APA already does this anyways, and adding such a sentence may not add any further pragmatic value.

Contributions by other organizations:

AADPRT: Brain conference is being organized with AADPRT, and has trained several psychiatry educators on teaching neurosciences. Melissa Arbuckle and Michael Travis, have presented the same content at previous APA annual meetings.

April 16th communication from Dr Sudak, President AADPRT to the CMELL committee comments on AADPRT's support '*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…*'

American College of Psychiatrists: Reporting of PRITE editorial board scores, now includes a separate section on Neurosciences. 2017 results for the PRITE included 69 questions on neurosciences out of total 300 questions.

ABPN:
The Psychiatry Milestone project (2013) has several milestones around neurosciences. They can assist with both formative and summative assessment of neuroscience knowledge and application.

PC3. Treatment Planning and Management

- 5.2/A Integrates emerging neurobiological and genetic knowledge into treatment plan4
- MK1. Development through the life cycle (including the impact of psychopathology on the trajectory of development and development on the expression of psychopathology)
- 5.1/A Incorporates new neuroscientific knowledge into his or her understanding of the development

MK3. Has a Clinical Neuroscience component

- 3.3 Describes neurobiological and genetic hypotheses of common psychiatric disorders and their limitations

- • 4.4 Explains neurobiological hypotheses and genetic risks of common psychiatric disorders to patients
- • 4.5/E Demonstrates sufficient knowledge to incorporate leading neuroscientific hypotheses of emotions and social behaviors10 into case formulation
- • 5.3 Explains neurobiological hypotheses and genetic risks of less common psychiatric disorders to patients
- • 5.4/D Integrates knowledge of neurobiology into advocacy for psychiatric patient care and stigma reduction12

American Association of Directors of Psychiatric Residency Training

PO Box 30618
Indianapolis IN 46230

April 16, 2018

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 2018 Annual Meeting took place on March 1-3, 2018, at the Hilton New Orleans. The 2019 Meeting will be held February 27 – March 2, 2019 at the Hilton San Diego Waterfront.

Current initiatives:

1. Diversity. At the 2018 Annual Meeting President Donna Sudak established a Committee on Diversity and Inclusion. This committee will provide AADPRT with a venue for ongoing education regarding diversity, a clearinghouse for educational materials about diversity, and representation within the leadership of the organization to advocate for issues about diversity and health disparities. The committee may partner with similar committees In AADPRT already in existence in a number of our allied organizations. The committee may also work in concert with other AADPRT Committees (e.g., IMG Caucus, recruitment, curriculum) in order to accomplish its mission.

2. Resident Wellness. In 2016 President Art Walaszek established a Taskforce on Resident Wellness chaired by Heather Vestal, MD. Taskforce members conducted a Resident Wellness Survey of the AADPRT membership; completed an inventory of similar initiatives among other specialty organizations; compiled a resident wellness toolkit; and participated in a Presidential Symposium on Resident Wellness at the AADPRT Annual Meeting. The task force has now concluded its work which is posted on the AADPRT website for the benefit of members.

3. Faculty Development. Deb Cowley, MD, chairs our Faculty Development Task Force, which works with the Program Committee to provide ongoing faculty development offerings during a half-day of our Annual Meeting. These run concurrently with our New Training Directors workshops and provide seasoned training directors with ongoing training and support.

3. Entrustable Professional Activities, Milestones, and Assessment. John Q. Young, MD, chairs the Assessment Committee, which incorporates the work of our EPA Task Force and CAP Milestones Task Forces. 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. We used input from members to inform the ACGME about concerns related to the suggested revisions to the Common Program Requirements in March 2018.

American Association of Directors of Psychiatric Residency Training

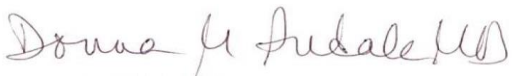
4. Residency Recruitment. We have seen a welcome but challenging increase in the number of applicants to Psychiatry residencies. A number of workshops at the Annual Meeting addressed managing this increase. We have been dismayed by the decrease in numbers of trainees seeking sub-specialty positions. Our Recruitment Committee, PGY4 Task Force and Child and Subspecialty Caucuses are working to track trends in this regard and to make recommendations for further action.

5. 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.

6. Addictions. In March 2017, President Sandra DeJong established an Addictions Taskforce chaired by Ann Schwartz, MD, with the goal to improve addictions training in residencies and CAP fellowships. The Taskforce has surveyed the membership regarding what training programs need in order to implement expert recommendations on addictions training and presented this data as a part of a Presidential Symposium on addictions at the Annual Meeting. The APA Presidential Symposium at this meeting "From Bench to Buprenorphine: The Role of Psychiatry Residencies and Fellowships in Addiction Psychiatry Training" reflects the Taskforce's work. Following the survey, the task force plans to develop a strategic plan for improving addictions training, including an outline of a developmental approach across training, facilitating the acquisition of milestone-based competencies that apply to addictions assessment and treatment, providing a clearing-house for existing educational resources and a platform for disseminating them and developing educational modules that turn content into dynamic, interactive adult-learning sessions.

We thank you for the continued opportunity to work with APA CMELL on the critical task of training future psychiatrists.

Sincerely,



Donna M. Sudak, MD

American Board of Psychiatry and Neurology, Inc.

MEMORANDUM

TO: APA CMELL Report

FROM: Larry R. Faulkner, M.D.
President and CEO

DATE: May 2018
SUBJECT: ABPN Report

1. New ABPN Directors

   - Dr. Amy Brooks-Kayal, from University of Colorado was elected to replace Dr. Kerry Levin on January 1, 2018.
   - Dr. Robert Boland from Brigham and Women's Hospital and Harvard Medical School was elected to replace Dr. Robert Ronis on January 1, 2018.

2. Certification Fees

   Candidate certification fees were decreased by 12% in 2008 (No increase in 2006, 2007, 2009, 2010, 2011, 2012, 2015, or 2017), 10% in 2013, 7% in 2014, 5% in 2016, and 5% in 2018. They will be decreased another 5% in 2019.

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 post pediatric portal programs and to update guidelines for existing programs. As of May 2018, there are 35 approved Combined Programs: 13 P/IM, 7 P/FM, 5 P/N, and 10 Triple Board. As of May 2018, there are 5 approved PPPPs.

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. Up to eight faculty members (four in psychiatry and four in neurology) are supported per year. Each ABPN Fellow receives $50,000 per year for two years.

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 spend three months at the ABPN office under the direct supervision of the President and CEO and 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 are paid by the ABPN.

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 meet to 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; the third ABPN Crucial Issues Forum on MOC was held on April 10-11, 2016; and the fourth ABPN Crucial Issues Forum on Physician Wellness and Burnout was held on April 9-10, 2017. The next ABPN Crucial Issues Forum on Strategic Planning at the ABPN will be held in May, 2019.

7. ABPN Research Award Program

The ABPN has established a Research Award Program to promote research pertinent to the mission of the ABPN. Up to four $100,000 research awards are granted each year (two in psychiatry and two in neurology) to academic faculty who are diplomates of the ABPN.

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
    - Peer supervision (4 hours)
    - Peer review committee review
    - Participation in ABPN-approved registry
    - Completion of the ABPN Pilot Project for MOC Part III

    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. Pilot Project for MOC Part III

    The ABPN is developing a Pilot Project for an optional alternative to its secure, 10-year MOC examinations in Psychiatry, CAP, Neurology, and CN. The Pilot Project will focus on repeated open-book, take-home, mini-tests based upon selected articles in the literature. Pilot participants will be required to answer 4 out of 5 questions correctly on their first attempt for at least 30 but no more than 40 articles in order to be excused from taking the MOC Examination. ABPN is developing its Pilot Project with committees that have a majority of members nominated by professional organizations (i.e., APA, AACAP, AAN, and CNS).

14. Double Counting PGY-4 for Subspecialty Training (in addition to CAP)

    Because opinions about this issue from psychiatry and neurology professional organizations are mixed, the ABPN has decided to make no changes in its current policy. This issue will likely be revisited in the future.

15. Requirement for ABPN Subspecialists (Other than CAP) to Maintain Primary Certification

    While a clear majority of psychiatry and neurology organizations have favored continuing the current ABPN policy of requiring ABPN subspecialists (other than CAP) to maintain their primary certification, some diplomates are very unhappy about the fact that other Member Boards do not have this requirement and that CAP diplomates do not have to maintain their primary certification. The ABPN has decided to once again ask its professional organizations for their opinion about this controversial issue. The APA has already responded that it remains in favor of continuing the current ABPN policy.

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

aap

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 the APA Council on Medical Education and Lifelong Learning

May 2018

Mission and Overview

The Association for Academic Psychiatry (AAP) focuses on education in psychiatry at every level from the beginning of medical school through lifelong learning for psychiatrists and other physicians. It seeks to help psychiatrists who are interested in careers in academic psychiatry to develop the skills and knowledge in teaching, research, and career development required to succeed. AAP provides members a forum to exchange ideas on teaching techniques, curriculum, and other issues and to work together to solve problems.

Major Initiatives in 2018

1. Website Redesign: We have contracted with a vendor to overhaul our entire website, including not only the public-facing content/design, but also the management software and interface. The goal is to make the website more functional and user-friendly for our members. We also hope to create a repository of enduring educational resources for members to adapt and use at their own institutions.

2. Revision and Approval of Bylaws: We are conducting a thorough review and update of our bylaws and governance structure.

3. Modernization of Organization: In addition to updating our outdated website and bylaws, we have made a number of other changes that will better serve our members, from updating award names for clarity to establishing new committees.

Opportunities

1. Awards (deadline early April unless noted otherwise):
   Medical Student Essay Contest *(June 1 deadline)*
   Resident Psychiatric Educator Award (formerly AAP Fellowship)
   Early Career Development Award (formerly Junior Faculty Development Award)
   Roberts Award (for mentorship)
   Psychiatric Educator Award
   Lifetime Achievement Award

2. Fellow/Distinguished Fellow *(June 1 deadline)*:
   Fellow requires membership for 5 years, attendance at a minimum of 3 AAP meetings, and 3 years of service to the organization.
   Distinguished Fellow requires membership for 10 years, attendance at a minimum of 5 meetings, and 7 years of service.

3. Master Educator Program: This three-year series of educational workshops provides a "mini-masters" in education. This year's series will cover *Creativity & Teaching* and *Student Assessment*.

4. Individual Writing Consultation **(new)**: Individual 30-60 minute appointments to review/discuss a manuscript under development, or to discuss how to turn a preliminary idea into a published paper.

5. Cultural Competence and Diversity Consultations: Individual consultations on cultural competence and diversity for program and/or individual career development, or a combination of both.

Annual Meeting – September 5-8, 2018, Pfister Hotel, Milwaukee, WI
The Educator's Compass: Navigating the Changing Landscape of Academic Psychiatry

Keynote: Darrell Kirch, MD, President/CEO, AAMC

Plenary Speakers:
Larry Faulkner, MD, President/CEO, ABPN
George Keepers, MD, Chair, Department of Psychiatry, Oregon Health and Science University
Linda Worley, MD, Associate Dean Northwest Arkansas/University of Arkansas for Medical Sciences
Moderated by Josepha Cheong, MD, University of Florida/Malcom Randall VAMC

In addition, the 2018 AAP Annual Meeting will offer:

- 53 Workshops (including joint sessions with AADPRT and AACDP)
- Master Educator Program
- Poster Session/Competition
- Media Session
- Works-in-Progress and Educator's Showcase
- Career Development Lunch for mentorship and CV review
- Night Out
- Presidential Book Club discussing the #1 New York Times Best Seller and 2014 National Book Award Finalist, *Can't We Talk about Something More Pleasant?: A Memoir*, by Roz Chast

Position Statement on Residency Training Needs in Addiction Psychiatry for the General Psychiatrist

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*.

General psychiatry residency training programs should optimize training such that general psychiatrists are competent in providing screening, brief intervention, referral to treatment (SBIRT); management of psychoactive substance intoxication and withdrawal; evidence-based pharmacotherapy for substance use disorders; management of co-occurring substance use and other psychiatric disorders; and should have exposure to evidence-based psychotherapy and other psychosocial interventions for substance use disorders such as motivational interviewing, cognitive-behavioral therapy, twelve-step programs, among others.

Authors: Karen Drexler, M.D.; Michael Ketteringham, M.D., M.P.H.; Keith Hermanstyne, M.D., M.P.H.

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APA Official Actions

Position Statement on Consistent Treatment of All Applicants for State Medical Licensure

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*

The APA fully endorses the need for an equitable, fair and consistent treatment for those applicants who graduated from medical school in the state they are applying, graduated from a school in another state or graduated from a school in another country.

APA Official Actions

Position Statement on Neuroscience Training in Psychiatric Residency Training

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: An essential element of the mission of the American Psychiatric Association is to promote excellence in psychiatric education and training in order to foster the highest quality of care for individuals with mental disorders, mental retardation and substance–related disorders, and their families. The increase in clinically applicable neuroscience knowledge has created a need for residency curricular development. The APA is already a partner in the National Neuroscience Curriculum Initiative, an NIMH-funded multi-center project that aims to create an accessible web-based set of materials to support residency training (www.nncionline.org/). The APA must take a leadership role in advocating for the necessary elements in residency education to prepare future psychiatrists to meet the behavioral health needs of Americans.

APA Position: A comprehensive understanding of neuroscience and its application to psychiatric treatment should be one of the core requirements of psychiatric training.

Authors: The Ad Hoc Work Group on Education and Training, 2015:
Richard F. Summers, M.D., Chairperson
Sheldon Benjamin, M.D., Member
Tami Benton, M.D., Member
Carol Bernstein, M.D., Member
Lara J. Cox, M.D., M.S., Member
Jed Magen, D.O., M.S., Member
Michele Pato, M.D., Member
Laura Roberts, M.D., Member
John Sargent, M.D., Member
Christopher Thomas, M.D., Member
Glenda Wrenn, M.D., Member
Greg Briscoe, M.D., ADMSEP Representative
Carlyle Chan, M.D., AAP Representative
Jeffrey Lyness, M.D., ABPN Representative
Mark Rapaport, M.D., AACDP Representative
Christopher Varley, M.D., AADPRT Representative
Annelle Primm, M.D., M.P H., M.P.H., APA Administration
Kristen Kroger, APA Administration
Nancy Delanoche, M.S., APA Administration
Tristan Gorrindo, M.D., APA Director of Education

Council on Medical Education and Lifelong Learning
Minutes 04/12/2018

Attending the Call: Mark Rapaport MD Chair, Rashi Aggarwal MD, Jose Vito MD, Julie Chilton MD (ECP), Chris Thomas MD, Venkata Kolli MD, Tony Hu DO, Phil Luber MD, Marcy Verduin MD, (AAP), John Spollen MD, (ADMSEP), Donna Sudak, MD (AADPRT), Claudine Jones-Bourne MD RFM, Erica Lubliner MD RFM, Jessica Merritt MD RFM, Tristan Gorrindo, MD APA Administration, Kristen Moeller, APA Administration,

Not attending: Benoit Dube MD, Erick Hung MD, Edward Silberman MD, Steven Fischel MD, PhD, Justin Hunt MD (ASM), Paul Nestadt MD, Eitan Kimchi MD, Rick Summers MD, Larry Faulkner MD (ABPN), Leon Cushenberry MD RFM, Ian Hsu MD, M.Phil. RFM, Linda Drozdowicz, MD, RFM, Muhammed Zeshan MD RFM, Laura Pientka DO, RFM, J. Corey Williams MD RFM, Albert Ning Zhou MD, RFM

Marshall Forstein MD Vice Chair (ASM) sent comments by email prior to the meeting.

Welcome and Attendance
The committee met by Phone April 12, 2018 4-5 pm.

1. **Upcoming meetings**
   Meet at Annual Meeting: Council on Medical Education and Lifelong Learning
   Saturday, May 5, 1:30 p.m. - 4:00 p.m.
   Central Park West, Second Floor,
   Sheraton Times Square
   (note: AAP and AADPRT are at the same time)

   Meet during Fall Component Meeting: Council on Medical Education and Lifelong Learning
   Thursday, September 13, 2018

2. **Issues emerging in allied education groups (AAP, AADCP, ADMSEP, AADPRT, ABPN) – Mark Rapaport**
   A. AAP, AADPRT, ADMSEP also expressed interested in collaborating as issues came up related to policy.

3. **Result of Personal Learning Project –** Prototype - http://apapsy.ch/plp **Chris Thomas and Tristan Gorrindo**
   A. Consider adding more learning formats
   B. Consider adding links to databases for additional resources
   C. Consider targeted survey to users to solicit more specific feedback
   D. Is the process too formal/structured for general members. Do we need to engage them in a different way?

4. **Comments from the CMELL to the Council on Advocacy and Government Relationships on two action items (attachment)**

   A. **Designation of Psychiatry as Primary Care for Any Medical School Scholarships Requiring Primary Care Service** (ASM2017A2 12.A)
      a. medical students have chosen Family Practice over psychiatry after learning that they would not be eligible for certain scholarships if they select Psychiatry.

b. Information was given regarding National Health Service: Medical Primary Care: Family Medicine, Internal Medicine, Pediatrics, Obstetrics/Gynecology, Geriatrics, Mental Health are eligible to apply to the NHSC Loan Repayment Program.
c. There is a real need to encourage psychiatry. The Council supports this action. The Council did not identify reasons to not support this action paper.

B. **Medical School Loan Repayment Subsidies for Psychiatrists Practicing in Community Mental Health Centers and State Psychiatric Facilities (ASM2017A2 12.B)**
a. Council supports the *Be It Resolved* of this action paper.

5. **Establishing a standing Committee on Physician Wellness under the Council**
A. There are synergies between CMELL and APA's wellbeing efforts
B. medical students don't go into MS with high levels of burnout, but a significant percentage leave MS and residency with burnout.
C. Council voted to move forward with a proposal to draft a formal action to the JRC to establish a standing committee on physician wellness

6. **Information Items: ACGME Common Program Requirements**

A. **Expanding Access to Psychiatry Subspecialty Fellowships (ASM2017A1 12.H)**
In the ACGME common requirements, to be final in summer 2018 there are now more opportunities available, here is the requirement as included in the 2018 revision.

Residency review committees choose from two options:
Option 1: All required clinical education for entry into ACGME-accredited fellowship programs must be completed in an ACGME-accredited residency program, an AOA-accredited residency program, in a program with ACGME International (ACGME-I) Advanced Specialty Accreditation, or in a Royal College of Physicians and Surgeons of Canada (RCPSC)- accredited or a College of Family Physicians of Canada (CFPC)- accredited residency program located in Canada. (Core)

Option 2: All required clinical education for entry into ACGME-accredited fellowship programs must be completed in an ACGME-accredited residency program, or an AOA-accredited residency program. (Core) Eligibility for ABMS or AOA Board certification may not be satisfied by fellowship training. Applicants must be notified of this at the time of application.

The Review Committee for _____ will allow the following exception to the fellowship eligibility requirements:
[Note: The Review Committee will decide whether or not to allow this exception. This section will be deleted for Review Committees that do not allow the exception.]
III.A.1.b).(1)
An ACGME-accredited fellowship program may accept an exceptionally qualified international graduate applicant who does not satisfy the eligibility requirements listed in III.A.1.
http://www.acgme.org/What-We-Do/Accreditation/Common-Program-Requirements/In-Revision

A. **APA Comment on the ACGME revision of the Common Program Requirements**
APA's comments on the CPR revision, sent March 22, are included below:

On behalf of the American Psychiatric Association and its 37,800+ members, we wish to provide feedback to the ACGME on the proposed CPR revisions.
We offer two friendly amendments (1.C) which strengthen the steps ACGME has already taken to support broader diversity and inclusiveness within medicine and medical leadership.

Additionally, and as has been noted in separate comments from American Association of Chairs of Departments of Psychiatry (AACDP) and American Association of Directors of Psychiatry Residency Training (AADPRT), the APA encourages the ACGME to evaluate any unfunded mandates that may be placed on training directors as a result of the CPR revisions. Specifically, we would encourage the ACGME to limit the scope of responsibility of program directors and Program Evaluation Committees to issues regarding the well-being, education, and scholarly activity of trainees. Issues related to faculty well-being, faculty development, and the quality/safety of care provide should be left to existing systems within hospital administrations and physician organizations that already monitor, track, and report on these issues.
Suggested revision to 1C appears in bold below.
*"The program, in partnership with its Sponsoring Institution, must engage in practices that focus on mission-driven, ongoing, systematic recruitment and retention of a diverse **and inclusive** workforce of residents, fellows (if present), faculty members, senior administrative staff members, and other relevant members of its academic community. (Core)*
*Background and Intent: It is expected that the Sponsoring Institution will have developed policies and procedures related to recruitment and retention of **minorities underrepresented in medicine and medical leadership** in accordance with the Sponsoring Institution's mission and aims. The program's annual evaluation must include an assessment of the program's efforts to recruit and retain a diverse workforce, as noted in V.C.2.a).(5).(c)."*

APA Comments on the revised program Requirements

- *The APA believes that the department should be primarily responsible for faculty hiring and duties, but the program directors should have input in the selection of teaching faculty.*

- *The APA believes that the review of and the creation of faculty development plans is the responsibility of the Department Chairs and sponsoring institutions.*

- *The APA believes that the responsibility for faculty wellness, the development of wellness programs, and the monitoring of career development is the responsibility of the institution, the GME office and DIO and department or division chair.*

7. **Position statements assigned to the Council**

Assignments to Take the lead in review of position statements for the May meeting

2015	Neuroscience Training in Psychiatry Residency Training	Medical Education	BOT APPROVED JULY 2015 ASM Approved May 2015
2015 (Retained 2008 PS)	Consistent treatment of all applicants for State Medical Licensure	Medical Education	BOT REAFFIRMED JULY 2015 ASM REAFFIRMED MAY 2015

2014	Residency Training Needs in Addiction Psychiatry for the General Psychiatrist	Medical Education	BOT Retained Dec 2014; ASM Retained Nov 2014

Criteria for Evaluating Position Statement

Any council reviewing a position statement for recommendation for retention, retirement, or revisions should provide a written statement (rationale) as to the reasons for their recommendation.

The following are minimum guidelines the council must use in making their decision for retention, retirement, or revision. A council may have additional reasons which should be stated in their report.

The council must first assess whether there is a need, based on the purpose of position statements (noted above), to have a position statement on the topic before them.

- The position statement is current, relevant and should be retained
- The topic of the current position statement is no longer relevant because of scientific developments or changes within the legislative or public environment
- There have been changes in healthcare delivery methods or in the healthcare system which make the subject and current position statement no longer relevant
- There have been changes in laws, legal systems, or licensures which make the current position statement no longer relevant
- Standard psychiatric practice as reflected by APA guidelines has changed making the current position statement no longer relevant
- Political or social trends have significantly changed making the current position statement no longer relevant
- There have been subsequent changes in APA policy or the APA code of ethics making the current position statement irrelevant or in conflict with existing policy or practice

If the council recommends that the position statement be revised, the council (or its component) should revise the position statement and submit it to the Joint Reference Committee as an action item with a request to retire the position statement and replace it with the revision. If the council recommends that the position statement should be revised, but believes that the council (or its components) are not the appropriate review body, a recommendation for revision (with a recommendation as to the appropriate review body) should be sent to the JRC.

8. **Charge of the Council**

   The Council is reviewing its charge to align it with the scope of the Council.

   - **Please review offline in preparation for May meeting and will finalize in May.**

9. **Maintenance of Certification -** Discussion

   A. Head of APA MOC Caucus to come and speak with CMELL at May meeting
   B. Invite Council members to join listserv and attend Caucus meeting in May

Division of Communications:

APA Resources for improving perceptions of Psychiatrists among non-medical Mental Health Professionals and Medical Students

Many of the day-to-day operations of the APA and its staff result in programs, activities and other resources designed to promote the role of psychiatrists as medical leaders for the mind, brain and body, and fight against stigma and misinformation around the diagnosis and treatment of mental illness and substance use disorders.

The most basic of these resources is a webpage on psychiatry.org that answers the question: "What is Psychiatry?" The page defines the practice of psychiatry, discusses the diagnosis and treatment of patients that the average psychiatrist engages in, and explores the medical training required to become a psychiatrist. The page also makes clear the difference between psychiatrists and psychologists, something that is often a source of confusion among the public and even at times the media.

Many other similar resources, such as "What is Mental Illness?," "What is ECT?" and "What is Telepsychiatry?," are part of the "Patients & Families" section on Psychiatry.org and exist to correct common misconceptions about the nature, diagnosis and treatment of mental illness and substance use disorders, inform members of the public and media, and reassure patients who may be apprehensive about undergoing these treatments or even seeking treatment at all.

The Patients & Families section is also home to a number of webpages dedicated to many specific mental disorders, such as depression, gender dysphoria, and addiction and substance use disorders. Each of these pages hosts a basic definition of a given disorder, blog posts and news items related to that disorder, frequently asked questions answered by experts in the field, additional resources hosted by APA and allied groups, upcoming events, and stories from patients sharing their personal experiences coping with a given disorder. New pages are added on a rolling basis, and each one is reviewed by a physician on a regular basis to ensure that the information it contains is accurate, easy to understand and medically correct.

One of the ways that APA lives up to its motto of "medical leadership for mind, brain and body is by serving as the go-to source for accurate, medically correct information on issues related to mental health and substance use disorders. The "Newsroom" section of psychiatry.org is full of APA's statements from APA leadership and spokespeople and makes clear where our organization and members stand on the important issues of the day as they pertain to psychiatry. The news releases hosted on this site cover everything from APA organizational news like election results and APA partnerships with allied groups, to the release of cutting-edge medical research.

Also included in the Newsroom section are APA's Blogs, which cover a similarly expansive array of topics. Many of these blogs are written with a lay-audience in mind, but others are aimed at medical professionals both in and outside the organization. The "What APA is Doing for You" section is designed to keep members informed about important initiatives being undertaken by the APA on behalf of its membership, including lobbying efforts by APA's Department of Government Relations at both the state and federal level.

APA engages in extensive outreach to doctors and medical students at home and abroad with the goal of building partnerships to support APA's broader mission and help end the stigma against mental illness

and substance use disorders among the public. Full pages are dedicated to international psychiatry, where APA is actively engaged in building a global network of psychiatrists, and resources for psychiatry residents and early-career psychiatrists. The Med Students page on Psychiatry.org has a wealth of information and resources designed with students considering a career in psychiatry in mind. In addition, APA offers free membership for medical students, who receive the full range of benefits available to members, including mentoring career development, and free subscriptions to the American Journal of Psychiatry and Psychiatric News.

APA maintains an active presence on all major social media platforms, including Facebook, Twitter, LinkedIn and Instagram. These channels offer APA a way to foster conversations directly with members and the public and give APA messaging astounding reach. Social media also allows us to collaborate with allied groups on events like Twitter Chats, which are fantastic for gauging public thinking around a given subject, such as depression, and promoting APA resources on that topic.

All of the resources listed above are designed to place APA, its members, and the profession of psychiatry in general in a place of confident leadership where matters of the mind and brain health are concerned. They are the online component of a larger network of that extends from every employee to the more than 37,800 members of the APA and their respective district branches, the work of the APA Foundation and the numerous publications of American Psychiatric Publishing.

Division of Education:

APA Programs for improving perceptions of Psychiatrists among non-medical Mental Health Professionals and Medical Students

- The Psychiatry Student Interest Group Network (PsychSIGN)
- Division of Membership Resources for Medical Students
  - https://www.psychiatry.org/residents-medical-students/medical-students/choosing-a-career-in-psychiatry
- Medical Student attendance/participation in APA Annual Meetings
- Collaborative relationship between Council on Medical Education and ADMSEP. ADMSEP President is a corresponding member of the council
- Education programs:
  - Applying the Integrated Care Approach: Skills for the PCP
  - Collaborative Care for Primary Care Providers
  - Applying the Integrated Care Approach: Learning Collaborative (1 through 14)
  - FOCUS 2017 - Advances in Collaborative Care
  - Treating Substance Use Disorders Through Collaborative Care
  - DSM 5: What You Need to Know (CE/CU credit to all mental health disciplines)

Charge of the Committee on Psychiatrist Well-being and Burnout:

Professional burnout and mental health vulnerability are significant concerns affecting physicians in training and practicing physicians. Professional burnout can impact physicians' health and quality of life, the quality of care they provide, and their productivity and workforce participation.

The **Committee on Psychiatrist Well-being and Burnout** will work through APA administration, and with Councils, Committees and other experts where needed. The Workgroup will coordinate its efforts with the work of allied organizations, including AMA, AAMC, ACGME and NAM, in addressing this problem.

The Committee will:

- make recommendations regarding the development of activities and products to facilitate APA's focus on well-being and burnout.
- create and or work with administration to develop products.

The Workgroup will address the following areas:

- Assess members' wellness, professional satisfaction and experience with burnout based on available data.
- Recommend specific educational activities about physician wellness, including work-life balance, desirable practice parameters, and self-care for APA members, residents, medical students and other physicians.
- Recommend resources other than education to support members' mental health, wellness and satisfaction. This will include resources for vulnerable psychiatrists.
- Recommend opportunities to provide support to other medical membership organizations regarding physician well-being and burnout.
- Work with communications and publication staff to develop recommendations for a communication strategy that will promote these products and opportunities.

Action Paper Worksheet
2018 Action Paper Budget Estimate

Action Paper Title:	Committee on Psychiatrist Well-being and Burnout
Action Paper Author(s):	Council on Medical Education and Lifelong Learning
Phone/email:	-
APA Admin. Name:	Kristen Moeller, Roke Iko, and Tristan Gorrindo
Phone/email	kmoeller@psych.org 202-559-3897 tgorrindo@psych.org

Attendance Summary:	**Author**	**APA Administration**
Number of Component Members	-	10
Number of Staff	-	2
Number of Non-Staff	-	-
Total	**-**	**12**

Author Estimate:

Travel Budget:	No. of Attendees	Airfare	Hotel/Lodging	Ground Transportation	Per Diem/Meals	Total
Meeting 1	8	$3,400	$2,600	$800	$1,184	$7,984
Meeting 2	-	-	-	-	-	-
Total Travel Budget		3,400	2,600	800	1,184	$7,984

Non-Staff Costs:	
LCD Projector	850
Laptop	300
Screen	180
Flipchart	-
Microphones	-
Total Non-Staff Costs:	**1,330**
Staff Costs:	
Description:	
1	- -
2	- -
3	- -
Total Staff Costs	-
Other Costs not included above:	
0	-
Total Author Estimate	**9,314**

APA Administration Estimate:

Travel Budget	No. of Attendees	Airfare	Hotel/Lodging	Ground Transportation	Per Diem/Meals	Total
Meeting 1	8	$3,400	$2,600	$800	$1,184	$7,984
Meeting 2	-	-	-	-	-	-
Total Travel Budget		**3,400**	**2,600**	**800**	**1,184**	**7,984**

Non-Staff Costs:	
LCD Projector	850
Laptop	300
Screen	180
Flipchart	-
Microphones	-
Total Non-Staff Costs:	**1,330**
Staff Costs:	
Description:	
1 Staff time - attendance/ minutes/reporting/communication to members; product development; affiliated meeting attendance (NAM, ACGME); website development; video production. 8 hrs/week * 50 week: total 400 hours annually	31,600
2	- -
3	- -
Total Staff Costs	**31,600**
Other Costs not included above:	
conference calls; jotform data collection	**200**
Total Administration Estimate	**41,114**

Rvsd. Jan. 2018

Action: ***Committee on Psychiatrists Well-being and Burnout***

APA Administration Feedback:

DEPARTMENT and/or COMPONENT:
Education

DEPARTMENT and/or COMPONENT: EXPLANATION OF COST:

<u>The Committee would be as other committees:</u>

<u>Committees</u> - 6 voting members, 2 consultants, 2 corresponding members. One in-person meetings at September Components with prior approval of the Council and JRC. The Committee may also meet at the Annual Meeting or IPS at no cost to APA (other than staff time & meeting room).

Item JRC 8.J
Joint Reference Committee
June 2018

Executive Summary
Council on Minority Mental Health and Health Disparities

Christina Mangurian, M.D., M.A.S., Chairperson

The Council on Minority Mental Health and Health Disparities (CMMH/HD) advocates for minority and underserved populations and psychiatrists who are underrepresented within the profession and APA. CMMH/HD seeks to reduce mental health disparities in clinical services and research, which disproportionately affect women and minority populations. CMMH/HD aims to promote the recruitment and development of psychiatrists from minority and underrepresented groups both within the profession and APA.

Action Items

ACTION: Will the Joint Reference Committee (JRC) consider creating a special task force to work with the scientific review committee to re-assess the scoring process for submissions for presentations at the Annual Meeting and IPS to ensure our presentations are inclusive, diverse, and prioritize various Council and Caucus-endorsed presentations?

ACTION: Will the JRC recommend that the Assembly approve the "Position Statement on Police Brutality and Black Males"?

ACTION: Will the JRC recommend that the Assembly approve the "Position Statement on Mental Health Equity and the Social and Structural Determinants of Mental Health"?

ACTION: Will the JRC recommend that the Assembly approve the "Position Statement on Human Trafficking"?

ACTION: Will the JRC recommend that the Assembly approve a new "Position Statement on Conversion Therapy and LGBTQ Patients"?

ACTION: Will the JRC recommend that the Assembly retire the "Position Statement on Therapies Focused on Attempts to Change Sexual Orientation"?

ACTION: Will the JRC recommend that the Board of Trustees (BOT)-approved Resource Document "*Assessment and Treatment of Gender Dysphoria and Gender Variant Patients: A Primer for Psychiatrists*" be added as a resource document on the APA website?

Information Items

Formation of Special Task Force

To our knowledge, there is no structural mechanism to formally prioritize Caucus and/or Council-endorsed submissions for our two APA main meetings (APA Annual Meeting and IPS). In addition, the

scoring process, at least for IPS, is currently on a 0-5 scale. Although the scientific review committee does a tremendous job and has a very diverse set of presentation at these meetings, it might behoove APA to create some structural changes to the review process to advance APA priorities (e.g., perhaps expanding the scale to 10 and adding points for endorsements). This scoring change should benefit *ALL* allied organizations, councils, and workgroups and not just those concerned with diversity.

Position Statements (4 Revisions)

The CMMH/HD revised three Position Statements as requested by the JRC in addition to creating a new one and requesting one for retirement.

Revised Position Statements:

- **"Police Brutality and Black Males"**
  A workgroup composed of CMMH/HD members reformatted the Position Statement and incorporated feedback provided by members of the JRC, Caucus of Black Psychiatrists, and the Council on Psychiatry and Law.

- **"Mental Health Equity and the Social and Structural Determinants of Mental Health"**
  A workgroup led by CMMH/HD members reformatted the Position Statement and incorporated feedback provided by members of the JRC.

- **"Human Trafficking"**
  A workgroup led by CMMH/HD members reformatted the Position Statement, inserted an issue statement and incorporated feedback as requested by members of the JRC.

New Position Statement:

- **"Conversion Therapy and LGBTQ Patients"**
  The Position Statement on "Conversion Therapy and LGBTQ Patients" is an update and a replacement of the Position Statement on "Therapies Focused on Attempts to Change Sexual Orientation" (2000). With current legislation around conversion therapy, it is important that APA reaffirm its stance against conversion therapy and comment on gender diverse individuals as well. The new Position Statement considers all gender identities and sexual orientations and encourages psychiatrists to affirm these individuals rather than pathologize them.

Retire Position Statement:

- "**Position Statement on Therapies Focused on Attempts to Change Sexual Orientation**"
  This Position Statement is being replaced by the new Position Statement on "Conversion Therapy and LGBTQ Patients."

Resource Document "*Assessment and Treatment of Gender Dysphoria and Gender Variant Patients: A Primer for Psychiatrists*"

Background: The Gender Dysphoria workgroup, originally reporting to the Council on Quality Care, recently moved to our Council. The workgroup's product, "*Assessment and Treatment of Gender Dysphoria and Gender Variant Patients: A Primer for Psychiatrists*," was approved by the Council on

Quality Care in May of 2016. Per our understanding, the December 2016 BOT meeting approved the resource document, but did not post on-line because the team was preparing for publication. The manuscript has recently been published, so now could be available on the APA website (https://www.liebertpub.com/doi/full/10.1089/trgh.2017.0053). A link to the peer-reviewed publication would be ideal since more evidence was added.

APA Toolkit: Stress and Trauma Related to the Political and Social Environment

CMMH/HD, Division of Diversity and Health Equity (DDHE), Division of Communications, in collaboration with the Office of the Medical Director, is organizing a toolkit about stress and trauma related to the current state of the political and social environment in the U.S. The toolkit aligns with CMMH/HD's mission of creating resources that focus on diversity and inclusion. Several workgroups, consisting of members from M/UR Caucuses and CMMH/HD, were formed to develop this resource. Final drafts were submitted to DDHE who will work with Communications on language and have versions vetted by experts in treating minority populations. DDHE leadership anticipates content completion by the end of Q3 2018.

Accreditation Council for Graduate Medical Education (ACGME) Update

ACGME Common Program Requirements (CPR) draft (affecting all residencies and fellowships of all specialties) is now under final review by the Committee. This marks the first time the word "disparities" appears in the CPR, although it has been in the psychiatry residency training program requirements. Following BOT Approval, the CMMH/HD submitted feedback during the comment and review period. Once the Committee finalizes, the ACGME Board will vote on the measure. The Board is expected to meet in the summer of 2018.

APA Comments on Proposed Conscience Rights Rule

CMMH/HD members provided comments on the Department of Health and Human Service's proposed Religious Freedom Rule as requested by APA's Department of Practice Management and Delivery Systems Policy (APA POC: Kathy Orellana, Associate Director.) The Division thanked the Council for its timely submission.

Workgroup Discussions

Continuing the work outlined from the 2017 September Components meeting, the Council has progressed with its effort to provide support to M/UR psychiatrists, the communities they serve, and general APA membership. Workgroups are organized around the following topics (see CMMH/HD May minutes for details).

- Efforts to increase M/UR membership
- Community-based work and reducing stigma
- History & Intergenerational relationships

APA 2018 Annual Meeting

Members of the CMMH/HD presented **13 scientific sessions** at the APA 2018 Annual Meeting in New York in May. Sessions included "Promoting wellbeing of African Americans: Tools to treat mental health needs and promote wellbeing during the current political and social climate," (featuring fellow Carine Nzodom, MD), "Parental Leave: Luxury or Necessity?," (presented by Chair Christina Mangurian, MD,

MAS; and fellow Carine Nzodom, MD), "Promoting Well-Being Among Women in the Current Political and Social Environment," (presented by Chair Christina Mangurian, MD, MAS; and fellow Louisa Olushoga, MD), "Women of Color and Intersectionality," (presented by Vice Chair Helena Hansen, MD, PhD), and "Advances in Transgender Mental Health," (presented by Vice Chair Eric Yarbrough, MD). The list of accepted submissions is attached.

Additionally, seven award lectures under the purview of the Council also occurred. These included:

- Simon Bolivar Award Lecture given by Juan Bustillo, MD, on "How Is the Schizophrenia Brain Changing: Was Kraepelin Right?"
- John Fryer Award Lecture given by Jack Drescher, MD, on "Dr. H. Anonymous and the Legacy of John E. Fryer, M.D."
- George Tarjan Award Lecture given by Fructuoso Irigoyen-Rascon, MD, PA, on "Don Quixote and the IMG: A Mind State"
- The Kun-Po Soo Award Lecture given by Devon E. Hinton, MD, PhD, on "Trauma, Culture, and Complex PTSD: Cambodian Genocide Survivors"
- Alexandra Symonds Award Lecture given by Leslie Hartley Gise, MD, on "We've Come a Part Way, Baby"
- Solomon Carter Fuller Award Lecture given Patricia Newton, MPH, MA, MD, on "Mental Health Challenges Facing Patients and Providers of African Descent"
- Oskar Pfister Award Lecture given by John Swinton, PhD, on "A Matter of Faith? The Role of Faith in the Experiences of Christians Living with Severe Mental Health Challenges"

DDHE sponsored *Conversations on Diversity* which included participants from CMMH/HD, M/UR Caucuses, and APA leadership. Eric Yarbrough, MD, and Ruth Shim, MD, MPH, served facilitators. "*Conversations"* allows members to strategize ways to increase diversity and inclusion within APA. A total of 75 people attended. Strategies developed by *Conversations* participants will be prioritize at the CMMH/HD and M/UR Committee Joint Meeting during September Components.

CMMH/HD Meeting at 2018 Annual Meeting

The Council convened at the Annual Meeting to review successes over the past year and to plan for the 2018-2019 cycle. Minutes of the meeting are attached.

Attachments

1. Position Statement on "Police Brutality and Black Males"
2. Position Statement on "Mental Health Equity and the Social and Structural Determinants of Mental Health"
3. Position Statement on "Human Trafficking"
4. Position Statement on "Conversion Therapy and LGBTQ Patients"
5. Position Statement on "Therapies Focused on Attempts to Change Sexual Orientation"
6. Gender Dysphoria Workgroup's publication titled, "Assessment and Treatment of Gender Dysphoria and Gender Variant Patients: A Primer for Psychiatrists"
7. List of Annual Meeting accepted submissions developed and facilitated by Council members
8. CMMH/HD May Meeting Draft Minutes

APA Official Actions

Position Statement on Police Brutality and Black Males

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:
Brutality of African-American males at the hands of law enforcement has spawned widespread national protests and generated justifiable national concern. Repeated examples and depictions of police brutality and use of unwarranted deadly force against black males has a profound impact on the emotional and psychological well-being of African-American families and communities, creating a living environment of fear and uncertainty. Blacks are significantly more likely to experience police brutality than are whites (Kahn, 2016). Additionally, young black men, within the ages of 15-34, were 9 times more likely than other Americans to be killed by police officers as of data collected in 2015; which was 4 times the rate of young white men (The Guardian, 2017). Research has demonstrated a strong and consistent link between depressive symptoms and experienced racial discrimination (Pascoe and Smart Richman, 2009). Perceived racism and discrimination have been identified as being associated with depression, increased substance use, and feelings of hopelessness among African American youths (Gibbons, 2004; Nyborg, 2003), which in turn are associated with suicidal behaviors in adolescents (Goldston, 1999; Goldston et al. 2001). The mental health of African-American males, as well as of the African-American community at large, is negatively impacted by overt and covert racism, as well as explicit and implicit bias. Microaggressions, a form of covert racism, manifests as a perceived slight wherein the recipient has an intuitive sense that an act of prejudice occurred during the interaction; with frequent exposure to microaggressions serving as a conduit for chronic stress (APA, 2017; Charkraborty & McKenzie, 2002). African-American males are disproportionately profiled to be criminals and are frequently stopped and searched based on the perceived notion of wrong doing with many profiled persons subsequently developing symptoms of anxiety and PTSD (APA, 2017; Aymer, 2016). The development of mental illness as a result of this phenomenon may also lead to a cycle of violence as not only are people with mental illness disproportionately likely to be victims of police killings, but people with mental illness who are black are at the highest risk (Saleh et. al, 2018). In light of the negative mental health impact of this problem, the field of psychiatry can play a vital role in promoting a positive relationship between law enforcement agencies and the black community, as well as provide high-quality treatment to those impacted by police brutality on black males in America.

Position:
APA condemns the brutal treatment of black males, the use of excessive force against black males, and the use of unwarranted and unnecessary deadly force against black males by law enforcement agencies and police departments.

1. APA recognizes and wishes to emphasize an understanding of the profoundly negative impact that police brutality on black males has on the mental health of black males, as well as the mental health of the black community as a whole.
2. APA encourages initiatives that foster direct collaboration between law enforcement and African-American communities in order to engender trust, cooperation, and understanding. Other necessary initiatives include, quality improvement programs on the part of law enforcement, community policing, and racial diversification of law enforcement officers and leadership.
3. APA encourages collaboration between law enforcement and mental health professionals for the purpose of developing programs that train law enforcement administrators and officers on racial bias/racial trauma and its response and impact on the mental health of the communities they serve.
4. APA encourages continued data collection, and research into understanding the driving factors behind disproportionate minority contact with the juvenile or criminal justice system, as well as research that continues to explore the mental health effects of police brutality and the use of excessive/deadly force on African-American males and the African-American community.
5. APA encourages the development of novel approaches and strategies to address the unique mental health needs of African-American males who have either, directly, or indirectly experienced police brutality and/or the use of unwarranted excessive/deadly force by law enforcement, as well as the mental health needs of their family and community members.

Authors:
Council on Minority Mental Health and Health Disparities

References:

1. American Psychiatric Association (2017). *APA Toolkit for Providers Treating African-Americans: Stress and Trauma Related to the Political and Social Environment*.
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11. The Guardian: The Counted Project. January 8, 2017. *Young Black Men Again Faced Highest Rate of US Police Killings in 2016*.
12. www.great-online.org/About/Evaluation

Background Information on Police Brutality and Black Men

In recent years, a cluster of highly publicized killings of African-American males at the hands of law enforcement has spawned widespread national protests and generated justifiable national concern. According to the United States Census Bureau, black/African-American persons make up approximately 13.3% of the American population. In 2007, the Census Bureau approximated that nearly 48% of the African-American population in the United States were male. This means that, roughly, 6% of the American population are black men. Unfortunately, although black men make up such a small number of the population, they accounted for 22% of individuals shot and killed by police in 2017. This is consistent with 2016 statistics that demonstrate African-American men comprising 23% of the total individuals shot and killed by police. While quite a few of the cases of unarmed black males being seemingly unjustifiably killed by police officers have brought into question the role of racism, prejudice, and discrimination; it is quite important to note that statistics demonstrate that black and white police officers are equally likely to use force against black males. Furthermore, socioeconomic status does not appear to be a distinguishing factor either as high income blacks are just as likely to be killed by police officers as low income blacks (Krieger, 2015).

Blacks are significantly more likely to experience police brutality than are whites (Kahn, 2016). Additionally, young black men, within the ages of 15-34, were 9 times more likely than other Americans to be killed by police officers as of data collected in 2015; which was 4 times the rate of young white men (the Guardian, 2017). The use of unnecessary force against black males is often viewed as a manifestation of racial discrimination and racial profiling by law enforcement. As identified by English, Lambert, Evans, and Zondervan (2014), one explanation for this may be "the gendered and racialized stereotypes that remain ubiquitous throughout US society that depict African-American males as deviant and violent". Further considering the perception of African-American males, research has demonstrated a link between the percentage of young African-American men in a neighborhood and greater perceptions of crime levels, even given equivalent neighborhood characteristics and crime levels (Quillian and Pager, 2001). This may indicate the greater likelihood that they are profiled and discriminated against (English et al., 2014). Furthermore, it must be understood that repeated examples and depictions of police brutality and use of unwarranted deadly force against black males has a profound impact on the emotional and psychological well-being of African-American families and communities, creating a living environment of fear and uncertainty; the loss of family and community members diminishes their social and economic resources as well. Research has demonstrated a strong and consistent link between depressive symptoms and experienced racial discrimination (Pascoe and Smart Richman, 2009). Perceived racism and discrimination have been identified as being associated with depression, increased substance use, and feelings of hopelessness among African American youths (Gibbons, 2004; Nyborg, 2003), which in turn are associated with suicidal behaviors in adolescents (Goldston, 1999; Goldston et al. 2001). As highlighted in the American Psychiatric Association's (APA) Toolkit for Providers Treating African-Americans (2017), negative social factors such as racism, racial bias and discrimination contribute to poor physical and mental health among racial/ethnic minority populations (Jones,

2008). The mental health of African-American males, as well as of the African-American community at large, is negatively impacted by overt and covert racism, as well as explicit and implicit bias. Microaggressions, a form of covert racism, manifests as a perceived slight wherein the recipient has an intuitive sense that an act of prejudice occurred during the interaction; with frequent exposure to microaggressions serving as a conduit for chronic stress (APA, 2017; Charkraborty & McKenzie, 2002). As documented in the literature, a range of negative health and social outcomes, such as worsened long-term life opportunities, increased risk for involvement in violence and violent victimization, decreased high school graduation and employment rates, damaged social networks and family functioning, and worsened mental health outcomes have all been linked to contact with the juvenile or criminal justice system, of which minorities are at highest risk (Brame et al., 2012; Clear, 2008; gatti et al. 2009; Hjalmarsson, 2007; Lambie and Randell, 2013, Massoglia, 2008; Pridemore, 2014; Turney et al., 2012). African-American males are disproportionately profiled to be criminals and are frequently stopped and searched based on the perceived notion of wrong doing with many profiled persons subsequently developing symptoms of anxiety and PTSD (APA, 2017; Aymer, 2016). The development of mental illness as a result of this phenomenon may also lead to a cycle of violence as not only are people with mental illness disproportionately likely to be victims of police killings, but people with mental illness who are black are at the highest risk (Saleh et. al, 2018).

The field of psychiatry is uniquely positioned to play a role in improving relationships between law enforcement agencies and the black community with a focus on black males. The APA can lead the way in generating initiatives that help educate law enforcement agencies, as well as the black community at large, on the negative mental health impact of police brutality on black males. This includes the APA continuing to develop currently fostered relationships with the International Association of Chiefs of Police in order to strengthen relationships and encourage bidirectional dialogue between law enforcement agencies and mental health professionals. One such initiative that has been shown to improve relationships between law enforcement and the communities in which they serve, as well as reduce the odds of gang participation in youth, is the G.R.E.A.T. program, which is a school-based gang and violence prevention program for children in the year immediately before the prime ages for introduction into gang and delinquent behavior (Esbensen, 2012). It emphasizes the reduction of risk factors and the increasing of protective factors. Its curriculum includes cognitive-behavioral training, social skills development, refusal skills training, and conflict resolution (www.great-online.org, 2018). The APA should further study this program, and other programs with similar methodology, as a potential model for future initiatives that may help address the issue of police brutality on black males, and its resultant mental health implications.

Authors:
Council on Minority Mental Health and Health Disparities

References

1. American Psychiatric Association (2017). *APA Toolkit for Providers Treating African-Americans: Stress and Trauma Related to the Political and Social Environment*.
2. Aymer, SR. (2016). "I can't breathe": *A Case Study – Helping Black Men Cope with Race-Related Trauma Stemming from Police Killing and Brutality*. Journal of Human Behavior in the Social Environment. May; 18; 26 (3-4): 367-76.
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Position Statement on Mental Health Equity and the Social and Structural Determinants of Mental Health

Authors: Enrico G. Castillo, Helena Hansen, Evita Rocha

Issue: Unequal access to social resources perpetuate mental health disparities, particularly for patients and their families who belong to groups that are marginalized or under-resourced. Unequal allocation of resources and application of institutional and public policies worsen these disparities. *Social determinants of mental health* include social supports, employment, civic engagement, socioeconomic and educational status, discrimination, and mental health stigma among other factors. *Structural determinants of mental health* include the actions and norms of systems and policies, such as the economic, legal, political, and healthcare systems. *Health equity* is a public health paradigm and quality goal that aims to promote equitable access to health-related opportunities when needs are equal, provide enhanced opportunities when needs are greater, and address systemic issues that perpetuate inequalities.

The APA includes in its values statement "advocacy for patients" and "care and sensitivity for patients and compassion for their families." This position statement is relevant to the APA because understanding and improving the social and structural determinants of health involves sensitivity to the lives and environments of patients and families, and promotion of mental health equity represents leadership and advocacy in this area. Psychiatrists have a key role in promoting mental health equity in clinical care, research, education, interventions, administration and public policy advocacy.

Position

The American Psychiatric Association:

- Supports legislation and policies that promote mental health equity and improve the social and structural determinants of mental health, and formally objects to legislation and policies that perpetuate structural inequities.
- Advocates for the dissemination of evidence-based interventions that improve both the social and mental health needs of patients and their families.
- Urges healthcare systems to ~~build~~ assess and improve their ~~capacity~~ capabilities to screen, understand, and ~~improve~~ address the structural and social determinants of mental health.
- Supports medical and public education on the structural and social determinants of mental health, mental health equity, and related evidence-based interventions.
    - Urges medical school and graduate medical education accrediting and professional bodies to emphasize educational competencies in structural and social determinants of mental health and mental health equity.
    - Urges psychiatry residency training directors and other psychiatric educators to use systematic approaches to teaching about structural and social determinants of mental health.
    - Supports the training of psychiatrists, in graduate and continuing medical education, in best practices to address the structural and social determinants of mental health and promote health equity.
- Advocates for increased funding for research to better understand the mechanisms by which structural and social determinants affect mental illness and recovery and to develop new evidence-based interventions to promote mental health equity.

Background

Social factors, such as a person's income or social supports, and institutional and policy structures, such as educational and healthcare policies, have the potential to facilitate or obstruct individuals' paths to well-being and recovery. As such, it is vital for an organization like the American Psychiatric Association to advocate for greater understanding of these social and structural determinants of mental health and to urge action to reduce disparities and promote mental health equity.

The Model for Analysis of Population Health and Health Disparities by the Centers for Population Health and Health Disparities of the National Institutes of Health describes three categories of social and structural determinants of health disparities. Distal determinants include social conditions and politics; intermediate factors include physical and social contexts and relationships, and proximal determinants include demographics, behaviors, and biological factors at the individual level. Research has shown that social and structural factors can affect mental health outcomes and recovery. Relevant citations for emerging research, public policies, and initiatives are included below.

Broadly speaking, health equity has 3 aims: to promote equitable access to health-related opportunities when needs are equal (horizontal equity), to provide enhanced opportunities when needs are greater (vertical equity), and to address the systems issues that perpetuate inequalities. Health equity reforms are emerging across the country. Organizations including the Substance Abuse and Mental Health Services Administration, Centers for Disease Control, the American Medical Association, World Psychiatric Association, and the American Public Health Association have declared health equity to be central to their missions. This speaks to the importance of these issues for patients; their relevance to psychiatric practice, education, and training; and the need for advocacy by the American Psychiatric Association.

The American Psychiatric Association should advocate for healthcare and other public policies that promote mental health equity. This position statement is in line with the mission of the American Psychiatric Association's Division of Diversity and Health Equity. Promoting mental health equity and addressing the structural/social inequities are central to the eradication of disparities in mental health and healthcare. Psychiatrists should consider the structural and social determinants of mental health and recovery in their clinical care, research, education, interventions, administration and public policy advocacy.

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17.

APA Official Actions

Position Statement on Human Trafficking

Approved by the Board of Trustees, XXXX
Approved by the Assembly, November 2017

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

Issue: There are estimated to be 40 million victims of human trafficking worldwide; however, only 1% of victims have been identified[1,2]. One study indicates that 88% of human trafficking victims have been seen by a medical provider while in captivity[3]. Those who are identified have high rates of mental illness[3,4]. ~~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.~~

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. ~~1.~~ Because human trafficking is a complex issue with legal, social, economic, and educational impacts, the American Psychiatric Association encourages mental health providers addressing this issue to collaborate across disciplines.
3. ~~2.~~ The American Psychiatric Association advocates for increased education of mental health 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. ~~3.~~ 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. ~~4.~~ 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.)

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Position Statement on Conversion Therapy and LGBTQ Patients

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

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Issue:
Since 1998, the American Psychiatric Association has opposed any psychiatric treatment, such as "reparative" or conversion therapy, which is based upon the assumption that homosexuality per se is a mental disorder or that a patient should change his/her homosexual orientation[1]. This position statement updates and replaces previous position statements about conversion therapy regarding sexual orientation, furthermore it also comments on conversion therapy with gender diverse patients in an attempt to prevent harm to any lesbian, gay, bisexual, transgender, or queer person.

In the past, diversity of sexual orientation and gender identity (e.g. homosexuality, bisexuality, and transgender identities) were seen as a mental illness. This changed in 1973 when the American Psychiatric Association stated that homosexuality per se is not a mental disorder[2]. While Gender Dysphoria remains a part of the DSM-5, there is growing social acceptance that human sexuality and gender identity can present in a variety of ways as part of the human condition[3,4,5,6,7,8,9,10,11,12,13].

The validity, efficacy, and ethics of clinical attempts to change an individual's sexual orientation have been challenged[14,15,16,17,18]. The literature also consists of anecdotal reports of people who claim that attempts to change were harmful to them, and others who claimed to have changed and then later recanted those claims[19,20,21,22,23,24,25,26,27,28,29,30,31]. Along a similar vein, gender diverse patients have been shown to benefit from gender-affirming therapies[32,33,34,35,36,37,38,39.40], and given the documented harm of "reparative" or conversion therapies regarding sexual orientation, it would likely be seen as unethical to research reparative therapy outcomes with gender diverse populations.

While many might identify as questioning, queer, or a variety of other identities, "reparative" or conversion therapy is based on the a priori assumption that diverse sexual orientations and gender identities are mentally ill and should change.

POSITION:

1. APA reaffirms its recommendation that ethical practitioners refrain from attempts to change individuals' sexual orientation.
2. APA recommends that ethical practitioners respect the identities for those with diverse gender expressions.
3. APA encourages psychotherapies which affirm individuals' sexual orientations and gender identities.

4. APA encourages legislation which would prohibit the practice of "reparative" or conversion therapies that are based on the a priori assumption that diverse sexual orientations and gender identities are mentally ill.

Authors:
Council on Minority Mental Health and Health Disparities

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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).

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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.

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Title: Assessment and Treatment of Gender Dysphoria and Gender Variant Patients: A Primer for Psychiatrists

Byline: The American Psychiatric Association Workgroup on Treatment of Gender Dysphoria Members: William Byne, M.D., Ph.D. (chair), Eli Coleman, Ph.D., A. Evan Eyler, M.D., M.P.H, Heino Meyer-Bahlburg, Dr. rer. nat., Dan Karasic, M.D., Jeremy D. Kidd, M.D., M.P.H., Richard Pleak, M.D., Jack Pula, M.D.

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Corresponding Address:
William Byne, M.D., Ph.D.
Research Bldg. Room 5F-04B
James J Peters VA Medical Center
130 West Kingsbridge Road
Bronx, NY 10468
Phone: (718) 584-9000, ext. 6046
Email: william.byne@mssm.edu

Abstract

Regardless of their area of specialization, adult psychiatrists are likely to encounter patients who are transgender; however, medical school curricula and psychiatric residency training devote little attention to caring for these patients. The primary aim of the present article is to assist adult psychiatrists who do not specialize in transgender clinical care in the delivery of respectful, clinically competent and culturally attuned care to gender variant patients including those who identify as transgender or transsexual or meet DSM-5 criteria for the diagnosis of Gender Dysphoria. The following are reviewed: The history and evolution of conceptualizations of gender variance, its classification and related terminology including differences between DSM-IV and DSM-5; the prevalence of transgender identity and Gender Dysphoria; the influences of biological and psychosocial factors on gender development; the clinical assessment and treatment of Gender Dysphoria in adults; and current societal trends, including increased societal acceptance of gender variance, legal protections for gender variant individuals and increased access to gender transition services.

Transgender and other gender variant people are sufficiently common that adult psychiatrists are likely to encounter such patients regardless of the area in which they practice; however, medical school curricula and psychiatric residency training have devoted little attention to assessing and caring for their needs (1, 2). In recognition of this deficit in provider training and its contribution to transgender health disparities (3, 4), calls for increased training have been made by several distinguished and authoritative bodies including the Institute of Medicine (5), the Department of Health and Human Services (6), the American Psychiatric Association (7), and the Association of American Medical Colleges (2). Even when implemented, such curricular enhancements will not address the needs of psychiatrists who have already completed their training.

The primary aim of the present article is to assist adult psychiatrists who do not specialize in transgender clinical care in the delivery of clinically competent, respectful and culturally attuned care to transgender patients. The article should also be helpful to other practicing mental health professionals and those in training. Caring for transgender patients entails providing a welcoming and affirmative clinical environment, conducting accurate diagnostic assessments, providing appropriate evidenced-based treatment and making necessary referrals when specialist care is needed including referrals to hormonal and surgical providers for those desiring such services in their gender transition.

We begin with a review of the history and evolution of conceptualizations of gender and gender variance, its classification and related terminology, including differences between DSM-IV and DSM-5. We then examine the prevalence of gender variance and what is known about its development before turning to the clinical assessment and treatment of gender dysphoria in adults, including those with intersex conditions. We conclude by examining current societal trends including increased social acceptance of gender variance, protections for gender variant individuals and increased access to gender transition services for adults. Specific guidance on these matters for child and adolescent psychiatrists can be found elsewhere (8). Definitions of key terms can be found in Table 1.

Insert Table 1 about here

History

Nineteenth and 20th century theories of gender variance and views of appropriate treatment were pathologizing and highly stigmatizing to transsexual people. While mainstream psychiatry is now more affirming of gender variance, transgender individuals often are aware of the past and may seek psychiatric care with trepidation. In addition, our patients are likely to have encountered providers who adhere to outdated stigmatizing theories and approaches to treatment. Therefore, it is important to be aware of this history.

People who we might call transgender today are evident in historical records since ancient times and some transitioned socially to live as members of the other gender prior to the availability of hormonal and surgical treatments for somatic transition (9-11). As reviewed elsewhere, the first documented use of isolated sex hormones for both male to female and female to male gender transition occurred in the 1930s (12, 13). Prior to that, attempts had been made to transplant gonads with the hope of manipulating secondary sex characteristics (14). The first gender confirming surgeries (aka *sex reassignment surgeries*) in the West were performed in Germany in the 1920s and 30's for feminizing surgeries and in the 1940s for masculinizing surgeries (13).

In the 19th and early 20th century, theorizing about what is now recognized as transgender phenomena was not distinguished from theorizing about what is today referred to as homosexuality (15). For example, the mid-19th century German lawyer and human rights activist, Karl Heinz Ulrich, hypothesized that some men were born with a woman's spirit but a male body. He believed these individuals constituted a third sex and called them urnings (16). While historians of homosexuality often regard Ulrichs' urnings as homosexual men, a female spirit in a male body closely resembles the narratives of 20th century theories of transsexuality. Until the middle of the 20th century, transgender presentations were, with rare exceptions, viewed as psychopathological, and Richard von Krafft-Ebing reinforced this view in his landmark publication, *Psychopathia Sexualis*, an early psychiatric diagnostic manual (17). There he documented cases of individuals who desired to live as members of the other sex and those who had been born as one sex and were living as members of the other, and referred to such presentations as "metamorphosis sexualis paranoia."

In the early 20th century, greater attention focused on both sexual and gender variance with the emergence of the field of sexology, notably in the work of Magnus Hirschfeld and his Institute for Sexual Science (18). A German physician and sexologist, Hirschfeld is credited with being the first to distinguish homosexuality from transsexuality, which he referred to as

"Transvestitismus" (19). Those distinctions, however, were not broadly accepted until decades later. Hirschfeld assisted surgeons in Europe who were already experimenting with gender reassignment surgery in the 1920s and advocated for the rights of both homosexual and gender variant individuals (16).

Harry Benjamin, a mid-century pioneering endocrinologist and sexologist, is credited with both popularizing the term *transsexual* in its current usage and for raising awareness about transsexual individuals within the medical profession. He offered hormone treatment at a time when mainstream physicians, including psychiatrists, regarded transsexual individuals as confused homosexuals, people with perverse fetishes, or delusional individuals in need of psychotherapy (20-25). Benjamin challenged the view that transsexuality was amenable to treatment with psychotherapy. He believed instead that treatment was primarily within the purview of medicine and that the aim of treatment should be to better align the physical body with one's gender identity. He had a complex theory that gender identity develops through early conditioning and associated psychological factors added to a foundation of the biological products of chromosomes and hormones. In his view psychological treatment could not change that foundation, although it might improve one's level of psychosocial functioning. His belief in the futility of psychotherapeutic attempts to change gender identity was pioneering at the time. His book, *The Transsexual Phenomenon* (26), was immensely successful in describing and explaining the gender-affirmative treatment path he pioneered. The possibility of gender transition seized the American popular imagination in 1952 when Christine Jorgensen, a former American armed services member, returned to the U.S. after transitioning from male to female in Denmark (25). The publicity surrounding Jorgensen's transition eventually led to greater popular, medical, and psychiatric awareness of transsexuality and increased public discussions of gender reassignment. Nevertheless, many medical and mental health professionals remained critical of offering hormonal and surgical transition procedures to treat people suffering from what they perceived to be either a severe neurotic or psychotic mental disorder [e.g., (20-25)].

The first two editions of the DSM (1952 and 1968) did not include any gender diagnoses (27). The psychiatric diagnosis of Trans-sexualism (sic) first appeared in ICD-9 in 1975 (28), and in 1980, DSM-III included Transsexuality, Gender Identity Disorder (GID) of Childhood, and Atypical Gender Identity Disorder, which were stated to be associated with moderate to severe coexisting personality disturbance (29). An etiologic link was suggested with disturbed parent-child relationships, which had been observed in limited clinical samples but were not a

generalizable characteristic (29). American psychiatrists, most notably, Robert Stoller, Ira B. Pauly, and Richard Green were proponents of Benjamin's more affirmative model of treatment. Proponents of this model founded the Harry Benjamin International Gender Dysphoria Association (HBIGDA) in 1979, renamed in 2006 the World Professional Association for Transgender Health (WPATH). The organization has produced seven iterations of standards for transgender care since 1979.

Up to forty university-based U.S. gender identity clinics opened between 1963-1979 (15, 25). These gender identity clinics provided interdisciplinary care that included psychiatrists and other mental health professionals, with the aim of assimilation and integration of transsexual individuals into the heterosexual cisgender world (15). Therefore, the clinics employed rigid selection criteria that excluded many transgender people, e.g., the ability of the patient to pass as a member of the experienced gender socially, vocationally and sexually (24, 25). In 1979 a follow-up study was published claiming that gender confirming surgery confers no objective advantage in terms of social rehabilitation (e.g., economic situation, "gender appropriate" cohabitation or marriage, current psychiatric treatment) (30). This study was used to justify the closure of Johns Hopkins gender clinic, despite the fact that the study also reported evidence of improved subjective sense of well-being post transition (30). Closure of other gender clinics followed a 1981 decision of the U.S. Department of Health and Human Services labeling transsexual surgery as experimental (31).

The university-based gender clinics played an important role in the provision of medical services to transgender people and in promoting research to improve that care (15, 25) . In the wake of the closure of the academic gender clinics in the U.S., transgender people came to rely on a loose network of medical and mental health providers, often affiliated with HBIGDA/WPATH. With transition services now offered outside of university-based clinics, U.S. medical schools and residency training programs offered little exposure to the provision of this care, leaving psychiatrists and other physicians poorly prepared for the growth in demand for transgender services seen in recent decades (1). In the early 1990's, starting at Tom Waddell Health Center in San Francisco, medical providers developed the "informed consent model" (see section on Assessment and Treatment) in which hormone treatment can be initiated by experienced primary care providers, in most cases without evaluation by a mental health professional. WPATH SOC 7 formally recognized informed consent in 2011 and the model has been replicated across the country and is increasingly available.

In 1994 the DSM-IV replaced Transsexualism with Gender Identity Disorder (GID) in adolescents and adults (32). Retention of the diagnosis by the DSM and its new name including the word "disorder" were perceived by advocates and some healthcare providers as stigmatizing and contributing to societal discrimination (33). DSM-5 work-groups began to deliberate in 2008 whether or not to continue to classify the entity as a psychiatric disorder, and, if so, what to call it. Advocates in favor of retention worried that complete removal of a coded diagnosis for medical classification and billing purposes would limit access to transition care, deny the full impact of dysphoria, and harm transgender individuals who experienced dysphoria (34). Ultimately, the diagnostic entity was retained but its name changed to Gender Dysphoria (GD) (35). Use of this diagnostic label requires that a person meets the specific criteria listed in DSM-5. This is distinctly different from the generic use of the term, *gender dysphoria*, which refers to the distress caused by a discrepancy between one's experienced gender and one's assigned gender, whether or not full DSM criteria for GD are met. For clarity here, specific references to the diagnostic entity in this paper will be capitalized or abbreviated (i.e., Gender Dysphoria or GD).

The name change from "Gender Identity Disorder" to "Gender Dysphoria" (36) shifted the focus to the *dysphoria* as the target of diagnosis and treatment rather than *identity* itself. Its retention in DSM-5 preserved diagnostic justification for care and access to third party reimbursement. In DSM-5 the diagnostic criteria were revised so as to include those whose identities fall outside the gender binary (i.e., those who identify their gender as something other than male or female) who had been excluded in the past. In addition, unlike previous versions of the DSM, individuals with intersex conditions also are not excluded from receiving the diagnosis in DSM-5. It is important to note that the GD diagnosis is given only to those who exhibit clinically significant distress or impairment associated with a perceived incongruence between their experienced/expressed gender and their assigned gender, and does not apply automatically to people who identify as transgender. For those who do meet criteria and undergo social and medical transition, active symptoms of GD often lessen or resolve. DSM-5 includes a post-transition specifier that applies to those requiring ongoing care (e.g., hormonal replacement therapy).

To avoid the stigma associated with psychiatric diagnoses, the International Classification of Diseases (ICD) has proposed to replace the ICD 10 diagnosis "Gender Identity Disorder," with "Gender Incongruence" in its next edition (ICD 11) and to move the diagnosis

out of the section on mental and behavioral disorders to a new section, “Conditions related to sexual health” (37).

Epidemiology

Epidemiological research has employed different measures of transgender populations resulting in varying prevalence rates. Some studies measure the fraction of a population which has received the DSM-IV diagnosis of GID or the ICD 10 diagnosis of Transsexualism, both of which include clinical populations who seek binary transition (male-to female or female-to male). The prevalence reported in DSM-5 ranged from 0.005% to 0.014% for transgender women, and 0.002%-0.003% for transgender men; these estimates were based on people who received a diagnosis of GID or Transsexualism, and were seeking hormone treatment and surgery from gender specialty clinics and, therefore, underestimate the prevalence of all individuals with gender dysphoria or who identify as transgender (35). The prevalence of transgender people receiving gender specialty care in the Netherlands has been estimated at 1:11,900 (0.008%) for transgender women and 1:30,400 (0.003%) for transgender men (38). More recent data of those obtaining surgery in Belgium were similar (39). In Sweden, the prevalence of people seeking surgical and legal gender change has been increasing, especially since 2000; point prevalence in December 2010 was 1:7,750 (0.013%) for transgender women and 1:13,120 (0.008%) for transgender men (40). A somewhat higher percentage, 0.023%, received a diagnosis of GID recorded in the health records of the U.S. Veteran’s Administration (41).

Other studies, rather than measuring the proportion of a population which received a clinical diagnosis, have reported on those who self-identified as transgender or gender incongruent, and found that measuring self-identity yields much larger numbers. In a large Massachusetts population-based phone survey, 0.5% of the population (age 18-64) identified as transgender (42). In another large population-based survey in the Netherlands, 1.1% of those assigned male at birth (age 15-70) reported an incongruent gender identity (stronger identification with a gender other than the one assigned at birth), as did 0.8% of those assigned female at birth (43). Recent surveys of youth showed even higher numbers. In New Zealand, 1.2% of high school students surveyed identified as transgender (44). In a survey of San Francisco middle school students (grades 6-8), 1.3% identified as transgender (45). More study is needed, but these larger numbers may indicate that many transgender people have not been

counted in clinical studies, including those with non-binary identities, those not seeking transition care, those receiving hormones outside of clinics specializing in transgender care or by self-administration, and others who identify as transgender when surveyed but do not report gender dysphoria to clinicians. When considering studies and literature that cite prevalence estimates for transgender identity and/or gender dysphoria, one should be cognizant of what is actually being measured (e.g., surveys of self-reported gender identity, clinical records of those receiving the diagnoses of GID or GD or requesting transition services) and how that may narrow or widen the estimate. This must be considered when subsequently translating the prevalence estimate into clinical and epidemiological applications.

Development

The chain of processes of sexual differentiation of body, brain, behavior, and development of gender identity is highly complex and only partly understood (46). Given that all mammals, including humans, reproduce sexually, it is no surprise that features of body, brain, behavior, and identity that are related to reproduction show bimodal distributions in the population. As many factors contribute to these processes, it is also no surprise that there are many people who fall between the two poles on one or more of the systems and variables under consideration.

Biological factors

The mammalian embryo is initially sexually bipotential**.** Early in gestation, "sex determination" occurs, i.e., the differentiation of the bipotential gonadal anlagen into either ovaries or testes. This depends on a complex of interacting factors encoded by numerous genes, including the so-called testis-determining gene SRY, which is normally located on the Y chromosome (47). Subsequently, testicular secretions orchestrate the differentiation of the male internal and external genitalia. Mullerian inhibitory substance, also from the testes, induces regression of female internal genital structures, whereas the 5 alpha-reduced metabolite of testosterone, dihydrotestosterone (DHT), is necessary for the differentiation and development of male external genital structures. In addition, typical male somatic development requires androgen sensitive receptors to mediate androgen's actions on gene expression. In the absence of the cascade set in motion by SRY, female differentiation usually occurs.

The ovary is relatively quiescent prenatally, but secretes substantial amounts of estradiol for the first 6 to 12 postnatal months; thereafter, the gonads are inactive in both sexes until sex-characteristic hormonal profiles emerge with the onset of puberty. During puberty, the development of secondary sex characteristics depends to varying degrees on the type and amount of steroid sex hormones available in the fetal circulation and their interaction with corresponding steroid-sensitive receptors and genes.

Highly sex-atypical variations in sex steroids, their receptors, or in the genes involved are associated with atypical sexual differentiation of the reproductive tract, and/or the external genitalia as well as of the secondary sex characteristics, resulting in intersex conditions (48).

Similarly, the sexual differentiation of the brain (49, 50) and, subsequently, of gendered behavior is influenced by steroid sex hormones (51) although the number of genes involved in brain differentiation is very much higher than the number involved in gonadal differentiation (52, 53). The role of androgens has been documented in both individuals without intersex conditions but with known variations in the normal range of prenatal androgens as well as in individuals with intersex conditions, including both 46,XX individuals with excess production of prenatal androgens (e.g., in association with adrenal hyperplasia) who exhibit masculinized behavior and 46,XY individuals with reduced androgen synthesis (e.g., due to gonadal dysgenesis) or reduced androgen receptor sensitivity who exhibit a reduction in masculinized behavior (54).

Psychosocial factors

In non-human mammals, and much more so in humans, psychological and social factors have a major additional influence on the behavioral outcome (55) . These psychosocial processes in humans include the verbal labeling (e.g., "boy", "girl") and nonverbal gender-cuing (e.g., gender-specific clothing and haircuts) of children by parents and others in their social environment and the shaping of gendered behavior by positive and negative reinforcement and later by explicit statements of gender-role expectations. On the part of the child, psychosocial influences include gender-selective observational learning/imitation, the formation of gender stereotypes and of related self-concepts, and self-socialization. The effects of such psychosocial factors on normative gender development have been documented in a vast body of research in developmental psychology (55). However, such psychosocial factors on their own have not been shown to cause long-term shifts in gendered behavior as strong as those seen in

individuals with severe intersex conditions or in transsexual individuals without these conditions.

Factors in gender-identity development

Systematic data on gender-identity development are much more limited than those on gendered behavior. Yet, the data available, especially for those with intersex conditions, lead to the conclusion that a definitive biological predetermination of gender identity seems unlikely. Not a single biological factor, but multiple factors (i.e., biological, psychological, and social) appear to influence the development of gender identity (56).

The development of gender dysphoria and gender transition in individuals without intersex conditions is even less well understood (57). Along with the dramatically increased referrals of gender variant individuals to specialized clinics in Western Europe and North America over the last two decades (58, 59), there has been a diversification of presentations beyond the original 'transsexual' who sought change to the 'other' gender via treatment with cross-sex hormones and surgeries. Currently many transgender people seek chest but not genital surgery, or only cross-sex hormones, or only a social transition without any medical changes. Many reject the confinement by the binary gender system altogether and simply desire flexibility in gender expression without formal transition to "the other gender", as, for instance, connoted by the self-label 'genderqueer' (60, 61).

Prospective follow-up studies of children who initially had met criteria for the diagnosis of GID) (replaced by GD in DSM-5), showed that the majority of those with onset of GID in early or early-middle childhood "desisted," i.e., did not continue with GID through adolescence and adulthood, but accommodated to their originally assigned ("natal") gender, frequently in combination with the development of a homosexual orientation (relative to their natal gender) in adolescence. Some of these "desisters", however, transitioned later in life (62). The data available do not allow a clear prediction before puberty of which child will persist and transition permanently, and which child will not (63). It is conceivable that with the introduction of stricter criteria for the diagnostic category of GD in DSM-5, the persistence rate will be higher (62), but this needs to be tested by future long-term follow-up studies. In many transgender women, cross-gender expression and identity develop later in adulthood, in some cases preceded by fetishistic cross-dressing in adolescence and with sexual arousal associated with seeing, imagining, or thinking of themselves dressed as a woman, a phenomenon termed

autogynephilia (64). This concept of a fetishism-related developmental pathway to transsexualism, however, is the focus of a major disagreement in the field (65, 66) . Regardless of their initial sexual orientation, during and after transitioning to their experienced gender, some individuals retain their pre-transition sexual attraction patterns, while others change, and the determinants of either trajectory are not well understood. Importantly, gynephilic attraction and a history of fetishistic arousal do not exclude natal males from eligibility for gender transition services according to current standards of care (67).

In regard to the biological factors that may contribute to the development of gender variance, some individual small-sample studies of transsexuals have produced suggestive findings of (modest) variations in sex steroids, steroid receptors, or steroid-enzyme genes, but overall the results have been inconsistent and/or currently lack replication (46). Thus, at this point, the evidence is insufficient for categorizing transgender identity as a form of CNS-limited intersexuality. Suggestive results have also come from individual neuroanatomic and neurofunctional studies of transsexuals; yet, all are still in need of high-quality replication studies by independent investigators (68, 69). Moreover, the available studies typically show considerable overlap between transsexuals and cisgender controls in the neuroanatomical or neurofunctional indicators of interest, so that they do not yet offer any clinical utility for diagnosis, prognosis, or treatment decisions.

Assessment and Treatment

Presentations

Transgender adults present for psychiatric services for a variety of reasons. Specific aspects of the assessment and type of treatment offered depend on the nature of the clinical concerns. Data are lacking regarding the relative commonality of reasons for seeking mental health care among transgender adults receiving these services. The literature regarding particular clinical presentations, such as consultation with adults seeking to obtain hormonal and surgical services, is extensive; however, many people who are transgender pursue psychiatric treatment for reasons that may be unrelated to their gender identity and gender expression, such as primary psychiatric illnesses (e.g., bipolar disorder), or partially related, such as the sequelae of childhood trauma.

Transgender presentations commonly seen in psychiatric practice include the following (7, 67): Exploration of identity and life direction, including gender identity and expression; treatment of the distress associated with experiences of gender-related abuse and stigmatization, and their sequelae; assistance in managing the process of gender transition, which may be similar to adjustment concerns that may arise in other multifaceted life changing processes; couple or family treatment, which may or may not be related to gender transition; consultation prior to initiation of hormonal treatments, surgical procedures, and at other crucial points in the gender transition process; consultation on referral from another mental health professional, endocrinologist, or primary care clinician for evaluation of potential co-occurring psychiatric illness; treatment of conditions related to gender dysphoria, such as depression or substance abuse; and treatment of co-occurring psychiatric conditions unrelated to the gender dysphoria.

Psychiatrists should be aware that transgender identity and other forms of gender variance are no longer considered evidence of psychological pathology, but are now regarded as aspects of human diversity (7, 8, 35). Psychiatric symptoms experienced by people who are transgender may be evidence of distress related to chronic stigmatization, often referred to as "minority stress" (70, 71); GD in need of treatment; or co-occurring illness, such as bipolar disorder or major depressive disorder. The autism spectrum disorders may be more prevalent among transgender children and adults than among their cis-gender peers (72, 73). Psychiatrists who work on transgender treatment teams often play a crucial role in the evaluation and treatment of patients with co-occurring serious or persistent mental illness.

Assessment

Clinical evaluation of adults with gender dysphoria is currently based on expert consensus (67, 74) and varies with the nature of the clinical concern. Persons whose gender transition occurred many years ago and who are seeking treatment for another problem may need much less attention to the gender history (awareness, identity development, expression) than those who are beginning gender transition and exploring options for subsequent gender presentation. Earlier life experiences of "gender shaming" and punishment may again become relevant in later crises; conversely, some people find over-emphasis on previous gender experiences inadvertently stigmatizing. It is important to avoid the assumption that co-existing mental health symptoms are due to GD unless that relationship is clear. There are no formal

guidelines for evaluation of clinical concerns that are not directly related to gender dysphoria or gender transition; usual clinical principles apply in those situations. Some people with GD develop the belief that depression or other problems will resolve with transition, though that may not occur. It can be useful to discuss the multi-factorial etiologies of psychiatric illness, such as depression, early in the course of treatment, and to establish clear goals.

Practice guidelines have primarily focused on clinical evaluation as part of the gender transition process. Aspects of the evaluation (and early phases of treatment) recommended in the WPATH Standards of Care and other sources include the following [italicized headings from the WPATH SOC 7 (67)]:

Assessment of the gender dysphoria: Useful areas of exploration may include age of awareness of gender difference from same-sex peers; experience of negative affect or self-perception (e.g., dysphoria) related to gender difference, distress with development of unwanted secondary sex characteristics during puberty, or associated concerns; experiences of gender-related shame and stigmatization; associated mental health symptoms and coping mechanisms; management of gender expression over the life course, and sources of support, such as family, partners, and transgender peers. Exploration of factors such as educational achievement, employment, peer and romantic relationship history and parenting can provide needed context for this information.

Providing information regarding options for gender identity and expression, and possible medical interventions: Many adults seeking medical services in support of gender transition are already quite knowledgeable about the potential effects of hormonal and surgical treatments, as well as possibilities for gender transition, nonconforming gender expression, and other alternatives. However, inaccurate information is also readily available on-line and through other sources, and a detailed discussion is usually warranted. This discussion can also foster the development of a therapeutic environment that will facilitate progress from consideration of options to readiness to take action to address the dysphoria in a manner that will increase life satisfaction and self-esteem. Persons who reside in rural areas may also lack in-person peer support and experience greater need for affirming, face-to-face discussion about gender experience and choices for expression.

Assess, diagnose, and discuss treatment options for coexisting mental health concerns: Adults who are transgender or gender nonconforming may suffer from psychiatric illnesses that are related to the GD itself, such as depression and anxiety disorders; to maladaptive coping,

such as substance abuse and eating disorders, or to experiences of maltreatment or victimization. In one recent epidemiological study conducted in 4 European countries, mood and anxiety disorders were significantly more common among transgender adults than in the general population, with combined lifetime prevalence approaching 70% (75). Children who are nonconforming in gendered appearance or behavior are often bullied or abused in other ways, and adults may suffer from posttraumatic stress disorder or other sequelae.

Gender transition can be successfully managed despite co-occurring psychiatric illness in most cases, but will usually require extra support and multidisciplinary clinical care. Medical education and psychiatric training can provide an excellent background for developing expertise in managing psychiatric medications in cases involving concurrent use of estrogen or testosterone preparations; differentiating between hormonal effects, medication effects, unrelated subjective experience and psychiatric symptoms; and distinguishing between gender concerns that may arise as epiphenomena of serious mental illness from GD; and treating co-occurring psychiatric illness during transition. Cases have been reported in which delusions about sex and gender occurred as a result of major mental illness and abated with treatment (76, 77) but these are rare. Most people seeking treatment of GD are in fact suffering from that condition, with or without mood and anxiety symptoms. Comprehensive psychiatric evaluation is crucial in cases involving GD and co-occurring serious mental illness.

If applicable, assess eligibility, prepare and refer for hormone therapy/surgery or surgeries: Most surgeons and insurers require mental health evaluation prior to gender transition-related surgeries; specifics vary between different practices and plans, but often include documentation from a psychiatrist or doctoral level psychologist. Documentation of the WPATH SOC 7 criteria of persistent “gender dysphoria,” capacity for informed consent and the sufficient control of co-occurring mental and physical health conditions may be done by the mental health provider or an experienced primary care provider prior to beginning hormone therapy (2). Current criteria for GD (35) should be used. Surgical criteria are similar, though genital procedures are usually not performed prior to hormone therapy of 12 months’ duration. Fertility preservation, such as cryopreservation of sperm, should also be discussed (78). WPATH SOC7 criteria for referral for gender confirming hormone treatments and surgeries are shown in Table 2.

Insert Table 2 about here

Treatment

The Report of the American Psychiatric Association Task Force on Treatment of Gender Identity Disorder (7) concluded that with subjective improvement as the primary outcome measure, the existing evidence base combined with clinical consensus is sufficient for the development of a psychiatric practice guideline for adults with GID. Areas for specific recommendations were similar to those listed above, plus distinguishing between GID with concurrent psychiatric illness and gender manifestations that are not part of GID but epiphenomena of other psychopathology; educating family members, employers and institutions about gender variance, and additional specifics regarding clinical and administrative documentation (DSM-IV-TR terminology was used in this document).

Specifics of clinical practice can be somewhat flexible depending on resource availability. The objective of treatment is alleviation of emotional distress and improvement in quality of life. Meaningful outcome measures concern subjective improvement and lack of regret regarding medical interventions, such as hormone treatment effects and surgeries (7), as gender dysphoria is a subjective experience without any reliably associated biomarker.

Treatment of GD is individually based. Psychotherapy is often useful, such as for the concerns described above. However, many people successfully transition gender with little or no psychotherapy. Many transgender adults need some combination of hormonal treatment and surgical procedures for relief of GD, but some experience relief with change in gender presentation or expression without any medical treatment or with adjustment in hormonal profile without surgery. In addition to those described above, some aspects of treatment include:

Assessment of suicide risk and suicide prevention. This is especially important during periods of heightened vulnerability, such as when the identity is disclosed to family, and more broadly (7, 79). Terada et al. (80) And Heylens et al. (75) suggest that gender dysphoria may be a risk factor for suicidality, independent of other psychiatric conditions. Suicide prevention may include psychotherapy with a "trans-positive" perspective, community support, and treatment of depression or other psychiatric illness with pharmacotherapy and other somatic modalities, or hospitalization, as indicated. Psychiatrists who provide inpatient care are often able to promote education and training about transgender and gender variance for the members of the medical, nursing and therapy staffs. Similarly, psychiatrists who refer to therapists (e.g., for

dialectical behavioral therapy or cognitive therapy) may need to provide education to those who lack experience working with transgender patients.

Facilitation of hormonal treatment. Though supplementation of estrogen, or testosterone, carries a risk of significant medical complications (74) both have been associated with alleviation of mood and anxiety symptoms in treatment of GD (81, 82). In addition to assessing appropriateness of hormonal treatment, as described above, psychiatrists can take an active role in educating patients about the effects of hormonal change and safe use of hormonal preparations, and can advocate with insurance carriers for coverage of these medications.

Facilitation of surgical treatment. Similar data regarding alleviation of specific psychiatric symptoms through gender confirming surgeries alone is not available, but review of the available literature (7) demonstrates both the benefit of surgery in alleviating GD and the rarity of postsurgical regret. Discrimination by insurance carriers has been rampant over time, as demonstrated by specific transgender exclusions, despite the opposition of the American Psychiatric Association (83) and other professional organizations (e.g., (67, 84)). For example, many plans cover hysterectomy if performed for a variety of non-malignant gynecological conditions, but not for treatment of GD among transmen. Though some progress has been made in recent years, additional advocacy is needed, both on behalf of individual patients and systemically, as will be discussed at the end of this paper.

Advocacy within the hospital or health system environment. Many transgender persons report negative experiences in hospitals, clinics and mental health centers (3). In addition to anti-transgender discrimination by members of the health professions and support staffs, structural problems also create difficulties for gender nonconforming people. The use of electronic health records can be problematic due to the binary (male/female) gender signifiers available in the software menus, the relative lack of privacy, and the difficulty in limiting who has access to the gender history, including history of gender transition. Psychiatrists and other professionals who work in large health systems can draw attention to these problems and help to facilitate improvement in the details of the electronic record. Other health system problems, such as the need for education about gender identity among persons in support services, including patient registration and financial services, and fair handling of complaints, can often be addressed through offers of assistance by members of the professional staff, including psychiatrists.

Insert Text Box (A welcoming environment and culturally competent care) Here

Provision of mental health care over time. Many transgender persons seek mental health treatment on an intermittent basis, such as while contemplating gender transition, at key points in the transition process, and subsequently, if symptoms worsen or important events occur. The knowledge that the psychiatrist remains available when needed is often helpful in maintaining stability and making personal progress over time.

Gender variation represents a normal aspect of human diversity, but GD can cause significant suffering and require treatment. Psychiatry provides a unique combination of medical and mental health education and skills that can be valuable in the care of people who are exploring gender identity, transitioning gender, or needing treatment for co-occurring psychiatric illness. Clinical consensus documents can offer general guidelines for care, though additional research will be helpful in providing more specific guidance over time. Treatment of GD should be patient centered, clinically flexible and individually determined.

Gender Variant Patients with Intersex Conditions

GD and patient-initiated gender transition occur with increased frequency in individuals with intersex conditions (85). They may develop from late pre-school age through late adulthood and vary from 0% to about two thirds of such persons, depending on the specific intersex syndrome, its severity, the gender originally assigned, and the postnatal sex-hormone history (86). GD in individuals with intersex conditions differs from GD in the absence of an intersex condition in presentation and clinical context including medical implications (87). Persons with the combination of GD and intersex condition encounter fewer barriers to legal gender reassignment, and the barriers to hormonal and surgical treatments are much lower, because hormone administration is often required as part of routine intersex care, infertility is quite common, and gender-assignment confirming genital surgery frequently performed already in infancy or early childhood, followed by additional surgical modifications in adolescence or young adulthood. Decisions regarding hormonal and surgical procedures are complicated by the highly variable somatic presentations of the many diverse intersex conditions. Thus, to be fully effective, the mental-health provider needs to be informed about the medical aspects of the condition at hand (e.g., (48, 88) as well as about the available data on long-term gender development and other psychological outcomes of such patients (e.g., for congenital adrenal hyperplasia (CAH) (89)). Moreover, intersex conditions are frequently associated with stigma,

which may result in shame and maladaptive coping mechanisms on the part of the patients as well as their parents, and even in medical settings (90).

Gender Evaluation

In DSM-5, the diagnostic category, GD, has been re-defined and now also applies to patients with intersex conditions (35). The questionnaires and interview schedules developed for the assessment of gender development in transgender individuals who do not have an intersex condition (91, 92) apply to those with these conditions as well, but need to be complemented by detailed medical, surgical, and related psychosocial histories including the histories of disclosure to the patient of her/his medical condition and surgical history and the patient's understanding of the implications.

Decisions on Gender Reassignment

For patients with intersex conditions, GD usually raises the question of transition to the "other" gender, and all issues of relevance to transgender persons without these conditions should also be considered here. Yet, the situation is often more complex than in transsexuality in the absence of an intersex condition. Factors contributing to such decisions, apart from the gender-behavior history, may be the awareness of the discrepancy between assigned gender and biological factors such as chromosomes or anatomic factors such as gonads, gender-atypical secondary sex characteristics such as breast development in males or hirsutism and masculine body built in women, and related psychosocial effects like being misidentified as the other gender or frank stigmatization. Different cultures and even subcultures within a given country may differ in the roles (including rights) associated with either gender, and in the salience and weight of criteria used in decision making on gender reassignment (93). When discussing gender options, clinicians need to consider the legal regulations of the country they work in as well as the religious and other ideologies that can influence the gender perspectives of parents and patients, especially when those are immigrants or visitors from foreign countries; thus, both a detailed exploration of parents' and patients' viewpoints as well as their psychoeducation about gender and issues related to their intersex condition need to be included (56).

As other transgender patients do, patients with a intersex condition and gender dysphoria also may benefit from a detailed discussion of the patient's expectations from the gender transition: the social effects from public gender change as well as the medical and social

effects of the attendant changes in hormone treatment and, if desired, of genital surgery. Some of the expectations may be quite unrealistic, and after detailed discussion, some patients may desire only some hormonal and/or surgical changes, or decide against physical and legal gender change altogether and pursue other ways of resolving gender-related concerns.

Medical treatments

Many patients with both an intersex condition and GD will be agonadal in later adolescence or adulthood, either because they were born that way (e.g., in syndromes involving gonadal dysgenesis) or due to surgery, for instance, for the prevention of gonadal malignancy. In those with intact gonads (especially 46,XX CAH raised female), loss of fertility may be another issue for consideration. Persons who are agonadal are usually on hormone replacement therapy by the time of late adolescence. Cessation of that treatment, change to treatment with hormones of the other gender, patient education for informed consent, and the monitoring of treatment effects is the task of the endocrinologist. Also, the technical aspects of genital surgery are more complex than in patients receiving gender confirming genital surgeries who do not have intersex conditions. Both the external genitalia and the internal reproductive tract in intersex conditions typically differ from what most surgeons are familiar with in transgender patients without these conditions. In addition, many patients with intersex conditions have already undergone one or more genital surgeries by late adolescence. The resulting postsurgical anatomy constitutes an additional challenge for the surgeon performing gender confirming surgery, and a good sex-functional outcome may be even more difficult to achieve.

Support groups

As is often seen in individuals with uncommon medical conditions, many people with intersex conditions experience varying degrees of isolation and loneliness. Therefore, linking them to existing intersex support groups by internet or face-to-face meetings can be very beneficial. Despite the emotional relief that support groups can provide, such contacts may sometimes cause additional concerns. For instance, the composition of the group (e.g., the syndromes represented within the group, the personalities of some group members, or the goals of the group) may not meet the individual's expectations, and the information provided may not always be accurate. Thus, some monitoring of the patient's experience with the chosen group is recommended.

Current Social Issues: Stigmatization and Access to Care

Transgender health advocates have worked to address societal discrimination against transgender people, including stigmatization of identity, discrimination in schools, workplaces, and health care, and to improve access to care. Increasingly, this advocacy has been embraced by major institutional and governmental agencies.

One large online survey, the National Transgender Discrimination Survey (3) showed that rejection, discrimination, victimization, and violence against transgender people occur in a multitude of settings and negatively affect transgender people across the life span. Transgender youth are often harassed and assaulted in schools, which is associated with dropping out and subsequent impoverishment. Many transgender people are harassed at work or lose jobs due to their gender identity and expression. Discrimination extends to health care settings, where patients may be refused care or treated disrespectfully, or do not have access to care.

U.S. public policy has contributed to the lack of access to care. A report by the National Center for Health Care Technology of the HHS Public Health Service issued in 1981, titled "Evaluation of Transsexual Surgery," deemed these procedures "experimental," and recommended that Medicare not cover transition-related care. This was formalized in a 1989 Health Care Financing Administration National Coverage Determination (31). Exclusion of transgender healthcare in private insurance as well as Medicaid and Medicare was near universal in the decades to come. A lack of funding for clinical care and for research led to the closing of transgender care programs at academic institutions in the years following the 1981 report.

Transgender health insurance exclusions are now rapidly being removed. This trend started with increasing numbers of employers in the last 15 years adding transition care to health coverage. Starting in 2013, some states have ruled that transgender health care exclusions are discriminatory and have banned them state-regulated health insurance. In 2014, the 1981 Medicare policy was reversed, removing categorical exclusions for transgender care (94). In 2015, the U.S. Department of Health and Human Services moved to end categorical exclusions for transgender care from all insurance and care providers who accept federal funding or reimbursement (95); and since 2016, insurers in the Federal Employees Health Benefits Program must include transition-related coverage for transgender federal employees (96); however, much work remains to actualize these policy changes, so that transgender people can access necessary care.

WPATH SOC 7 (67) has attempted to improve access to care by including the informed consent model for hormone administration. In multidisciplinary clinics providing transgender care, primary care providers can assess for and diagnose longstanding GD that might benefit from treatment with hormones and administer hormones without referral from a mental health professional. However, patients with co-occurring mental health conditions should be referred to mental health providers when appropriate. Alternatively, in most clinical settings the initial assessment of GD should come from a mental health professional. WPATH has advocated for the depathologization of transgender identity, the medical necessity of transgender care, and for improved access to legal gender change (67).

The American Psychiatric Association has also attempted to reduce stigma and improve access to care. As discussed above, the DSM-IV diagnosis of GID, regarded as stigmatizing by many transgender health and advocacy groups, was replaced with GD in DSM-5 (97). In addition, the American Psychiatric Association approved position papers on discrimination and access to care. Its statement on discrimination against transgender and gender variant individuals (98) opposes all private and public discrimination on transgender individuals, and its statement on access to care for transgender and gender variant individuals (83) urged the removal of all categorical health care exclusions for transgender people and advocated for the expansion of access to care.

Increased access to care must be accompanied by culturally competent research in transgender health, recommended by the Institute of Medicine (5) and outlined in the NIH's Strategic Plan to Advance Research on the Health and Well-being of Sexual and Gender Minorities (99). Expanded and improved education of health care providers is necessary, and the American Association of Medical Colleges has produced guidelines for curricular and climate change to improve transgender health (2). Principles of culturally competent care for transgender patients should be included in residency training as well.

Table 1: Terminology

Assigned gender: the gender attributed to an individual after birth; for most individuals, this corresponds to the sex on their original birth certificate, aka assigned sex.*

Cisgender: a term for individuals whose experienced and expressed gender are congruent with their gender assigned at birth.

Experienced gender: one's sense of belonging or not belonging to a particular gender; aka *gender identity*.

Expressed gender: how one expresses one's experienced gender.

Gender: a person's social status as male (boy/man) or female (girl/woman) or alternative category.*

Gender assignment: assignment of a gender to an individual. In typically developed newborns the initial or "natal" gender assignment is usually made on the basis of the appearance of the external genitalia.

Gendered behavior: Behavior in which males and females differ on average.

Gender binary: a gender-categorization system limited to the two options, male and female.

Gender confirming surgery: surgical procedures intended to alter primary and/or secondary sex characteristics to affirm a person's experienced gender identity, aka sex reassignment surgery.

Gender dysphoria (not capitalized)**:** distress caused by the discrepancy between one's experienced/expressed gender and one's assigned gender and/or primary or secondary sex characteristics.

Gender Dysphoria (capitalized)**:** a diagnostic category in DSM-5, with specific diagnoses defined by age-group-specific sets of criteria. The present paper addresses only Gender Dysphoria in adults.

Gender identity: one's identity as belonging or not belonging to a particular gender, whether male, female or a non-binary alternative; aka experienced gender.

Gender Identity Disorder: a diagnostic category in DSM-III and DSM-IV that was replaced in DSM-5 by *Gender Dysphoria.*

Gender incongruence (not capitalized): Incongruence between experienced/expressed gender and assigned gender and/or psychical gender characteristics.

Gender Incongruence (capitalized): A diagnostic category (analogous to Gender Dysphoria in DSM-5) proposed for ICD-11.

Gender variance: any variation of experienced or expressed gender from socially ascribed norms within the gender binary.

Genderqueer: an identity label used by some individuals whose experienced and/or expressed gender does not conform to the male/female binary or who reject the gender binary.

Gender role: cultural/societal definition of the roles of males and females (or of alternative genders).

Gender transition: the process through which individuals alter their gender expression which may or may not involve medical/surgical interventions.

Intersex: (1) A subset of the somatic conditions known as disorders of sex development in which chromosomal sex is inconsistent with genital sex, or in which the genital or gonadal sex is not classifiable as either male or female. As used here *intersex* does not refer to individuals who report their identity as intersex in the absence of a verifiable intersex condition.

Sex: a person's categorization as biologically male or female, usually on the basis of the genitals and reproductive tract.*

Transgender: an umbrella term usually referring to persons whose experienced or expressed gender does not conform to normative social expectations based on the gender they were assigned at birth.

Transsexual: a subset of transgender individuals who desire to modify, or have modified, their bodies through hormones or surgery to be more congruent with their experienced gender.

* On official documents such as birth certificates, driver's licenses, or passports, the traditional category "sex" is equivalent to "gender" in current psychological terminology.

Table 2. WPATH SOC7 Criteria and Referrals Needed for Gender-Affirming Hormone Therapy and Surgery in Adults

Criteria for Hormone Therapy (One Referral*)

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country
4. If significant medical or mental health concerns are present, they must be reasonably well-controlled.

Criteria for Surgeries

Criteria for mastectomy and creation of a male chest in female to male patients and breast augmentation (implants/lipofilling in male to female patients (One Referral*)

Identical to criteria for hormone therapy

Criteria for hysterectomy and salpingooophorectomy in female to male patients and for orchiectomy in male to female patients (Two Referrals*)

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to give consent for treatment;
3. Age of majority in a given country;
4. If significant medical or mental health concerns are present, they must be well controlled.
5. 12 continuous months of hormone therapy as appropriate to the patient's gender goals (unless hormones are not clinically indicated for the individual).

Criteria for metoidioplasty or phalloplasty in female to male patients and for vaginoplasty in male to female patients (Two Referrals*)

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country;
4. If significant medical or mental health concerns are present, they must be well controlled;
5. 12 continuous months of hormone therapy as appropriate to the patient's gender goals (unless hormones are not clinically indicated for the individual).
6. 12 continuous months of living in a gender role that is congruent with the patient's identity.

* Insurance carriers have varied requirements regarding the credentials of those who provide referrals letters as well of for the duration and type of provider-patient relationship and treatment. According to the WPATH SOC7 (67), mental health professionals with the competencies described within the SOC7 are best prepared to conduct assessments of gender dysphoria and provide referrals; however, "these tasks may instead be conducted by another type of health professional who has appropriate training in behavioral health and is competent in the assessment of gender dysphoria, particularly when functioning as part of a

multidisciplinary specialty team that provides access to feminizing/masculinizing hormone therapy."

Text box 1

A Welcoming Environment and Culturally Competent Care

Transgender patients have often suffered negative experiences in medical settings and the resulting discomfort may interfere with engagement in health care (3). A welcoming environment and employing principles of culturally competent care help create a sense of safety and provide a basis for the development of a therapeutic alliance (100).

Here are recommendations for creating a welcoming environment and providing culturally competent care:

1) Creating a welcoming environment is the responsibility all staff members a patient may encounter, including receptionists and registration clerks, housekeeping personnel (e.g. when a patient is using the restroom), social workers, nursing staff, and physicians. Training ideally should be provided to all staff.
2) Patients should be able to use the restroom consonant with their gender identity, and have the option of a single person restroom when available.
3) Preferred names should be prominent in electronic health records and other charts. Staff should be trained to look for preferred names before calling the patient's name. Using the legal name of the patient not only may be viewed as disrespectful, but might reveal the transgender identity of the patient as transgender to others in the waiting room.
4) If not known, clinicians should ask the patient's preferred name and pronouns, then use them, and chart them for future reference. "They/them" may be preferred non-gendered pronouns, especially for patients with non-binary gender identities.
5) The clinician should follow the patient's lead in describing gender identity and goals for transition, without predetermined assumptions of binary gender or transition outcome.
6) Gender dysphoria may or may not be the presenting symptom for a transgender patient. As with any patient, an exploration of the patient's concerns on initial evaluation should determine the degree of focus on gender dysphoria versus other presenting problems.

Abbreviations:

CAH congenital adrenal hyperplasia
DSM Diagnostic and Statistical Manual
GD Gender Dysphoria
GID Gender Identity Disorder
HBIGDA Harry Benjamin International Gender Dysphoria Association
HHS U.S. Department of Health and Human Services
WPATH World Professional Association for Transgender Health
WPATH SOC7 WPATH Standards of Care, version 7

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AM2018 ACCEPTED SUBMISSIONS

Sponsorship/Endorsement	Fellow Initiated	Stress/Trauma Toolkit Submission	M/UR Caucus & CMMH/HD Joint Submission	Format/Session Title
Council on Minority Mental Health and Health Disparities		✓	✓	Workshop 1501–Addressing Asian Mental Health and Wellbeing during this Challenging Political Climate
Council on Minority Mental Health and Health Disparities Caucus of Black Psychiatrists		✓	✓	Workshop 1792–Promoting wellbeing of African Americans: Tools to treat mental health needs and promote wellbeing during the current political and social climate
Council on Minority Mental Health and Health Disparities Caucus of Women Psychiatrists		✓	✓	Workshop 1914–Parental Leave: Luxury or Necessity?
Council on Minority Mental Health and Health Disparities Caucus of Women Psychiatrists		✓	✓	Workshop 2477–Promoting Wellbeing Among Women in the Current Political and Social Environment
Council on Minority Mental Health and Health Disparities Caucus of Asian American Psychiatrists				Workshop 1121–Digital Mental Health Innovations for Minority Populations: A Potential Solution to Fulfill Unmet Needs
Group for Advancement of Psychiatry				Workshop 1932–Inside the Matrix: A Workshop on the Ethics, Evaluation, and Opportunity of Mental Health Video Games
	✓			Poster 1012–Increasing Engagement in Depression Care by Chinese Americans through a Customized and Culturally Relevant Smartphone Platform
Caucus on Religion, Spirituality and Psychiatry				Symposium 1124–Defining Core Competencies for Dealing with Spirituality and Religion in Psychiatry
Council on Minority Mental Health and Health Disparities		✓	✓	Symposium 2794–At Risk: Undocumented Immigrant Mental Health in the Current Political Climate
Council on Minority Mental Health and Health Disparities				Media Workshop 2844–Cultural Depictions of Resilience in the Face of Inevitable Family Dissolution in the Films "Make Way for Tomorrow" and "Tokyo Story"
	✓			Workshop 2370–Black and White: The Cost of Unexamined Racial Bias
	✓			Poster 1576–Copycat Suicide Attempt Following Netflix Show "13 Reasons Why" : A Case Report and Literature Review
	✓			Poster 2179-- Does thirty-day readmission has relevance in psychiatric patient population?
	✓			Workshop 1431–Mental Health Provider's Primer Regarding Terminology, Lessons and Resources on Sexual Orientation and Gender Identity and Expression
	✓			Workshop 2066–Suicide During Transition of Care; What Clinicians Can Do to Lower Suicide Rate?
	✓			Workshop 2126–Finding Your Match: The Process of Obtaining Residency and Fellowship Positions
Council on Minority Mental Health and Health Disparities				Workshop 1176–Conversations on Diversity
				Workshop 1198–Women of Color and Intersectionality
				Workshop 2778–Building a Network of Future Leaders in Organized Psychiatry #mentorship goals
Council on Minority Mental Health and Health Disparities M/UR Caucus for Hispanic Psychiatrists		✓		Toward Hispanic-American Well-Being: Understanding Cultural Concepts of Distress, Responses to Stress/Trauma, and Adaptation of Services
				Workshop -Advances in Transgender Mental Health
				Workshop -Structural Competency in Psychiatric Practice and Training: Clinical Intervention on Social Determinants of Health Inequalities

KEY
Highlighted Sessions = Panel includes Members of the Council on Minority Mental Health and Health Disparities

Council on Minority Mental Health and Health Disparities
May Meeting

Sunday, May 6, 2017 9:00 A.M. – 12:00 P.M. (EST)

Olmstead, Seventh Floor, New York Marriot Marquis

DRAFT MINUTES

Roll Call

Present:

1. Christina Mangurian, MD (Chair)
2. Helena Hansen, MD (Vice Chair)
3. Eric Yarbrough, MD (Vice Chair)
4. Debbie Carter, MD
5. Enrico Castillo, MD
6. Keith Hermanstyne, MD
7. Francis Lu, MD
8. Nubia Chong, MD (SAMHSA Fellow 1st Year)
9. Christine Crawford, MD (SAMHSA Fellow 2nd Year)
10. Jai Gandhi, MD (SAMHSA Fellow 2nd Year)
11. Carine Nzodom, MD (Diversity Leadership Fellow 2nd Year)
12. Louisa Olushoga, MD (Diversity Leadership Fellow 1st Year)
13. Evita Rocha, MD (SAMHSA Fellow 2nd Year)
14. Elizabeth Rynzar, MD (Leadership Fellow 1st Year)
15. Samra Sahlu, MD (Diversity Leadership Fellow 2nd Year)
16. Nhut Tran, MD (Public Psychiatry Fellow 1st Year)
17. Walt Wilson, JR, MD, MHA (SAMHSA Fellow 1st Year)
18. Emily Wu, MD (SAMHSA Fellow 1st Year)

Staff:

1. Omar Davis, CAPM (Liaison)
2. Vabren Watts, PHD
3. Ranna Parekh, MD, MPH

Absent:

1. Amanda Graves, MD
2. Sidney Hankerson, MD (Early Career Psychiatrist Representative)
3. Mary Roessel, MD (Consultant)
4. Francis Sanchez, MD (M/UR Committee Chair)

Excused Absence:

1. Elizabeth Horstmann, MD

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DRAFT MINUTES

2. Ijeoma Chukwu, MD (Corresponding Member)
3. Felix Torres, MD (Assembly Representative)

Guests:

1. Saul Levin, MD, MPA, FRCP-E, CEO and Medical Director, APA
2. William Byne, MD
3. Robin Cooper, MD
4. Megan Marcinko, Director of Federal Relations, Division of Government Relations
5. Mikael Troubh, Director of Federal Relations, Division of Government Relations
6. Kathy Orellana, Associate Director, Practice Management and Delivery Systems Policy
7. Annie Le, Medical Student

Important Events During the APA Annual Meeting

Dr. Mangurian praised members for producing a plethora of diversity related sessions which are reflected in Division of Diversity and Health Equity's (DDHE) Cultural and Psychiatry Sessions track. Members will present at thirteen scientific sessions.

Review of Progress Over Past Year

Members of the CMHH/HD collaborated with the Assembly Committee of Representatives of Minority/Underrepresented (M/UR) Groups as well as non-minorities to produce the following products:

- Developed and finalized the Stress and Trauma Toolkit. Subpopulation Groups include Hispanic, Black, Undocumented, Women, Asian, Indigenous, and LGBTQ.
- Presented at thirteen scientific sessions during APA 2018 Annual Meeting
- Initiated and deployed a new platform to monitor the review and development of Position Statements
- Revised and created new Position Statements
    - *New*
        - Conversion Therapy
        - Equitable Treatment of Substance Use Disorders Across Racial Lines
        - Mental Health Equity and the Social and Structural Determinants of Mental Health
        - Police Brutality and African American Men
        - Undocumented Immigrants and Deferred Action for Childhood Arrivals (DACA)
    - *Revised*
        - Religious Persecution and Genocide

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        - Religious Discrimination
        - Abortion
        - Resolution Against Racism
        - Human Trafficking
        - Discrimination Against Transgender and Gender Variant Individuals
        - Access to Care for Transgender and Gender Variant Individuals
    - Slated for development in 2018
        - Intersectionality
        - Racist patients
        - Over policing of youth
- Organized workgroups around the following topics:
    - Increasing M/UR membership in the APA and Enhancing relationships with M/UR caucuses and other councils
    - History & intergenerational relationships
    - Community-based work and reducing stigma
    - Slack Work Space for CMMH/HD
- Commented on the Department of Health and Human Services (HHS) Proposed Conscience Rights Rule
    - CMMH/HD members provided comments on the HHS's proposed Religious Freedom Rule as requested by APA's Division of Policy and Programs. The Division thanked them for their timely submission.
- Appointment of a second Vice Chair
    - Eric Yarbrough, MD, was appointed as Vice Chair. This appointment comes with several responsibilities including overseeing Position Statements (e.g. New, Revised, etc.) being developed and reviewed by the CMMH/HD.
- Accreditation Council for Graduate Medical Education (ACGME) Update
    - Following BOT Approval, the CMMH/HD responded to a call for comments for consideration in ACGME's Common Program Requirements (CPR). This marks the first time the word "disparities" appears in the CPR, although it has been in the psychiatry residency training program requirements. The ACGME Committee is reviewing comments made by March 22, 2018 deadline. Once they finalize, it goes to the ACGME Board for approval. The Board is expected to meet in the summer.
- Appointment of member/resident Liaisons
    - The CMMH/HD appointed member and resident liaisons to strengthen dialogue among APA Components

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Planning for September Components Joint Meeting

- Members of the CMMH/HD and M/UR Caucuses will look for ways to partner with the other APA
- Proposed Agenda Topics:
    - Structure to Maximize Impact (Workgroups vs Monthly Calls)
    - DDHE and Website Feedback
    - Position Papers Brainstorming and Drafting
    - Membership
    - Continued Discussions around Intersectionality
    - Improving the Liaison Role
    - Working together to reduce conflicting times of M/UR activities at APA meeting
        - Proposal to have APA Education and Meetings teams come to the table to discuss the merger of all Award lectures and presentations. The effort would mitigate the effects of scheduling conflicts and may boost overall attendance
    - M/UR Evening Reception at AM

APA Leadership's Remarks

- Dr. Levin thanked the leadership and the CMMH/HD for their contributions. He thanked departing Resident Fellow Members (RFMs) and implored them to become active in their District Branches. To rise in the APA, one must begin there. Dr. Levin reemphasized that the country is changing, and that District Branches need them.

- Quizzed about his concerns, Dr. Levin stated that the Board froze during the "Black Live Matters" event. And that Councils, the experts on these kinds of challenges, should be poised to respond appropriately. Send us your thoughts and the let board massage them. Absence a Position Statement, APA will deploy the "Social Issues" committee which will serve as a rapid response team.

Workgroup Reports

Community-based Work and Reducing Stigma

- The Workgroup is considering a "Back to School" program which is like the one being deployed by the American Medical Association (AMA). The program would entail doctors visiting schools in underserved neighborhoods. Conversations would cover topics such as warning signs related to depression, anxiety, etc. The Workgroup is considering plans to operationalize at APA Annual Meetings or IPS Meetings. The structure would resemble a half day workshop. Presentations would be tailored to Middle and High schools. Council members recommended that the work

group socialize the program with school counselors and to partner with the Council on Child and Adolescents. The CMMH/HD leadership requests a written plan for this work.

Gender Dysphoria

- Dr. William Byne, co-chair of the workgroup on Dysphoria, gave an overview of the groups work and it fits within the purview of the CMMH/HD. In 2008, a taskforce launched an effort to tackle the treatment of patients with Gender Identity Disorder (GID). Nothing was in the DSM, so the APA convened a task force to develop a Position Statement. Completing its study in 2011, the workgroup had uncovered research on all groups except for youth. As a next step they proposed that APA follow the American Academy of Child and Adolescent Psychiatry parameters. Then AMA came out with more rigorous guidelines; but they could only prioritize certain items. As the task for was being sunsetted they asked the APA for permission to form a Workgroup. The request was approved, and the Council on Quality of Care was given oversight. The workgroup submitted its findings to the American Journal of Psychiatry, which was approved. Moving forward, the CMMH/HD will make the case to the JRC, in June, that the material be published on APA's website as a resource document.

History & Intergenerational Relationships

- The workgroup is working on a documentary proposal were members would interview people associated with the 1969 anniversary of Chester Pierce's attendance at the APA board meeting. The workgroup is currently in the process of drafting a budget proposal which will include particulars such as purpose of the project, Its relevance to APA today, a script, etc.

<u>The CMMH/HD expressed appreciation to the following departing members:</u>

Name	Role	Career Status	State
Felix Torres, MD	Assembly Representative	Mid	NY
Debbie Carter, MD	Member	Senior	CO
Francis Sanchez, MD	M/UR Committee Chair	Mid	IA
Amanda Ruiz, MD	Member	Mid	CA
IJeoma Chuwu, MD	Corresponding	Early	CA

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Sidney Hankerson, MD	Early Career Psychiatrist	Early	NY

- Also, at its May meeting, Council members bid farewell to outgoing resident fellow members (RFMS) assigned to the Council from the various APA/APAF fellowship programs. These residents were acknowledged for their active support and participation in Council deliberations and projects.

The list of departing RFMs are:

- Carine Nzodom, MD, Diversity Leadership Fellow, 2nd year
- Samra Sahlu, MD, Diversity Leadership Fellow, 2nd year
- Christine Crawford, MD, SAMHSA Fellow, 2nd year
- Jai Chetan Gandhi, MD, SAMHSA Fellow, 2nd year
- Evita Marie Rocha, MD, SAMHSA Fellow, 2nd year

- Residents expressed appreciation for the opportunities that were extended to them. The Residents commented that they were inspired and that topics such as microaggressions and wellness drew their interest. One fellow stated that it would be helpful to pair incoming residents with ones which have previously served which could help newcomers acclimate to the CMMH/HD's culture. The idea will be further discussed at the next fellowship teleconference.

- Leadership encouraged them to write to their District Branches to obtain letters of recommendation for appointment to the CMMH/HD or other APA components.

APA Division of Government Relations (DGR) Update

- The program was eliminated in the President's FY 2019 Proposed Budget to Congress, but the recommended funding levels would have to be approved through the appropriations process.
- During a stakeholder meeting with Dr. McCance-Katz, she said that the FY 2019 budget proposal was pretty much finalized by the time she joined SAMHSA. She expressed the value of the program and carefully walked the fine line of supporting the President's Budget while expressing her support of stakeholders advocating for the program given its value.
- We don't anticipate Congress eliminating the program, which continues to have bipartisan support.
- The FY 2019 appropriations process is just beginning, and we will monitor for any applicable changes to funding for underserved areas.

Council on Minority Mental Health and Health Disparities
May Meeting

Sunday, May 6, 2017 9:00 A.M. – 12:00 P.M. (EST)

Olmstead, Seventh Floor, New York Marriot Marquis

DRAFT MINUTES

- The APA administration is actively engaged with Congress; lobbying the minority Caucuses and members of the appropriations committee – working in collaboration with an MFP coalition and individually on behalf of APA—to ensure continued funding for the SAMHSA Minority Fellowship Program.
- Via the FY 2018 Omnibus, the MFP received a total of $9,059 million, inclusive of $1 million dollar in additional funding for grantees to implement fellowships in psychology, addiction psychiatry, and addiction medicine with a specific focus in addressing the needs of individuals with substance use disorders.

Council/Caucus Liaison Reports

- **Caucus on Spirituality, Religion & Psychiatry** (Liaison: Francis Lu, MD)
  - Dr. Lu highlighted the list of related scientific sessions. One notable event included the Oskar Pfister award lecture, which was presented to John Swinton, MD
- **Council on Quality Care** (Liaisons: Elizabeth Ryznar, MD; Debbie Carter, MD)
  - Council discussion focused on these issues:
    1. JCAHO
       - Inpatient hospital accreditation by JCAHO and the impact of managing ligature risks, leading to some hospitals closing psych units because of the physical architectural changes that are needed for windows, doors, other room area, patient sense of increased stigma in being stripped rooms or rooms with no doors, and the issue if using a "staff support that is with the patient 24/7 how to train the staff, pay for staff also raise hospital costs
    2. PARITY
       - Discussed follow up with new SAMSHA head about state reports mental health parity diagnoses and some district branches reporting poor enforcement.
  - Sam Shugarman (Shugarman@psych.org) was offered as the ongoing contact person by the chair of the committee Gray Norquist, M.D.,M.S.P.H.

- **Council on Consult-Liaison Psychiatry (Liaison: Keith Hermansytne, MD)**
  - There was significant discussion about a proposal to establish a Women's council. Proponents of the proposal feel that while some councils like CMMH/HD and Consult-Liaison tackle aspects that are related to women, there is no current council that prioritize women's issues, especially as it relates to policy. There was also the thought that having a council would allow for additional resources dedicated to women's issues.

Council on Minority Mental Health and Health Disparities
May Meeting

Sunday, May 6, 2017 9:00 A.M. – 12:00 P.M. (EST)

Olmstead, Seventh Floor, New York Marriot Marquis

DRAFT MINUTES

The council voted and decided not to endorse the idea at this time. David Gitlin, MD was curious if CMMH/HD has been approached about this idea.

- **HIV Steering Committee (Liaison: Keith Hermansytne, MD)**
  - The current committee leader, Daena Petersen, MD, is strongly interested in partnering with CMMH/HD and is looking to increase minority membership in the committee. She mentioned that she would try to reach out to Christiana Mangurian, MD.

- **Caucus of Black Psychiatrists (Liaison: Keith Hermansytne, MD)**
  - There was some discussion about the potential SAMHSA MFP/Minority AIDS funding cut that was discussed at the CMMH/HD meeting.
  - Please contact Keith Hermanstyne, MD, for questions, and he will provide and update if there's additional information. He will be away but will return emails starting on May 25th.

DDHE Report

- APA/APAF Fellowship Applications increased 24% during the 2018-2019 application cycle
- In April, 57 psychiatry resident trainees were selected to participate in APA/APAF Fellowship program (2018-2020):
  - 10 APA/APAF Leadership Fellows
  - 5 Child and Adolescent Psychiatry Fellows
  - 10 Diversity Leadership Fellows
  - 1 Jeanne Spurlock Congressional Fellow
  - 10 Public Psychiatry Fellows
  - 1 Research Fellow
  - 20 SAMHSA funded Minority Fellows
- Geographical diversity increased as Oklahoma joined the list of represented states
- Workforce Diversity Initiatives
  - Black Men in Psychiatry Early Pipeline (BMPEP) Program
    - 2018 Recruitment Activities
      - Onboarded four new undergraduate students (One Freshmen; One Post-baccalaureate; One Junior; One Sophomore)
      - Washington University of St. Louis, Wayne State University and Duquesne joins Howard University as member institutions
- DDHE announces upcoming releases of Diversity Related Educational Resources
  - **Pulsed-Learning Activity (PLA) Modules**
    - Microaggression (**Available Online**)

Council on Minority Mental Health and Health Disparities
May Meeting

Sunday, May 6, 2017 9:00 A.M. – 12:00 P.M. (EST)

Olmstead, Seventh Floor, New York Marriot Marquis

DRAFT MINUTES

- Cultural Formulation Interview
- Transgender Mental Health

- **CME Modules**
  - Ethnopsychopharmacology
  - Social Determinants of Mental Health
  - Transgender Mental Health
  - Health Disparities
  - Work-Life Balance for Women
- **Educational Resources**
  - Mental Health Facts for Queer/Questioning (**Available online**)
  - Update for Best Practice Highlights for Treating Diverse Patient Populations (**Available online**)
  - Stress and Trauma Related to the Current Social and Political Climate
  - A Guide for International Medical Graduates
  - Domestic Violence Toolkit
  - Human Trafficking Toolkit

June JRC Report Action Item

The CMMH/HD will submit an Action Item in the June JRC which requests the JRC to provide clarification on the process utilized in weighing Council endorsed scientific abstracts/sessions. The June JRC will explain the request in greater detail.

Caucus on Climate Change and Mental Health Briefing (Chair: Robin Cooper, MD)

This caucus originated out of the CMMH/HD and was assigned to the Disaster Committee initially. Drs. Felix Torres and Vivian Pender, former members of the CMMH/HD, contributed to its efforts. It is now clear that minority and vulnerable people are typically hit first. That stated Dr. Cooper wants to ensure that the CMM/HD is made aware of challenges as they surface. Dr. Mangurian agrees and offers the services of the Council's liaisons. They will continue to keep the CMMH/HD apprised of developments. Dr. Elizabeth Rzynar, a first year Leadership Fellow, volunteered to serve as liaison. Be advised that a meeting will take place in San Juan Puerto where-in attendees will discuss policy and systemic issues which have gripped the country.

Meeting adjourned

COUNCIL ON PSYCHIATRY AND LAW

EXECUTIVE SUMMARY:
The Council on Psychiatry and Law evaluates legal developments of national significance and governmental actions that will affect the practice of psychiatry, including the subspecialty of forensic psychiatry. The Council has recently worked simultaneously on a number of projects through individual workgroups. The Council and its subcomponent Committee on Judicial Action each held separate meetings in New York. The draft Minutes from the Council meeting are attached (*Attachment #1*).

1. **ACTION: WILL THE JOINT REFERENCE COMMITTEE APPROVE THE PROPOSED "RESOURCE DOCUMENT ON RISK-BASED GUN REMOVAL LAWS"?**

   The Council on Psychiatry and Law has developed a draft Resource Document on Risk-Based Gun Removal Laws (*Attachment #2*). The document is intended to provide guidance to clinicians about the existence and application of laws, including so-called "red flag" laws, which allow for removal of weapons on the basis of risk. The document highlights some areas for clinicians pertaining to these laws. After discussion in the drafting process, it was preferred that the document references these laws as "risk-based gun removal laws" for clarity.

2. **ACTION: WILL THE JOINT REFERENCE COMMITTEE RECOMMEND RETIREMENT OF THE 1981 POSITION STATEMENT "CONFIDENTIALITY OF MEDICAL RECORDS: DOES THE PHYSICIAN HAVE A RIGHT TO PRIVACY CONCERNING HIS OR HER OWN HEALTH RECORDS"?**

   The Council on Psychiatry and Law has determined that the 1981 Position Statement "Confidentiality of Medical Records: Does the Physician Have a Right to Privacy Concerning His or Her Own Health Records" (*Attachment #3*) is antiquated. In addition, the Council believes that the necessary elements of that document are sufficiently covered by the Position Statement on Inquiries about Diagnosis and Treatment of Mental Disorders in Connection with Professional Credentialing and Licensing (2015; Amended 2017) (*Attachment #4*). Therefore, the Council recommends that the 1981 Position Statement should be retired.

3. **ACTION: POSITION STATEMENT REVIEW**

   a. **Legislative Intrusion and Reproductive Choice (2013)** (*Attachment #5*)
   The Council believes the Position Statement is current, relevant and should be retained.

   ACTION: WILL THE JOINT REFERENCE COMMITTEE APPROVE THE REQUEST OF THE COUNCIL TO RETAIN THE POSITION STATEMENT ON LEGISLATIVE INTRUSION AND REPRODUCTIVE CHOICE (2013)?

   b. **Firearm Access, Acts of Violence and the Relationship to Mental Illness and Mental Health Services (2014; revised 2018)** (*Attachment #6*)
   The Council believes the Position Statement is current, relevant and should be retained (including the amendment proposed by the Council and approved by the Assembly in May 2018).

ACTION: WILL THE JOINT REFERENCE COMMITTEE APPROVE THE REQUEST OF THE COUNCIL TO RETAIN THE POSITION STATEMENT ON LEGISLATIVE INTRUSION AND REPRODUCTIVE CHOICE (2014; revised 2018)?

4. REVIEW OF DOCUMENTS DRAFTED BY OTHER COUNCILS

As directed by the Joint Reference Committee in its February 2018 Summary of Actions, the Council has recently reviewed and provided feedback on a number of documents prepared by other APA components. Specifically:

a. Proposed Position Statement on Mental Health Needs of Undocumented Immigrants, Including Childhood Arrivals, Asylum Seekers, and Detainees

This document was prepared by the Council on Minority Mental Health and Health Disparities. The Joint Reference Committee referred it to the Council on Psychiatry and Law for review and input and directed that the Council report directly to the Joint Reference Committee for its June 2018 meeting. Within the Council on Psychiatry and Law, there are a variety of opinions about the recommended revisions for this document. Therefore, the Council has chosen to create a marked copy of the document containing the various suggestions of its members (*Attachment #7*). The Council would suggest that the totality of these comments be provided to the Council on Minority Mental Health and Health Disparities for consideration. The Council on Psychiatry and Law welcomes the opportunity to review a revised draft of the document when available.

b. Proposed Position Statement on Police Brutality and Black Men

The document was prepared by the Council on Minority Mental Health and Health Disparities. As directed by the Joint Reference Committee, the Council on Psychiatry and Law reviewed the document and offered comments on it to the Council on Minority Mental Health and Health Disparities. A representative of that Council has informed the Council on Psychiatry and Law that its comments were well-received and are being considered. The Council on Psychiatry and Law informed him that it would welcome the opportunity to review a revised draft of the document when available.

c. Proposed Resource Document on The Assessment of Capacity for Medical Decision Making

This document was prepared by the Council on Consultation-Liaison Psychiatry (formerly the Council on Psychosomatic Medicine). As directed by the Joint Reference Committee, the Council on Psychiatry and Law reviewed the document and provided extensive comments to the document's Council. Subsequently to providing its written feedback, members of the Council on Psychiatry and Law also participated in a conference call with some of the document authors regarding the comments. The Council on Psychiatry and Law members who participated in the call had the impression that the authors were overwhelmed and perhaps resentful about the extent of feedback that had been provided by the Council on Psychiatry and Law. For that reason, the Council on Psychiatry and Law members did not vigorously pursue their feedback and as a result they have lingering concerns about the content of this document. The Council on Psychiatry and Law requests and would find useful some direction to both Councils

from the Joint Reference Committee about their roles and whether any further involvement is desired from the Council on Psychiatry and Law on this document.

INFORMATIONAL ITEMS

1. INVOLUNTARY COMMITMENT FOR SUBSTANCE USE DISORDER

A workgroup of the Council is continuing to refine a proposed position statement on the topic of involuntary civil commitment for Substance Use Disorder. The Council held a lively discussion about this topic during its May meeting and the workgroup will endeavor to revise the draft document to incorporate that discussion. Once a revised draft is prepared, the Council will collaborate with the Council on Addiction Psychiatry for its review and feedback regarding the document.

2. STALKING AND INTRUSIVE BEHAVIORS BY PATIENTS TOWARDS PSYCHIATRISTS

The Council is continuing its effort to develop a Resource Document to provide guidance and resources to psychiatrists who are confronted with the issue of stalking or other intrusive behaviors by their patients. The issue was discussed during the Council's May meeting and is one of significant concern to a number of members. The workgroup will work to develop a draft document for the Council to consider at its September Meeting.

3. PHARMACEUTICAL MARKETING

The Council has raised concerns regarding the marketing practices of a particular pharmaceutical company relating to criminal justice entities and legislators, in particular. A workgroup has been formed which will call for specific anecdotal evidence from members about specific instances of troubling marketing practices. In addition, the workgroup will begin to develop a position statement on the topic of APA supporting alternatives to incarceration and wanting to ensure that medical professionals are involved in any evaluations or recommendations relating to treatment of those involved in the criminal justice system.

4. VOLUNTARY AND INVOLUNTARY HOSPITALIZATION

A workgroup of the Council has begun to develop a proposed position statement on the topic of voluntary and involuntary hospitalization. A lively discussion with a number of views took place during the May meeting. The workgroup will work on revising the document to incorporate the points raised during the Council's discussion.

5. COMMITTEE ON JUDICIAL ACTION

The Committee on Judicial Action, a subcomponent of the Council chaired by Dr. Marvin Swartz, reviews cases at every level of the judicial system and makes recommendations about those in which APA involvement as a friend of the court would be appropriate. Recently the Committee participated in a petition of certiorari to the United States Supreme Court in the case of *Dassey v. Dittman*, concerning the standard of voluntariness of a confession made by a juvenile with cognitive limitations. The Committee is also currently considering possible APA involvement in a brief to the United States Supreme Court in the case of *Madison v. Alabama*, which involves the death penalty and the effect of dementia and other manifestations of mental health issues on the legality of execution of an individual.

COUNCIL ON PSYCHIATRY AND LAW

2018 APA Annual Meeting

Tuesday, May 8, 2018

7:00PM – 11:00PM

Sheraton New York Times Square Hotel, New York East Room, 3rd Floor

PRESENT:

Members: Debra A. Pinals, MD, Chair; Peter Ash, MD; Alec Buchanan, MD, PhD; Carl Erik Fisher, MD; Elizabeth B. Ford, MD; Richard Frierson, MD; Stephen K. Hoge, MD; Louis Kraus, MD; Jeffrey Metzner, MD; Patricia Recupero, MD, JD; Robert Trestman, MD, PhD; Cheryl Wills, MD; **Corresponding Members:** Paul Appelbaum, MD; Renee Binder, MD; Marvin S. Swartz, MD; Reena Kapoor, MD; **Legal Advisor:** Richard Bonnie, LLB; **Ex-Officio/AAPL:** Jeffrey Janofsky, MD; **Visiting Members from Committee on Judicial Action:** Michael Champion, MD; Robert Weinstock, MD; Howard Zonana, MD; **APAF Public Psychiatry Fellows:** Jessica Bayner, MD; **APAF Diversity Leadership Fellows**: Furqan Nusair, MD; Lisa Harding, MD; **SAMHSA Fellows**: Bhinna Park, MD; **Guests:** Elie Aoun, MD; Abhishek Jain, MD; Maya Prabhu, MD; Grace Lee, MD; Raymond Patterson, MD; Walter Wilson, MD (liaison from Council on Minority Mental Health and Health Disparities); Kimberly Resnick, MD; Danielle Kushner, MD; Catherine Meyere, MD; Megan Pruitt, MD; Kai Darby, MD; Keith Brown, MD; Robert Aziz, MD; Pratik Bahekar, MD; Nhut Tran, MD; **APA Staff:** Phil Wang, MD, Director of Research; Diana Clarke, Assistant Director of Research; Megan Marcinko, Co-Director of Federal Affairs for Department of Government Relations; Zhuoyin Yang; Alison Crane;

I. Greetings, Introductions, and Conflict of Interest Disclosures

Dr. Pinals opened the meeting by welcoming the attendees, who identified themselves by name and affiliation and reported any possible conflicts of interest.

II. Visit from Saul Levin, MD, MPA, APA Chief Executive Officer and Medical Director

Saul Levin, MD, MPA, Chief Executive Officer and Medical Director visited and thanked the Council for its prolific and impressive work.

III. Approval of September Component Council Minutes

Dr. Pinals presented the Minutes from the 2017 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 APPROVED THE SEPTEMBER 2017 MINUTES AS WRITTEN.

IV. Informational Update from APA's Department of Governmental Relations

Megan Marcinko, co-director of Federal Affairs for the Department of Governmental Relations, gave an update about APA's lobbying activities recently.

V. Update from APA's Department of Research regarding Jail Mental Health Screening App

Phil Wang, MD and Diana Clarke, PhD provided an updated regarding the Jail Mental Health Screening App development, including goal of creating software model and API solution to increase the number of institutions that may be able to access it. They will send materials for distribution to the Council and prepare a blurb package for members to showcase it to correctional facilities. Goal will be to have these things available for Council during September meeting. Request for Council members to be able to experiment with the screening app itself prior to meeting.

VI. Report of the Committee on Judicial Action

Dr. Marvin Swartz, Chair of the Committee on Judicial Action, provided an update on recent cases considered by the Committee.

VII. Stalking and Intrusive Behaviors Towards Psychiatrists by Patients

Dr. Maya Prabhu and Dr. Debra Pinals, co-chairs of the workgroup, provided an update on the work done towards drafting a Resource Document. Some items of concern to ensure are included within the document were discussed, including possibility of creating a model action plan for university setting and the need to ensure all staff are protected (and not just the psychiatrists).

VIII. Regulation of Mobile Medical Apps

Dr. Patricia Recupero, chair of the workgroup, gave an update on the work that has been attempted. Two telephone conferences were attempted, but neither garnered much participation. Dr. Recupero interpreted that as a sign that this document may not be a priority at the moment. Some other groups within APA may be already at work on this area. For now, this topic will be tabled by the Council.

IX. Risk-Based Gun Removal Laws

Dr. Reena Kapoor, chair of the workgroup, discussed changes made to the document regarding the circumstances in which confidentiality obligations of a physician can be waived. Also noted desire to finish the document as soon as possible as "red flag" laws seem to be hot topic. Dr. Pinals noted misperception of many that these laws allow clinician ability to breach confidentiality, when in fact they do not. Dr. Metzner noted it might be helpful to provide proposed language a District Branch could use to have a law that allows breach of confidentiality. Questions were raised about the standard and burden of proof in the gun-removal situations. It was noted that no diagnosis is required under these laws (instead it is a finding of dangerousness or risk, not based on mental illness). Risk-based laws to take guns away are a different thing under penal law than criminal laws and mental health interventions. Protection for patients at hearing stage isn't written into document (when mental illness is alleged). Could add to document a few sentences about hearing (that document assumes people will have due process protections at hearing). Distinction made between some normative questions and fact that the Resource Document as drafted is descriptive in nature. Discussion of whether or not to add new states to Appendix or to include only a few states as a sample of what laws look like. Council

agreed Resource Document will be moved forward to JRC on May 23rd. Council would like to have press around placement of Resource Document on website – PsychNews Article is desired (perhaps linked to 2014 Position Statement revisions, which Alison should explore with APA leadership).

X. Involuntary Commitment for Substance Use Disorders

Dr. Elie Aoun, Dr. Debra Pinals and Mr. Richard Bonnie described the evolution of thinking about whether something should be said on this topic at the moment. Dr. Aoun described Council on Addictions thinking on the topic; generally, that Council is not widely in support of these laws but since they exist there is a need for an evidence-based principled approach to treatment even in the context of laws that are out there. Suggestion to add some discussion about possible crowding out of mental health services funding if focus is on these laws (need for funding of this not to take away from mental health). There are efforts of first responders to pursue legislation that would allow them to press charges if persons refuse treatment. Existence of law in some states in which the facilities do not exist (so the law is of no effect) noted. Possibility of streamlining document to only focus on item 4 as the stated position was discussed. Perhaps document should say APA does not support these laws, but where they exist there are some minimums that should be included. Plan is for workgroup to reconvene to make edits; then circulate to Council on Addiction. Goal will be to finalize for submission to JRC in time for October meeting.

XI. Pharmaceutical Marketing

Dr. Carl Fisher described concerns that had been raised regarding marketing by particular pharmaceutical company towards criminal justice entities and legislators. Some action items are (1) calls for specific cases or anecdotal evidence of efforts (first hand reports); and (2) could talk about a position statement on topic along the lines of the fact that APA supports alternatives to incarceration and is concerned about ensuring that medical evaluations and medical professionals are involved in any recommendations relating to treatment. There was support by the Council for a Position Statement of that nature, so workgroup will continue to work on issue.

XII: Voluntary and Involuntary Hospitalization

Dr. Marvin Swartz, chair of the workgroup, described workgroup's discussion considering what should be said about involuntary commitment in modern circumstances and contemporary context. Draft document was intended to be Position Statement on contemporary involuntary hospitalization. Articulated idea that patients should have access to hospital treatment if inpatient is necessary level of care and acknowledge certain portion of patients are unable or unwilling to consent to voluntary hospitalization, so some mechanism should exist for involuntary hospitalization. Series of principles about involuntary hospitalization then articulated. Discussion about whether draft statement should limit those who can do evaluation for involuntary hospitalization to psychiatrists only (or include other medical professionals). Need to consider lack of psychiatrists in a number of states (concern higher for non-physicians to do examination than another physician). Some concerns raised about use of the term "harm" (and whether mental or physical) in document. Concern about whether lack of capacity to give

informed consent becomes a ground for commitment without dangerousness. Discussion of drawing line between acute and judicial process relating to commitment (i.e. emergency certification or hold is one step in the process; civil commitment is taken to mean some sort of official action by state that confines a person against their will (usually for longer period of time, etc.)). There are different standards for acute involuntary hospitalization and ongoing civil commitment (physician signs paper for acute involuntary hospitalization and civil commitment is something a judge must decide). May need to add footnote to define how term involuntary hospitalization is being used. Workgroup will reconvene and continue work on document to pick up points raised in discussion.

XIII: Manfred S. Guttmacher Award Selection Committee

Dr. Michael Champion described selection made by award selection committee. Disappointment was expressed about Award Presentation "not being in program or on App" and need to recognize PRMS as sponsor. Discussion about how Guttmacher is endowed by PRMS, which organization believes it still endowed award. Staff Liaisons will look into endowment status. In early late summer discussion will be scheduled regarding award presentation planning for May 2019. New award selection committee was appointed for 2018-2020.

XIV. Isaac Ray Award Selection Committee

In Dr. Gold's absence, staff provided update of award and new submissions being received until June 1st. New award selection committee was appointed for 2018-2020.

XV: Review of Documents Referred by JRC

1. **Proposed Position Statement on Mental Health Needs of Undocumented Immigrants, including Childhood Arrivals, Asylum Seekers and Detainees** – CPL will send redline with a significant amount of feedback from CPL (some of which is inconsistent) to JRC with its report for the JRC to consider.
2. **Proposed Position Statement on Police Brutality and Black Men** – Feedback on this document has been provided to the responsible Council (Minority Mental Health and Health Disparities). Dr. Wilson, liaison from Council on Minority Mental Health and Health Disparities, attended portion of CPL meeting and confirmed feedback was received and is helpful to that Council. CPL has requested that it see document again.
3. **Resource Document: The Assessment of Capacity for Medical Decision Making** – CPL wants to inform JRC that it has lingering concerns about this document and that there was impression that the responsible Council resented the amount of feedback provided by CPL which complicated the process. Direction from JRC about roles would be useful is more involvement is desired from CPL.

XVI. Position Statement Review

1. **Legislative Intrusion and Reproductive Choice (2013)** – Council believes the Position Statement should be retained.

ACTION: THE COUNCIL ON PSYCHIATRY AND LAW RECOMMENDS THAT THE POSITION STATEMENT ON LEGISLATIVE INTRUSION AND REPRODUCTIVE CHOICE BE RETAINED. THE POSITION STATEMENT IS CURRENT, RELEVANT AND SHOULD BE RETAINED.

2. **Firearm Access, Acts of Violence and the Relationship to Mental Illness and Mental Health Services (2014)** – Council believes that the Position Statement should be retained (and amended as proposed by Council and approved by Assembly during May 2018 meeting).

ACTION: THE COUNCIL ON PSYCHIATRY AND LAW RECOMMENDS THAT THE POSITION STATEMENT ON FIREARM ACCESS, ACTS OF VIOLENCE AND THE RELATIONSHIP TO MENTAL ILLNESS AND MENTAL HEALTH SERVICES BE RETAINED (REVISION WAS APPROVED BY ASSEMBLY DURING MAY 2018 MEETING).

XVII. 1981 Position Statement on Confidentiality of Medical Records and 2015 Position Statement on Inquiries About Diagnosis and Treatment of Mental Disorders in Connection with Professional Credentialing and Licensing – Council believes that the 1981 statement is outdated and sufficiently covered by the new 2015 (and revised in 2018) Position Statement. It therefore recommends that the 1981 statement be retired.

ACTION: THE COUNCIL ON PSYCHIATRY AND LAW RECOMMENDS THAT THE POSITION STATEMENT ON CONFIDENTIALITY OF MEDICAL RECORDS (1981) BE RETIRED. THERE HAVE BEEN SUBSEQUENT CHANGES IN APA POLICY (NAMELY THE 2015 POSITION STATEMENT, AS REVISED IN 2018) THAT MAKE THE 1981 STATEMENT UNNECESSARY.

XVIII: Guardianship Laws and Consent to Hospitalization (potential new topic)

Issue was raised during discussion about voluntary and involuntary hospitalization and Council explored whether it wishes to convene a new group to consider the topic of guardianship laws and consent to hospitalization. Council determined to carry this item over for the CPL agenda in September.

XIX. Information Items and New Business

1. **National Commission on Correctional Health Care** - Dr. Pinals described that she was appointed to be APA representative to National Commission on Correctional Health Care.
2. **Potential topics for September Meeting**: Potential topics suggested were: recent cases related to Tarasoff; jail mental health app; guardianship; legal responses to opioid epidemic; competency restoration; cyber-stalking and harassment; intellectual disability and false confession; *Eldred* case and how legal system views addiction and free will

The Council meeting adjourned at 11:02pm.

Resource Document on Risk-Based Gun Removal Laws

Reena Kapoor, M.D.
Elissa Benedek, M.D.
Richard J. Bonnie, L.L.B.
Tanuja Gandhi, M.D.
Liza Gold, M.D.
Seth Judd, M.D.
Debra A. Pinals, M.D.

Final – Approved by Council on Psychiatry and Law 5/8/18

Introduction

In 2014, the American Psychiatric Association (APA) published a "Resource Document on Access to Firearms by People with Mental Disorders,"[1] which addressed the complex relationship between firearms, mental illness, suicide, and violence. The document highlighted the limitations of existing legislative strategies, such as the National Instant Criminal Background Check System (NICS), in combating the problems of gun-related suicide and violence in the United States. It noted that registries like NICS can be helpful in some situations, but they are minimally effective in identifying people at acute risk of harm to self or others. In addition, they can unfairly stigmatize individuals with mental illness. As an alternative strategy, the resource document considered a different type of law: that which temporarily restricts access to firearms during a crisis, regardless of mental health diagnosis. Such laws, which had been implemented in Indiana, Connecticut, and California at the time, are risk-based and not tied directly to mental illness or histories of adjudicated civil commitment. Preliminary data indicated that the laws were particularly effective as a suicide prevention strategy, and they deserved further study as a violence reduction measure. Since the publication of the 2014 resource document, the national dialogue on gun violence has progressed, including further consideration of risk-based firearm restriction.

The current resource document summarizes the growing body of research surrounding risk-based firearm removal laws. These laws go by several names: gun violence restraining orders (GVROs),[2] risk-based gun removal,[3] dangerous persons firearms seizure,[4] extreme risk protection orders,[5] and others. They have also been loosely referenced as "Red Flag Laws" because of their ability to initiate a process for firearm removal when a "red flag" of concern about an individual's firearm possession is raised by his or her conduct.

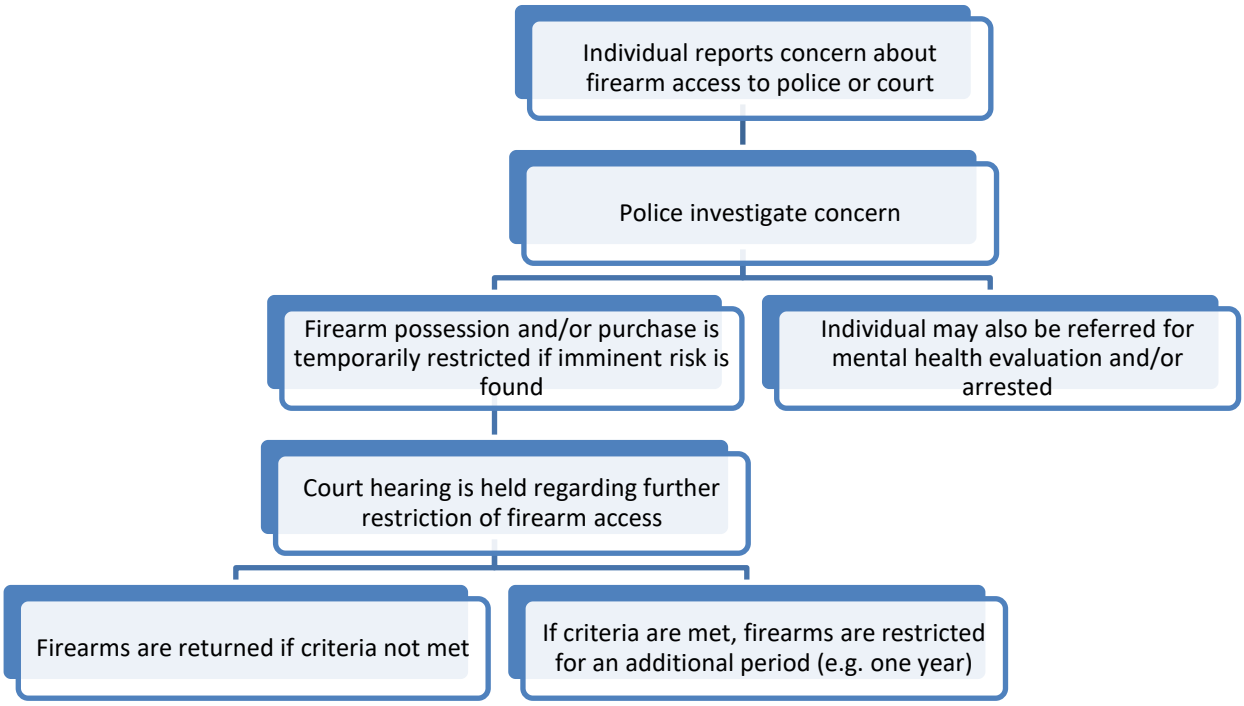
In this document, we use the term "risk-based gun removal laws" to include legislation that aims to restrict access to firearms temporarily for individuals determined to be acutely dangerous to themselves or others. At the time of this writing, four states—Connecticut,[6] Indiana,[4] Washington,[5] and California,[7] —had enacted laws that allow clinicians or family members to initiate firearm removal based on dangerousness, regardless of psychiatric diagnosis. Several other states have similar laws allowing firearm removal by law enforcement officers,[8,9,10] and still more states are actively considering implementation of risk-based gun removal programs. In addition, President Trump and the National Rifle Association recently endorsed these laws after another tragic mass shooting event. Given the rapidly shifting legislative landscape around this issue, this document limits its discussion to the Connecticut, Indiana, Washington, and California laws, which serve as illustrative examples of risk-based gun removal legislation.

How Do Risk-Based Gun Removal Laws Work?

Although procedures vary from state to state, all risk-based gun removal laws are designed to address crisis situations in which there is an acute concern about an individual's access to firearms. For example, a person can call the police if she notices that her friend has been drinking heavily and making threats to harm himself. A spouse can ask for removal of firearms from the home based on escalating threats of violence in a marital relationship. An individual can even call the police him- or herself, asking for guns to be removed temporarily because of concern about suicide or violence.

Once the police and/or courts have been notified, an investigation must be conducted and a determination made about whether a genuine threat to self or others exists. In some states, a warrant is required, but sometimes police officers can remove firearms even without one. Officers responding to a crisis typically do more than remove firearms; they assess the person of concern and take further action as necessary, including referral for mental health evaluation or arrest. Typically, firearms can be removed for a short period before a hearing must be held and then for a longer period if the criteria are met at the hearing. The total authorized period of removal ranges from two weeks to one year, depending on the state. After the restriction period has ended, individuals whose guns have been removed can petition the court to have them returned.

Figure 1 outlines a typical framework for dangerousness-based gun removal:



Policies and practices vary significantly among states with gun removal laws regarding who can initiate the gun removal process, whether a warrant is required, what factors the court must consider before ordering firearm removal, what must be proven in court, how long the firearms are restricted, and what process is used to restore the individual's firearm access. *Appendix A* delineates the key features and differences between laws in Connecticut, Indiana, California, and Washington.

Outcomes Data

Connecticut and Indiana implemented their risk-based gun removal laws in 1999 and 2006, respectively, after tragedies involving mass shootings. To date, they are the only two states with published data about the laws' outcomes.[3, 11, 12, 13]

How often are risk-based gun removal laws used?

Although concerns from gun owners have been raised that these laws may lead to widespread reporting and unwarranted gun removal, data from Connecticut and Indiana indicate that risk-based gun removal laws are used infrequently. In the 14 years of the Connecticut study (1999 to 2013), 762 "risk-warrants" (Connecticut's term for gun removal warrants based on dangerousness) were issued—an average of 51

per year.[3] Connecticut has approximately 227,000 gun-owning households, [14, 15] so 51 warrants per year affect only a tiny fraction (0.02%) of gun-owners in the state. An average of 7 guns per risk-warrant were seized.[3]

In Marion County, Indiana, 404 petitions for gun removal were requested between 2006 and 2013—approximately 58 per year. Parker estimated that 0.04% of gun-owning households in the county were affected by gun removal laws.[13] On average, 2.7 guns were seized per petition in Indiana (1096 total firearms, including 555 handguns and 525 long guns).[13]

Who typically initiates the firearm removal process?

In Connecticut, about half of the reports to police were made by an acquaintance of the person of concern – 41% from family members and 8% from employers or clinicians.[3] The remaining 51% of reports were made by people who did not know the person of concern or did not disclose their relationship to the police.

Whose firearms are removed?

Data from Connecticut indicate that the typical subject of gun removal was a middle-aged or older married man (average age of 47) [11] and that 5% of the male subjects were military veterans. Most of the subjects (88%) were not known to Connecticut's public behavioral health system at the time the risk-warrants were served, indicating that they had not received treatment for a serious mental illness in the prior year.[3] Likewise, the majority of subjects were not involved with the criminal justice system; 88% had no criminal conviction in the year before or after the gun removal.[3]

Under what circumstances are firearms removed?

Most Connecticut cases involved a concern about self-harm (61%), with a concern about harm to others in 32% of cases. Nine percent of the subjects posed a risk of harm both to self and others. In 16% of cases, a risk of harm to self or others was not specified; these cases typically involved individuals who were too intoxicated or psychotic for that distinction to be made.[3] Similarly, in Indiana, removal of a firearm was most likely to occur upon threatened or attempted suicide (68.1%), followed by circumstances such as domestic disturbance (28.5%), intoxication (25.5%), actual or threatened violence (21.0%), and psychosis (16.3%).[13]

What happens to firearms after they are removed?

In 99% of the Connecticut cases, police search led to removal of firearms. In most cases, the outcome of the mandatory court hearing following gun removal was not known. However, among the known outcomes, the seized firearms were held by police (60%), ordered destroyed or forfeited (14%), returned directly to the subject (10%), or transferred to another individual known to the subject and legally eligible to possess them (8%).[3]

In Indiana, court-ordered retention of the firearm (63%) was the primary outcome, which correlated strongly with the gun owner's failure to appear at the court hearing. In cases where the owner failed to appear, the court typically ordered the destruction of the firearm five years after the initial removal petition. During the first three years of Indiana's gun removal statute, the court commonly suspended the individual's license to carry a gun. Dismissal of the case was another common outcome (29%), and this result was closely linked to the defendant appearing in court. Other less frequent outcomes included firearms destroyed with agreement of the owner (8.9%) and transfer of seized weapons to another individual (5.7%).[13]

What happens to the individual after his or her firearms are removed?

In both Connecticut and Indiana, the most common police action at time of gun removal was transport to the hospital for psychiatric evaluation (55% and 74%, respectively).[3,13] In Indiana, 8% of individuals were arrested, and 14% were not detained at all. [13] In Connecticut, 17% of individuals were arrested, and 27% were not detained. [3] The Connecticut data indicate that, in the year following gun removal, 29% of subjects received services through the public mental health system, suggesting that gun removal served as an entry point into psychiatric treatment.[3]

How long is firearm access restricted?

By statute, firearms can be held for 14 days in Connecticut before a court hearing, after which the restriction can be extended for a period of up to one year.[6] No data are available regarding how long the restriction typically lasts in that state. In Indiana, the statute indicates that firearms can be held for up to 14 days, after which a court hearing must occur, and the restriction can be extended for up to 180 days. However, Parker noted that, in practice, the time frames for gun removal in Indiana often do not meet statutory requirements. Parker's study found that it took about 140 days for the prosecutor to petition to retain guns seized by the police (rather than the required 14 days), with a significant decrease during the last three years of the study to 88 days. Resolution of the cases occurred in just

over 280 days (9 months) after the time police had seized the firearm (rather than the statutory 14 days plus 180 days). [13]

Key Findings from Studies of Risk-Based Gun Removal Laws

Although the risk-based gun removal laws in Connecticut and Indiana were both enacted in the aftermath of highly publicized mass shootings, data indicate that they are most often used in response to concerns about suicide risk, not violence.[3,13] The laws are directed toward individuals in crisis, typically without a known history of mental illness. In addition to decreasing violence and suicide risk by removing firearms, the laws provide an opportunity for treatment intervention. In fact, most individuals whose firearms were seized were also taken to a hospital for psychiatric evaluation, and approximately 30% remained in treatment one year later.

Swanson et al.[3] emphasize the utility of risk-based gun removal laws as a public health strategy to prevent suicide. Although their data are relatively limited, the authors conclude that Connecticut's law may prevent one suicide for every 10 to 20 gun removals, primarily by delaying access to firearms during a period of acute crisis. In Indiana, Parker[13] is hesitant to draw conclusions about violence or suicide prevention, but he does note the potential utility of reducing access to weapons for high-risk individuals for an average of 9 months.

The findings from Connecticut and Indiana are consistent with a larger body of research supporting "means reduction"—the removal of the means by which individuals might act harmfully to themselves or others—as a suicide prevention tool. Population-wide restriction of lethal means has been demonstrated to be effective in reducing suicide when the method is both highly lethal and common (e.g. guns in the United States), and when the restriction is supported by the community.[16,17,18] Similarly, rates of suicide by firearm decrease when restrictions are placed on firearm access, particularly by youth. International studies have demonstrated reduced rates of firearm and overall suicide following legislation and policy changes reducing access to firearms in Australia,[19,20] Switzerland,[17] New Zealand,[21] and Israel.[22]

Restricting access to firearms has also been found effective in decreasing rates of suicide in the United States. States with more firearm restrictions and lower rates of gun ownership have lower rates of both overall suicide and firearm suicide.[23-26] Conversely, states with fewer restrictions on firearm ownership and higher rates of gun ownership have higher rates of firearm related suicides.[27, 28] Notably, suicide attempt rates were similar in both high and low gun-ownership states, but mortality rates were twice as

high in high-gun ownership states. The differences in mortality were entirely attributable to differences in firearm suicide rates. [29]

Advantages and Limitations of Risk-Based Gun Removal

As noted in the 2014 Resource Document,[1] risk-based gun removal laws are attractive for several reasons. First, they focus on acute dangerousness rather than on psychiatric history or diagnosis, decreasing the stigma associated with mental illness and disavowing the mistaken premise that mental illness is the primary cause of acute violence risk. Second, in contrast to a registry (e.g., NICS), which primarily limits the ability to purchase firearms, risk-based gun removal laws provide a legal framework for removing firearms from individuals at a time that is closely linked to the risk of a dangerous act. Third, gun removal laws can supplement the legal options available to mental health professionals responding to a patient who poses a serious risk to self or others. Even in situations when the provisions of the laws are not formally invoked, their existence can create leverage for families and friends to persuade patients to voluntarily surrender weapons to them temporarily for safekeeping. Fourth, risk-based gun removal laws provide a way to reach individuals who do not seek psychiatric assistance and whose suicide or violence risk might otherwise go undetected.

Despite these advantages, several concerns have been raised about risk-based gun removal. The laws have been criticized for the heavy procedural burden they place on courts and police officers, straining already scarce resources.[3] In addition, although the Connecticut and Indiana statutes were implemented over a decade ago, public awareness of these laws—as well as that of mental health and other health professionals—may be limited. Finally, because the state statutes differ significantly from each other, and outcomes data are preliminary, best practices for risk-based gun removal have yet to be established.

Guidance for Mental Health Professionals

Mental health clinicians often struggle to manage patients who pose a risk of harm from firearms, even in states with well-established gun removal laws. Many clinicians are uncomfortable asking patients about access to guns, and in some cases, gun rights advocates have attempted to prevent them from doing so (thus far unsuccessfully).[30] When clinicians do become aware of firearm risks, they may not know of their state's risk-based firearm removal statutes or how to use them in practice.

Certainly, educating physicians generally about firearms is an important step in managing risk. To this end, some medical organizations have created educational programs aimed at enhancing physicians' ability to talk about firearms from a health and safety perspective with their patients.[31, 32] Although general knowledge about guns is helpful, specific education about risk-based gun removal is also necessary. Without this step, mental health clinicians may miss important opportunities to intervene in times of crisis to keep their patients and others safe.

When a patient tells a mental health clinician about a firearm risk – for example, saying that he has been contemplating suicide using a handgun kept at home – the clinician's first step is to perform a clinical assessment. If the clinician concludes that a serious risk exists, he or she may proceed down two paths. On the first path, the patient can be referred for emergency psychiatric assessment and/or hospitalization. On the second path, the clinician may also (or instead, depending on risk considerations) pursue removal of firearms from the patient's home. In many cases, removal can be accomplished by encouraging a friend or family member either to take temporary possession of the weapons or to contact police for removal of the firearm. However, in states with gun removal laws, the clinician may be able to use an emergency exception to confidentiality to ask the police directly to intervene, even if a patient refuses to allow contact. Both paths – providing care for the patient and limiting access to guns – may be pursued simultaneously.

It is important to understand that risk-based gun removal laws are designed primarily to enable concerned citizens to intervene when they perceive a danger related to firearms; the laws are not typically written with mental health professionals in mind. They do not delineate the exact circumstances in which mental health clinicians may breach patient confidentiality in order to make a report to the police, nor do they mandate such breaches. Furthermore, they do not include immunity protections from civil liability related to breaches of confidentiality. Given this ambiguity, clinicians are well-advised to familiarize themselves with their local laws about exceptions to confidentiality, seeking consultation from an attorney or forensic psychiatrist where possible. At a minimum, clinicians should clearly identify the factors that raise concern about a patient's gun possession and that might warrant disclosure to the police. They should also document their reasoning and consider whether other measures, such as emergency hospitalization or voluntarily surrender of guns to a trusted person, would be sufficient to keep the patient and/or others safe. Alternatively, clinicians should consider whether the threat of harm to others would justify a disclosure to law enforcement under other applicable state laws (e.g., *Tarasoff* [33] or New York's SAFE Act [10]) without fear of liability. As in all clinical circumstances,

careful consideration of possible actions requires analysis of the risks of disclosure versus non-disclosure.

When a disclosure is determined necessary, it is important to note that risk-based gun removal laws do not provide guidance about how much information should be disclosed to the police. The guiding principle of "disclose as little confidential information as possible to accomplish the objective at hand" may be helpful to remember in these cases. For example, the clinician will likely need to disclose the patient's name, the location of the firearms, and any information that supports the clinician's opinion that a serious risk exists (such as the patient's statements about suicide, past history of self-harm, and additional suicide risk factors). However, disclosing a full psychosocial history and other details about treatment may be unnecessary to accomplish the objective of facilitating the police's assessment of imminent risk.

If the police decide to intervene and restrict an individual's access to firearms, the clinician may be asked to testify in a subsequent hearing about whether the guns should be returned. Data from Indiana and Connecticut indicate that many individuals waive their right to a court hearing, but if one occurs, the clinician may be asked to explain the circumstances leading to the gun removal or opine on the patient's ongoing risk. Again, clinicians should seek consultation in these cases, ideally well in advance of the hearing. State laws about disclosure of medical information during court proceedings vary widely; in some states, patients may be able to invoke an evidentiary privilege under these circumstances in an effort to keep the clinical information out of court. Consultation with a forensic psychiatrist colleague and/or risk management attorney can be helpful should this circumstance arise.

Additionally, clinicians may have questions about whether to continue working with a patient after reporting a patient's firearm risk. Gun removal laws do not preclude contact between the reporting individual and the one whose guns are removed, and the decision whether to continue the treatment relationship must be made based on clinical factors against the backdrop of the clinician's obligation not to abandon the patient. Again, consultation with a mental health colleague or risk management professional can be helpful. In some cases, patients may be grateful for the clinician's care and concern during the firearm crisis, but in others they may be angry at the clinician for initiating the process that led to what they perceive to be a violation of their rights. In the latter circumstance, it may be appropriate to transfer the patient to another clinician, taking care to provide an appropriate handoff and avoid abandonment.

Finally, although only a small number of states have risk-based gun removal laws, clinicians practicing in other jurisdictions may still have options and/or mandates to manage acutely dangerous situations involving firearms. For example, if a patient makes a threat to shoot her boss, as noted above, the clinician may have a duty to protect the intended victim by hospitalizing the patient, issuing a warning to the identified victim, and/or providing notification to law enforcement. In a different scenario, if a patient discloses that his children have access to an unlocked firearms storage cabinet, a report to child protective services may be required. Clinicians can easily lose sight of appropriate strategies to manage risk and provide care for patients during the emotionally charged clinical encounters that surround threats of harm from firearms. Risk-based firearm removal laws can be helpful under these difficult circumstances. However, it is important to remember that the laws have typically been designed to facilitate intervention by families and concerned citizens. Although they may be a helpful tool for mental health professionals, risk-based gun removal laws must be seen as just one part of a larger strategy to manage risk and provide appropriate clinical care for patients who pose a threat of suicide or violence.

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Appendix A: Selected State Statutes Regarding Preemptive Firearm Removal from Persons at Risk of Violence Towards Self or Others (Prepared by Kelly Roskam, J.D., Consortium for Risk-Based Firearm Policies]

Table 1: Connecticut and Indiana

Table 2: California

Table 3: Washington

Table 1.	Connecticut	Indiana	
Type of process	**Warrant**	**Warrant**	**Warrant-less**
Who initiates the process?	• Two law enforcement officers, or • A state's attorney, or • An assistant state's attorney.	Law enforcement officer.	Law enforcement officer.
What must be proven?	The entity seeking the warrant must show probable cause to believe that a person poses a risk of imminent injury to himself, herself, or another, such person possesses one or more firearms, and such firearm(s) are within or upon any place, thing or person.	The law enforcement officer must show probable cause exists to believe that the individual is dangerous and in possession of a firearm.	
Factors considered in deciding whether the burden has been met	To issue a warrant, judges shall consider: • Recent threats or acts of violence directed toward himself, herself or another, and • Recent acts of cruelty to animals. Judges may also consider, but are not limited to: • The reckless use, display, or brandishing of a firearm, • A history of the use, attempted use, or threatened use of physical force by such person against another, • Prior involuntary confinement of such person in a hospital for persons with psychiatric disabilities, and • The illegal use of controlled substances or abuse of alcohol.	No factors are specified.	No factors are specified.
Court Review/Approval	Court approval is required prior to the removal of firearms.	Court approval is required prior to the removal of firearms.	Court approval is not required prior to the removal of firearms.
Length of prohibition on purchase/possession of	Removal of firearms pursuant to the warrant lasts up to 14 days until a hearing can be held.	The removal of firearms lasts up to 14 days from the return of an executed warrant.	The removal of firearms lasts up to 14 days after written submission to the

firearms and removal of firearms			court justifying the warrant-less removal.
How are firearms removed?	Law enforcement shall execute the warrant to search for and seize firearms.	Law enforcement shall execute the warrant to search for and seize firearms.	Law enforcement shall seize the firearms.
~~Table 1. (cont'd)~~	~~Connecticut~~	~~Indiana~~	
	~~Warrant~~	~~Warrant~~	~~Warrant less~~
Is a hearing automatically scheduled to provide an opportunity to challenge it, and if so, when is it held?	Yes, a hearing shall be held within 14 days of the issuance of a warrant.	Yes, a hearing shall be held within 14 days of the return of an executed warrant.	Yes, a hearing shall be held within 14 days of a written submission.[1]
What must be proven at the hearing?	The state must prove by clear and convincing evidence that the owner remains "a risk of imminent injury to self or others."	The state must prove by clear and convincing evidence that the respondent is dangerous.	
Length of prohibition on purchase/possession of firearms and removal of firearms	Up to one year after the hearing.	180 days after the hearing, at which point the respondent may petition for return.	
Statute(s)	Conn. Gen. Stat. Ann. § 29-38c.	Ind. Code Ann. § 35-47-14.	

[1] An officer seizing a firearm from an individual without a warrant shall submit a written statement to the court describing the basis for the seizure. If the court finds probable cause to believe the individual to be dangerous, the law enforcement agency shall retain the firearm(s).

Table 2.	California		
Type of process	A civil court order called the Gun Violence Restraining Order ("GVRO").		
Type of GVROs	**Temporary Emergency GVRO**	**Ex Parte GVRO**	**Final GVRO**
Who initiates the process?	Law enforcement only.	Law enforcement or an immediate family member.	Law enforcement or an immediate family member.
What must be proven?	The petitioner must show reasonable cause to believe (1) the subject of the petition poses an immediate and present danger of causing personal injury to himself, herself, or another AND (2) less restrictive alternatives have been ineffective, or are inappropriate or inadequate for the situation.	The petitioner must show a substantial likelihood (1) the subject of the petition poses a significant danger, in the near future, of personal injury to himself, herself, or another AND (2) less restrictive alternatives have been ineffective, or are inappropriate or inadequate for the situation.	The petitioner must prove by clear and convincing evidence (1) the subject of the petition, or person subject to an ex parte GVRO, poses a significant danger of personal injury to himself, herself, or another AND (2) less restrictive alternatives have been ineffective, or are inappropriate or inadequate for the situation.
Factors considered in deciding whether the burden has been met	No factors specified.	The court shall consider the following factors: • A recent threat or act of violence directed toward himself, herself, or another, • A violation of an emergency protective order, • A recent violation of an unexpired protective order, • A conviction for an enumerated violent offense, • A pattern of violent acts or violent threats within the past 12 months. Judges may consider any other relevant evidence, including, but not limited to: • The unlawful, reckless use, display, or brandishing of a firearm, • The history of use, attempted use, or threatened use of physical force, • Any prior arrest for a felony offense, • Any history of a violation of a protective order, • Evidence of alcohol or controlled substance abuse, • Recent acquisition of firearms, ammunition, or other deadly weapons.	
Court Review/Approval	Court review or approval is required prior to the prohibition on purchase/possession and removal of firearms taking effect.		
Length of prohibition on possession of firearms	21 days.	21 days or less (until hearing).	One year.

~~Table 2. (cont'd)~~	~~California~~		
	~~Temporary Emergency GVRO~~	~~Ex Parte GVRO~~	~~Final GVRO~~
How are firearms removed?	Upon request of a law enforcement officer serving a GVRO, firearms and ammunition shall be surrendered immediately to the control of the officer. If no request is made by the law enforcement officer, the respondent shall surrender all firearms and ammunition, within 24 hours, to the control of the local law enforcement agency, to a licensed firearms dealer, or by selling such firearms and ammunition to a licensed firearms dealer. Law enforcement may seek a warrant to search for and seize firearms and ammunition unlawfully possessed by the subject of a GVRO.		
Is a hearing automatically scheduled to provide an opportunity to challenge it, and if so, when is it held?	No.	Yes, within 21 days of the issuance of an ex parte GVRO.	No (the hearing is held before the issuance of a final GVRO).
Statute(s)	Cal. Penal Code § 18100 *et seq*.		

Table 3.	Washington	
Type of process	A civil court order called the Extreme Risk Protection Order ("ERPO").	
Type of ERPOs	**Ex Parte ERPO**	**Final ERPO**
Who initiates the process?	A law enforcement officer, law enforcement agency, or family or household member.	A law enforcement officer, law enforcement agency, or family or household member.
What must be proven?	Petitioners must show a reasonable cause to believe that the respondent poses a significant danger of causing personal injury to self or others in the near future by having in his or her custody or control, purchasing, possessing, or receiving a firearm.	Petitioners must prove by a preponderance of the evidence that the respondent poses a significant danger of causing personal injury to self or others by having in his or her custody or control, purchasing, possessing, or receiving a firearm.
Factors considered in deciding whether the burden has been met	Court may consider any relevant evidence, including, but not limited to the following: • Recent act or threat of violence by the respondent against self or others, • A pattern of acts or threats of violence by the respondent within the past 12 months, • Any "dangerous mental health issues, • A violation by the respondent of a protection order or no-contact order, • A previous or existing ERPO issued against the respondent; • A violation of a previous or existing ERPO issued against the respondent; • A conviction of the respondent for a crime of domestic violence; • Ownership, access to, or intent to possess firearms; • Unlawful or reckless use, display, or brandishing of a firearm by the respondent; • History of use, attempted use, or threatened use of physical force by the respondent against another person; • History of stalking another person; • Any prior arrest of the respondent for a felony offense or violent crime; • Corroborated evidence of the abuse of controlled substances or alcohol by the respondent; and • Evidence of the recent acquisition of firearms by the respondent.	
Court Review/Approval	Court review or approval is required prior to the prohibition on purchase/possession and removal of firearms taking effect.	
Length of prohibition on possession of firearms	14 days or less (until hearing).	One year.
How are firearms removed?	A law enforcement officer serving any ERPO shall request that the respondent immediately surrender all firearms in his or her custody, control, or possession and any concealed pistol license issued to the respondent. The law enforcement officer shall take possession of all respondent's firearms that are surrendered, in plain sight, or discovered pursuant to a lawful search. If personal service by a law enforcement officer is no possible, or not necessary because the respondent was present at the ERPO hearing, the respondent shall surrender the firearms in a safe manner to the control of the local law enforcement agency within 48 hours of being served with the order by alternate service or within 48 hours of the hearing at which the respondent was present. Where the respondent fails to surrender firearms or a CPL, law enforcement may seek a search warrant.	

~~Table 3. (cont'd)~~	~~Washington~~	
	~~Ex Parte ERPO~~	~~Final ERPO~~
Is a hearing automatically scheduled to provide an opportunity to challenge it, and if so, when is it held?	Yes, a hearing shall be held within 14 days of the issuance of an ex parte ERPO.	No (the hearing is held before the issuance of a final ERPO).
Statute(s)	Wash. Rev. Code Ann. § 7.94.010 *et seq*.	

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.

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[*]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

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Telephone: (888) 357-7924 • Fax: (202) 682-6850 • Email: apa@psych.org

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
Amended by the Council on Psychiatry and the Law, September 2017

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

Issue:
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 a 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.**
6. **If the applicant raises a mental health diagnosis or treatment as an explanation for conduct or behavior that may otherwise warrant denial of credentials or licensure, the licensing board may inquire into such diagnosis or treatment. Such inquiry shall be narrowly, reasonably, and individually tailored. Medical or hospital records requested shall be by way of narrowly tailored requests and releases that provide access only to information that is reasonably needed to assess the applicant's fitness to practice. All personal or health-related information shall be kept strictly confidential and shall be accessed only by individuals with a legitimate need for such access.[1]**
7. **Personal health information collected by the board should be kept confidential and should be destroyed after a reasonable period of time.**

Authors: Council on Psychiatry and the Law.
Written by Richard Bonnie, Paul Appelbaum, and Patricia Recupero.

[1] Language adapted from 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, Terms and Conditions, § (A) (13) (c).

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 these 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 through seventh principles are designed to assure that applicant's personal health data remain confidential unless there are specific circumstances under which information obtained during the agency's inquiry may be made public.

  The settlement agreement in Louisiana further provides that if any inquiry is made regarding the applicant's health status, the licensing board (or a medical professional retained by the board) will first request statements from the applicant and, if reasonably deemed necessary by the licensing board (or a medical professional retained by the board), the applicant's treating professional. The treating professional's statements shall be accorded considerable weight, and medical records shall not be requested unless a statement from, and further dialogue with, the applicant's treating professional fails to resolve the board's reasonable concerns regarding the applicant's fitness to practice.[2]

  The settlement agreement in Louisiana also provides that an independent medical examination shall not be requested unless all other means described in this paragraph fail to resolve the board's reasonable concerns regarding the applicant's fitness to practice, and, if requested, shall occur at a time and location convenient to the applicant.[2]

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[1] ABA Bar Admissions Resolution, 18 Mental and Physical Disability Law Reporter 597 (1994).

[2] Settlement Agreement Between the United States of America and the Louisiana Supreme Court under the Americans with Disabilities Act, August 13, 2014, http://www.ada.gov/louisiana-supreme-court_sa.htm.

Position Statement on Legislative Intrusion and Reproductive Choice

Approved by the Board of Trustees, December 2013
Approved by the Assembly, November 2013

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A growing number of state legislatures have enacted or are considering legislation requiring physicians who are counseling and treating pregnant women to follow specific scripts and protocols in communicating with their patients and providing medical care to them. These required scripts include inaccurate statements about the effects of abortion on the woman's health and well-being. Prescribed examination protocols typically include mandated ultrasound procedures which women are encouraged or required to view. Although it is appropriate for states to require disclosure of material information regarding the risks of any recommended treatment and to obtain informed consent, these statutes are not designed to assure informed decision-making; instead they represent an unprecedented effort by the government to use physician communications as an instrument for discouraging pregnant women from exercising their constitutional right to make their own reproductive choices. These laws intrude into the privacy of physician-patient communications and, in so doing, compromise the rights of both patients and physicians. They are strongly opposed by the American Psychiatric Association.

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. Restricting the manufacture and sale for civilian use of large-capacity magazines and firearms with features designed to increase their rapid and extended killing capacity;
   ~~d~~e. Banning possession of firearms on the grounds of colleges, hospitals, and similar institutions by anyone other than law enforcement and security personnel; and
   ~~e~~f. 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.

GENERAL CPL COMMENTS:

(1) Consider whether to keep the 2013 Position Statement on Detained Immigrants with Mental Illness instead of adopting this one (noted that is clear and less controversial). Reference Position Statement on treatment of individuals in jails and prisons – this should be consistent with that.

(2) Consider whether APA should wade into the debate over immigration policy in general. It's one things to argue for adequate mental health treatment for persons in this country regardless of their legal status and whether in detention or not. It's another to implicitly urge particular approaches to immigration on somewhat loosely-related mental health grounds.

(3) Consider whether to combine point 1 and 3 into a single sentence: "The APA advocates for undocumented immigrants to receive appropriate treatment for mental and physical disorders, including while in detention".

(4) Consider whether APA should call for better access to attorneys for children and people with substantial mental disorders. 2013 federal district court case Franco v. Holder recognized right to legal representation for immigration detainees with serious mental disorder that renders them unable to represent themselves. Consider adding "All children and people with mental disorders (at a minimum) should have access to legal representation, and policies and procedures should be put in place to encourage access to attorneys."

Title: **Position Statement on Mental Health Needs of Undocumented Immigrants, including Childhood Arrivals, Asylum-Seekers, and Detainees**

Issue: Thirteen percent of the United States population is foreign-born, and a quarter of those are undocumented immigrants (1, 2). Undocumented immigrants have limited access to healthcare, are less likely to seek out health care, and have less satisfying healthcare encounters (3). Studies have demonstrated a link between restrictive immigration policies and poorer mental health among undocumented immigrants and recent immigrants (4, 5). For example, among adults eligible for Deferred Action for Childhood Arrivals (DACA) and children of DACA eligible adults, mental health burden fell a significant degree after the introduction of DACA (6, 7). A subset of undocumented immigrants are asylum seekers; this population carries a high burden of trauma from their country of origin (8). Asylum seekers who obtain legal status wait on average 3.9 years for that change (2), sometimes in detention centers, and in the meantime are at risk of further trauma and worsening of mental illness (8).

APA Position Statement:

1. The APA advocates for improvement of access to mental and physical health care for undocumented immigrants.
2. The APA urges federal policy makers to recognize the impact that immigration policy has on the mental health of undocumented immigrants. More specifically:
   - the APA acknowledges the benefits that DACA conferred on the mental health of eligible persons and recommends that federal policy makers consider mental health consequences when debating DACA's continuation.
   - the APA recognizes that trauma and the threat of trauma in one's home country negatively impact the mental health of asylum seekers and recommends that this be considered when determining the status of asylum seekers.
   - the APA recognizes the deleterious effects of detention centers on the mental health of asylum seekers and immigrants detained for legal proceedings; therefore, it encourages the use of less restrictive alternatives for monitoring.
3. The APA urges federal policy makers and responsible agency officials to ensure that detained individuals with mental disorders receive appropriate mental health treatment.

Commented [AC1]: Consider stronger statement about need to improve quality of care in detention center. (e.g. Human Rights Watch document describing examples of poor quality care in detention centers).

Commented [AC2]: Consider whether to delete this, as the issues are a policy morass for which APA has no particular expertise.

Other CPL members voice support as well for a more focused statement, but mental health treatment access and addressing trauma and isolation may be considered fairly within APA's purview

Another view expressed that APA could comment on need for adequate mental health treatment in facilities since they are being used and will continue to be used (similar to documents specific to correctional facilities), or include statement that immigration detention facilities are correctional facilities. However the detention and separation of children from parents in these facilities is a problematic practice, as is isolation of children

Suggestion to add to sentence about deleterious effects on mental health observation that many detainees are traumatized or otherwise vulnerable

Another view presented against deleting this item, as it is important to point out that uncertain immigration status or threat of returning to a dangerous country has potential mental health consequences for an individual. 2a and b merely ask policy makers to consider these factors when deciding asylum cases.

Bullet #2, first paragraph: There is no foundation to suggest that 100% of DACA-eligible persons would benefit from the program more than returning to their home countries or elsewhere. Thus, adding one of the following descriptors – some, many, or most, depending on the evidence that you are referencing would be more appropriate.

Bullet #2, second paragraph: add the word "*can*" between country and negatively or add the word "sum" between the words *of* and *asylum* to render the statements more reasonable.

2c presents question of whether such a statement fits with positions on correctional facilities more broadly Has APA gone so far as to say that prisons/jails bad for mental health and alternative sentences should be considered? If not, may not want to say in just this context as all people in correctional facilities face similar harms.

On 2c another view expressed that there is a point in calling for least restrictive altenrative for monitoring (e.g. asylum seekrs allowed to continue claims in a community-based setting) (since immigration detention for flight risk not punishment).

Favor general recognition of deleterious effects of detention centers on mental health of asylum seekers and immigrants detained for legal proceeding and favor comment on need for adequate treatment while in facililties.

Bullet #2, third paragraph: Delete this one: The extent of restrictive containment for individuals in immigration detention facilities is a matter of national security and exceeds the scope of psychiatric practice.

4. The APA encourages public government officials to be mindful of the need to use respectful language when referencing undocumented immigrants, and their country of origin, to reduce the emotional burden and stigma felt by this vulnerable groups.

Authors: In December 2017, a subcommittee appointed by the Council on Minority Mental Health and Health Disparities drafted the Position Statement.

Adoption Date: Pending

Commented [AC3]: Consider whether this is a reaction merely to President's recent reference to African countries or a common problem among government officials.

Another view expressed to not underestimate the impact and stigma caused when such language is spoken by the President.

Bullet #4:If the goal of this statement is to have public officials, including those who supervise individuals in immigration detention centers to treat detainees humanely or with respect, then say that. The latter part of Bullet #4 has no place in this document as it addresses diplomatic matters that exceed the scope of our expertise and practice. There are other avenues that may be used by government officials (and social media) to address this.

Background

Citations:

(1) US Census Bureau. "Selected Social Characteristic in the United States, 2015 American Community Survey 1-Year Estimates." Available at https://factfinder.census.gov

(2) Baker B, Rytina N. "Estimates of the Unauthorized Immigrant Population Residing in the United States: January 2012." Population Estimates (March 2013), DHS Office of Immigration Statistics, available at: https://www.dhs.gov/sites/default/files/publications/Unauthorized%20Immigrant%20Population%20Estimates%20in%20the%20US%20January%202012_0.pdf

(3) Ortega AN, Fang H, Perez VH, Rizzo JA, Carter-Pokras O, Wallace SP, Gelberg L. Health care access, use of services, and experiences among undocumented Mexicans and other Latinos. *Archives of Internal Medicine* 2007; 167 (21): 2354-60.

(4) Martinez, O., Wu, E., Sandfort, T., Dodge, B., Carballo-Dieguez, A., Pinto, R., … Chavez-Baray, S. Evaluating the Impact of Immigration Policies on Health Status Among Undocumented Immigrants: A Systematic Review. *Journal of Immigrant and Minority Health / Center for Minority Public Health* 2015; *17*(3), 947–970.

(5) Hatzenbuehler ML, Prins SJ, Flake M, Philbin M, Frazer MS, Hagen D, Hirsch J. Immigration policies and mental health morbidity among Latinos: A state-level analysis. *Social Sciences and Medicine* 2017; 174:169-178.

(6) Venkataramani AS, Shah SJ, O'Brien R, Kawachi I, Tsai AC. Health consequences of the US Deferred Action for Childhood Arrivals (DACA) immigration programme: a quasi-experimental study. *Lancet* 2017; 2(3): e175-e181.

(7) Hainmueller J, Lawrence D, Marten L, Black B, Figueroa L, Hotard M, Jimenez TR, Mendoza F, Rodriguez MI, Swartz JJ, Laitin DD. Protecting unauthorized immigrant mothers improves their children's mental health. *Science* epub 31 Aug 2017.

(8) Silove D, Steel Z, Waters C. Policies of deterrence and the mental health of asylum seekers. *Journal of the American Medical Association* 2000; 284 (5): 604-611.

(9) American Psychiatric Association. (2013). Position Statement on Detained Immigrants with Mental Illness. Washington, DC. Martinez D, Recupero R, Pumariega A, Vaicius A, Council on Psychiatry and Law, Council on Minority Mental Health and Health Disparities, American Association for Social Psychiatry, APA Hispanic Caucus

Addendum to Item JRC #8.L
Joint Reference Committee
June 2017

Action Item

Will the Joint Reference Committee recommend that the Assembly approve the proposed Position Statement on the Utilization of Measurement Based Care?

- Please see the attached proposed position statement.
- Background document forthcoming.

Council on Quality Care
Report to the Joint Reference Committee
June 2018

Title:
Position Statement on the Utilization of Measurement Based Care
Issue:
As health care focuses increasingly on the value of services rather than volume, it is essential for healthcare providers (including psychiatrists, other physicians, and behavioral health clinicians) to demonstrate the provision of quality care and the subsequent impact on individualized patient outcomes. Measurement-based care (MBC), described as "the systematic administration of symptom rating scales and use of the results to drive clinical decision making at the level of the individual patient" has been shown to improve patient outcomes (Fortney et al. 2016). Psychiatrists utilizing MBC use standardized, objective measurements at regular intervals in the assessment and treatment of patients to inform clinical decision-making and provide tangible evidence of treatment benefits across a variety of settings and psychiatric conditions. Rating scales have been developed that measure symptoms, side-effects, functioning, and patient experience. Some of these have been automated for computerized delivery to the patient. However, consistent implementation of valid and reliable measurement tools has not yet become universal in mental health care. Variation between typical and optimal outcomes creates an opportunity to improve psychiatric care. Support of Measurement Based Care (MBC) by the American Psychiatric Association (APA) would encourage its broader adoption and facilitate development of new measurement tools as well as clearer standards for how they should and should not be used.
APA Position:
The American Psychiatric Association (APA) supports the use of Measurement Based Care (MBC) by psychiatrists in the evidence-based treatment of mental health conditions in a manner that is streamlined, efficient and does not create burden that can negatively impact the clinical interaction. MBC can, when implemented appropriately, support clinical care, improve patient outcomes, and demonstrate the value of psychiatric care.
Authors:
Subgroup to the Workgroup on Quality and Performance Measurement charged by the Council on Quality Care: David Kroll, MD Alexander Young, MD Carol Alter, MD
Adoption Data:

Item JRC #8.L
Joint Reference Committee
June 2017

Executive Summary

Action Item

Will the Joint Reference Committee recommend that the Board of Trustees (BOT) approve a full day Committee on Quality and Performance Measurement meeting during the September 2018 Components Meeting to continue the quality measurement topic prioritization process, initiated in December 2017?

- Prioritization is an ongoing process to inform internal and external quality measure development to improve gaps in care for patients with mental and substance use disorders.
- Most of the Committee members will be present for their respective Council meetings that week.
- Estimated Cost ($5,000.00) would include: meeting room, lunch, AV request, and member travel. Attachment.

Referral Updates

As originally requested by the JRC in June 2017, the Council on Quality Care continued to work with several mental health patient advocacy groups to address updates to the language included in the 2015 Position Statement Action Paper: Use of the Concept of Recovery (JRCFEB178.M.1/ASM2017A1 4.B.20).

- The patient advocacy groups were pleased by the statement but did offer some recommended edits.
- Due to the timing of the recommended edits, the Council has not yet had a chance to review and finalize the draft for JRC review.
- We respectfully request the JRC extend the deadline for response to this referral until the next JRC meeting, this fall.

Meeting Minutes

- Please see the minutes of the May 2018 meeting of the Council on Quality Care. Attachment.

Proposed Budget Estimate
Committee on Quality and Perforamnce Measurement
Prioritization Meeting During 2018 Fall Component Meetings

Per the 2018 Cost Estimates for APA Meeting Travel

Justification	**Costs**	**Total**
3 Council Members traveling for their respective Council meetings	1-night additional hotel: $355.00 1-day additional per diem: $74.00	($355+74) *3 = $1287.00
2 Committee Members traveling to participate	1-night hotel stay: $355.00 cost of airfare: $425.00 per diem: $74.00 Ground Transportation: $50.00	($425+$355 + $74 + $50) *2 = $1808.00
Mid-meeting meal	cold lunch: $82.00 cold drinks: $8.50	($82.00+8.50) *5 = $452.50
Meeting AV Supplies	projector: $850.00 screen: $180.00	$850.00+$180.00 = $1030.00
Total estimated for 1-day meeting		$4577.50

Minutes
Council on Quality Care
May 7, 2018
New York City, New York

Attendees: Carol Alter, MD, Melissa Arbuckle, MD, PhD (Vice-Chair), Margie Balfour, MD, PhD, Jacob Behrens, MD, Greg Dalack, MD, Jerry Halverson, MD, Ray Hsiao, MD, Grayson Norquist, MD (Chair), Harold Pincus, MD, Megan Pruett, MD, Kunmi Sobowale, MD, Steven Starks, MD, Alex Young, MD, MSHS, Bonnie Zima, MD, MPH,

Invited Guests: Dan Anzia, MD, Robert Cabaj, MD, Laura Fochtmann, MD, Matthew Goldman, MD, Jacqueline Hobbs, MD, Geetha Jayaram, MD Brent Nelson, MD, Glenda Wrenn, MD

Administration: Debbie Gibson, MSc, Kristin Kroeger, Jennifer Medicus, Samantha Shugarman, MS, Phil Wang MD, DrPH

Absent: Steve Altchuler, MD, PhD, Nkemka Esiobu MD, MPH, Matthew Isles-Shih, MD, Roger Kathol, MD, Roberto Montenegro, MD, PhD

I. Opening/Introductions: Grayson Norquist, MD, Chair
   A. Conflict of Interest/Disclosure Statements
      Dr. Norquist welcomed all meeting participants and acknowledged and thanked Council members whose Council terms will end following today's meeting. This includes Dr. Young, Dr. Halverson, Dr. Dalack, and Dr. Altchuler.

II. Minutes from last meeting: Grayson Norquist, MD, Chair
   A. The Council members voted and approved the minutes from the March 6, 2018 meeting. (Without edits requested, Dr. Dalack motioned to vote on the document, and Dr. Hsiao seconded.)

III. PsychPRO: Registry Discussion: Phil Wang, MD, DrPH
   A. Web-based Portal Usage
      Dr. Wang thanked Council members involved with the swift development and ongoing oversight of the registry. After providing an overview of PsychPRO's success in 2017 as a Centers for Medicare and Medicaid Services (CMS) designated Qualified Clinical Data Registry (QCDR) that assisted users to earn bonus payments during the 2019 payment year, he addressed the low enrollment to the PsychPro patient portal. Originally mentioned during the March 2018 Council meeting, Dr. Wang explained that given APA's plan to develop patient reported outcome quality measures, the APA application to the CMS Measure Development Cooperative Agreement Funding Opportunity would notably increase patient enrollment in the portal, if funds are awarded.

   B. Progress Update and Discussion
      Dr. Wang explained that while originally scheduled for completion by the second quarter of 2018, APA's contracted registry vendor, FigMD, is making progress with connecting practices that use Epic electronic health record (EHR) systems across registries. As part of this effort, Epic's lead behavioral health staff contacted APA to identify the best way for Epic EHR systems to connect with

PsychPRO. With APA staff taking the lead, Epic will attempt to learn from APA members who are also Epic users how the two platforms may be integrated and best fit users' needs.

Dr. Wang fielded questions from meeting participants about using PsychPRO to address the needs of those who plan to use the registry for quality improvement activities, other than CMS's Quality Payment Program (this includes the Merit-based Incentive Payment System (MIPS) and advanced Alternative Payment Models). Dr. Wang explained that standardized patient reported outcome tools are currently available for use within the patient portal, and that with National Committee on Quality Assurance (NCQA) as the sub-recipient/partner in the APA plan to develop quality measures under the CMS Cooperative Agreement Funding Opportunity, APA plans to define a protocol for the regular use of standardized screening tools for the purposes of measurement-based care (MBC). This aligns with accrediting organizations' and health plans' participation requirements and allows patients and providers to receive real-time feedback that immediately impacts treatment decisions. Dr. Behren's suggested the Registry Oversight Workgroup (ROW) and APA staff think about ways to engage general APA members to use PsychPRO, who do not participate in quality reporting programs, but would use PsychPRO as a tool to inform on the degree of quality care they provide.

Since MBC elucidates clinical and functional outcomes based on the ongoing use of standardized rating scales, meeting participants asked questions about the ability and appropriateness to apply social determinants of health when deciding the risk adjustment strategies for the outcome measures. Dr. Wang and Ms. Shugarman confirmed that both APA and NCQA team-members have discussed ways to address social risk factors and other patient factors that impact mental illness and substance use disorders, while ensuring appropriate data capture, and attempting to fill gaps in care for patients with mental health and substance use disorders.

Ms. Kroeger informed meeting participants of the recent private payer meeting convened by APA, in relationship to PsychPRO's involvement with MBC in routine clinical practice. With the focus of the meeting on improving access to care, some discussion included the utilization of MBC and payers tracking quality measures. She further described that a meeting-participant (payer) suggested their company work with APA to locate catchment areas within which this particular payer would be willing to pilot MBC through PsychPRO.

Other questions regarding PsychPRO capabilities included questions about electronic interoperability. Dr. Wang and Dr. Fochtmann explained the interoperability of PsychPRO and the electronic terminologies currently used. Understanding the importance of expanding registry and EHR interoperability, APA is engaged with developing SNOMED terminology for DSM, in addition to the currently applied LOINC terminology.

IV. Remarks by Saul Levin, MD, MPA, CEO of the American Psychiatric Association

A. Remarks included APA advocacy and next steps related to the high priority issue of the TJC and CMS increased enforcement of Ligature Risk and Other Self-Harm Assessment and citations. More details on this can be found in section IV.F. of this document.

V. Quality Strategy Presentation: Samantha Shugarman, MS, Liaison to the Council on Quality and the Committee on Quality and Performance Measurement (Workgroup on Performance and Quality Measurement), Deputy Director of Quality

A. Slide Set Presentation

Ms. Shugarman presented a slide set to the Council entitled, "APA Quality Strategy: Aligning Priorities to Achieve the Highest Quality Care." She explained that the purpose of this

presentation was to establish why APA should consider defining a quality strategy that includes quality measurement apart from the CMS Measure Development Cooperative Agreement Funding Opportunity. Ms. Shugarman described the need for APA to define a measure development strategy that aligns with that of the PsychPRO Registry and APA Practice Guidelines.

Ms. Shugarman posed the question to the Council (and to the Workgroup on Quality and Performance Measurement in months prior), "Is the process of prioritizing measurement topics, defining measurement concepts, developing quality measurement tools, and maintaining existing APA-stewarded quality measures necessary for APA to continue to define what constitutes high quality care for psychiatrists?" The Council agreed that this should be a priority area for the Association.

Immediately following the presentation, Dr. Alter, Workgroup on Quality and Performance Measurement chair, continued with the Workgroup report and discussion as it related to Ms. Shugarman's presentation.

Action:

1. Ms. Shugarman will share the presentation slides with Council members.

VI. Reporting Component Update

A. Workgroup on Quality and Performance Measurement (Committee on Performance Measurement): Carol Alter, MD, Chair

a. Dr. Alter, chair of the Workgroup on Quality and Performance Measurement explained that while the CMS measure development funding, if awarded, would be an incredibly helpful opportunity for the APA to establish itself as a leader in this quality space. However, she emphasized the need for APA's Board of Trustees (BOT) to support the development of an infrastructure that would support the continued maintenance of APA-stewarded measures (PCPI transferred), of measures developed under the CMS funding, as well as new measure development separate from the CMS funding.

Dr. Alter explained that, in discussion with the Workgroup and with guidance from Ms. Shugarman and Ms. Kroeger, the next steps to pushing this project forward would be to request resources necessary to contract with a consultant to develop a business case illustrating the different options available when considering the operationalization of quality measure development. Dr. Alter relayed to the Council the specific the questions the Workgroup would like answered during the development of the business case:

- What is at risk by ceasing or solely maintaining CMS funded measures?
- What are the incentives and disincentives for APA to operationalize ongoing quality measure development?
- What is affordable?
    - Regular ongoing development or
    - Incremental development

The Council voted to support the Workgroup on Quality and Performance Measurement's recommendation that the Council on Quality Care support and recommend hiring a consultant to develop the business case. Depending on the next steps required for the approval of the consultant hiring process, the Workgroup would like to have the final business case by September 2018.

b. Measurement Topic Prioritization Process
During the Workgroup meeting on, May 6, 2018, the Workgroup discussed the development of an ongoing measure topic/concept, development, and maintenance prioritization process. The format agreed upon included the now-reinstated Committee-on-Quality-and-Performance-Measurement meeting at least once per year (likely at the Annual Meeting on or Fall Components Meeting) to discuss the following:

1. Current topics that they agree are necessary and important to inform psychiatrists on the quality of care administered. These topics can be submitted through an open submission process supported by psychiatry.org, through Council, Committee, or other APA governance group. Other sources of topic suggestion can come from trends seen in PsychPRO, or by practice guideline development. US Department of Health and Human Services or one of its agencies (e.g., CMS) and other national organizations involved in quality measurement may also inform this decision process.
2. Based on the discussion during the in-person meeting, the Committee will agree to seat a two- to four-member pre-technical expert panel (pre-TEP) who are experts in the given subject for possible new development or maintenance. The pre-TEP will be responsible for reviewing materials provided by the APA Quality staff.
    - The Pre-TEP will inform the Committee on appropriate next steps based on what is currently in the quality measurement landscape on the subject.
3. The Committee will decide on whether to charge the Pre-TEP with a new development or maintenance project.

c. Position Statement on the Utilization of Measurement Based Care
Dr. Alter provided an updated draft of the Position Statement on the Utilization of Measurement Based Care (MBC). Ms. Shugarman explained that a vote by the Assembly in November 2018 is the next step for it to become APA policy. Minimal discussion on this included length of the document. Dr. Behrens and Dr. Hsiao, both Assembly members, explained that position statements require an "up/down" vote. Unlike action papers, this document will not be edited after to submission to the Assembly.

The Council voted to submit this position statement for the vote during the Assembly meeting in November.

Action:

1. Following an internal budget review, a consultant will be hired under the leadership of the Department of Policy, Partnerships, and Programs and Dr. Norquist will share this update during the Council report to the Joint Reference Committee in June 2018 for next step recommendations.
2. Ms. Shugarman will update Dr. Norquist and Dr. Alter on the findings of the budget review.
3. Ms. Shugarman will reshare with the Council a line-numbered version of the Position Statement on the Utilization of MBC. The edits Ms. Shugarman receives will not impact the substantive message of the Position Statement. Upon receiving edits, Ms. Shugarman will take the necessary steps to submit the Position Statement for vote during the November 2018 Assembly.

B. Caucus on Psychotherapy: Eric Plakun, MD
a. Dr. Plakun joined the meeting to review the Caucus's goals for the coming year. He also explained that due to his new role as Area One Trustee to the BOT, he will step down as leader

of the Caucus. He informed meeting participants that in the weeks leading up to the Annual Meeting, the APA supported an election and determined that David Mintz, MD, would succeed as leader of the Caucus.

Dr. Norquist informed Dr. Plakun of Council discussions during the past two meetings that included an effort to determine which council is best suited to address the needs of the Caucus. Dr. Norquist explained that given the Caucus's emphasis on initiatives related to education, he contacted the chair of the Council on Medical Education and Lifelong Learning (CMELL) and discussed the appropriateness for the Caucus to be reassigned. Dr. Plakun informed the Council that similar conversations had been held within the Caucus leadership. Though not opposed to reassignment under CMELL, the Dr. Plakun explained that the Caucus leadership is interested in becoming an approved council of APA.

Action:

1. Dr. Norquist agreed to communicate with Dr. Mintz, the new Caucus Leader, and Mark Rapaport, MD, CMELL chair, on the appropriateness of the Caucus to be reassigned to CMELL, a council that can better guide the Caucus's work.
2. Ms. Shugarman will follow-up with Department of Education staff to guide this process through the governance process.

C. Committee on Mental Health and Information Technology: Brent Nelson, MD, Chair
Dr. Nelson was pleased to share activities accomplished or continuing to be addressed by the Committee on Mental Health and Information Technology (CMHIT). This includes redefining the Committee's goals. For example, the BOT recently approved a recommendation report of the APA BOT's Ad Hoc Work Group on Access and Innovation in Psychiatric Care. Within this report was a recommendation to refine the Committee's charge to include activities that ensure cross-functional work within and outside APA. Dr. Nelson further explained the Committee's efforts to revise the charge, to determine ways to ensure appropriate and accurate communication among PsychPRO's Registry Oversight Workgroup (ROW) and staff, and to increase activity in the digital therapeutics space.

Dr. Nelson highlighted successes since he began as chair in May 2018. For instance, the implementation and utilization of the Microsoft Teams software application has enhanced communication and product development for the CMHIT. Given their first-hand success, the Committee plans to develop a primer to help other APA components and staff liaisons take advantage of this tool.

Representing APA externally, CMHIT continued to provide APA's voice nationally through participation in the Office of the National Coordinator for Health Information Technology (ONC) comments on the ONC Playbook section on behavioral health and by representing APA at the HL7 Data Standards Conference. As part of working with HL7, APA helps provide guidance on how to ensure EHRs have broad-use data elements that may be utilized by psychiatrists.

Meeting participants discussed ways to use technology to engage APA members and non-members who are unaware of the ongoing APA activities and products through Facebook pages. Non-scientific polls developed and posted on targeted Facebook pages are ways to highlight (and educate on) APA initiatives and garner interest and increase membership. The Council asked APA staff of the requirements to organize an EHR/IT vendor section in the

Exhibit Hall at the next Annual Meeting.

Action:

1. Ms. Shugarman agreed to share with the Council, the final BOT approved recommendation report of the Ad Hoc Work Group on Access and Innovation in Psychiatric Care.
2. Ms. Shugarman agreed to follow-up with appropriate APA staff to learn whether a section in the Exhibit Hall for EHR/IT vendors is possible.

D. Committee on Practice Guidelines: Dan Anzia, MD, incoming-Chair

Dr. Anzia, incoming-chair, participated in the discussion of the Committee on Practice Guidelines (CPG). He discussed goals set for the 2018-2019 year. Because of the contract agreement with Doctor Evidence®, systematic literature reviews will begin to occur more rapidly. For instance, while it is a stretch-goal, the writing group assigned to develop the guidelines on schizophrenia are attempting to complete their work by the close of 2018 or start of 2019. However, May 2019 has been defined as the safe-goal date, at which point the writing group will have finalized their process.

Other guideline writing groups about to begin include those focused on bipolar disorders and eating and disorders. Once those writing groups begin active development, reviews for borderline personality disorder, delirium, anxiety, and suicide will occur and be available for the writing groups to begin the writing process much more quickly than in the past.

Dr. Anzia updated the Council on the topic of utilizing and posting APA and non-APA resource documents to a psychiatry.org Practice Guideline landing page. Ms. Medicus informed the group that she had worked closely with APA's general counsel to ensure appropriate wording of a statement that will inform visitors to the landing page that the materials posted do not represent official APA-approved clinical practice guidelines.

Action:

1. Ms. Shugarman will contact Ms. Medicus to determine the vetting process for posting the resource documents on the APA landing page.

E. Workgroup on Patient Safety: Geetha Jayaram, MD, Chair

a. Dr. Jayaram shared updates on the progress of Workgroup initiatives during May 2017-2018.

1. Guidance on- and standardization of- patient observations and suicide precautions, a project that began prior to May 2017, is currently collecting survey data from clinicians working inpatient psychiatric facilities at the University of Florida Medical Center and Johns Hopkins Hospital. Dr. Jayaram explained to the Council that due to a lengthy Institutional Review Board (IRB) process, that University of Florida and Johns Hopkins would be the two sites with clinicians responding to the survey. Dr. Jayaram stated that she expects this project to conclude by May 2019.
2. Participation in mock root cause analyses, as part of residency training, is a newer requirement of the American College of Graduate Medical Education (ACGME). To provide psychiatric residency training directors with sample psychiatric cases (currently non-existent) the Patient Safety Workgroup accepted the charge to use previously developed patient cases from an APA resource document developed by the Patient Safety Workgroup. Presently, proposed revisions of ACGME Milestone Toolkit is under review by the American Association of Directors of Psychiatric Residency Training

(ADDPRT) that will include these mock root cause analyses cases. It is anticipated that acceptance by AADPRT will occur no later than September 2018.

3. The Workgroup began a review of patient safety assessment tools with an anticipated completion period of May 2019. The content of the review is intended to be presented to the Council on Quality Care, that will then recommend the review to the JRC as a resource for posting to psychiatry.org. The review will include Failure Modes Effects Analysis, Lean Six Sigma, and other methods of systems analysis.

b. Dr. Jayaram expressed the Workgroup's interest in becoming elevated to an official Committee under the Council on Quality Care. She cited the large turnout of APA Annual Meeting attendees at a patient safety-focused symposium in which she participated as evidence to support a patient safety educational track at the next APA annual meeting or IPS meeting. Dr. Wrenn, incoming Council consultant and current chair of the IPS Scientific Programming Committee, described the process of the Scientific Programming Committee for the IPS meeting as informal, and the inclusion of patient safety programming as likely achievable by communicating it to the IPS Programming Committee for 2019. Dr. Jayaram suspected patient safety programming to be more difficult and requested the Council support the elevation to official Committee and the addition of a Patient Safety education track.

Action:

1. Ms. Shugarman agreed to examine the steps required of Committee elevation and scientific programming educational track consideration.

F. Workgroup on Standards, Surveys, and Procedures: Samantha Shugarman, MS, Council Liaison

a. The Joint Commission

1. Ms. Shugarman informed the meeting participants of the 2017 dissolution of the Joint Commission's (TJC) Hospital and Behavioral Health Professional Technical Advisory Panels (PTACs) and of the recently formed TJC Behavioral Health Advisory Council to which APA has appointed Ronald Burd, MD, as representative.
2. As discussed during Dr. Levin's remarks to the Council earlier during today's meeting, Ms. Shugarman reinforced that a major focus of the BOT has been on the increased enforcement and inconsistent nature of TJC ligature point and other self-harm risk assessment onsite survey. To better understand the impact of the increased enforcement by TJC and CMS on this section of the onsite survey, APA invited members and other involved administrators to complete the non-scientific, APA-developed, "Ligature Point and Other Self-Harm Risk Assessment Experience Survey." Dr. Levin and Ms. Shugarman discussed the findings which included details on the impact the enforcement is reportedly having to reduce access to psychiatric care. Ms. Shugarman described the preliminary results of the APA Experience Survey by explaining that multiple states reported closures to psychiatric inpatient hospital units, psychiatric bed closures, and reductions in access to psychiatric services and clinicians. Ms. Shugarman also shared the letter sent to CEO of TJC expressing APA's support for reducing rates of suicide or self-harm by hanging at these facilities, but also pointed out the associated negative unintended consequences.

   Ms. Shugarman described that it was striking to learn that TJC and CMS surveyors responsible for executing the onsite surveys have little or no experience with psychiatric inpatient hospital units. Given the unique qualities of a psychiatric inpatient hospital unit, it would benefit TJC, CMS, and psychiatric inpatient units subject to these surveys,

to engage with APA in ongoing communication and education on what consists of reasonable expectations at this care setting. Ms. Shugarman posed the possibility for cross-work between the Council on Quality Care and CMELL; and possibly the Council on Research, given the dearth of evidence in suicide and patient safety standardization at the inpatient facility level of care.

3. Ms. Shugarman also informed the Council of a solicitation for comments with a deadline of today. Through Survey Monkey®, TJC requested feedback on edits to their National Patient Safety Goals (NPSG) on Suicide Prevention. Ms. Shugarman reported that in addition to completing the survey on behalf of the APA, she shared it with early responders of the APA Ligature Point and Other Self-Harm Risk Assessment Experience Survey.

b. URAC

Dr. Kathol, APA's representative to the URAC Board of Directors and a member of the Council on Quality Care, was unable to attend today's meeting. As such, Ms. Shugarman shared an update on his behalf.

Dr. Kathol communicated with Ms. Shugarman that URAC is in the process of developing accreditation criteria for substance abuse treatment settings and for the coordination of medical and behavioral health care. Specifically, such accreditation criteria has potential to expand psychiatrists' regular involvement in non-psychiatric inpatient, emergency department, and post-acute medical care settings.

Ms. Shugarman expressed that these changes have the potential to change billing procedures by allowing psychiatrists to bill directly to medical payors for the services they deliver. Given that psychiatrists become part of the medical network of providers rather than remain a separate behavioral health construct, and are supported by managed care organizations rather than by managed behavioral health organizations, the opportunity to deliver value-based behavioral health care in the medical setting could then expand from outpatient Collaborative Care/TEAMcare models to other areas of behavioral health service delivery.

Dr. Wrenn, a new consultant to the Council suggested APA take a more proactive role with other accreditors, like the Commission on Accreditation of Rehabilitation Facilities (CARF) and NCQA. She further shared that she is an appointee to the NQCA Board of Directors (BOD). Ms. Shugarman expressed an ongoing interest with APA to have a more active role at NCQA, in addition to Dr. Wrenn's seat on the BOD. Apart from the recent collaboration on the CMS Measure Development Cooperative Agreement Funding Opportunity, Ms. Shugarman explained that the NCQA measure development process was closed, with APA participation opportunities limited to their public comment periods. As Ms. Shugarman was unfamiliar with CARF, Dr. Wrenn described it as an accrediting organization focused on ambulatory care. Ms. Shugarman agreed to identify if APA could become more informed and involved.

Action:

1. Ms. Shugarman agreed to update the Council with any updates on the Ligature Point and Other Self-Harm Risk Assessment issue.
2. Ms. Shugarman agreed to forward the APA Ligature Point and Other Self-Harm Risk Assessment Experience Survey link to Council members. She then requested that they share it with those involved with the TJC onsite survey.
3. Ms. Shugarman agreed to follow-up by researching opportunities for APA involvement with CARF.
4. Ms. Shugarman agreed to follow-up with Dr. Wrenn on ways APA can become more involved with NCQA activities.
5. Ms. Shugarman to discuss with Dr. Norquist ways to engage with CMELL and COR on educational and research opportunities to inform on suicide prevention during the TJC and CMS onsite survey process.

VII. Joint Reference Committee (JRC) Draft Action Review: Samantha Shugarman, MS, Council Liaison

A. Position Statement on Use of the Concept of Recovery

a. Discussion of patient advocacy organizations' recommended edits.
The statement shared with Mental Health America (MHA) received positive feedback. The Council agreed to the recommended edits made by MHA. However, despite several attempts made by Ms. Kroeger to solicit feedback from NAMI, a reply was never received.

Dr. Wrenn and Dr. Norquist both volunteered to use their contacts at NAMI to request feedback on the current position statement.

Dr. Plakun mentioned concern that the Position Statement does not conform with the APA approved position statement format. Given the original approval of this statement occurring prior to the change in approved format, it was unclear of the responsibility to manipulate the updated version into the newer format. Ms. Shugarman agreed to follow-up with Governance staff to ensure edits are submitted to the JRC within the proper format.

Action:

1. Ms. Shugarman agreed to contact Ms. Kroeger to learn of her preference for Dr. Norquist and Dr. Wrenn to share it with their respective NAMI contacts. If Ms. Kroeger approves, Ms. Shugarman will frame the request via email and will share it with both Dr. Norquist and Dr. Wrenn for feedback from their NAMI contacts by the June 2018 JRC meeting.
2. Ms. Shugarman agreed to follow-up with Governance staff to ensure edits are submitted to the JRC within the proper format.

VIII. Old Business: (12:45 – 1:30 PM)

A. Safety monitoring and next steps NCQA Quality Measure: ADHD Stimulant Follow-Up Care, Bonnie Zima, MD
Resource information: Practitioner's Manual: An Informational Outline of the Controlled Substances (USDOJ, 2006)

a. Originally discussed during the March 2018 meeting, the Council addressed the subject of using poorly interpreted evidence to support the development and execution of poorly specified quality measures and its unintended consequences on patient safety. During today's meeting, Dr. Zima and the rest of the Council invited the Workgroup on Patient Safety to consider helping to mold the APA advocacy effort to improve medication safety monitoring. It was also suggested that given the limited volume of evidence on prescription safety

monitoring, there is potential to collaborate with the COR.

Action:

1. Ms. Shugarman will communicate with Dr. Norquist and Dr. Zima on next steps.

IX. Announcements

A. APA-convened Meetings: Samantha Shugarman, MS, Council Liaison

Ms. Shugarman announced upcoming meetings in order of occurrence.

a. September Components Meeting
    1. The Council on Quality Care will tentatively meet on Thursday, September 13, 2018. Though not finalized as the reservation process has not opened, this meeting historically has taken place on the Thursday of the Components Meeting week. Efforts will be made to reserve that day.

b. IPS Meeting
    1. 2018: Takes place October 4-7, 2018 in Chicago.
    2. 2019: APA's abstract submission portal will open in November 2018. Ms. Shugarman will update Council members of the precise date, once released.

c. Annual Meeting
    1. 2019: May 18-22, 2019 in San Francisco.
    2. APA's abstract submission portal will open in June 2018. Ms. Shugarman will update Council members of the precise date, once released.

X. Adjourned

Item #8.M
Joint Reference Committee
June 2018

COUNCIL ON RESEARCH (CoR)
REPORT TO THE JOINT REFERENCE COMMITTEE (JRC)

Executive Summary

1. **Action Items:**
   - **ACTION 1:** Will the JRC recommend that the Assembly vote to approve the revised Position Statement on Mental Health Screening, Diagnosis, and Treatment During Pregnancy and Postpartum (**Attachment 1**)?
   - **ACTION 2:** Will the Joint Reference Committee approve the revised Resource Document on Neuroimaging (**Attachment 2**)?

2. **Update on CoR Actions during the APA 2018 Annual Meeting**
   I. The CoR reviewed and approved of the Position Statement on the use of generic vs. proprietary drugs (see the Other Action Items section of the CoR Minutes in **Attachment 3**)
   II. The CoR reviewed the Position Statement on somatic cell nuclear transfer (SCNT) research and motioned to refer it back for further clarification, particularly regarding the phrasing "reproduce purposes" (see the Other Action Items section in **Attachment 3**)
   III. The CoR reviewed and approved of the Position Statement on atypical antipsychotic medications (see the Other Action Items section in **Attachment 3**)

3. **Referral Item Updates:**
   Agenda Item #: 8.M.1
   Title: Proposed Position Statement: Mental Health Screening, Diagnosis, and Treatment During Pregnancy and Postpartum (LEAD).
   Update: In response to the JRC recommendation, the working group appointed by the CoR to create a Position Statement has revised the attached statement to be clear, concise and short (**Attachment 1**).
   Agenda Item #: 8.L.1
   Title: Providing Education and Guidance for the Use and Limitations of Pharmacogenomics in Clinical Practice
   Update: In response to the JRC request for the CoR to re-evaluate the need to draft a resource document on the issue, the CoR agreed on the attached response (**Attachment 4**)

4. **ATTACHMENTS:**

   Attachment 1: Position Statement on Mental Health Screening, Diagnosis, and Treatment During Pregnancy and Postpartum-submitted for review by the JRC

   Attachment 2: Resource Document on Neuroimaging-submitted for review by the JRC

   Attachment 3: Draft of Minutes from the Council on Research's Meeting at 2018 APA Annual Meeting

   Attachment 4: Council on Research's Response to JRC's Request for A Resource Document for Pharmacogenomics

ATTACHMENT 1

APA Official Actions

Position Statement: Screening and Treatment of Mood and Anxiety Disorders During Pregnancy and Postpartum

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: The incidence of mood and/or anxiety disorders in the antenatal and postnatal periods is surprisingly high in the United States and has become a serious public health problem; 1 out of 7–10 pregnant women and 1 out of 5–8 postpartum women will develop a depressive and/or anxiety disorder, and 1 out of 1,000 perinatal women will develop a psychotic disorder. The incidence of these disorders is highest in women from lower socioeconomic backgrounds. Even though depressive disorders are among the most common, emerging evidence warrants a more comprehensive conceptualization of perinatal psychiatric illness to include bipolar disorder and common comorbid illnesses such as general anxiety disorder, obsessive compulsive disorder, and panic disorder. Many studies have shown that depressive symptoms during pregnancy are associated with decreased prenatal care and adverse perinatal outcomes such as preterm birth and low birth weight. Perinatal mental health disorders can be severe; maternal suicide is the second leading cause of death among postpartum women, and approximately 300 infanticides occur in the United States each year. Untreated postpartum mood disorders are also associated in studies with impairments in cognitive, behavioral, and emotional development in the offspring during childhood and adolescence. However, early treatment of mothers with these disorders may prevent these developmental problems. At this time, only a minority of clinicians are using validated screening tools to detect these disorders. Despite the availability of evidence-based treatments, most pregnant and postpartum women with these disorders do not receive adequate assessment or treatment. To improve obstetric outcomes and maternal health, achieve optimal child development, and lower the numbers of maternal and infant deaths, it is imperative that the APA take the lead in prioritizing education and research about these disorders, as well as their screening, diagnosis, and treatment.

POSITIONS

The APA recognizes that the risks for psychiatric illness in women are greatest during the reproductive years of their lives, including during pregnancy and the postpartum periods. To prevent long-lasting, adverse effects on the mother, infant, and family, the APA strongly recommends the following:

- All pregnant and postpartum women should be assessed for both the presence of and risks for a psychiatric disorder.
- All ~~obstetrical~~ clinical providers should provide education to perinatal women on how to recognize the symptoms of depressive, anxiety, and psychotic disorders.
- ~~All obstetrical care providers should screen for depression with a validated screening tool twice during pregnancy and once postpartum; all pediatric clinicians should screen for depression~~

~~throughout the first six months postpartum. A systematic response to screening should be in place to ensure that psychiatric disorders are appropriately assessed, treated, and followed.~~

- All perinatal patients should be evaluated for depressive, anxiety, and psychotic disorders throughout the pregnancy and postpartum period. We recommend screening for depression with a validated screening tool twice during pregnancy, once in early pregnancy for preexisting psychiatric disorders and once later in the pregnancy; we also recommend postpartum patients be screened for depression during pediatric visits throughout the first six months postpartum as recommended by the American Academy of Pediatrics. A systematic response to screening should be in place to ensure that psychiatric disorders are appropriately assessed, treated, and followed.
- The APA recommends that psychiatrists ~~behavioral health clinicians~~ educate their patients about the risks associated with untreated psychiatric illness during pregnancy and lactation, as well as the risks and benefits—for both the woman and her baby—of using psychotropic medications while pregnant or breastfeeding.

Authors

Nancy Byatt, DO, MS, MBA
Debbie Carter, MD
Kristina M. Deligiannidis, MD
C. Neill Epperson, MD
Samantha Meltzer-Brody, MD, MPH
Jennifer L. Payne, MD
Gail Robinson, MD, CM, O.Ont
Nazanin E. Silver, MD, MPH, FACOG
Zachary Stowe, MD
Maureen Sayres Van Niel, MD
Katherine L. Wisner, MD, MS
Kim Yonkers, MD

ATTACHMENT 2

Section I: Introduction

~~Wayne Drevets~~
~~Scott Rauch~~

Background

In May 2009, an Action paper was passed by the APA Assembly (and approved by the Board of Trustees in July 2012) calling for the ~~development~~developed of an APA Position Paper on the Clinical Application of Brain Imaging in Psychiatry. This action paper was developed in response to questions raised by claims being made that brain imaging technology had already reached the point that it was useful for making a clinical diagnosis and for helping in treatment selection. Given the APA's mission to educate both its members and the public-at-large about the science and clinical practice of psychiatry, the Workgroup was appointed under the auspices of the APA Council on Research in January 2010 to develop an evidenced-based review of the current state of the art of clinical utility of brain imaging for psychiatric diagnosis and for predicting treatment response in the following diagnostic areas: adult mood and anxiety disorders, psychotic disorders, cognitive disorders, substance use disorders, and childhood disorders including ADHD, Bipolar Disorder, Depression/Anxiety, and Autistic Disorder. This paper, which was updated in 2017 (and approved by the Board of Trustees in 2018) begins with a general introduction about the challenges in developing valid and reliable biomarkers for psychiatric disorders and then provides a comprehensive review of the current research on brain imaging biomarkers across the various diagnostic categories. Although there are a number of promising results presented, by the standards proposed in the introduction to this paper, there are currently no brain imaging biomarkers that are ~~currently~~ clinically useful for any diagnostic category in psychiatry.

Overview of Applications of Neuroimaging in Psychiatric Disorders

The application of neuroimaging technology in psychiatric research has revolutionized clinical neuroscience perspectives on the pathophysiology of the major psychiatric disorders. Research using a variety of types of neuroimaging techniques has shown that these conditions are associated with abnormalities of brain function, structure and receptor pharmacology. These data also corroborate the conclusions reached from genetic, endocrine, and clinical pharmacology research involving these disorders to suggest that under the current nosology the major psychiatric disorders likely reflect heterogenous groups of disorders with respect to pathophysiology and etiology.

Despite the invaluable leads that the neuroimaging studies have provided regarding the neurobiological bases for psychiatric disorders, ~~however,~~ they have yet to impact significantly the diagnosis or treatment of individual patients. In clinical medicine, considerable interest ~~has~~

~~existed~~exists in developing objective, biologically-based tests for psychiatric illnesses. From ~~the~~a clinical perspective such advances could yield important benefits such as predicting treatment response, differentiating between related diagnostic categories, and potentially treating at-risk patients prophylactically to prevent ~~neurotoxicity~~the development of neuropathology and clinical deterioration.

Nevertheless, the effect size of neuroimaging and other noninvasive biological abnormalities identified to date in psychiatric disorders has been relatively small, ~~such that~~and the imaging measures established by replication across laboratories do not provide sufficient specificity and sensitivity to accurately classify individual cases with respect to the presence of a psychiatric illness. This review focuses specifically on the *potential* clinical utility of biomarkers assessed using modern neuroimaging technologies, and the *approach* required to validate imaging biomarkers for use as clinical diagnostics.

The Quest for Biomarkers in Psychiatry

Both the clinical practice of psychiatry and the development of novel therapeutics have been hindered by the lack of biomarkers that can serve as accessible, objective indices of the complex biological phenomena that underpin psychiatric illness. The inaccessibility of brain tissue, the lack of knowledge about pathophysiology, and the uncertain link between abnormal measurements on any biological test and pathogenesis all have impeded the development of biomarkers for psychiatric disorders. As a result progress toward improving diagnostic capabilities and defining or predicting treatment outcome in psychiatry has lagged that achieved in other areas of medicine. Thus it frequently remains difficult to establish whether individual patients suffer from a particular disease, how individual patients can best be treated, and whether experimental treatments are effective in general.

The need for clinical biomarkers has become acute, as their absence particularly has hindered research aimed at developing novel therapeutics. Due at least partly to the lack of well-established pathophysiological targets for new drugs, relatively large numbers of experimental compounds are failing in increasingly expensive late-stage clinical trials. As a result, drug development pipelines ~~are becoming dry~~contain few compounds that offer clinically meaningful differentiation from currently available treatments, and ~~several~~many companies have discontinued their research and development of pharmaceuticals for psychiatric conditions. The ramifications of these limitations for clinical practice also are significant, as psychiatric nosology and diagnosis largely have remained at a standstill since the development of DSM-III, the clinical approach to treatment decisions for individual patients remains empirical ("trial and error"), and ~~mzny~~many patients ~~are~~remain inadequately helped by extant treatments.

Current Application of Neuroimaging Biomarkers in Psychiatric Diagnosis

For over two decades imaging has maintained a well-established but narrow place in the diagnostic evaluation of patients with psychiatric disease, largely because of the usefulness of neuromorphological MRI in detecting and characterizing structural brain abnormalities such as lesions and atrophy. Thus the role of imaging in patients with psychopathology historically has

been limited to one of exclusion of potentially etiological medical conditions: namely to rule out neoplasm, hematoma, hydrocephalus, or other ~~potentially surgically treatable~~ neurological causes of psychiatric symptoms that are treatable with neurosurgery or medications, or to detect the presence of cerebrovascular disease or gross atrophy. Although clinically important, these conditions appear to play a role in the pathogenesis of psychiatric symptoms in only a small proportion of cases presenting for the evaluation of mood, anxiety or psychotic disorders.

Increasingly a major quest of researchers has been to identify neuroimaging results that offer diagnostic capabilities for ~~particular~~major psychiatric diseases as well as for their relevant differential diagnoses. Currently neuroimaging is not recommended within either the U.S. or the European practice guidelines for positively defining diagnosis of any primary psychiatric disorder. Nevertheless, advances in *research* applications of neuroimaging technology have provided leads that may foreshadow future *clinical* applications of imaging biomarkers for establishing diagnosis and predicting illness course or treatment outcome. The ensuing review discusses issues that have been addressed within other areas of clinical medicine to establish the validity and reliability of imaging diagnostics, with the aim of providing principles to guide the evaluation of neuroimaging applications in clinical psychiatry.

Biomarker Definition, Validation and Qualification

The NIH has defined a biomarker (i.e., biological marker) as: “A characteristic that is objectively measured and evaluated as an indicator of normal biologic processes, pathogenic processes, or pharmacologic responses to a therapeutic intervention.”
(De Gruttola et al. 2001). A biomarker thus can define a physiological, pathological, or anatomical characteristic or measurement that putatively relates to some aspect of either normal or abnormal biological function~~.~~ or structure. Biomarkers thus may assess many different types of biological characteristics ~~or parameters~~, including receptor ~~expression patterns,~~ or protein binding, hemodynamic parameters, MRI or radiographic ~~or~~images of structure composition, other imaging-based measures, or ~~electrophysiologic~~electrophysiological parameters.

The term "biomarker" connotes different meanings in different contexts, based upon the intended application of the information a biomarker provides. Within clinical medicine, biomarkers include measures that suggest the etiology of, susceptibility to, activity levels of, or progress of a disease. In addition, alterations in patient-associated biomarkers related to an intervention may be used to predict the likelihood of experiencing a robust clinical outcome or an adverse reaction to a treatment. Finally, in drug development a biomarker can be any measure of drug action that is proximal to its clinical effect, including biomarkers that correlate with drug response or quantify the extent to which a drug occupies ~~specific receptors in a~~the molecular target ~~tissue~~.

Notably, the U.S. Food and Drug Administration (FDA) recently has developed guidance that addresses multiple types of biomarkers ~~that can be applied~~which are applicable to drug development, including prognostic, predictive, pharmacodynamic, and surrogate biomarkers. A

prognostic biomarker is a baseline patient or disease characteristic that categorizes patients by degree of risk for disease occurrence or progression. A *predictive* biomarker is a baseline characteristic that categorizes patients by their likelihood for response to a particular treatment. A *pharmacodynamic* biomarker is ~~a dynamic~~an assessment of physiological or structural change that shows that a biological response has occurred in a patient after having received a therapeutic intervention. A *surrogate* endpoint is defined as a biomarker intended to substitute for a clinical efficacy endpoint. Conceivably each of these biomarker types holds the potential to be clinically useful in psychiatric research or practice. Nevertheless, in its guidance the FDA identified the most valuable role for biomarkers as their use in clinical *diagnostics*.

In considering the development of neuroimaging biomarkers as clinical diagnostics, the FDA guidance on biomarkers for drug development merits comment. Generally, the requirements of biomarkers for quantification of drug effects in research and development, which depend upon population means with variance estimates, converge with the requirements of diagnostics in clinical practice, which are assessed on a per-patient basis. The common element in both is longitudinal quantification; both analyses require baseline and follow-up effects of treatments. For example, clinical evidence from the ~~national oncologic~~National Oncologic PET Registry motivated the expanded coverage by ~~medicare~~Medicare for FDG-PET/CT in the detection and staging of cancer and in the monitoring of cancer treatment response. ~~Thus~~Therefore as diagnostics, biomarkers are of interest to health care providers and consumers for parallel applications, since earlier detection of disease facilitates earlier intervention, which~~,~~ when followed by effective, individualized treatment, can improve patient outcomes.

With respect to establishing the utility of a biomarker, it is useful to distinguish between the terms “validation” and “qualification”. *Validation* generally refers to the determination of the performance characteristics of a measurement — for example, the measurement’s reliability, sensitivity and specificity — in measuring a ~~particular~~discrete biological construct. The validation process is particularly relevant for securing regulatory approval to market techniques for commercial use as clinical diagnostics, as described in the subsequent section.

The term *qualification* refers to establishing the credibility of a biomarker in its application to questions specifically relevant to drug development. In drug development the ultimate use of a biomarker is as a *surrogate* end point, which requires that the biomarker has been *qualified* to substitute for a clinical standard of truth (i.e., the biomarker reasonably predicts the clinical outcome and therefore can serve as a surrogate). After a biomarker is "qualified" by the FDA, industry can use the markers in a similar context in multiple drug trials, drug classes, or clinical disorders, without having to repeatedly seek the agency's approval ["Qualification Process for Drug Development Tools," ~~(http://www.fda.gov/downloads/Drugs/GuidanceComplianceRegulatoryInformation/Guidances/UCM230597.pdf)].~~

(https://www.fda.gov/downloads/drugs/guidances/ucm230597.pdf)] The FDA *qualification* process for biomarkers also encompasses guidance on drug-development tools, including radiographic or other imaging-based measurements. Qualification of a drug-development tool

is based on a conclusion that within the stated context of use, the results of assessment with the tool can be relied upon to have a specific interpretation and application under regulatory review. The FDA guidance indicates, "While a biomarker cannot become qualified without a reliable means to measure the biomarker, FDA clearance of a measurement device does not imply that the biomarker has been demonstrated to have a qualified use in drug development and evaluation." Instead the qualification process is limited to specific patient populations and a specific therapeutic intervention. In addition to the biomarker assay *validation* data, clinical data are required to support the biomarker *qualification*. A corollary of this regulatory principle is that the FDA qualification of a drug-development tool for one application does not extend to its use in other applications.

Evaluating the Validity of Diagnostic Biomarkers in Clinical Medicine

The validity of a diagnostic biomarker for any medical disorder generally is established via evaluation of its sensitivity, specificity, prior probability, positive predictive value, and negative predictive value (Mayeux 1998). ~~*Sensitivity*~~Diagnostic *sensitivity* refers to the capacity of a biomarker to identify a substantial percentage of patients with the disease-of-interest~~(~~; sensitivity is expressed as: true positive cases divided by [true positive cases plus false negative cases] x 100~~). Thus a~~. A sensitivity of 100% thus corresponds to a marker that identifies 100% of patients with the target condition. ~~*Specificity*~~Diagnostic *specificity* refers to the capacity of a test to distinguish the target condition from normative conditions (e.g., aging) and other pathological conditions (e.g., other diseases) or related, nonspecific effects related to the illness (e.g., effects of drugs used to treat symptoms of the illness in question); specificity is expressed as: true negatives divided by [true negative cases plus false positive cases] x 100~~).~~. A test with 100% specificity would ~~be capable of differentiating~~differentiate the target condition from other conditions in every case. *Prior probability* is defined as the frequency of occurrence of a disease in a particular population (true positives plus false negatives divided by the total population). A perfect biomarker would detect only true positives and no false negatives and thus would reflect accurately the prevalence of the disease in the population.

Positive predictive value (PPV) is the percentage of people who have a positive test who can be shown by a definitive examination (e.g., subsequent biopsy or autopsy~~ or biopsy~~) to have the disease~~(~~, calculated as the number of true positives divided by ~~[~~the sum of true positives plus false positives~~]).~~. A positive predictive value of 100% indicates that all patients with a positive test actually have the disease. For a biomarker to be considered useful clinically, it generally is expected to show a positive predictive value of approximately 80% or more (e.g., Consensus Report…1998). The PPV is heavily influenced by the prior probability, however, such that the PPV becomes smaller for increasingly rare events or conditions; as the frequency of the disease in the test population becomes smaller, the proportion of positive test results which reflect false positive results becomes larger.

Negative predictive value represents the percentage of people with a negative test that subsequently proves not to have the disease on definitive examination~~(~~, calculated as the number of true negatives divided by ~~[~~the sum of true negatives plus false negatives~~]).~~. A

negative predictive value of 100% indicates that the test completely rules out the possibility that the individual has the disease, at least at the time the individual is tested. A reliable marker with a high negative predictive value is extremely useful in clinical medicine, although a test with low negative predictive value can in some cases still be useful if it also has high positive predictive value.

In the development of medical laboratory tests or imaging assessment, the threshold for distinguishing abnormal from normal alters the sensitivity and specificity in opposite ways. ~~Thus if~~If the threshold is set further from the distribution of normative values then the test becomes less sensitive for detecting true positives, but more specific for rejecting true negatives. The convention in establishing diagnostic tests for medical conditions has been to select an intermediate choice that minimizes the total error from both false positives and false negatives (Lilienfeld et al 1994).

~~In the case of AD the~~The *Consensus Report of the Working Group on Molecular and Biochemical Markers of Alzheimer's Disease~~, for~~ affords a meritorious example~~,~~ of balancing clinical utility and scientific rigor in developing guidelines for diagnostic biomarkers in neuropsychiatric disorders (Consensus Report….1998). This Report recommended that ~~in order~~ to qualify as a biomarker, the measurement in question should detect a fundamental feature of neuropathology and be validated in neuropathologically-confirmed cases, and in such cases the test should ~~have~~show a sensitivity >80% for detecting AD and a specificity of >80% for distinguishing AD from other dementias~~ (Consensus Report….1998). In addition, the Report recommended that the biomarker should be reliable, reproducible, non-invasive, simple to perform, and inexpensive (Box 1). Finally, the Workgroup advised that an essential step in establishing a biomarker is that the scientific literature includes confirmation by at least two independent studies conducted by qualified investigators with the results published in peer-reviewed journals.~~.

~~The~~These guidelines were applied generally to the validation of ~~diagnostic~~PET biomarkers ~~for AD~~developed to estimate the density of β-amyloid neuritic plaque in the brain. While the neuropathological identification of amyloid plaques, typically at autopsy, has been ~~facilitated by the capability for~~ recognized as essential to confirming the diagnosis ~~*post mortem*. Thus the current clinical criteria for returning a diagnosis of "probable AD" provide a sensitivity of about 85% when compared to autopsy-confirmed cases. In order for a diagnostic *biomarker* to be clinically *useful*, therefore, its sensitivity must exceed this value when correlated to neuropathology (otherwise there is no benefit to performing the test). For example, the validation of a diagnostic~~of AD, PET radioligands for β-amyloid were developed simply to estimate the density of β-amyloid neuritic plaque in the brain (such plaques also have been detected in patients with some other neurologic disorders, as well as in elderly individuals with normal cognition; Yang et al. 2012). The validation of the first FDA-approved neuroimaging ~~marker~~biomarker for β-amyloid pathology in AD, [F-18]florbetapir, ~~is being evaluated partly~~thus depended on the ~~basis~~correlation of ~~correlating~~ florbetapir-PET data acquired *antemortem* in terminally ill patients, with evidence of β-amyloid in the same subjects *post mortem*~~.~~ *(Clark et al 2011).* The results rated as positive or negative for β-amyloid agreed in 96% of 29 individuals

assessed in the primary analysis cohort. ~~In~~As a secondary analysis~~,~~ in a non-autopsy cohort, florbetapir-PET images were rated as amyloid negative in 100% of 74 *younger* individuals who were cognitively normal ~~(Clark et al 2011),~~ suggesting that negative results on this test hold high negative predictive value. However, a subsequent study found that in healthy *elderly* individuals showing no evidence of cognitive decline (mean age =69.4 + 11.1 years) the florbetapir PET image was classified as amyloid positive in 14% via visual inspection and 23% using a quantitative threshold (Johnson et al. 2013).

~~Nevertheless~~The FDA code of regulations (in 21 CFR 315.5[a]) mandates that the effectiveness of a diagnostic radiopharmaceutical agent should be determined by an evaluation of the ability of
the agent to provide useful clinical information related to the proposed indications for use (reviewed in Yang et al. 2012). Since current *clinical* criteria for returning a diagnosis of "probable AD" provide a sensitivity of about 85% when compared subsequently to autopsy-confirmed cases of AD, to be *clinically useful* an imaging *biomarker* ideally would show sensitivity exceeding this value when correlated to neuropathology (otherwise there is no benefit to performing the test). Ultimately, two FDA advisory committees endorsed the implicit clinical value of information obtained from brain β-amyloid imaging, and the florbetapir approval was based on this endorsement along with clinical data showing sufficient scan reliability and performance characteristics.

The FDA approved label (https://pi.lilly.com/us/amyvid-uspi.pdf) states that [F-18]florbetapir is indicated "to estimate β-amyloid neuritic plaque density in adult patients with cognitive impairment who are being evaluated for AD and other causes of cognitive decline. A negative Amyvid [florbetapir] scan indicates sparse to no neuritic plaques, and is inconsistent with a neuropathological diagnosis of AD at the time of image acquisition; a negative scan result reduces the likelihood that a patient's cognitive impairment is due to AD. A positive Amyvid scan indicates moderate to frequent amyloid neuritic plaques; neuropathological examination has shown this amount of amyloid neuritic plaque is present in patients with AD, but may also be present in patients with other types of neurologic conditions as well as older people with normal cognition." Based upon the limitations of the extant clinical data using this biomarker, the FDA also required a "Limitations of Use" section stating that, "A positive Amyvid scan does not establish a diagnosis of AD or other cognitive disorder", and that its "effectiveness has not been established for predicting development of dementia or other neurologic condition". Finally, under "Warnings and Precautions", the label states, "Image interpretation errors (especially false negatives) have been observed."

In regards to the latter concern, the outcome of the initial FDA evaluation of [F-18]florbetapir-PET ~~for commercial use as a clinical diagnostic tool~~ illustrates another central principle in the validation of an imaging ~~diagnostic~~ biomarker, namely that the reliability of ratings across radiologists must be relatively high. In January 2011, the Peripheral and Central Nervous System Drugs Advisory Committee of the FDA recommended *against* approval of the new drug application for [F-18]florbetapir injection, based largely on concerns about the variability of ratings across readers. The Advisory Committee chair~~,~~ said during an interview after the

meeting, "We would like to see some structured training and evidence of consistency among readers" (http://www.medscape.com/viewarticle/739297). In the pivotal trial described in the previous paragraph, Clark et al. (2011) used the median of three readers' visual ratings on a five-point scale to assign the extent to which the PET scan was positive for amyloid protein binding. Since inspection of the data from individual readers ~~ultimately~~ raised questions about inter-rater reliability, the FDA response focused ~~primarily~~ on the need to establish a reader-training program for market implementation that would ~~serve to~~ ensure ~~reader~~ accuracy and consistency of interpretation of ~~existing~~ [F-18]florbetapir scans. To evaluate scan reliability a clinical study had new readers examine images acquired in individuals with presumptive AD or mild cognitive impairment, as well as persons with normal cognition. The previously obtained images from autopsied patients were also included in the study (NCT01550549). Among five readers who interpreted images from 151 subjects, the kappa score for interrater reliability was 0.83 (95% confidence interval, 0.78 to 0.88). For the autopsy subgroup of 59 subjects, the median scan sensitivity was 82% (range, 69 to 92), and the median scan specificity was 95% (range, 90 to 95) for the five new readers. Nevertheless, the FDA required the sponsoring company to institute a dedicated training program and mandated that the success of the reader-training process be further evaluated in a post-marketing study.

The need to ensure that readers consistently can detect clear positive or negative results extends to the clinical application of any imaging procedure for which the results depend on the *subjective* interpretation of a reader. For biological assays that can be *objectively* quantified, the accuracy often is characterized by comparing the assay results obtained for a known standard (e.g., a test sample with known concentration for the target compound) and the reliability or reproducibility is statistically expressed with respect to the variability in the quantitative results obtained after ~~performing~~ repeated testing on the same sample. In contrast, many types of clinical imaging assessments depend upon subjective interpretation, such as a radiologist's reading of a radiographic or nuclear medicine (e.g., PET, SPECT) image ~~on the basis of~~based upon gross visual inspection of the image. In this case, the variability of such interpretations is evaluated by characterizing the reliability and variability of the results obtained within and across raters.

Thus, *intra-rater reliability* can be established by assessing the extent to which readings performed *under blind conditions* by the same reader on the *same image* on different days are in agreement, ~~and/or~~as well as the extent to which the same ~~radiologist renders~~reader returns the same results when comparing multiple images obtained from the same patient ~~on~~across different days. Similarly, *inter-rater reliability* is assessed by having multiple radiologists read the same set of images while blind to the evaluations returned by the other readers. These intra-rater and inter-rater reliability assessments thus evaluate, respectively, the intra-individual variability (reflecting the failure of a reader to be consistent with ~~themselves~~himself or herself) and the ~~inter-individual~~across-rater variability of interpretations (reflecting inconsistency of interpretation among different readers).

Challenges in Establishing the Validity of Diagnostic Biomarkers in Psychiatry

~~An important~~A critical challenge in the application of neuroimaging to psychiatric diagnosis is that the clinical utility of such tests depends partly upon their ability to distinguish multiple conditions from one other. ~~In general~~Generally both the intra-individual and inter-individual variability of interpretation increases in proportion to the number of diagnostic categories that are considered clinically relevant. ~~In other words~~Thus the fewer the categories into which readers are assigning results, the greater the degree of agreement between readers. This tendency was illustrated historically by the results of a landmark study that evaluated the variability in interpreting chest X-ray films during lung cancer screening (Lilienfeld and Kordan, 1966). The study radiologists showed 65.1% agreement when they were required to place the film results into one of five categories (suspected neoplasm, other significant pulmonary abnormality, cardiovascular abnormality, nonsignificant abnormality, and negative), compared to 89.4% agreement if they were instead required to place the results into only two categories (positive or negative for significant pulmonary abnormality). Presumably, a diagnostic biomarker assessment aimed at informing the differential diagnosis of psychiatric disorders would need to address more than two categories, however, increasing the variability of image interpretations across readers.

In psychiatry, the need to differentiate various conditions from each other depends partly on the clinical imperative to return distinct treatment recommendations for different disorders. It might be argued, for example, that for a neuroimaging procedure to add clinical value in the evaluation of an adult patient with impaired attention, ~~the differential diagnosis relevant to the treating physician includes~~differentiation is needed between at least four categories, namely major depressive disorder, bipolar disorder, attention deficit disorder, and anxiety disorders~~, at a minimum~~ (American Psychiatric Association, 2000), since the standard of care differs between these categories. Thus, the variability across raters will be relatively higher (i.e., lower inter-rater reliability) for a diagnostic imaging study that must differentiate among several psychiatric disorders that share symptomatology but require distinct treatment approaches, as compared to the case ~~such as that~~ described above for [F-18]florbetapir-PET, which ~~hinges~~hinged on only ~~on~~ two categories (β-amyloid positive versus negative).

~~Furthermore~~A more challenging problem for the development of *diagnostic* biomarkers in psychiatry has been that the absence of certain knowledge about the pathophysiology of psychiatric disorders precludes the identification and validation of such biomarkers. For example, the determinations of positive and negative predictive value are limited by the absence of an established objective standard for establishing diagnosis in psychiatric disease (e.g., analogous to the neuropathologically verified diagnosis of AD). ~~Thus the absence of certain knowledge about the pathophysiology of psychiatric disorders will hinder the development and validation of *diagnostic* biomarkers. Greater~~In contrast, greater optimism has been associated with establishing *predictive* biomarkers of treatment response~~,~~ and *surrogate* biomarkers of treatment outcome. Moreover, many examples *pharmacodynamic* biomarkers of the effect of pharmacological probes exist, and ~~*surrogate* biomarkers of treatment outcome based on translational studies that ultimately can facilitate discovery of pathophysiology.~~ have proven useful to establish central target engagement for multiple classes of psychiatric treatment.

Nevertheless, it ~~might~~may be argued that the Consensus Report of the Working Group on Molecular and Biochemical Markers of Alzheimer's Disease (1998) reviewed above offers a potential template for developing clinically-meaningful, *diagnostic* biomarkers of psychiatric disease~~. Of course,~~ as well. Although the fundamental recommendation that ~~"in order"~~… to qualify as a biomarker the measurement in question should detect a fundamental feature of neuropathology and be validated in neuropathologically-confirmed cases" cannot yet be applied directly to psychiatric disorders~~. Thus~~, the ~~psychiatric imaging~~neuroimaging field ~~is moving~~may nevertheless move forward ~~by establishing gold-standard diagnoses~~ using criteria based conventions (APA, ~~2000).~~2013) as "gold-standard" diagnoses. If this approach for establishing the "actual" diagnosis is accepted, then the remainder of this Consensus Report can be meaningfully adapted to biomarker validation in psychiatric disorders.

This approach would ~~argue~~require that a diagnostic biomarker ~~should~~would have a sensitivity >80% for detecting a particular psychiatric disorder and a specificity of >80% for distinguishing this disorder from other clinically relevant psychiatric or medical disorders (~~Box~~Table 1). The biomarker ~~ideally~~ also should be reliable, reproducible, non-invasive, simple to perform, and (ideally) inexpensive. ~~Finally, the~~The validating data used to establish a biomarker ~~requires~~must include confirmation by at least two independent sets of qualified investigators (i.e., with at least one constituting replication in an independent clinical sample studied using the same methodology) with the results published in peer-reviewed journals. Finally, to be clinically useful the biomarker should show a clear improvement over the current standard-of-care in accurately establishing a diagnosis based on corroborating evidence (e.g., obtained via prospective assessment of the longitudinal disease course).

According to this standard, the psychiatric imaging literature currently does not support the application of ~~a~~any diagnostic biomarker to positively establish the presence of any primary psychiatric disorder. Although assessments of intra-rater and inter-rater reliabilities commonly are reported for quantitative neuroimaging measures, these have been limited to establishing *measurement* reliability (e.g., ~~of cerebral volumes or neuroreceptor binding potential), but not to the reliability of diagnostic interpretation. **Thus the peer-reviewed scientific literature does not yet contain an example of a diagnostic imaging biomarker with regard to a psychiatric disorder or treatment for which relatively high intra- and inter-rater reliabilities have been reported in two independent studies.** Similarly**, there is not yet a case in the literature where neuroimaging measures obtained from the same region(s) of interest has shown both a sensitivity of >80% for detecting a particular psychiatric disorder and a specificity of >80% for distinguishing this disorder from healthy controls or other relevant psychiatric disorders.** Nevertheless, the ensuing sections review progress toward developing such biomarkers using state-of-the-art neuroimaging technologies. Notably this literature contains several examples of *individual* studies for which sensitivity and specificity approach or exceed 80%, and it is conceivable that some of these findings ultimately may be replicated in independent studies.~~ cerebral volumes or neuroreceptor binding potential), but not to the reliability of diagnostic classification.

~~Table~~Similarly, the literature does not yet establish a *predictive* biomarker for therapeutic response to a specific treatment within psychiatric disorders. In the ensuing chapters, however, the results of some individual studies that used neuroimaging biomarkers to predict outcome to a specific treatment are reviewed to exemplify preliminary findings that ultimately could be validated as biomarkers, if they prove reproducible in an independent study conducted by an independent laboratory using the same methods in an independent participant sample, and if the biomarker measure proves sufficiently reliable, sensitive and specific to an extent that exceeds the current standard-of-care (i.e., psychiatric interview).

Summary

According to the conventions reviewed herein, the peer-reviewed, scientific literature does not yet establish the validity and clinical utility of an imaging biomarker or group of imaging biomarkers ("biomarker signature") for use in determining the diagnosis of a particular psychiatric disorder or predicting the therapeutic response to a particular treatment. For example, there is not yet an independently replicated finding in the literature of a neuroimaging measure obtained from a specific region(s)-of-interest that has shown a sensitivity >80% for classifying individual patients as having a particular psychiatric disorder along with a specificity >80% for ruling out individuals who do not have the disorder. Similarly, there has not yet been an independently replicated neuroimaging measure that has shown *both* >80% sensitivity for predicting the therapeutic response to a specific treatment *and* >80% selectivity for identifying individuals who will not benefit from the treatment.

Nevertheless, the future appears bright as neuroimaging technologies and image analysis methodologies continue to improve, and the ensuing sections review progress toward developing biomarkers using state-of-the-art neuroimaging technologies. This literature contains several noteworthy examples of *individual* studies for which sensitivity and/or specificity approach or exceed 80%, and in which specificity relative to both healthy controls and patients with distinct diseases has been explored. It thus remains conceivable that some of these findings ultimately may prove reproducible and clinically useful in independent studies.

Box 1.~~.~~

RECOMMENDED STEPS IN THE PROCESS OF ESTABLISHING A BIOMARKER

1. ~~**1.**~~ **There should be at least two independent studies that specify the biomarker's sensitivity, specificity, and positive and negative predictive values.**

2. ~~**2. Sensitivity**~~**The sensitivity of the biomarker and specificity should be no less than 80%; positive predictive value should ~~approach 90~~exceed 80%.**

3. ~~**3. The**~~**These validation studies should be well powered, conducted by investigators with expertise to conduct such studies, and the results published in peer-reviewed journals.**

4. ~~4.~~ **The studies should specify the type of control subjects, ~~including normal~~and include healthy subjects ~~and~~as well as those with ~~a dementing illness~~related but ~~not AD.~~ distinct illnesses.**

5. ~~5.~~ **Once a ~~marker~~biomarker is accepted, follow-up data should be collected and disseminated to monitor its accuracy and diagnostic value~~.~~ within the relevant clinical population.**

Adapted from (Consensus Report…1998)

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Section II: Progress Toward ~~a~~ Diagnostic Imaging Biomarkers of ~~Depression~~Mood Disorders[1]

~~Wayne Drevets, M.D.~~

~~Scott Rauch, M.D.~~

While statistically significant group differences in various neuroimaging measures are commonly observed in patients with mood ~~and anxiety~~ disorders, translating these findings into diagnostic tests for the *individual* patient has proven ~~to be~~ difficult. In general, the conventional path to validating a diagnostic test is first to generate a potential discriminant function from a ~~patient~~training cohort of affected participants and controls, and then to test this discriminant function in an *independent* cohort. Currently, no such tests have been validated through replication in an independent ~~cohorts~~laboratory and subject sample, subject to peer-review.

~~Difficulties~~ The challenges to developing diagnostic imaging biomarkers for mood disorders are ~~manifold~~numerous. Mood ~~and anxiety~~ disorders are ~~highly heterogeneous entities and there is~~ thought to comprise groups of disorders that are heterogenous with respect to etiology and pathophysiology. Consistent with this expectation considerable overlap exists in the statistical distributions ~~between patients~~of measurements obtained from individuals with mood disorders and those from healthy controls ~~in~~with respect to regional brain volumes, receptor binding ~~potential, BOLD~~ potentials, metabolic and hemodynamic ~~response~~activity, and other neuroimaging measures. Secondly, functional neuroimaging ~~techniques~~measures – especially fMRI data– are highly sensitive to ~~normal temporal fluctuations~~nonspecific alterations in patient physiology that may have ~~nothing~~little to do with mood symptoms (e.g. associated with caffeine consumption and nicotine exposure) (1, 2), and to physiological changes produced by medications used to treat psychiatric symptoms (e.g. benzodiazepines and antipsychotic drugs) or medical conditions that ~~are~~ commonly ~~comorbid~~occur comorbidly with mood disorders ~~and may themselves affect imaging data~~ (e.g. diabetes mellitus and hypertension) (3)~~, medication, which may independently affect neurophysiology (e.g. lithium and antidepressants)~~ (4)~~, and scanner resolution, which will determine the type of morphometric and functional changes that~~

[1] ~~Prepared~~This section was written by ~~Wayne~~ Jonathan Savitz, ~~Drevets, M.D> and~~ Scott Rauch, Ziad Saad and Wayne C. Drevets~~M.D.~~

~~can be measured.~~. The development of imaging-based diagnostic algorithms that are robust enough to be applied across cohorts and sites ~~will thus be a significant challenge. Thirdly,~~ thus has proven challenging. Thirdly, in some cases psychotropic medication can alter the physical properties of the ~~statistical power of functional~~ imaging ~~scans, and~~signals (lithium's effects on the ~~ability~~T1 signal in MRI) used to discriminate white matter and gray matter boundaries using structural MRI~~, increases with time,~~ or to assess hemodynamic changes during fMRI (e.g., some antipsychotic drugs alter the magnitude of the BOLD signal), potentially ~~leading to a tradeoff between accuracy and time burden/cost. Fourthly, medication is a potent confound not only because it may affect~~ confounding measures of brain structure and function, ~~but because it may bias~~and biasing classification algorithms~~. The algorithms~~ (Cousins et al. 2013; Röder et al. 2013; Savitz & Drevets, 2016). The resultant models thus may distinguish patients from controls based on the impact of different classes of medication rather than diagnosis-specific neurophysiology. ~~Conversely, if an algorithm is~~A corollary to this problem is that a model developed and trained on an unmedicated ~~sample, it may be inaccurate when applied to a~~ subject sample with a disorder may not sensitively classify individuals with the same disorder if they are medicated ~~subject~~.

~~Currently, researchers are still in the process of developing robust diagnostic classifiers within just one cohort of patients at a time. The challenge~~The challenge in neuroimaging studies is to determine how best to identify the key prediction signals in the mass of data produced by ~~neuroimaging.~~state-of-the-art scanners for each participant. One approach is to ~~use~~apply machine learning~~. Machine learning refers to~~, a group of ~~statistical methods~~ algorithms that are used to ~~develop algorithms to detect patterns or regularities within~~ derive models for predicting classes or outcomes from high-dimensional data~~. An~~ (Arbabshirani et al. 2017). Machine learning approaches typically require a model building step using a training dataset, followed by a model testing step using an independent dataset. For example, an empirical ~~data~~fMRI training ~~set – for example, the MRI data~~dataset from one group of participants with a specific DSM-IV-~~diagnosed patients versus~~ diagnosis plus a healthy ~~controls~~control group - is used to develop ~~an algorithm~~a model that optimally distinguishes between these groups. ~~Theoretically, the computer will~~The resultant model then ~~be able to make intelligent decisions about~~ is tested on an independent dataset to assign class memberships to the new cases based on the ~~examples provided in~~patterns established from the training set. That is, the program "learns" from experience.

Once ~~an algorithm~~a classification model has been developed, the gold standard is to validate it on an independent cohort~~.~~ of subjects obtained at a different study site, with the accuracy of each step dependent on including relatively large subject sample sizes. These requirements reflect the limitation of machine-learning that iterative training and cross-validation on the same data overestimate the classifier performance (Hastie et al. 2009), and that classifiers trained on one data set at a single site may not generalize to data collected at multiple sites (Nielsen et al. 2013; Plitt et al. 2014). However, as discussed below, most of the papers published to date have ~~made use of a~~ relied exclusively upon less stringent validation ~~method –~~ methods (e.g., the "leave out one" approach~~.~~), motivated largely by the relatively modest number of subjects included in each study (e.g., in most MRI-based studies that classified single subjects with MDD, the sample size of the depressed subject group has ranged from 18 to 57; Arbabshirani et al. 2017). That is, all subjects except one ~~patient-control pair~~ are initially chosen to comprise the training set and ~~an algorithm~~a model that best separates the diagnostic groups from each other is applied to the omitted ~~pair~~participant to predict their diagnostic status or treatment response. The process ~~is~~ then is iteratively applied to each ~~subject pair~~participant to test the ability of the algorithm to distinguish between categories. That is, each omitted ~~subject pair~~participant comprises one ~~training example. The "~~testing sample. This 'leave ~~out~~ one~~"~~ out' approach ~~is less stringent because one~~ provides an estimate of how well the particular *modeling approach* is expected to perform on independent data. To determine how well a particular model's performance would ~~expect to find significant variation across subject samples. A proportion of this variation is likely to be noise – i.e. the confounding effects of temporal fluctuations, medications and other factors discussed above, and a proportion of this variation is likely to result from disease heterogeneity. Only by testing~~ generalize, however, it must be tested on an ~~algorithm on an~~ independent ~~cohort, can one demonstrate~~set of data that were not part of the ~~discriminator is robust to these confounds.~~training set.

The accuracy of the ~~algorithm~~classifier model is best represented by its sensitivity and specificity ~~scores~~values. Sensitivity refers to the percentage of patients correctly classified as having the diagnosis while specificity refers to the percentage of healthy controls ~~who are incorrectly~~

~~labeled~~or controls with a different disorder who are correctly identified as not having the target condition.

A laudatory example of developing machine learning algorithms to classify depressed subjects as well as to predict treatment response was reported by Drysdale et al (2016). These investigators used resting-state fMRI (rsfMRI), which measures spontaneous regional fluctuations in the BOLD signal, to identify MDD subtypes according to distinct patterns of functional connectivity (correlation of fluctuations) between brain regions. Their analyses revealed four "biotypes" defined by homogeneous patterns of dysfunctional connectivity in frontostriatal and limbic networks. They then showed that these biotypes were prognostically informative for predicting the antidepressant response to repeated transcranial magnetic stimulation (rTMS). Finally, they tested the sensitivity and specificity of the model for classifying participants as depressed or healthy in an independent data set acquired across multiple MRI centers.

The approach followed in this study are instructive for their study design, attention to technical considerations for noise reduction, and combination of both clinical symptom ratings and rsfMRI data. First, they included only scans that were of sufficient technical quality to provide interpretable information. They then implemented standardized, state-of-the-art, preprocessing procedures to control for nonspecific motion-, scanner- and age-related effects in rsfMRI data, and co-registered the functional volumes to a common stereotaxic array to allow comparisons across individuals. They then applied a previously validated parcellation system to delineate 258 functional network nodes across the brain, from which they extracted BOLD signal time series. The correlation matrices calculated between each node provided an unbiased estimate of the whole-brain architecture of functional connectivity in each subject. They additionally used subject level clinical rating scale information both to identify anhedonia- and anxiety-weighted components in the rsfMRI subtypes, and to define a common functional anatomical "core of pathology" (encompassing insula, orbitofrontal cortex, ventromedial prefrontal cortex and subcortical areas implicated in previous studies of depression), which predicted the severity of three 'core' symptoms from the Hamilton Rating Scale for Depression present in almost all patients. Superimposed on this shared pathological core were distinct patterns of abnormal

functional connectivity that differentiated four biotypes, which were further characterized by specific clinical-symptom profiles.

The clustering analysis was performed in a "cluster-discovery" sample (n = 220), in which classification of depressed versus healthy subjects was optimized in the full training data set (n=333 MDD participants; n=378 heathy controls), and leave-one-out cross-validation and permutation testing were used to assess performance and significance. Support-vector machine (SVM; a type of supervised learning model) classifiers yielded overall accuracy rates of up to 89.2% for accurately classifying subjects into depressed versus control categories based on the regional connectivity features. In cross-validation (leave-one-out), individual patients and healthy controls were diagnosed correctly with sensitivities of 84.1–90.9% and specificities of 84.1–92.5%. The investigators then tested the most successful classifier for each depression biotype in an independent replication data set consisting of 125 depressed participants and 352 healthy controls imaged across13 study sites. Overall, 86.2% of subjects in this independent replication data set were correctly diagnosed as having MDD.

Finally, to further validate the four MDD biotypes, Drysdale et al. assessed their temporal stability, prediction of treatment outcome, and specificity for classifying participants with other psychiatric disorders. In a subset of 50 depressed subjects who underwent a second rsfMRI scan 4–6 weeks after the first scan, 90% of subjects were assigned to the same biotype in both scans. In 124 subjects who received high-frequency rTMS of the dorsomedial prefrontal cortex for 5 weeks, rTMS proved effective for 82.5% (n= 33/40), 25.0% (n= 4/16), 61.0% (n= 25/41) and 29.6% (n= 8/27) for biotypes 1, 2, 3 and 4 respectively. Classification of treatment response according to connectivity features plus biotype diagnosis yielded a predictive accuracy of 89.6%, compared to only 62.6% when clinical symptoms alone were used to predict treatment outcome. Finally, among 39 patients diagnosed with generalized anxiety disorder, which is closely related to MDD, 69.2% were classified as belonging to one of the depression biotypes with most (59.3%) being assigned to the anxiety-associated biotype. In contrast, only 9.8% of 41 patients with schizophrenia were classified into a depression biotype.

While the Drysdale et al. (2016) algorithm for classifying MDD appears promising, future studies are needed to replicate these results in an independent laboratory and subject sample. The

authors published the list of coordinate-based ROIs, but also would need to provide the model parameters for identifying subtypes as well as those for predicting rTMS response in order to enable replication attempts. A replication study should include a sufficiently large sample size to provide confidence about the subtyping approach. Ideally, future research also is needed to ensure that one or more of the biotypes is not simply driven by nonspecific effects (e.g., medications or co-morbidities). Finally, the *reliability* of the classifiers needs characterization using fMRI data acquired at varying spatial resolutions and from different MRI scanner types.

Other researchers have explored the development of single-subject prediction/ classification models using task-based fMRI, diffusion MRI, or structural MRI-based measures of brain tissue composition. These studies have included smaller samples and their results were subjected to fewer validating comparisons than those reported by Drysdale et al. 2016. Moreover, their results also await replication in independent laboratories and subject samples. While these studies are reviewed elsewhere (Arbabshirani et al. 2017), some examples are described below to illustrate different types of imaging parameters that can be fruitfully studied for their potential as biomarkers.

Sun et al. (5) created cortical *density* maps for 36 healthy controls and 36 patients with recent onset schizophrenia-spectrum or affective psychosis. On a group level, the patients displayed reduced gray matter density in regions such as the anterior cingulate and lateral surfaces of the prefrontal and temporal cortices compared to the control group. Machine learning methods then were ~~then~~ applied to the data to test whether these findings could be applied at the individual subject level. Using a sparse multinomial logistic regression classifier, 129 surface voxels were linearly combined for classification allowing for 86% accuracy in distinguishing between patients and controls. Clusters with the highest weightings included the frontal pole, superior and middle temporal regions of the left hemisphere, and the superior temporal, somatomotor, and subgenual anterior cingulate cortex ~~(sgACC)~~ regions of the right hemisphere.

In another structural MRI approach, Redlich et al. (2014) compared gray and white matter volumes between unipolar and bipolar depressives using voxel-based morphometry, and then developed a novel pattern classification approach to discriminate between groups. The study

sample consisted of 58 currently depressed subjects with bipolar I disorder, 58 age- and sex-matched unipolar depressed patients, and 58 matched healthy controls, with half of each subgroup imaged at one of two imaging sites. Using machine learning the classifier was trained at one imaging site and the model was tested in the independent sample from the other site. At both sites, individuals with BD showed reduced gray matter volumes in the hippocampus and amygdala relative to individuals with MDD, whereas individuals with MDD showed reduced gray matter volume in the subgenual anterior cingulate cortex compared with individuals with BD. Pattern classification yielded up to 79.3% accuracy for differentiating the two depressed groups by training and testing the classifier at one site, and up to 69.0% accuracy when this classifier was tested in the independent sample at the other site. Notably when individual subjects were instead classified into three categories, namely MDD, BD or healthy control, the best accuracy was reduced to 48.3% for testing in the independent sample.

In a task-based fMRI study, Fu et al. (6) used the voxel-wise hemodynamic response to sad faces to distinguish ~~acutely~~ depressed ~~patients~~participants with ~~major depressive disorder (~~MDD~~,~~ (n=19) from healthy controls (n=19) with 82% sensitivity and 89% specificity. Regions with the highest vector weights included the dorsal ~~ACC (dACC),~~anterior cingulate, middle and superior frontal gyri, hippocampus, caudate, thalamus, and amygdala. The same group achieved a less robust 65% sensitivity and a 70% specificity with the use of a working memory paradigm in 20 healthy subjects and 20 unmedicated ~~patients with major depression~~depressed subjects (7). Interestingly, despite the difference in task paradigm there was some overlap in the regions that distinguished patients and controls in the sad face task – namely the caudate, and the superior and middle-frontal gyri.

In another task-based fMRI study, the hemodynamic ~~response of~~responses within the default mode and temporal lobe networks during an auditory oddball paradigm ~~was~~were applied *a priori* to a sample of 14 medicated patients with bipolar disorder, type I (BD I), 21 medicated patients with schizophrenia, and 26 healthy controls (8). The authors ~~were able to~~could distinguish BD patients from schizophrenic patients ~~and healthy controls~~ with 83% sensitivity and 100% specificity. ~~The accuracy of the BD versus healthy control classification was not provided. Most recently,~~

Hahn et al. (9) utilized three independent fMRI paradigms in an attempt to maximize classification accuracy: the passive viewing of emotionally-valenced faces, and two different versions of the monetary incentive delay task emphasizing potential winnings and potential losses, respectively. A decision tree algorithm derived from the combination of the imaging task classifiers produced a diagnostic sensitivity of 80% and a specificity of 87% in a sample of 30 patients with depression (both unipolar and bipolar) and 30 healthy controls.

~~Several~~In addition, several studies have ~~recently~~ used machine learning methods to evaluate predictors of response to treatment with antidepressant medication. In one ~~such~~ study, a whole brain voxel-based morphometry (VBM) analysis predicted treatment response to fluoxetine with 89% sensitivity and 89% specificity. ~~The~~In contrast, the same algorithm derived from the VBM analysis only differentiated MDD patients (n=37) from healthy controls (n=37) with 65% sensitivity and 70% specificity (10). Response to treatment was associated with increased gray matter density of the rostral ACC, left posterior cingulate cortex, left middle frontal gyrus, and right occipital cortex at baseline (10).

Gong et al. (11) used structural MRI to predict antidepressant efficacy in 61 treatment naïve patients with depression. Patients who failed to respond to 2 adequate trials of an antidepressant were distinguished from treatment responders with 70% sensitivity and 70% specificity based on gray and white matter volumes~~:~~. The treatment responders had both greater and lower baseline volumes of different regions in the frontal, temporal, parietal and occipital cortices, as well lower baseline volume of the putamen (11).

Using task-based fMRI, Costafreda and colleagues (12) reported that in 16 unmedicated patients who met criteria for a major depressive episode, pretreatment response to implicitly-presented sad faces in regions such as the ~~dACC~~dorsal anterior cingulate cortex, midcingulate gyrus, superior frontal gyrus, and posterior cingulate cortex predicted subsequent response to cognitive behavioral therapy with a sensitivity of 71% and a specificity of 86%.

Other attempts at predicting response to treatment have been less successful. The functional imaging correlates of a verbal working memory task only predicted response to fluoxetine with 52% specificity, although sensitivity was 85% (7). Conversely, 62% of patients who achieved clinical remission and 75% of patients who did not remit following 8 weeks of antidepressant treatment, were correctly identified as responders and non-responders, respectively, with a sad face processing task (6).

In sum, ~~current~~many of the published diagnostic classification and treatment prediction methods have yielded sensitivities and specificities that range from ~~70~~80-90%. ~~That is, approximately 3 out of 10 patients with a mood disorder would be incorrectly diagnosed as healthy, and approximately 1 out of 10 healthy individuals would be incorrectly diagnosed with a mood disorder.~~ Nevertheless, none of the above-mentioned studies ~~have~~has achieved this degree of ~~diagnostic~~ success in an independent cohort, and this will be a crucial test for the field. Ultimately, the patient burden and/or risk of the scan, together with its financial cost, will have to be balanced against the potential benefits of testing ~~such as~~in terms of improved outcomes and ~~more~~greater cost ~~efficient treatment~~and time efficiencies. The extent to which diagnostic and treatment misclassification will be tolerated by clinicians and the health care industry ~~will~~may ultimately be determined by this cost-benefit ratio.

Independent of the technical challenges involved in developing diagnostic algorithms, we raise the issue of whether the current approach to developing neuroimaging-based tests for the *diagnosis of psychiatric disorders* is philosophically flawed. The claim that the machine learning approach will lead to objective biomarkers of psychiatric illness that will supplant the clinical interview is circular because the algorithms are trained to categorize patients based on clinical (i.e. DSM-IV) diagnoses. Yet the *raison d'etre* of the biomarker is the future supersession of the subjective diagnosis as the gold standard. Our current diagnostic categories may subsume multiple distinct disorders and thus attempting to forcibly align neurobiology with DSM diagnoses is arguably regressive. In contrast, research that aims to identify neuroimaging biomarkers of treatment response should be encouraged as this approach is not subject to the same tautological trap.~~The~~

Ultimately the identification of neurobiologically distinct subtypes of mood disorders may be a more fruitful approach to understanding the underlying biology of psychiatric illness (13). The recent evidence of subtypes defined both by symptom clusters and immunometabolic biomarkers corroborates the existence of biologically distinct subgroups within the MDD population, which has important ramifications for studies of neuroimaging classifiers and treatment predictors (e.g., Lamers et al. 2013; Simmons et al. 2016). It is conceivable that combinations of neuroimaging data with immunometabolic or other biomarker types ultimately may prove more successful than either data type alone at providing diagnostic classification and treatment prediction models. ~~In contrast, research that aims to identify neuroimaging biomarkers of treatment response should be encouraged as this approach is not subject to the same tautological trap.~~

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Section III: Progress Towards Biomarkers of Psychotic Disorders

Written by Cameron Carter

Going back to the original observations of enlarged ventricles in schizophrenia ~~[1, 2]~~[1, 2] as well as to observations of functional hypofrontality (~~[3]~~[3], ~~[4]~~[4]) and increased striatal dopamine release ~~[5]~~[5] a broad range of reliable and well replicated changes in brain structure, function and chemistry and been revealed using modern neuroimaging techniques. As is the case for many other behavioral and neurobiological measures that have been shown to be altered in schizophrenia, these widely replicated group differences belie a substantial degree over overlap between individual ~~subjects~~subject data from patients with schizophrenia compared to controls and other patient groups. This has placed a major limitation on the use of neuroimaging as a diagnostic biomarker of schizophrenia. As imaging methods have become more sophisticated, leading to the generation of massive multidimensional data sets, there has been a renewed interest in the diagnostic use of these methods by applying a new set of statistical and computation tools that have gained traction in areas of biomedicine. These new tools offer the hope of identifying subtle patterns in complex data sets that can be used to accurately identify group membership . This approach, known as Classification Analysis, applies statistical and/or computational methods to identify a "hyperplane" of features in high dimensional data that can be used to distinguish between groups. The goal of such an approach is to use individual subject MRI data (structural, functional or both) to differentiate between membership in diagnostic groups with high positive and negative predictive value.

This is a rapidly developing field and there are now a number of reports of what would be considered good classification rates for samples that include schizophrenia patients and either

healthy controls or patients with bipolar disorder. This includes a small number of studies that report positive and negative predictive values that exceed 80% (~~[6, 7]~~[6, 7] Demirci, see also Calhoun ~~[8]~~[8]~~who presented specificity and sensitivity data in this range). As discussed below, many of the studies published to date have significant methodological limitations and it is important to note that in no case has a method been independently replicated in an independent and comparable sample of patients and /or controls, one of the key requirements for diagnostic biomarker status as discussed above.~~who presented specificity and sensitivity data in this range as well as a recent study by Squarcini et al (2017) in first episode patients). Recent studies using multimodal imaging (such as the combination of fMRI functional connectivity data and MEG measures of oscillatory activity and other similar approaches using structural and functional MRI measures) have shown improved classification over that obtained using each method alone and it is likely that the use of multiple image based as well as other features (cognitive and clinical measures for example) might eventually lead to the development of valid and reliable diagnostic biomarkers (14)(Cetin et al, 2016), (Janousova et a., 2015).

As discussed below, many of the studies published to date have significant methodological limitations and it is important to note that in no case has a method been independently replicated in an independent and comparable sample of patients and /or controls, one of the key requirements for diagnostic biomarker status as discussed in Section I. Furthermore the very few studies that have tested the replicability of a classifier have performed much less than optimally (15) Schnack et al, 2015).

As this research approach has matured it has also become clear that there are a number of critical methodological issues that have limited progress toward that application of this approach to enhance clinical diagnosis. As discussed in Demirci et al ~~2008~~(6) a number of studies have only classification accuracy for the entire sample rather than separately for each group. High overall classification can be driven by very good classification performance for one group (either patients for controls) but poor performance for another, which would limit the clinical utility of such an approach. Many of the early classification studies were conducted in very small samples such that their generalizability would be questionable and as such must be considered proof of concept. There are a number of ways in which classification methodology can be biased, such as by selecting the features forming the basis of classification based upon the entire data set being classified or failing to keep test and training set separate during all steps of the analysis. These problems are present to some degree in a number of the published studies using classification methodology to distinguish schizophrenia patients from other groups.

~~In a recent critical~~The review by Demirci et al (~~2008) stress~~6) stresses the importance of large, well characterized and described sample sizes, multi-site data sets, and unbiased use of classification methods along with detailed reporting of results in future classification studies using imaging data in schizophrenia patients.

In addition to ~~classifying~~ differentiating patients from controls, efforts have been made to extend this approach to the important area of risk prediction. Risk syndromes for psychotic

disorders, based upon clinical assessment techniques that detect the presence of sub-threshold symptoms~~[9]~~[9] have been shown to be reliably applied in ~~the~~ research ~~setting~~settings across the ~~word~~world and predictive of transition to psychosis in the 20-40% range. This relatively low positive and negative predictive value limits the utility of this approach for guiding treatment. A number of research groups have sought to identity structural and functional changes in the brain in the risk state and to evaluate the predictive value of these findings for clinical and functional outcomes. The results of these studies has been quite variable, For example one of the leading groups in this area~~,~~ reported the presence of reduced cortical gray matter in prefrontal cortex and the temporal lobes ~~are seen~~ in at risk individuals who later made the transition to psychosis while medial temporal lobe abnormalities accompanied the emergence of psychotic symptoms~~[10]~~[10]. A more recent paper from the same group, using different analytic methods, reported the opposite finding, with reduced prefrontal gray matter being related to the risk syndrome per se while reduced medial temporal lobe gray matter was related to transition. The latter study had one of the larger samples reported to ~~data~~date but clearly additional well powered studies and meta analyses will be needed to clarify the relationship between changes in gray matter and psychosis risk in the clinical high risk syndrome. To date one study has reported the use of pattern classification analysis based upon structural MRI data to ~~classify~~differentiate high-risk subjects from controls as well as those who later transition to psychosis versus those who do not. In this single study the classification success rate was over 80% for each group and also for a second independent healthy control group. Further replication in an independent at risk group will be needed to establish the reliability and generalizability of this potentially promising result~~[11]~~[11].

Two final points related to the use of structural and functional MRI data for classification should be made. The first is that there is little standardization of either the acquisition or analysis methods and for this approach to have a clinical impact the field would need to develop consensus on this. More fundamentally, the validation of classification methods requires a gold standard, and for mental disorders in general and schizophrenia in particular this is a tall order. DSM schizophrenia itself is clearly a heterogeneous disorder that has phenotypic overlap at the behavioral level as well as in brain structure and possible function and so it may be unrealistic to achieve a consistently high level of classification in clinical practice.

In summary considerable effort is currently being invested in using modern statistical and computational tools to utilize structural and functional MRI for diagnostic purposes in patients with schizophrenia and related disorders. This approach has yielded some promising results but also methodological caution that seems largely addressable as more rigorous studies are performed on a much larger scale than has been typical to date. While there is reason to be hopeful that these methods will eventually yield generalizable and replicable results that will permit their application in clinical practice at this time classification analyses remain a research tool only.

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Section IV: Imaging Biomarkers Associated with Cognitive Decline

Jonathan McConathy, M.D. and Yvette I. Sheline, M.D.

Introduction

In the past decade there has been a proliferation of neuroimaging studies examining cognitive decline in the elderly. Many of these studies have been small with small numbers of enrollees. It is becoming increasingly important to determine which studies and methods have achieved sufficient sensitivity and specificity that they can guide diagnostic or therapeutic decisions. The major focus of molecular and structural imaging for dementia has been on Alzheimer-type dementia (AD), frontotemporal dementia (FTD), and dementia with Lewy bodies (DLB). These three types of dementia differ in terms of presentation, prognosis, etiology and response to therapeutics, although clinical overlap is not uncommon (1-5). We will highlight those studies with sufficient power to make meaningful conclusions concerning the role of imaging biomarkers in cognitive decline and dementia.

Traditionally, the clinical work up of dementia has focused on clinical assessment, neuropsychological testing, and exclusion of other etiologies. The National Institutes of Aging (NIA) and the Alzheimer's Association have issued new diagnostic criteria for AD and mild cognitive impairment (MCI) that build upon the 1984 NINDCS/ARDRA guidelines and now suggest that the use of biomarkers and neuroimaging can enhance diagnostic confidence (3, 6). Specific definitions for stages of preclinical AD were introduced as well (7). Preclinical AD Stage I was defined as asymptomatic cerebral amyloidosis (the presence of amyloid on positron emission tomography (PET) scan or lumbar puncture (LP). Stage II was defined as Stage I plus downstream neurodegeneration (the presence of elevated tau on LP, abnormal fluor-deoxyglucose ~~(~~[FDG~~)~~[metabolism on PET scan or abnormal volumetric loss on structural magnetic resonance imaging ~~(~~[MRI~~)~~] scan). Stage III was defined as Stage II with the addition of subtle cognitive decline (7). An important concept introduced in these guidelines is the AD pathophysiological process (e.g. β-amyloid deposition in the brain) which can be observed in some cognitively normal individuals and is thought to represent preclinical disease in this group of people. The AD pathophysiologic process is distinct from AD dementia which requires objective evidence of cognitive deficits established through clinical assessment. Autopsy studies have demonstrated that the accuracy of clinical diagnosis for AD is approximately 80% (8-9). In addition to limitation in accurate diagnosis, reliance on clinical assessment alone may not be optimal for clinical trials for therapies that slow or prevent the progression of dementia because some of the preclinical AD pathophysiological processes appear to precede clinical manifestations of dementia by many years (10-11). Biomarkers for the AD pathophysiological process could be used to select participants in clinical trials as well as to monitor response to therapies. It is important to note that these recent guidelines issued by the NIA and Alzheimer's Association restrict the application of imaging and CSF biomarkers to research applications and do not include these biomarkers in their clinical diagnostic criteria. Of note, these guidelines were published prior to the FDA approval of PET tracers for amyloid imaging in adults with cognitive impairment.

Structural Biomarkers

Very mild Alzheimer's disease (AD) or mild cognitive impairment (MCI) are characterized by magnetic resonance imaging (MRI) volumetric decreases in medial temporal lobe structures including the hippocampus (12) where hippocampal volume is correlated with beta-amyloid (Aβ□-associated memory decline (13-14). Subjects with MCI who show abnormalities in MRI and/or CSF biomarkers are at greater risk for cognitive decline and progression to AD than subjects without these abnormalities(15). However, the cross-sectional sensitivity and specificity of volumetric differences compared with controls has not been demonstrated. At this time, therefore, structural MRI alone cannot be used alone to diagnose clinical dementia. In contrast, the sensitivity for detecting within-subject changes in structure is quite high. In one study, predictive prognosis of MR images obtained at one time point versus combining single-time-point measures with 1 year change measures were compared. To determine the value of including measures of longitudinal change in addition to the atrophy measures from a single-time-point MR imaging examination, individualized risk estimates were derived from the atrophy scores for thickness and volume measures calculated at the 1-year follow-up MR exam. Using the risk based on the atrophy progression scores, the discrimination improved significantly in the ability to predict conversion to AD, relative to predictive ability of using single-time-point measures (16). A study which examined subregional neuroanatomical volumetric change as a biomarker for AD to quantify the comparative sensitivity for detection of longitudinal atrophy changes, found that the regions with most sensitivity were entorhinal cortex and inferior temporal cortex (17). This could potentially provide a sensitive method to detect within subject change and potentially enough power to detect treatment induced change. For example, in prospective therapeutic trials, the number of intent-to-treat subjects necessary to detect differences in trajectory as a function of an intervention can be estimated (17). In addition to stand-alone prediction of AD, MRI has been used to augment CSF biomarkers. In MCI subjects who were abnormal on both CSF and MRI measures there was a 4 times higher risk to progress to AD within less than 2 years than those who were abnormal on only one of these measures (18-19). A recent study using the NIA-AA definition of preclinical AD found that in a one year followup study the rates were significantly different across the stages (20). The rate in stage 0 was 5%, Stage I (amyloidosis only) was 11%, Stage II (including structural MRI abnormalities) was 21% and Stage III, with the addition of cognitive change was 43% (20). Thus, adding structural MRI to amyloid alone improved the prediction of progression. On the other hand, another study found that the best predictors of progression to AD, such as entorhinal thickness or trail making test B was comparable to any combination of predictors (21).

PET and SPECT Biomarkers

Molecular imaging uses tracers whose in vivo uptake patterns and kinetics indicate and quantify the presence or activity of specific biochemical processes including receptors, transporters, enzymes and metabolic pathways. Currently, positron emission tomography (PET) and single

photon emission computed tomography (SPECT) which use radiolabeled tracers are the primary molecular imaging techniques used for imaging in dementia in humans. PET has higher spatial and temporal resolution and is more easily quantified than SPECT. There has been a great deal of work of the past 3 decades using PET and SPECT for human neuroimaging clinically and in the research setting.

Molecular imaging has established utility for neuroimaging in dementia, particularly AD (22-23). The glucose analogue 2-[^{18}F]fluoro-2-deoxy-D-glucose (FDG), several ^{11}C- and ^{18}F-labeled tracers that bind Aβ neuritic plaques, the SPECT perfusion agents ^{99m}Tc-labeled ethyl L,L-cysteinate dimer (ECD) and hexamethylpropyleneamine oxime (HMPAO), and the dopamine transporter ligand FPCIT will be discussed in this section as biomarkers for specific dementias. [^{18}F]FDG and SPECT perfusion imaging have been evaluated in each of these types of dementia, while Aβ imaging has focused primarily on AD. FPCIT has been used primarily to differentiate dementia with Lewy bodies (DLB) from AD.

There are a number of other PET and SPECT tracers that have potential applications in dementia. Tracers targeting nicotinic and cholingergic acetylcholine receptors, acetylcholinesterase, dopamine D_1 and D_2 receptors, serotonin 5-HT_{1A} and 5-HT_{2A} receptors, vesicular monoamine transporters (VMAT), and the peripheral benzodiazepine receptors in activated microglia have all shown differences between subjects with dementia compared to controls (23-25). These tracers represent promising research tools, but there is not enough data to support their use as imaging biomarkers for dementia at this time.

Pathologic analysis of brain tissue obtained at autopsy is considered the best reference standard for establishing the sensitivity, specificity and accuracy of biomarkers in dementia. There are several considerations unique to PET and SPECT biomarkers for dementia. The methods used for image acquisition, reconstruction and analysis can affect the diagnostic performance of these imaging modalities, particularly when quantitative data analysis is performed. Because of spatial resolution limitations of PET and SPECT, brain atrophy can artifactually decrease measured tracer uptake and can be a potential confound to visual and quantitative analysis. Correction for atrophy can be performed based on anatomic imaging with CT or MRI.

Alzheimer's disease (AD)

1) [^{18}F]FDG

[^{18}F]FDG-PET is the most widely used PET tracer in the United States for both oncologic and dementia imaging, and the regional uptake and retention of the PET tracer FDG in the brain can provide a quantitative measure of brain glucose metabolism. Numerous studies have demonstrated progressively decreasing brain uptake of FDG in AD patients over time,

predominantly in the parietotemporal, frontal and posterior cingulate cortices which is thought to reflect neuronal injury and loss. Currently, FDG-PET studies are reimbursed by the Centers for Medicare and Medicaid Services (CMS) for differentiating suspected AD from FTD. The clinical interpretation of FDG-PET studies for the diagnosis of dementia can be performed by qualitative visual analysis of the relative levels of FDG uptake in relevant regions of the brain. Quantitative analysis of regional FDG uptake can also be performed through comparison with normative databases, and there is data suggesting that this type of analysis can improve diagnostic accuracy, particularly for less experienced interpreters (26-27).

The sensitivity of FDG-PET for the diagnosis of early AD is approximately 90% although the specificity for distinguishing AD from other types of dementia is lower (71-73%) in studies that used autopsy confirmation as the reference standard (27-28). There is also data supporting the use of FDG-PET to predict which healthy individuals will develop mild cognitive impairment (MCI) and which individuals with MCI will progress to clinical AD (29-30). Recent studies suggest that FDG may be a better marker for progressive cognitive decline compared to amyloid imaging and CSF measures of Aβ levels (31). However, there is also growing evidence that abnormal brain accumulation of tracers targeting Aβ occurs before changes in FDG uptake (10, 32).

A relatively small number of studies have examined the ability of FDG to discriminate patients with AD from those with FTD or DLB. In FTD, the typical pattern of FDG hypometabolism predominantly involves the anterior aspects of the frontal and temporal lobes, often asymmetrically. In studies of subjects with AD and FTD, high specificities have been reported (93-98%) with more variable sensitivities (53-95%) (33-35). Some of this variation is likely due to differences in patient population, methods and reference standard (pathologic confirmation versus clinical diagnosis). In a study of 31 patients with autopsy-confirmed AD and 14 with FTD, FDG-PET was more accurate than clinical assessment and differentiated AD from FTD with a specificity of 98% and sensitivity of 86% (34). The pattern of glucose hypometabolism is similar in AD and DLB, but occipital hypometabolism typically is present in DLB but not in AD which can be used to distinguish these dementias. In studies of subjects with AD and DLB, the reported sensitivities and specificities are variable with ranges of values of 75 -83% and 72-93%, respectively (36) (37).

2) Amyloid imaging

Abnormal homeostasis and aggregation of beta-amyloid (Aβ) is a hallmark of the pathologic diagnosis of AD and is thought to play a central role in the pathogenesis of AD (38-39). The deposition of Aβ in the brain appears to precede the development of AD by up to 10-15 years (11, 40). A number of small molecule PET and SPECT tracers suitable for measuring Aβ in the living human brain have been developed over the past decade. One of the first amyloid imaging

agent developed was the PET tracer [^{11}C]Pittsburgh compound B (PiB), and this tracer has been used extensively for research in subjects with AD and other dementias. More recently, several ^{18}F-labeled amyloid imaging agents have been developed and evaluated for Aβ imaging including florbetapir (AV-45), (41) flutemetamol, (42) florbetaben,(43), FDDNP, (44) and AZD4694 (45). These tracers are better suited to routine clinical use due to the longer half-life of F-18 compared to C-11 (110 min vs. 20 min). These tracers are similar in terms of mechanism of action by binding to the fibrillary form of the Aβ protein that occurs in neuritic amyloid plaques (46).

In April 2012, [^{18}F]florbetapir was approved by the FDA for detecting abnormally increased β-amyloid deposition in the brain in patients with cognitive decline. Comparison with autopsy results demonstrated that positive florbetapir-PET studies corresponded to moderate or frequent Aβ plaques on neuropathology. Both flutemetamol and florbetaben are currently in late phase clinical trials and appear to have similar diagnostic properties based on the available published data (47-48). With this class of tracers moving from the research to the clinical setting, their proper use will require referring health care providers and imaging physicians to understand which patient populations will benefit from β-amyloid imaging as well as the implications of both positive and negative imaging studies. For florbetapir, a negative study (no abnormally increased cortical tracer uptake) is inconsistent with the diagnosis of dementia due to AD but does not exclude other dementias or neurological disorders that are not associated with β-amyloid pathology. In contrast, a positive study with florbetapir indicates the presence of abnormal levels of amyloid but does not by itself establish the diagnosis of AD dementia. As with PiB, positive florbetapir PET studies can occur in 20-30% of cognitively normal older people, (49) and the significance of this finding is an area of active research. Additionally, Aβ deposition has been reported in DLB, and AD pathology can potentially coexist with neurological conditions causing cognitive decline. Because abnormal Aβ PET and CSF studies are currently the earliest known phenotypic marker of the AD pathophysiological process and appear to precede clinically detectable cognitive decline, these agents may be particularly useful if disease-modifying therapies become available.

The most rigorous published evaluations of the correlation between imaging findings and pathologic confirmation of AD at autopsy are currently available for PiB and florbetapir. Small studies comparing the brain uptake of PiB and Aβ plaques on histopathologic analysis have yielded mixed results, and sensitivity and specificity measurements cannot be provided based on this limited data (50-51). A recent study using florbetapir demonstrated 96% qualitative agreement of PET imaging with Aβ burden on histopathologic analysis in a group of 29 subjects (15 meeting pathologic criteria for AD, 14 free of Aβ pathology) (52). In the same study, 74 healthy controls less than 50 years of age all were negative for Aβ based on florbetapir-PET. One limitation of this study was the use of consensus reads between 3 nuclear medicine physicians with individual readers having more variable performance. The data reported by the

FDA in the prescribing information document for florbetapir includes data from 59 subjects who had autopsies performed after florbetapir-PET, and the majority reader method provided sensitivity of 92% and specificity of 100%, although the sensitivity for individual readers ranged from 69-95% (53).

3) Perfusion imaging

The use of lipophilic ^{99m}Tc-labeled complexes that readily cross the blood brain barrier (BBB) with subsequent trapping are well-established radiopharmaceuticals for measuring brain perfusion (54). Regional decreases in brain perfusion measured with the ECD and HMPAO are similar to the regional decreases in glucose metabolism in AD, and regional cerebral blood flow (rCBF) has been proposed as method for diagnosing AD (55). In general, direct comparisons between FDG-PET and rCBF measured with SPECT have shown higher sensitivity and specificity with FDG-PET (56). In the past, the large differential in cost and availability between PET and SPECT cameras and radiopharmaceuticals greatly favored the use of SPECT. However, the recent widespread adoption of FDG-PET for oncologic imaging has decreased this difference significantly.

Frontotemporal dementia (FTD)

1) [^{18}F]FDG-PET

[^{18}F]FDG has shown utility in distinguishing AD from FTD based on different patterns of decreased regional brain glucose metabolism. Unlike AD, the brain regions with the most marked relative decreased in [^{18}F]FDG uptake are in the frontal and/or anterior temporal cortices in FTD. Overall, studies of subjects with AD and FTD, high specificities have been reported (93-98%) with more variable sensitivities (53-95%) (33-35). The largest study assessing the ability of [^{18}F]FDG to distinguish AD (n=31) from FTD (n=14) with pathologic confirmation found sensitivity of 86% and specificity of 97% (34).

2) SPECT perfusion

Measurement of rCBF with SPECT perfusion agents has been used to distinguish FTD from AD. In a study using ^{99m}Tc-labeled HMPAO in subjects with pathologically confirmed FTD (n=25) and AD (n=31), reduction of frontal rCBF permitted diagnosis of FTD with a sensitivity of 80% and specificity of 65% (57). When bilateral frontal reduced rCBF was present, the sensitivity was unchanged but the specificity increased to 81%. However, diagnosis based on SPECT alone was less accurate than clinical diagnosis.

3) Amyloid agents

There is currently insufficient data to define the role of amyloid imaging agents as a biomarker to distinguish FTD from AD, although the different pathophysiologies and several small studies suggest that Aβ imaging may be useful to distinguish FTD from AD. Together, these studies demonstrate that 11-25% of patients with clinically diagnosed FTD have abnormally increased cortical Aβ deposition as measured with [^{11}C]PIB or [^{18}F]fluorbetaben (58-60). None of these studies had autopsy confirmation, and the significance of the Aβ deposition in the FTD subjects is unclear. One hypothesis is the small percentage of patients with FTD and abnormal cortical Aβ deposition may be in part explained by co-morbid FTD and AD in the same patient.

Dementia with Lewy bodies (DLB)

1) [^{18}F]FDG-PET

[^{18}F]FDG has shown utility in distinguishing AD from DLB based on different patterns of decreased regional brain glucose metabolism (61-62). The pattern of decreased brain [^{18}F]FDG uptake in DLB is similar to AD with the exception of involvement of occipital cortex, particularly the primary visual cortex, in DLB but not AD. In studies of subjects with AD and DLB, the reported sensitivities and specificities are variable with ranges of values of 75 -83% and 72-93%, respectively (36) (37, 61). In a study combining both clinical and histopathologic confirmation of diagnosis, [^{18}F]FDG-PET was found to have a 90% sensitivity and 80% specificity for distinguishing AD from DLB (61).

2) SPECT perfusion

Studies examining the ability of ^{99m}Tc-labeled ECD and HMPAO to distinguish AD from DLB have shown similar sensitivity and specificity as [^{18}F]FDG-PET (63). The regional pattern of decreased brain perfusion is similar to the pattern of glucose metabolism observed with [^{18}F]FDG. Some studies have reported 85% sensitivity and 85% specificity for this indication,(64) although other groups have found substantially lower values (sensitivity of 65%, specificity of 87%) (65). Additionally, these studies used clinical diagnosis as the reference standard and were not histopathologically confirmed.

3) Dopamine transporter (DAT) imaging

The SPECT agent [^{123}I]FPCIT (ioflupane) has been used to discriminated DLB from other dementias based on the loss of dopaminergic neurons which in turn leads to decreased DAT density in the striatum. This agent has also been used to study the loss of dopaminergic neurons that occurs in Parkinson's disease and related syndromes and is clinically approved for clinical use in Europe and the U.S. to distinguish Parkinsonian syndromes from essential tremor (66). A

2007 multicenter trial in Europe with 326 subjects demonstrated that FPCIT has a sensitivity of 78% and specificity of 90% for distinguishing DLB from other dementias, primarily AD, using clinical diagnosis as the reference standard (67). A smaller retrospective study (n=44) demonstrated lower sensitivity (63%) but higher specificity (100%) based on consensus diagnosis after 12 month follow up as the reference standard (68). A small prospective study that included 20 patients with dementia and pathologic analysis at autopsy, FPCIT was 88% specific and 100% specific for differentiating DLB from other dementias compared to lower values of 75% and 44%, respectively, based on initial clinical diagnosis (69).

4) Amyloid agents

There is insufficient data to use amyloid imaging agents to distinguish DLB from AD. The available data suggests that Aβ deposition occurs frequently in DLB and may correlate with cognitive deficits (70-71).

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Section V: Progress Toward Diagnostic Imaging Biomarkers for Substance Use Disorders[2]

The heritability of substance use disorders, including alcoholism, is estimated at 50% ~~[1]~~[1], suggesting a strong biological basis for their development, that interacts with the effects of the shared environment. In addition, there are known neurobiological effects of drugs of abuse, some of which are related to their reinforcing effects, tolerance development and the formation of the addiction process, that are, at least in some part, common across substances of abuse. Neurodegenerative processes also appear to take place upon prolonged abuse, with a number of neuropsychological consequences, including co-morbidity with other psychiatric and neurological processes, making the parsing out of mechanisms associated with addiction processes particularly challenging.

The vast majority of studies have examined differences in neuroimaging data (structural measures, connectivity, function, neurotransmission) between addicted samples and controls, and in some cases, have studied the relationship between those measures and variables related to the severity of the addiction, craving, withdrawal symptoms and treatment effectiveness. The extant data on structural MRI ~~and~~, functional MRI (fMRI), magnetic resonance spectroscopy (MRS), functional and neurochemical positron emission tomography (PET) and single-photon emission tomography (SPECT) are reviewed here with specific examples. ~~The potential for neuroimaging~~Neuroimaging and related surrogate markers ~~for~~have the ~~definition~~potential of defining addiction neurobiology~~, including elements related to risk/vulnerability~~, effects of drugs of abuse on various measures, and their relationship with particular individual characteristics and responses to treatment ~~are highlighted in the following paragraphs.~~ . Biological markers related to risk/vulnerability are of particular importance as they address the potential for prevention and early intervention. The latter has been highlighted by the recent investment in acquisition of longitudinal phenotypic and neuroimaging data in late childhood and early adolescence by the National Institutes of Health in the Adolescent Brain Cognitive Development (ABCD) multicenter study. The following paragraphs summarize some of the existing data on neuroimaging biomarkers of the addictions.

Alcohol: Atrophic changes in gray matter as well as white matter damage have been amply documented in chronic alcoholics, involving frontal ~~[2]~~[2], cerebellar [3] and hippocampal structures ([4-6]), presumably accounting for neuropsychological deficits, and reflecting the neurotoxic effects of chronic alcohol consumption. Reductions in gray matter volume in chronic alcoholics and improvements in those measures after prolonged abstinence have also been observed for some structures related to decision making and motivated behavior (i.e., dorsolateral prefrontal cortex, insular cortex, nucleus accumbens, amygdala), with corresponding~~, correlated~~ improvements in neuropsychological measures (e.g., executive functions) [7]. Reductions in white matter connectivity using diffusion tensor imaging (DTI) have been documented in the fornix and cingulum, confirming the effects of alcoholism on white matter tract integrity ~~[8]~~[8]. ~~Recent work has also described an~~An impairment of abstinent alcoholics in performing an incentive conflict task that examines conflict resolution and the regulation of behavioral responses to potential gains and losses has also been described. Areas

[2] This section written by Jon-Kar Zubieta, MD, PhD, ~~The~~ University of ~~Michigan~~Utah Medical School

involved in these processes showed reductions in gray matter volume among the alcoholics that were more profound in those individuals undergoing multiple detoxifications, suggesting that multiple withdrawals, and not just alcohol ~~consumptions~~consumption, may also have effects on neuronal integrity and potentially the function of those regions ~~[9]~~[9]. In a small sample of patients with either uncomplicated alcoholism or Korsakoff's syndrome it was observed that microstructural anomalies in the white matter in the Papez circuit were associated with the more severe forms of alcoholism and with memory dysfunction, potentially providing information as to predisposition to cognitive decline in chronic alcoholics [10].

Reductions in markers of neuronal integrity as measured by MRS of the frontal lobes have been consistently found in alcoholism, with reductions in N-acetylaspartate (NAA) and glutamate/glutamine (Glu) content in heavy drinkers [11, 12]. These are effects that also appear in other substance use disorders, such as methamphetamine and nicotine dependence [13], likely reflecting the neurotoxic effects of chronic substance abuse.

A number of studies have examined brain regions involved in cue-reactivity with functional MRI (fMRI). Alcohol-related cues are associated with the activation of the prefrontal cortex, striatum and thalamus in ~~alcoholics~~alcoholic use disordered volunteers, compared to healthy controls [~~10, 11~~14, 15]. A pilot study examined the level of activation in these regions among relapsers vs. non-relapsers, showing that alcohol intake over a 3-month follow-up period was associated with greater baseline cue-induced reactivity in the anterior cingulate, medial prefrontal cortex and striatum [~~12~~16]. These findings, together with evidence that naltrexone reduces cue-induced activation in the ventral striatum [~~13~~17], led to the development of a multicenter study for the stratification of patients into different treatments based on cue-induced reactivity using fMRI measures as one of the predictors [~~14~~18]~~. This study is still ongoing, but it represents a strategy where the use of "functional endophenotypes" may help maximize treatment response in alcoholism.~~. Its results showed that increases in cue-induced reactivity of the ventral striatum were associated with better treatment responses to naltrexone, suggesting the utility of fMRI for the prediction of treatment responses in alcoholism [19]. Along similar lines, and this time utilizing an impulsiveness task, it was observed that monozygotic twins discordant for alcohol use disorder showed hypermethylation of the 3'-protein-phosphate-1G (PPM1G) gene locus, and effect linked to the fMRI signal responses in the right subthalamic nucleus, part of the output of the ventral striatum through the indirect striatopallidal pathway, a network centrally involved in motivational mechanisms and reward response integration [20].

Neurochemical imaging with PET and radiotracers have reported reductions in dopamine D2/3 receptor availability in the striatum of detoxified alcoholics in most studies (reviewed in ~~[15]).~~[21]). In the ventral striatum these have been found to correlate with both alcohol craving and cue-induced activation of the medial prefrontal cortex and anterior cingulate in parallel fMRI experiments [~~16~~22]. As reviewed below for other substances of abuse, and in particular psychostimulants, reductions in D2/3 receptor availability is a consistent finding in the drug abuse literature, likely to reflect the role of dopamine in the reinforcement of both natural and drug-associated rewards. Chronic alcohol use has been additionally associated with reductions in presynaptic dopamine function in the ventral striatum and putamen, as measured by

amphetamine- and methylphenidate-induced dopamine release [~~17, 18~~23, 24]. In the latter study, dopamine release was further negatively associated with the metabolism of the orbitofrontal cortex in healthy controls but not alcoholics, suggesting a disruption of prefrontal-ventral basal ganglia regulatory processes in alcoholism. Less consistent, mixed results have been reported for other measures of presynaptic dopamine or serotonergic function, such as the availability of dopamine transporters (DAT) [~~19, 20~~25, 26], serotonin transporters (SERT) [~~21-23~~27-29] or dopamine uptake as measured by [^{18}F]fluorodopa [~~24, 25~~30, 31]. Similar conflicting results have been reported for other targets of alcohol effects, such as the opioid system and μ-opioid receptors [~~26, 27~~32, 33], although relationships with alcohol craving were reported in both studies, and the $GABA_A$-benzodiazepine receptor site [~~28, 29~~34, 35]. Methodological differences between studies (radiotracer selectivity, length of abstinence, co-morbidities with other substances, such as tobacco smoking) are likely to account for some of the lack of consistency across studies.

A growing body of literature is also examining potential precursive factors that may underlie a predisposition for early alcohol and drug use among youth and adolescents "at risk", such as those with high-levels of sensation seeking, family history of alcoholism, and the effects of early alcohol and drug involvement. A blunted nucleus accumbens response during reward anticipation has been found in young adults at risk for alcoholism based on family history [~~30~~36], as well as in youth during an affective word processing task [~~31~~37] and it has been suggested that a composite of impulsivity and negative affectivity may induce changes in reward response circuitry predisposing to the engagement in substance use behaviors ~~[9]~~[9]. Family history of alcoholism has also been associated with higher levels of dopamine D2/3 receptors in the basal ganglia of unaffected relatives in one study, suggesting that those elevations may represent a protective factor [~~32~~38].

~~Opiates~~Opioids: Heroin-dependent volunteers have shown diffuse reductions in gray matter volume in the prefrontal, cingulate cortex and ~~supplementaty~~supplementary motor cortex, as well as reductions in fractional anisotropy as measured with DTI in frontal regions, further associated with duration of heroin use [~~33, 34~~39, 40]. A very specific form of heroin abuse, the inhalation of heated heroin vapor, has been additionally related to the development of spongiform encephalopathy as diagnosed with structural MRI ~~[35].~~[41]. Using resting state connectivity measures and fMRI, alterations in functional connectivity, affecting prefrontal, cingulate, ventral basal ganglia and amygdala networks, have been reported in abstinent heroin-dependent volunteers, with the extent of those anomalies corresponding to the duration of heroin use [~~36-38~~42-44]~~.~~. Functional connectivity indexes of the caudate nucleus, an area linked to both substance use disorders and the formation of habitual behaviors, were also different between heroin-dependent volunteers that relapsed after treatment in comparison with non-relapsers, and further associated with craving ratings, suggesting the potential utility of these measures to predict treatment responses in this population [45]. Reductions in the capacity to engage brain regions involved in impulse control and inhibitory responses have also been reported, even after prolonged abstinence ~~[39].~~[46]. As with other drugs of abuse, the presentation of heroin-associated cues during fMRI has been shown to increase brain regional activity (prefrontal, temporal cortical regions and amygdala) in currently

using as well as detoxified heroin-dependent volunteers, compared to non-abusing controls [~~40, 41~~47, 48]. In the latter study, a reduction in responses to neutral cues in the prefrontal cortex was additionally observed. Cue-induced brain regional activity in heroin-dependent volunteers is reduced after methadone treatment in the insular cortex, amygdala and hippocampal formation [~~42~~49].

~~Recent work~~Work examining structural and functional measures in prescription ~~opiate~~opioid-dependent individuals has shown selective reductions in the volume of the amygdala, as well as in DTI fractional anisotropy measures in amygdala-associated pathways. Reductions in the functional connectivity of the anterior insula, nucleus accumbens and amygdala were also observed, compared to that of controls, which were associated with duration of prescription ~~opiate~~opioid abuse [~~43~~50]. Similarly to other drugs of abuse, ~~opiate~~opioid dependence has been associated with reductions in dopamine D2/3 receptors, further correlated with length of ~~opiate~~opioid and other drug use [~~44, 45~~51, 52]. Increases in μ-opioid receptor availability have also been reported in a pilot study [~~46~~53], potentially reflecting compensatory changes after prolong ~~opiate~~opioid agonist use, or the effects of detoxification.

Psychostimulants: In cocaine dependence, reductions in gray matter volume and density have been reported in cortical and subcortical structures when compared to abstainers and control samples, and have been associated with lifetime cocaine or duration of cocaine use (most recently in [~~47-49~~54-56]. In one of these studies, the effects of comorbidity with alcohol abuse was also examined, and related to reductions in dorsolateral prefrontal cortex gray matter volume. ~~An effect of a common~~Common genetic ~~polymorphism~~polymorphisms previously associated with the interaction of childhood maltreatment with the development of antisocial traits, low monoamine oxidase function~~,~~ MAO-A~~, gene was~~ genes, were also found to interact with lifetime cocaine use to induce larger reductions in orbitofrontal gray matter ~~in that study~~ [~~47~~54]. In healthy samples, this polymorphism has been associated with reductions in gray matter volume in some subcortical structures (nucleus accumbens, anterior cingulate cortex), but increases in the orbitofrontal cortex [~~50~~57]. Reductions in gray matter measures among psychostimulant-dependent samples have been related to performance on memory tests, reaction time ~~[49]~~[56], as well as with attentional control and compulsivity of use [~~48~~55]. In the latter study, increases in caudate volume were also observed. While not directly examined in a longitudinal fashion, these data suggest that gray matter measures may undergo ~~an~~ inverted U-shape curve changes that ~~is~~are likely to vary regionally in ~~its~~their progression, as increased consumption of this psychostimulant interacts with interindividual differences driven by genetic variation and potentially environmental influences.

From a functional imaging perspective, and similar to what has been proposed in alcohol dependence, reductions in actual reward sensitivity, but increased sensitivity to the potential for rewards (e.g., expectation of drug reward acquisition) are thought to underlie the drive to consume psychostimulant drugs, and may also represent a precursive neurobiological mechanism that increases the possibility of early engagement in drug use. These processes are thought to take place through the interaction of cognitive~~,~~ regulatory regions~~,~~ (e.g., prefrontal cortical areas), with those involved in reward responding, such as the ventral striatum ~~[51].~~[58].

FMRI resting state data has shown reductions in the functional connectivity between the ventral tegmental area and ventral basal ganglia and thalamus, between the amygdala and the medial prefrontal cortex and between hippocampus and dorsomedial prefrontal cortex; the reductions in functional connectivity between the ventral tegmental area and ventral basal ganglia/thalamus were correlated with years of cocaine use. These data would be consistent with an effect of chronic cocaine on mesocorticolimbic circuits, but also represent an example of alterations at the level of ~~functional relationships~~top-down regulation between cortical and subcortical structures in cocaine dependence [~~52~~59]. Another study, however, showed increased connectivity in perigenual anterior cingulate networks in cocaine-dependent volunteers, compared to controls. This increased strength of connectivity was further associated with poorer performance on delayed discounting and reversal learning tasks in the cocaine-dependent group (reflecting difficulties in delaying rewards and in adaptive learning) ~~[53]~~[60]. Increases in connectivity were also reported recently by another group and associated with impulsivity scores and cocaine use severity [61].

In chronic cocaine abusers, the literature on cue-elicited functional PET and fMRI effects has shown that cocaine-related cues activate the dorsolateral prefrontal, orbitofrontal, anterior ~~cingulated~~ and posterior cingulate cortices, amygdala, thalamus, insula, dorsal and ventral striatum to a greater extent in cocaine-dependent volunteers than in non-users [~~54-60~~62-68]. During cognitive tasks, greater activation of brain regions involved in decision-making, conflict resolution (ventral prefrontal cortex, posterior cingulate cortex) has been positively associated with cocaine abstinence measures [~~61~~69]. Conversely, greater regional activation during the presentation of drug cues, involving the sensory association cortex, motor cortex and posterior cingulate cortex were associated with poorer treatment effectiveness, measured as cocaine-free urine samples [~~62~~70]. Greater activation of the thalamus, caudate, amygdala and parahippocampal gyrus during monetary reward expectation in recently detoxified cocaine-dependent volunteers have also been negatively correlated with treatment outcome measures, such as cocaine-negative urine toxicology, self-reported abstinence and treatment retention ~~[63].~~[71]. While preliminary, and hardly diagnostic in nature, these studies do seem to point to neuroimaging measures as potential biological markers in clinical trials to determine the predictability of outcomes in substance abusing samples, and potentially aid in treatment stratification.

Because of the direct effects of cocaine on dopaminergic and in general aminergic neurotransmission, as well as secondary effects on other neurotransmitter systems, such as the endogenous opioid, a substantial volume of literature has examined neurochemical markers using PET and SPECT in cocaine-dependent volunteers. Consistent across studies, reductions in dopamine D2/3 receptor availability *in vivo* have been reported [~~64-67~~72-75], that appear to persist long after detoxification, based on both human [~~65~~73] and non-human primate studies [~~68~~76]. These reductions have been further related to the pleasurable effects of cocaine [~~69, 70~~77, 78], but not to the likelihood of self-administration [~~64~~72]. In addition, amphetamine and methylphenidate-induced release of dopamine have been found consistently reduced in the basal ganglia of cocaine-dependent volunteers, documenting a disruptive effect of this psychostimulant on dopaminergic neurotransmission, potentially driving further consumption

and high frequencies of relapse upon detoxification and treatment [~~67, 71~~75, 79]. Drug-related cues have also been documented to increase dopamine release in the basal ganglia, correlating with craving for cocaine in addicted volunteers [~~72, 73~~80, 81]. Central to theories related to the reinforcing effects of psychostimulants, sensitization to the effects of cocaine has been shown in one study of healthy, non-addicted volunteers, whereby the repeated administration of amphetamine was associated with increases in dopamine release, an effect that was observed at two weeks and up to one year from the administration of three doses of amphetamine [~~74~~82]. Effects of cocaine-dependence in recently detoxified addicts, with increases in availability, have been reported for DAT [~~75~~83] and SERT [~~76~~84], probably reflecting upregulatory changes after chronic blockade by cocaine, albeit their behavioral consequences are presently unknown. Increases in the availability of μ-opioid receptors in prefrontal, temporal cortex and amygdala have also been reported, and are consistent with the known interactions between dopaminergic and opioid systems in mesocorticolimbic regions. These have been related to craving for cocaine shortly after detoxification ~~[77]~~[85], shown to persist over months after cocaine-cessation, and additionally related to shorter time to relapse [~~78, 79~~86, 87].

The literature on the amphetamine-type psychostimulants, including methamphetamine and 3,4-methylenedioxymethamphetamine (MDMA), is somewhat more limited in volume, and has emphasized the neurotoxic effects of these compounds. Amphetamine use has been associated with selective increases in the volume of basal ganglia structures [~~80, 81~~88, 89]. The enlargements observed in striatal structures have been ascribed to effects of psychostimulants on water content, inflammation, trophic neuromodulators and glial activation during neural injury, which after persistent damage may induce long-lasting reductions in cellular content and volumes [~~82~~90]. These enlargements ~~appear~~appeared against a more generalized background of reductions in gray matter volume in cortical regions, amygdala and the hippocampus, the latter correlating with impairments in verbal memory [~~83, 84~~91, 92], accentuating the effects of aging on those brain regions ~~[85]. Reductions in gray matter volumes are~~[93]. Reductions in gray matter volumes were most pronounced in experienced users, compared to low exposure users [~~86~~94]~~.~~. Consistent with those findings, reductions in high-energy metabolism in the prefrontal cortex have been described using [^{31}P]-MRS in methamphetamine dependence [95]. As with cocaine, impaired prefrontal cortical function, as measured with glucose metabolism and PET [~~87~~96] or fMRI during cognitive [~~88, 89~~97, 98] and emotion processing tasks [~~90, 91~~99, 100] has been observed in methamphetamine abusers, and has been related to impulsivity, aggression and cognitive dysfunction in these individuals. Treatment with modafinil, potentially through its dopaminergic effects, has been shown to improve performance during an associative reversal-learning task and induce greater increases in the functional responses of the insular cortex and prefrontal cortical regions (ventral prefrontal and anterior cingulate) in abstinent methamphetamine-dependent individuals, compared to a non-abusing control sample [~~92~~101]. This exemplifies the use of neuroimaging tools to determine not only the functional alterations associated with substance abuse, but also to objectively assess the effect of potential treatments.

In a study examining predictors of treatment response, Paulus et al [~~93~~102] utilized a decision-making task to test the possibility that regional activation during this task predicted relapse of use. Greater activation of the right insula, posterior cingulate and middle temporal gyrus were predictive of better outcomes (longer time to relapse) during a one year follow-up period with 94% sensitivity and 86% specificity. In parallel to findings in cocaine-dependent volunteers, methamphetamine abusers also show reductions in basal ganglia dopamine D2/3 receptor availability [~~94~~103], which have been further associated with measures of impulsivity [~~95~~104].

Nicotine and Marijuana: Tobacco use and nicotine dependence have been associated with reduced cortical gray matter volumes in chronic smokers, compared to non-smokers, ~~and~~ potentiating the effects of aging on those structures [~~96, 97~~105, 106]. Reductions in gray matter have also been reported for subcortical structures, such as the thalamus and substantia nigra, compared to non-smokers [~~96, 97~~105, 106]. A large community-based sample reported smaller nucleus accumbens volume with greater lifetime use of cigarettes and an association between larger putamen volume with a lower age at smoking initiation ~~[98].~~[107]. Most studies on cannabis, however, have not found consistent reductions in structural measures or structural connectivity using DTI, albeit reductions in hippocampal, parahippocampal and amygdala gray matter volume have been reported in chronic cannabis users [~~99-101~~108-110].

Tobacco smoking after overnight abstinence has been associated with reductions in the activity of ~~reward~~cognitive-emotional state processing regions, such as the anterior ~~cingulated~~cingulate and hippocampus, further correlating with ~~the change~~changes in cigarette craving after smoking [~~102~~111]. Contrary to those results, dose-dependent increases in the activity of numerous cortical ~~and regions~~areas has been observed after intravenous nicotine after smoking freely [~~103~~112], suggesting that withdrawal state, together with the direct and indirect effects of nicotine (and potentially its route of administration) on the human brain are important modifiers of neuronal responses. In this regard, differential effects of smoking abstinence and satiation on neural responses have also been ~~recently~~ reported during a probabilistic reward task [~~104~~113].

Presentation of smoking cues has been shown to induce greater activation of prefrontal cortical areas, amygdala, and ventral and dorsal striatum in smokers compared to non-smokers [~~105-109~~114-118]. Compounds such as ~~buproprion~~bupropion and varecicline, clinically utilized to reduce craving during smoking cessation have been additionally shown to reduce the activation of the ventral striatum, prefrontal and cingulate cortex during the presentation of smoking cues [~~110, 111~~119, 120]. Nicotine replacement has also been shown to increase brain regional activity and the correlations between alpha-EEG power ~~to~~and brain activity ~~correlations~~ in cortical regions, an effect interpreted as reflecting the negative effects of nicotine withdrawal on attentional networks, with respective improvements after replacement [~~112, 113~~121, 122]. Effects of genetic variation have also been described, with variable number of tandem repeats in the ~~dopamine transporter~~DAT gene influencing brain regional responses to smoking cues. Individuals with 9-repeats had greater responses to smoking cues in ventral striatal and prefrontal regions, compared to smokers homozygous for the 10-repeat allele in the SLC6A3 gene [~~114~~123]. Differences in responses to smoking cues in female smokers have also been

reported for allelic variations in a single nucleotide polymorphism of the nicotinic acetylcholine receptor (nAChR) alpha-5 subunit [~~115~~124].

Increases in the availability of beta-2 nAChR's have been reported in smokers during acute abstinence using selective radiotracers [~~116~~125], with reductions towards baseline after 2-3 months of abstinence [~~117~~126]. After smoking to satiation, high levels of receptor occupancy have been reported, in the 55 to 80% range [~~118~~127].
Smoking has additionally been shown to acutely activate dopamine D2/3 neurotransmission in the ventral basal ganglia, as measured with PET and [^{11}C]raclopride. These effects have been associated with reductions in craving for cigarettes [~~119~~128], improved mood [~~120~~129], the hedonic effect of smoking ~~[121]~~[130] and with the severity of nicotine addiction, as measured by the Fagerström scale of nicotine dependence [~~122~~131]. The baseline level of DA D2/3 receptors of smokers has been found to correlate with Fagerström scores (albeit D2/3 receptor availability was not significantly different between smokers and non-smokers), while nicotine plasma levels were related to the magnitude of DA release after smoking in another study ~~[123].~~[132]. Reductions in D2/3 receptors have been reported in one report in the basal ganglia of heavy smokers using [^{18}F]fallypride, with positive correlations with craving in the ventral basal ganglia, and negative relationships with craving in the anterior cingulate and inferior temporal cortex [~~124~~133], as well as reductions in dopamine D1 receptors in the striatum of smokers, using [^{11}C]SCH23390 and PET ~~[125].~~[134]. DA release in response to nicotine gum administration has also been found to be greater in smokers, compared to non-smokers, and proportional to the degree of nicotine dependence [~~126~~135].

Increases in the release of endogenous opioids acting on μ-opioid receptors during smoking nicotine-containing cigarettes, compared to denicotinized cigarettes have been described ~~in a pilot study~~ [~~122~~]131, 136], as well as effects of the A118G μ-opioid receptor polymorphism on both baseline receptor availability and changes in μ-opioid receptor availability when smoking nicotine-containing cigarettes [~~127~~137].

This highlight of neuroimaging studies related to substance abuse reflects the complexity of the interactions between substances of abuse and their neurobiological substrates. There is evidence of neurotoxic and degenerative effects that to a ~~large~~fair extent, show overlap across substances, with no research examining differences that maybe diagnostic or predictive. In some cases, both anatomical and functional measures related to the effects of drugs of abuse have been associated with the severity of the addiction, however this type of relationship is not likely to change clinical practice. Similarly, an emerging literature is linking genetic variation with anatomical and functional effects of drugs of abuse. While the examination of relatively simple to obtain genetic markers with the circuitry where their interaction takes place in terms of the processes of addiction may provide a more comprehensive view of their potential use in practice, this is a field largely in its infancy, which will require larger scale, more definitive studies. It is also hampered by the very low predictive value of a given genetic variation ~~at the~~for behavioral measures or at the individual level. Studies examining cue-induced increases in the activity of brain regions related to craving and the drive to consume drugs are starting to show some relationships with treatment responses and outcomes, as is the study of the

functional relationships between frontal, regulatory regions with reward-responsive structures. At the present time, those studies are largely exploratory and in need of replication in naturalistic settings. Persistent changes in neurotransmitter receptors, particularly dopaminergic, are observed across substance of abuse, and being linked to addiction severity, the rewarding effects of drugs or even some of the personality factors that increase risk for addiction, such as impulsivity and reward vulnerability. These measures are typically obtained in highly specialized settings, and their translation to practice through less expensive, easier to obtain surrogate markers, is presently lacking. Last, a nascent literature is examining neurobiological measures that precede the onset of the addictions, providing an objective understanding of factors that contribute to resiliency and vulnerability to disease. These studies, while potentially helpful in prevention efforts, are still at a very early stage, and will require the definition of consistent relationships with addiction trajectories for them to be of use in clinical settings. While much has been learned about the effects of drugs of abuse on human neurobiology, and the potential of imaging to link neurobiological mechanisms with risk/vulnerability and treatment response, the present state of knowledge is far from being generalizable to clinical settings in a manner that would affect clinical decision-making for a given individual, and to this date remain ~~at the~~ exploratory ~~stage~~and in need of replication.

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Progress Toward Diagnostic Imaging Biomarkers for Child Psychiatric Disorders

Daniel P. Dickstein M.D. [1]*, Kerri L. Kim Ph.D. [1], Karen E. Seymour Ph.D. [2] Lauren Kasoff [1],

Introduction:

Among the most important scientific trends in the past thirty years is the growing recognition that neuropsychiatric disorders are developmental disorders, with antecedents starting in childhood. Though in some respects, this "back-to-the-future" phenomenon takes us back to psychiatry's founding, it differs from prior incarnations in an important aspect: empirical data. Starting with the Decade of the Brain initiative in the 1990s, and continuing with the present emphasis on translational research, studies have shown that psychiatric illness can start in childhood, and that patients have brain/behavior alterations from typically-developing controls (TDC) without psychopathology. Magnetic resonance imaging (MRI) is the most common form of neuroimaging technique used in children to probe neural structure, function (aka functional MRI [fMRI]), and connectivity because it does not use radiation, unlike postitron emission tomography (PET) or computed tomography (CT) scans. Neuroimaging is critically important to advance what we know about the neural mechanisms underlying childhood psychiatric disorders, holding the promise of future biomarkers that could augment clinical history for better, more specific, and earlier psychiatric diagnosis and treatment—akin to methods currently employed to fight cancer with greater and greater success.

To qualify as a potential biomarker, a finding must not only be a quantitative difference between patients with a specific form of psychopathology compared to TDCs without psychopathology, but it also must be specific to that disorder compared to other psychiatric disorders. At least three possible study designs can examine specificity: (1) multi-group studies comparing patient group A to patient group B and TDCs without psychiatric illness; (2) machine learning studies that first train a computer to recognize group A based on certain neuroimaging parameters and then test the accuracy of these computer algorithms in correctly identifying if a particular person belongs to illness group A or not; (3) studies employing neuroimaging pre- and post-treatment to identify neural predictors of treatment response. Of course, to be considered a biomarker, the finding would also have to be independently replicated.

Broadly considering neuroimaging findings as potential biomarkers for child psychiatric disorders, two statements can be made at the present time. First, neuroimaging research is leading to substantial progress in our understanding of the brain/behavior mechanisms underlying child psychiatric disorders. Second, at present, no findings in any disorder would

qualify as a neuroimaging biomarker for any psychiatric disorder in children or adolescents that could be used clinically to guide the diagnosis or treatment of any individual child. While that is the goal, at present, anyone making such claims is, at best, misrepresenting themselves, and at worst taking advantage of a family's need for hope.

This review seeks to summarize the state of the field with respect to neuroimaging research as potential ~~biomarker~~biomarkers on three of the most important categories of child psychiatric disorders: (1) attention deficit/hyperactivity disorder, (2) mood and anxiety disorders (including major depressive disorder, bipolar disorder, disruptive mood dysregulation disorder, and generalized anxiety disorder), and (3) autism spectrum disorder (including the formerly separate diagnoses of autistic disorder and Asperger's disorder).

ATTENTION-DEFICIT/HYPERACTIVTY DISORDER (ADHD):

ADHD is among the most common pediatric psychiatric disorders affecting approximately 3-10% of school-age children [1-3]. ADHD involves developmentally-inappropriate symptoms of inattention, hyperactivity and impulsivity, with resultant functional impairment, including academic underachievement and school failure, problems in social relations, emotion dysregulation, risk for antisocial behavior patterns including substance use, and increased levels of risky sexual behavior [4-7].

Neuroimaging research has suggested that fronto-striatal alterations lie at the core of ADHD [8]. One of the most interesting lines of research supporting this position comes from longitudinal structural imaging studies of children with ADHD as they progress through adolescence and young adulthood. For example, compared to TDCs, children with ADHD have delays of around 2-5 years in the peak of cortical thickness and surface area, and these delays are greatest in the frontal, superior temporal and parietal regions [9,10]. Moreover, while TDCs have expansion of the ventral striatum's (VS) surface area with age, children with ADHD have a progressive contraction [11]. Such reductions in children with ADHD compared to TDCs are also seen in dorsal striatal regions [11]. Taken together, longitudinal structural imaging studies have demonstrated that ADHD is unlikely the result of a static, unchanging lesion, but rather represents a developmental lag in neural development [9,12,13]. Present longitudinal neuroimaging studies are striving to delineate "growth curves" of brain development in typical children as they become adolescents and adults so as to define where ADHD youth diverge from this trajectory in a potentially clinically applicable way. Nevertheless, ***there is no current neuroimaging biomarker for ADHD***.

ADHD: Structural MRI Studies

As is true for many neuropsychiatric disorders, the vast majority of structural MRI studies in ADHD are cross-sectional studies that compare the volume of certain brain regions of interest (ROIs) in ADHD vs. TDC participants. However, there are a growing number of studies that have begun to test the specificity of such alterations.

Meta-analyses have consistently shown children with ADHD have decreased grey matter volume vs. TDCs, in basal ganglia structures including the putamen, caudate, and globus pallidus [14-16]. Nakao et al. found that increasing age and stimulant medication use were associated with increased basal ganglia volumes among ADHD youth (N=378), suggesting that stimulant medication treatment may "normalize" these structural anomalies [16]. Finally, in the first mega-analysis of structural data—re-analyzing original MRI data from participants aggregated from different studies (N=1713 ADHD, N=1529 TDC; age range 4-63 years), Hoogman et al. found widespread subcortical reductions in participants with ADHD vs. TDCs in the basal ganglia (accumbens, caudate, and putamen) and limbic regions, including the amygdala and hippocampus, plus an overall reduction in total cerebral volume [17]. Of note, effect sizes were greatest in children vs. adults, corroborating abovementioned work showing ADHD may involve a delay in maturation, rather than a permanent "lesion".

Multi-group imaging studies have evaluated the specificity of these neural alterations in ADHD by comparing them to other patient populations, such as children with autism spectrum disorders (ASDs) or bipolar disorder (BD). For example, one study showed that medication naïve boys with ADHD (N=44) had volume reductions in total gray matter, total brain volume, and the right posterior cerebellum compared to medication naïve boys with ASD (N=19) or TDCs (N=33) [18]. In contrast, an earlier study found no ADHD-specific grey matter differences comparing ADHD, ASD, and TDC children (N=15 of each) highlighting the inconsistencies within the literature [19].

To date, three structural MRI studies have compared children with ADHD to those with pediatric BD with, and without, comorbid ADHD [20-22]. For example, Lopez-Larson et al. compared children with ADHD (N=23), children with BD only (BD-ADHD, N=30), children with BD and comorbid ADHD (BD+ADHD, N=23) and TDCs (N=29) and found youth with ADHD had smaller caudate and putamen volumes relative to both BD groups and smaller amygdala volumes relative to all three other groups [20]. Interestingly, another study comparing these four groups by Liu et al. showed that ADHD youth had specific significant reductions in total caudate and putamen volume relative to BD and TDCs whereas BD youth had specific significant

increases of total caudate, putamen and globus pallidus relative to ADHD youth [21]. Results examining cortical thickness between these groups have shown that in the right lateral orbitofrontal cortex (OFC) and left subgenual cingulate the effect of BD and ADHD is independent rather than additive yielding a unique phenotypic signature for participants in the comorbid group (BD + ADHD group) [22].

The last 15 years has witnessed considerable growth in the number of ADHD studies using machine learning to predict group membership, For example, using six ROI measurements (i.e., length of the bilateral plana temporala, length of bilateral insula and width of the bilateral anterior frontal region), Semrud-Clikeman et al. achieved a 60% accuracy rate in predicting diagnosis for 6-16 years-old diagnosed with either ADHD combined type (N=10), dyslexia (N=10), or TDC (N=10) [23]. When including age and full-scale intelligence quotient (FSIQ), accuracy improved to 87%. Similarly, two studies used caudate morphometry to predict group membership (i.e., ADHD or TDC). First, Soliva et al. used the ratio of right caudate body volume (rCBV) to bilateral caudate body volume (rCBV/bCBV) to achieve 94.74% specificity in the correct prediction of diagnosis, and an estimated negative predictive value of 93.64% [24]. In a second study, Igual et al. examined a fully-automated segmentation of the caudate (using the internal and external capsules) in the classification of children with ADHD and TDCs (N=39 per group), achieving 72% accuracy, 86% specificity, and 95% negative predictive value [25]. While requiring replication in larger samples and groups without ADHD, these results using machine learning are quite promising.

The neuroimaging/treatment literature in children with ADHD is extremely mixed, with most studies comparing medication naïve ADHD children vs. ADHD children on medications, rather than pre-post designs involving the same participants) [26,27]. For example, Castellanos et al. found no differences in total cerebral volume between medication naïve children with ADHD and those taking medication [13]. Similarly, ROI-based studies have found no volumetric differences in the anterior cingulate cortex (ACC) [28], corpus callosum [29], caudate [30,31], putamen [31], or globus pallidus [31] between children with ADHD taking medication vs. others who are medication naïve. Moreover, in Hoogman's abovementioned volumetric mega-analysis, among those ADHD participants for whom stimulant medication history was available (42%; N=719), there was no volumetric differences in any structures between ADHD participants with a history of stimulant medication use (82%), those who were stimulant naïve (11%), and TDCs [17].

In contrast to these studies suggesting that ADHD medications do not affect brain volume, other studies do support that possibility—suggesting that ADHD stimulant medications

provide compensatory increases in key ROIs. For example, Ivanov et al. found larger regional volumes in the left cerebellar surface in children with ADHD taking stimulant medication (N=31) vs. those who were stimulant naïve (N=15), with duration of stimulant treatment positively correlated with cerebellar volumes suggesting compensatory morphological changes associated with stimulant treatment [32]. Similarly, Villemonteix et al. showed that never medicated children with ADHD (N=33) exhibited decreased grey matter volume in the insula and middle temporal gyrus compared to stimulant-treated ADHD (N=20) and TDC (N=24), but no differences between stimulant-treated ADHD and TDC youth suggesting that stimulant medication may have a "normalization" effect on grey matter volume [33]. Furthermore, the authors found a positive association between duration of treatment and grey matter volume in the nucleus accumbens in medicated children with ADHD [33]. Also, in one of the few longitudinal studies examining medication effects, Shaw et al demonstrated an excessive rate of cortical thinning in the right motor strip, left middle/inferior frontal gyrus, and right parieto-occipital region in the never-medicated ADHD group (N=19) compared to those with a history of psychostimulant use (N=24) and TDCs (N=24) [34].

ADHD: Diffusion-Tenor Imaging (DTI)

DTI is another form of structural MRI that tests the integrity and connectivity of cerebral white matter tracts via diffusion of water (the most common molecule in the human brain). Common DTI measures include fractional anisotropy (FA), which reflects the relative diffusion of water and has values ranging from zero (isotropic [unrestricted] diffusion in all directions) to one (diffusion only along one axis, and restricted in all others) and mean diffusivity (MD) which measures the amount of water diffusion in any direction. DTI studies of ADHD have focused on white matter tracts connecting PFC and striatal regions implicated in the etiology of ADHD [35,36].

To date, only a few meta-analyses of ADHD DTI data have been conducted. Earlier studies with smaller sample sizes have indicated altered FA, in widespread regions of the brain including most consistently the anterior corona radiata, forceps minor and internal capsule [37]. Consistent with this early review, Chen et al., found widespread white matter disruption in a large meta-analysis of 470 individuals with ADHD and 477 TDCs. Specifically, individuals with ADHD had reduced FA in the splenium of the corpus callosum, right sagittal stratum, and left tapetum of the corpus callosum [38]. Further analyses showed that mean age of patients was negatively associated with reduced FA in the splenium of the corpus callosum suggesting that as age increases, FA decreases in this region for individuals with ADHD [38]. Unfortunately, this

meta-analysis included both children and adults with ADHD given the small sample sizes of current DTI studies; therefore, few conclusions can be drawn about the specific nature of white matter integrity in children with ADHD.

There are a few multi-group DTI studies comparing children with ADHD compared to children with other forms of psychopathology; however, these studies often present limited sample sizes and have not been replicated thus limiting the conclusions that can be drawn [39-43]. For example, Pavuluri et al. found ADHD youths (N=13) had significantly lower FA and regional fiber coherence index (i.e., a measure of the degree of coherence in a given fiber tract) in white matter fibers of the internal capsule connecting the neocortex and the brainstem compared to children with BD (N=13), and age- and IQ-matched TDCs (N=15) [39]. Furthermore, both ADHD and BD youths had significantly lower FA in the anterior corona radiata compared to TDC [39]. These results suggest that ADHD may be characterized by more diffuse white matter changes while BD may result in more focal changes residing in the prefrontal anterior corona radiata and posterior cingulate.

In another recent example, Ameis et al. compared structural connectivity in youth with ADHD (N=31), ASD (N=71), obsessive-compulsive disorder (OCD; N=36) and TDCs (N=62) [42]. While participants with ADHD had reduced FA compared to those with OCD in the anterior thalamic radiation, genu of the corpus callosum, cortico-spinal tract, arcuate, and inferior-fronto-occipital fasciculi, FA reductions in the splenium was reduced in all of the patient groups vs. TDCs. As in the prior study, the conclusion is that ADHD (and ASD) involves widespread white matter disruptions, in this case compared to those with OCD or TDCs.

In a third example, van Ewijk et al. examined the role of ODD in white matter connectivity in children with ADHD. Compared to children with ADHD alone, those with comorbid ADHD+ODD had reduced FA in fronto-temporal tracts and parts of the basal ganglia [43]. These differences were independent of ADHD symptoms suggesting that ODD confers greater risk for white matter disruptions independent of ADHD [43].

In the only DTI classification study to date, Yoncheva et al conducted a study including 82 children with ADHD and 80 TDCs. They found that mode of anisotropy, a measure of whether anisotropy is more planar (e.g., due to predominantly crossing fibers within a voxel) or more linear, in combination with ADHD rating scales resulted in a 94.12% positive predictive value, 96.67% sensitivity, and 94.59% specificity (Cohen's *d* =0.68) [44]. Moreover, mode of anisotropy had substantially greater predictive power for diagnosis than any of the other DTI measures (area under the curve ROC = 0.70) [44].

To date, no DTI studies of individuals with ADHD have examined white matter integrity before and after treatment. However, one study examined the cumulative effect of stimulant medication in children with ADHD (ages 9-26 years old, N=172) vs. TDCs (N= 96). Results showed that cumulative stimulant intake was negatively correlated with mean diffusivity (MD; a measure of the amount of water diffusion in any direction) in the orbitofrontal-striatal pathway such that higher cumulative stimulant intake was associated with lower MD in both hemispheres suggesting higher structural connectivity is associated with higher dose/longer duration of stimulant treatment [45].

ADHD: Functional MRI (fMRI)

Aligning with the structural MRI literature, fMRI studies primarily show hypoactivation of fronto-striatal regions [46]. Several ADHD fMRI meta-analyses have been conducted drawing on the increased power of larger, aggregated samples. For example, Dickstein et al. who found a widespread hypoactivity in frontal regions (e.g., dorsolateral prefrontal cortex [dlPFC], inferior PFC, OFC, and ACC) and portions of the basal ganglia aggregating 16 studies of ADHD vs. TDC participants [47]. Cortese's et al. conducted a larger meta-analysis of 55 fMRI studies (39 child, 16 adult) and similarly found overall ADHD-related hypoactivation in the bilateral frontal, right parietal and temporal, and bilateral putamen areas [46]. In contrast, they found ADHD-related hyperactivation in the right angular gyrus, middle occipital gyrus, posterior cingulate cortex and mid-cingulate cortex. When limited to child-only studies, ADHD participants had hypoactivation in fronto-parietal and ventral attention networks [46]. Taken together, these results are consistent with theoretical models of ADHD which implicate disruption in fronto-striatal networks [8].

In addition to generalized meta-analyses of task-based fMRI, there have also been many reviews focused on fMRI neural activation during particular tasks tapping specific domains of function, such as response inhibition, sustained attention, and reward responsiveness. For example, Hart et al.'s review of inhibition and attention fMRI studies (21 studies: 287 individuals with ADHD, 320 TDCs) showed that individuals with ADHD had hypoactivation in the right inferior frontal cortex, supplemental motor area, ACC, caudate, and thalamus compared to TDCs [48]. However, when age effects were examined, only basal ganglia and supplemental motor area abnormalities were present in children with ADHD vs. TDCs. For attentional control tasks (13 studies: 171 individuals with ADHD, 178 TDCs), results showed ADHD participants had significantly less activation than TDCs in the fronto-basal ganglia-parieto-cerebellar network responsible for visuospatial attention [48]. Finally, a meta-analysis of the ADHD reward

processing literature showed that during reward anticipation, individuals ADHD have ventral striatal hypo-responsiveness vs. TDCs (Cohen's *d*=0.48-0.58) [49].

Against this background, several multi-group fMRI studies have examined the specificity of these alterations. For instance, during a sustained attention task, boys with ADHD had reduced left dlPFC activation vs. boys with ASD or TDCs (N=20 in each of these three groups) [50]. Another study of sustained attention showed children with ADHD (N=18) had reduced activation in the ventrolateral PFC (vlPFC) and increased activation in the cerebellum vs. children with either with conduct disorder (CD, N=14) and TDCs (N=16) [51]. Interestingly, when reward was introduced into the task, children with CD had specifically OFC hypoactivation, suggesting that functional differentiation between attentional alterations in ADHD and reward in CD worthy of follow up.

Studies of inhibitory control have shown reduced frontal lobe activation (e.g., dlPFC, vlPFC, right inferior PFC) in children with ADHD vs. children with either primary BD, CD, or OCD [52-54]. Moreover, in a large-scale meta-analysis of inhibition task activation in adults with ADHD (N=541, mean age = 19.6 years) compared to adults with OCD (N= 287, mean age = 27.1 years) results showed two distinctly different patterns of activation such that adults with ADHD had reduced activation in the basal ganglia, especially the putamen, as well as the insula compared to adults with OCD and TDCs, while adults with OCD had increased activation in these regions relative to patients with ADHD and TDCs [55]. Further, adults with ADHD had disorder-specific reduced activation in the vlPFC. The results of this analysis suggest that while inhibitory control deficits are present in both ADHD and OCD, the neural mechanisms of action underlying these deficits appear to have different neurobiological origins [55].

A number of studies have probed neural response to emotional stimuli in children with ADHD compared to other forms of psychopathology. Brotman et al. compared emotional face processing alterations in children ages 8-17 years with either: (1) ADHD (N=18), (2) BD (N=43), (3) Severe mood dysregulation (SMD; N=29), or (4) TDC (N=37) [56]. ADHD participants had significantly increased neural activity in the left amygdala when rating their fear of emotionally neutral faces compared to BD, SMD, and TDC participants suggesting the involvement of the limbic system in the etiology of ADHD [56]. In an examination of the neural basis of cognitive control during emotional processing, results comparing children with ADHD vs. children with BD and TDCs showed an ADHD-specific under-activation in the vlPFC again suggesting the importance of cognitive control regions in the etiology of ADHD [57]. Finally, using an affective n-back task to compare children with ADHD vs. children with BD vs. TDCs, Passarotti et al., found

that relative to the BD group, children with ADHD had greater deployment of prefrontal working memory circuitry whereas children in the BD group had greater deployment of emotional processing circuitry suggesting different neural phenotypes for ADHD and BD [58]. In a succinct review of the literature comparing neural activation in children with ADHD compared to those with BD, Passarotti and Pavuluri specify that in ADHD dysfunction is primarily due to deficits in top-down cognitive control regions (i.e., dorsal frontostriatal regions), whereas in BD dysfunction is driven by deficits in "bottom-up" motivational and emotional circuitry (i.e., ventral frontostriatal regions) [59]. Taken together, while ADHD is primarily considered to be a behavioral disorder, these finding also suggest the importance of understanding the neural underpinning of emotional processing in individuals with ADHD [7,60].

Only a few studies have examined reward processing in children with ADHD compared to other forms of psychopathology. In a study comparing reward responsiveness in boys with ASD (N=18), boys with ADHD (N=19) and TDC boys (N=18), results showed that ADHD boys had medial prefrontal hyperactivation in response to social rewards while ASD boys had ventral striatal hypoactivation to monetary rewards and both clinical groups showed fronto-striato-parietal hypoactivation compared to TDCs when monetary rewards were present [61]. Therefore, while youth with ADHD had equally high striatal activation to monetary and social rewards, the ASD group displayed low striatal response to both reward types suggesting that while both disorders have aberrant responses to reward processing, they may have unique etiologies.

Studies testing computerized algorithms in predicting ADHD group status are few in number. One example includes Hart et al.'s study that used Gaussian process classifiers to predict ADHD group status with data from a time-discrimination task, showing an overall classification accuracy of 75% (80% sensitivity, 70% specificity) [62]. In particular, aberrant activity in fronto-limbic regions such as the ventromedial PFC, ventral ACC, parahippocampal gyrus and cerebellum were most predictive of ADHD [62]. Another study by Hart et al. used Gaussian process classifiers with fMRI activation during a stop-signal task with an even greater accuracy of 77% (90% sensitivity, 63% specificity) [63]. In a third example Hammer et al. used working memory task data from four different tasks resulting in a diagnostic accuracy rate of 92.5% when using fMRI data compared to an accuracy of 75% when using the behavioral task data alone suggesting the important additive contribution of neuroimaging data in the classification of ADHD diagnosis [64]. Finally, a fourth large study of stop-signal performance in participants with ADHD (N=184), unaffected siblings (N=103), and TDCs (N=128) showed that

neural activation during successful stop trials yielded an accuracy rate of almost 60% (63% sensitivity, 57% specificity) [65].

In contrast, there have been numerous studies imaging/treatment studies examining the acute effects of psychostimulant medication on neural activation in children with ADHD. Generally, studies comparing medication naïve ADHD patients to those treated with ADHD stimulants suggest that these medications "normalize" brain activation (i.e., increase) in PFC regions, including the ACC, during multiple tasks of inhibition, error processing, and sustained attention. For example, Rubia et al.'s meta-analysis of the task-based fMRI treatment literature including 14 studies of children with ADHD (N=212) showed that stimulants most consistently enhanced activation in the right inferior frontal cortex/insula and putamen [66]. However, to date, there has been only one longitudinal study examining the long-term effects of methylphenidate on executive attention in children with ADHD [67]. This study showed that one year later, while TDCs showed an increase in neural activity in the right temporo-patietal junction, important for the disengagement of attention, children with ADHD did not show this differential pattern of neural activity [67]. Further, medicated ADHD patients showed reduced activation in the insula and striatum during reorienting one year later suggesting a tendency for the "normalization" of neural activity subsequent to medication [67].

ADHD: Resting State Functional Connectivity (RSN-FC)

Augmenting task-dependent, event-related fMRI, the past several years have witnessed a groundswell of interest in task-independent fMRI collected while the participant is at rest, and also known as "resting state functional connectivity" (RSFC) or "intrinsic functional connectivity" (IFC). In general, studies suggest that 95% of the brain's metabolism is devoted to RSFC, whereas only 5% is devoted to task-dependent activities, such as making decisions, or attending to specific stimuli [68,69].

Discovery science in resting-state fMRI is particularly robust in ADHD, due in part to projects designed to share data-sets amongst research such as the "1000 Functional Connectomes Project" in which researchers have posted their resting state fMRI data on the Neuroimaging Informatics Tools and Resources Clearinghouse (NITRC), a ~~publically~~publicly available website (www.nitrc.org/projects/fcon_1000) [70,71]. Many RSFC studies suggest ADHD involves reduced RSFC in the so-called "Default Mode Network" (DMN), which includes a large network of brain regions associated with task-irrelevant mental processes and mind wandering.

Studies have also found atypical RSFC in limbic cortico-striato-thalamo-cortical (CSTC) loop circuits supporting neuropsychological models of ADHD known as the "dual pathway model"—which posits that ADHD involves considerable heterogeneity of neural cognitive alterations, with some having primary neurocognitive deficits involving executive function and the cognitive CSTC loop, while other's primary deficit involves affective and motivational systems and the limbic CSTC loop [72-74].

To date, only a few multi-group RSFC studies have evaluated the specificity of findings in ADHD youth to those with other forms of psychopathology. Di Martino et al. found an ADHD-specific increase in degree centrality, a measure indexing the number of direct connections for a given node (i.e., high degree centrality=numerous direct connections with other nodes), in the right caudate, pallidum, and putamen among youth with ADHD (N=45) vs. those with ASD (N=56) and TDCs (N=50), once again highlighting the importance of the basal ganglia in the etiology of ADHD [75]. In another example, Ray et al. showed a differential pattern of "rich club organization" of RSFC—defined as a tendency for high-degree nodes (i.e., nodes within a network that are highly connected) to be more densely connected among themselves than to nodes of a lower degree—among ADHD (N=20), ASD (N=16), and TDCs (N=20) children [41]. Specifically, ADHD had under-connectivity in the rich club, while ASD had over-connectivity in the rich club [41]. In a third example, two recent studies evaluated RSFC in children with ADHD vs. those with BD. Hafeman et al. compared RSFC collected during an emotional processing task in youth with BD (N=22), youth with ADHD (N=30) and TDCs (N=26), and results showed decreased RSFC between the amygdala and right superior frontal gyrus in the ADHD vs. BD group [76]. In contrast, Son et al. compared youth with BD (N=22), youth with ADHD (N=25) and TDCs (N=22) and found no significant ADHD-specific differences between groups [77]. Such contrasting findings may be the result of different methodologies for conducting RSFC analysis.

In contrast, efforts of the ADHD-200 competition (http://fcon_1000.projects.nitrc.org/indi/adhd200/index.html) have fueled a groundswell of interest in computerized classification of ADHD by RSFC results. The ADHD-200 competition encouraged teams of researchers to develop machine learning methods to classify ADHD diagnosis using a standardized dataset consisting of RSFC data from 491 TDCs and 285 children with ADHD. Results from the winning team showed a diagnostic accuracy rate of 60.51% (21% sensitivity, 94% specificity) [78]. Interestingly, another team achieved an accuracy rate of 62.52% using only phenotypic data (e.g., age, IQ, gender, etc) and no RSFC or imaging data, supporting the notion that neuroimaging is not the only means of predicting disease, and

that we are in the early days of using imaging biomarkers to predict any psychiatric diagnosis, including ADHD.

Very few neuroimaging/treatment studies of RSFC among ADHD children and adolescents exist. In one example, Hong et al. found reduced RSFC in participants with ADHD who were considered "good responders" (N=48) to MPH treatment vs. "poor responders" (N=30), particularly connectivity between the ventral caudate/nucleus accumbens and the right rectal and orbitofrontal gyri as well as the dorsal caudate to bilateral frontal cortices [79]. In another example, An et al. examined regional homogeneity (ReHo), which calculates the temporal similarity of time series of a given voxel to those of its nearest neighboring voxels, in resting-state fMRI data among boys with ADHD (N=23) scanned initially off medication, and then a second time half of the ADHD boys received 10mg methylphenidate (MPH) while the other half received placebo [80]. They found MPH vs. placebo upregulated activity in the left inferior frontal cortex, right OFC, and cerebellar vermis, while it downregulated activity in the right parietal and visual cortex. Interestingly, when patients were treated with MPH, no RSFC differences were observed between the ADHD and control groups, suggesting a "normalizing" effect of MPH [80].

MOOD AND ANXIETY DISORDERS:

Beyond ADHD, neuroimaging research has also advanced our understanding of the brain/behavior interactions underlying pediatric mood and anxiety disorders. Similar with ADHD though, most studies have employed cross-sectional neuroimaging methods to identify structural, DTI, and fMRI differences between participants with mood and anxiety disorders vs. TDCs. Given the considerable overlap between such disorders, although quantitative differences have been identified by such studies, there is clear need to probe their specificity, to independently replicate their findings, and to delineate their longitudinal trajectory. ***Thus, there are no neuroimaging findings that would be considered biomarkers for pediatric mood and anxiety disorders on a case-by-case basis at present, though the discovery of such biomarkers is an important and needed goal.***

For this review, we focus on the following mood conditions: major depressive disorder [MDD], bipolar disorder [BD], and ~~the new DSM-5~~ disruptive mood dysregulation disorder [DMDD].

DEPRESSION:

Depression causes significant morbidity and mortality in children, adolescents, and young adults annually, including school and work absenteeism, substance abuse, and inter-personal conflict [81,82] . More disturbing is the fact that suicide has risen to become the 2nd leading cause of death among those ages 10-24 years old in the U.S. [83] .

Neuroimaging studies of pediatric depression have focused primarily on the amygdala as well as the PFC, including the OFC and ACC. Yet, there is relatively little consistency in the direction (increased vs. decreased) of these findings, regardless of whether the neuroimaging method involves structural MRI, fMRI, or DTI. For example, in comparing three structural MRI studies of amygdala volume in pediatric depression vs. TDCs, one study reported bilateral decreases while two failed to find such significant differences [84-86] .

Studies are also now in the early phase of employing machine learning or computer models of neuroimaging data to predict group membership. Given the infancy of this work, no solid conclusions can yet be formed about the utility of such data as a diagnostic tool in the real-world.

DEPRESSION: Structural MRI

Fallucca et al. conducted the only multi-group structural MRI study of pediatric depression, comparing those children with MDD (N=24), OCD (N=24), and TDC (N=30). Focusing on cortical thickness, they found that the right peri-calcarine gyrus, post-central gyrus, and superior parietal gyrus were thinner in depressed vs. OCD and TDC youths, whereas the left-sided temporal pole was thicker in depressed youths than in either group [87]. Moreover, secondary analyses showed that these cortical thickness differences were primarily driven by children with MDD who had a family history of MDD (N=15)—a finding directly in contrast with those of Nolan et al., who did not find PFC volume differences when comparing depressed youth with depressed family members to TDC [88] . Instead, they found that depressed youth with non-familial MDD had significantly larger left PFC than those with familial MDD or TDC. Such inconsistencies highlight the current state of the neural underpinnings of pediatric depression.

Wehry et al. more recently conducted a quasi-multi-group study using voxel-based morphometry (VBM) to compare gray matter volumes among adolescents with MDD plus comorbid anxiety disorder(s) (N=12), those with MDD but no comorbid anxiety (N=14), and TDC (N=41). They found that those with MDD plus comorbid anxiety had decreased gray matter volumes in the DLPFC vs. those with MDD alone, and increased gray matter volumes in pre-

and post-central gyri vs. TDC [89]. This study, however, is limited by small sample size and also heterogeneity of comorbid anxiety disorders allowed (i.e., generalized anxiety, social anxiety, and anxiety not otherwise specified), precluding conclusions about any single anxiety disorder. To allow for comparison across studies, further efforts are needed utilizing standardized methods of assessment and longitudinal design that account for extraneous factors (e.g., family history, comorbid conditions, age, medication status).

Finally, as aforementioned, researchers are now beginning to use computer modeling to assess the role of such neuroimaging findings as potential biomarkers for depression. One example is by Foland-Ross et al. who used support vector machines (SVMs) to examine if baseline cortical thickness could identify adolescents who go on to develop clinically meaningful depressive symptoms vs. those who remain depression free [90] . Specifically, they followed N=33 female adolescents (10-15 years old), who at initial evaluation were Axis I disorder naïve, for up to 5 years. The primary finding was that baseline cortical thickness predicted the onset of depression with 70% accuracy (69% sensitivity, 70% specificity, p=0.02) comparing those who developed MDD (N=18) vs. those who remained depression free (N=15), with the right medial OFC, right precentral, left ACC and bilateral insular cortex most notably contributing to this prediction.

A second study by Wu et al. also used SVMs to compare the role of several neuromorphometric indices (including cortical thickness, volume and folding patterns) in categorizing individual adolescents, N=25 diagnosed with MDD and N=26 demographically matched TDCs [91]. The model with 78.4% accuracy identified 40/51 adolescents (76% sensitivity, 80.8% specificity, p=0.000049). Dissimilar to Foland-Ross et al., the volumetric and cortical folding in the right thalamus and right temporal pole were most involved in differentiating the depressed from control teens. Although both research groups were able to predict with high accuracy those who were depressed vs. not, the findings of Wu and also of Foland-Ross are based upon small sample sizes. Moving forward, there is need to include larger samples, demonstrate the specificity of such findings for pediatric depression vs. other psychiatric disorders, and to focus on the replicability of findings.

DEPRESSION: Diffusion Tensor Imaging (DTI)

While a few DTI studies have examined potential white matter abnormalities associated with pediatric depression, none are known to gauge the specificity of findings through use of a multi-group design [92,93] .

DEPRESSION: Functional MRI (fMRI)

The state of fMRI research in pediatric depression mirrors that of structural MRI studies in that few have probed the specificity of difference between MDD vs. TDC youths.

In fact, only three known studies have begun to evaluate the specificity of emotional face processing in pediatric depression. In the first, Thomas et al. compared emotional face processing in girls with either MDD, anxiety (i.e., primary GAD or panic disorder), or TDC (N=5 in each group). They found that depressed girls had significantly less left amygdala activity than anxious or TDC girls when viewing faces regardless of the stimuli's emotional content [94] . One strength of this research is the use of a multi-group design—comparing youth with MDD to TDC and another clinical group. However, complicating these findings is the reliance on such small samples, as well the comorbid conditions potentially unaccounted for. While none of the anxious youth were diagnosed with MDD, N=2/5 youth with MDD had GAD.

In the second study, Roberson-Nay et al. evaluated emotional face encoding using a subsequent memory paradigm. Specifically, participants first completed an event-related fMRI scan requiring them to attend to emotional face stimuli. Then they completed a post-scan memory task that required them to identify if they had, or had not, seen certain emotional face stimuli during the fMRI task. Unlike Thomas and colleagues who found decreased amygdala activity among depressed youth, they found that MDD youths (N=10) had increased left amygdala activity when successfully encoding emotional faces compared to anxious (N=11) and TDC (N=23) participants [95] . Again, a notable subset of depressed youth had comorbid anxiety (N=4/10) while no anxious participants (i.e., 3 separation anxiety, 3 social anxiety, 9 GAD) were given a comorbid MDD diagnosis.

In the third study, Beesdo et al. compared emotional face viewing in three groups of children ages 7-17 years: (1) MDD (N=26; 14 with comorbid anxiety and 12 without comorbid anxiety); (2) anxious youths without depression (N=16), and (3) TDC (N=45). Among their findings, they noted disorder-specific alterations when passively viewing faces, with MDD participants having decreased activation, and anxious participants having increased activation, when viewing fearful vs. happy faces. Addressing the potential influence of comorbidity lacking

in other studies, Beesdo found that excluding the subset of adolescents with comorbid MDD and anxiety did not alter results [96] .

Two other studies compared face viewing in children with MDD vs. TDC, although they also considered the potential impact of comorbid anxiety. Hall et al. compared unmedicated adolescents with MDD (N=32) to age and sex-matched TDC (N=23) [97]. They found that youth with MDD had greater bilateral amygdala activity than TDC in response to fearful vs. happy faces, such that this finding remained significant when controlling for comorbid anxiety. In contrast, van den Bulk et al., compared adolescents with depression and/or anxiety disorders (N=25 total; N=17 MDD or dysthymia, N=6 with an anxiety disorder, N=2 with adjustment disorder with depression/anxiety) to TDCs (N=26) [98]. They found no significant between-group differences in activation patterns on the whole brain or specific ROI level (amygdala). However, they noted that dimensional anxiety scores (and not depression scores) predicted right amygdalar activity when viewing fearful, happy and neutral faces. Again, next steps need to focus on including larger samples and additional psychiatric comparison groups in order to examine the specificity and replicability of such findings.

Finally, Forbes et al. paired fMRI with a treatment study to evaluate neural activation changes as a result of treatment response. This study compared pre- and post-treatment neural activity on a reward anticipation task among depressed adolescents (N=13) receiving either cognitive behavioral therapy (CBT; N=7) or CBT plus a selective serotonin reuptake inhibitor (SSRI; N=6). Among their findings, they demonstrated that less medial PFC and greater striatal activity pre-treatment was associated with post-treatment clinical severity and reductions in comorbid anxiety symptomatology. Importantly N=10/13 participants had co-morbid GAD. This suggests that fronto-striatal activity may be important in pediatric depression, plus highlighting the potential phenomenological and/or DSM nosological conundrum of the overlap between MDD and GAD, especially in children where irritable mood can serve as a diagnostic symptom for either disorder [99]. Tao et al. then compared N=19 adolescents with MDD (N=4 with comorbid anxiety, N=2 with comorbid ADHD, N=8 with comorbid dysthymia or "other") to N=21 TDCs such that the former underwent an 8-week trial of fluoxetine treatment. At baseline, results showed that depressed youth had significantly greater activation in multiple ROIs including the amygdala, OFC and subgenual ACC during an emotional face processing task. At post-treatment, these activations were decreased and comparable to repeat TDC scan results [100].

DEPRESSION: Resting State Functional Connectivity (RSFC)

While a growing number of studies have used RSFC in adults with MDD (e.g., Sheline et al., 2010; Veer et al., 2010; Anand et al., 2005), fewer have focused on pediatric MDD and those that have included only TDC as a comparison group [101-103] .

Taken as a whole, although there clearly have been strides toward understanding the pathophysiology of pediatric depression, findings can best be described as preliminary as studies have used varying cross-sectional methodologies (e.g., different MRI tasks) with small samples of diagnostically complicated youth (e.g., presence of comorbid diagnoses). To better examine the diagnostic specificity of neural differences and gauge their worth as potential biomarkers, future studies should therefore aim to replicate previous findings with larger samples, using similar (if not the same) imaging paradigms and methods for analysis—particularly to compare depressed youth to TDC, as well as other clinical groups.

ANXIETY DISORDERS:

Diagnoses included under the rubric of anxiety disorders have shifted with the adoption of the ~~Diagnostic and Statistical Manual, 5th Edition (~~DSM-5~~).~~. Specifically, OCD and ~~post-traumatic~~posttraumatic stress disorder have been moved out of the anxiety disorders group to ~~alternative classifications,~~other diagnostic groupings (OCD moving to the Obsessive-Compulsive and Related Disorders, and PTSD to Trauma and Stressor-related disorders) in line with phenomenological and neurobiological evidence that they differ from the "phobic" anxiety disorders –i.e., GAD, social anxiety (SOC), panic (PD), separation anxiety (SAD), and specific phobias (SP). These five disorders, the focus of the current review, are commonly collapsed under the umbrella term of 'anxiety disorders' in studies examining their overarching clinical features, functional impairment, and neural underpinnings. Moreover, this grouping is largely consistent with the findings of several important studies describing them as the fear-based internalizing disorders (compared to dysphoric or distress disorders which include GAD, MDD, and dysthymia) [104-106]. GAD was nevertheless included in this grouping given its relevance (and high co-occurrence) with other anxiety disorders, as well as the paucity of efforts existing to delineate the pathophysiology of GAD alone [107] .

That said, studies of anxiety implicate a "fear circuit" consisting of the amygdala, medial and lateral PFC, and hippocampus in the underlying pathophysiology [108] . More broadly, these studies include animal models, typically developing humans across the lifespan, and adult patients diagnosed with anxiety. Neuroimaging studies of pediatric anxiety have focused on these ROIs, though conclusions about potential biomarkers are again limited by relatively small sample sizes and the need for more studies that can test the specificity of such findings.

Pediatric Anxiety Disorders: Structural MRI

Structural MRI studies have implicated the amygdala in the pathophysiology of pediatric anxiety. However, the direction (increased or decreased volume) of these findings vs. TDC participants is often inconsistent. For example, De Bellis et al. found that GAD participants (N=12) had significantly larger right and total amygdala volumes vs. age-, sex-, height-, and handedness-matched TDCs (N=24) [109]. In contrast, Milham et al. found the opposite, with anxious youths (GAD, SAD, and/or SOC) having decreased left amygdala volume and no difference in either right or total amygdala volume vs. age-, gender-, and intelligence-matched TDC (N=34) [110] . In line with Milham et al., Mueller et al. also found smaller amygdala and hippocampal gray matter volume (with inverse pattern for the insula) in 39 adolescents diagnosed with an anxiety disorder (GAD, SOC, SP, and/or SAD) compared to 63 TDCs [111]. Post-hoc analyses explored the specificity of these findings, showing that SOC contributed uniquely to the amygdala and hippocampus gray matter volume reductions although this finding must be considered preliminary given the small number of youth diagnosed with social anxiety (N=11). Strawn and colleagues have conducted a series of studies evaluating structural changes among adolescents with GAD vs. TDCs. In two such studies, they found that adolescents with GAD (N=15) have decreased gray matter volume in the left orbital gyrus and posterior cingulate (N=28 TDC) [112] , and that adolescents with GAD plus SOC and SAD (N=32) had decreased volume of the inferior frontal gyrus, left postcentral gyrus and cuneus vs. TDCs (N=27) [113]. Strawn also found that, compared to TDCs (N=19), GAD youth without comorbid depression (N=13) had increased cortical thickness in areas implicated in fear learning, extinction, and regulation of the amygdala, including the right inferolateral and ventromedial PFC, left inferior and middle temporal cortex, and right lateral occipital cortex [114].

To the best of our knowledge, no study has tested the specificity of potential structural MRI alterations in pediatric anxiety disorders. This deficiency is related to the lack of large, well-powered multi-group studies. Qin et al., however, have examined machine learning algorithms to assess the utility of structural and functional MRI abnormalities for predicting trait anxiety among TDCs without formal anxiety disorder diagnoses (N=76, of which N=38 were boys) at the individual level [115]. They found increased volume in the left amygdala predicted higher parent-reported anxiety symptoms ($r_{(\text{predicted, observed})} = 0.33$, $p=0.005$), although right amygdala volume did not ($r_{(\text{predicted, observed})} = 0.10$, $p=0.17$). They also found that greater functional connectivity between the left amygdala and multiple brain regions (e.g., lateral occipital and inferior temporal cortices in the sensory association cortex, frontal eye field and superior parietal lobe, putamen

and ventral striatum in the basal ganglia, and thalamus, hypothalamus, and midbrain) significantly predicted individual anxiety per parent report. Next steps are needed to examine the specificity and replicability of such prediction findings among youth diagnosed with clinical anxiety disorders and with a longitudinal study design.

Pediatric Anxiety Disorders: Diffusion Tensor Imaging (DTI)

Unfortunately, to the best of our knowledge, there are no DTI studies that evaluate the specificity of white matter abnormalities in pediatric anxiety disorders (i.e., GAD, SOC, SAD, PD, SP).

Pediatric Anxiety Disorders: Functional MRI

As in studies of pediatric depression, several studies have used event-related fMRI to examine the brain/behavior interactions underlying pediatric anxiety disorders. Also, as in studies of depression, many of these have employed emotionally-valenced visual stimuli, including faces, and have focused on the amygdala given its role in both fear circuitry and face processing.

In fact, the multi-group studies by Beesdo et al. and Thomas et al. described above in the pediatric depression section are among the best examples. Specifically, Beesdo et al. found that anxious youths without depression (N=16) had significantly greater amygdala activation when passively viewing fearful vs. happy faces compared to those with MDD plus comorbid anxiety (N=26) and to TDC participants (N=45) [96]. Additionally, Thomas et al. found similar patterns of exaggerated amygdala activity for a small sample of anxious youth vs. separate groups of TDC and depressed peers (N=5 in each group). While both anxious and TDC youth showed overall increased amygdala activity when viewing faces regardless of emotional content, only the anxious youth had significantly increased right amygdala activity when viewing fearful vs. neutral faces, and the magnitude of this neural activation correlated positively with child-reported anxiety on the Screen for Child Anxiety Related Disorders (SCARED). In contrast, the depressed group showed decreased left amygdala activity when viewing fearful faces suggesting different neural alterations in pediatric anxiety versus depression [94].

Other fMRI studies, while not outright comparing two patient groups to TDC participants, have at least attempted to acknowledge the potential role of comorbid conditions.

In this vein, Monk et al. compared GAD (N=17) to TDC participants (N=12) while attending to emotional faces. Their main finding was that those with GAD had significantly increased amygdala activity vs. TDCs when viewing angry faces, and that level of activation was significantly and positively correlated with anxiety disorder severity. Post-hoc comparisons to test specificity showed that both GAD only (N=9) and those with both GAD and MDD (N=8) had greater amygdala activation than TDCs, suggesting that comorbid depression was not driving their results [116].

Swartz et al. aimed to extend the understanding of amygdala dysfunction present in pediatric anxiety disorders by assessing its activation and connectivity over time. Specifically, they compared youth with anxiety (N=34, primary GAD, SP, SAD, some with secondary diagnoses of OCD and PTSD) to TDCs (N=19) while performing an emotional face-matching task. Activation patterns were compared for different portions of the task, which was separated into thirds (initial vs. prolonged exposure to stimuli) [117]. They showed that anxious youth had increased amygdala activation during the first third of the task compared to TDCs, but that this activation significantly decreased over time. There was also evidence that youth with anxiety had altered prefrontal cortex-amygdala connectivity, such that TDCs had greater context-modulated connectivity during the first third of the task whereas anxious youth had increased context-modulated connectivity during the second third of the task.

Studies have also begun to focus on examining the pathophysiology underlying pediatric anxiety disorders using non- face processing tasks although only a few have included two clinical groups and healthy controls. For example, Guyer et al. compared adolescents with GAD (N=18, all without comorbid SOC) to those with SOC (N=14, 3 with comorbid GAD) to TDCs (N=26) using the monetary incentive delay task, which engages the striatum during anticipation of monetary gains or losses [118]. Findings showed that youth with SOC had greater activation in the caudate and putamen when anticipating incentives vs. TDCs and GAD, whereas youth with GAD showed a unique valence-specific putamen response (i.e., greater activation during potential gain vs. loss trials). Fitzgerald et al., used the multi-source interference task to examine activation, particularly in the posterior medial frontal cortex (pMFC) and DLPFC, among female youth with non-OCD anxiety disorders (N=23; GAD, SOC, and SAD) vs. those with OCD (N=21) and TDCs (N=25) [119]. Findings showed that the non-OCD and OCD groups had hypoactive DLPFC error processing compared to TDCs, while there were no differences found in activation between the clinical groups.

No studies have employed machine learning techniques to evaluate fMRI neuroimaging findings as potential biomarkers of pediatric anxiety disorders. However, McClure et al. have paired neuroimaging with treatment to explore potential neural markers of treatment response. Specifically, they showed that greater pre-treatment amygdala activation during a face-attention task was significantly associated with better treatment response for youth with primary GAD or SOC (N=12) receiving either 8-weeks of CBT (N=7) or fluoxetine (N=5). Of note, treatment type (psychotherapy vs. medication) was chosen by families, and all participants significantly improved during treatment, though neural predictors of treatment outcome were not compared across treatments [120].

To address this limitation, Maslowsky et al. 2010 extended McClure's findings by comparing vlPFC and amygdala activity for GAD participants treated with CBT vs. those treated with fluoxetine (N=7 of each). While both groups significantly improved and had increased post- vs. pre-treatment vlPFC activity, only the CBT group had increased bilateral amygdala activity. Post-treatment vlPFC or amygdala activation did not significantly relate to the decrease in anxiety symptoms from pre- to post-treatment [121].

Pediatric Anxiety Disorders: Resting State Functional Connectivity (RSFC)

To our knowledge, there are not yet any studies examining RSFC in pediatric anxiety disorders that include multiple clinical groups and healthy controls. The few studies that have compared anxious youth, particularly those with GAD to TDCs only, highlight the connectivity of the amygdala. For example, Roy et al. evaluated RSFC between sub-nuclei of the amygdala and the rest of the brain in adolescents with GAD (N=15 total; N=12 with comorbid SOC, SP, PD, SAD, MDD and/or OCD) vs. TDCs (N=20) [122]. They found that youth with GAD had complicated patterns of disruption in an amygdala-based network, including decreased connectivity between the centromedial amygdala and the VMPFC and between the superficial amygdala and cerebellum. They also found youth with GAD had increased connectivity between the centromedial amygdala, insula and superior temporal gyrus; superficial amygdala, DLPFC and DMPFC; and basolateral amygdala and cerebellum. Post-hoc analyses examined the potential effect of comorbidity, first by excluding youth with GAD and comorbid MDD, and then those with GAD and comorbid SOC. All group differences in amygdala functional connectivity remained significant. Similarly, Liu et al. found alterations in amygdala connectivity when comparing youth with first-episode GAD (N=26) to age-matched TDCs (N=20) [123]. Specifically, youth with GAD had decreased functional connectivity between the left amygdala

and left DLPFC, as well as increased connectivity between the right amygdala and right posterior and anterior lobes of the cerebellum, insula, superior temporal gyrus, and putamen.

In summary, the current state of neuroimaging as a potential biomarker of pediatric anxiety disorders resembles that of depression—i.e., these data are important clues about the pathophysiology of anxiety, but they are far from ready for clinical application to the diagnosis and treatment of anxiety disorders in children. For this to ever become a reality, we need more studies, involving large samples and longitudinal assessments. There is also a need to determine the specific brain/behavior interactions underlying particular types of anxiety, rather than clustering them.

Pediatric Bipolar Disorder (BD):

As discussed above, we note that mechanism-oriented research, including neuroimaging and other phenomenological data, meant to address ongoing controversies about bipolar disorder (BD) in children and adolescents led to changes in DSM-5. Specifically, studies led by Leibenluft et al. compared two groups of children to one another and to TDCs: (1) "narrow phenotype BD youth" with distinct episodes of euphoria and (2) "severe mood dysregulation (SMD) youth" with a chronic course of functionally impairing irritability [124,125]. More than a decade of research, including structural and fMRI studies, led to the inclusion of a new diagnosis in DSM-5 known as "disruptive mood dysregulation disorder" (DMDD) based on the SMD criteria of chronic disabling irritability not due to another cause, such as ADHD, ASD, etc. Nevertheless, BD remains an important diagnosis because of the substantial associated morbidity and also difficulty making the diagnosis, including parsing it from other conditions, such as ADHD and now DMDD despite DSM-5 prompts that suggest the dichotomy should be clear. Data preceding DSM-5's ~~release~~releasein 2013 suggested that more children in the U.S. and internationally were being diagnosed with BD from the mid-1990s through the mid-2000s [126-128]. It remains unclear if these DSM-5 changes have reduced this trend or potentially shifting it to increases in children diagnosed with DMDD. Thus, there is a pressing need for greater understanding of the neural mechanisms underlying BD that might be leveraged to improve sensitivity and specificity of diagnosis, or to develop targeted treatments.

Research examining neural correlates of BD has focused on fronto-temporal neurocircuitry. In particular, researchers have explored the relationships between frontal regions of the DLPFC and VLPFC, temporal regions, including the amygdala, and striatal

regions, including the caudate and accumbens area. As highlighted below, there are a number of multi-group and treatment/imaging studies that have begun to evaluate the specificity of these neuroimaging findings in BD youths, but there are few studies that employ machine learning or other computer algorithms to predict diagnostic status or treatment outcome. Such work is progressing, but is important to note that, as in the other disorders discussed, there is no current neuroimaging biomarker for pediatric BD that is useful on a clinical case-by-case basis.

Pediatric BD: Structural MRI

Structural MRI studies have implicated fronto-temporal alterations in the pathophysiology of pediatric BD. By far, the most consistent anatomical finding in pediatric BD is significantly reduced amygdala volume compared to TDC, now found in seven of nine cross-sectional structural MRI studies to date [129-135], but not in two others [136,137]. This is among the more replicated neuroimaging findings in either children or adults with any form of psychiatric illness.

Although there are few multi-group structural MRI studies that compare BD youths to those with other forms of psychopathology, it is interesting to note that the two that failed to find significant decreases in amygdala volume were multi-group studies. Specifically, Lopez-Larson et al. studied four groups of children: (1) those with BD plus comorbid ADHD (N=23), (2) those with BD without ADHD (N=30), (3) those with ADHD without BD (N=23), and (4) TDC participants (N=29). Rather than finding BD-specific structural MRI differences, instead they found that ADHD youths had significantly smaller total amygdala volume as well as total caudate and putamen volume vs. BD with ADHD, BD without ADHD, and TDC groups [137].

Frazier et al. also conducted a four-group, cross-sectional MRI study, including the following: (1) BD plus psychosis (N=19), (2) BD without psychosis (N=35), (3) schizophrenia (N=20), and (4) TDC (N=29). There were no significant differences between the BD and schizophrenia groups with respect to amygdala (or hippocampal) volume. However, they did identify a group X sex interaction, with schizophrenic males having the smallest left amygdala volume, while BD females having the smallest hippocampal volumes [136].

Two interesting multi-group morphometry studies have been conducted with BD and DMDD youth. The first by Adleman et al. found that both BD (N=55) and SMD youth (N=78) had decreased gray matter volume of the pre-supplementary motor area (pre-SMA), DLPFC, and insula vs. TDCs (N=68), while BD youth had increases in the globus pallidus vs. the other two groups. At a mean of approximately 2 years later, BD youth had abnormal increases of the right superior and inferior parietal lobule and precuneus [138]. The second by Gold et al. from the

same NIMH research group found specific changes in the left DLFPC, with BD youth (N=20) having decreased, and anxious youth (N=39) having increased volume compared to TDCs (N=53). Both BD and DMDD (N=52) participants had decreased gray matter volume vs. TDCs in the right DLPFC [139].

With respect to other multi-group comparisons, as discussed in the ADHD section, Liu et al. compared the following four groups of children and adolescents: (1) BD plus comorbid ADHD (N=17), (2) BD without ADHD (N=12), (3) ADHD without BD (N=11), and TDC (N=24) [138]. Although the ADHD-only findings have been discussed in the ADHD section, it is notable that Liu found that BD-only participants had larger caudate, putamen, and globus pallidus volumes than the other groups [140].

Chiu et al. evaluated anterior cingulate gyrus volume in children with (1) BD (N=16), (2) ASD (N=24), and (3) TDC (N=15). Results showed that BD participants had significantly smaller left anterior cingulate gyrus volumes compared to both the ASD and TDC participants. There was no such difference in right anterior cingulate gyrus volume [141].

Pediatric BD: Diffusion Tensor Imaging (DTI)

Few DTI studies have evaluated the specificity of white matter alterations to pediatric BD by conducting multi-group studies. Separately, Frazier et al. compared children (1) with BD (N=10), (2) at-risk for BD by having a first-degree relative with BD (N=7), and (3) TDC (N=8). The BD group had decreased FA in the cingulate-paracingulate white matter vs. both at-risk and TDC participants, whereas both BD and at-risk participants had reduced FA in the bilateral superior longitudinal fasciculus [142]. In another study, Pavuluri et al. compared FA in children with (1) BD (N=13), (2) ADHD (N=13) and (3) TDC (N=15). No findings distinguished the BD participants from either the ADHD or TDC groups [39]. Additionally, one study using DTI to classify BD vs. TDC has been conducted. A recent study by Mwangi et al. used FA and axial and radial diffusivity from BD and TDC participants (N=16 of each), to train a support vector machine algorithm that had 87.5% specificity and 68.75% sensitivity for predicting group status, though this study did not use an independent sample of BD and TDC participants to test this algorithm [143].

Pediatric BD: Functional MRI (fMRI)

FMRI studies of pediatric BD participants have probed the brain and behavior interactions underlying a number of cognitive and emotional processes, including emotional face processing, attention, and cognitive flexibility. Most of these studies have identified relative

differences between BD and TDC youths. However, some have begun to address issues of specificity by multi-group comparisons or by pairing imaging with treatment.

For example, Brotman et al. evaluated attention to emotional faces by comparing youths diagnosed with: (1) BD (N=43), (2) ADHD (N=18), (3) SMD (N=29), and (4) TDC participants (N=37). Whereas prior studies had demonstrated that pediatric BD participants had altered PFC–amygdala–striatal neural activation vs. TDC children when viewing faces, including pictures of faces with happy, angry, or neutral emotions [135,144,145], Brotman et al. did not find BD-specific findings. Instead, in addition to the ADHD-specific findings discussed in the ADHD-fMRI section, Brotman et al found that SMD participants had significantly decreased amygdala neural activation vs. those either meeting Leibenluft et al. 2003's criteria for narrow-phenotype BD (i.e., having clear-cut episodes of mania with elevated, expansive mood), or those with ADHD or TDC [56,124].

Thomas et al. used an implicit face-emotion processing task to demonstrate that BD participants (N=20) had significantly less amygdala activity in response to angry vs. neutral faces than either SMD (N=21) or TDC participants (N=16) [146].

Passarotti et al. employed an emotional valence Stroop task (i.e., requiring participants to match the color of a positive, negative or neutral word to a one of two presented colored circles) to study children and adolescents with either (1) BD (N=17), (2) ADHD (N=15), and (3) TDC (N=14). Both BD and ADHD participants had greater DLPFC and parietal cortex activation than TDC when viewing negative vs. neutral words. Despite these shared regions of hyperactivity, differences between the patient groups also emerged. Specifically, BD participants had greater activation in the VLPFC and ACC, whereas the ADHD group showed decreased VLPFC and ACC activity [57].

Passarotti et al. again compared youth with BD (N=23) or ADHD (N=14), and TDC (N=19) participants while watching faces. They found that BD participants had greater activity in regions implicated in emotional processing (e.g., left medial PFC, subgenual ACC), while the ADHD group showed greater activity in regions implicated in prefrontal working memory (e.g., left DLPFC, pre-motor regions) [147].

There are several treatment/imaging studies involving pediatric BD participants. For example, Chang et al. have examined the brain activity of BD adolescents (N=8) treated with lamotrigine. Specifically, they evaluated brain activity while viewing negative and neutral emotional pictures at baseline and following eight weeks of treatment [148]. They found a

significant decline in depressive symptoms that was also associated with decreased right amygdala activity when viewing negative pictures.

Pavuluri and colleagues have conducted a series of important studies comparing fMRI activity in BD youths before and after treatment with several anti-manic medications, including lamotrigine, risperidone, and divalproex. These studies employ block-design methodology, which is very good at detecting between-group differences in neural activation though its ability to detect group-by-cognitive task differences is limited compared to event-related fMRI experiments. Taken as a whole, these studies corroborate the fact that anti-manic medications differentially influence the neurocircuitry underlying pediatric BD [149-152].

Such studies, pairing neuroimaging and treatment, are very important to advancing our understanding of potential bio-behavioral markers that would guide treatment, akin to what is commonplace in cancer treatment. However, it is early in this process, with need for replication to ascertain what, if any, neural markers can ultimately guide treatment decisions or predict outcome.

Pediatric Bipolar Disorder: Resting State Functional Connectivity (RSFC)

The number of RSFC studies among BD youth has grown over the past few years, with studies particularly interested in RSFC alterations in the PFC-amygdala-striatal circuit implicated in pediatric BD [153-155]. However, there is a real need for studies to take the next step—i.e., to examine specificity. At present, one of the few examples that has done this is a study by Stoddard et al. who used a seed-based analysis of sub-nuclei of the amygdala to show that BD youth (N=14) had significantly and specifically increased RSFC between the left basolateral amygdala and the medial aspect of the left frontal pole vs. both TDC (n=20) and SMD youth (N=19) with chronic severe irritability [156].

AUTISM SPECTRUM DISORDER (ASD):

ASD which includes autistic disorder, Asperger's Disorder, and pervasive developmental disorder not otherwise specified (PDD-NOS) previously separated in DSM-IV, are among the most common and impairing psychiatric conditions affecting children and adolescents today.

The Centers for Disease Control (CDC) has shown that the incidence of ASD had risen 10-fold from the year 1980 to the year 2000, affecting as many as 1/68 children up to age 8 in the United States according to a 2016 article [157,158]. As in other disorders, such as pediatric BD, it remains uncertain if this represents better awareness of ASD, over- or mis-diagnosis, or a combination.

Thus, there is a pressing need to understand the neural underpinnings of ASD. As in other disorders, studies have employed structural MRI, fMRI, and DTI to elucidate the underlying neurobiology associated with ASD. Most of these have examined brain changes in ASD children and adolescents compared to TDC, with few examining the specificity of these findings by comparing sub-types of ASD participants to one another (i.e., autistic disorder vs. Asperger's Disorder) or to those with other neuropsychiatric conditions (i.e., those with primary ADHD or other non-ASD developmental delay [DD]).

A plethora of brain regions from every lobe have been implicated in the neuropathology of ASD, from sub-regions of the PFC to temporal, parietal, and occipital cortex, as well as the cerebellum [159,160]. One important finding in ASD research has been early brain overgrowth in those affected by ASD. This has been demonstrated not only in neuroimaging studies, but also in studies examining head circumference and post-mortem neuropathology in those affected by ASD [161-167]. However, for individual children, such findings are not yet useful as diagnostic biomarkers of ASD, whereby a measurement could rule in, or rule out, ASD.

It is beyond the scope of this piece to summarize the wealth of neuroimaging studies conducted with those affected by ASD across the lifespan. Thus, what follows represents only a sampling of this work. However, to date, no replicated MRI neuroimaging biomarker for ASD has been identified that can improve the specificity or quality of ASD diagnosis or its treatment.

ASD: Structural MRI

Multi-group studies have begun to probe the specificity of structural MRI alterations associated with ASD. For example, Kaufmann et al. evaluated cerebellar vermis volume in 3-9 year-old boys with: (1) idiopathic autism (N=10), (2) Down syndrome plus autism (N=16), (3) fragile X syndrome plus autism (N=13), or (4) TDC participants (N=22). Results showed that the ratio of cerebellar vermis lobules VI-VII to total intracranial area was smaller only in those with idiopathic autism compared to the other groups, whereas increases in lobules VI-VII were seen in autism associated with fragile X syndrome [168]. In another example, Petropoulos et al. failed to find specific alterations among 3-4 year olds with either (1) ASD (N=45), (2) TDC

(N=26), or (3) DD (N=14), though they were examining a different brain region—the mid-sagittal corpus collosum—and also did not focus exclusively on boys [169].

Other studies have begun to compare structural MRI alterations between participants with ASD and those with other forms of developmental delay. For example, Petropoulos et al. compared 2-4 year olds with either (1) ASD (N=60), (2) TDC (N=10), and (3) developmental delay (DD; N=16). For this study, DD participants' delay was based upon impairments in standardized intellectual and adaptive tests, but not meeting ASD criteria by the Autism Diagnostic Observation Schedule–Generic (ADOS-G) or clinical evaluation. Covarying for age, they found that DD participants had prolonged cortical gray matter and white matter T2 relaxation vs. both ASD and TDC participants, whereas ASD participants had prolonged cortical gray matter T2 relaxation, but not white matter T2 relaxation, compared to TDC participants. They conclude that their data implicate a more general delay in neuronal maturation among DD participants, whereas ASD participants' delay may involve gray, but not white, matter [170]. Herbert et al. compared ASD participants to those with developmental language delay (DLD). They found no significant differences in white matter volume between ASD and DLD participants, though both differed from TDC [171]. A related study by Herbert et al. evaluated cortical asymmetry among boys with (1) ASD (N=16), (2) DLD (N=15), and (3) TDC (N=15). Compared to TDC participants, those with either ASD or DLD had a greater aggregate volume of significantly asymmetrical cortical parcellation units (leftward plus rightward; 41.7% ASD, 32.6%, 20.1%) and larger aggregate volume of right-asymmetrical cortex (28% ASD, 22% DLD, 7% TDC). This rightward bias was more pronounced in ASD participants than those with DLD. Moreover, DLD but not ASD participants had a small but significant loss of leftward asymmetry compared with TDC participants. From this, the authors conclude that the right-asymmetry increase may be a consequence of early abnormal brain growth trajectories in ASD and DLD, while higher-order association areas may be most vulnerable to connectivity abnormalities associated with white matter increases [172].

With respect to studies comparing ASD participants to those with other forms of psychopathology, Voelbel et al. compared boys with (1) ASD (N=38), (2) BD (N=12), and (3) TDC (N=13). They found that ASD participants had greater left and right caudate volume when covarying for intracranial volume and stimulant use. Likewise, larger left and right caudate volumes in ASD predicted a riskier response strategy in an attention task, while the inverse was significant in TDC participants [173].

Similarly, Mostofsky et al. evaluated the relationship between motor cortex white matter volume and motor performance among children with either (1) ASD (N=20), (2) TDC (N=36), or (3) primary ADHD (N=20). Motor impairments were evaluated using the Physical and Neurological Examination of Subtle Signs (PANESS). They found that the correlation between PANESS score and left motor cortex white matter volume significantly differentiated ASD children from those with either ADHD or TDC, with increased white matter volume predicting poorer motor skill. From this, the authors concluded that these alterations in cerebral volume in ASD participants may be more representative of global patterns of brain abnormalities likely mediating other aspects of ASD, including social and communication deficits [174].

Brieber et al. used voxel-based morphometry to evaluate whole-brain alterations between 10-16 year olds with (1) ASD (total N=15 including N=13 with Asperger's plus N=2 HFA) (2) ADHD (N=15), and (3) TDC (N=15). They found ASD-specific increases in gray matter volume of the right supramarginal gyrus, an area mediating mentalising and theory of mind abilities [19].

Several studies have begun testing the role of structural MRI parameters in confirming the clinical classification of ASD participants. For example, Akshoomoff et al. used discriminant function analysis of MRI brain measures, including cerebellar vermis volume, total brain volume, and gray and white matter volumes, to classify ASD (N=52) and TDC (N=15) participants. They found that 95.8% of ASD and 92.3% of TDC participants were correctly classified. By adding functional impairment measures, they correctly classified 85% of ASD cases as lower functioning and 68% of ASD cases as higher functioning [175].

Relatedly, Jiao et al. used machine-learning techniques to determine if thickness- and/or volume-based structural MRI parameters could accurately distinguish between children with ASD (N=22) and TDC (N=16). They found that thickness-based models were more effective than volume-based methods in differentiating ASD from TDC participants, with an 87% accuracy rate [176] In a separate, but related study, Jiao et al. 2011 used machine learning techniques to test if thickness- and volume-based measures could differentiate between 6-15 year olds with either Asperger's Disorder (N=5) or high-functioning autism (HFA; i.e., autistic disorder with normal IQ; N=13). However, they found that neither of these was able to effectively distinguish between these two groups [177].

Although such results are promising, they require further study, as there is no consistent, replicated structural difference, or pattern of differences, that yet would serve as a biomarker to of ASD. Importantly, these studies have failed to consistently differentiate across the ASDs—

i.e., to differentiate among participants with autistic disorder, Asperger's Disorder, or PDD-NOS—or to consistently differentiate participants with either HFA, low-functioning autism (LFA, autistic disorder with IQ<70), or Asperger's Disorder, including studies examining the amygdala or hippocampus; cerebellum or cerebellar vermis; or total gray matter, white matter, or cerebral volume [178-181]. The failure of neuroimaging studies to reliably distinguish between ASD subtypes, coupled with similar concern about symptom assessments (i.e., diagnostic interviews and questionnaires) likely contributed to DSM-5's change to lump all ASDs together.

ASD: Diffusion Tensor Imaging (DTI)

Several recent DTI studies have begun to evaluate the specificity of white matter alterations among ASD participants. For example, Barnea-Goraly et al. evaluated white matter integrity via DTI scans among children with ASD (N=13), their unaffected siblings (N=13), and a separate group of unrelated TDC (N=11). They found that children with ASD and, to a lesser extent, their unaffected siblings, had reduced white matter FA in the right medial prefrontal white matter, right anterior forceps, corpus callosum, right superior longitudinal fasciculus, superior temporal gyrus, and temporoparietal junctions [182].

Lange et al. examined white matter measurements from the superior temporal gyrus (STG) and temporal stem in males with either HFA or TDC (N=30 of each). With respect to the STG, they found reversed hemispheric asymmetry of two measures of white matter diffusion coherence: tensor skewness, and FA. Specifically, HFA participants had greater STG tensor skewness on the right and decreased FA on the left compared to TDC participants. They also found increased omni-directional, parallel, and perpendicular diffusion in the right, but not left, temporal stem among HFA participants vs. TDC. Most interesting, these six measures had a very high rate of discriminating ASD from TDC participants with 92% accuracy (94% sensitivity, 90% specificity) in their original sample as well as a replication sample of males with idiopathic autism (N=12) and TDC (N=7) [183].

Ingalhalikar et al. devised and tested a DTI-based classifier system among ASD (N=45) and TDC (N=30) participants. Their model employed a high-dimensional non-linear support vector model to develop an abnormality score involving FA differences mainly in right occipital regions as well as in left superior longitudinal fasciculus, external and internal capsule while mean diffusivity (MD) discriminates were observed primarily in right occipital gyrus and right temporal white matter. Using this abnormality score, their ability to distinguish between ASD and TDC participants achieved 80% accuracy using leave one out (LOO) cross-validation, with high significance p<0.001 (~74% sensitivity, ~84% specificity) [184].

In sum, DTI research is clearly an emerging and promising tool in understanding neurodevelopmental alterations associated with ASD. However, there is a need to both replicate the above findings, as well as to test their specificity by comparing ASD participants to those with other forms of developmental delay or other primary psychopathology.

ASD: Functional MRI (fMRI)

FMRI studies have probed numerous circuits implicated in ASD, including those with tasks probing cognitive and emotional processes as well as task-independent RSFC. However, like structural MRI studies, these studies are limited by small sample sizes, lack of replication, and an inability to consistently discern between ASD and other disorders. Presently, there are no fMRI neural biomarkers that can diagnose ASD.

Several multi-group studies have examined fMRI activation among ASD youth during cognitive processes, including attention, response to biological motion, and empathy. For example, Malisza et al. evaluated visual attention in children with (1) ASD (N=8), (2) ADHD (N=9), and (3) TDC (N=9). They found that the ASD group had greater activation in the occipital gyrus and less activation in the hippocampal gyrus than either ADHD or TDC participants, suggesting that attentional processing relies on different neural mechanisms in ASD and ADHD participants [185]. Christakou et al. also used fMRI to examine sustained attention in boys with ASD (N=20), ADHD (N=20), and TDC (N=20). ASD boys had increased cerebellar activation vs. ADHD and TDC participants, whereas ADHD boys had significantly reduced left DLPFC activation vs. ASD participants. They also found that ADHD and ASD boys had significantly reduced activation compared to TDC participants in bilateral striato-thalamic regions, left DLPFC, and superior parietal cortex as well as significantly increased precuneus [50].

Kaiser et al. evaluated the brain response to biological motion—meaning motion that looks like that of an animate object (e.g., an animal walking, running, or sitting in contrast to random motion, like swirling dots)—in children and adolescents with either (1) ASD (N=25), (2) their unaffected siblings (N=20), or (3) TDC (N=17). ASD participants had specific decreases in neural activity in areas including the right amygdala, ventromedial PFC, and bilateral fusiform gyri. Interestingly, unaffected siblings had compensatory increases in brain activity vs. either those with ASD or TDC in the right ventromedial PFC—anterior and inferior to their other finding—as well as the posterior superior temporal sulcus. Thus, Kaiser's study suggests both state and trait neural alterations associated with ASD [186].

Greimel et al. examined empathy in (1) ASD adolescent boys (N=15 including N=12 with Asperger's syndrome plus N=3 HFA), (2) fathers of ASD participants (N=11), (3) TDC adolescent boys (N=15), and (4) fathers of TDC participants (N=9). Both ASD children and their fathers had significantly reduced activation of the right anterior fusiform gyrus compared to their age-equivalent TDC participants [187].

Among the studies using fMRI brain activation to evaluate diagnostic classification of participants, Lai et al. conducted a two-stage study of neural activation in ASD. First, they evaluated brain activation while listening to human speech in ASD (N=12) and TDC (N=15) participants. Then, they collected additional fMRI data in ASD participants while sedated for clinically-indicated MRI scans (N=27). They correctly classified 26 of 27 (96%) of the sedated ASD participants from the second experiment using the mean amplitude and spread of neural activity in the superior temporal gyrus from the first experiment [188].

Autism spectrum disorders: Resting State Functional Connectivity (RSFC)

The number of studies examining specificity of RSFC alterations in ASD is growing, thanks in part to data-sharing efforts such as "ABIDE"—the Autism Brain Imaging Database Exchange [189]. For example, DiMartino et al. compared RSFC among children with ASD (N=56), ADHD (N=45), or TDCs (N=50). She found ASD-specific increases in RSFC in bilateral temporo-limbic regions, and also ADHD-specific increases in RSFC in right striatum and pallidus [75]. In another example, Chen et al. showed 79% accuracy using support vector machines to classifying analysis of low frequency fluctuations (ALFF) among with either ASD (N=112) or TDCs (N=128) ages 12-18 years [190].

No doubt, the future will bring additional studies examining the potential of fMRI with and without task in classifying ASD, especially now that the challenge of splitting it into DSM-oriented subtypes has been removed, at least for now.

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ATTACHMENT 3

COUNCIL ON RESEARCH (CoR) Minutes
APA Annual Meeting
Sheraton New York Times Square Hotel
Gramercy, Lower Lobby
New York City, NY
Monday, May 7, 2018; 1:30-4:30 p.m.

PRESENT

Members: Dwight Evans, MD (Chairperson); Carolyn Rodriguez, MD, PhD (Vice Chairperson); Charles Nemeroff, MD, PhD; Anand Kumar, MD; Cynthia Neill Epperson, MD; Tami Benton, MD; Alik Widge, MD, PhD; Linda Carpenter, MD; James Potash, MD, MPH; John Krystal, MD; Michael First, MD; Glenn Martin, MD; Ned Kalin, MD; Wilson Compton, MD, MPE; William McDonald, MD; Bankole Johnson, DSc, MD; Kenechi Ejebe, MD (APAF/SAMHSA Fellow); Adrienne Grzenda, MD, PhD (APA/APAF Psychiatric Research Fellow); Amalia Londono Tobon, MD (APA/APAF SAMHSA Fellow); Amanda Degenhardt, MD (APA/APAF Leadership Fellow), Vasiliki Karagiorga, MD, PhD (Candidate; APAF/Child and Adolescent Psychiatry Fellow); Awais Aftab, MD (APA/APAF Leadership Fellow)

Staff: Philip Wang, MD, DrPH; Diana Clarke, PhD, MSc; Stephanie Smith, PhD; Keila Barber, MHS; Grace Lee, PhD, MHS

ABSENT

Daniel Pine, MD; Mauricio Tohen, MD, DrPH, MBA; Christine Moutier, MD; Jennifer Dwyer, MD, PhD (APAF/Child and Adolescent Psychiatry 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

- 2017 September Component Meeting minutes were unanimously approved.

III. Other Component Updates

- Committee on Research Training: *Charles Nemeroff, M.D., Ph.D. & Diana Clarke, Ph.D.*
    - 54 attendees/3 SOBP Awardees and trainees expressed enjoyment of the Research Colloquium
    - Discussed the development of two tracks, the importance of keeping Track 1, and the possibility of adding an MD/PhD track
    - Colloquium has become a year-long experience for awardees (i.e., webinars, SOBP & ACNP meetings), and there is a need to facilitate more communication between the mentors and mentees

- Continuing outreach to international organizations so that we can keep the international participants in Research Colloquium.
- Dr. Ned Kalin, new editor of APA AJP beginning in January 2019, can help with advertisement of colloquium

- Research Awards: *Diana Clarke, Ph.D.*
  - Dr. Clarke reminded CoR of award nominations
  - The 2018 Research Awards:
    - Award for Research in Psychiatry: Maria Oquendo, MD, PhD
    - Health Services Research Award- Early Career Award: Sonya Gabrielian, MD, MPH
    - Health Services Research Award- Senior Scholar Award: Roberto Lewis-Fernandez, MD
    - Judd Marmor Award: Alan F. Schatzberg, MD
    - Blanche F. Ittleson Award: Hilary Blumberg, MD
    - APAF/ AACDP Research Mentorship Award: David Ross, MD, PhD
    - Kempf Fund Award: Mentor: L. Elliot Hong, MD; Mentee: Joshua Chiappelli, MD
    - Bruno Lima Awards: Michael Blumenfield, MD; Robert Ursano, MD
- Caucus on Complementary and Alternative Medicine
  - No update
- Committee on Psychiatric Dimensions of Disasters
  - Written update provided
  - JRC approves the establishment of the Caucus on Climate Change on Mental Health
  - Dr. Joshua Morganstein will replace Dr. Bob Ursano as the Chairperson of the Committee
  - The Committee coordinated with the APA Communications Department to reach out to the District Branches and State Associations impacted by recent tragic events

IV. APA Registry Discussion: *Philip Wang, M.D., Dr.P.H., Diana Clarke, Ph.D., Debbie Gibson, M.Sc.*

- EPIC Discussion- currently working with them and will eventually need a test beta site
- Portal Discussion

V. Updates from Saul Levin, M.D., M.P.A., APA CEO and Medical Director

- Begins quest to look for more funding for Research Colloquium and to also have international participants to attend Colloquium
- ABPN gave funding to APA for Registry
- Invites staff to new APA building

VI. Diagnostic and Treatment Markers Work Group Component Update: Charles Nemeroff, M.D., Ph.D.

- The following reports have been published with the lead author listed:
  - Ketamine consensus-JAMA Psychiatry (Dr. Nemeroff)
  - Pharmacogenomics of Antidepressants-AJP (Dr. Nemeroff)
  - EEG predictors of Antidepressant Response-resubmitted to AJP (Dr. Widge)
  - Hormones in the Treatment of Depression-in preparation (Dr. Kalin)
  - Psychedelics as Therapeutic Agents-in draft form (Dr. McDonald)
  - Social Media in Clinical Research-in draft form (Dr. Rodriguez)

- The Workgroup also led a very successful symposium at the Annual Meeting on biomarkers
- Plans for the upcoming year:
    - Clinical utilities of biomarkers for Alzheimer's Disease (Dr. Kumar)
    - Early developmental markers of Schizophrenia (TBA)
    - Biomarkers of Autism (TBA)
    - Machine learning for psychiatrists (Drs. Widge and Grzenda)
- Requests were made for the appointment of both Drs. Steve Siegel and Anand Kumar to the Workgroup and as consultants or members to the Council on Research

VII. Other Action Items:

- JRC Request: Pharmacogenomics- Is there a need to draft a resource paper? *Dwight Evans, M.D.*
    - Concerns about the heavy marketing of the application of pharmacogenomics in routine clinical practice (e.g., at the annual meeting) despite insufficient evidence were raised
    - It is important for CoR to make a progressive and cautious statement on the application of pharmacogenomics in routine clinical practice for psychiatric disorders, specifically advising the psychiatric field to appropriately prescribe treatments based on current evidence
    - Discussed the possibility of partnering with the communications group at APA to get the statement out to the public via a press release

  ACTION: Drs. Nemeroff and Krystal will draft a position statement and circulate it among CoR members. After reaching consensus, the statement will be provided to JRC in mid-May.
- Neuroimaging Resource Document- request to send revised version to JRC: *Michael First, M.D.*

  ACTION: Motion to send the paper to JRC
- Review of position statements
    - 1st position statement on the use of generic vs. proprietary drugs

  ACTION: CoR approved the position statement for submission to the JRC in its current form
    - 2nd position statement on somatic cell nuclear transfer (SCNT) research

  ACTION: CoR motioned to refer the statement back for clarification, particularly regarding "reproductive purposes"
    - 3rd position statement on atypical antipsychotic medications

  ACTION: CoR approved the position statement for submission to the JRC in its current form

VIII. Adjournment – Dr. Evans thanked the group for its continued hard work, and the meeting was adjourned at 4:30 pm.

ATTACHMENT 4

American Psychiatric Association Council on Research's Response to JRC Request for a Resource Document for Pharmacogenomics[1]

The APA Council on Research has concluded that the current state-of-the-art does not yet support the application of pharmacogenomics in routine clinical practice to predict treatment efficacy in psychiatric disorders.

The APA Council on Research would like to ensure that the Scientific Program Committee is informed of the current limitations in the empirical support for applications of pharmacogenomics in psychiatry.

The APA Council on Research is concerned that companies are marketing pharmacogenomics testing in psychiatry, including at the annual meeting of the APA, in advance of adequate validation of their ability to predict outcome.

In conclusion, the APA Council on Research agrees with the Council on Quality Care that there is insufficient evidence to draft a Resource Document.

[1]The above response passed with one dissenting vote from Dr. Bankole A. Johnson, who was in favor of the following statement:

> "The APA Council of Research is concerned that the current state-of-the-art does not support the application of pharmacogenomics to predict the efficacy of antidepressant treatment for mood and anxiety disorders and suicide prevention.
> The APA Council on Research is concerned that companies appear to be marketing pharmacogenomics testing for predicting the efficacy of antidepressants for such disorders in advance of validation by adequately-powered clinical studies or approval by the Food and Drug Administration.
> The APA Council on Research agrees with the Council on the Quality of Care that, at this time, there is insufficient evidence to draft a Resource Document but would be willing to commit to a periodic review to provide further guidance to clinicians."

Joint Reference Committee
February 11-12, 2018
DRAFT SUMMARY OF ACTIONS

As of February 21, 2018

JRC Members Present:

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

James Batterson, MD: Full time faculty Children's Mercy Hospital; APA honoraria as Speaker-elect

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

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

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

Saul Levin, MD, MPA: CEO/Medical Director; APA salary; Chair of the APAF Board of Directors; Clinical Professor at George Washington University

Paul O'Leary: receives income from SHKO Medicine; University of Alabama Medicine; Cooper Green Mercy Hospital; provides telepsychiatry to three facilities; small private practice; and forensic work related to court martials and independent medical exams.

Excused Absence:

Linda Drozdowicz, MD (APAF Leadership Fellow)

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 Strategy Officer – RFM/ECP Liaison
Kristin Kroeger	Chief of Policy, Programs, and Partnerships
Ranna Parekh, MD, MPH	Director, Division of Diversity and Health Equity

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 2017 Joint Reference Committee Meeting *Will the Joint Reference Committee approve the draft summary of actions from the October 2017 meeting?*	The Joint Reference Committee approved the draft summary of actions from the October 2017 meeting.	Yoshie Davison, MSW Margaret Cawley Dewar Laurie McQueen	Association Governance
3	**Report of the CEO Medical Director**			

3.1	Referral Update ACGME Standard for Common Program Requirement for Psychiatry Residency Programs (JRCOCT178.I.3) The Joint Reference Committee referred to the Council on Medical Education and Lifelong Learning for review, the Council on Minority Mental Health and Health Disparities' support for an ACGME accreditation standard for psychiatry residency programs on diversity programs and partnerships to achieve health care equity and eliminate health disparities.	On November 21, 2017, the Executive Committee of the APA Board of Trustees held a conference call during which it supported sending comments drafted by the Council on Medical Education and Lifelong Learning regarding the importance of diversity training to the ACGME. The comments were submitted by APA Administration on Wednesday, November 22, 2017, and ACGME confirmed receipt the following week. Specifically, the comments submitted to ACGME contained the following language: "The American Psychiatric Association wishes to communicate to the ACGME its support of the establishment of an ACGME accreditation standard III. C. in the section "The Learning and Working Environment" in the Institutional Requirements on diversity programs and partnerships to achieve health care equity and eliminate health care disparities. In a medical education program, the facts that having medical students and faculty members from a variety of socioeconomic backgrounds, racial and ethnic groups, and other life experiences can 1) enhance the quality and content of interactions and discussions for all students throughout the preclinical and clinical curricula and 2) result in the preparation of a physician workforce that is more culturally aware and competent and better prepared to improve access to healthcare and address current and future health care disparities."	The Joint Reference Committee thanked the CEO/Medical Director for this update and for addressing the issue brought forth in the action paper.	Completed

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
4	**Update from the Ethics Committee** In November 2017, the Assembly approved action paper 2017A2 12.K, which asks that the APA will direct the authors of the *APA Commentary on Ethics in Practice* to bring its language into congruence with that of the *AMA Principles of Medical Ethics 10.1.1*, including a thoughtful exploration of the complexities involved. This would apply to any psychiatrist making any benefit and/or policy determinations. Please see the memo from the Ethics Committee which responds to the action paper's request.	The Joint Reference Committee referred the report back to the Ethics Committee respectfully requesting that they consider revising the wording on page 3rd of the report regarding primary and secondary obligations of a physician medical director/physician reviewer. The Joint Reference Committee commended the Ethics Committee on their thoughtful and considered response to this issue. With the revision of this sentence the report will be stronger and provide more clarity to the issue.	Colleen Coyle, JD Alison Crane, JD	Ethics Committee Report to JRC – June 2018 Deadline: 5/23/2018
5	**Board of Trustees Referral**			
5.A	<u>Proposed Position Statement on Human Trafficking</u> The Board of Trustees voted to refer the Proposed Position Statement on *Human Trafficking* to the Joint Reference Committee. **Will the Joint Reference Committee refer the proposed Position Statement back to the Council on Minority Mental Health and Health Disparities for additional review and revision?**	The Joint Reference Committee referred the proposed Position Statement on *Human Trafficking* to the Council on Minority Mental Health and Health Disparities for revision. The feedback from the Board of Trustees will be provided to the Council.	Ranna Parekh, MD, MPH Omar Davis	Council on Minority Mental Health and Health Disparities Report to JRC – June 2018 Deadline: 5/23/2018

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
5.B	<u>Revised Position Statement on Abuse and Misuse of Psychiatry</u> The Board of Trustees voted to refer the Revised Position Statement on Abuse and Misuse of Psychiatry to the Joint Reference Committee. **Will the Joint Reference Committee refer the proposed Position Statement back to the Council on International Psychiatry for additional review and revision?**	The Joint Reference Committee referred the Revised Position Statement on *Abuse and Misuse of Psychiatry* to the Council on International Psychiatry for revision. The feedback from the Board of Trustees will be provided to the Council. The Joint Reference Committee also requested that the Council on International Psychiatry reformat the proposed position statement in keeping with the APA position statement template.	Jon Fanning, MS, CAE Ricardo Juarez, MS	Council on International Psychiatry Report to JRC – June 2018 Deadline: 5/23/2018
6	Report of the Assembly			
6.1	<u>Designation of Psychiatry as Primary Care for Any Medical School Scholarships Requiring Primary Care Service</u> (ASM2017A2 12.A) The action paper asks that APA advocate for state and federal legislation labeling psychiatry as primary care for any medical school scholarships requiring primary care residencies and service to a community. **Will the Joint Reference Committee refer action paper *2017A2 12.A: Designation of Psychiatry as Primary Care for Any Medical School Scholarships Requiring Primary Care Service* to the appropriate Component(s) for input or follow-up?**	The Joint Reference Committee referred the action paper *Designation of Psychiatry as Primary Care for Any Medical School Scholarships Requiring Primary Care Service* (ASM2017A2 12.A) to the Council on Advocacy and Government Relations (LEAD) and the Council on Medical Education and Lifelong Learning for input and recommendations regarding potential implementation.	Ashley Mild Deana McRae Tristan Gorrindo, MD Kristen Moeller	Council on Advocacy and Government Relations (LEAD) Council on Medical Education and Lifelong Learning Report to JRC – June 2018 Deadline: 5/23/2018

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
6.2	<u>Medical School Loan Repayment Subsidies for Psychiatrists Practicing in Community Mental Health Centers and State Psychiatric Facilities</u> (ASM2017A2 12.B) The action paper asks that the APA advocate for state and federal legislation to provide funds to help repay loans for psychiatrists in community mental health centers and state psychiatric hospitals. **Will the Joint Reference Committee refer action paper *2017A2 12.B: Medical School Loan Repayment Subsidies for Psychiatrists Practicing in Community Mental Health Centers and State Psychiatric Facilities* to the appropriate Component(s) for input or follow-up?**	The Joint Reference Committee referred the action paper *Medical School Loan Repayment Subsidies for Psychiatrists Practicing in Community Mental Health Centers and State Psychiatric Facilities* (ASM2017A2 12.B) to the Council on Advocacy and Government Relations (LEAD) and the Council on Medical Education and Lifelong Learning for input and recommendations.	Ashley Mild Deana McRae Tristan Gorrindo, MD Kristen Moeller	Council on Advocacy and Government Relations Council on Medical Education and Lifelong Learning Report to JRC – June 2018 Deadline: 5/23/2018

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
6.3	**<u>Transitional Care Services Post-Psychiatric Hospitalization</u> (ASM2017A2 12.C)** Action paper asks: That the American Psychiatric Association advocate to national policymakers to increase federal funding for psychiatric access-to-care/transition-based clinics aimed at readily available short-term coverage in psychiatric care for uninsured, low-income, and serious mental illness populations. That the American Psychiatric Association promotes the concept of a transitional care based clinic model, aimed at bridging the gap between hospitalization and outpatient follow-up, to ACGME/GME leadership, in an effort to grow interest in implementation of such clinics in GME based settings. **Will the Joint Reference Committee refer the action paper *2017A2 12.C: Transitional Care Services Post-Psychiatric Hospitalization* to the appropriate Component(s) for input or follow-up?**	The Joint Reference Committee referred the action paper *Transitional Care Services Post-Psychiatric Hospitalization* (ASM2017A2 12.C) to the Council on Advocacy and Government Relations (LEAD), Council on Healthcare Systems and Financing, Council on Quality Care and the Council on Addiction Psychiatry. The councils are asked to provide input and recommendations to the JRC on the potential implementation of this action paper. The Council on Addiction Psychiatry is asked to address transitional care services post-psychiatric hospitalization for persons with substance use disorders and make recommendations as to the inclusion of substance-use disorders in the ask.	Ashley Mild Deana McRae Kristin Kroeger Kathy Orellana Samantha Shugarman, MS Michelle Dirst	Council on Advocacy and Government Relations (LEAD) Council on Healthcare Systems and Financing Council on Quality Care Council on Addiction Psychiatry Report to JRC – June 2018 Deadline: 5/23/2018

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
6.4	<u>Enacting APA Positions: State Medical Board Licensure Queries</u> (ASM2017A2 12.D) Action paper asks that: 1. The American Psychiatric Association query the licensing boards (M.D., D.O) and, in each state, territory or licensure jurisdiction query their compliance with APA policy and with the ADA act allowing questions only about current mental and physical impairment affecting current ability to practice medicine. 2. The American Psychiatric Association notify each Board of Medicine in writing whether or not their medical licensure application(s) reflect current APA position regarding queries about their applicants' mental health history. The APA will notify each District Branch of the APA of the status of the Board of Medicine or Board of Osteopathic Medicine in its jurisdiction, and will publish on the APA website a list of jurisdictions and whether or not their policies on queries are congruent with the Position of the APA. 3. The American Psychiatric Association notify the Federation of State Medical Boards Work Group of its Position Statement entitled Position Statement on Inquiries about Diagnosis and Treatment of Mental Disorders in Connection with Professional Credentialing and Licensing, adopted in 2015, in advance of the January 2018 meeting of the FSMB Work Group. **Will the Joint Reference Committee refer the action paper *2017A2 12.D: Enacting APA Positions: State Medical Board Licensure Queries* to the appropriate Component(s) for input or follow-up?**	The Joint Reference Committee referred the action paper *Enacting APA Positions: State Medical Board Licensure Queries* (ASM2017A2 12.D) to the CEO/Medical Director's Office – Office of the General Counsel for input and recommendations on potential implementation as well as other departments as needed.	Saul Levin, MD, MPA Colleen Coyle, JD	CEO/Medical Director's Office Office of the General Counsel Report to JRC – June 2018 Deadline: 5/23/2018

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
6.5	<u>Recognition of Psychiatric Expertise: Efficiency and Sufficiency</u> (ASM2017A2 12.E) Action paper asks that: 1. APA encourages the AMA to adopt a policy that the MOC should not be a requirement for maintenance of licensure, hospital privileges, insurance credentialing or employment 2. The APA should support a SA-CME learning option in lieu of the 10-year exam and encourage the ABPN to accelerate the timeline for reform of the MOC process. 3. The MOC should not be part of the licensure requirements for interstate compacts. **Will the Joint Reference Committee refer the action paper *2017A2 12.E: Recognition of Psychiatric Expertise: Efficiency and Sufficiency* to the appropriate Component(s) for input or follow-up?**	The Joint Reference Committee referred the action paper *Recognition of Psychiatric Expertise: Efficiency and Sufficiency* (ASM2017A2 12.E) to the Council on Medical Education and Lifelong Learning and the APA AMA Delegation for implementation. The JRC requested a report back in June 2018 on the Council's and the Delegation's progress.	Tristan Gorrindo, MD Kristen Moeller Kristin Kroeger Becky Yowell	Council on Medical Education and Lifelong Learning APA AMA Delegation Report to JRC – June 2018 Deadline: 5/23/2018
6.6	<u>Conflicts of Interest Not Limited to Pharmaceutical Companies</u> (ASM2017A2 12.G) (Attachment 6 - Action paper, cost estimate, administration comments) The action paper asks that the American Psychiatric Association, through its Annual Meeting Scientific Program Committee, review the current mechanism for reporting conflicts of interest, which mainly are limited to pharmaceutical companies, with an eye toward encouraging the reporting of conflicts which extend beyond pharmaceutical companies. **Will the Joint Reference Committee refer the action paper *2017A2 12.G: Conflicts of Interest Not Limited to Pharmaceutical Companies* to the appropriate Component(s) for input or follow-up?**	The Joint Reference Committee referred action paper *Conflicts of Interest Not Limited to Pharmaceutical Companies* (ASM2017A2 12.G) to the Scientific Program Committee and Conflict of Interests Committee for their input with recommendations to expand COI forms, define terms, and link COIs in submission process. A report to the JRC was requested for the October 2018 meeting.	Tristan Gorrindo, MD Leon Lewis Yoshie Davison, MSW Margaret Cawley Dewar Laurie McQueen	Scientific Program Committee Association Governance Report to JRC – October 2018 Deadline: TBD

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
6.7	Non-Physician Registration Fee for Annual Meetings (ASM2017A2 12.H) The action paper asks that allied health professionals pay the same registration fee as non-member physicians at the Annual Meeting. **Will the Joint Reference Committee refer the action paper 2017A2 12.H: *Non-Physician Registration Fee for Annual Meeting* to the appropriate Component(s) for input or follow-up?**	The Joint Reference Committee referred the action paper *Non-Physician Registration Fee for Annual Meetings* (ASM2017A2 12.H) to the CEO/Medical Director's office and requested that a response be provided to the Assembly May 2018 meeting. The JRC noted that this issue was raised previously and reviewed twice by component groups, the Board of Trustees, and the Administration. While it is postulated that non-psychiatrists are filling sessions instead of APA Members, it is due to the complexities involved in allocating the variable space available for scientific programs, courses and other sessions at the Annual Meeting, that caused the five incidents of too small a conference room, and not due to non-physician members taking up space. This task is highly complex.	Saul Levin, MD Tristan Gorrindo, MD Cathy Nash	CEO/Medical Director's Office Education Department Meetings Department Assembly – May 2018 Deadline: 3/15/18

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
6.8	APA Position Statement Strongly Recommending Twelve Weeks of Paid Parental Leave (ASM2017A2 12.I) (Attachment 8 - Action paper, cost estimate, administration comments) The action paper asks that the APA approve and adopt the attached position statement recommending 12 weeks of paid parental leave. [Note: The Assembly voted to approve the action paper as a position statement.] **Will the Joint Reference Committee refer the position stateme 2017A2 12.I: *APA Position Statement Strongly Recommendi Twelve Weeks of Paid Paternal Leave* to the appropria Component(s) for input or follow-up?**	The Joint Reference Committee referre action paper *APA Position Statement Strongly Recommending Twelve Weeks of Paid Parental Leave* (ASM2017A2 12.I) to the Office of the General Counsel, Council on Healthcare Systems and Financing (LEAD), and the Council on Advocacy and Government Relations. Prior to review by the Councils, the Office of the General Counsel is asked to provide input on the current APA parental leave policy and how this may or may not differ with APA's policy and the laws of the District of Columbia. The Council on Healthcare Systems and Financing is asked to assess how such a policy may affect members in different practice settings. Council on Advocacy and Government Relations is asked to review how such a policy by be received or accepted in the political and advocacy arena.	Colleen Coyle, JD Kristin Kroeger Kathy Orellana Ashley Mild Deana McRae	Office of the General Counsel Council on Healthcare Systems and Financing Council on Advocacy and Government Relations Report to JRC – June 2018 Deadline: 5/23/2018

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
6.9	Helping Members Join Caucuses (ASM2017A2 12.J) The action paper asks that the APA new member and membership renewal emails have a direct link to joining a caucus. **Will the Joint Reference Committee refer the Assembly passed action paper 2017A2 12.J: *Helping Members Join Caucuses* to the appropriate Component(s) for input or follow-up?**	The Joint Reference Committee referred the action paper *Helping Members Join Caucuses* (ASM2017A2 12.J) to the Membership Committee for input and recommendations regarding implementation of the action paper. A report to the JRC is requested for June 2018.	Jon Fanning, MS, CAE Stephanie Auditore	Membership Committee Report to JRC – June 2018 Deadline: 5/23/2018
6.10	Achieving Congruence between the APA Commentary on Ethics in Practice and the AMA Principles of Medical Ethics Concerning Ethical Obligations of Psychiatrists Making Benefit Determination Decisions (ASM2017A2 12.K) The action paper asks that the APA will direct the authors of the *APA Commentary on Ethics in Practice* to bring its language into congruence with that of the *AMA Principles of Medical Ethics 10.1.1*, including a thoughtful exploration of the complexities involved. This would apply to any psychiatrist making any benefit and/or policy determinations. **Will the Joint Reference Committee refer the action paper 2017A2 12.K: *Achieving Congruence between the APA Commentary on Ethics in Practice and the AMA Principles of Medical Ethics Concerning Ethical Obligations of Psychiatrists Making Benefit Determination Decisions* to the appropriate Component(s) for inpu or follow-up?**	Please see item 4, the Ethics Committee Report on page 2 of this summary.	Colleen Coyle, JD	Ethics Committee

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
6.11	<u>Adopting an APA Position Statement Supporting Implementation of the Mental Health Parity and Addiction Equity Act (MHPAEA or parity law)</u> (ASM2017A2 12.L) Action paper asks: A. That the Assembly recommend adoption of an APA position statement, appropriately formatted, as follows: It is the position of the APA that: 1. Insurance and/or other third party MHSUD utilization management and medical necessity criteria should be developed by individuals who are trained as psychiatrists or by work groups that include psychiatrists. 2. Insurance and/or other third party MHSUD utilization management and medical necessity criteria should be in full compliance with requirements of applicable state and federal parity laws, including with MHPAEA requirements that quantitative limits (QTLs) and non-quantitative limits (NQTLs) for MHSUD care should be comparable to and no more stringent than medical necessity criteria for medical and surgical care, except as allowed by the law. 3. Insurance companies and/or other third parties offering coverage for both medical/surgical and MHSUD treatment—including those that do so through MHSUD "carve outs"—have an obligation to provide to their medical directors, psychiatrist reviewers, other clinicians who make benefit determinations, and to treating clinicians and to covered individuals, current and accurate information about whether and how their MHSUD utilization review and medical necessity criteria comply with MHPAEA QTL and NQTL requirements. B. The Assembly will directly refer this action paper outlining specific elements of a position statement to the Board of Trustees for adoption at their next meeting, including holding a separate vote to this effect, if required by Assembly rules. **Will the Joint Reference Committee refer the Assembly passed action paper 2017A2 12.L: *Adopting an APA Position Statement Supporting Implementation of the Mental Health Parity and Addiction Equity Act (MHPAEA or parity law)* to the appropriate Component(s) for input or follow-up?**	The Joint Reference Committee referred the action paper *Adopting an APA Position Statement Supporting Implementation of the Mental Health Parity and Addiction Equity Act (MHPAEA or parity law)* (ASM2017A2 12.L) to the Council on Healthcare Systems and Financing (LEAD) and the Council on Advocacy and Government Relations for input and feedback.	Kristin Kroeger Kathy Orellana Ashley Mild Deana McRae	Council on Healthcare Systems and Financing (LEAD) Council on Advocacy and Government Relations Report to JRC – June 2018 Deadline: 5/23/2018

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
6.12	Joint Meeting of the Council on Minority Mental Health and Health Disparities and the Assembly Committee of Representatives of Minority/Underrepresented Groups (ASM2017A2 12.M) The action paper asks that: 1) That the American Psychiatric Association will support another Joint Meeting of the Council on Minority Mental Health and Health Disparities and the Assembly Committee of Representatives of Minority/Underrepresented Groups, in alignment with the APA's fourth strategic initiative addressing diversity. 2) That such meeting will take place during the Annual September Components Meeting of the American Psychiatric Association in September 2018. [N.B.: At its meeting in October, the Joint Reference Committee recommended that the Board of Trustees approve the request for the seven M/UR Caucus Assembly Representatives (or their designees) to meet with the Council at the 2018 September Components Meeting at the same level of funding as this year at approximately $9,000 from the Assembly Budget and additional costs for members of the Council on Minority Mental Health and Health Disparities from the component's budget. This action was approved by Board of Trustees at its December 2017 meeting.] **Will the Joint Reference Committee refer the action paper 2017A2 12.M: *Joint Meeting of the Council on Minority Mental Health and Health Disparities and the Assembly Committee of Representatives of Minority/Underrepresented Groups* to the appropriate Component(s) for input or follow-up?**	The Joint Reference Committee thanked the Assembly for forwarding action paper ASM2017A212.M *Joint Meeting of the Council on Minority Mental Health and Health Disparities and the Assembly Committee of Representatives of Minority/Underrepresented Groups* for consideration. In October 2017, the Board of Trustees approved the request of the Council on Minority Mental Health and Health Disparities to hold a joint meeting of the Council and the Assembly Committee of Representatives of Minority/Underrepresented Groups. The Assembly agreed to fund their M/UR representatives. No further action is needed.	Ranna Parekh, MD, MPH	Division of Diversity and Health Equity December 2018

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
6.13	<u>Civil Liability Coverage for District Branch Ethics Investigations</u> (ASM2017A2 12.N) The action paper asks that: 1. The American Psychiatric Association shall make a copy of the APA Director & Officer Liability policy available upon request by District Branch. 2. The American Psychiatric Association shall amend the APA Operations manual to include information regarding indemnification of district branches for liability related to ethics investigations. 3. The American Psychiatric Association shall develop a written policy and protocol to provide expenditures to district branches specifically to support ethics investigations. **Will the Joint Reference Committee refer the action paper 2017A2 12.N: *Civil Liability Coverage for District Branch Ethics Investigatio* to the appropriate Component(s) for input or follow-up?**	The Joint Reference Committee referred the action paper *Civil Liability Coverage for District Branch Ethics Investigations* (ASM2017A2 12.N) to the Board of Trustees. The JRC noted that it was not in the best interests of the APA to release the APA Director and Officer Liability policy beyond the summary document already provided to the District Branches on the DB Executives Website.	Yoshie Davison, MSW Margaret Cawley Dewar Ardell Lockerman	Board of Trustees – March 2018

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
6.14	Council on Women's Mental Health (ASM2017A2 12.O) The action paper asks that the American Psychiatric Association develop a Council on Women's Mental Health to address mental health conditions and health related disorders pertaining to mental health that affect women **Will the Joint Reference Committee refer the action paper 2017A2 12.O: *Council on Women's Mental Health* to the appropriate Component(s) for input or follow-up?**	The Joint Reference Committee discussed the action paper *Council on Women's Mental Health* (ASM2017A2 12.O) followed by an executive session. The Joint Reference Committee appreciated that the leadership's attention was brought to this issue as it is important and needs better coordination. The Joint Reference Committee referred the action paper to the Board of Trustees and requested that an Ad Hoc Work Group on Women's Mental Health be formed. It was the JRC's hope that an Ad Hoc Work Group would thoughtfully assess the issues at hand and make recommendations to the Board of Trustees on how to address Women's Mental Health issues across the Association.	Yoshie Davison, MSW Margaret Cawley Dewar Ardell Lockerman	Board of Trustees – March 2018

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
6.15	Addressing the Negative Impact of the Rule of 95 on Dues Revenue (ASM2017A2 12.P) The action papers asks that the Board of Trustees (BOT) establish a Task Force charged with reviewing the Rule of 95 and making recommendations to be presented to the BOT in time for possible action by the BOT and the Assembly at the November 2018 Assemb Meeting. Membership on this Task Force could be drawn from the BOT, APA management, the Assembly leadership, the Membership Committee, and DB and State Association leadership and staff and shall include representation from the Senior Psychiatrists, RFMs, an ECPs. **Wil the Joint Reference Committee refer the action paper 2017A2 12.P: *Addressing the Negative Impact of the Rule of 95 on Dues Revenue* to the appropriate Component(s) for input or follow up?**	The Joint Reference Committee thanked the Assembly for forwarding action paper ASM2017A212.P *Addressing the Negative Impact of the Rule of 95 on Dues Revenue* for consideration and reports that a Board of Trustees Ad Hoc Work Group on the Rule of 95 has been established. This action paper has been referred to the BOT AWHG on the Rule of 95 to be incorporated into its ongoing work.	Jon Fanning, MS, CAE Colleen Coyle, JD	Board of Trustees Ad Hoc Work Group on the Rule of 95
6.16	Revised Position Statement: Need to Maintain Long-Term Care Facilities for Certain Individuals with Serious Mental Illness (JRCJUNE178.F.1/ASMNOV174.B.2 The Assembly did not approve the Revised Position Statement: *Nee to Maintain Long-Term Care Facilities for Certain Individuals with Serious Mental Illness* as the Assembly had concerns about the title and felt some revisions are needed to clarify the intent of the position statement. **Will the Joint Reference Committee refer the Revised Position Statement: *Need to Maintain Long-Term Care Facilities for Certain Individuals with Serious Mental Illness* to the appropriate Component(s) for input or follow-up?**	See item 8.F.2 – The Council on Healthcare Systems and Financing revised the proposed *Position Statement on the Need to Maintain Intermediate and Long-Term Hospita Care for Certain Individuals with Seriou Mental Illness* to address the concerne raised by the Assembly in November 2017.	Kristin Kroeger Kathy Orellana	Council on Healthcare Systems Financing
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 report on current activities.		Completed

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, summary of current activities, and information items.	The Joint Reference Committee thanked the Council for its report on current activities.		Completed
8.B.1	Revised Position Statement on Psychologists and Other Mental Health Professionals and Hospital Privileges **Will the Joint Reference Committee recommend that the Assembly approve the revised *Position Statement Psychologists and Other Mental Health Professionals and Hospital Privileges* and if approved, forward it to the Board of Trustees for consideration?** Through JRC directive, the Council on Advocacy and Government Relations established a joint Council work group with the Council on Psychosomatic Medicine to broaden the 2007 position statement to encompass perspective of those psychiatrists working in general medical and hospital setting in addition to those in psychiatric hospitals. Taking into consideration the work group's recommended modifications, the Council voted to support advancing the revised position statement as written.	The Joint Reference Committee referred the revised *Position Statement Psychologists and Other Mental Health Professionals and Hospital Privileges* back to the Council on Advocacy and Government Relations. The JRC is concerned about the phrase "to act in roles consistent with their specialization and training" in the last sentence. In consultation with Council on Healthcare Systems and Financing, the JRC asked that the Council on Advocacy and Government Relations review and address how this phrase could potentially be misconstrued given scope of practice issues. If the goal is to recommend that a psychiatrist should be the lead of the medical team, then consider revising the statement to so indicate. The Joint Reference Committee requested that the Council on Advocacy and Government Relations reformat the proposed position statement in keeping with the APA position statement template. In addition, there was a minor edit to add a period after "disease" to break up the sentence in "…and often co-morbid general medical disease the APA Advocates…."	Ashley Mild Deana McRae Kristin Kroeger Kathy Orellana	Council on Advocacy and Government Relations (LEAD) Council on Healthcare Systems and Financing Report to JRC – June 2018 Deadline: 5/23/2018

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
8.C	**Council on Children, Adolescents, and Their Families** Please see item 8.C for the Council's report, a summary of current activities, and information items.	The Joint Reference Committee thanked the Council for its report on current activities. The Joint Reference Committee brought to the Council's attention potential discriminatory practices in insurance coverage plans for college tuition costs due to a student's medical issue. The Chair will confer with College Mental Health Caucus for input and provide recommendations.	Ranna Parekh, MD, MPH Tatiana Claridad	Council on Children, Adolescents, and Their Families Report to JRC – June 2018 Deadline: 5/23/2018
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 report on current activities.		Completed
7.A	3-year Assessment of the Council on Communications **Will the Joint Reference Committee review and provide feedback to the Council on Communications based on the materials submitted for its 3-year assessment?**	The Joint Reference Committee accepted the 3-year assessment materials from the Council on Communications. The JRC suggested that the Council partner with APA Publishing to promote its publications via social media.		Completed
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 report on current activities.		Completed

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
7.B	Council Assessments – Council on Geriatric Psychiatry **Will the Joint Reference Committee review and provide feedback to the Council on Geriatric Psychiatry based on the materials submitted for its 3-year assessment?**	The Joint Reference Committee accepted the 3-year assessment materials from the Council on Geriatric Psychiatry and thanked the Council for its work over the past year. The Council is very hard working and has developed high-quality work product.		Completed
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 report on current activities.		Completed
8.F.1	Proposed Position Statement on Peer Support Services **Will the Joint Reference Committee recommend that the Assembly approve the *proposed Position Statement on Peer Support Services* and if approved, forward it to the Board of Trustees for consideration?** **N.B.** If the revised position statement is approved by both the Assembly and the Board of Trustees, the *2012 Position Statement Support for Peer Support Services* will be retired.	The Joint Reference Committee recommended that Assembly approve the proposed *Position Statement on Peer Support Services*. The Joint Reference Committee requested that the Council on Healthcare Systems and Financing reformat the proposed position statement in keeping with the APA position statement template and return the reformatted statement to the JRC not later than **March 7, 2018**.	Kristin Kroeger Kathy Orellana Yoshie Davison, MSW Margaret Cawley Dewar Allison Moraske	Council on Healthcare Systems and Financing Report to JRC: **MARCH 7, 2018** Assembly – May 2018 Deadline: 3/15/18

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
8.F.2	Proposed Position Statement on the Need to Maintain Intermediate and Long-Term Hospital Care for Certain Individuals with Serious Mental Illness **Will the Joint Reference Committee recommend that the Assembly approve the *proposed Position Statement on the Need to Maintain Intermediate and Long-Term Hospital Care for Certain Individuals with Serious Mental Illness* and if approved, forward it to the Board of Trustees for consideration?** **N.B.** If the revised position statement is approved by both the Assembly and the Board of Trustees, the *1974 Position Statement on the Need to Maintain Long-Term Inpatient Psychiatric Hospitals and the 2014 Position Statement on the Federal Exemption from Medicaid Institutions for Mental Disease*, will be retired.	The Joint Reference Committee recommended that Assembly approve the proposed *Position Statement on the Need to Maintain Intermediate and Long-Term Hospital Care for Certain Individuals with Serious Mental Illness*. The Joint Reference Committee requested that the Council on Healthcare Systems and Financing reformat the proposed position statement in keeping with the APA position statement template and return the reformatted statement to the JRC not later than **March 7, 2018**.	Kristin Kroeger Kathy Orellana Yoshie Davison, MSW Margaret Cawley Dewar Allison Moraske	Council on Healthcare Systems and Financing Report to JRC: **MARCH 7, 2018** Assembly – May 2018 Deadline: 3/15/18
8.F.3	Revised Position Statement on Telemedicine in Psychiatry **Will the Joint Reference Committee recommend that the Assembly approve the *revised Position Statement on Telemedicine in Psychiatry* and if approved, forward it to the Board of Trustees for consideration?** **N.B.** If the revised position statement is approved by both the Assembly and the Board of Trustees, the *2015 Position Statement on Telemedicine in Psychiatry* will be retired.	The Joint Reference Committee recommended that Assembly approve the revised *Position Statement on Telemedicine in Psychiatry*. The Joint Reference Committee requested that the Council on Healthcare Systems and Financing reformat the proposed position statement in keeping with the APA position statement template and return the reformatted statement to the JRC not later than **March 7, 2018**.	Kristin Kroeger Kathy Orellana Yoshie Davison, MSW Margaret Cawley Dewar Allison Moraske	Council on Healthcare Systems and Financing Report to JRC: **MARCH 7, 2018** Assembly – May 2018 Deadline: 3/15/18

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
8.F.4	Resource Document: Best Practices in Videoconferencing-Based Telemental Health **Will the Joint Reference Committee approve the Resource Document *Best Practices in Videoconferencing-Based Telemental Health*, developed in concert with the American Telemedicine Association?** **Note:** Over the past six months, the APA's Committee on Telepsychiatry has worked jointly with the American Telemedicine Association (ATA) to develop this guidance document. The document is currently moving through the approval process at both the APA and the ATA and it is hoped that the document will be approved by both associations by their May Annual Meetings. Once approved, the document would reside concurrently on the APA's Telepsychiatry toolkit and the website of the American Telemedicine Association.	The Joint Reference Committee approved the Resource Document: *Best Practices in Videoconferencing-Based Telemental Health***.** The JRC requested that a disclaimer be added to the document noting that this is not an APA Practice Guideline.	Yoshie Davison, MSW Margaret Cawley Dewar Ardell Lockerman	Board of Trustees – March 2018 For Information Only
8.F.5	Request for Work Group: Level of Service Intensity Instrument **Will the Joint Reference Committee support the creation of a joint workgroup, under the Council on Healthcare Systems and Financing, the Council on Quality Care, and the Council on Research, to develop an APA-owned Level of Service Intensity Instrument?** The council supports the APA developing a levels of care assessment tool, but only if APA will commit the funding and resources to achieve the gold standard. For reference, AACAPs tool is estimated to have cost $200,000 over 15 years ago for research alone.	The Joint Reference Committee supported the creation of a joint workgroup, under the Council on Healthcare Systems and Financing, with membership derived from the Council on Healthcare Systems and Financing, Council on Quality Care, and Council on Research. The JRC requests a report in October 2018 on the work group's progress. It is expected that that work group will evaluate the pros and cons of the development of a level of service instrument, the potential avenues and funding for such development and make a recommendation to the JRC.	Kristin Kroeger Kathy Orellana Samantha Shugarman, MS Philip Wang, MD, DrPH	Council on Healthcare Systems and Financing (LEAD) Council on Quality Care Council on Research Report to JRC – October 2018 Deadline: TBD

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 report on current activities.		Completed
8.G.1	Information Item: Update on the status of the proposed Caucus on Mental Health and Climate Change	The Joint Reference Committee thanked the Council on International Psychiatry for its report and feedback on the status of the proposed Caucus on Mental Health and Climate Change. The JRC, in consultation with the Administration, will assign a proposed Caucus on Mental Health and Climate Change, once established, under the Committee on Psychiatric Dimensions of Disasters.	Philip Wang, MD, DrPH Ricardo Juarez, MS	Council on Research Committee on Psychiatric Dimensions of Disasters
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 the update on its current activities and thanked the council for providing more information on the ABPN pilot program on MOC.		Completed
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 report on current activities.		Completed

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
8.I.1	Revised Position Statement on Abortion **Will the Joint Reference Committee recommend that the Assembly approve the *revised Position Statement on Abortion* and if approved, forward it to the Board of Trustees for consideration?** **NB:** If the revised position statement is approved by both the Assembly and the Board of Trustees, the 1978 Position Statement on Abortion will be retired.	The Joint Reference Committee recommended that the Assembly approve the *revised Position Statement on Abortion* and if approved, forward it to the Board of Trustees for consideration. The JRC made minor editorial revisions to the position statement.	Yoshie Davison, MSW Margaret Cawley Dewar Allison Moraske	Assembly – May 2018 Deadline: 3/15/18
8.I.2	Revised Position Statement: Resolution Against Racism and Racial Discrimination and Their Adverse Impacts on Mental Health **Will the Joint Reference Committee recommend that the Assembly approve the *revised Position Statement: Resolution Against Racism and Racial Discrimination and Their Adverse Impacts on Mental Health* and if approved, forward it to the Board of Trustees for consideration?** **NB:** If the revised position statement is approved by both the Assembly and the Board of Trustees, the 2006 *Position Statement: Resolution Against Racism and Racial Discrimination and Their Adverse Impacts on Mental Health* will be retired.	The Joint Reference Committee recommended that the Assembly approve the revised *Position Statement: Resolution Against Racism and Racial Discrimination and Their Adverse Impacts on Mental Health* and if approved, forward it to the Board of Trustees for consideration. The Joint Reference Committee requested that the Council on Minority Mental Health and Health Disparities reformat the proposed position statement in keeping with the APA position statement template and return the reformatted statement to the JRC not later than **March 7, 2018**.	Ranna Parekh, MD, MPH Omar Davis Yoshie Davison, MSW Margaret Cawley Dewar Allison Moraske	Council on Minority Mental Health and Health Disparities Report to JRC: **MARCH 7, 2018** Assembly – May 2018 Deadline: 3/15/18

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
8.I.3	Revised Position Statement on Religious Persecution and Genocide **Will the Joint Reference Committee recommend that the Assembly approve the *revised Position Statement on Religious Persecution and Genocide* and if approved, forward it to the Board of Trustees for consideration?** **NB:** If the revised position statement is approved by both the Assembly and the Board of Trustees, the 1977 *Position Statement on Religious Persecution and Genocide* will be retired.	The Joint Reference Committee recommended that the Assembly approve the revised *Position Statement on Religious Persecution and Genocide* and if approved, forward it to the Board of Trustees for consideration. The Joint Reference Committee requested that the Council on Minority Mental Health and Health Disparities reformat the proposed position statement in keeping with the APA position statement template and return the reformatted statement to the JRC not later than **March 7, 2018**.	Ranna Parekh, MD, MPH Omar Davis Yoshie Davison, MSW Margaret Cawley Dewar Allison Moraske	Council on Minority Mental Health and Health Disparities Report to JRC: **MARCH 7, 2018** Assembly – May 2018 Deadline: 3/15/18
8.I.4	Proposed Position Statement on Mental Health Needs of Undocumented Immigrants, including Childhood Arrivals, Asylum Seekers, and Detainees **Will the Joint Reference Committee recommend that the Assembly approve the *proposed Position Statement on Mental Health Needs of Undocumented Immigrants, including Childhood Arrivals, Asylum Seekers, and Detainees* and if approved, forward it to the Board of Trustees for consideration?**	The Joint Reference Committee referred the proposed *Position Statement on Mental Health Needs of Undocumented Immigrants, including Childhood Arrivals, Asylum Seekers, and Detainees* to the Council on Psychiatry and Law for review and input. A report to the JRC is request for its meeting in June 2018.	Colleen Coyle, JD Alison Crane, JD	Council on Psychiatry and Law Report to JRC – June 2018 Deadline: 5/23/2018

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
8.I.5	Proposed Position Statement on Equitable Treatment of Substance Use Disorders Across Racial Lines **Will the Joint Reference Committee recommend that the Assembly approve the *proposed Position Statement on Equitable Treatment of Substance Use Disorders Across Racial Lines* and if approved, forward it to the Board of Trustees for consideration?**	The Joint Reference Committee referred the proposed *Position Statement on Equitable Treatment of Substance Use Disorders Across Racial Lines* to the Council on Addiction Psychiatry and requested that they review the document and provide comment and feedback, including any potential revisions.	Kristin Kroeger Michelle Dirst	Council on Addiction Psychiatry Report to JRC – June 2018 Deadline: 5/23/2018
8.I.6	Proposed Position Statement on Mental Health Equity and the Social and Structural Determinants of Mental Health **Will the Joint Reference Committee recommend that the Assembly approve the *proposed Position Statement on Mental Health Equity and the Social and Structural Determinants of Mental Health* and if approved, forward it to the Board of Trustees for consideration?**	The Joint Reference Committee referred the proposed *Position Statement on Mental Health Equity and the Social and Structural Determinants of Mental Health* back to the Council on Minority Mental Health and Health Disparities for further revision and requested a report back to the JRC in June 2018. The JRC requested that the Council review the World Psychiatric Association's statement on mental health equity and social determinants of health. The JRC requested the that Council revise the language of bullet #3 to indicate that mental health systems would assess their capacity to screen. Additionally, it was unclear if there are evidence-based instruments for systems to use to accomplish this assessment.	Ranna Parekh, MD, MPH Omar Davis	Council on Minority Mental Health and Health Disparities Report to JRC – June 2018 Deadline: 5/23/2018

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
8.I.7	Proposed Position Statement on Police Brutality and Black Men **Will the Joint Reference Committee recommend that the Assembly approve the *proposed Position Statement on Police Brutality and Black Men* consideration?**	The Joint Reference Committee referred the proposed *Position Statement on Police Brutality and Black Men* back to be reformatted by the Council on Minority Mental Health and Health Disparities into a brief issue statement. Much of the information in the introductory statement could form background information for the position statement. The JRC suggested that the wording on the 3rd recommendation be revised to acknowledge the ongoing collaboration and partnership between the APA and the International Association of Chiefs of Police and other law enforcement agencies. The JRC also referred the position statement for review and comment to the Council on Psychiatry and Law after the position statement has been reformatted by the Council on Minority Mental Health and Health Disparities.	Ranna Parekh, MD, MPH Omar Davis Colleen Coyle, JD Alison Crane, JD	Council on Minority Mental Health and Health Disparities Council on Psychiatry and Law Report to JRC – June 2018 Deadline: 5/23/2018

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
8.I.8	Proposed Position Statement on Discrimination of Religious Minorities **Will the Joint Reference Committee recommend that the Assembly approve the *proposed Position Statement on Discrimination of Religious Minorities* and if approved, forward it to the Board of Trustees for consideration?**	The Joint Reference Committee recommended that the Assembly approve the *Proposed Position Statement on Discrimination of Religious Minorities* as revised by the JRC. The JRC requested that the Council on Minority Mental Health and Health Disparities review the title revision and suggested rewording to recommendation #4 made by the JRC and reformat the proposed position statement in keeping with the APA position statement template and return the reformatted statement to the JRC not later than **March 7, 2018**.	Ranna Parekh, MD, MPH Omar Davis Yoshie Davison, MSW Margaret Cawley Dewar Allison Moraske	Council on Minority Mental Health and Health Disparities Report to JRC: **MARCH 7, 2018** Assembly – May 2018 Deadline: 3/15/18
8.I.9	Retire 2013 Position Statement on Detained Immigrants with Mental Illness **Will the Joint Reference Committee recommend that the Assembly retire the 2013 *Position Statement on Detained Immigrants with Mental Illness* and if retired, forward it to the Board of Trustees for consideration?** Rationale: A newly drafted Position Statement — *Mental Health Needs of Undocumented Immigrants, including Childhood Arrivals, Asylum-Seekers, and Detainees* — incorporates content from *Detained Immigrants with Mental Illness* and includes additional resources that address the current political and social climate. To eliminate duplicative publications, CMMH/HD recommends the Position Statement be retired.	The Joint Reference Committee deferred consideration of retiring the 2013 ***Position Statement on Detained Immigrants with Mental Illness*** until the June 2018 JRC meeting pending revision of the proposed Position Statement — *Mental Health Needs of Undocumented Immigrants, including Childhood Arrivals, Asylum-Seekers, and Detainees* — incorporates content from *Detained Immigrants with Mental Illness*.		JRC – June 2018 Add as Old Business on Agenda Deadline: 5/23/2018

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
8.J	**Council on Psychiatry and Law** Please see item 8.J for the Council's report, summary of current activities, and information items.			Completed
8.J.1	Revised Proposed Position Statement: Weapons Use in Hospitals and Patient Safety **Will the Joint Reference Committee recommend that the Assembly approve the revised proposed *Position Statement on Weapons Use in Hospitals and Patient Safety* and if approved, forward it to the Board of Trustees for consideration?** The Council on Psychiatry and Law has developed a Position Statement on Weapons Use in Hospitals and Patient Safety. The draft Position Statement was revised by the Council in response to feedback from the Joint Reference Committee after considering the draft document during its October meeting. Specifically, revisions were made to clarify that the document focuses on appropriate clinical responses to patient violence, and that the usual clinical response from clinical personnel should never include weapons use.	The Joint Reference Committee recommended that the Assembly approve the revised proposed *Position Statement on Weapons Use in Hospitals and Patient Safety* and if approved, forward it to the Board of Trustees for consideration. The JRC made an editorial revision to the position statement.	Yoshie Davison, MSW Margaret Cawley Dewar Allison Moraske	Assembly – May 2018 Deadline: 3/15/18
8.K	**Council on Psychosomatic Medicine** Please see item 8.K for the Council's report, summary of current activities, and information items.			Completed
8.K.1	Request to Change the Name of the Council **Will the Joint Reference Committee recommend that the Board of Trustees approve changing the name of the Council on Psychosomatic Medicine to the Council on Consultation-Liaison Psychiatry to conform with the official name change of the subspecialty?**	The Joint Reference Committee recommended that the Board of Trustees approve the changing the name of the Council on Psychosomatic Medicine to the Council on Consultation-Liaison Psychiatry.	Yoshie Davison, MSW Margaret Cawley Dewar Ardell Lockerman	Board of Trustees – March 2018

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
8.K.2	<u>Resource Document: The Assessment of Capacity for Medical Decision Making</u> **Will the Joint Reference Committee approve the Resource Document *on the Assessment of Capacity for Medical Decision Making?*** The authors of the resource document reviewed the classic and emerging literature on decisional capacity, including literature on clinical approaches to determination of decisional capacity, specific psychiatric and neurologic illness affecting decisional capacity, use of standardized rating instruments, and modification of clinical examination techniques specific to decisional capacity determinations. The authors cover nine topic areas pertinent to decisional capacity determinations, with review of the relevant literature for each topic, and offer a proposed clinical methodology for decisional capacity determinations in the context of comprehensive psychiatric evaluations.	The Joint Reference Committee thanked the council for developing this much needed resource document and referred it back to the Council on Psychosomatic Medicine for additional revisions. The Resource Document was also referred to the Council on Psychiatry and Law and the Council on Geriatric Psychiatry for their review and feedback. The content of the document would be strengthened with the addition of content related to the process for obtaining informed consent, how decisional capacity changes over time especially in those with neurocognitive disorders, and information on how to clarify and operationalize these processes. The JRC thought that the document would benefit from some copy editing for consistency and clarity. Specific comments from the JRC will be provided to the Council on Psychosomatic Medicine.	Kristin Kroeger Michelle Dirst Colleen Coyle, JD Alison Crane, JD Ranna Parekh, MD, MPH Sejal Patel	Council on Psychosomatic Medicine (LEAD) Council on Psychiatry and Law Council on Geriatric Psychiatry Report to JRC – June 2018 Deadline: 5/23/2018
8.L	**Council on Quality Care** Please see item 8.L for the Council's report, summary of current activities, and information items.			Completed

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
8.L.1	Referral Update – no action required Providing Education and Guidance for the Use and Limitations of Pharmacogenomics in Clinical Practice (JRCJUNE176.5, ASM2017A1 12.G). **LEAD**: Council on Quality Care As originally requested by the JRC in June 2017, the Council on Quality Care continued to work with several APA component groups to address the varying resolves found within the Action Paper: • The APA Staff Liaison to the Council on Research shared the Council on Research-charged Work Group on Biomarkers draft paper on the use of pharmacogenomics and the treatment of depression (recently approved by the Board of Trustees for submission to the American Journal of Psychiatry) with the Council on Quality Care. • After reviewing the paper, the Council discussed and agreed there is insufficient evidence to draft a resource document describing the use and limitations of pharmacogenomics in psychiatric clinical practice. The Council agreed they would charge the Committee on Practice Guidelines with including pharmacogenomics considerations as part of systematic literature reviews, when appropriate to the practice guidelines topic under development. • They also suggested the APA Staff Liaison to the Council on Research speak with AJP staff about the possibility of linking this paper to practice guidelines, when appropriate recommendations are made on the subject of pharmacogenomics	The Joint Reference Committee thanked the Council for the update. In light of recent data suggesting the positive impact of pharmacogenomics on those with major depression, the JRC asked that the Council on Research re-evaluate the need to draft a resource document on this issue. An update from the council is requested for the JRC June 2018 meeting.	Philip Wang, MD, DrPH	Council on Research Report to JRC – June 2018 Deadline: 5/23/2018
8.M	**Council on Research** Please see item 8.M for the Council's report, summary of current activities, and information items.			

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
8.M.1	Revised Proposed Position Statement: Mental Health Screening, Diagnosis, and Treatment During Pregnancy and Postpartum **Will the Joint Reference Committee recommend that the Assembly vote to approve the proposed *Position Statement on Mental Health Screening, Diagnosis, and Treatment During Pregnancy and Postpartum* and if approved, forward it to the Board of Trustees for consideration?**	The Joint Reference Committee recommended that the Assembly approve the proposed *Position Statement on Mental Health Screening, Diagnosis, and Treatment During Pregnancy and Postpartum* and if approved, forward it to the Board of Trustees for consideration.	Yoshie Davison, MSW Margaret Cawley Dewar Allison Moraske	Assembly – May 2018 Deadline: 3/15/18
9	Other Items			
9.A	Proposed Resource Document: Psychiatric Impact of Environmental Toxicants **Will the Joint Reference Committee approve the proposed Resource Document *Psychiatric Impact of Environmental Toxicants*?**	The Joint Reference Committee referred the proposed Resource Document *Psychiatric Impact of Environmental Toxicants* to the Council on Children, Adolescents, and Their Families (LEAD) and the Council on Research and requested that they review and provide input on the proposed resource document.	Ranna Parekh, MD, MPH Tatiana Claridad Philip Wang, MD, DrPH	Council on Children, Adolescents, and Their Families (LEAD) Council on Research

NEXT JOINT REFERENCE COMMITTEE MEETING

June 4, 2018 – Monday **Report Deadline: May 23, 2018 @ Noon (Wednesday)**
APA Headquarters
Washington, DC

Action	CEO/MDO Response	Staff/Component Responsible	Status
6.4 Enacting APA Positions: State Medical Board Licensure Queries (ASM2017A2 12.D) **Will the Joint Reference Committee refer the action paper *2017A2 12.D: Enacting APA Positions: State Medical Board Licensure Queries* to the appropriate Component(s) for input or follow-up?**	This Action Paper calls for the APA to: (1) query licensing boards in each state, territory or other licensure jurisdiction about their compliance with the APA policy and with the Americans with Disabilities Act with respect to questioning about mental and physical impairment affecting current ability to practice medicine; (2) notify each licensing board in writing whether or not their medical licensure application complies with the APA's stated policy and publish a list of jurisdictions and whether or not they are congruent with the APA position on the APA's website; and (3) notify the Federation of State Medical Boards Work Group of the APA's 2015 Position Statement prior to the January 2018 meeting of that group. The Council on Psychiatry and Law proposed additional language to the 2015 *Position Statement on Inquiries about Diagnosis and Treatment of Mental Disorders in Connection with Professional Credentialing and Licensing*. The language concerns the permissible scope of inquiries about mental health diagnosis for treatment, if raised by an applicant as an explanation for conduct that may otherwise warrant denial of licensure. It also relates to the confidentiality that should be afforded to medical records if requested and reasonably necessary to assess the applicant's fitness to practice. These additions were approved by the Joint Reference Committee in October 2017 and by the Assembly at its May 2018 meeting. It will be reviewed by the Board of Trustees in July.	Saul Levin, MD, MPA Colleen Coyle, JD	APA asks that Assembly members and District Branch executives to identify states where they know a problem exists. APA will utilize summer law student interns in 2018 to perform a survey first in those identified states to understand the practice of each licensing board. With supervision from the Office of the General Counsel, it is recommended that said interns could draft a letter to each individual licensing board to inform it of whether or not the APA believes its practices are in compliance with the requirements of the Americans with Disabilities Act (and the APA's corresponding Position Statement). It may be helpful to have the additions to the 2015 Position Statement fully approved as soon as possible after mid-June, so that the students could reference the most up-to-date version of the APA's position when drafting communications to the relevant licensing agencies. Further, the request calls for APA to publish a list of licensing boards and their standards on its website. APA will not be able to constantly monitor licensing boards for changes made to their practices. Therefore, any information posted on the APA's may become inaccurate.

Action	CEO/MDO Response	Staff/Component Responsible	Status
6.8 APA Position Statement Strongly Recommending Twelve Weeks of Paid Parental Leave (ASM2017A2 12.I) **Will the Joint Reference Committee refer the position statement 2017A2 12.I: APA Position Statement Strongly Recommending Twelve Weeks of Paid Paternal Leave to the appropriate Component(s) for input or follow-up?**	This Action Paper asks that the APA approve and adopt a position statement recommending twelve weeks of paid parental (i.e. both parents) leave. APA's parental leave policy has recently been updated, as a result of the relocation of the office from Virginia to the District of Columbia. APA complies with the Family Medical Leave Act (FMLA) of D.C. (more generous that the federal FMLA) which is as follows: (1) Employees are permitted to take unpaid medical leave of up to sixteen weeks in any 24-month period; (2) Employees are permitted to take unpaid family leave of up to sixteen weeks in any 24-month period for the birth, adoption or foster care placement of a child; (3) Employees are eligible for these FMLA benefits if they have worked at APA for at least 12 months and have worked at least 1,250 hours over the previous 12 months. In addition to the FMLA requirements, D.C. has passed the Universal Paid Leave Act of 2015, which establishes a paid leave system for employees in D.C. The law will allow for up to 8 weeks of paid family and medical leave; the benefit payable will be a portion of the employee's salary up to $1000/week. Payment of benefits will be provided from the Family and Medical Leave Fund, which will be administered by the D.C. government and funded by a 0.62% payroll tax that will be imposed on DC employers starting July 1, 2019. Eligibility begins July 1, 2020. APA anticipates paying $118,00 in tax to fund the program.	Colleen Coyle, JD Kristin Kroeger Kathy Orellana Craig Obey Ashely Mild Deana McRae	The average annual salary of an APA staff member who may be most likely to use Family and Medical Leave Act benefits is $80,324. Since June of 2017, the average length of family leave taken by APA employees due to childbirth has been 12.67 weeks (based on a sample size of 3 employees). If each of these employees received the average annual salary stated above and received paid parental leave from APA, the cost to APA for salary alone (not including benefits) during family leave would have been $39,112 per employee. $117,336 per year based on an average of 3 employees per year ($150,190 including benefits). APA is considering organizing an employee task force to consider the pros and cons of having more generous paid parental leave at APA. We are seeking all employees' input on the issue because when one employee takes extended paid leave, others will be required to cover for him/her, without additional compensation, because the budget does not allow for hiring of temporary replacements. APA will also need to consider what changes should be made to the policy, if adopted, once payment of benefits become available from the DC Family and Medical Leave Fund in July 2020.

OFFICE OF THE GENERAL COUNSEL

In its most recent Summary of Actions, issued February 21, 2018, the Joint Reference Committee asked for the Office of the General Counsel to provide input on two items before it for consideration. Input and recommendation from the Office of the General Counsel for each item is provided below.

1. **Item #6.4 "Enacting APA Positions: State Medical Board Licensure Queries (ASM2017A2 12.D)"**

   This Action Paper calls for the APA to: (1) query licensing boards (MD and DO) in each state, territory or other licensure jurisdiction about their compliance with the APA policy and with the Americans with Disabilities Act with respect to questioning about mental and physical impairment affecting current ability to practice medicine; (2) notify each medicine licensing board (and the relevant APA District Branch for that jurisdiction) in writing whether or not their medical licensure application complies with the APA's stated policy and publish a list of jurisdictions and whether or not they are congruent with the APA position on the APA's website; and (3) notify the Federation of State Medical Boards Work Group of the APA's 2015 Position Statement prior to the January 2018 meeting of that group.

   It is worth noting that the Council on Psychiatry and Law has recently proposed the addition of language to the relevant APA policy statement (2015 *Position Statement on Inquiries about Diagnosis and Treatment of Mental Disorders in Connection with Professional Credentialing and Licensing*) (the Position Statement). That proposed language concerns the permissible scope of inquiries about mental health diagnosis for treatment, if raised by an applicant as an explanation for conduct that may otherwise warrant denial of licensure. It also relates to the confidentiality that should be afforded to medical records if requested and reasonably necessary to assess the applicant's fitness to practice. These additions were approved by the Joint Reference Committee in October 2017 and are to be considered by the Assembly at its May 2018 meeting. If approved by the Assembly, it will then be sent to the Board of Trustees for review. The Position Statement (both as originally drafted and amended) is designed to summarize the key principles that should guide professional licensing agencies with respect to their licensure questionnaires and protocols. It discusses the Department of Justice's interpretation of the requirements of the Americans with Disabilities Act and adapts language from a 2014 settlement agreement based on that federal law. Thus it ensures APA's position statement reflects the most recent federal guidance on this issue.

   The Office of the General Counsel is not, without additional resources, staffed sufficiently to perform a state-by-state survey of licensing board practices in every relevant jurisdiction, as to undertake such a survey requires review of statutes and regulations as well as researching relevant case law interpreting the statutes and regulations and then analyzing in each jurisdiction whether the rules and their application comply with the Americans with Disabilities Act (ADA). To meet the purpose of the Action Paper, we also suggest a two-pronged approach to this analysis: First, we will ask Assembly members and District Branch executives to identify states where they know a problem exists. Second, we suggest asking the law students we anticipate having intern in the APA office during the summer of 2018 to perform the survey first in those identified states to understand the practice of each licensing board. With supervision from our Office, the interns could also draft a letter to each individual licensing board to inform it of whether or not the APA believes its practices are in compliance with the requirements of the Americans with Disabilities Act (and the APA's corresponding Position Statement). They would first address the known problem states and then, if time permits, research remaining states.

We anticipate having the assistance of interns between mid-June and mid-August 2018. We can include this work among the other projects for which they have been hired. Much of the work should be able to be performed during that time. It may be helpful to have the additions to the 2015 Position Statement fully approved as soon as possible after mid-June, so that the students could reference the most up-to-date version of the APA's position when drafting communications to the relevant licensing agencies. We'd ask the Joint Reference Committee to consider expediting review of the proposed additions to the Position Statement.

We do not believe the portion of the request that calls for the APA to publish on the APA's website a list of licensing board jurisdictions and whether or not their practices are congruent with the APA Position Statement should be approved. Each District Branch would be copied on the communication made to the relevant licensing board and would be able to advise an interested member as to the APA's assessment about the licensing board's practice as of the date in time that letter is sent. However, licensing boards may continually update and change their practices (and hopefully those that are determined to be not in compliance will consider doing so after receipt of the APA's letter to that effect). Taking into consideration the investment of manpower that will be required to perform the initial survey of licensing board practices, APA will not be able to constantly monitor licensing boards for changes made to their practices. Therefore, any information posted on the APA's website as to the assessment made by APA at a particular moment in time may become inaccurate. Once the initial work is done, ongoing monitoring of changes to regulations and licensing board practices should be done by the District Branches.

2. Item #6.8 "APA Position Statement Strongly Recommending Twelve Weeks of Paid Parental Leave (ASM2017A2 12.I)"

This Action Paper asks that the APA approve and adopt a position statement recommending twelve weeks of paid parental (i.e. both parents) leave. The Office of the General Counsel has been asked for input on APA's parental leave policy, as well as the laws of the District of Columbia. That information follows.

APA's parental leave policy has very recently been updated, as a result of the relocation of the office from Virginia to the District of Columbia. APA complies with the Family Medical Leave Act (FMLA) of the District of Columbia (which is more generous that the federal FMLA) as follows:

> (1) Employees are permitted to take unpaid *medical* leave of up to sixteen (16) weeks in any 24-month period; AND
> (2) Employees are permitted to take unpaid *family* leave of up to sixteen (16) weeks in any 24-month period for the birth, adoption or foster care placement of a child;
> (3) Employees are eligible for these FMLA benefits if they have worked at APA for at least 12 months and have worked at least 1,250 hours over the previous 12 months.
>
> Although the FMLA benefits provide unpaid leave, APA administers the policy in conjunction with its vacation leave, sick leave, and short/long-term disability benefits (if applicable), so that an employee may combine his/her leave benefits to receive up to the amount of his/her weekly base pay while on family leave. Employees who experience pregnancy/birth are eligible to receive short-term disability program benefits, which provide 60% of an employee's weekly earnings (up to $750) for a maximum of 11 weeks. [APA is self-insured for short-term disability insurance, so the cost of this benefit is 100% absorbed by APA]. Parents who

do not experience pregnancy/birth (including fathers and adoptive parents) are not eligible for the short-term disability benefit so are limited to vacation and sick leave for payment. APA's sick leave policy is generous, as full-time employees earn 4 hours of leave per pay period and are permitted to carry over 720 hours of sick leave each year. Sick leave is fully paid.

In addition to the FMLA requirements, the District of Columbia has passed the Universal Paid Leave Act of 2015, which establishes a paid leave system for employees in the District of Columbia. The law will allow for up to 8 weeks of paid family and medical leave; the benefit payable will be a portion of the employee's salary up to $1000/week. Payment of benefits will be provided from the Family and Medical Leave Fund, which will be administered by the District of Columbia government. The Fund will be funded by a 0.62% payroll tax that will be imposed on District of Columbia employers (including APA and including those who already provide a paid maternity leave) starting July 1, 2019. Employees will be eligible to begin receiving benefits by July 1, 2020. Using today's payroll numbers, APA will be paying $118,000 annually for this tax beginning next year.

According to data provided by the APA's Human Resources department, the average annual salary of an APA staff member who may be most likely to use Family and Medical Leave Act benefits is $80,324. (This is based on the average salary for all female employees at APA who are less than 40 years old). APA currently has 188 employees. Since June of 2017, the average length of family leave taken by APA employees due to childbirth has been 12.67 weeks (based on a sample size of 3 employees). If each of these employees received the average annual salary stated above and received paid parental leave from APA, the cost to APA for salary alone (not including benefits) during family leave would have been $39,112 per employee. This would have totaled $117,336 for all three employees. A 28% estimate for benefit costs on that amount is $32,854, for a total of $150,190 when benefits are added to the salary cost.

In addition to the cost of salary payments to the employee on leave, APA may also need to consider the cost it would incur to replace the absent employee (either by temporarily replacing that employee with a temporary worker, relying on other staff members to perform the work, or both). If APA did not hire temporary replacements for the four-month period of leave, then existing staff would be asked to take on additional responsibilities for one-third of the year – a request that will take a toll on morale.

Neither cost is identified here, but APA's experience suggests that having a temporary worker usually costs about the same as the relevant employee's fully-loaded salary. Similarly, the benefits to APA of offering paid family leave to employees (including employee morale and well-being) are not identified here.

APA is considering organizing an employee task force to consider the pros and cons of having more generous paid parental leave at APA. We are seeking all employees' input on the issue because when one employee takes extended paid leave, others will be required to cover for him/her, without additional compensation, because the budget does not allow for hiring of temporary replacements. APA will also need to consider what changes should be made to the policy, if adopted, once payment of benefits become available from the DC Family and Medical Leave Fund in July 2020.

AMERICAN PSYCHIATRIC ASSOCIATION

To: Altha Stewart, MD
Chair, Joint Reference Committee
From: Ezra H. Griffith, MD
Chair, APA Ethics Committee
Date: March 29, 2018
Re: Assembly Action Paper Assignment to Ethics Committee (2017A2 12.K)

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

BACKGROUND

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

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

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

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

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

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

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

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

DISCUSSION

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

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

Commentary Topic 3.1.3 Dual agency and overlapping roles

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

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

Commentary Topic 3.4.1 Working within organized systems of care

The Ethics Committee, in addressing questions about the role of a managed care or utilization reviewer, has noted that the reviewing psychiatrist is not a treating physician in this circumstance. The interests of the managed care plan or system of care are not the same as interests of the patient, although they overlap to some degree.

The patient's treating physician has a duty to advocate for the best interests of the patient, while the reviewing physician has a duty to assess whether the care meets the criteria the plan has established. In fulfilling his/her duty to the managed care employer, the reviewing physician continues to have a responsibility to keep in mind the health interests of the patient. This responsibility is grounded in respect for persons and in the physician's commitment to the health of individuals and of society. [1]

[1] *E.g. Ethics Opinion on Dual Agency Issues When Working Within Organized Systems Of Care,* at https://www.psychiatry.org/psychiatrists/practice/ethics.

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

The AMA Opinion at issue states:

10.1.1 Ethical Obligations of Medical Directors

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

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

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

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

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

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

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

Joint Reference Committee
American Psychiatric Association

Draft Agenda – Part Two

Location: APA Headquarters, Washington, DC

June 4th, 2018 - Monday
Meeting: 9:00 am – 4:00 pm

6 **Assembly Report** – Paul O'Leary, MD

6.1 APA Endorsement of AMA Position Opposing Unsupervised Practice of Non-Physician Practitioners (ASM2018A1 12.A)
(Attachment 1 - Action paper, cost estimate, administration comments)
The action paper asks that the American Psychiatric Association endorse the positions (H35.988, H35.989 and H35.962) taken by the American Medical Association as long as they remain positions of the American Medical Association to oppose the practice of non-physician practitioners to practice without physician supervision.

Will the Joint Reference Committee refer the action paper *2018A1 12.A: APA Endorsement of AMA Position Opposing Unsupervised Practice of Non-Physician Practitioners* to the appropriate Component(s) for input or follow-up?

6.2 Psychiatric Care as Medical Care (ASM2018A1 12.B)
(Attachment 2 - Action paper, cost estimate, administration comments)
The action paper asks that the Council of Psychiatry and Law draft an appropriate statement in opposition to psychiatry being considered separate from medical benefits, create resource documents, and set further recommendations for APA policy.

Will the Joint Reference Committee refer the action paper *2018A1 12.B: Psychiatric Care as Medical Care* to the appropriate Component(s) for input or follow-up?

6.3 Supervision of Psychiatric Mental Health Nurse Practitioners and Physician Assistants in Psychiatry by Psychiatrists (ASM2018A1 12.C)
(Attachment 3 - Action paper, cost estimate, administration comments)
The action paper asks:
1. That the APA will encourage and support research to determine the efficacy and safety of unsupervised mental health practice by Psychiatric Mental Health Nurse Practitioners and Physician Assistants compared to Psychiatrists.

2. That the APA will develop a position statement in support of appropriate supervision of Psychiatric Mental Health Nurse Practitioners and Physician Assistants in Psychiatry.
3. That because of the various types of doctoral degrees that are available to non-physicians, that the APA advocate that all healthcare professionals wear a designation of their license large enough for all patients to see, i.e., physician, nurse clinician, physician assistant, etc.
4. That the APA will include simplified information for public consumption on the patient and family section of the APA website comparing the education of Psychiatrists and prescribing non-physicians for awareness and educated consumer choice.

Will the Joint Reference Committee refer the action paper *2018A1 12.C: Supervision of Psychiatric Mental Health Nurse Practitioners and Physician Assistants in Psychiatry by Psychiatrists* to the appropriate Component(s) for input or follow-up?

6.4 Requesting CMS Help Us Improve Addiction Treatment Process (ASM2018A1 12.D)
(Attachment 4 - Action paper, cost estimate, administration comments)
The action paper asks that the APA advocate with CMS to cover for the purposes of billing for urine drug screens all diagnostic codes that are part of the Substance Use Disorders section of ICD.10.

Will the Joint Reference Committee refer the action paper *2018A1 12.D: Requesting CMS Help Us Improve Addiction Treatment Process t*o the appropriate Component(s) for input or follow-up?

6.5 Position Statement on Psychologist Prescribing (ASM2018A1 12.E)
(Attachment 5 - Action paper, cost estimate, administration comments)
The action paper asks that the American Psychiatric Association join with the American Academy of Child and Adolescent Psychiatry and the American Medical Association opposing any legislation or regulation at the state or federal level that would grant psychologists prescribing privileges. We oppose psychologists prescribing medication because training in psychology does not provide medical education that is essential for the appropriate and safe prescription of medications.

Will the Joint Reference Committee refer the action paper *2018A1 12.E: Position Statement on Psychologist Prescribing* to the appropriate Component(s) for input or follow-up?

6.6 Medication Assisted Treatment of Physicians in Treatment Participating in Physician Health Programs (ASM2018A1 12.F)
(Attachment 6 - Action paper, cost estimate, administration comments)
The action paper asks that our American Psychiatric Association review available evidence on the use of medication assisted treatment by physicians in recovery with substance use disorders, and

Based on the results of a review of available evidence, that the American Psychiatric Association develops a position statement on the use of medication assisted treatment by physicians under the supervision of physician health programs.

That our APA work with the AMA and other appropriate entities to ensure that physicians seeking treatment of substance use disorders through Physician Health programs are afforded evidence-based Medication-Assisted Treatment (MAT).

Will the Joint Reference Committee the action paper *2018A1 12.F: Medication Assisted Treatment of Physicians in Treatment Participating in Physician Health Programs* to the appropriate Component(s) for input or follow-up?

6.7 Researching a Single Payer Nationwide Health Care System (ASM2018A1 12.H)
(Attachment 7 - Action paper, cost estimate, administration comments)
The action paper asks that the APA, through its Council on Healthcare Systems and Financing, conduct a study and evaluate Single Payer Health Plans compared with the other Health Care Delivery models which could provide universal access to health care, inclusive of mental health care, in the United States.

Will the Joint Reference Committee refer the action paper 2018A1 12.H: *Researching a Single Payer Nationwide Health Care System* to the appropriate Component(s) for input or follow-up?

6.8 Improving Identification and Treatment of Borderline Personality Disorder (ASM2018A1 12.I)
(Attachment 8 - Action paper, cost estimate, administration comments)
The action paper asks that the APA's Division of Education create a Supplemental Education and Training (SET) learning module on common factor treatment approaches for BPD.

Will the Joint Reference Committee refer the action paper 2018A1 12.I: *Improving Identification and Treatment of Borderline Personality Disorder* to the appropriate Component(s) for input or follow-up?

6.9 Improving Access to the ABPN Examinations (ASM2018A1 12.J)
(Attachment 9 - Action paper, cost estimate, administration comments)
The action paper asks that APA lobby the ABPN to offer a minimum of four five-day examination periods through the year.

Will the Joint Reference Committee refer the action paper 2018A1 12.J: *Improving Access to the ABPN Examinations* to the appropriate Component(s) for input or follow-up?

6.10 Service Members and Their Families Deserve Quality Psychiatric Treatment (ASM2018A1 12.K)
(Attachment 10 - Action paper, cost estimate, administration comments)
The action paper asks that the APA make an appeal to TriCare for formulary coverage that includes an appropriate balance of conventional and atypical long-acting injectable antipsychotic medications

Will the Joint Reference Committee refer the action paper 2018A1 12.K: *Service Members and Their Families Deserve Quality Psychiatric Treatment* to the appropriate Component(s) for input or follow-up?

6.11 Defending the Public Service Loan Forgiveness (PSLF) Program (ASM2018A1 12.L)]
(Attachment 11 - Action paper, cost estimate, administration comments)
The action paper asks:
1) The American Psychiatric Association will support the continuation of the Public Service Loan Forgiveness program and make its defense an advocacy priority as an access to care matter.
2) The American Psychiatric Association will partner with other medical societies (e.g. the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians, etc.), when appropriate, to further this advocacy goal.

Will the Joint Reference Committee refer the action paper 2018A1 12.L: *Defending the Public Service Loan Forgiveness (PSLF) Program* to the appropriate Component(s) for input or follow-up?

6.12 APA Supports Psychiatrists to Practice Psychiatry Without the Unproven Requirements of the MOC (ASM2018A1 12.M)
(Attachment 12 - Action paper, cost estimate, administration comments)
The action paper asks that the APA advocate with the ABMS and ABPN to return to lifetime board certification.

Will the Joint Reference Committee refer the action paper 2018A1 12.M: *APA Supports Psychiatrists to Practice Psychiatry Without the Unproven Requirements of the MOC* to the appropriate Component(s) for input or follow-up?

6.13 Developing a Web Based Tool Kit for Psychiatrists and Patients Who Wish to Appeal Adverse Medical Necessity Decisions by Managed Care Entities (ASM2018A1 12.N)
(Attachment 13 - Action paper, cost estimate, administration comments)
The action paper asks that the APA will improve its webpage, "appealing treatment denials", to provide assistance to clinicians and patients who believe they face improper denial of access to medically necessary care. The webpage will offer a user-friendly tool kit that describes steps to maximize the likelihood of an appeal being successful.

Will the Joint Reference Committee refer the action paper 2018A1 12.N: *Developing a Web Based Tool Kit for Psychiatrists and Patients Who Wish to Appeal Adverse Medical Necessity Decisions by Managed Care Entities* to the appropriate Component(s) for input or follow-up?

6.14 Addition of Adequate Amounts of Phosphatidylcholine (choline) to all Prenatal Vitamins (ASM2018A1 12.O)
(Attachment 14 - Action paper, cost estimate, administration comments)
The action paper asks that the American Psychiatric Association supports that evidence-based amounts of bioavailable choline be added to all prenatal vitamins.

Will the Joint Reference Committee refer the action paper 2018A1 12.O: *Addition of Adequate Amounts of Phosphatidylcholine (choline) to all Prenatal Vitamins* to the appropriate Component(s) for input or follow-up?

6.15 Psychiatric Management of the Impact of Racism on Social and Clinical Events (ASM2018A1 12.Q)
(Attachment 15 - Action paper, cost estimate, administration comments)
The action paper asks that the APA enhance membership and public education about the mental health effects of racial discrimination, micro-aggression, race-based violence, racially motivated mass killings and similar events, through duly implemented curricular guidelines for medical schools, residency training, and continuing medical education programs, as well as media outreach.

That the index of subsequent versions of DSM will refer to race and racism content currently present in sections and subsections.

Will the Joint Reference Committee refer the action paper 2018A1 12.R: *Psychiatric Management of the Impact of Racism on Social and Clinical Events* to the appropriate Component(s) for input or follow-up?

6.16 A Call to Recognize and Honor the Psychiatrists Who Served in Vietnam (ASM2018A1 12.R)
(Attachment 16 - Action paper, cost estimate, administration comments)
The action paper asks that the American Psychiatric Association will formally recognize the men and women psychiatrists who served in Vietnam.

Will the Joint Reference Committee refer the action paper 2018A1 12.R: *A Call to Recognize and Honor the Psychiatrists Who Served in Vietnam* to the appropriate Component(s) for input or follow-up?

6.17 Streamlining the APA Application Renewal Process (ASM2018A1 12.T)
(Attachment 17 - Action paper, cost estimate, administration comments)
The action paper asks that the APA continue streamlining the renewal process by initiating, as one option, a one-click payment link that allows a member to directly pay dues without logging into the website or going through multiple screens that could distract or prevent the member from renewing.

Will the Joint Reference Committee refer the action paper 2018A1 12.T: *Streamlining the APA Application Renewal Process* to the appropriate Component(s) for input or follow-up?

6.18 Survey of Membership (ASM2018A1 12.V)
(Attachment 18 - Action paper, cost estimate, administration comments)
The action paper asks that the APA convene a study group to determine the best and most cost-effective mechanism to assess demographics from the membership addressing a wide variety of practice styles and professional activities including, but not limited to:

- Employment settings: private practice, government employment, academic appointment, group practice, collaborative care models, etc.
- Participation in insurance: including private healthcare, Medicare/Medicaid, private pay and Worker's Compensation, etc.
- Utilization of electronic medical records

The results of the study group would be formulated into a survey or other mechanism to be administered to the entire membership in order to assist the APA in addressing future policies and advocacy with full knowledge of the potential scope of impact on the individual members.

Will the Joint Reference Committee refer the action paper 2018A1 12.V: *Survey of Membership* to the appropriate Component(s) for input or follow-up?

6.19 Proposed Position Statement: Screening and Treatment of Mood and Anxiety Disorders During Pregnancy and Postpartum (JRCFEB188.M.1; ASM2018A1 14.A)
(Attachment 19 - Action paper, cost estimate, administration comments)
The Assembly voted to refer the Proposed Position Statement: *Screening and Treatment of Mood and Anxiety Disorders During Pregnancy and Postpartum* back to the JRC for further review and revision.

Will the Joint Reference Committee refer the Proposed Position Statement: *Screening and Treatment of Mood and Anxiety Disorders During Pregnancy and Postpartum* to the appropriate Component(s) for input or follow-up?

9 Other Business – TBD

NEXT JOINT REFERENCE COMMITTEE MEETING

October 1st, 2018 - **MONDAY**
APA Headquarters
Washington, DC
Report Deadline: September 21st, 2018 @ Noon

EXECUTIVE SUMMARY
Assembly

The Assembly met in New York City, New York, May 4-6, 2018 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 20.

The Assembly brings the following action items:

1. **APA Endorsement of AMA Position Opposing Unsupervised Practice of Non-Physician Practitioners (ASM Item #2018A1 12.A) [Attachment 1]**

   Action paper 2018A1 12.A asks that the American Psychiatric Association endorse the positions (H35.988, H35.989 and H35.962) taken by the American Medical Association as long as they remain positions of the American Medical Association to oppose the practice of non-physician practitioners to practice without physician supervision.

   Action: Will the JRC refer the Assembly passed action paper *2018A1 12.A:* APA Endorsement of AMA Position Opposing Unsupervised Practice of Non-Physician Practitioners to the appropriate Component(s) for input or follow-up?

2. **Psychiatric Care as Medical Care (ASM Item #2018A1 12.B) [Attachment 2]**

   Action paper 2018A1 12.B asks that the Council of Psychiatry and Law draft an appropriate statement in opposition to psychiatry being considered separate from medical benefits, create resource documents, and set further recommendations for APA policy.

   Action: Will the JRC refer the Assembly passed action paper *2018A1 12.B:* Psychiatric Care as Medical Care to the appropriate Component(s) for input or follow-up?

3. **Supervision of Psychiatric Mental Health Nurse Practitioners and Physician Assistants in Psychiatry by Psychiatrists (ASM Item #2018A1 12.C) [Attachment 3]**

   Action paper 2018A1 12.C asks:

   1. That the APA will encourage and support research to determine the efficacy and safety of unsupervised mental health practice by Psychiatric Mental Health Nurse Practitioners and Physician Assistants compared to Psychiatrists.

   2. That the APA will develop a position statement in support of appropriate supervision of Psychiatric Mental Health Nurse Practitioners and Physician Assistants in Psychiatry.

3. That because of the various types of doctoral degrees that are available to non-physicians, that the APA advocate that all healthcare professionals wear a designation of their license large enough for all patients to see, i.e., physician, nurse clinician, physician assistant, etc.

4. That the APA will include simplified information for public consumption on the patient and family section of the APA website comparing the education of Psychiatrists and prescribing non-physicians for awareness and educated consumer choice.

Action: Will the JRC refer the Assembly passed action paper *2018A1 12.C:* Supervision of Psychiatric Mental Health Nurse Practitioners and Physician Assistants in Psychiatry by Psychiatrists to the appropriate Component(s) for input or follow-up?

4. Requesting CMS Help Us Improve Addiction Treatment Process (ASM Item # 2018A1 12.D) [Attachment 4]

Action paper 2018A1 12.D asks that the APA advocate with CMS to cover for the purposes of billing for urine drug screens all diagnostic codes that are part of the Substance Use Disorders section of ICD.10.

Action: Will the JRC refer the Assembly passed action paper *2018A1 12.D:* Requesting CMS Help Us Improve Addiction Treatment Process *t*o the appropriate Component(s) for input or follow-up?

5. Position Statement on Psychologist Prescribing (ASM Item # 2018A1 12.E) [Attachment 5]

Action paper 2018A1 12.E asks that the American Psychiatric Association join with the American Academy of Child and Adolescent Psychiatry and the American Medical Association opposing any legislation or regulation at the state or federal level that would grant psychologists prescribing privileges. We oppose psychologists prescribing medication because training in psychology does not provide medical education that is essential for the appropriate and safe prescription of medications.

Action: Will the JRC refer the Assembly passed action paper *2018A1 12.E:* Position Statement on Psychologist Prescribing to the appropriate Component(s) for input or follow-up?

6. Medication Assisted Treatment of Physicians in Treatment Participating in Physician Health Programs (ASM Item # 2018A1 12.F) [Attachment 6]

Action paper 2018A1 12.F asks that our American Psychiatric Association review available evidence on the use of medication assisted treatment by physicians in recovery with substance use disorders, and

Based on the results of a review of available evidence, that the American Psychiatric Association develops a position statement on the use of medication assisted treatment by physicians under the supervision of physician health programs.

That our APA work with the AMA and other appropriate entities to ensure that physicians seeking treatment of substance use disorders through Physician Health programs are afforded evidence-based Medication-Assisted Treatment (MAT).

Action: Will the JRC refer the Assembly passed action paper *2018A1 12.F:* Medication Assisted Treatment of Physicians in Treatment Participating in Physician Health Programs to the appropriate Component(s) for input or follow-up?

7. Researching a Single Payer Nationwide Health Care System (ASM Item #2018A1 12.H) [Attachment 7]

Action paper 2018A1 12.H asks that the APA, through its Council on Healthcare Systems and Financing, conduct a study and evaluate Single Payer Health Plans compared with the other Health Care Delivery models which could provide universal access to health care, inclusive of mental health care, in the United States.

Action: Will the JRC refer the Assembly passed action paper 2018A1 12.H: Researching a Single Payer Nationwide Health Care System to the appropriate Component(s) for input or follow-up?

8. Improving Identification and Treatment of Borderline Personality Disorder (ASM Item #2018A1 12.I) [Attachment 8]

Action paper 2018A1 12.I asks that the APA's Division of Education create a Supplemental Education and Training (SET) learning module on common factor treatment approaches for BPD.

Action: Will the JRC refer the Assembly passed action paper 2018A1 12.I: Improving Identification and Treatment of Borderline Personality Disorder to the appropriate Component(s) for input or follow-up?

9. Improving Access to the ABPN Examinations (ASM Item #2018A1 12.J) [Attachment 9]

Action paper 2018A1 12.J asks that APA lobby the ABPN to offer a minimum of four five-day examination periods through the year.

Action: Will the JRC refer the Assembly passed action paper 2018A1 12.J: Improving Access to the ABPN Examinations to the appropriate Component(s) for input or follow-up?

10. Service Members and Their Families Deserve Quality Psychiatric Treatment (ASM Item #2018A1 12.K) [Attachment 10]

Action paper 2018A1 12.K asks that the APA make an appeal to TriCare for formulary coverage that includes an appropriate balance of conventional and atypical long-acting injectable antipsychotic medications

Action: Will the JRC refer the Assembly passed action paper 2018A1 12.K: Service Members and Their Families Deserve Quality Psychiatric Treatment to the appropriate Component(s) for input or follow-up?

11. Defending the Public Service Loan Forgiveness (PSLF) Program (ASM Item #2018A1 12.L) [Attachment 11]

Action paper 2018A1 12.L asks:
1) The American Psychiatric Association will support the continuation of the Public Service Loan Forgiveness program and make its defense an advocacy priority as an access to care matter.

2) The American Psychiatric Association will partner with other medical societies (e.g. the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians, etc.), when appropriate, to further this advocacy goal.

Action: Will the JRC refer the Assembly passed action paper 2018A1 12.L: Defending the Public Service Loan Forgiveness (PSLF) Program to the appropriate Component(s) for input or follow-up?

12. APA Supports Psychiatrists to Practice Psychiatry Without the Unproven Requirements of the MOC (ASM Item #2018A1 12.M) [Attachment 12]

Action paper 2018A1 12.M asks that the APA advocate with the ABMS and ABPN to return to lifetime board certification.

Action: Will the JRC refer the Assembly passed action paper 2018A1 12.M: APA Supports Psychiatrists to Practice Psychiatry Without the Unproven Requirements of the MOC to the appropriate Component(s) for input or follow-up?

13. Developing a Web Based Tool Kit for Psychiatrists and Patients Who Wish to Appeal Adverse Medical Necessity Decisions by Managed Care Entities (ASM Item #2018A1 12.N) [Attachment 13]

Action paper 2018A1 12.N asks that the APA will improve its webpage, "appealing treatment denials", to provide assistance to clinicians and patients who believe they face improper denial of access to medically necessary care. The webpage will offer a user-friendly tool kit that describes steps to maximize the likelihood of an appeal being successful.

Action: Will the JRC refer the Assembly passed action paper 2018A1 12.N: Developing a Web Based Tool Kit for Psychiatrists and Patients Who Wish to Appeal Adverse Medical Necessity Decisions by Managed Care Entities to the appropriate Component(s) for input or follow-up?

14. Addition of Adequate Amounts of Phosphatidylcholine (choline) to all Prenatal Vitamins (ASM Item #2018A1 12.O) [Attachment 14]

Action paper 2018A1 12.O asks that the American Psychiatric Association supports that evidence-based amounts of bioavailable choline be added to all prenatal vitamins.

Action: Will the JRC refer the Assembly passed action paper 2018A1 12.O: Addition of Adequate Amounts of Phosphatidylcholine (choline) to all Prenatal Vitamins to the appropriate Component(s) for input or follow-up?

15. Psychiatric Management of the Impact of Racism on Social and Clinical Events (ASM Item #2018A1 12.Q) [Attachment 15]

Action paper 2018A1 12.Q asks that the APA enhance membership and public education about the mental health effects of racial discrimination, micro-aggression, race-based violence, racially motivated mass killings and similar events, through duly implemented curricular guidelines for medical schools, residency training, and continuing medical education programs, as well as media outreach.

That the index of subsequent versions of DSM will refer to race and racism content currently present in sections and subsections.

Action: Will the JRC refer the Assembly passed action paper 2018A1 12.R: Psychiatric Management of the Impact of Racism on Social and Clinical Events to the appropriate Component(s) for input or follow-up?

16. A Call to Recognize and Honor the Psychiatrists Who Served in Vietnam (ASM Item #2018A1 12.R) [Attachment 16]

Action paper 2018A1 12.R asks that the American Psychiatric Association will formally recognize the men and women psychiatrists who served in Vietnam.

Action: Will the JRC refer the Assembly passed action paper 2018A1 12.R: A Call to Recognize and Honor the Psychiatrists Who Served in Vietnam to the appropriate Component(s) for input or follow-up?

17. Streamlining the APA Application Renewal Process (ASM Item #2018A1 12.T) [Attachment 17]

Action paper 2018A1 12.T asks that the APA continue streamlining the renewal process by initiating, as one option, a one-click payment link that allows a member to directly pay dues without logging into the website or going through multiple screens that could distract or prevent the member from renewing.

Action: Will the JRC refer the Assembly passed action paper 2018A1 12.T: Streamlining the APA Application Renewal Process to the appropriate Component(s) for input or follow-up?

18. Survey of Membership (ASM Item #2018A1 12.V) [Attachment 18]

Action paper 2018A1 12.V asks that the APA convene a study group to determine the best and most cost-effective mechanism to assess demographics from the membership addressing a wide variety of practice styles and professional activities including, but not limited to:

- Employment settings: private practice, government employment, academic appointment, group practice, collaborative care models, etc.

- Participation in insurance: including private healthcare, Medicare/Medicaid, private pay and Worker's Compensation, etc.

- Utilization of electronic medical records

The results of the study group would be formulated into a survey or other mechanism to be administered to the entire membership in order to assist the APA in addressing future policies and advocacy with full knowledge of the potential scope of impact on the individual members.

Action: Will the JRC refer the Assembly passed action paper 2018A1 12.V: Survey of Membership to the appropriate Component(s) for input or follow-up?

19. **Proposed Position Statement: Screening and Treatment of Mood and Anxiety Disorders During Pregnancy and Postpartum (JRC Item #8.M.1/ASM Item #2018A1 14.A) [Attachment 19]**

The Assembly voted to refer the Proposed Position Statement: *Screening and Treatment of Mood and Anxiety Disorders During Pregnancy and Postpartum* back to the JRC for further review and revision.

Action: Will the JRC refer the Proposed Position Statement: *Screening and Treatment of Mood and Anxiety Disorders During Pregnancy and Postpartum* 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 2018 to May 2019:

Speaker-Elect: Paul J. O'Leary, MD, Area 5

Recorder: Seeth Vivek, MD, Area 2

2. **Proposed Position Statement: *Peer Support Services* (JRCFEB188.F.1/ASM Item #2018A1 4.B.1)**

The Assembly voted to approve the Proposed Position Statement: *Peer Support Services*. This will be forwarded to the Board of Trustees for consideration in July 2018.

3. **Revised Position Statement on *Telemedicine in Psychiatry* (JRCFEB188.F.3/ ASM Item #2018A1 4.B.2)**

The Assembly voted, on its Consent Calendar, to approve the Revised Position Statement on *Telemedicine in Psychiatry*. This will be forwarded to the Board of Trustees for consideration in July 2018.

4. **Revised Position Statement on *Abortion* (JRCFEB188.I.1/ ASM Item #2018A1 4.B.3)**

The Assembly voted to approve the Revised Position Statement on *Abortion.* This will be forwarded to the Board of Trustees for consideration in July 2018.

5. **Revised Position Statement: *Resolution Against Racism and Racial Discrimination and Their Adverse Impacts on Mental Health* (JRCFEB188.I.2/ ASM Item #2018A1 4.B.4)**

The Assembly voted to approve the Revised 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 2018.

6. **Revised Position Statement on *Religious Persecution and Genocide* (JRCFEB188.I.3/ ASM Item #2018A1 4.B.5)**

The Assembly voted, on its Consent Calendar, to approve the Revised Position Statement on *Religious Persecution and Genocide*. This will be forwarded to the Board of Trustees for consideration in July 2018.

7. **Proposed Position Statement on *Discrimination of Religious Minorities* (JRCFEB188.I.8/ ASM Item #2018A1 4.B.6)**

The Assembly voted to approve the Proposed Position Statement on *Discrimination of Religious Minorities*. This will be forwarded to the Board of Trustees for consideration in July 2018.

8. **(Revised) Proposed Position Statement: *Weapons Use in Hospitals and Patient Safety* (JRCFEB188.J.1/ ASM Item #2018A1 4.B.7)**

The Assembly voted, on its Consent Calendar, to approve the (Revised) Proposed Position Statement: *Weapons Use in Hospitals and Patient Safety*. This will be forwarded to the Board of Trustees for consideration in July 2018.

9. **Proposed Position Statement: *Risks of Adolescents' Online Activity* (JRCOCT178.C.1/ ASM Item #2018A1 4.B.8)**

The Assembly voted, on its Consent Calendar, to approve the Proposed Position Statement: *Risks of Adolescents' Online Activity*. This will be forwarded to the Board of Trustees for consideration in July 2018.

10. **Revised Position Statement: *Access to Care for Transgender and Gender Diverse Individuals* (JRCOCT178.I.3/ ASM Item #2018A1 4.B.9)**

The Assembly voted to approve the Revised Position Statement: *Access to Care for Transgender and Gender Diverse Individuals*. This will be forwarded to the Board of Trustees for consideration in July 2018.

11. **Revised Position Statement *Discrimination Against Transgender and Gender Diverse Individuals* (JRCOCT178.I.4/ ASM Item #2018A1 4.B.10)**

The Assembly voted, on its Consent Calendar, to approve Revised Position Statement *Discrimination Against Transgender and Gender Diverse Individuals*. This will be forwarded to the Board of Trustees for consideration in July 2018.

12. **Proposed Position Statement: *Solitary Confinement (Restricted Housing) of Juveniles* (JRCOCT178.J.2/ ASM Item #2018A1 4.B.11)**

The Assembly voted, on its Consent Calendar, to approve the Proposed Position Statement: *Solitary Confinement (Restricted Housing) of Juveniles*. This will be forwarded to the Board of Trustees for consideration in July 2018.

13. **Proposed Position Statement: *Psychiatric Services in Adult Correctional Facilities* (JRCOCT178.J.3/ASM Item #2018A1 4.B.12)**

The Assembly voted, on its Consent Calendar, to approve the Proposed Position Statement: *Psychiatric Services in Adult Correctional Facilities*. This will be forwarded to the Board of Trustees for consideration in July 2018.

14. **Proposed Position Statement: *Research with Involuntary Psychiatric Patients* (JRCOCT178.J.5/ASM Item #2018A1 4.B.13)**

The Assembly voted to approve the Proposed Position Statement: *Research with Involuntary Psychiatric Patients.* This will be forwarded to the Board of Trustees for consideration in July 2018.

15. **Revised Position Statement*: Inquiries about Diagnosis and Treatment of Mental Disorders in Connection with Professional Credentialing and Licensing (2015)* (JRCOCT8.J.6/ASM Item #2017A1 4.B.14)**

The Assembly voted, on its Consent Calendar, to approve the Revised Position Statement: *Inquiries about Diagnosis and Treatment of Mental Disorders in Connection with Professional Credentialing and Licensing (2015)*. This will be forwarded to the Board of Trustees for consideration in July 2018.

16. **Revised 2014 Position Statement on *Firearms Access, Acts of Violence and the Relationship to Mental Illness and Mental Health Services* (ASM Item #2018A1 4.B.15)**

The Assembly voted to approve the Revised 2014 Position Statement on *Firearms Access, Acts of Violence and the Relationship to Mental Illness and Mental Health Services*. *As the Board of Trustees approved this position statement at its March 2018 meeting contingent upon the Assembly's approval, this will be forwarded to the Board of Trustees as an information item only.

Attachment #1

Item 2018A1 12.A
Assembly
May 4-6, 2018

ACTION PAPER
FINAL

TITLE: APA Endorsement of AMA Positions Opposing Unsupervised Practice of Non-Physician Practitioners

WHEREAS:
Mid-level practitioners are valuable members of a team-based approach to patients' care.

A psychiatrist has a minimum of eight years of combined medical school and residency training to be educated and trained in providing advanced competent care for psychiatric patients.

Advanced Practice Nurse Practitioners (APRNs) and Physician Assistants (PAs) have 18 months and 2 years of post-baccalaureate education, respectively, without a residency.

In a survey conducted by the Physician Assistant Education Association (PAEA), 86% of physician assistant educators responded that the current PA educational model does not prepare graduates to practice without a supervisory, collaborating, or other specific relationship with a physician *(Physician Assistant Education Association. OTP Task Force. Optimal Team Practice: The Right Prescription for New PA Graduates? May 8, 2017)*.

Advanced Practice Nurse Practitioners (APRNs) and Physician Assistants (PAs) are actively lobbying state legislative bodies for independent practice without physician supervision.

Physician-led team-based care has been at the center of the American Medical Association (AMA) Policy as well as APA Policy (which was part of the reason of the new tagline "Medical Leadership for Mind, Brain and Body").

Supervision of mid-level practitioners strengthens the mental health workforce and has the goal of providing excellence in care to the vulnerable mentally ill community.

The AMA has a policy to support maintaining the authority of medical licensing and regulatory boards to regulate the practice of PAs.

Resolution 214 was recently passed that amended AMA Policy H-35.988 so that the AMA shall 1) Oppose enactment of the Advance Practice Registered Nurse (APRN) Multistate Compact, due to the potential of the APRN Compact to supersede state laws that require APRNs to practice under physician supervision, collaboration, or oversight; 2) A creation of a national strategy to effectively oppose the continual, nationwide efforts to grant independent practice to non-physician practitioners (APRN, PA, Doctor of Medical Science, Advance Practice Respiratory Therapists); 3) Oppose state and national level legislative efforts aimed at inappropriate scope of practice expansion of non-physician healthcare practitioners.

Resolution 229 in the AMA House of Delegates was recently passed that the AMA opposes the holders of the degree of Doctor of Medical Science from being recognized as a new category of health care

practitioners licensed for the independent practice of medicine, and work with interested state medical associations and national medical specialty societies to oppose legislation to create a Doctor of Medical Science license.

Resolution 230 in the AMA House of Delegates passed opposing physician assistant independent practice.

BE IT RESOLVED:
That the American Psychiatric Association endorse the positions (H35.988, H35.989 and H35.962) taken by the American Medical Association as long as they remain positions of the American Medical Association to oppose the practice of non-physician practitioners to practice without physician supervision.

AUTHOR:
Debra Atkisson, M.D., DFAPA, Representative, Texas Society of Psychiatric Physicians
(drdatkisson@aol.com)
Sarit Hovav, M.D., FAPA, Deputy Representative, IMG Psychiatrists
Heather Hauck, M.D., FAPA, Representative, Society of Uniformed Psychiatrists

ESTIMATED COST:
Author: $0
APA: $41,101

ESTIMATED SAVINGS: $0

ESTIMATED REVENUE GENERATED: $0

ENDORSED BY: Area 5 Council, Texas Society of Psychiatric Physicians

KEY WORDS: Patient, Safety, Physician, Supervision, Mid-level Practitioners

APA STRATEGIC PRIORITIES: Advancing Psychiatry, Education

REVIEWED BY RELEVANT APA COMPONENT:

Action Paper Worksheet
2018 Action Paper Budget Estimate

Action Paper Title:	12.A: APA Endorsement of AMA Position Opposing Unsupervised Practice of Non-Physician Practitioners
Action Paper Author(s):	Debra Atkisson, M.D., DFAPA, Representative, Texas Society of Psychiatric Physicians
Phone/email:	drdatkisson@aol.com
APA Admin. Name:	Erin Philp and Deana McRae, Department of Government Relations
Phone/email	(202) 459-9747 / ephilp@psych.org and dmcrae@psych.org

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

Author Estimate:

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

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

APA Administration Estimate:

Travel Budget	No. of Attendees	Airfare	Hotel/Lodging	Ground Transportation	Per Diem/Meals	Total
Meeting 1	2	$850	$650	$200	$296	$1,996
Meeting 2	-	-	-	-	-	-
Total Travel Budget		**850**	**650**	**200**	**296**	**1,996**

Non-Staff Costs:	
LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	**-**
Staff Costs:	
Description:	
1 Year-round lobbying efforts by the DGR State Affairs five-member team	27,650
2 Developing advocacy materials ands resources to disseminate	7,900
3 Staff time preparing and attending national strategy meetings (25 hours partnership activities AND 20 hours monitor AMA policy)	3,555
Total Staff Costs	**39,105**
Other Costs not included above:	
0	-
Total Administration Estimate	**41,101**

Rvsd. Jan. 2018

Action Paper #12.A: *APA Endorsement of AMA Positions Opposing Unsupervised Practice of Non-Physician Practitioners*

APA Administration Feedback:

DEPARTMENT OF GOVERNMENT RELATIONS (DGR) REVIEW:
In reviewing the action paper, the author has asked for the American Psychiatric Association (APA) to endorse the American Medical Association's (AMA) position to oppose the practice of non-physician practitioners to practice without physician supervision. The Department of Government Relations continues to work to address the various legislative battles our DBs/SAs frequently face.

In addition, the author has asked for the APA to work in collaboration with the AMA to create a national strategy to oppose model legislation, and advocacy campaigns, that would allow non-physician practitioners to practice independent of physician supervision. As a founding member of the AMA Scope of Practice Partnership, the APA continues to work with the American Medical Association and other national medical societies to develop resources and direct advocacy efforts to address concerns regarding scope of practice expansion by non-physician providers.

DEPARTMENT OF GOVERNMENT RELATIONS (DGR) EXPLANATION OF COST:
The Department of Government Relations projects that an advocacy campaign based on the premise of the action paper may entail 350 hours of APA Administration lobbying efforts provided during legislative sessions (inclusive of conference calls with membership), 100 hours for research and materials creation and 25 hours of national partnership activity.

APA AMA DELEGATION REVIEW:
Costs associated with this position statement consist of primarily of staff time to coordinate the review of the existing AMA policies on these issues, support APA representatives to AMA strategy meetings and is appropriate support the Assembly taskforce if established.

APA AMA DELEGATION EXPLANATION OF COST:
Ongoing refinement of existing or new AMA policies on this matter would be handled through the APA AMA Delegation as part of the regular policy development process. We estimate 20 hours of staff time to monitor and coordinate responses to policy proposals between APA and AMA's House of Delegates at a cost of $1,580.

Attachment #2
Item 2018A1 12.B
Assembly
May 4-6, 2018

ACTION PAPER
FINAL

TITLE: Psychiatric Care as Medical Care

WHEREAS:
There are several insurers throughout the country who do not consider Mental Health as a Medical benefit, but rather a separate, "mental health benefit" placing it with coverage with non-physicians such as therapists and chiropractors.

When assessing insurance benefits for patients who seem to be in-network for that particular insurer, the insurer will classify the psychiatrist as not being in-network, as the confusion is that there are no medical benefits associated with the physician as they are not considered "medical", but rather "mental health" – which is typically another benefit patients may or may not have.

This confusion causes many patients not to receive the care they need because when trying to seek care from an M.D./D.O. psychiatrist, that psychiatrist is not included in the medical benefits, and therefore treatment may be incorrectly denied.

Psychiatrists are physicians and therefore should not be separated out in a separate plan.

BE IT RESOLVED:
That the Council of Psychiatry and Law draft an appropriate statement in opposition to psychiatry being considered separate from medical benefits, create resource documents, and set further recommendations for APA policy.

AUTHORS:
Sarit Hovav, M.D., FAPA, Deputy Representative, IMG Psychiatrists (drhovav@lifetimeinsight.com)
Debra Atkisson, M.D., DFAPA, Representative, Texas Society of Psychiatric Physicians
Heather Hauck, MD, FAPA, Representative, Society of Uniformed Services Psychiatrists

ESTIMATED COST:
Author: $0
APA: $1,580

ESTIMATED SAVINGS:

ESTIMATED REVENUE GENERATED: $0

ENDORSED BY:

KEY WORDS: policy, insurance, coverage, parity, MHPAEA, discrimination

APA STRATEGIC PRIORITIES: Advancing Psychiatry

REVIEWED BY RELEVANT APA COMPONENT:

Action Paper Worksheet
2018 Action Paper Budget Estimate

Action Paper Title:	12.B: Enforcing Parity Laws with Insurance Companies
Action Paper Author(s):	Sarit Hovav, M.D., FAPA, Deputy Representative, IMG Psychiatrists
Phone/email:	818-331-0233 drhovav@lifetimeinsight.com
APA Admin. Name:	Maureen Bailey, Parity Compliance and Enforcement
Phone/email	mbailey@psych.org

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

Author Estimate:

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

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

APA Administration Estimate:

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

Non-Staff Costs:	
LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	-
Staff Costs:	
Description:	
Summarizing parity education, enforcement and regulation done, to date, on the federal and state level. This will take staff 20 hours of writing and editing time.	
1	1,580
2	-
3	-
Total Staff Costs	**1,580**
Other Costs not included above:	
0	-
Total Administration Estimate	**1,580**

Action Paper # 12.B: *Enforcing Parity Laws with Insurance Companies*

APA Administration Feedback:

PARITY COMPLIANCE AND ENFORCEMENT EXPLANATION OF COST:

Resolution #1 - Considerable work has been done in the areas called for by the Action Paper. Summarizing parity education, enforcement and regulation done, to date, on the federal and state level will require 20 hours of staff writing and editing time.

Resolution #2 - Staff understood this to mean a desire for a APA to create a policy stating that insurance plans use of "carve outs" to process claims is discriminatory and prohibited by MHPAEA. The parity law does not prohibit plans' use of carve outs. Plans can use carve outs to process claims and be in compliance with MHPAEA. Staff followed up with the author. The author will be submitting a rewritten second resolution reflecting her desire that APA pursue federal and state legislation mandating insurers treat psychiatrists as medical doctors, rather than mental health/substance use disorders providers, for purposes of processing claims. Estimated staff time is pending clarification of the intent and requested output of the resolution.

Attachment #3
Item 2018A1 12.C
Assembly
May 4-6, 2018

ACTION PAPER
FINAL

TITLE: Supervision of Psychiatric Mental Health Nurse Practitioners and Physician Assistants in Psychiatry by Psychiatrists

WHEREAS:
Mid-level professionals are valuable members in a physician-led team approach to patient treatment.

Psychiatric Mental Health Nurse Practitioners (PMH-NPs/APRNs/ARNPs) and Physician Assistants (PAs) have 18-36 months post-baccalaureate education before they are allowed to practice. An increasing number of Nurse Practitioner (NP) programs allow no nursing experience prior to matriculation, and some allow 100% online curriculum.

The minimum number of clinical hours required for NPs is 500 for Master's Degree programs and 1000 for a Doctor of Nursing Practice ("DNP"), the equivalent of 10-20 fifty-hour work weeks. Physician Assistant postgraduate fellowships to work in mental health require 2000 hours and a 120-question exam.

There is an emerging doctoral level program for PAs (Doctor of Medical Science, DMS) which is a 9 month to two-year program. There are no requirements for number of observed clinical interviews. There are no additional requirements to practice in a subspecialty compared to 1-2 years of additional fellowship training to sub-specialize for Psychiatrists.

Psychiatrists complete medical school and residency over the course of 8 years at a minimum before they can practice independently. This residency (longer than Family Medicine, Internal Medicine, and Pediatrics) ensures we understand the intricacies of our medically complex patients and special populations.

The relative lack of time and depth of training and demonstration of skill leaves our patients vulnerable.

Professional organizations such as the American Academy of Dermatology have created infographics and easily digested information in efforts to advocate for the profession and educate the public regarding the education disparity.

Every state has its own regulation regarding the extent of physician supervision of PMH-NPs and PAs; although, in some states there is no requirement at all.

In states that require supervision there is substantial variability in the type and degree of supervision.

There is a current move to enact legislation allowing for unsupervised practice of PAs in addition to NPs such as in New Mexico where supervision is only required for the first 3 years of practice.

The Tennessee Medical Association has come out firmly against legislation allowing unsupervised practice of PAs with DMS.

Efforts are underway legislatively to establish independent practice of non-physician clinicians in all states.

Supervision enhances good psychiatric care and the mental health workforce improves.

"The Scope of Practice Partnership (SOPP) is a collaborative effort of the American Medical Association, American Osteopathic Association (AOA), national medical societies, state medical associations, and state osteopathic medical associations that focuses the resources of organized medicine to oppose scope of practice expansions by non-physician providers that threaten the health and safety of patients." *(https://www.ama-assn.org/about/scope-practice)*

The American Psychiatric Association is already part of SOPP and has given a $60,000 grant to Virginia to fight the APRN independent practice effort.

BE IT RESOLVED:

1. That the APA will encourage and support research to determine the efficacy and safety of unsupervised mental health practice by Psychiatric Mental Health Nurse Practitioners and Physician Assistants compared to Psychiatrists.

2. That the APA will develop a position statement in support of appropriate supervision of Psychiatric Mental Health Nurse Practitioners and Physician Assistants in Psychiatry.

3. That because of the various types of doctoral degrees that are available to non-physicians, that the APA advocate that all healthcare professionals wear a designation of their license large enough for all patients to see, i.e., physician, nurse clinician, physician assistant, etc.

4. That the APA will include simplified information for public consumption on the patient and family section of the APA website comparing the education of Psychiatrists and prescribing non-physicians for awareness and educated consumer choice.

AUTHORS:
Sarit Hovav, M.D., FAPA, Deputy Representative, IMG Psychiatrists (drhovav@lifetimeinsight.com)
Debra Atkisson, M.D., DFAPA, Representative, Texas Society of Psychiatric Physicians
Heather Hauck, MD, FAPA, Representative, Society of Uniformed Services Psychiatrists

ESTIMATED COST:
Author: $0
APA: $42,660

ESTIMATED SAVINGS: None

ESTIMATED REVENUE GENERATED: NA

ENDORSED BY: Area 5 Council

KEY WORDS: Patient safety, scope of practice, nurse, assistant, practitioner, midlevel, PA, NP, DNP, MSC, SOPP

APA STRATEGIC PRIORITIES: Advancing Psychiatry, Education

REVIEWED BY RELEVANT APA COMPONENT:

Action Paper Worksheet
2018 Action Paper Budget Estimate

Action Paper Title:	12.C: Supervision of Psychiatric Mental Health Nurse Practitioners and Physician Assistants in Psychiatry by
Action Paper Author(s):	Sarit Hovav, M.D., FAPA, Deputy Representative, IMG Psychiatrists
Phone/email:	818-331-0233 drhovav@lifetimeinsight.com
APA Admin. Name:	Erin Philp and Deana McRae, Department of Government Relations
Phone/email	202-459-9747 / ephilp@psych.org OR 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		-	-	-	-	$0

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

APA Administration Estimate:

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

Non-Staff Costs:	
LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	-
Staff Costs:	
Description:	
1 APA Administration lobbying efforts provided during legislative sessions (inclusive of conference calls with membership)	27,650
2 research and materials creation	11,850
3 national partnership activity	3,160
Total Staff Costs	**42,660**
Other Costs not included above:	
0	-
Total Administration Estimate	**42,660**

Rvsd. Jan. 2018

Action Paper 12.C: *Supervision of Psychiatric Mental Health Nurse Practitioners and Physician Assistants in Psychiatry by Psychiatrists*

APA Administration Feedback:

DEPARTMENT OF GOVERNMENT RELATIONS (DGR) & POLICY, PROGRAMS, & PARTNERSHIPS (PPP) REVIEW:
In reviewing the action paper, the author has asked for the American Psychiatric Association (APA) to develop a position statement in support of physician supervision of psychiatric mental health nurse practitioners and physician assistants in psychiatry. The Department of Government Relations will continue to work to address the various legislative battles our DBs/SAs frequently face. The Division of Policy will provide subject matter expertise in assisting the lobbying efforts.

In addition, the author has asked for the APA to advocate, on the federal level, that all healthcare professionals clearly and accurately state their level of training, education and licensing. The Department continues to work with other national medical societies/associations to ensure patients are knowledgeable and aware of the education and training of the health care provider to whom is delivering care.

The author has additionally asked for the APA to publish an education comparison chart of mental health practitioners, informing the public and policymakers to the varying differences in training. In 2015, APA developed a toolkit for the purpose of educating the public on matters related to expanding scope of practice. Educational resources will be created by the Department, in collaboration with DBs/SAs, for both public consumption and policymakers as they make decisions relating to the expansion of scope of practice.

DEPARTMENT OF GOVERNMENT RELATIONS (DGR) and POLICY, PROGRAMS, & PARTNERSHIPS (PPP) EXPLANATION OF COST:
The Department of Government Relations and the Division of PPP projects that an advocacy campaign based on the premise of the action paper may entail 350 hours of APA Administration lobbying efforts provided during legislative sessions (inclusive of conference calls with membership), 150 hours for research and materials creation and 40 hours of national partnership activity.

Attachment #4
Item 2018A1 12.D
Assembly
May 4-6, 2018

ACTION PAPER
FINAL

TITLE: Requesting CMS Help Us Improve Addiction Treatment Process

WHEREAS:
1. CMS and other payors encourage us to be as specific as possible when coding a diagnosis.

2. ICD-10-CM lists 56 separate diagnostic codes for opioid use disorders but the Local Coverage Determination (LCD): Controlled Substance Monitoring and Drugs of Abuse Testing (L36029) lists just 15 codes as allowed for payment. This leaves 41 legitimate billing codes for opioid use disorders for which drug screens on urine are not being reimbursed.

3. Thousands of people are dying from the epidemic of opiate dependence and other substance use disorders across all age spans and the government states it is behind addressing this loss of life with treatment, designating it the opiate crisis.

4. For many of the other abused drugs the situation is even worse. For example, the codes for cannabis abuse, cocaine abuse, and other stimulant use are only covered when in remission, not the codes for active abuse.

5. The ability to perform random drug screens is routinely used in most chemical dependency treatment programs, and specifically those using Medication Assisted Treatment. Because certain codes are not allowed, the drug screens done in the course of treatment are not being covered. Many labs are restricted from billing the agency or patient for codes that are denied, thus placing the treatment programs at risk of not being able to find a lab willing to perform their drug screens if too many samples are being rejected for payment.

BE IT RESOLVED:
The APA advocate with CMS to cover for the purposes of billing for urine drug screens all diagnostic codes that are part of the Substance Use Disorders section of ICD.10.

AUTHOR:
Eileen McGee, M.D., Representative, Ohio Psychiatric Physicians Association

ESTIMATED COST:
Author: $564
APA: $7,110

ESTIMATED SAVINGS: 0

ESTIMATED REVENUE GENERATED: 0

ENDORSED BY:

KEY WORDS: Opiate treatment, Drug Screens, Billing Codes

APA STRATEGIC PRIORITIES: Advancing Psychiatry

REVIEWED BY RELEVANT APA COMPONENT: Submitted for review to the Council of Healthcare Systems and Financing

References:
2018 ICD-10-CM Codes for Opioid Related Disorders
Local Coverage Determination (LCD): Controlled Substance Monitoring and Drugs of Abuse Testing (L36029) Revision Effective Date for services performed after 10/01/2017

Action Paper Worksheet
2018 Action Paper Budget Estimate

Action Paper Title:	12.D: Requesting CMS Help Us Improve Addiction Treatment Process
Action Paper Author(s):	Eileen McGee, M.D., Representative, Ohio Psychiatric Physicians Association
Phone/email:	440-478-4934/eileen@themcgees.net
APA Admin. Name:	Kathy Orellana, Department of Practice Management and Delivery Systems Policy
Phone/email	korellana@psych.org

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

Author Estimate:

Travel Budget:	No. of Attendees	Airfare	Hotel/Lodging	Ground Transportation	Per Diem/Meals	Total
Meeting 1	2	$0	$0	$100	$148	$248
Meeting 2	-	-	-	-	-	-
Total Travel Budget		-	-	100	148	$248

Non-Staff Costs:	
LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	**-**
Staff Costs:	
Description:	
1 Attend meeting with CMS to advocate for this position	316
2	-
3	-
Total Staff Costs	316
Other Costs not included above:	
none	-
Total Author Estimate	**564**

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 Research and engagement with CMS staff	4,740
2 Lobbying and partner engagement	2,370
3	-
Total Staff Costs	**7,110**
Other Costs not included above:	
0	-
Total Administration Estimate	**7,110**

Rvsd. Jan. 2018

Action Paper 12.D: *Requesting CMS Help Us Improve Addiction Treatment Process*

APA Administration Feedback:

COUNCIL ON ADDICTION PSYCHIATRY:
Council members were largely in favor of resolving this issue.

DEPARTMENT OF PRACTICE MANAGEMENT AND DELIVERY SYSTEMS POLICY: Staff would need to research the underlying issues of the 41 billing codes that are not currently being reimbursed before reaching out to CMS. Staff anticipate the need for 1-2 calls and potentially an in-person meeting with CMS staff.

DEPARTMENT OF GOVERNMENT RELATIONS: In reviewing the action paper, the author has asked APA to advocate with CMS. The Department of Government Relations would work with the Department on Practice Management and Delivery Systems Policy to directly engage the US Dept. of Health and Human Services and the members of the Administration for reimbursement of urine drug screens.

EXPLANATION OF COST:
DEPARTMENT OF PRACTICE MANAGEMENT AND DELIVERY SYSTEMS POLICY: Staff estimates that to execute the above approach, it will take a minimum of 60 hours of staff time to research the billing code issues and outreach to CMS.

DEPARTMENT OF GOVERNMENT RELATIONS: Staff estimates an advocacy campaign based on the premise of the action paper would entail 20 hours of APA Administration lobbying efforts and 10 hours for national partnership activity.

Attachment #5

Item 2018A1 12.E
Assembly
May 4-6, 2018

ACTION PAPER
FINAL

TITLE: Position Statement on Psychologists Prescribing

WHEREAS:
Whereas: Heath care policies should be protective of public safety, and

Whereas: the safe practice of medicine requires competencies in physiology in health and disease, as well as basic and advanced pharmacology, taught by instructors competent in medicine and in specialty practice consistent with standards adopted by qualified medical training organizations, and

Whereas: the requirements for clinical training at the doctorate level in psychology do not include basic and advanced training in physiology or pharmacology, and

Whereas: for over 25 years there have been efforts to legislate prescribing privileges that circumvent such educational standards thereby placing the public safety at risk, and

Whereas: there is evidence in the public record, including newspapers articles and lawsuits alleging harm from prescriptions from prescribing psychologists, and

Whereas: position statements are important in the advocacy efforts of the APA, and

Whereas: the American Academy of Child and Adolescent Psychiatry adopted a policy statement opposing prescribing privileges for professionals who do not possess adequate training in September 2017, and

Whereas: advocating for safe policies regarding medication treatment is a high priority for many if not most APA members, and

Whereas: the APA has the opportunity to stand with our colleagues in the AACAP to advocate for safe health policy, informed by educators, therefore

BE IT RESOLVED:
The American Psychiatric Association join with the American Academy of Child and Adolescent Psychiatry and the American Medical Association opposing any legislation or regulation at the state or federal level that would grant psychologists prescribing privileges. We oppose psychologists prescribing medication because training in psychology does not provide medical education that is essential for the appropriate and safe prescription of medications.

AUTHORS:
Craig Zarling, M.D., Area 7 Representative
Mark Haygood, D.O., ECP Representative, Area 5

ESTIMATED COST:
Author: $425
APA: $790

ESTIMATED REVENUE GENERATED:

ESTIMATED SAVINGS:

ENDORSED BY:

KEY WORDS: Policy, Prescribing, Education

APA STRATEGIC PRIORITIES: Supporting Psychiatry

REVIEWED BY RELEVANT APA COMPONENT: Council on Advocacy and Government Relations
Statements of support-8members

“don’t need a position statement to track outcomes”

“Support. Need to be aware of Noerr-Pennington antitrust protection-the AACAP statement was developed with that in mind, hence it focusses on opposition to legislation”

“add statistics on bad outcomes”

“consider adding statement that prescribing psychologists would not be helpful in increasing access”

“has there been a push by APA to research outcomes in states where there are prescribing psychologists? Consider adding a statement on outcomes research”

Action Paper Worksheet
2018 Action Paper Budget Estimate

Action Paper Title:	12.E: Adoption of the American Academy of Child and Adolescent Psychiatry's Policy Statement
Action Paper Author(s):	Craig Zarling, M.D., Area 7 Representative
Phone/email:	craig.zarling@comcast.net
APA Admin. Name:	Ashley Mild, Department of Government Relations
Phone/email	202-459-9747 / amild@psych.org

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

Author Estimate:

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

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

Staff Costs:

	Description:	
1	Staff will need to organize and distribute informational materials for the Assembly and other decision making groups	158
2	Staff will need to support communication in meetings where paper is discussed	158
3	Staff will need to input statement into APA database	79
Total Staff Costs		395

Other Costs not included above:	
printing of copies of action paper	30
Total Author Estimate	**425**

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	research and materials creation	790
2		-
3		-
Total Staff Costs		**790**

Other Costs not included above:	
0	
	-
Total Administration Estimate	**790**

Rvsd. Jan. 2018

Action Paper 12.E: *Adoption of the American Academy of Child and Adolescent Psychiatry's Policy Statement on Psychologist Prescribing*

APA Administration Feedback:

DEPARTMENT OF GOVERNMENT RELATIONS (DGR) & POLICY, PROGRAMS, & PARTNERSHIPS (PPP) REVIEW:
In reviewing the action paper, the author has asked for the Assembly to adopt the American Academy of Child and Adolescent Psychiatry's policy statement in opposition to psychologists prescribing. If the Assembly elects to approve the adoption of the AACAP's policy statement, the Department will continue its work with DBs/SAs in opposing expansion of scope of practice for psychologists. In addition, the Department will utilize the position to develop and disseminate resource materials as a means of informing policymakers of the Association's policy concerning non-physician providers practicing out of their scope of practice.

DEPARTMENT OF GOVERNMENT RELATIONS (DGR) and POLICY, PROGRAMS, & PARTNERSHIPS (PPP) EXPLANATION OF COST:
To support the action paper ask, the APA Administration projects staff time may entail 10 hours for research and resources.

Attachment #6

Item 2018A1 12.F
Assembly
May 4-6, 2018

ACTION PAPER
FINAL

TITLE: Medication Assisted Treatment of Physicians in Treatment Participating in Physician Health Programs

WHEREAS:

1. Physicians seeking treatment for substance use disorders generally do so under the auspices of physician health programs, which help advocate that they maintain their medical license.
2. Many physician health programs are concerned about the use of medication to maintain sobriety, in particular agonist therapy for opioid use disorder, such as methadone and buprenorphine, and forbid the use of some agents.
3. Medication assisted treatment often provides the best hope for achieving and maintaining recovery.
4. Physicians under supervision of the health programs may be required to forgo some of the most effective treatments for substance use disorders.
5. It is unclear that the use of medication assisted treatment poses a threat to the public such that it should be forbidden by physician health programs.

BE IT RESOLVED:
That our American Psychiatric Association review available evidence on the use of medication assisted treatment by physicians in recovery with substance use disorders, and

Based on the results of a review of available evidence, that the American Psychiatric Association develops a position statement on the use of medication assisted treatment by physicians under the supervision of physician health programs.

That our APA work with the AMA and other appropriate entities to ensure that physicians seeking treatment of substance use disorders through Physician Health programs are afforded evidence-based Medication-Assisted Treatment (MAT).

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

SPONSOR:
Mary Anne Albaugh, M.D., Representative, Pennsylvania Psychiatric Society

ESTIMATED COST:
Author: $1,580
APA: $1,185

ESTIMATED SAVINGS:

ESTIMATED REVENUE GENERATED:

ENDORSED BY:

KEY WORDS: Medication assisted treatment, substance use disorders, physician health plans

APA STRATEGIC PRIORITIES: Advancing Psychiatry, Diversity

REVIEWED BY RELEVANT APA COMPONENT:

Action Paper Worksheet
2018 Action Paper Budget Estimate

Action Paper Title:	12.F: Medication Assisted Treatment and Physician Health Plans
Action Paper Author(s):	Kenneth M. Certa, M.D., Representative, Pennsylvania Psychiatric Society
Phone/email:	215-955-6655/kenneth.certa@jefferson.edu
APA Admin. Name:	Michelle Dirst, Department of Practice Management and Delivery Systems Policy
Phone/email	mdirst@psych.org/ Tel: 202.559.3716

Attendance Summary:	**Author**	**APA Administration**
Number of Component Members	10	2
Number of Staff	2	-
Number of Non-Staff	-	-
Total	**12**	**2**

Author Estimate:

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

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

Staff Costs:

	Description:	
1	The major work for this action paper will be a review of the policies of the physician health plans concerning the use of medication assisted treatment.	790
2	Finding evidence to support policies may be difficult; it may be necessary to look to other profession, such as pilots or commercial drivers.	790
3	This specific work is part of a larger initiative on physician wellness.	-
Total Staff Costs		1,580

Other Costs not included above:	
This is a small but important part of the physician wellness initiative.	-
Total Author Estimate	**1,580**

APA Administration Estimate:

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

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

Staff Costs:

	Description:	
1	Staff would work with the Council to update the position statement and move it through the approval process.	1,185
2		-
3		-
Total Staff Costs		**1,185**

Other Costs not included above:	
0	
	-
Total Administration Estimate	**1,185**

Rvsd. Jan. 2018

Action Paper 12.F: *Medication Assisted Treatment and Physician Health Plans*

APA Administration Feedback:

DEPARTMENT OF PRACTICE MANAGEMENT AND DELIVERY SYSTEMS POLICY:

The Council on Addiction Psychiatry is in the process of developing a position statement on Physician Health Plans. Included is a recommendation to make evidence-based treatment for substance use disorders available. At one point the statement specifically mentioned MAT but it was taken out to shorten the paper. However, it could be added back in. Given the work we have done in training for MAT, we have information available about the effectiveness of MAT.

The position statement could be amended to specifically mention medication assisted treatment and their effectiveness.

EXPLANATION OF COST:
Staff time would be 3-4 hours to work with the Council to update the statement and move it through the approval process.

Attachment #7
Item 2018A1 12.H
Assembly
May 4-6, 2018

ACTION PAPER
FINAL

TITLE: Researching a Single Payer Nationwide Health Care System

WHEREAS:

1. Whereas 50% of every healthcare dollar goes to administrative costs rather than to patient care.
2. Whereas Millions of Americans are uninsured or under insured in the current health care system in the United States.
3. Whereas health care costs are escalating at an unsustainable pace
4. Whereas many Americans do not have free choice of clinician or hospital for their medical care
5. Whereas psychiatric patients are routinely denied access to medications and therapies they urgently require
6. Whereas the Single-Payer Nation Wide Health Care System herein proposed would allow individual physicians to "opt out" of the system and contract directly with patients.
7. Whereas a Single-Payer Nation Wide Health Care System would provide coverage to millions who are uninsured and upgrade coverage for millions more and would pay for itself by eliminating administrative overhead.
8. Whereas, under this system every resident of the United States would be covered for all necessary medical care at any hospital or doctor's office that had not chosen to opt out of the system; coverage would include outpatient and inpatient medical care, rehabilitation, mental health care, long-term care, dental services, and prescription medications; and all premiums, co-pays, deductibles, and co-insurance would be eliminated.
9. Whereas, The Health Care System would be federally funded resulting in an overall drop in administrative costs by 15% compared to our current system of care, freeing up 500 million dollars annually for expanded and improved coverage.
10. Whereas, the increase in government costs and modest increase in taxes would be fully offset by savings in premiums and out of pocket expenses.
11. Whereas, these savings would finance health care for all
12. Whereas, health care for all would be facilitated by placing hospitals and health facilities on an annual budget set by the Federal government
13. Whereas physicians who do not opt out would be paid on a simple fee schedule or by salary depending on practice location.
14. Whereas, medications would be purchased wholesale directly from the pharmaceutical companies, and
15. Whereas, this would provide a system of health care equivalent to Medicare for all.
16. Whereas, supports for a single payer health care system is building in Congress, as indicated by the "Expanded and Improved Medicare for All Act" (H.R. 676) which now has 120 co-sponsors, (https://www.congress.gov/bill/115th-congress/house-bill/676?q=%7B%22search%22%3A%5B%22congressId%3A115+AND+billStatus%3A%5C%22Introduced%5C%22%22%5D%7D&r=26)
17. Whereas, the APA Board of Trustees have ratified on December 10, 2017 that Healthcare, Including Mental Healthcare, Is a Human Right

BE IT RESOLVED:
That the APA, through its Council on Healthcare Systems and Financing, conduct a study and evaluate Single Payer Health Plans compared with the other Health Care Delivery models which could provide universal access to health care, inclusive of mental health care, in the United States.

AUTHORS:
Joseph Mawhinney, M.D., Representative, Area 6 (drmawhinney@sbcglobal.net)
David Fogelson, M.D., Representative, Southern California Psychiatric Society
Leslie Gise, M.D., Representative, Hawaii Psychiatric Medical Association
James Fleming, M.D., Representative, Missouri Psychiatric Physicians Association

SPONSOR:
Robin Cooper, M.D., APA Member

ESTIMATED COST:
Author: $4,673
APA: $15,800

ESTIMATED SAVINGS: None

ESTIMATED REVENUE GENERATED: None

ENDORSED BY: Assembly Committee on Access to Care, Missouri Psychiatric Physicians Association

KEY WORDS: Access to Care; Single Payer System

APA STRATEGIC PRIORITIES: Advancing Psychiatry, Diversity

REVIEWED BY RELEVANT APA COMPONENT: Submitted for review to Council on Healthcare Systems and Financing, and the Council on Advocacy and Government Relations.

REFERENCES
1. Himmelstein DU, Woolhandler S. Cost without benefit: administrative waste in U.S. health care. N Engl J Med 1986; 314:441-5.
2. Iglehart JK. Canada's health care system. N Engl J Med 1986; 315.202-8, 778-84.
3. Detsky AS, Stacey SR, Bombardier C. The effectiveness of a regulatory strategy in containing hospital costs: The Ontario experience. 1967-1981. N Engl J Med 1983; 309:151-9.
4. Home JM, Beck RG. Further evidence on public versus private administration of health insurance. J Public Health Policy 1981; 2-274-90.
5. Himmelstein DU, Woolhandler S. Free care: a quantitative analysis of the health and cost effects of a national health program. Int J Health Serv 1988; 18:393-9.

Action Paper Worksheet
2018 Action Paper Budget Estimate

Action Paper Title: 12.H: Towards a Single Payer Nationwide Health Care System
Action Paper Author(s): Joseph Mawhinney, M.D., Representative, Area 6
Phone/email: 858-583-1572/drmawhinney@sbcglobal.net
APA Admin. Name: Kathy Orellana, Department of Practice Management and Delivery Systems Policy
Phone/email korellana@psych.org

Attendance Summary:	**Author**	**APA Administration**
Number of Component Members	10	-
Number of Staff	2	-
Number of Non-Staff	2	-
Total	14	-

Author Estimate:

Travel Budget:	No. of Attendees	Airfare	Hotel/Lodging	Ground Transportation	Per Diem/Meals	Total
Meeting 1	12	$1,700	$1,300	$200	$296	$3,496
Meeting 2	-	-	-	-	-	-
Total Travel Budget		1,700	1,300	200	296	$3,496

Non-Staff Costs:	
LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	-
Staff Costs:	
Description:	
1 COORDINATE MEETINGS AND CONFERENCE CALLS	395
2 ASSIST IN THE STUDY AND DOCUMENTATION OF FINDING	632
3 -	-
Total Staff Costs	1,027
Other Costs not included above:	
CONFERENCE CALLS(3); (ALSO NOTE THAT 2 CONSULTANTS ARE INCLUDED IN AIRFARE, HOTEL AND MEAL COSTS)	150
Total Author Estimate	4,673

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 Research and evaluation	9,480
2 Research for meetings and partner engagement	6,320
3 -	-
Total Staff Costs	15,800
Other Costs not included above:	
0	-
Total Administration Estimate	15,800

Rvsd. Jan. 2018

Action Paper 12.H: *Towards a Single Payer Nationwide Health Care System*

APA Administration Feedback:

DEPARTMENT OF PRACTICE MANAGEMENT AND DELIVERY SYSTEMS POLICY:
As the Council on Healthcare Systems and Financing has pointed out, there have been several proposals put forth on how to achieve a single payer system, meaning this evaluation may take considerable staff time to research. Staff would also need to work Council members to determine the metrics to compare all health care delivery models on and to set guidelines for the implication on access to mental health and substance use disorder coverage and treatment.

DEPARTMENT OF GOVERNMENT RELATIONS:
In reviewing the action paper, the author has not identified a specific ask of the Department of Government Relations. It is presumed, in order to conduct a thorough study and evaluation of a single payer health plan, the Department would review current single payer legislation in Congress and canvass the position of stakeholders, including other national medical societies.

EXPLANATION OF COST:
DEPARTMENT OF PRACTICE MANAGEMENT AND DELIVERY SYSTEMS POLICY:
Staff estimates that to execute the evaluation it will take a minimum of 120 hours of staff time.

DEPARTMENT OF GOVERNMENT RELATIONS:
Staff estimates staff time based on the premise of the action paper would entail 60 hours for research and meetings, and 20 hours for national partnership activity.

Attachment #8
Item 2018A1 12.I
Assembly
May 4-6, 2018

ACTION PAPER
FINAL

TITLE: Improving Identification and Treatment of Borderline Personality Disorder

WHEREAS:
Borderline personality disorder is present in approximately 10% of psychiatric outpatients [1] and 20% of psychiatric inpatients [2].

In non-psychiatric settings, the disorder is present in 6% of primary care patients [3].

Borderline personality disorder is associated with high humanitarian [4, 5, 6, 7] and economic costs on par with that of psychotic disorders [8].

Borderline personality disorder is a potentially lethal condition and carries a lifetime risk of suicide of 5-10% [7].

Devastating in its own right, the disorder also has a negative prognostic effect on the course of other mental health conditions, increasing treatment resistance in major depressive disorder, generalized anxiety disorder, social anxiety disorder, and posttraumatic stress disorder [9, 10].

Patients affected by the disorder are routinely underdiagnosed [11] or misdiagnosed [12], which precludes referral to appropriate evidence-based treatments.

The mainstay of treatment is psychotherapy.

There are several common factor approaches that do not require intensive training in order to successfully treat patients living with this disorder [13].

Psychiatry residency programs currently teach about borderline personality disorder, while adding new burdens to a busy residency curriculum is unfeasible.

Psychiatry residencies can use the limited time available to teach a common factor approach and address issues related to misdiagnosis, underdiagnosis, lethality, and adverse impact on the course of other psychiatric conditions.

BE IT RESOLVED:
That the APA's Division of Education create a Supplemental Education and Training (SET) learning module on common factor treatment approaches for BPD.

AUTHORS:
Andres Abreu, M.D., Representative, Maine Association of Psychiatric Physicians
Sarah Fineberg, M.D., Ph.D., APA Member
Annya Tisher, M.D., Representative, Maine Association of Psychiatric Physicians
Eric Plakun, M.D., Representative, American Academy of Psychodynamic Psychiatry and Psychoanalysis

ESTIMATED COST:
Author: $9,412
APA: $12,572

ESTIMATED SAVINGS:

ESTIMATED REVENUE GENERATED:

ENDORSED BY:

KEY WORDS: Residency training

APA STRATEGIC PRIORITIES: Advancing Psychiatry, Education

REVIEWED BY RELEVANT APA COMPONENT:
Council on Medical Education and Lifelong Learning:
Thanks for sending us the action you are working on and giving us an opportunity to provide informal feedback. Should this become an action assigned to the Council the full Council would weigh in and bring additional points of view.

We have a few considerations that come to mind:

- Our Council might note that the trend at the RC is to reduce program specific requirements and to focus on common program requirements (across all specialties). If APA were to advocate for a specific training requirement, it's worth noting that the next window for Psychiatry program requirement revision is in 5 years.
- From the budget, it looks like you are suggesting a meeting of 13 persons (8 travelers). It's not clear to me who would be meeting; would that be the experts in the common factor approach getting together to draft the specifics of what would be taught? Can this work be accomplished within an existing APA component via a workgroup without incurring travel costs?

FYI: here is a link to the current ACGME psychiatry requirements:https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/400_psychiatry_2017-07-01.pdf

REFERENCES:

1. Zimmerman M, Rothschild L, Chelminski I. The prevalence of DSM-IV personality disorders in psychiatric outpatients. Am J Psychiatry 2005; 162:1911.

2. Zimmerman M, Chelminski I, Young D. The frequency of personality disorders in psychiatric patients. Psychiatr Clin North Am 2008; Sep;31(3):405-20.

3. Dubovsky AN, Keifer MM. Borderline personality disorder in the primary care setting. Med Clin North Am. 2014 2014; Sep;98(5):1049-64.

4. IsHak WW, Elbau I, Ismail A, et al. Quality of life in borderline personality disorder. Harv Rev Psychiatry 2013; May-Jun; 21(3):138-50.

5. McGlashan TH, Grilo CM, Sanislow CA, et al. Two-year prevalence and stability of individual DSM-IV criteria for schizotypal, borderline, avoidant, and obsessive-compulsive personality disorders: toward a hybrid model of axis II disorders. Am J Psychiatry 2005; 162:883.

6. Paris J. Implications of long-term outcome research for the management of patients with borderline personality disorder. Harv Rev Psychiatry 2002; 10:315.

7. Widiger TA, Weissman MM. Epidemiology of borderline personality disorder. Hosp Community Psychiatry 1991; Oct;42(10):1015-21.

8. Laurenssen EMP, Eeren HV, Kikkert MJ, et al. The burden of disease in patients eligible for mentalization-based treatment (MBT): quality of life and costs. Health Qual Life Outcomes 2016; 14:145.

9. Skodol AE, Grilo CM, Keyes KM, et al. Relationship of personality disorders to the course of major depressive disorder in a nationally representative sample. Am J Psychiatry 2011 Mar; 168(3):257-264.

10. Keuroghlian AS, Gunderson JG, Pagano ME, et al. Interactions of borderline personality disorder and anxiety disorders over 10 years. J Clin Psychiatry 2015 Nov; 76(11):1529-34.

11. Zimmerman M, Mattia JI: Differences between clinical and research practices in diagnosing borderline personality disorder. Am J Psychiatry 1999; 156:1570–1574.

12. Zimmerman M, Ruggero CJ, Chelminski I, et al: Psychiatric diagnoses in patients previously overdiagnosed with bipolar disorder. J Clin Psychiatry 2010; 71:26–31.

13. Sledge W, Plakun EM, Bauer S, et al: Psychotherapy for suicidal patients with borderline personality disorder: an expert consensus review of common factors across five therapies. Borderline Personal Disord Emot Dysregul 2014 Nov; 11;1:16.

Action Paper Worksheet
2018 Action Paper Budget Estimate

Action Paper Title:	12.I: Improving Identification and Treatment of Borderline Personality Disorder
Action Paper Author(s):	Andres Abreu, M.D., Representative, Maine Association of Psychiatric Physicians
Phone/email:	608-239-6964 / abreu.andres@gmail.com
APA Admin. Name:	Kristen Moeller and Tristan Gorrindo, M.D., Division of Education
Phone/email	kmoeller@psych.org 202- 559-3897 tgorrindo@psych.org

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

Author Estimate:

Travel Budget:	No. of Attendees	Airfare	Hotel/Lodging	Ground Transportation	Per Diem/Meals	Total
Meeting 1	13	$3,400	$3,250	$650	$962	$8,262
Meeting 2	-	-	-	-	-	-
Total Travel Budget		3,400	3,250	650	962	$8,262

Non-Staff Costs:	
LCD Projector	-
Laptop	300
Screen	-
Flipchart	75
Microphones	380
Total Non-Staff Costs:	**755**
Staff Costs:	
Description:	
1 Coordination of components staff involving email and telephone conference; printing and mailing of letter	395
2	- -
3	- -
Total Staff Costs	395
Other Costs not included above:	
0	-
Total Author Estimate	**9,412**

APA Administration Estimate:

Travel Budget	No. of Attendees	Airfare	Hotel/Lodging	Ground Transportation	Per Diem/Meals	Total
Meeting 1	13	$3,400	$3,250	$650	$962	$8,262
Meeting 2	-	-	-	-	-	-
Total Travel Budget		**3,400**	**3,250**	**650**	**962**	**8,262**

Non-Staff Costs:	
LCD Projector	-
Laptop	300
Screen	-
Flipchart	75
Microphones	380
Total Non-Staff Costs:	**755**
Staff Costs:	
Description:	
1 Coordination of components staff involving email and telephone conference; printing and mailing of letter	395
2 Above referenced meeting cites attendance of 3 staff	1,896
3 additional 16 hours of staff time is estimated for planning and coordination of an in person meeting as described in the author's budget	1,264
Total Staff Costs	**3,555**
Other Costs not included above:	
0	-
Total Administration Estimate	**12,572**

Rvsd. Jan. 2018

Action Paper 12.I: *Improving Identification and Treatment of Borderline Personality Disorder*

APA Administration Feedback:

DIVISION OF EDUCATION EXPLANATION OF COST:

These preliminary comments were provided to the author on March 9.

Thanks for sending us the action you are working on and giving us an opportunity to provide informal feedback. Should this become an action assigned to the Council the full Council would weigh in and bring additional points of view.

a few considerations that come to mind:

- Our Council might note that the trend at the RC is to reduce program specific requirements and to focus on common program requirements (across all specialties). If APA were to advocate for a specific training requirement, it's worth noting that the next window for Psychiatry program requirement revision is in 5 years.
- The authors budget suggests a meeting of 13 persons (8 travelers). It's not clear who would be meeting; would that be the experts in the common factor approach getting together to draft the specifics of what would be taught? Can this work be accomplished within an existing APA component via a workgroup without incurring travel costs?
- here is a link to the current ACGME psychiatry requirements: https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/400_psychiatry_2017-07-01.pdf

Regarding the budget:

1. Could the work be accomplished without incurring travel costs?
2. APA added cost of 3 staff attending a one-day meeting as per the budget provided by the author and staff time for coordination of the meeting.

Attachment #9
Item 2018A1 12.J
Assembly
May 4-6, 2018

ACTION PAPER
FINAL

TITLE: Improving Access to the ABPN Examinations

WHEREAS:
Whereas: Maintenance of Certification through ABPN currently includes a requirement to pass an examination every ten years (the high stakes examination);

Whereas: The re-certification examination is offered at specific testing sites throughout the United States during two five-day periods annually;

Whereas: Psychiatrists have professional and personal commitments that may compete with these extremely limited testing dates, e.g., taking the stand as an expert witness at trial, a family member hospitalized, etc.

Whereas: The ABPN has the resources to establish an adequate pool of questions for additional testing dates and the testing sites are highly secure;

Whereas: The APA is working with ABPN to improve the process of Maintenance of Certification;

BE IT RESOLVED:
The APA lobby the ABPN to offer a minimum of four five-day examination periods through the year.

AUTHOR:
Debra M. Barnett, M.D., Representative, Florida Psychiatric Society (drdebb1@verizon.net)

ESTIMATED COST:
Author: $0
APA: $632

ESTIMATED SAVINGS:

ESTIMATED REVENUE GENERATED:

ENDORSED BY: Area 5 Council, Florida Psychiatric Society, Greater Tampa Bay Psychiatric Society

KEY WORDS: ABPN examinations, Maintenance of Certification

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

REVIEWED BY RELEVANT APA COMPONENT:

Action Paper Worksheet
2018 Action Paper Budget Estimate

Action Paper Title:	12.J: Improving Access to the ABPN Examinations
Action Paper Author(s):	Debra M. Barnett, M.D., Representative, Florida Psychiatric Society
Phone/email:	drdebb1@verizon.net
APA Admin. Name:	Kristen Moeller and Tristan Gorrindo, M.D., Division of Education
Phone/email	kmoeller@psych.org 202-559-3897 tgorrindo@psych.org

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

Author Estimate:

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

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

Staff Costs:

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

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

APA Administration Estimate:

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

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

Staff Costs:

	Description:		
1	Staff time - coordination of the effort to lobby ABPN for improved access to ABPN examinations		632
2		-	-
3		-	-
Total Staff Costs			**632**

Other Costs not included above:	
0	-
Total Administration Estimate	**632**

Rvsd. Jan. 2018

Action Paper 12.J: *Improving Access to the ABPN Examinations*

APA Administration Feedback:

DIVISION OF EDUCATION EXPLANATION OF COST: The author had no cost estimate. APA administration estimated the paper would require 8 staff hours to coordinate/lobby the ABPN for improved access to ABPN examinations

Attachment #10
Item 2018A1 12.K
Assembly
May 4-6, 2018

ACTION PAPER
FINAL

TITLE: Service Members and Their Families Deserve Quality Psychiatric Treatment

WHEREAS:
Whereas: TriCare is the third-party payer for healthcare for service members, retirees and their family members;

Whereas: The formulary for TriCare only includes the long-acting injectables Haloperidol and Fluphenazine Decanoate;

Whereas: Psychiatric patients may require an atypical antipsychotic for their long-acting injectable because a conventional (first generation) antipsychotic is either not recommended or is actually contra-indicated.

BE IT RESOLVED:
The APA make an appeal to TriCare for formulary coverage that includes an appropriate balance of conventional and atypical long-acting injectable antipsychotic medications.

AUTHOR:
Debra M. Barnett, M.D., Representative, Florida Psychiatric Society (drdebb1@verizon.net)

ESTIMATED COST:
Author: Unknown
APA: $5,135

ESTIMATED SAVINGS:

ESTIMATED REVENUE GENERATED:

ENDORSED BY: Area 5 Council, Florida Psychiatric Society, Greater Tampa Bay Psychiatric Society

KEY WORDS: Service Members, TriCare, antipsychotic medications

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

REVIEWED BY RELEVANT APA COMPONENT:

Action Paper Worksheet
2018 Action Paper Budget Estimate

Action Paper Title:	12.K: Veterans and Their Families Deserve Quality Psychiatric Treatment
Action Paper Author(s):	Debra M. Barnett, M.D., Representative, Florida Psychiatric Society
Phone/email:	drdebb1@verizon.net
APA Admin. Name:	Ashley Mild, Department of Government Relations
Phone/email	202-459-9747 / amild@psych.org

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

Author Estimate:

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

Non-Staff Costs:	
LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	-
Staff Costs:	
Description:	
1 The required number of staff and meetings is currently unknown	-
2	-
3	-
Total Staff Costs	-
Other Costs not included above:	
Unknown	-
Total Author Estimate	Unknown -

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 research current coverage, outcome data associated, and the barriers to coverage	3,950
2 development of resource materials	790
3 national partnership activity	395
Total Staff Costs	**5,135**
Other Costs not included above:	
0	-
Total Administration Estimate	**5,135**

Rvsd. Jan. 2018

Action Paper 12.K: *Veterans and Their Families Deserve Quality Psychiatric Treatment*

APA Administration Feedback:

DEPARTMENT OF PRACTICE MANAGEMENT & DELIVERY SYSTEMS POLICY / DEPARTMENT OF GOVERNMENT RELATIONS REVIEW:

In reviewing the action paper, the author has asked APA to appeal to TRICARE concerning formulary coverage. Each quarter, the TRICARE formulary is reviewed and updated to reflect a uniform pharmacy formulary. The American Psychiatric Association would direct advocacy efforts to the Department of Defense Pharmacy and Therapeutics Committee, submitting a request for coverage of conventional and atypical long-acting injectable antipsychotic medications.

DEPARTMENT OF PRACTICE MANAGEMENT & DELIVERY SYSTEMS POLICY / DEPARTMENT OF GOVERNMENT RELATIONS EXPLANATION OF COST:

The Department of Government Relations estimates staff time based on the premise of the action paper may entail 50 hours to research current coverage, outcome data associated, and the barriers to coverage; 10 hours for the development of resource materials (including correspondence and key points for APA membership); and 5 hours of national partnership activity.

Attachment #11
Item 2018A1 12.L
Assembly
May 4-6, 2018

ACTION PAPER
FINAL

TITLE: Defending the Public Service Loan Forgiveness (PSLF) Program

WHEREAS:

1) Medical education has become increasingly expensive leading to an ever-larger debt burden for young physicians. In 2014, the median debt of U.S. medical school graduates was $180,000 (1);
2) This expense and debt burden can be a factor in a medical students' selection of specialty, causing some that would consider psychiatry to select higher paying specialties. Students from middle-income backgrounds with more debt are less likely to choose primary care and other specialties with lower expected salaries (2);
3) The PSLF program was initiated to mitigate medical school loan burden by allowing students to select specialties without debt as a consideration. In a recent study analyzing medical student essays about debt, many students expressed concern about their level of debt impacting specialty choice (1);
4) The PSLF program increases access to care for underserved populations by encouraging young physicians to practice in a non-profit, public system. A recent study analyzing survey data from recent medical school graduates showed a significant correlation between graduates' intentions to work with underserved populations and their intention to enter loan forgiveness programs (3);
5) This program, administered by the United States Department of Education, has an uncertain future as a budget priority for this and future administrations. The education budget proposed by President Trump in May 2017 included a provision to end the public loan forgiveness program (4);
6) The PSLF program is of great importance and concern to our RFMs and ECPs, many of whom have already accepted positions and begun loan repayment plans with the intent of qualifying for this program. As of May 2017, over 500,000 people were on track to receive this benefit (4).

BE IT RESOLVED:

1) The American Psychiatric Association will support the continuation of the Public Service Loan Forgiveness program and make its defense an advocacy priority as an access to care matter.
2) The American Psychiatric Association will partner with other medical societies (e.g. the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians, etc.), when appropriate, to further this advocacy goal.

AUTHORS:
Brian S. Hart, M.D., FAPA, Representative, Indiana Psychiatric Society
Michael M. Francis, M.D., FAPA, Representative, Indiana Psychiatric Society
N. Kyle Jamison, M.D., APA Member

ESTIMATED COST:
Author: $1,422
APA: $10,665

ESTIMATED SAVINGS: $0

ESTIMATED REVENUE GENERATED: $0

ENDORSED BY: Assembly Committee of Resident-Fellow Members

KEY WORDS: Access to Care, Advocacy, Loan Forgiveness

APA STRATEGIC PRIORITIES: Advancing Psychiatry

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

- I strongly support this effort to help our ECP and RFM colleagues start in a better financial position. I also believe it will encourage more medical students to enter our profession and positively affect the psychiatric workforce. This document should be an APA priority.
- I support as well.
- Agree and support
- I support
- I support this
- I strongly support this paper
- I support
- This I strongly support. It's not only important but is good incentive for folks from disadvantaged backgrounds, for those interested in working with underserved and for medical students picking psychiatry.
- Support

References:

1. Phillips, J.P., Wilbanks, D.M., Salinas, D.F., & Doberneck, D.M. (2016). Educational debt in the context of career planning: A qualitative exploration of medical student perceptions. *Teaching and Learning in Medicine, 28:3,* 243-251.

2. Phillips, J.P., Weismantel, D.P, Gold, J.G., & Schwenk, T.L (2010). Medical student debt and primary care specialty intentions. *Family Medicine, 42(9):* 616-622.

3. Garcia, A.N., Kuo, T., Arangua, L, & Perez-Stable, E.J. (2018). Factors associated with medical school graduates' intention to work with underserved populations: Policy implications for advancing workforce diversity. *Academic Medicine, 93(1):* 82-29.

4. Brown, E., Strauss, V., & Douglas-Gabriel, D. (2017, May 17). Trump's first full education budget: Deep cuts to public school programs in pursuit of school of choice. *The Washington Post.* Retrieved from https://www.washingtonpost.com/local/education/trumps-first-full-education-budget-deep-cuts-to-public-school-programs-in-pursuit-of-school-choice/2017/05/17/2a25a2cc-3a41-11e7-8854-21f359183e8c_story.html?utm_term=.97d609d1cfba

Action Paper Worksheet
2018 Action Paper Budget Estimate

Action Paper Title:	12.L Defending the Public Service Loan Forgiveness (PSLF) Program
Action Paper Author(s):	Brian S. Hart, M.D., FAPA, Representative, Indiana Psychiatric Society
Phone/email:	doctorbrianhart@gmail.com
APA Admin. Name:	Ashley Mild, Department of Government Relations
Phone/email	202-459-9747 / amild@psych.org

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

Author Estimate:

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

Non-Staff Costs:	
LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	-
Staff Costs:	
Description:	
1 Staff time spent researching PSLF and its impact.	632
2 Time spent specifically advocating to continue PSLF per year.	790
3	-
Total Staff Costs	1,422
Other Costs not included above:	
0	-
Total Author Estimate	**1,422**

APA Administration Estimate:

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

Non-Staff Costs:	
LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	-
Staff Costs:	
Description:	
1 APA Administration meetings (5 hours internal) and national partnership activity (15 hours)	1,580
2 APA Administration lobbying efforts (inclusive of conference calls with membership)	6,320
3 research and materials creation (including testimony, support letters, website content)	2,765
Total Staff Costs	**10,665**
Other Costs not included above:	
0	-
Total Administration Estimate	**10,665**

Rvsd. Jan. 2018

Action Paper 12.L: *Defending the Public Service Loan Forgiveness (PSLF) Program*

APA Administration Feedback:

DEPARTMENT OF GOVERNMENT RELATIONS REVIEW:
The author has asked for the American Psychiatric Association to direct advocacy efforts towards supporting the continuation of the US Department of Education's Public Service Loan Forgiveness (PSLF) program. The recently passed FY2018 omnibus appropriations bill authorized $350 million toward a technical fix for borrowers who would otherwise qualify for PSLF but are enrolled in ineligible loan repayment plans. In addition, the bill authorized $2.3 million directing the Secretary to conduct outreach, providing eligibility terms and conditions to intended borrows. APA already advocates for loan forgiveness programs on the federal level and will continue their advocacy efforts specific to the continuation of the PSLF program. The Administration will expand their advocacy efforts, working with the Association of the American Medical College, the AMA House of Medicine, and other national stakeholders to educate policymakers of the long-term effect on the US health care system, if the program were to be eliminated, as proposed by the Trump Administration.

DEPARTMENT OF GOVERNMENT RELATIONS EXPLANATION OF COST:
The Department of Government Relations projects that an advocacy campaign based on the premise of the action paper may entail 5 hours of APA Administration meetings, 80 hours of APA Administration lobbying efforts (inclusive of conference calls with membership), 35 hours for research and materials creation (including testimony, support letters, website content) and 15 hours of national partnership activity.

Attachment #12
Item 2018A1 12.M
Assembly
May 4-6, 2018

ACTION PAPER
FINAL

TITLE: APA Supports Psychiatrists to Practice Psychiatry Without the Unproven Requirements of the MOC

WHEREAS:
WHEREAS, the APA has established the policy:
"Decision regarding physician licensure, hospital privileges, credentialing or participation in insurance panels shall not in any way be contingent on completion of or participation in Maintenance of Certification."

WHEREAS, continuing medical education which serves the purpose of lifelong learning is already required for maintaining licensure, and Lifetime certification has been the standard until 1994 and many doctors do not participate by choice or have been grandfathered in, and

WHEREAS, formal research studies have shown no difference in quality of care or patient outcomes between physicians participating in MOC and physicians with lifetime certifications. (1,2), and

WHEREAS, according to nationwide surveys and studies, the MOC program of the ABMS is contributing to burnout, and burnout is causing physicians to retire early, and (3,4,5) there is already a significant nationwide psychiatry shortage (6,7) and

WHEREAS, mid-level providers can practice psychiatry independently in over 20 states and nationwide at Veteran Administration Hospitals in all states without supervision from psychiatrists and without MOC and without a 4-year residency and many psychiatrists nationwide are finding their jobs are being replaced by mid-level providers and

WHEREAS, most job openings for psychiatrists require medical school, a 4-year residency, Board Certification, and the unproven MOC for those doctors board certified after 1994, and so the "voluntary" MOC process is becoming less so in practice.

BE IT RESOLVED:
That the APA advocate with the ABMS and ABPN to return to lifetime board certification.

AUTHORS:
Russell Pet, M.D., Representative, Rhode Island Psychiatric Society
Debbie McInteer, M.D., APA Member

ESTIMATED COST:
Author: $0
APA: $10,270

ESTIMATED SAVINGS: 0

ESTIMATED REVENUE GENERATED: 0

ENDORSED BY: Area 1 Council

KEY WORDS: ABPN, Boards, Maintenance of Certification, MOC

APA STRATEGIC PRIORITIES: Advancing Psychiatry, Education

REVIEWED BY RELEVANT APA COMPONENT:

References:

1. https://www.ncbi.nlm.nih.gov/pubmed/25490326
2. https://www.ncbi.nlm.nih.gov/pubmed/25490325
3. http://practicalneurology.com/2016/12/moc-and-physician-burnout/
4. http://medicaleconomics.modernmedicine.com/medical-economics/news/top-15-challenges-facing-physicians-2015?page=full
5. http://medicaleconomics.modernmedicine.com/medical-economics/content/tags/abms/moc-examination-costs-and-impact-physicians?page=0,2
6. https://aamc-black.global.ssl.fastly.net/production/media/filer_public/c9/db/c9dbe9de-aabf-457f-aee7-1d3d554ff281/aamc_projections_update_2017_final_-_june_12.pdf
7. Already By 2017 there was a shortage in primary care of 8,400 physicians and psychiatry (2,400 shortfall) and this is on a trajectory to increase: A 2017 study conducted for the AAMC by IHS Inc., predicts that the United States will face a shortage of between 40,800-104,900 physicians by 2030. There will be shortages in both primary and specialty care, and specialty shortages will be particularly large. These shortages pose a real risk to patients.
https://aamc-black.global.ssl.fastly.net/production/media/filer_public/c9/db/c9dbe9de-aabf-457f-aee7-1d3d554ff281/aamc_projections_update_2017_final_-_june_12.pdf

Action Paper Worksheet
2018 Action Paper Budget Estimate

Action Paper Title:	12.M: APA Supports Psychiatrists To Practice Psychiatry Without the Unproven Requirements of the MOC
Action Paper Author(s):	Russell Pet, M.D., Representative, Rhode Island Psychiatric Society
Phone/email:	508 675-0089/lrp@forestofgrace.org
APA Admin. Name:	Kristen Moeller and Tristan Gorrindo, M.D., Division of Education
Phone/email	kmoeller@psych.org 202 559 3897 tgorrindo@psych.org

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

Author Estimate:

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

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

Staff Costs:

	Description:		
1	No estimated cost to Author/Members.		-
2		-	-
3		-	-
	Total Staff Costs		-

Other Costs not included above:	
No expected Author/Member Expenses	-
Total Author Estimate	**-**

APA Administration Estimate:

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

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

Staff Costs:

	Description:	
1	80 hours of APA Administration lobbying efforts provided during legislative sessions (inclusive of conference calls with membership)	6,320
2	25 hours for research and materials creation	1,975
3	25 hours of national partnership activity.	1,975
	Total Staff Costs	**10,270**

Other Costs not included above:	
0	-
Total Administration Estimate	**10,270**

Rvsd. Jan. 2018

Action Paper 12.M: *APA Supports Psychiatrists to Practice Psychiatry Without the Unproven Requirements of the MOC In a Time of Severe Psychiatric Shortage*

APA Administration Feedback:

DEPARTMENT OF EDUCATION EXPLANATION OF COST:

Feedback was provided directly to this action paper's authors by telephone.

The proposed action paper does not seek to establish new APA policy on MOC but rather seeks to disseminate existing policy to outside stakeholders. The first paragraph of the Be It Resolved asks the APA to engage with ABMS. APA is currently participating in the ABMS Vision Initiative which is examining the future of MOC across all specialties. APA has publicly made statements that if changes are not substantial and significant, it will look towards considering alternatives to the current AMBS MOC process. The first paragraph of the Be It Resolved is incomplete, but if the authors are looking for the APA Administration to continue expressing our concern in existing forums and venues with ABMS, then the cost is negligible.

The second paragraph of the Be It Resolved seeks to have the APA Administration promote it's established policies regarding MOC to states, hospitals, and insurance panels through regulatory, legislative, and collaborative efforts. With details regarding requested activities, the best model for estimating funding and level of effort for this kind of action comes from APA's efforts around engaging legislative and regulatory staff on safe prescribing (scope of practice). That effort -- which involves the use of APA's state lobbyists, Division of Government Relations staff, and Division of Programs, Policies, and Partnerships staff – is estimated to include 130 hours annually of staff time to include preparation time, direct briefings, and internal coordination in support lobbying efforts in the states which are currently considering MOC related legislation. This estimate also includes research and materials preparation beyond that which is already published on www.psychiatry.org/mocreform

DEPARTMENT OF GOVERNMENT RELATIONS (DGR) REVIEW:

In reviewing the action paper, the author has asked for the American Psychiatric Association (APA) to direct advocacy efforts to educate states, hospitals, and insurance panels to consider initial board certifications as a lifetime certification; and to encourage policy makers to eliminate the requirement for maintenance of certification with exceptions. To date, there are a number of states that have enacted legislation declaring that physician licensure cannot be contingent on completion of MOC requirements. The Department of Government Relations will continue to advocate to ensure that decisions regarding licensure, hospital privileges and credentialing, and/or participation on insurance panels should not be conditioned upon a physician's completion of or participation in Maintenance of Certification or Osteopathic Continuous Certification. In addition, the Department will work with DBs/SAs to develop resources (i.e., testimony, model legislation, and letters of support) to educate policymakers on the impact the process will have on the practice of providers.

DEPARTMENT OF GOVERNMENT RELATIONS (DGR) EXPLANATION OF COST:

The Department of Government Relations projects that an advocacy campaign based on the premise of the action paper may entail 80 hours of APA Administration lobbying efforts provided during legislative sessions (inclusive of conference calls with membership), 25 hours for research and materials creation and 25 hours of national partnership activity.

Attachment #13

Item 2018A1 12.N
Assembly
May 4-6, 2018

ACTION PAPER
FINAL

TITLE: Developing a Web Based Tool Kit for Psychiatrists and Patients Who Wish to Appeal Adverse Medical Necessity Decisions by Managed Care Entities

WHEREAS:
Many patients and the psychiatrists who treat them have had the experience of denial of insurance coverage for mental health or substance use disorder treatment they believe is medically necessary;

Fewer than 5% of appeals are successful when reviewed by the insurance company issuing the initial denial or by their contracted appeal review agency;

When the appeal review agency is truly independent, the success rate for appeals jumps to nearly 60%;

Appealing such denials can be a complicated, frustrating, and confusing process that is often difficult to navigate;

Web based information about appeals is available on non-APA websites, where it is sought after and found to be helpful (e.g., http://www.austenriggs.org/blog-post/appealing-denial-mental-health-care);

Appeals are most likely to lead to a reversal of a denial when 3 factors are included in the appeal. These include [1] Use of the patient's voice as an active agent in the appeal process, [2] Anchoring appeals to third party resources representing generally accepted standards, such as APA Practice Guidelines, the Level of Care Utilization System (LOCUS) developed by the American Association of Community Psychiatrists or relevant published research, [3] Invoking the terms of the federal parity law as part of the appeal, when relevant (e.g., noting when a mental health denial is based on what appears to be a quantitative or non-quantitative limit on care that would not be imposed in medical or surgical care);

BE IT RESOLVED:
That the APA will improve its webpage, "appealing treatment denials", to provide assistance to clinicians and patients who believe they face improper denial of access to medically necessary care. The webpage will offer a user-friendly tool kit that describes steps to maximize the likelihood of an appeal being successful.

AUTHORS:
Eric M. Plakun, M.D., Representative, Academy of Psychodynamic Psychiatry and Psychoanalysis
Manuel Pacheco, M.D., Deputy Representative, Area 1

ESTIMATED COST:
Author: $16,807
APA: $4,740

ESTIMATED SAVINGS:

ESTIMATED REVENUE GENERATED:

ENDORSED BY: Area 1 Council

KEY WORDS: Medical necessity, generally accepted standards, insurance appeals

APA STRATEGIC PRIORITIES: Advancing Psychiatry, Education

REVIEWED BY RELEVANT APA COMPONENT:

Action Paper Worksheet
2018 Action Paper Budget Estimate

Action Paper Title:	12.N: Developing a Web Based Tool Kit for Psychiatrists and Patients Who Wish to Appeal Adverse Medical
Action Paper Author(s):	Eric M. Plakun, M.D., Representative, Academy of Psychodynamic Psychiatry and Psychoanalysis
Phone/email:	413 931-5208, eric.plakun@austenriggs.net
APA Admin. Name:	Maureen Bailey, Parity Compliance and Enforcement
Phone/email	mbailey@psych.org

Attendance Summary:	**Author**	**APA Administration**
Number of Component Members	9	-
Number of Staff	3	-
Number of Non-Staff	-	-
Total	**12**	**-**

Author Estimate:

Travel Budget:	No. of Attendees	Airfare	Hotel/Lodging	Ground Transportation	Per Diem/Meals	Total
Meeting 1	12	$3,825	$2,925	$450	$666	$7,866
Meeting 2	12	3,825	2,925	450	666	7,866
Total Travel Budget		7,650	5,850	900	1,332	$15,732

Non-Staff Costs:	
LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	285
Total Non-Staff Costs:	**285**

Staff Costs:

	Description:		
1	Preparation of web page		790
2		-	-
3		-	-
	Total Staff Costs		790

Other Costs not included above:	
0	-
Total Author Estimate	**16,807**

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	We need to update and add resources to our website and attend committee meetings.		4,740
2		-	-
3		-	-
	Total Staff Costs		**4,740**

Other Costs not included above:	
0	-
Total Administration Estimate	**4,740**

Rvsd. Jan. 2018

Action Paper 12.N: *Developing a Web Based Tool Kit for Psychiatrists and Patients Who Wish to Appeal Adverse Medical Necessity Decisions by Managed Care Entities*

APA Administration Feedback:

PARITY COMPLIANCE AND ENFORCEMENT EXPLANATION OF COST:

We already have many of these resources created including, other things, appeal letters, patients' rights poster. Staff presume the author has something different in mind. Also, the Kennedy Forum has a complaint collection site, as does the Department of Labor and many state insurance commissioners offices. The Legal Action center also has materials on these matters. Staff presume the author has something different in mind. In any case we would need to synthesize the state of the art update and add resources to our website and create a new resource. It should be noted that creating a portal on APA's website to collect complaints from patients/providers could create a duty for the APA to resolve all complaints lodged and involve significant staff time. Staff time to work with the contemplated committees and to produce and implement on the website would entail a minimum of 60 hours. Working with online reports and disposition of same cannot be reliably estimated.

Attachment #14
Item 2018A1 12.O
Assembly
May 4-6, 2018

ACTION PAPER
FINAL

TITLE: Addition of Adequate Amounts of Phosphatidylcholine (choline) to all Prenatal Vitamins

WHEREAS:
"Choline is a key component in various molecules that strengthen cell membranes, form neurotransmitters, and help nerve cells communicate with one another."

It has been established that phosphatidylcholine (choline) is critical to the proper development of the brain and spinal cord in humans.

In 1998, the Institute of Medicine (now National Academy of Medicine) established the following daily Dietary Reference Intake (DRI) of choline: 450mg for pregnant women and 550mg for lactating women.

Supplementing vitamins with choline during pregnancy may reduce the risk of subsequent development of mental illness including neurodevelopmental effects of prenatal alcohol exposure, schizophrenia, dementia and other mental illnesses.

Supplementation with choline during infancy and childhood may lead to improved lifelong memory and reduce memory problems associated with aging.

A recent review by Carl Bell, MD revealed "none of the top 25 prenatal multivitamins contained the daily-recommended choline intake for a pregnant woman (450 mg/d)."

A resolution passed by delegates at the 2017 AMA Annual Meeting supports the addition of adequate amounts of choline to all prenatal vitamins to ensure that pregnant women have adequate choline levels.

Choline deficiency is a preventable cause of intellectual disability.

It is currently known that choline deficiency, commonly brought about by prenatal alcohol exposure, is a significant public health problem.

BE IT RESOLVED:
That the American Psychiatric Association supports that evidence-based amounts of bioavailable choline be added to all prenatal vitamins.

AUTHORS:
Constance E. Dunlap, M.D., DFAPA, Representative, Washington Psychiatric Society

Carl Bell, M.D., DLFAPA, APA Member

SPONSORS:
Elizabeth Morrison, M.D., DLFAPA, Representative, Washington Psychiatric Society
Eliot Sorel, M.D., DLFAPA, Representative, Washington Psychiatric Society
Susan Rich, M.D., MPD, DFAPA, APA Member
Shree Vinekar, M.D., DLFAPA, DLFAACAP, MACPsych, Representative, Oklahoma Psychiatric Physicians Association
Gabrielle Shapiro, M.D., DFAACAP, DFAPA, Representative, New York County Psychiatric Society
Vincenzo Di Nicola, M.D., DFAPA, Representative, Quebec & Eastern Canada District Branch
Leslie Hartley Gise, M.D., Representative, Hawaii Psychiatric Medical Association
Jessica Isom, M.D., MPH, RFM Representative, Area 1

ESTIMATED COST:
Author: $0
APA: $12,640

ESTIMATED SAVINGS: $0

ESTIMATED REVENUE GENERATED: $0

ENDORSED BY: Area 3 Council, Washington Psychiatric Society

KEY WORDS: prevention, positive psychiatry, public health, clinical care

APA STRATEGIC PRIORITIES: Advancing Psychiatry, Supporting Research
Supporting Education

REVIEWED BY RELEVANT APA COMPONENT: (submitted to) Council on Addiction Psychiatry, Council on Geriatric Psychiatry

REFERENCES:
Zeisel, Steven H. et al. (2017, April). Choline: an essential nutrient for public health. *Nutrition Reviews* 75 (4): 225-240. https://www.nutraingredients-usa.com/Article/2017/06/26/AMA-calls-for-more-choline-in-prenatal-vitamins#
The AMA Releases New Guidelines for Proper Prenatal Supplementation. Media Connections Premarketing. https://mediaconnections.com.au/ama-releases-new-guidelines-proper-prenatal-supplementation/
Bell, Carl. (2017, August 1.), AMA's stance on choline, prenatal vitamins could bring 'staggering' results. *Clinical Psychiatry News.* https://www.mdedge.com/clinicalpsychiatrynews/article/144765/adhd/amas-stance-choline-prenatal-vitamins-could-bring
Bell, MD. *Fetal Alcohol Spectrum Disorders in African American Communities: Continuing the Quest for Prevention in Perspectives*, in Health Equity & Social Determinants of Health, National Academy of Medicine. https://nam.edu/perspectives-on-health-equity-and-social-determinants-of-health/

Prenatal choline and the development of schizophrenia. *Shanghai Archives of Psychiatry.* https://www.ncbi.nlm.nih.gov/pubmed/26120259
Mellott, Tiffany J. et al. (Perinatal Choline Supplementation Reduces Amyloidosis and Increases Choline Acetytransference Expression in the Hippocampus of the APPswePS1dE9 Alzheimer's Disease Model Mice. http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0170450
Ross, R. G., S. K. Hunter, C. Hoffman, L. McCarthy, B. M. Chambers, A. J. Law, S. Leonard, G. O. Zerbe, and R. Freedman. (2016). Perinatal phosphatidylcholine supplementation and early childhood behavior problems: Evidence for CHRNA7 moderation. *American Journal of Psychiatry* 173 (5): 509–516.

Action Paper Worksheet
2018 Action Paper Budget Estimate

Action Paper Title:	12.O: Addition of Adequate Amounts of Phosphatidylcholine (choline) to all Prenatal Vitamins
Action Paper Author(s):	Constance E. Dunlap, M.D., DFAPA, Representative, Washington Psychiatric Society
Phone/email:	-
APA Admin. Name:	Michelle Dirst, Department of 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		-	-	-	-	$0

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

APA Administration Estimate:

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

Non-Staff Costs:	
LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	-
Staff Costs:	
Description:	
1 Develop a statement and reach consensus from relevant Councils	12,640
2	-
3	-
Total Staff Costs	**12,640**
Other Costs not included above:	
0	-
Total Administration Estimate	**12,640**

Rvsd. Jan. 2018

Action Paper 12.O: *Addition of Adequate Amounts of Phosphatidylcholine (choline) to all Prenatal Vitamins*

APA Administration Feedback:

DEPARTMENT OF PRACTICE MANAGEMENT AND DELIVERY SYSTEMS POLICY:
We support feedback provided by the Research Council to recognize the limitation with regard to human evidence base.

COUNCIL ON RESEARCH:
Perhaps the Action Paper should acknowledge limitations in the human evidence base supporting this recommendation.

I do not see evidence of harm from prenatal folate supplementation. There is a large literature in animals describing benefits of prenatal choline supplementation for a number of specific animal models (Neurosci Biobehav Rev. 2006;30(5):696-712).

First, while ameliorating choline deficits may be protective against some conditions (neural tube defects, for example), it is not clear that choline supplementation is a strategy for cognitive enhancement in humans:

> *1: Cheatham CL, Goldman BD, Fischer LM, da Costa KA, Reznick JS, Zeisel SH. Phosphatidylcholine supplementation in pregnant women consuming moderate-choline diets does not enhance infant cognitive function: a randomized, double-blind, placebo-controlled trial. Am J Clin Nutr. 2012 Dec;96(6):1465-72. doi: 10.3945/ajcn.112.037184. Epub 2012 Nov 7. PubMed PMID: 23134891; PubMed Central PMCID: PMC3497930.*

Second, evidence that choline supplementation prevents the emergence of neurocognitive deficits in the context of neurodevelopmental disorders, like schizophrenia, is also questionable. I quote the conclusion from the abstract of a paper from Bob Freedman from 2015:

> *The low risk and short (six month) duration of the intervention makes it especially conducive to population-wide adoption. Similar findings with folate for the prevention of cleft palate led to recommendations for prenatal pharmacological supplementation and dietary improvement. However, definitive proof of the efficacy of prenatal choline supplementation will not be available for decades (because of the 20-year lag until the onset of schizophrenia), so public health officials need to decide whether or not promoting choline supplementation is justified based on the limited information available.*

My cursory read of the literature suggests that the protective effects of choline supplementation against cognitive impairments in adulthood are at this point not established in humans. Would we recommend choline supplementation to prevent memory impairment based on animal models when the validity of these animal models is probably limited?

EXPLANATION OF COST:
The APA would have to develop a statement and reach consensus from the relevant Councils to support the requirement that adequate amounts of bioavailable choline be added to all prenatal vitamins.

We anticipate 160 hours of staff work to develop a position statement and have it approved through the APA process.

Attachment #15
Item 2018A1 12.Q
Assembly
May 4-6, 2018

ACTION PAPER
FINAL

TITLE: Psychiatric Management of the Impact of Racism on Social and Clinical Events

WHEREAS:
APA's Strategic Priorities include eliminating health inequities based on bias, prejudice, xenophobia, and racism and supporting and increasing diversity within APA; serving the needs of evolving, diverse, underrepresented, and underserved patient populations; and working to end disparities in mental health care.

Acknowledged and unacknowledged racial and ethnic biases among clinicians are known factors leading to mental health care disparities and inequities, including denial of treatment, ineffective treatment, misdiagnosis, and poor clinical outcomes.

The 2006 APA Resolution Against Racism and Racial Discrimination, adopted on July 2006, recognizes that racism and racial discrimination:

- adversely affect mental health by diminishing the victim's self-image, confidence and optimal mental functioning.
- are two of the factors leading to mental health care disparities.
- render the perpetrator unprepared for the 21st century society that is becoming increasingly multicultural and global.

The current version of DSM 5 does not mention race or racism in its index.

BE IT RESOLVED:
That the APA enhance membership and public education about the mental health effects of racial discrimination, micro-aggression, race-based violence, racially motivated mass killings and similar events, through duly implemented curricular guidelines for medical schools, residency training, and continuing medical education programs, as well as media outreach.

That the index of subsequent versions of DSM will refer to race and racism content currently present in sections and subsections.

AUTHORS:
Constance E. Dunlap, M.D., DFAPA, Representative, Washington Psychiatric Society
Rahn Bailey, M.D., DFAPA, Representative, Black Psychiatrists
Carl Bell, M.D., DLFAPA, APA Member

SPONSORS:
Kimberly Gordon, M.D., FAPA, APA Member
Elizabeth Morrison, M.D., Representative, Washington Psychiatric Society

Eliot Sorel, MD, DLFAPA, Representative, Washington Psychiatric Society

ESTIMATED COST:
Author: $6,803
APA: $114,306

ESTIMATED SAVINGS: $0

ESTIMATED REVENUE GENERATED: $0

ENDORSED BY: APA Caucus of Black Psychiatrists, Washington Psychiatric Society

KEY WORDS: DSM, diagnosis, discrimination, education, health inequities, insanity defense, race, racism, diversity, prejudice, prevention, public health, violence, xenophobia

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

REVIEWED BY RELEVANT APA COMPONENT: (submitted to)
Council on Minority Mental Health and Health Disparities, Council on Medical Education and Lifelong Learning, Council on Research, Council on International Psychiatry

REFERENCES:

1. American Psychiatric Association. Resolution Against Racism and Racial Discrimination, 2006.
2. Bell, Carl. "Racism and Psychopathology" in The Oxford Handbook of Personality Disorders, 2012.
3. Poussaint, Alvin. They Hate. They Kill. Are They Insane? *The New York Times*, 1999.
4. Pinderhughes, Charles. "Racism and Psychotherapy" in *Racism and Mental Health,* 1973.
5. Bell, Carl. Contagion, Mass Shootings, and Fetal Alcohol Exposure. *Clinical Psychiatry News*, August 2015. http://www.clinicalpsychiatrynews.com/views/single-view/contagion-mass-shootings-and-fetal-alcohol- exposure/2d9f144ddf92fbe20f10a791acd9cdc8.html.
6. Centers for Medicare and Medicaid Services https://www.cms.gov/icd10manual/fullcode_cms/P0897.html
7. https://www.splcenter.org/news/2017/11/13/hate-crimes-rise-second-straight-year-anti-muslim-violence-soars-amid-president-trumps
8. Bailey, Rahn K. "A Doctor's Prescription for Health Care Reform: The National Medical Association tackles disparities, stigma, and the status quo" (reference TBD)

Action Paper Worksheet
2018 Action Paper Budget Estimate

Action Paper Title: 12.Q: Study of the Impact of Racism on Clinical Treatment
Action Paper Author(s): Constance E. Dunlap, M.D., DFAPA, Representative, Washington Psychiatric Society
Phone/email: -
APA Admin. Name: Keila Barber, Division of Research
Phone/email 202-559-3901 / Kbarber@psych.org

Attendance Summary:	**Author**	**APA Administration**
Number of Component Members	2	37
Number of Staff	1	4
Number of Non-Staff	-	-
Total	**3**	**41**

Author Estimate:

Travel Budget:	No. of Attendees	Airfare	Hotel/Lodging	Ground Transportation	Per Diem/Meals	Total
Meeting 1	3	$850	$1,300	$100	$444	$2,694
Meeting 2	3	850	1,300	100	444	2,694
Total Travel Budget		1,700	2,600	200	888	$5,388

Non-Staff Costs:	
LCD Projector	850
Laptop	300
Screen	-
Flipchart	75
Microphones	190
Total Non-Staff Costs:	**1,415**
Staff Costs:	
Description:	
1	- -
2	- -
3	- -
Total Staff Costs	-
Other Costs not included above:	
0	-
Total Author Estimate	**6,803**

APA Administration Estimate:

Travel Budget	No. of Attendees	Airfare	Hotel/Lodging	Ground Transportation	Per Diem/Meals	Total
Meeting 1	41	$17,425	$26,650	$4,100	$6,068	$54,243
Meeting 2	41	17,425	26,650	4,100	6,068	54,243
Total Travel Budget		**34,850**	**53,300**	**8,200**	**12,136**	**108,486**

Non-Staff Costs:	
LCD Projector	850
Laptop	300
Screen	180
Flipchart	-
Microphones	1,330
Total Non-Staff Costs:	**2,660**
Staff Costs:	
Description:	
1 DSM Staff liaison to work with the group	1,580
2 Council on Research Staff liaison to work with the group	1,580
3	- -
Total Staff Costs	**3,160**
Other Costs not included above:	
0	-
Total Administration Estimate	**114,306**

Rvsd. Jan. 2018

Action Paper 12.Q: *Study of the Impact of Racism on Clinical Treatment*

APA Administration Feedback:

DIVISION OF RESEARCH REVIEW: If the ask is to consider race and/or racism as a mental disorder or part of a mental diagnosis in the DSM, then this action paper will also need to be under the purview of the DSM Steering Committee.

DIVISION OF RESEARCH CORRESPONDNCE WITH THE AUTHOR: On March 27, 2018, Dr. Constance Dunlap spoke with Ms. Keila Barber to provide a more elaborate explanation of the authors' intention for the action paper and to explain the author/member estimate provided. Ms. Barber informed Dr. Dunlap that the total cost estimate would generate more than $10,000 due to size of the Council on Research if they were to meet in person.

Dr. Dunlap informed Ms. Barber of the following:

- Dr. Dunlap explained that she was unsure of the correct number of Component members to list on the cost estimate form.
- The authors are open to ideas on how to address the issue of racism and carryout the "Be it Resolved" mentioned in the action paper. For example, the authors are aware that additional components may need to be involved to carry out the task or the task may need to be assigned to another appropriate component.

DIVISION OF RESEARCH EXPLANATION OF COST: The APA Administration estimate includes the cost for the Council on Research (approximately 29 including their fellows) and the DSM Steering Committee to meet (approximately 15 members). However, does the Council on Research and DSM Steering Committee need to meet in person to handle the task at hand? Similar to other items assigned to both components, it is possible that the task can be completed through phone and email communication.

The number of non-component staff is estimated to be four, which includes the staff liaison for each component and the Director and Deputy Director of Research. It is difficult to determine the amount of staff time required for the liaisons of both components. It would depend on how often the components would like to meet or schedule calls and the specific tasks which would be assigned to the liaisons.

DIVISION OF DIVERSITY AND HEALTH EQUITY REVIEW:

1. In 2015, the Board of Trustees adopted APA's fourth strategic initiative which specifically reads as follows: "Supporting and increasing diversity within APA; serving the needs of evolving, diverse, underrepresented, and underserved patient populations; and working to end disparities in mental health care."
2. DSM5 includes cultural formulation (CF) and the cultural formulation interview (CFI) in the body.

Attachment #16
Item 2018A1 12.R
Assembly
May 4-6, 2018

ACTION PAPER
FINAL

TITLE: A Call to Recognize and Honor the Psychiatrists Who Served in Vietnam

WHEREAS:
The U.S. government has implemented a process of providing impetus and support for Vietnam War semi-Centennial commemorative activities and ceremonies throughout America to thank and honor Vietnam veterans for their service and sacrifice on behalf of the United States and to thank and honor the families of these veterans (Public Law 110-181 SEC.598, 2008 National Defense Authorization Act). To this date, over 12,000 such events have either been held or are scheduled
(see http://www.vietnamwar50th.com/about/commemoration_objectives/).

The Vietnam War proved to be exceedingly challenging and costly. The ground war began in South Vietnam in 1965 with the commitment of American combat troops, which followed a 12-year period of U.S. financial aid and military advisors. The result was eight years of warfare, involving almost 2.6 million American servicemen and women. The war produced 47,400 combat deaths and over 350,000 additional wounded in action. In fact, U.S. casualty numbers for Vietnam eclipsed those for World War I (321,000) and were double those for the Korean War (158,000). Regarding the more recent wars in Iraq and Afghanistan, in terms of U.S. military deaths from all causes, the Vietnam War produced roughly 7.5 times as many as occurred in these two theaters combined.

An estimated 200 psychiatrists, including two women, served with the Army, Navy, and USAF within South Vietnam and in surrounding waters between 1964 and 1973. As for the roughly 135 serving with the Army (the Army comprised 66% of the troops in Vietnam), two-thirds were drafted civilians--citizen soldiers--while the remainder had trained in military programs. Almost all psychiatrists served a single 12-13-month deployment. There was one fatality, Dr. Peter B. Livingston, who is remembered on the Vietnam Veterans Memorial Wall in Washington.

The military morale and mental health challenges that arose in Vietnam over the course of the war were in many respects both prodigious and unprecedented.

> During the first half of the war, the deployed psychiatrists treated, or supervised treatment of, a wide array of psychiatric conditions, but they reported seeing surprisingly small numbers of combat exhaustion cases, i.e., traumatic combat stress reactions cases, compared to the numbers predicted from earlier wars. Furthermore, the combat exhaustion cases that did arise were effectively treated, at least by military standards, by specialized and non-specialized psychiatric personnel applying the traditional military forward treatment doctrine (i.e., brief, simple treatments such as safety, rest, wound care, and physical replenishment; peer support; sedation, if necessary; and opportunities for emotional catharsis, all applied as close to the soldier's unit as practical and accompanied by expectations of rapid recovery of duty, even combat, function). These treatments were, in many instances, augmented with 1st generation psychotropic medications. In time, however, evidence mounted that suggested the enemy's guerrilla strategy and tactics, rising opposition to the war at home, and the bloody, ambiguous, and often discouraging nature of fighting in Vietnam, were causing increasing numbers of low-grade psychological and psychosomatic reactions, as well as behavior disorders such as heavy drug use (typically marijuana) and excessive combat aggression.

Some psychiatrists there came to think that these symptoms and behaviors were collectively expressive of "partial trauma" or "strain trauma." (emotionally taxing events—singular or recurring—that were not of sufficient intensity at the time to make them disabling, but that were nonetheless psychologically injurious). It is especially noteworthy that from the outset military psychiatrists went to Vietnam supplied with medications not previously used on the battlefield: neuroleptics, anxiolytics, and the tricyclic antidepressants. In contrast to the sedatives used sparingly in earlier wars because they could produce sustained central nervous depression and interfere with military performance, these new medications were widely prescribed and thought to produce salutary results. Most importantly, the record reveals a great deal of improvisation in the use of these medications under war-time conditions.

Psychiatric matters became exponentially more difficult in the second half of the war following the enemy's Tet Offensives in the winter of 1968 and the consequent social upheaval in the U.S. Opposition to the war at home rapidly accelerated to become highly charged and confrontational. In Vietnam the U.S. military saw a dramatic drop in morale associated with unprecedented high levels of dissent, misconduct, drug use (especially heroin), and psychiatric referrals, despite a progressive reduction of combat intensity. The Army's psychiatric hospitalization rate quadrupled during these years compared to that in the buildup phase of the war. In time, order and discipline became precarious as did military preparedness, while military leaders, law enforcement, and mental health services were all severely challenged. In July, 1972, near the bitter end of the war, *one out of every eight soldiers* was medically evacuated from Vietnam for psychiatric reasons--primarily for drug dependency (especially heroin).

The war in Vietnam also brought upon the military psychiatrists serving there a disturbing ethical dilemma rarely encountered in civilian settings. Although it had been previously recognized that the military psychiatrist was often under strain when required to help normal men adapt to an abnormal situation…that an exquisite moral dilemma could arise associated with physician/psychiatrists "expecting" soldiers to return to combat following treatment…the experience in Vietnam was evidently even worse. As military service became increasingly despised by the young troops because of the war's intense unpopularity at home, and despair and its behavioral expressions skyrocketed, the deployed psychiatrists had only a limited capacity for making this bearable. And yet the soldiers believed that it was the duty of the mental health contingent to relieve them of their unbearable situation.

Despite the enormous personal and professional challenges and risks these psychiatrists faced, the extant record amply demonstrates their sustained devotion to providing the best care for the troops that they could, their willingness to overcome hardship pursuant of that end, and their record of capable and commendable service. The arrival of the war's 50th anniversary offers a unique opportunity to honor those who selflessly performed to the best of their ability what they believed was their duty to their country.

BE IT RESOLVED:
That the American Psychiatric Association will formally recognize the men and women psychiatrists who served in Vietnam.

AUTHORS:
Adam T. Kaul, Representative, Psychiatric Society of Virginia
Norman Camp, M.D., Colonel, Medical Corps, US Army (Ret), APA Member

SPONSORS:
Jack Bonner, M.D., Representative, Senior Psychiatrists
Varun Choudhary, M.D., Representative, Psychiatric Society of Virginia

ESTIMATED COST:
Author: $0
APA: $1,975

ESTIMATED SAVINGS: $0

ESTIMATED REVENUE GENERATED: $0

ENDORSED BY: Society of Uniformed Services Psychiatrists, Area 5 Council

KEY WORDS: Military, Vietnam

APA STRATEGIC PRIORITIES: Advancing Psychiatry

REVIEWED BY RELEVANT APA COMPONENT:

Action Paper Worksheet
2018 Action Paper Budget Estimate

Action Paper Title:	12.R: A Call to Recognize and Honor the Psychiatrists Who Served in Vietnam
Action Paper Author(s):	Adam T. Kaul, M.D., Representative, Psychiatric Society of Virginia
Phone/email:	
APA Admin. Name:	Glenn O'Neal, Department of Corporate Communications & Public Affairs
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		-	-	-	-	$0

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

APA Administration Estimate:

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

Non-Staff Costs:	
LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	-
Staff Costs:	
Description:	
1 Researching/writing/editing a Psychiatric News story about psychiatrists who served in the Vietnam war.	1,106
2 Layout in Psychiatric News print & online edition for Vietnam War psychiatrits profile.	158
3 Flag flown over capitol in honor of veteran psychiatrists, to be framed and displayed in APA library.	711
Total Staff Costs	**1,975**
Other Costs not included above:	
0	-
Total Administration Estimate	**1,975**

Rvsd. Jan. 2018

Action Paper 12.R: *A Call to Recognize and Honor the Psychiatrists Who Served in Vietnam*

APA Administration Feedback:

CORPORATE COMMUNICATIONS AND PUBLIC AFFAIRS/ DEPARTMENT OF GOVERNMENT RELATIONS EXPLANATION OF COST:

The APA Administration hears and agrees with the author's call to recognize and honor psychiatrists who served honorably in the Vietnam War. The administration proposes to do so by researching and writing a piece for Psychiatric News that will tell the story of the physicians who provided mental health care for their fellow soldiers during the complex and costly conflict that was Vietnam.

Researching, writing and editing a Psychiatric News story on psychiatrists who served in Vietnam: 14 hours @$79/hour = $1,106

Layout for Psychiatric News print and web editions: 2 hours staff time @$79/hour = $158

Total cost for design & production of web assets: $1,264

APA's Department of Government Relations provided secondary feedback on the paper, suggesting that a flag be flown over the U.S. Capitol in honor of veteran psychiatrists who served in all U.S. conflicts. This is a free service provided by the office of a given member of Congress. The flag would later be framed and put on display in the APA's library and rare books room alongside other important artifacts from the history of APA and psychiatry.

Staff time to liaise with members of congress to arrange flag flying over the Capitol: 5 hours @$79/hour = $395

Framing and putting flag on display in APA Library: ~$300.

Attachment #17
Item 2018A1 12.T
Assembly
May 4-6, 2018

ACTION PAPER
FINAL

TITLE: Streamlining the APA Application Renewal Process

WHEREAS:
The APA's new Salesforce-based platform provides new opportunities to streamline and improve member processes.

The APA has already begun implementing membership renewal processes that is more streamlined and requires fewer steps to complete.

The APA has already passed an action paper in 2018 asking to ease the process for former members to reinstate, which has driven these improvements.

The APA has significantly increased Resident-Fellow and Early Career membership, which both prefer to conduct transactions online.

Previously, new members had to call, fax, or mail payment information to the APA in order to join.

BE IT RESOLVED:
The APA continue streamlining the renewal process by initiating, as one option, a one-click payment link that allows a member to directly pay dues without logging into the website or going through multiple screens that could distract or prevent the member from renewing.

AUTHORS:
Mark Haygood, D.O., MS, ECP Representative, Area 5
Simha Ravven, M.D., ECP Representative, Area 1

ESTIMATED COST:
Author: $237
APA: $237

ESTIMATED SAVINGS:

ESTIMATED REVENUNE GENERATED:

ENDORSED BY: Area 5 Council

KEY WORDS: Membership; Application Process

APA STRATEGIC PRIORITIES: Advancing Psychiatry

REVIEWED BY RELEVANT APA COMPONENT: None; however, the APA staff reviewed the feasibility of the action to be performed.

Action Paper Worksheet
2018 Action Paper Budget Estimate

Action Paper Title:	12.T: Streamlining the APA Application Renewal Process
Action Paper Author(s):	Mark Haygood, D.O., MS, ECP Representative, Area 5
Phone/email:	256-490-7318/mhaygood78@gmail.com
APA Admin. Name:	Stephanie Auditore, Membership
Phone/email	202-559-3567/sauditore@psych.org

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

Author Estimate:

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

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

Staff Costs:

	Description:		
1	Staff member will initiate a one-click payment link, as an option, on the APA website to streamline the APA application renewal process.		237
2		-	-
3		-	-
	Total Staff Costs		237
Other Costs not included above:			
0			-
		Total Author Estimate	**237**

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	Continue implement one-click payment as part of renewal and reinstatement campaigns.		237
2		-	-
3		-	-
	Total Staff Costs		**237**
Other Costs not included above:			
0			-
		Total Administration Estimate	**237**

Action Paper 12.T: *Streamlining the APA Application Renewal Process*

APA Administration Feedback:

MEMBERSHIP DEPARTMENT:

APA has received consistent feedback from residents and early career members that membership processes should be able to be accomplished in as few steps as possible and online. When building a new membership database in 2017, one of the key functionalities we ensured to include was the ability to pay directly online for new enrollments as well as renewals. We believe this will significant ease the enrollment and renewal process and agree with the author that doing so helps prevent distractions that could inhibit the member from reinstating or renewing.

EXPLANATION OF COST: Membership department agrees with the author's cost estimate.

Attachment #18

Item 2018A1 12.V
Assembly
May 4-6, 2018

ACTION PAPER
FINAL

TITLE: Survey of Membership

WHEREAS:
1. There does not appear to be an accurate and comprehensive database regarding the professional activities and practice patterns of APA members.

2. APA members engage in a variety of diverse activities including, but not limited to academic appointments, contracted positions within community mental health centers, group private practices, single provider private practices and government employment.

3. Numerous changes are rapidly occurring related to practice requirements, reimbursement, continuing education, medical record keeping and organizational provider structures.

4. The APA has been involved in making policy and advocacy decisions without an accurate database documenting the practice patterns and needs of the membership. Subsequently, policies and decisions may be proposed without adequately understanding the impact and needs of various subsets of the membership. For example, recent news stories have indicated that a significant number of the membership does not participate in Medicare. Additionally, a large subset of the membership does not contract with private health insurers to provide patient care.

5. The interests and needs of individual, self-employed private practitioners may not necessarily coincide with those of employed psychiatrists, government psychiatrists or those with academic appointments.

BE IT RESOLVED:
That the APA convene a study group to determine the best and most cost-effective mechanism to assess demographics from the membership addressing a wide variety of practice styles and professional activities including, but not limited to:

- Employment settings: private practice, government employment, academic appointment, group practice, collaborative care models, etc.

- Participation in insurance: including private healthcare, Medicare/Medicaid, private pay and Worker's Compensation, etc.

- Utilization of electronic medical records

The results of the study group would be formulated into a survey or other mechanism to be administered to the entire membership in order to assist the APA in addressing future policies and advocacy with full knowledge of the potential scope of impact on the individual members.

AUTHOR:
James Gregory Kyser, M.D., Representative, Tennessee Psychiatric Association

ESTIMATED COST:
Author: $790
APA: $30,728

ESTIMATED SAVINGS: none

ESTIMATED REVENUE GENERATED: none

ENDORSED BY: Area 5 Council

KEY WORDS: Survey, practice behaviors

APA STRATEGIC PRIORITIES: Advancing Psychiatry

REVIEWED BY RELEVANT APA COMPONENT:

Action Paper Worksheet
2018 Action Paper Budget Estimate

Action Paper Title: 12.V: Survey of Membership
Action Paper Author(s): James Gregory Kyser, M.D., Representative, Tennessee Psychiatric Association
Phone/email: 615-456-7350 / gregkyser@bellsouth.net
APA Admin. Name: Stephanie Auditore, Membership
Phone/email 202-559-3567/sauditore@psych.org

Attendance Summary:	**Author**	**APA Administration**
Number of Component Members	-	-
Number of Staff	1	-
Number of Non-Staff	6	-
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		-	-	-	-	$0

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

Staff Costs:

	Description:		
1	Coordinate 2 phone meetings or email study groups to write a survey of membership practices.		790
2		-	-
3		-	-
	Total Staff Costs		790

Other Costs not included above:

Contract with "Survey Monkey" to contact membership and gather results. $35 per month or $408 per year.	-
Total Author Estimate	**790**

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	Coordinate 2 phone meetings or email study groups to write a survey of membership practices.	2,370
2	Conduct the email campaign to collect and track responses and manage the survey response rate.	2,370
3	Analyze responses to survey.	1,580
	Total Staff Costs	**6,320**

Other Costs not included above:

In addition to a Survey Monkey membership, conducting a full membership survey would require at least two mailings, at an estimated cost of $24,000.	**24,408**
Total Administration Estimate	**30,728**

Rvsd. Jan. 2018

Action Paper 12.V: *Survey of Membership*

APA Administration Feedback:

DEPARTMENT OF MEMBERSHIP:

The APA regularly encourages members to complete their profile as part of ongoing promotional campaigns. Included in the profile are various question about practice setting, areas of focus, populations treated, etc. Due to the volume of questions, it sometimes challenging to get members to complete their profile. However, with this said, about 39% of our members have either partially or completely completed their profiles. This is a substantially higher than the 5% or lower response rate that are typical of APA surveys. Also, surveys are very expensive and time consuming to administer. Questions asked in the profile can be found here (Upon login select "About Me" from the left-side menu).

EXPLANATION OF COST:

Given our experience conducting member surveys, we know that both email and print mailing solicitations would be required to generate enough responses to make the data meaningful. In addition, there are a number of members who have either opted out of email or do not have an email address on file, so a mailed survey would be required to engage them. The cost, based on other mailings we have conducted of similar size, of mailing a survey to all domestic membership would be $16,000, and we also anticipate the need for a second mailing to those who have not responded to the email or initial mailing and have estimate the cost of that follow-up mailing to be $8,000.
Additionally, based on previous surveys conducted the staff time required to conduct the survey would far exceed 10 hours and we estimate it to be closer to 80 hours.

Attachment #19
Item 2018A1 14.A
Assembly
May 4-6, 2018

APA Official Actions

Position Statement: Screening and Treatment of Mood and Anxiety Disorders During Pregnancy and Postpartum

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: The incidence of mood and/or anxiety disorders in the antenatal and postnatal periods is surprisingly high in the United States and has become a serious public health problem; 1 out of 7–10 pregnant women and 1 out of 5–8 postpartum women will develop a depressive and/or anxiety disorder, and 1 out of 1,000 perinatal women will develop a psychotic disorder. The incidence of these disorders is highest in women from lower socioeconomic backgrounds. Even though depressive disorders are among the most common, emerging evidence warrants a more comprehensive conceptualization of perinatal psychiatric illness to include bipolar disorder and common comorbid illnesses such as general anxiety disorder, obsessive compulsive disorder, and panic disorder. Many studies have shown that depressive symptoms during pregnancy are associated with decreased prenatal care and adverse perinatal outcomes such as preterm birth and low birth weight. Perinatal mental health disorders can be severe; maternal suicide is the second leading cause of death among postpartum women, and approximately 300 infanticides occur in the United States each year. Untreated postpartum mood disorders are also associated in studies with impairments in cognitive, behavioral, and emotional development in the offspring during childhood and adolescence. However, early treatment of mothers with these disorders may prevent these developmental problems. At this time, only a minority of clinicians are using validated screening tools to detect these disorders. Despite the availability of evidence-based treatments, most pregnant and postpartum women with these disorders do not receive adequate assessment or treatment. To improve obstetric outcomes and maternal health, achieve optimal child development, and lower the numbers of maternal and infant deaths, it is imperative that the APA take the lead in prioritizing education and research about these disorders, as well as their screening, diagnosis, and treatment.

POSITION:

The APA recognizes that the risks for psychiatric illness in women are greatest during the reproductive years of their lives, including during pregnancy and the postpartum periods. To prevent long-lasting, adverse effects on the mother, infant, and family, the APA strongly recommends the following:

- All pregnant and postpartum women should be assessed for both the presence of and risks for a psychiatric disorder.
- All obstetrical care providers should provide education to perinatal women on how to recognize the symptoms of depressive, anxiety, and psychotic disorders.

- All obstetrical care providers should screen for depression with a validated screening tool twice during pregnancy and once postpartum; all pediatric clinicians should screen for depression throughout the first six months postpartum. A systematic response to screening should be in place to ensure that psychiatric disorders are appropriately assessed, treated, and followed.
- The APA recommends that behavioral health clinicians educate their patients about the risks associated with untreated psychiatric illness during pregnancy and lactation, as well as the risks and benefits—for both the woman and her baby—of using psychotropic medications while pregnant or breastfeeding.

Authors:
Nancy Byatt, DO, MS, MBA
Debbie Carter, MD
Kristina M. Deligiannidis, MD
C. Neill Epperson, MD
Samantha Meltzer-Brody, MD, MPH
Jennifer L. Payne, MD
Gail Robinson, MD, CM, O.Ont
Nazanin E. Silver, MD, MPH, FACOG
Zachary Stowe, MD
Maureen Sayres Van Niel, MD
Katherine L. Wisner, MD, MS
Kim Yonkers, MD

Attachment #20

Assembly
May 4-6, 2018
New York City, New York

DRAFT SUMMARY OF ACTIONS

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2018 A1 1.A.1	Ratification of APA Bylaws: Will the Assembly vote to ratify the proposed language in the APA by-laws replacing the Rule of 95 with a semi and fully retired category?	The Assembly voted to ratify the proposed language in the APA by-laws replacing the Rule of 95 with a semi and fully retired category.	Chief of Staff • Association Governance Chief Membership & Strategy Officer • Membership FYI- Board of Trustees
2018 A1 4.B.1	Proposed Position Statement on *Peer Support Services*	The Assembly voted to approve the Proposed Position Statement on *Peer Support Services*.	Board of Trustees, July 2018 FYI- Joint Reference Committee, June 2018
2018 A1 4.B.2	Revised Position Statement on *Telemedicine in Psychiatry*	The Assembly voted, on its Consent Calendar, to approve the Revised Position Statement on *Telemedicine in Psychiatry*.	Board of Trustees, July 2018 FYI- Joint Reference Committee, June 2018
2018 A1 4.B.3	Revised Position Statement on *Abortion*	The Assembly voted to approve the Revised Position Statement on *Abortion*.	Board of Trustees, July 2018 FYI- Joint Reference Committee, June 2018
2018 A1 4.B.4	Revised Position Statement: *Resolution Against Racism and Racial Discrimination and Their Adverse Impacts on Mental Health*	The Assembly voted to approve the Revised Position Statement: *Resolution Against Racism and Racial Discrimination and Their Adverse Impacts on Mental Health*.	Board of Trustees, July 2018 FYI- Joint Reference Committee, June 2018
2018 A1 4.B.5	Revised Position Statement on *Religious Persecution and Genocide*	The Assembly voted, on its Consent Calendar, to approve the Revised Position Statement on *Religious Persecution and Genocide*.	Board of Trustees, July 2018 FYI- Joint Reference Committee, June 2018
2018 A1 4.B.6	Proposed Position Statement on *Discrimination Against Religious Minorities*	The Assembly voted to approve the Proposed Position Statement on *Discrimination Against Religious Minorities*.	Board of Trustees, July 2018 FYI- Joint Reference Committee, June 2018
2018 A1 4.B.7	Revised Proposed Position Statement: *Weapons Use in Hospitals and Patient Safety*	The Assembly voted, on its Consent Calendar, to approve the Revised Proposed Position Statement: *Weapons Use in Hospitals and Patient Safety*.	Board of Trustees, July 2018 FYI- Joint Reference Committee, June 2018
2018 A1 4.B.8	Proposed Position Statement: *Risks of Adolescents' Online Behavior*	The Assembly voted, on its Consent Calendar, to approve the Proposed Position Statement: *Risks of Adolescents' Online Behavior*.	Board of Trustees, July 2018 FYI- Joint Reference Committee, June 2018

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2018 A1 4.B.9	Revised Position Statement *Access to Care for Transgender and Gender Diverse Individuals*	The Assembly voted to approve the Revised Position Statement *Access to Care for Transgender and Gender Diverse Individuals*.	Board of Trustees, July 2018 FYI- Joint Reference Committee, June 2018
2018 A1 4.B.10	Revised Position Statement *Discrimination Against Transgender and Gender Diverse Individuals*	The Assembly voted, on its Consent Calendar, to approve the Revised Position Statement *Discrimination Against Transgender and Gender Diverse Individuals*.	Board of Trustees, July 2018 FYI- Joint Reference Committee, June 2018
2018 A1 4.B.11	Proposed Position Statement: *Solitary Confinement (Restricted Housing) of Juveniles*	The Assembly voted, on its Consent Calendar, to approve the Proposed Position Statement: *Solitary Confinement (Restricted Housing) of Juveniles*.	Board of Trustees, July 2018 FYI- Joint Reference Committee, June 2018
2018 A1 4.B.12	Proposed Position Statement: *Psychiatric Services in Adult Correctional Facilities*	The Assembly voted, on its Consent Calendar, to approve the Proposed Position Statement: *Psychiatric Services in Adult Correctional Facilities*.	Board of Trustees, July 2018 FYI- Joint Reference Committee, June 2018
2018 A1 4.B.13	Proposed Position Statement: *Research with Involuntary Psychiatric Patients*	The Assembly voted to approve the Proposed Position Statement: *Research with Involuntary Psychiatric Patients*.	Board of Trustees, July 2018 FYI- Joint Reference Committee, June 2018
2018 A1 4.B.14	Revised Position Statement: *Inquiries about Diagnosis and Treatment of Mental Disorders in Connection with Professional Credentialing and Licensing (2015)*	The Assembly voted, on its Consent Calendar, to approve the Revised Position Statement: *Inquiries about Diagnosis and Treatment of Mental Disorders in Connection with Professional Credentialing and Licensing (2015)*.	Board of Trustees, July 2018 FYI- Joint Reference Committee, June 2018
2018 A1 4.B.15	*Revised 2014 Position Statement on Firearms Access, Acts of Violence and the Relationship to Mental Illness and Mental Health Services*	The Assembly voted to approve the Revised 2014 Position Statement on *Firearms Access, Acts of Violence and the Relationship to Mental Illness and Mental Health Services*.	FYI- Board of Trustees, July 2018 FYI- Joint Reference Committee, June 2018
2018 A1 5.A	Will the Assembly vote to approve the minutes of the November 3-5, 2017 meeting?	The Assembly voted to approve the Minutes & Summary of Actions from the November 3-5, 2017 meeting.	Chief of Staff • Association Governance
2018 A1 6.B	Will the Assembly vote to approve the Consent Calendar?	Items 2018A1 4.B.4 and 4.B.9 were removed from the Consent Calendar. The Assembly approved the Consent Calendar as amended.	Chief of Staff • Association Governance
2018 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 of Staff • Association Governance
2018 A1 7.A	2018-2019 Election of Assembly Officers	The Assembly voted to elect the following candidates as officers of the Assembly from May 2018 to May 2019: Speaker-Elect: Paul J. O'Leary, MD, Area 5 Recorder: Seeth Vivek, MD, Area 2	Chief of Staff • Association Governance

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2018 A1 7.B.1	Will the Assembly vote to approve the application of the Association of Women Psychiatrists (AWP) to become an Assembly Allied Organization/Subspecialty?	The Assembly voted to approve the application of the Association of Women Psychiatrists (AWP) to become an Assembly Allied Organization/Subspecialty.	Chief of Staff • Association Governance
2018 A1 12.A	APA Endorsement of AMA Position Opposing Unsupervised Practice of Non-Physician Practitioners	The Assembly voted to approve item 2018A1 12.A, which asks that the American Psychiatric Association endorse the positions (H35.988, H35.989 and H35.962) taken by the American Medical Association as long as they remain positions of the American Medical Association to oppose the practice of non-physician practitioners to practice without physician supervision.	Joint Reference Committee, June 2018
2018 A1 12.B	Psychiatric Care as Medical Care	The Assembly voted to approve item 2018A1 12.B, which asks that the Council of Psychiatry and Law draft an appropriate statement in opposition to psychiatry being considered separate from medical benefits, create resource documents, and set further recommendations for APA policy.	Joint Reference Committee, June 2018
2018 A1 12.C	Supervision of Psychiatric Mental Health Nurse Practitioners and Physician Assistants in Psychiatry by Psychiatrists	The Assembly voted to approve item 2018A1 12.C, which asks: 1. That the APA will encourage and support research to determine the efficacy and safety of unsupervised mental health practice by Psychiatric Mental Health Nurse Practitioners and Physician Assistants compared to Psychiatrists. 2. That the APA will develop a position statement in support of appropriate supervision of Psychiatric Mental Health Nurse Practitioners and Physician Assistants in Psychiatry. 3. That because of the various types of doctoral degrees that are available to non-physicians, that the APA advocate that all healthcare professionals wear a designation of their license large enough for all patients to see, i.e., physician, nurse clinician, physician assistant, etc. 4. That the APA will include simplified information for public consumption on the patient and family section of the APA website comparing the education of Psychiatrists and prescribing non-physicians for awareness and educated consumer choice.	Joint Reference Committee, June 2018
2018 A1 12.D	Requesting CMS Help Us Improve Addiction Treatment Process	The Assembly voted to approve item 2018A1 12.D, which asks that the APA advocate with CMS to cover for the purposes of billing for urine drug screens all diagnostic codes that are part of the Substance Use Disorders section of ICD.10.	Joint Reference Committee, June 2018

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2018 A1 12.E	Position Statement on Psychologist Prescribing	The Assembly voted to approved item 2018A1 12.E, which asks that the American Psychiatric Association join with the American Academy of Child and Adolescent Psychiatry and the American Medical Association opposing any legislation or regulation at the state or federal level that would grant psychologists prescribing privileges. We oppose psychologists prescribing medication because training in psychology does not provide medical education that is essential for the appropriate and safe prescription of medications.	Joint Reference Committee, June 2018
2018 A1 12.F	Medication Assisted Treatment of Physicians in Treatment Participating in Physician Health Programs	The Assembly voted to approve item 2018A1 12.F, which asks that our American Psychiatric Association review available evidence on the use of medication assisted treatment by physicians in recovery with substance use disorders, and Based on the results of a review of available evidence, that the American Psychiatric Association develops a position statement on the use of medication assisted treatment by physicians under the supervision of physician health programs. That our APA work with the AMA and other appropriate entities to ensure that physicians seeking treatment of substance use disorders through Physician Health programs are afforded evidence-based Medication-Assisted Treatment (MAT).	Joint Reference Committee, June 2018
2018 A1 12.G	Endorsing a Single Payer Nationwide Health Care System	The Assembly voted to **postpone** voting on item 2018A1 12.G until the November 2018 Assembly meeting.	Assembly, November 2018
2018 A1 12.H	Researching a Single Payer Nationwide Health Care System	The Assembly voted to approve item 2018A1 12.H, which asks that the APA, through its Council on Healthcare Systems and Financing, conduct a study and evaluate Single Payer Health Plans compared with the other Health Care Delivery models which could provide universal access to health care, inclusive of mental health care, in the United States.	Joint Reference Committee, June 2018
2018 A1 12.I	Improving Identification and Treatment of Borderline Personality Disorder	The Assembly voted to approve item 2018A1 12.I, which asks that the APA's Division of Education create a Supplemental Education and Training (SET) learning module on common factor treatment approaches for BPD.	Joint Reference Committee, June 2018
2018 A1 12.J	Improving Access to the ABPN Examinations	The Assembly voted to approve item 2018A1 12.J, which asks that APA lobby the ABPN to offer a minimum of four five-day examination periods through the year.	Joint Reference Committee, June 2018
2018 A1 12. K	Service Members and Their Families Deserve Quality Psychiatric Treatment	The Assembly voted to approve item 2018A1 12.K, which asks that the APA make an appeal to TriCare for formulary coverage that includes an appropriate balance of conventional and atypical long-acting injectable antipsychotic medications.	Joint Reference Committee, June 2018

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2018 A1 12.L	Defending the Public Service Loan Forgiveness (PSLF) Program	The Assembly voted to approve item 2018A1 12.L, which asks: 1) The American Psychiatric Association will support the continuation of the Public Service Loan Forgiveness program and make its defense an advocacy priority as an access to care matter. 2) The American Psychiatric Association will partner with other medical societies (e.g. the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians, etc.), when appropriate, to further this advocacy goal.	Joint Reference Committee, June 2018
2018 A1 12.M	APA Supports Psychiatrists to Practice Psychiatry Without the Unproven Requirements of the MOC	The Assembly voted to approve item 2018A1 12.M, which asks that the APA advocate with the ABMS and ABPN to return to lifetime board certification.	Joint Reference Committee, June 2018
2018 A1 12.N	Developing a Web Based Tool Kit for Psychiatrists and Patients Who Wish to Appeal Adverse Medical Necessity Decisions by Managed Care Entities	The Assembly voted to approve item 2018A1 12.N, which asks that the APA will improve its webpage, "appealing treatment denials", to provide assistance to clinicians and patients who believe they face improper denial of access to medically necessary care. The webpage will offer a user-friendly tool kit that describes steps to maximize the likelihood of an appeal being successful.	Joint Reference Committee, June 2018
2018 A1 12.O	Addition of Adequate Amounts of Phosphatidylcholine (choline) to all Prenatal Vitamins	The Assembly voted to approve item 2018A1 12.O, which asks that the American Psychiatric Association supports that evidence-based amounts of bioavailable choline be added to all prenatal vitamins.	Joint Reference Committee, June 2018
2017 A1 12.P	Aligning the Financial Contributions of the APA*PAC* with the Stated Policy of the APA Regarding Firearm Regulation	The Assembly did not approve the action paper.	N/A
2018 A1 12.Q	Psychiatric Management of the Impact of Racism on Social and Clinical Events	The Assembly voted to approve item 2018A1 12.Q, which asks that the APA enhance membership and public education about the mental health effects of racial discrimination, micro-aggression, race-based violence, racially motivated mass killings and similar events, through duly implemented curricular guidelines for medical schools, residency training, and continuing medical education programs, as well as media outreach. That the index of subsequent versions of DSM will refer to race and racism content currently present in sections and subsections.	Joint Reference Committee, June 2018
2018 A1 12.R	A Call to Recognize and Honor the Psychiatrists Who Served in Vietnam	The Assembly voted to approve item 2018A1 12.R, which asks that the American Psychiatric Association will formally recognize the men and women psychiatrists who served in Vietnam.	Joint Reference Committee, June 2018
2018 A1 12.S	Guidelines for Public Statements by Psychiatrists	The Assembly did not approve the action paper.	N/A

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2018 A1 12.T	Streamlining the APA Application Renewal Process	The Assembly voted to approve item 2018A1 12.T, which asks that the APA continue streamlining the renewal process by initiating, as one option, a one-click payment link that allows a member to directly pay dues without logging into the website or going through multiple screens that could distract or prevent the member from renewing.	Joint Reference Committee, June 2018
2018 A1 12.U	Action Paper Follow up by the Assembly	The Assembly voted to approve item 2018A1 12.U, which asks that the Assembly direct the Speaker to appoint an ad hoc work group which will determine the functionality of a database that provides easy access to all members of the APA in order to track the progress of every Action Paper approved by the Assembly and to make those Action Papers searchable including by keywords.	Assembly Executive Committee, July 2018
2018 A1 12.V	Survey of Membership	The Assembly voted to approve item 2018A1 12.V, which asks that the APA convene a study group to determine the best and most cost-effective mechanism to assess demographics from the membership addressing a wide variety of practice styles and professional activities including, but not limited to: • Employment settings: private practice, government employment, academic appointment, group practice, collaborative care models, etc. • Participation in insurance: including private healthcare, Medicare/Medicaid, private pay and Worker's Compensation, etc. • Utilization of electronic medical records The results of the study group would be formulated into a survey or other mechanism to be administered to the entire membership in order to assist the APA in addressing future policies and advocacy with full knowledge of the potential scope of impact on the individual members.	Joint Reference Committee, June 2018
2018 A1 12.W	APA Referendum Voting Procedure	The Assembly did not approve the action paper.	N/A
2018A1 14.A	Proposed Position Statement: *Screening and Treatment of Mood and Anxiety Disorders During Pregnancy and Postpartum*	The Assembly voted to refer the Proposed Position Statement: Screening and Treatment of Mood and Anxiety Disorders During Pregnancy and Postpartum back to the Joint Reference Committee.	Joint Reference Committee, June 2018