### November 2018 Assembly Action Papers

[Click on the highlighted item number to view the item in the packet.]

<table>
<thead>
<tr>
<th>Item #s</th>
<th>Action Paper Titles</th>
<th>Authors’ Cost Estimates</th>
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<td>2018A2 12.B</td>
<td>Psychiatric Oversight of Mental Health Treatment in Child Welfare and Juvenile Justice Programs</td>
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ACTION PAPER

TITLE: American Psychiatric Association (APA) to Institute Biannual Review of the Medications for the Treatment of Psychiatric and Substance Use Disorders on the World Health Organization’s (WHO) Essential Medicines List (EML)

WHEREAS:

WHEREAS: The WHO’s EML is a list of medications to treat a broad variety of conditions that impact people across the globe. The list serves as a basis for all member countries in acquiring and providing those medications to its populations, and thus is particularly important for developing countries to structure their formularies. It is updated every two years in an effort to reflect the latest evidence for efficacy, safety, and cost-effectiveness of medications. Practitioners or larger organizations may submit an application for updating the EML.

WHEREAS: Upon review of the most recent list, updated in 2017, it is noted that there are just two medications listed to treat depressive disorders: amitriptyline (as a representative of its pharmacological class, tablet: 25 mg; 75mg) and fluoxetine (solid oral dosage form: 20 mg, with an age restriction of >8 years). Fluoxetine was added in 2007, and it appears no changes to this specific list have been made since then. As it stands, the list appears deficient. The prescription of tricyclic antidepressants presents a number of challenges. As the APA 2010 guidelines in the treatment of depressive disorders note, “TCAs are generally not optimal in patients with cardiovascular conditions, cardiac conduction defects, closed angle glaucoma, urinary retention, significant prostatic hypertrophy, or eating disorders with significant malnutrition or purging. In older adults with malnutrition, autonomic disorders (e.g. diabetic neuropathy, Parkinson’s disease), or low blood pressure, TCAs may exacerbate hypotension and orthostasis, resulting in syncope or falls.” TCAs also carry a number of drug-drug interactions, thereby further limiting which patients could benefit from amitriptyline.

WHEREAS: Fluoxetine is an appropriate antidepressant to include on the list but it too is associated with a number of drug-drug interactions. The latest evidence suggests that escitalopram is one of the most efficacious and tolerable medications within the SSRI class, and one of the most common first-line treatments for depression. A review of its cost-effectiveness has been completed by several authors of this paper, which further suggests that it may escitalopram fact be more cost-effective than the other SSRIs, particularly due to its efficacy in achieving either remission or meaningful symptom reduction. Now that the generic version of escitalopram has been introduced to the market in 2012, it may be even more cost-effective than previously determined.

WHEREAS: The authors of this paper are currently in the process of filling out the application to include escitalopram on WHO’S EML, in an effort to improve the availability of pharmacological interventions for the treatment of depression worldwide. Treatment of depression and related psychiatric conditions is a particular concern with the high incidence and prevalence noted in disaster settings worldwide. While adding one medication may help, there are good arguments to be made for including an SNRI and considering bupropion and mirtazapine, particularly given an antidepressant response rate of 50-75%
per APA guidelines. The deadline for applications for suggested additional medications is December 7, 2018, and each suggestion must be on a separate and individual submission. Reviews are done biannually, so next possibility for suggestions is December, 2020. The authors are, therefore, also seeking support from psychiatrists involved with international psychiatry for this effort as well as components of the APA to add multiple submissions, as an official action paper will not be processed before the December 7, 2018, if accepted by the APA Assembly to be submitted to the APA Board of Trustees for consideration.

BE IT RESOLVED:

The APA will create a process for biannual review of the World Health Organization’s Essential Medicines List, focused on essential medications for the treatment of psychiatric and substance use disorders. The recommendation is that the Council on International Psychiatry would conduct the review through APA staff efforts, and that the Council of Advocacy and Government Relations and the Council of Minority Mental Health and Health Disparities would be asked to consult and review suggestions. The APA may also seek collaboration with the World Psychiatric Association (WPA) in the future efforts, but would not be a requirement for the APA to proceed with this process.

AUTHORS:
Robert Paul Cabaj, M.D., Representative, Northern California Psychiatric Society
Iona Machado, M.D., APA Member

ESTIMATED COST:
Author: $790
APA: $3,160

ESTIMATED SAVINGS: $0

ESTIMATED REVENUE GENERATED: $0

ENDORSED BY: Northern California Psychiatric Society, in principle

KEY WORDS: Medications

APA STRATEGIC PRIORITIES: Advancing Psychiatry

REVIEWED BY RELEVANT APA COMPONENT: Council on International Psychiatry
### Action Paper Worksheet

**2018 Action Paper Budget Estimate**

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- LCD Projector
- Laptop
- Screen
- Flipchart
- Microphones

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#### Staff Costs:

- **Description:**
  List psych meds on WHO EML Spring even-numbered years, present to Council on Intern'l Psych, and submit changes to WHO in early December.
  
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  2. -
  3. -

#### Total Staff Costs: 790

#### Other Costs not included above: -

- None

#### Total Author Estimate: 790

#### APA Administration Estimate:

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#### Non-Staff Costs:
- LCD Projector
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- Microphones

#### Total Non-Staff Costs: -

#### Staff Costs:

- **Description:**
  Staff time to coordinate: the review (by conference call and email), development of an action plan and submission process as appropriate.

  1. 3,160
  2. -
  3. -

#### Total Staff Costs: 3,160

#### Other Costs not included above: -

- None

#### Total Administration Estimate: 3,160


**Action Paper Title:** 12.A: APA to Institute Biannual Review of the Medications for the Treatment of Psychiatric and Substance Use Disorders

**Action Paper Author(s):**
- Robert Paul Cabaj, M.D., Representative, Northern California Psychiatric Society
- Becky Yowell, Reimbursement Policy Specialist, APA Administration

**APA Administration Feedback:**

**DEPARTMENT:** Policy, Programs/Partnerships; Department of Reimbursement Policy

**EXPLANATION OF COST:** The cost of this effort would be in the staff time necessary to identify and work with/coordinate the activities of APA members (work group) charged with the review of the existing list, development of recommendations and submission of the application. This would include identifying and assembling relevant background materials based on what is required as part of the application process. The number of applications submitted in any two-year cycle will also impact the amount of staff time required for this effort.
TITLE: Psychiatric Oversight of Mental Health Treatment in Child Welfare and Juvenile Justice Programs

WHEREAS:
Many children and adolescents are removed from their homes, schools and communities through no fault of their own when their home is unsafe, or their parents are found unfit to be custodial guardians.

Justice-involved youth who have been adjudicated can be mis-diagnosed in the hope that their criminality will respond to psychotropic medication.

The behaviors and emotions caused by psychosocial disruption, be it due to parental neglect or abuse, or the family and neighborhood conditions that can contribute to criminality, can mimic psychiatric disorders.

In the experience of the authors, working in juvenile justice, there have been an alarming number of referrals for psychotropic medication prescribing for the chief complaint of “anger.”

Decisions to obtain psychiatric evaluations are referred by agency case managers and foster agencies who often underappreciate the effect the psychosocial disruption on the child's emotional and behavioral functions and are often unaware of the child's developmental, medical and psychiatric histories.

Because the child's case manager and welfare agencies are under tremendous pressure to preserve the foster child's placement, combined with inadequate history, the psychiatric evaluations suffer from poor history and over emphasis on unwanted behaviors and under reporting of the context that promotes them.

Individual practitioners are at a disadvantage because of a poor data base and are prone to diagnose more serious mental illnesses and treat with biological treatments that the child or adolescent may not need.

The acceleration of antipsychotic medications over the last two decades even in very young children can be understood at least in part by the routine described above.

Unwarranted antipsychotic medication over a life time add to risk of irreversible movement disorders and risk of metabolic syndrome without clinical justification.

Psychiatric diagnoses tend to hide the nature of social system problems because the effects of disruption and attachments become conceived of as psychiatric disorders rather than the practices that instigate some behavioral and emotional dysfunction. This stunts the development of psychosocial remedial programs this population needs.

Individual practitioners are unable to detect trends across the community that child welfare and juvenile
justice services cover.

The county and state child and adolescent agencies do not always have psychiatric participation in their administrations and therefore can be blind to quality trends identified by our profession.

BE IT RESOLVED:
That the APA endorses the practice of psychiatric oversight, by legislation or agency administrative practices, of specific program elements of state and county child and adolescent welfare and juvenile justice programs. Oversight is defined by a properly funded and staffed quality assurance program to detect appropriate and relevant diagnostic procedures leading to valid diagnoses AND appropriate prescription and administration of psychotropic medications by prescribing providers. The quality assurance program should be directed by a board-certified child and adolescent psychiatrist.

AUTHORS:
Philip Malinas, M.D., Representative, Nevada Psychiatric Association
Norton Roitman, M.D., APA Member

ESTIMATED COST:
Author: $0
APA: $9,480

ESTIMATED SAVINGS: $0

ESTIMATED REVENUE GENERATED: $0

ENDORSED BY: Area 7 Council

KEY WORDS: child welfare, juvenile justice, psychiatric oversight

APA STRATEGIC PRIORITIES: Advancing Psychiatry

REVIEWED BY RELEVANT APA COMPONENT: Council on Children, Adolescents and Their Families; Council on Healthcare Systems and Financing
**Action Paper Worksheet**

**2018 Action Paper Budget Estimate**

**Action Paper Title:** 12.B: Psychiatric Oversight of Mental Health Treatment in Child Welfare and Juvenile Justice Programs  
**Action Paper Author(s):** Philip Malinas, M.D., Representative, Nevada Psychiatric Association  
**Phone/email:** 775-813-5246/philip@malinasmd.com  
**APA Admin. Name:** Michelle Dirst, Practice Management & Delivery Systems  
**Phone/email:** midirst@psych.org

### Attendance Summary:

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### Other Costs not included above: -

**Total Administration Estimate** 9,480

Rvd. Jan. 2018

APA Administration Feedback:

DEPARTMENT: Department of Practice Management and Systems Delivery & the Department of Government Relations

The APA Administration will review relevant APA position statements and resource documents that may impact achieving the task. In addition, APA Administration will evaluate relevant legislation and regulatory action on mental health treatment in the child welfare and juvenile justice programs and support psychiatric oversight.

EXPLANATION OF COST:
The APA Administration projects it will take 120 hours of staff time to analyze legislation/regulations and communicate support for psychiatric oversight.
ACTION PAPER

TITLE: Access to Care Challenges and the Role of Residents

WHEREAS:
Whereas, shortage of psychiatrists contributes significantly to access to quality care and,

Whereas, the possibility of adding residency slots in psychiatry seems improbable and,

Whereas, Psychologists and other mid-level providers have used the access issue to push for expansion of scope initiatives and,

Whereas, even with the addition of APNs, the crisis seems not to abate, and

Whereas, arguably residents and fellows who have advanced in their training deliver higher quality of care than other mid-level providers, and

Whereas, PG3 and PG4 level residents in psychiatry, offer options to provide care in a variety of health settings, and

Whereas, there are over 2500 residents that could potentially moonlight in these areas, and

Whereas, there are bona fide considerations such as work hours, criteria for permanent licensure varying in different states, and

Whereas, there is need to ensure training is not compromised, while there may be settings that add to the competencies of residents,

BE IT RESOLVED:
That our APA, through its existing Components and Councils or Task force/workgroup, to review a broad range of related issues, including but not limited to the necessary requirements in terms contracts with 3rd party payers, relevant tele-psychiatry training to allow underserved areas to be served, working with Program directors, to raise awareness of the critical role moonlighting residents have in our workforce, including opportunities that may be less known, and Be it further resolved, that a status report be given to the APA Assembly no later than the APA Annual meeting in May 2019.

AUTHORS:
Shastri Swaminathan, M.D., Representative, Illinois Psychiatric Society
Jeffery Bennett, M.D., Representative, Illinois Psychiatric Society
Linda Gruenberg, M.D., Representative, Illinois Psychiatric Society
Jagannathan Srinivasaraghavan, M.D., Representative, Illinois Psychiatric Society
ESTIMATED COST:
Author: $0
APA: $790

ESTIMATED SAVINGS: $0

ESTIMATED REVENUE GENERATED: $0

ENDORSED BY: Area 4 Council

KEY WORDS: Access to care, workforce, residents

APA STRATEGIC PRIORITIES: Advancing Psychiatry

REVIEWED BY RELEVANT APA COMPONENT:
### Action Paper Worksheet

**2018 Action Paper Budget Estimate**

**Action Paper Title:** 12.C: Access to Care Challenges and the Role of Residents  
**Action Paper Author(s):** Shastri Swaminathan, M.D., Representative, Illinois Psychiatric Society  
**Phone/email:** docshrink1@gmail.com  
**APA Admin. Name:** Kristen Moeller, Division of Education  
**Phone/email:** 202 559 3897 kmoeller@psych.org

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**Total Author Estimate:** -

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#### Other Costs not included above:

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**Total Administration Estimate:** 790

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Rvd. Jan. 2018

**APA Administration Feedback:**

**DEPARTMENT:** Division of Education/Council on Medical Education

**EXPLANATION OF COST:**
Estimate is based on the following understanding of the action:

The review and informative report would be prepared by existing Components and Councils or Task force/workgroup – the report would inform: Program Directors, Chairs, leadership of DBs and Residents

The authors are asking for a **review, with the output of a report covering:**

- contract issues that may be barriers across the United States
- duty hours that may be barriers
- additional barriers
- the Review would include information about how to raise awareness among program directors regarding the role moonlighting residents have in our workforce.

The author of the paper gave additional information: There is a great deal of misinformation about contracts w third party payers, working in community mental health centers which seems to hold them back. The idea is that many of these opportunities involve Telepsychiatry which generally does not need specific training except some experience is preferred. The idea here was expose Residents to this sort of delivering care so they could avail of this opportunity while they are moonlighting.
TITLE: Medicaid Reform and Access to Quality Mental Health Care

WHEREAS:
Whereas, Medicaid is the single largest insurance providing for services to 40% of all mental health care recipients and

Whereas, Medicaid is a state-based program with significant matching federal dollars, and

Whereas, in an attempt to manage cost a vast majority of States, have turned the delivery of care to Managed care organizations, and

Whereas, the experience of these MCOs have been highly variable, being successful in some States in controlling cost though not necessarily improving quality or access, or creating severe access problems, with inadequate providers, archaic prior authorization requirements, and varying formularies, and

Whereas, leadership and members in our DBs are looking for examples of well-run State programs, and

Whereas, the data that comes State generated website based information is unreliable and falsely declares that managed Medicaid as being an all-around success. therefore

BE IT RESOLVED:
That our APA, through its Council on Healthcare and Financing and other appropriate Councils and Committees in concert with DBs, review the experience of different States, especially those successful in providing quality care and control costs which other States can be modeled after, and
Be it further resolved that a detailed status report be given to the Assembly, no later than May of 2019.

AUTHORS:
Shastri Swaminathan, M.D., Representative, Illinois Psychiatric Society
Jeffery Bennett, M.D., Representative, Illinois Psychiatric Society
Linda Gruenberg, M.D., Representative, Illinois Psychiatric Society
Jagannathan Srinivasaraghavan, M.D., Representative, Illinois Psychiatric Society

ESTIMATED COST:
Author: $0
APA: $18,960

ESTIMATED SAVINGS: $0

ESTIMATED REVENUE GENERATED: $0

ENDORSED BY: Area 4 Council
KEY WORDS: Medicaid, public aid, reform, mental health, access

APA STRATEGIC PRIORITIES: Advancing Psychiatry

REVIEWED BY RELEVANT APA COMPONENT:
### Action Paper Worksheet
#### 2018 Action Paper Budget Estimate

**Action Paper Title:** 12.D: Medicaid Reform and Access to Quality Mental Health Care  
**Action Paper Author(s):** Shastri Swaminathan, M.D., Representative, Illinois Psychiatric Society  
**Phone/email:** docshrink1@gmail.com  
**APA Admin. Name:** Kathy Orellana, Practice Management & Delivery Systems  
**Phone/email:** korellana@psych.org

#### Attendance Summary:

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#### Non-Staff Costs:

- LCD Projector  
- Laptop  
- Screen  
- Flipchart  
- Microphones

**Total Non-Staff Costs:**

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| 1           | Review of State Medicaid programs and development of a report | 18,960  
| 2           | - | -  
| 3 | - | -

**Total Staff Costs:** 18,960

#### Other Costs not included above:

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**Total Author Estimate:**

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| 3 | - | -

**Total Staff Costs:** 18,960

#### Other Costs not included above:

- -

**Total Administration Estimate:** 18,960

Rvd. Jan. 2018

**APA Administration Feedback:**

**DEPARTMENT/COMPONENT:** The Council on Healthcare Systems and Financing and the Department of Government Relations

The APA Administration will work with the Council, and other appropriate components, to identify existing resource documents, whitepapers and evidence-based data relevant to state Medicaid plans. However, with limited resources within the APA, the Administration recommends seeking collaborative opportunities to work with external stakeholders to provide a comprehensive review of state Medicaid plans and develop a report in coordination with the Council.

**EXPLANATION OF COST:**

The APA Administration projects 240 hours for the staff to review state Medicaid plans.
ACTION PAPER

TITLE: Simplification of Electronic Health Record Required Documentation by Physicians

WHEREAS:
International studies show that one-third to one-half of physicians experience burnout;
Burnout affects physician professionalism, patient safety and satisfaction;
Physician satisfaction with EHRs is generally low;
Medicare Meaningful Use requires additional time/click burden to physicians;
The use of EHR is a major contributor to physician burnout;
Many U.S. governmental forms provide an estimate of “time required to complete” (ex, IRS);
Since “If it’s “not measured”, it is “not important”;

BE IT RESOLVED:
1. That the APA/AMA delegation push for a time study TO ITEMIZE the amount of time required by the physician provider to complete existing Medicare / Medicaid: 1) clinical documentation; and 2) documentation of efficacy of healthcare quality measures.
These should optimally be itemized by data field (ex: time for smoking cessation entry)].

2. That the APA/AMA delegation push for a study ITEMIZING the amount of time required by the physician provider for any new Medicare/Medicaid documentation requirement, as well as the efficacy of such requirements, prior to the establishment of the requirement.

3. That the APA/ AMA encourage EHR vendors to:1) create time estimates for both clinical and quality measures 2) make such time estimates visible and accessible to clinician 3) regularly update such time estimates based upon real world clinical feedback.

4. That APA / AMA send correspondence to all State Medicaid and Medicaid Medical Directors encouraging collaboration among state insurance agencies in regard to narrowing which quality measures will be focus of attention over given period of time such that the time required for clinicians to complete is sensible, reasonable.

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

ESTIMATED COST:
Author: $7,900
APA: $7,900

ESTIMATED SAVINGS:
References:


**Action Paper Worksheet**

**2018 Action Paper Budget Estimate**

**Action Paper Title:** 12.E: Simplification of Electronic Health Record Required Documentation by Physicians  
**Action Paper Author(s):** Mary Fitz-Gerald, M.D., Representative, Louisiana Psychiatric Medical Association  
**Phone/email:** mfitzg@lsuhsc.edu 318-675-6045  
**APA Admin. Name:** Becky Yowell, Reimbursement Policy  
**Phone/email:** 202-683-8298/byowell@psych.org

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**Total Author Estimate 7,900**

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**Other Costs not included above:** -

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**Total Administration Estimate 7,900**

Rvd Jan. 2018
APA Administration Feedback:

DEPARTMENT: Policy, Programs/Partnerships; Department of Reimbursement Policy

EXPLANATION OF COST: The cost of this effort would be staff time necessary to facilitate advocacy efforts with the various stakeholder groups (AMA, EHR vendors, Medicaid). This would include getting a handle on the existing literature on this issue as well as past and current activities relevant to the proposal. As you may be aware, CMS has recently proposed changes that could impact the amount of time necessary for clinical documentation.
TITLE: Peer Support Services for Families

WHEREAS:
1. Family peer support workers are family members of people living with mental illness, who are trained to give support to other families of people living with mental illness. 
2. Family Peer Support Services (Peer Support Services for Families) help caregivers to navigate the resources available in their communities. 
3. Peer Support Services for families helps families and caregivers of people living with mental illness through face-to-face meetings &/or phone calls to offer hope and guidance. 
4. Family members and caregivers of those with mental illness often play important roles in initiating and supporting treatment. 
5. Support from family and other caregivers can make a big difference in outcomes. 
6. Families and caregivers often feel isolated and require knowledge of best approaches to helping their loved ones. 
7. Self-help programs have been shown to provide a variety of benefits for family members. 
8. Good family support appears to be an important facilitator of treatment engagement during the first several months of outpatient treatment. 
9. Clinicians may increase their effectiveness by directly addressing issues of family burden and distress while also providing referrals to community supports. 
10. The APA already has a position statement on Peer Support Services, which does not include Peer Support for FAMILIES. 
11. The APA supports access to quality psychiatric care.

BE IT RESOLVED:
That: 
1. The APA refer this paper to the Assembly Committee on Public and Community Psychiatry to propose modifications to the APA Position Statement on Peer Support and to report these back to the Assembly at the May, 2019 Assembly meeting. 
2. The modification shall reflect the sentiment of the Assembly that APA supports the value of family peer support services given the role of these services in improving access to recovery-oriented, quality psychiatric care and treatment.

AUTHORS:
Judy Glass, M.D., Representative, Quebec & Eastern Canada District Branch 
Jeffrey Geller, M.D., MPH, Representative, American Association of Community Psychiatrists

SPONSORS:
Gabrielle Shapiro, M.D., Representative, New York County Psychiatric Society 
Lisa Catapano-Friedman, M.D., Vermont Psychiatric Association 
Mary Jo Fitz-Gerald, M.D., Louisiana Psychiatric Medical Association 
Joseph C. Napoli, M.D., Representative, Area 3
Daniel P. Neff, M.D., Representative, Pennsylvania Psychiatric Society
Joshua Sonkiss, M.D., Representative, Alaska Psychiatric Association

ESTIMATED COST:
Author: $790
APA: $79

ESTIMATED SAVINGS: $0

ESTIMATED REVENUE GENERATED: $0

ENDORSED BY: Area 1 Council, Assembly Committee on Access to Care, Assembly Committee on Public and Community Psychiatry

KEY WORDS: Family peer support, access to care, recovery

APA STRATEGIC PRIORITIES: Advancing Psychiatry, Education

REVIEWED BY RELEVANT APA COMPONENT: Submitted for review to the Council on Children, Adolescents and Their Families

References:
1. [https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5548144/](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5548144/) Outcomes of a Family Peer Education Program for Families of Youth and Adults with Mental Illness, (Schiffman, Reeves, Kline, Medoff, Lucksted, Hoagwood, Fang, Dixon)
3. [https://www.mdcoalition.org/blog/have-you-ever-wondered-what-is-family-peer-support](https://www.mdcoalition.org/blog/have-you-ever-wondered-what-is-family-peer-support)
Position Statement on Peer Support Services

Approved by the Board of Trustees, July 2018
Approved by the Assembly, May 2018

“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:** Peer support is an essential component of recovery-oriented systems of care. It offers advantages in outreach and engagement, provision of hope, coaching and modeling, recovery skill building, and system navigation. Peer support services have been found to enhance outcomes in a wide variety of service settings and programs. APA’s formal support of the value of peer support services demonstrates the commitment of the psychiatric community to participate in the development of recovery-oriented services within systems of care.

**POSITION:**

The American Psychiatric Association supports the value of peer support services and is committed to their participation in the development and implementation of recovery-oriented services within systems of care. APA also advocates for appropriate payment for these services. Peer support personnel should have training appropriate to the level of service they will be providing.

Psychiatrists should be knowledgeable of the value and efficacy of the wide array of peer support services in recovery and support the integration of these services into the comprehensive continuum of care.

**Authors:**
Council on Healthcare Systems and Financing

© Copyright, American Psychiatric Association, all rights reserved
### Action Paper Title:
12F: Peer Support Services for Families

### Action Paper Author(s):
Judy Glass, M.D., Representative, Quebec & Eastern Canada District Branch

### APA Admin. Name:
Kathy Orellana, Practice Management & Delivery Systems

### Phone/email:
jcgg@sympatico.ca

corellana@psych.org

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#### Attendance Summary:

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- LCD Projector: -
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- Flipchart: -
- Microphones: -

**Total Non-Staff Costs:**

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#### Staff Costs:

1. 10 hours of staff time: 790

2. - -

3. Total Staff Costs:

**Other Costs not included above:**

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**Total Author Estimate:** 790

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#### APA Administration Estimate:

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- Microphones: -

**Total Non-Staff Costs:**

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#### Staff Costs:

1. Staff will provide guidance to the Committee on Public and Community Psychiatry on the proposed edits: 79

2. - -

3. Total Staff Costs: 79

**Other Costs not included above:**

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**Total Administration Estimate:** 79

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Rsvd. Jan. 2018

APA Administration Feedback:

DEPARTMENT: Practice Management and Delivery Systems Policy

EXPLANATION OF COST:
Staff time to provide Assembly Committee on Public and Community Psychiatry technical assistance.
TITLE: Removing Barriers to Improve Healthcare Access in Puerto Rico

WHEREAS:
Medicaid funding to Puerto Rico was capped at $335,300,000 during the fiscal year 2016.

The Affordable Care Act provided Puerto Rico $5.4 billion in Medicaid funding for the period of July 1, 2011 to September 30, 2019. This has been used to supplement the cap.

Once this funding runs out, Puerto Rico will be subject to the cap once again.

The Federal Medical Assistance Percentages (FMAP) is used to decide the amount of Federal matching funds for each State expenditures for certain social services. The FMAP rate in Puerto Rico is fixed at 55%. If Puerto Rico’s FMAP were calculated using the same formula as for the states, it would be 83%. However, the benefit of the FMAP would be limited by the Medicaid cap. Puerto Rico spent $2.46 billion on Medicaid in 2016; when factoring in the $335.3 million cap, this denotes an effective reimbursement rate of only 14%.

The AMA also supports the elimination of inequities in Medicaid reimbursement (H-390.953) as well as advocating the U.S. Congress to pass legislation to adequately fund Medicaid to Puerto Rico and the U.S. Virgin Islands (D-290.975).

BE IT RESOLVED:
That the APA advocate for sustained and adequate funding for healthcare and mental healthcare in Puerto Rico by removing barriers to healthcare, such as the Medicaid cap.

That APA support using the FMAP rate applied to the mainland U.S. states to Puerto Rico and other U.S. territories.

That APA work with all appropriate medical societies and associations to advocate for the elimination of inequities in Medicaid and Medicare funding for Puerto Rico and other U.S. territories

AUTHORS:
Jose P. Vito, M.D., Representative, New York County Psychiatric Society
Alan T. Rodríguez Penney, M.D., APA Member
Hector A. Colón-Rivera, M.D., APA Member
David R. Díaz, M.D., APA Member

SPONSORS:
James L. Fleming, M.D., Representative, Missouri Psychiatric Association
Joseph C. Napoli, M.D., DLFAPA, Representative, Area 3
Felix Torres, M.D., FAPA, MBA, Representative, New York County Psychiatric Society
Oscar Perez, M.D., Representative, Hispanic Psychiatrists
Gabrielle Shapiro, M.D., Representative, New York County Psychiatric Society
Maria Bodic, M.D., FAPA, ECP Representative, Area 2
Jeffrey L. Geller, M.D., Representative, American Association of Community Psychiatrists
Anish Dube, M.D., Representative, Asian-American Psychiatrists
Ubaldo Leli, M.D., Representative, LGBTQ Psychiatrists
Navjot Brainch, M.D., RFM Representative, Area 2

ESTIMATED COST:
Author: $0
APA: $9,875

ESTIMATED SAVINGS: $0

ESTIMATED REVENUE GENERATED: $0


KEY WORDS: Puerto Rico, healthcare inequity

APA STRATEGIC PRIORITIES: Advancing Psychiatry

REVIEWED BY RELEVANT APA COMPONENT:
### Action Paper Worksheet
#### 2018 Action Paper Budget Estimate

**Action Paper Title:** 12.G: Removing Barriers to Improve Healthcare Access in Puerto Rico  
**Action Paper Author(s):** Jose P. Vito, M.D., Representative, New York County Psychiatric Society  
**Phone/email:** 202-459-9747 / dmcrae@psych.org  
**APA Admin. Name:** Deana McRae, Department of Government Relations  
**Phone/email:**  

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#### Non-Staff Costs:
- LCD Projector  
- Laptop  
- Screen  
- Flipchart  
- Microphones  

**Total Non-Staff Costs:**  

#### Staff Costs:

**Description:**  

1. APA staff time to coordinate with the other medical societies  
2. APA general lobbying campaign including Capitol Hill meetings  
3.  

**Total Staff Costs:**  

#### Other Costs not included above:  

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**Total Author Estimate:**  

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### APA Administration Estimate:

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#### Non-Staff Costs:
- LCD Projector  
- Laptop  
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- Microphones  

**Total Non-Staff Costs:**  

#### Staff Costs:

**Description:**  

1. APA staff time to coordinate with the other medical societies  
2. APA general lobbying campaign including Capitol Hill meetings  
3.  

**Total Staff Costs:**  

**Other Costs not included above:**  

0

**Total Administration Estimate:** 9,875

Rsvd. Jan. 2018

APA Administration Feedback:

**DEPARTMENT:** The Department of Government Relations
The Department of Government Relations supports the concept of advocating for sustained funding to ensure access to quality healthcare and mental healthcare in Puerto Rico and other US territories. While an important issue to address, the Department recognizes the issue does not currently align with APA priorities. In addition, the Department understands the action paper tackles a complex issue and may be impacted by both limited resources and the political environment.

**DEPARTMENT:** Department of Practice Management and Systems Delivery
The Department of Practice Management and Systems Delivery concurs with the comments received from the members of the Council on Healthcare Systems and Financing. The Council agrees the APA should support efforts to increase access to care in Puerto Rico and the territories, the priority should continue to focus on maintain Medicaid coverage for individuals with mental health and substance use disorders given the continuous efforts to roll it back.

**EXPLANATION OF COST:**
The APA Administration is unable to approximate total lobbying cost associated with the action paper. The Administration projects 75 hours of staff time to coordinate with the other medical societies; and a general lobbying campaign will entail 50 hours of Capitol Hill meetings (roughly the interested members of the relevant House and Senate committees).
ACTION PAPER

TITLE: Request for APA President to Write a Letter to DirecTV and other Broadcasters Concerning the Scientology Channel

WHEREAS:
Whereas: The Church of Scientology has long been anti-Psychiatry; and

Whereas: Scientology has distributed numerous print articles and books that are propaganda and have little or no basis in historical or scientific fact, such as “Psychiatry: The Men Behind Hitler” and “Psychiatry: The Ultimate Betrayal”; and

Whereas: Scientology has established The Citizen’s Commission on Human Rights, a blatantly antipsychiatry organization they claim to be a watchdog for psychiatry and whose goal is to "eradicate abuses committed under the guise of mental health and enact patient and consumer protections"; and

Whereas: The Commission has sent letters directly to psychiatrists cautioning them that they are under scrutiny and are liable to be reported for illegal and unethical practices in psychiatry, for which charge they have no evidence; and

Whereas: Scientology has opened a museum in Los Angeles titled “Psychiatry: An Industry of Death”; and

Whereas: Scientology has now developed its own TV channel, aired on DirecTV and other broadcasters, that is disseminating false and misleading information about Psychiatry; and

Whereas: This misinformation could discourage individuals from seeking help for mental illnesses; and

Whereas: The APA has a duty to combat this type of damaging misinformation that could lead to many people not seeking the mental health treatment they deserve: Now, therefore,

BE IT RESOLVED:
1. That the APA Assembly will request the President of the APA to write a letter to DirecTV and any other broadcaster that airs the Scientology channel expressing our opposition to the false and misleading information being disseminated on their system.
2. That the Public Affairs department of the APA provide speaking points for members to address the incorrect and dangerous information about psychiatry being disseminated on the Scientology channel

AUTHORS:
Philip L. Scurria, M.D., Representative, Area 5
Debra Atkisson, M.D., Representative, Texas Society of Psychiatric Physicians
Jack Bonner, M.D., Representative, Senior Psychiatrists
ESTIMATED COST:
Author: $0
APA: $1,975

ESTIMATED SAVINGS: 0

ESTIMATED REVENUE GENERATED: 0

ENDORSED BY:

KEY WORDS: Scientology

APA STRATEGIC PRIORITIES: Advancing Psychiatry, Education

REVIEWED BY RELEVANT APA COMPONENT:
## Action Paper Worksheet

### 2018 Action Paper Budget Estimate

**Action Paper Title:** 12H: Request for APA President to Write a Letter to DirecTV and other Broadcasters Concerning the

**Action Paper Author(s):** Philip L. Scurria, M.D., Representative, Area 5

**Phone/email:** 6018834107, pscurria59@gmail.com

**APA Admin. Name:** Glenn O’Neal, Communications

**Phone/email:** goneal@psych.org, (202) 609-7084

### Attendance Summary:

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**Total Travel Budget:** $0

#### Non-Staff Costs:

- LCD Projector
- Laptop
- Screen
- Flipchart
- Microphones

**Total Non-Staff Costs:** $0

#### Staff Costs:

1. Researching all network carriers of Scientology Channel, as well as current and upcoming programming on the channel. 395

2. Drafting letters to each network carrier of Scientology channel. 1,185

3. Editing & eventual distribution of letters to network carriers of Scientology channel. 395

**Total Staff Costs:** 1,975

**Other Costs not included above:** $0

**Total Author Estimate:** $0

### APA Administration Estimate:

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**Total Travel Budget:** $0

#### Non-Staff Costs:

- LCD Projector
- Laptop
- Screen
- Flipchart
- Microphones

**Total Non-Staff Costs:** $0

#### Staff Costs:

1. Researching all network carriers of Scientology Channel, as well as current and upcoming programming on the channel. 395

2. Drafting letters to each network carrier of Scientology channel. 1,185

3. Editing & eventual distribution of letters to network carriers of Scientology channel. 395

**Total Staff Costs:** 1,975

**Other Costs not included above:** $0

**Total Administration Estimate:** 1,975

Rvds. Jan. 2018
Action Paper 12.H: Request for APA President to Write a Letter to DirecTV and other Broadcasters Concerning the Scientology Channel

APA Administration Feedback:

DEPARTMENT: APA Division of Communications

The Scientology Channel was launched in March 2018 and is currently streaming on Direct TV, Spectrum, Apple, iTunes, Roku, YouTube and Google Chromecast. They also have their own streaming app and stream online from their website. The Scientology Channel does not have paid advertising, so it appears that the channel is funded by the organization. Direct TV has 195 channels, Google Chromecast has over 100 and YouTube has 60 plus channels and millions of videos. While Scientology has paid to have their channel on multiple platforms, they seem to be struggling with content that draws in an audience according to press reports.

APA Communications Department does not recommend the proposed action of writing letters to all the outlets that are streaming the Scientology Channel. Writing the letters may inadvertently raise the profile of the channel.

EXPLANATION OF COST:

The Division of Communications estimates that 25 hours of staff time would be required to research the various network carriers of the Scientology Channel, as well as the current and upcoming programming of the channel, and to draft, edit and distribute letters to the various network carriers of the channel. At a rate of $79 per hour, the cost for this would come to a total of $1,975.
ACTION PAPER

TITLE: Protecting Public Mental Health from the Adverse Effects of Climate Change by Ending APA Investments in Fossil Fuel Companies (Divestment)

WHEREAS:
1. Whereas: The Intergovernmental Panel on Climate Change has concluded that the burning of fossil fuels by humans to generate energy is the principal driver of climate change and is a direct threat to both environmental and human health; and (1)

2. Whereas: The American Psychiatric Association (APA) has “recognized that climate change poses a threat to public health, including mental health” and has committed to “support and collaborate with patients, communities and other healthcare organizations engaged in efforts to mitigate adverse health and mental health effects of climate change” through the adoption of the APA Position Statement on Mental Health and Climate Change (March 2017) (2) and

3. Whereas: Leading medical associations including the American Medical Association (AMA) and the APA have joined the Medical Societies Consortium on Climate and Health to enact “efforts to implement comprehensive and economically sensitive approaches to limiting climate change to the fullest extent possible”(3) and

4. Whereas: The AMA has adopted official policy (# D-135.969) which states that the American Medical Association, Foundation, and any affiliated corporations, will work in a timely, incremental and fiscally responsible manner end all financial investments or relationships (divestment) with companies that generate the majority of their income from the exploration for, production of, transportation of, or sale of fossil fuels (4)

5. Whereas: The World Health Association, the Canadian Medical Association, and the British Medical Association and other medical organizations have also adopted policies for divestment of financial holdings in fossil fuel companies (5)

6. Whereas: The APA code of ethics "recognizes a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health"; and (6)

7. Whereas: As physicians committed to the principle of “First do no harm”, we share an ethical obligation to minimizing fossil fuel consumption, and to strive to influence the health care institutions within which we practice and our professional societies to divest from companies that produce and promote use of the fossil fuels that drive climate change; and

8. Whereas: The health and mental health impacts of climate change fall disproportionately upon the mentally ill, and particularly upon children and other underrepresented populations who require greater protective efforts to avoid catastrophic mental health impacts,
9. Whereas: There is accumulating evidence that investments in fossil fuel companies may eventually represent a material risk for financial returns on investments and that there is a fiduciary responsibility to protect the financial wellbeing of the organization,

BE IT RESOLVED:
That:
1. the American Psychiatric Association and the APA Foundation work in a timely, incremental and fiscally responsible manner to end all financial investments or relationships (divestment) with companies that generate the majority of their income from the exploration for, production of, transportation of, or sale of fossil fuels and

2. that the APA Treasurer report back to the Assembly by the May 2019 and at Assembly meetings thereafter on the schedule and progress of these divestment activities.

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Meg Chaplin, M.D., APA Member
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Isabel Norian, M.D., Representative, New Hampshire Psychiatric Society
Gary Ralph, D.O., FAPA, FAPA, APA Member
Ana Turner, M.D., FAPA, APA Member
Kenneth Thompson, M.D., APA Member
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Anne Richardson M.D., APA Member
Uyen-Khanh Quang-Dang M.D., APA Member
Terry Kupers, M.D. MSP, APA Member
Carl I. Cohen, M.D., DLFAPA, APA Member
Keith McCoy, M.D., APA Member
Robert Feder, M.D., Representative, New Hampshire Psychiatric Society
Lawrence Lurie, M.D., DLFAPA, APA Member
Jeanie Tse, M.D., APA
Khurram Durrani, M.D., DFAPA, APA Member
Kyra Minninger, M.D., APA Member
Frank Clark, M.D., FAPA, APA Member
William Bowens, M.D., APA Member
William B. Lawson, M.D., PhD, DLFAPA, APA Member
Holly Valerio, M.D., APA Member
David Fogelson, M.D., Representative, Southern California Psychiatric Society

ESTIMATED COST:
Author: $7,392
APA: $7,392

ESTIMATED SAVINGS:

ESTIMATED REVENUE GENERATED:


KEY WORDS: Divestment, fossil fuels, position statements, climate change, public health, vulnerable populations

APA STRATEGIC PRIORITIES: Advancing Psychiatry, Education, Diversity
REVIEWED BY RELEVANT APA COMPONENT:
David Keen, CFO/APA in consultation with the APA’s investment advisor and the APA Investment Oversight Committee. This is current status of feedback from David Keen as an email to the lead author, Dr Fleming on Sept 17th:

“Our investment advisor has done a preliminary review, which has not be reviewed by APA Investment Oversight Committee. The review suggests that there are cost effective ways to implement the action paper, but does suggest that there is an increase in investment risk because the portfolio will be less diversified. APA would need to move from passively managed index funds to investments that are screened for fossil fuels and eliminate the investment vehicles that can not be screened such hedge funds or real estate funds. This action paper would require a rewrite of the investment policy by the investment oversight committee.”
David Keen, CFO, American Psychiatric Association

RESPONSE FROM THE AUTHORS: The authors discussed concerns raised by David Keen and the APA’s investment advisor with consultants in the clean energy investment field. Here is a summary of our response based on these consultations:

1. We agree that diversification is an essential successful strategy since it serves as a tool to reduce risk. However, there are a myriad of ways to “slice and dice” that diversification: by asset class, by industry, by style, geographic location, etc. There are many sources of consultation available to the Investment Oversight Committee that can advise strategies for desired diversification with fossil fuel alternative investments. In addition to the availability to consult with experts the AMA has identified, we can provide additional sources guiding fossil free investment planning;

2. The Action Paper protects against risk by stating the transition away from fossil fuel investment is to be done in a “incremental and fiscally responsible fashion”. The Action Paper does not call for either immediate or 100% elimination of fossil fuel investment. Initially, we recommend a strategy which is more conservative but still tries to eliminate investments in those companies with the highest climate risk (e.g. see https://fossilfreefunds.org/carbon-underground-200);

3. Our consultants have advised that fossil free passively managed index funds and real estate funds do exist and that current investments can be a gradually shifted to these fossil free funds;

4. Rather than keeping risk low, retaining fossil fuel investments is being recognized by many investors as being risky in and of itself due to several factors:
   • The energy sector is being disrupted by a combination of necessity, policy and technology
   • Emerging markets make up all energy demand growth, and are opting for renewables over fossil fuels
   • This will cause a peaking of fossil fuel demand in the 2020s
   • Investors lose money at peaks (e.g. see: https://www.carbontracker.org/reports/2020-vision-why-you-should-see-the-fossil-fuel-peak-coming/)

References:

(2) APA Position Position Statement; Mental Health and Climate Change
https://www.psychiatry.org/patients-families/climate-change-and-mental-health-connections

(3) Medical Societies Consortium on Climate and Health;
https://medsocietiesforclimatehealth.org/about/mission-and-consensus-statement/

4) AMA to Protect Human Health from the Effects of Climate Change by Ending its Investments in Fossil Fuel Companies-D-135.969 (Official Policy of the American Medical Association (approved June 2018), (https://policysearch.ama-assn.org/policyfinder NOTE: enter key word: fossil fuel divestment)

(5) Appendix: Health Care Organizations that have Divested to AMA Divest divest/invest summary report to AMA, May 2018

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(6) Section 7; The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry (2017 edition; APA)
Case for Fiscally Responsible Divestments from Fossil Fuels  
Robin Cooper, MD, DLFAPA  
September 17, 2018

There is currently considerable discussion about the vulnerability of investments in fossil fuel companies, leading to consideration of a fiduciary responsibility to consider climate risk in managing investment strategies.

While proposing the recent resolution to protect public health through divestiture from fossil fuel assets to the American Medical Association, the authors of the resolution obtained consultation from economic advisors for the Divest/Invest Network (1) who made the claim “financial regulators now recognize that climate change poses material financial risk to portfolios, and fund fiduciaries thus have a legal duty to manage that risk”. They further comment: “Health organizations that continue to invest in fossil fuels are compromised ethically, financially and from the perspective of fiduciary duty.” (1)

In their testimony to the AMA House of Delegates, the authors presented information indicating some of the financial risks of sustaining investments in fossil fuel companies as well as the negligible negative and increasingly positive effect of divestment on portfolio returns (2).

Financial advisors have made the case that continued fossil fuel investment carries significant risk. They claim that technological progress is driving costs of renewable energy down, creating more demand for these renewable sources while demand for fossil fuels is decreasing. As demand decreases, fossil fuel companies will be stuck with “stranded assets” and returns on their long term investments will be threatened (3).

Some of the arguments in favor of divestment are: (4)

- Mounting financial risks associated with climate change and the prospect that fossil fuel reserves will be “stranded” posing a risk to investor value
- Global stock Indexes without fossil-fuel holding out perform indexes with fossil fuel holding;
- Divestment from fossil fuels can be done without impact or risk to returns according to Grantham May, large worldwide asset management firm
- Increasing number of climate related legal suits from municipalities, governmental entities, civic groups and individuals against fossil fuel companies
- Fiduciary duty with legal duty to manage mounting financial risks associated with climate change
- Greater ease for institutions and individuals to divest with proliferation of new fossil-free financial products and investment tools and availability of index providers

The American Medical Association, in adopting the Divestment Policy, has also
“pledged to develop tools for individual physicians and other health organizations to understand and implement divestment.” They have made the commitment to share resources and collaborate in implementation of divestment strategies. (5)

Attach resources below.

1-Divest/Invest:
https://www.divestinvest.org/


3- Trillion Dollar Transformation; a collaborative project of Mercer, a global consulting firm with expertise in health industry, and Center for International Environmental Law;


### Action Paper Worksheet

#### 2018 Action Paper Budget Estimate

**Action Paper Title:**
12.I: Protecting Public Mental Health from the Adverse Effects of Climate Change by Ending APA Investments in

**Action Paper Author(s):**
James Fleming, M.D., Representative, Missouri Psychiatric Society

**Phone/email:**
816-213-1885/JFLEMINGMD@YAHOO.COM

**APA Admin. Name:**
David Keen, Chief Financial Officer

**Phone/email:**
dkeen@psych.org

#### Attendance Summary:

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- LCD Projector
- Laptop
- Screen
- Flipchart
- Microphones

#### Staff Costs:
- Description:
  
  The costs estimates are based on the assumption of one extra meeting per year of the Investment Oversight Committee which has 8 members. David Keen, CFO along with 5 other APA staff attend these meetings but staff costs were not included as suggested by Mr Keen

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#### Total Staff Costs

#### Other Costs not included above:

#### APA Administration Estimate:

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- Description:
  
  1.  
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  3.  

#### Total Staff Costs

#### Other Costs not included above:

#### Total Administration Estimate

Rvsd. Jan. 2018

**Total Author Estimate**

**Total Administration Estimate**

Read: Jan. 2018
The costs estimates are based on the assumption of one extra meeting per year of the Investment Oversight Committee which has 8 members. David Keen, CFO along with 5 other APA staff attend these meetings but staff costs were not included as suggested by Mr Keen.

SUBMITTED BY JAMES FLEMING, MD
LEAD AUTHOR OF ACTION PAPER ON FOSSIL FUEL DIVESTMENT
Action Paper 12.I: Protecting Public Mental Health from the Adverse Effects of Climate Change

APA Administration Feedback:

DEPARTMENT: Finance Department

EXPLANATION OF COST:
The cost is not currently quantifiable because the impacts of this policy change will be measured in the differences in investment returns and the investment oversight committee has not had ample time to study the proposal.

APA’s investment advisor has done a preliminary review and there are screened investment vehicles available to accomplish the change in the APA investment policy; however, none of vehicles currently exist in the APA investment portfolio so they would need to be transitioned to those screened vehicles. The concern from a purely financial perspective is the increase in investment risk, which results from removing investment options available to the Investment Oversight Committee. The impact is two-fold: 1) It tends to increase volatility in the investment returns because the underlying investments are more concentrated and 2) It eliminates certain types of investments available for use by the Investment Oversight Committee because there are not screening tools available for several investment classes such as real estate trusts or hedge funds.

It should also be pointed out that the income from the investment portfolio is used to fund the operating budget. APA includes 50% of the prior three years average investment returns as income in the operating budget. If this policy change results in reduced investment income it will require expense reductions in the operating budget.
ACTION PAPER

TITLE: Unbiased Expert Consensus Panels for Developing Treatment Guidelines Support Access to Quality Psychiatric Care

WHEREAS:
Throughout medicine in both the US and overseas, including in psychiatry and other mental health disciplines, expert consensus panels are convened to review evidence and develop treatment, level of care access or other kinds of clinical guidelines (e.g., APA Practice Guidelines, the UK National Institute for Health and Care Excellence [NICE] guidelines and the Swedish National Guidelines on treatment for depression and anxiety);

APA has been a leader in ensuring that representatives from all relevant treatment modalities are included in the membership of its expert consensus panels (e.g., the APA Steering Committee for Practice Guidelines);

Allegiance effects (e.g., to a school of psychotherapy) have repeatedly been shown to influence study design and/or outcomes in ways that bias results of studies and selection of recommended treatments (Clarke J. Guest Editorial on NICE guidelines, Psychoanalytic Psychotherapy, 2018:32:2, 95-101, DOI: 10.1080/02668734.2018.1462036).

Some expert consensus panels are biased by the exclusion of members who are expert representatives of forms of treatment under review and consideration, and by the unbalanced inclusion of expert representatives whose allegiance leads to biased review of evidence and thus to biased recommendations (Abbas A, Luyten P, Steinert C, Leichsenring F, et al. Bias towards psychodynamic therapy: framing the problem and working toward a solution. Journal of Psych. Practice. 2017;23, 361-365);


Nevertheless, bias against PDT has contributed to a negative view of this treatment modality among many in the mental health fields, including exclusion of PDT in guideline recommendations (Abbass et al., above);

Some expert consensus panels reviewing forms of psychotherapy to develop recommendations for treatment guidelines exclude representatives who are expert in research into relevant treatments or include members who are biased against relevant treatments (e.g., PDT, Interpersonal Therapy [IPT]);

One example of bias in study design is an often cited study purported to demonstrate the superiority of exposure therapy to psychodynamic psychotherapy in treatment of PTSD. The methods section,
however, reveals that the comparison PDT was provided by exposure therapists with a day of training in PDT that included the instruction to change the subject if a patient spoke about the trauma associated with their PTSD. This comparison treatment is not PDT for PTSD, but a sham treatment that is named based on bias against PDT (Gilboa-Schechtman E, Foa EB, Shafran N, et al. Prolonged exposure versus dynamic therapy for adolescent PTSD: a pilot randomized controlled trial. J Am Acad Child Adolesc Psychiatry. 2010;49:1034–1042);

An example of bias in guideline recommendations is a NICE guideline for the treatment of depression under development in the UK, which has been widely criticized for its lack of transparency, consistency and objectivity because of bias in evolving recommendations based on guideline panel membership favoring CBT and medications, without fair consideration of PDT (Clarke, J above);

The existence of such bias impugns the integrity of all psychotherapy research, undermines credibility in evidence-based clinical guidelines, and diminishes patient access to effective, high quality treatment modalities;

BE IT RESOLVED:
That the Board of Trustees will convene a work group to include members of the Board, the Assembly, the Council on Quality Care and the Council on Research to develop an APA position statement to the effect that:

*It is the position of the APA that*

[1] *Credible mental health expert consensus panels to develop practice guidelines and/or other treatment recommendations should include a diverse and balanced membership with expertise in all relevant treatments under consideration for inclusion—including, in expert consensus panels reviewing psychotherapy, representatives with specific knowledge of contemporary PDT and IPT research.*

[2] *Expert consensus panels should actively work to reduce bias in their deliberations and should seek to arrive at their recommendations objectively.*

The work group shall report back to the May 2019 Assembly about progress, and shall complete development of this position statement by the November 2019 Assembly.

**AUTHORS:**
Samar Habl, M.D., Representative, Academy of Psychodynamic Psychiatry and Psychoanalysis
Eric Plakun, M.D., APA Member

**ESTIMATED COST:**
Author: $6,824
APA: $4,396

**ESTIMATED SAVINGS:**

**ESTIMATED REVENUE GENERATED:**

**ENDORSED BY:**
KEY WORDS: Expert consensus panels, quality care, psychotherapy, practice guidelines

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

REVIEWED BY RELEVANT APA COMPONENT: Sent to APA Council on Research and APA Council on Quality Care.
**Action Paper Worksheet**

**2018 Action Paper Budget Estimate**


**Action Paper Author(s):** Samar Habi, M.D., Representative, Academy of Psychodynamic Psychiatry and Psychoanalysis

**APA Admin. Name:** Jennifer Medicus, Practice Management Delivery Systems Policy

**Phone/email:** 202.559.3972 jmedicus@psych.org

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<td>12 conference calls to complete work.</td>
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| Total Administration Estimate | $4,396 |

Rvd. Jan. 2018

APA Administration Feedback:

DEPARTMENT: Practice Management Delivery Systems and Policy/Committee on Practice Guidelines

We are not sure if a position statement is needed as it relates to APA practice guidelines. As acknowledged in the 2nd “whereas”, we already work to have balanced representation on our writing groups. The APA addressed this issue by creating standing writing groups made up of members representing a wide variety of backgrounds (professional background, practice type, geography, race/ethnicity). Topic experts are added to the writing groups depending on the guideline subject (disorders, interventions, etc.) and may include non-psychiatric representatives such as psychologists, RNs, physicians of other specialties, and others. In selecting writing group members, the overarching goal is to assure a breadth and depth of knowledge and expertise that can be drawn upon in assessing the available evidence. We also obtain public input on guideline drafts and specifically solicit input from the Assembly and Components as well as a wide range of experts, professional organizations and patient/family organizations. The desired outcome in composing writing groups and obtaining wide input on guideline documents is to minimize the possibility of intellectual bias, as has been discussed by the National Academy of Medicine (NAM) in their report on development of trustworthy practice guideline.

The authors may also have envisioned a position statement that would provide guidance to other national and international treatment-related guideline groups. If that is part of the authors’ scope, it would be helpful to incorporate language to that effect in the Resolved.

We would also note that any position statement should be mindful of and align with the requirements of groups such as NAM, NGC/ECRI, or others who use the AGREE II instrument to assess guideline quality. It is essential that the APA continue to fulfill these requirements to ensure that we continue to meet high quality guideline development standards. Most other guideline development organizations would also need to fulfill these requirements.

We also recommend that any position statement avoid use of the word “consensus” (e.g., as in "expert consensus panels"). Consensus panels are often formed to create consensus documents across organizations; such panels typically follow a different and, usually, less rigorous approach. Although the APA uses the phrase "guideline writing group," the phrase "expert panel" would be sufficient and would be understood by the practice guideline community.

EXPLANATION OF COST: Costs are based on 12 conference calls, including staff time – monthly calls for the year to develop the statement. It could end up being fewer calls depending on how the work goes.
TITLE: American Psychiatric Association (APA) Advocates to the American Medical Association (AMA) CPT Editorial Panel for Add-on Billing Codes for Suicide Risk Assessments

WHEREAS:

With suicide rates on the rise in recent years, suicide is becoming a public health issue in United States. In April 2016, the National Center for Health Statistics reported a 24 percent increase in the suicide rate in United States from 1999 to 2014. On June 7, 2018, the Centers for Disease Control and Prevention (CDC) issued a press release stating that suicide rates were rising across the United States, with an increase of at least 6% in each state. Suicide is currently the 10th leading cause of death in the U.S.

Research has shown that 38% of people who attempt suicide had some type of healthcare visit within a week prior to the suicide attempt, 64% within a month, and nearly 95% within a year. These are the people that can be identified at risk for suicide during a suicide risk assessment and provided with the necessary treatment.

There is increased pressure on physicians to perform thorough suicide risk assessments and provide the appropriate counseling, treatment, and documentation. With the average time of fifteen minutes for outpatient visits, having protected time to complete a suicide screening can be critical to support an avenue for a comprehensive suicide risk assessment. Two research studies reported that only 36% of the primary care physicians conducted a suicide risk assessment in patients presenting with complaints of depression. The researchers concluded that suicide assessment is “another of the thorny issue in Pandora’s box, raising many of the same fears and concerns of inadequate expertise and insufficient time in a busy practice.”

A suicide risk assessment can take anywhere from five to thirty minutes, if not more, depending on the complexity and the gravity of symptoms that may emerge during the assessment. Without having protected time and being adequately compensated for, physicians might not be inclined to spend the much needed time to perform such assessments.

Traditional billing codes of 99201-99205 - for a new patient, and 99211-99215 - for established patient, may not reflect the extensive time that a physician will spend with a suicidal patient. Although adding 90785 - interactive complexity add-on code, can be useful in crisis, the code is not explicit enough. A more specific code, that can be used only for suicide risk assessment will not only provide physicians the appropriate time for suicide screening, but also encourage the use of such a tool, and ultimately, give suicide risk assessment the importance it deserves.

Requests for add-on CPT billing codes can be submitted to the AMA CPT Editorial Panel. Even though anyone can submit an application for changes to CPT codes (i.e., medical specialty societies, individual physicians, hospitals, third-party payers), having such a request advocated by the APA would likely increase the odds of approval.
BE IT RESOLVED:
That the APA advocates for add-on billing codes for suicide risk assessments to the AMA CPT Editorial Panel.

That the suicide risk assessment billing codes reflect the complexity of the assessment with the purpose of providing sufficient time for screening, but also for counseling, and treatment.

AUTHORS:
Cristina Secarea, M.D., RFM Representative, Area 3
Anita Rao, M.D., RFM Representative, Area 4
Jorien Campbell, M.D., RFM Representative, Area 6

SPONSORS:
James LePage, M.D., RFM Deputy Representative, Area 5
Mary Ann Schaepper, MD, M. Ed, Representative, Southern California Psychiatric Society
Constance E. Dunlap, M.D., DFAPA, Representative, Washington Psychiatric Society
Debra Atkisson, M.D.,DFAPA, Representative, Texas Society of Psychiatric Physicians
Annette Hanson, M.D.,, Representative, Maryland Psychiatric Society;
Joshua Sonkiss, MD, Representative, Alaska Psychiatric Association
Gabrielle Shapiro, M.D., DFAACAP, DFAPA, Representative, New York County Psychiatric Society
Mary Jo Fitz-Gerald, M.D., MBA, Representative, Louisiana Psychiatric Medical Association
Bonnie Fauman, M.D., Representative from American Association for Social Psychiatry
Jeffrey I. Bennett, M.D., Representative, Illinois Psychiatric Society
Joseph C Napoli, M.D., DLFAPA, Representative, Area 3

ESTIMATED COST:
Author: $0
APA: $3,160

ESTIMATED SAVINGS: TBD

ESTIMATED REVENUE GENERATED: TBD

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

KEY WORDS: suicide, suicide risk assessment, advocacy, billing, CPT codes

APA STRATEGIC PRIORITIES: Advancing Psychiatry

REVIEWED BY RELEVANT APA COMPONENT:

References:
### Action Paper Worksheet

#### 2018 Action Paper Budget Estimate

**Action Paper Title:** 12K: APA Advocates to the AMA CPT Editorial Panel for Add-on Billing Codes for Suicide Risk Assessments

**Action Paper Author(s):** Cristina Secarea, M.D., RFM Representative, Area 3

**Phone/Email:** 302-228-7002/cristina_secarea@yahoo.com

**APA Admin. Name:** Becky Yowell, Reimbursement Policy

**Phone/Email:** 202-683-8298/byowell@psych.org

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**Total Staff Costs:**

**Other Costs not included above:**

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**Total Non-Staff Costs:**

**Staff Costs:**

1. Description: Staff time to facilitate review/development of recommendations regarding reimbursement options for suicide assessments. 3,160

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**Total Staff Costs:** 3,160

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**Total Administration Estimate:** 3,160

Rv'd Jan. 2018

APA Administration Feedback:

DEPARTMENT: Policy, Programs/Partnerships; Department of Reimbursement Policy; Committee on RBRVS, Codes and Reimbursements

EXPLANATION OF COST:
The cost of this effort would be staff time necessary to facilitate review of existing reimbursement mechanisms to determine any gaps in coding. This would include discussions with subject matter experts and member experts from primary care physician organizations. The cost estimate is for the initial analysis of the reimbursement landscape. If a gap is identified, further costs would depend on engagement of other physician groups the process of shepherding a proposal through the CPT and RUC processes.
ACTION PAPER

TITLE: Providing Support to Forcibly Separated Immigrant Children and Families

WHEREAS:

Whereas: Psychosocial support for refugee children and their families is a worldwide concern, with the number of children and adolescent immigrants increasing in the last decade [UNHCR Global Trends, 2016]

Whereas: It is well known that immigration can have an impact on the social and emotional development of children, especially those separated from their families.

Whereas: The United States adopted a "zero-tolerance" policy in May 2018, resulting in federal prosecutors filing criminal charges against any adult apprehended crossing the border illegally, including those traveling with minors. Thousands of children were separated from their parents as a consequence of this policy.

Whereas: The separation of children from their caregivers creates acute distress that harms a child's ability to cope, which can lead to mental illness. This is further exacerbated because many of these families are already dealing with the effects of stress and trauma from their countries of origin. These children frequently experience extreme fear, have difficulties with emotion regulation, and are at an increased risk of other mental illnesses, such as depression, anxiety, and posttraumatic stress disorder (PTSD).

Whereas: A substantial body of literature confirms both the importance of the caregiver-child relationship on the mental health and well-being of the child, and that exposure to violence and other traumatic events is associated with an increased likelihood of mental health conditions, including PTSD and depression [CDC]. Conversely, healthy connections with caregivers help children regulate themselves in the face of trauma or stress.

Whereas: On June 20, 2018, the American Psychiatric Association (APA) and 17 other mental health organizations jointly expressed their concern in a letter addressed to the Departments of Justice, Homeland Security and Health and Human Services, urging the administration of President Donald Trump to end its policy of separation of children from their parents at the United States border. [APA, 2018]

Whereas: The APA is committed to the principle that mental health is an essential part of the well-being of children, adolescents and their families and believes that all children should have the right to live in a healthy environment free from violence and with access to evidence-based, trauma informed, physical and mental health care services. [APA Presidential Task Force, 2008]
BE IT RESOLVED:
That the APA will continue to safeguard access to quality services that are developmentally and culturally appropriate to meet the mental health needs of all immigrants and refugee children, adolescents and their families by:

1. Developing resources that promote best practices on prevention and early intervention for immigrant children and adolescents.
2. Create a culturally and developmentally competent educational toolkit with the appropriate information and support. The tools should address the underlying ethical and medical-legal barriers in treating this population.
3. Endorse the use of qualified professionals in conducting the assessments of these children and adolescents.
4. Make the relevant screening instruments and other resources publicly available on the APA website.
5. Provide these resources to Immigration and Customs Enforcement (ICE) detention centers and persons doing asylum evaluations so that gaps in providing culturally competent care for these children and adolescents can be effectively addressed.

AUTHORS:
Anish R. Dube, M.D., MPH, Representative, Asian-American Psychiatrists
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Gabrielle Shapiro, M.D., Representative, New York County Psychiatric Society
Felix Torres, M.D., MBA, Representative, New York County Psychiatric Society

SPONSORS:
Judy Glass, M.D., Representative, Quebec & Eastern Canada District Branch
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Joseph C. Napoli, M.D., Representative, Area 3
James A. Polo, M.D., Representative, Washington State Psychiatric Association
Constance E. Dunlap, M.D., Representative, Washington Psychiatric Society
William Greenberg, M.D., Deputy Representative, Area 3
James L. Fleming, M.D., Representative, Missouri Psychiatric Physicians Association

ESTIMATED COST:
Author: $2,370
APA: $2,370

ENDFORDED BY: Hispanic Psychiatrists; Asian-American Psychiatrists, Washington Psychiatric Society

KEY WORDS: Forced separations; immigrant detention centers; vulnerable populations

APA STRATEGIC PRIORITIES: Advancing Psychiatry, Education, Diversity

REVIEWED BY RELEVANT APA COMPONENT: Council on Children, Adolescents and their Families
References:


### Action Paper Worksheet
#### 2018 Action Paper Budget Estimate

**Action Paper Title:** 12. L: Providing Support to Forcibly Separated Immigrant Children and Families  
**Action Paper Author(s):** Anish R. Dube, M.D., MPH, Representative, Asian-American Psychiatrists  
**Phone/email:** anish.dube@gmail.com  
**APA Admin. Name:** Vabren Watts, Division of Diversity and Health Equity  
**Phone/email:** vwatts@psych.org

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

**Total Non-Staff Costs:**

**Staff Costs:**

1. Arrange for teleconference calls and keep minutes.  
2. -  
3. -

**Total Staff Costs:**

**Other Costs not included above:**

**Total Author Estimate:** 2,370

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

**Total Non-Staff Costs:**

**Staff Costs:**

1. Develop resources on best practices for prevention and early intervention for mental health of immigrant children/adolescents  
2. Recommend that item #2 can be added to the APA Stress and Trauma Toolkit due to the Current Social and Political Climate (by the CMMH/HD). This addition will address the underlying ethinical and medical-legal barriers in treaing this population.  
3. All resources go through internal APA review processes (Divisions of Education and Communications) before being publicly available on the APA website.

**Total Staff Costs:**

**Other Costs not included above:**

**Total Administration Estimate:** 2,370

---

Rvds. Jan. 2018
Action Paper 12.L: Providing Support to Forcibly Separated Immigrant Children and Families

APA Administration Feedback:

**DEPARTMENT:** Division of Diversity and Health Equity (DDHE)

1) **Developing resources on best practices for prevention and early intervention for mental health of immigrant children/adolescents:** DDHE staff will enlist experts from Council on Children, Adolescents, and their Families and the Council on Minority Mental Health and Health Disparities (CMMH/HD) to create resources. The resources will then go through APA Administration processes including editing, education division review. Staff time (from DDHE/Educational Division/Communications Division) is roughly 30 hours.

**EXPLANATION OF COST:** We estimate 30 hours of staff time to execute this duty.

2) **Create a culturally and developmentally competent educational toolkit with appropriate information and support. The tools should address the underlying ethical and medical-legal barriers in treating this population:** The Council on Minority Mental Health and Health Disparities (CMMH/HD) is completing an APA toolkit on Stress and Trauma Related to Socio-Political Climate which the Council on Children, Adolescents and Their Families has already contributed a child and adolescent vignette. The Council on Children can be asked to include the underlying ethical and medical legal barriers in treating this population.

**EXPLANATION OF COST:** none

3) **Endorse the use of qualified professionals in conducting the assessment of these children and adolescents:** DDHE/Policy Division ask for clarification of what is being asked of Divisions/Administration.

**Division on Policy:** We concur with the Division and Health Equity comments and would like more clarification.

4) **Make the relevant screening instruments and other resources publicly available on the APA website:**

DDHE will work with APA Education Division. There is an inherent process of having toolkits reviewed/edited. This will then be made available in appropriate public facing APA sites as well APA site for members.

5) **Provide these resources to Immigration and Customs Enforcement (ICE) detention centers and persons doing asylum evaluations so that gaps in providing culturally competent care for these children and adolescents can be effectively addressed.**

**DEPARTMENT:** Policy, Programs, and Partnerships

APA staff can share resources with ICE to distribute to its field offices and detention centers.
ACTION PAPER

TITLE: Addressing Racial Discrimination Against Psychiatry Trainees & Practicing Psychiatrists

WHEREAS:
1. The APA has had a longstanding commitment to diversity as evidenced by 41 of the 175 existing position statements are regarding diversity and culture. Further supporting a diversified workforce is a natural next step in the APA with built in support from the existing Division of Education.

2. Incidents of physician mistreatment in the form of race-based discrimination perpetrated by patients and their families is shockingly commonplace. Resident physicians, in particular, may be at higher risk for discriminatory abuse from patients (1-5). This data is troubling and likely represents a pervasive experience and attitude towards incidents of discrimination by trainees. These studies highlight discrimination as a potential threat to personal and professional wellbeing during residency training as a result of the hostile learning environment (Appendix 1).

3. Race-based discrimination of physicians has been described in various forms such as: patient’s requesting non-black physicians, microaggressions and overt racial slurs. Scholars have made efforts to stimulate dialogue around these issues (6-11). Paul-Emil et al. constructed an algorithm to help hospitals in navigating the legal complexity of racial discrimination by patients, specifically (12); however, there remains a dearth of literature in evaluation, adjudication, and responses to discriminatory behavior perpetrated by patients.

4. Patient and family discrimination related to racial/ethnic background poses a particular challenge for trainees and their colleagues. To date, no standardized process for recognition, reporting, review or response currently exists for incidents of race-based discrimination in hospital centers. Addressing such as complex issues begins with recognition of race-based discrimination situations which may not always share conscious agreement. Many situations are nuanced and subject to interpretation, while other situations are egregious and generally agreed upon as racist. A process of reporting and review should take place to support the residents and others who have been the target of the racism, affirm values of diversity and inclusion across clinical settings, and to inform a process for responding to these complex situations at the resident-supervisor, clinical and institutional level.

5. This discrimination has not been fully addressed by the APA in its efforts to support the stated mission, goals, ethical commentary, position statements on diversity, bias and discrimination, nor its strategic priorities (Appendix 2).

6. The APA does not currently offer explicit professional guidance to residents, fellows, medical and/or psychiatric educators, or practicing psychiatrists on how to address race-based discrimination from patients and families.
7. There is existing guidance and best practices on how to address mistreatment of trainees and practicing physicians in the literature and several avenues for disseminating this information to psychiatry trainees and those supervising their education (Appendix 3, 4).

BE IT RESOLVED:
That a web-based toolkit addressing racial discrimination against psychiatry trainees and practicing psychiatrists be developed and maintained by the Council on Medical Education and Lifelong Learning and the Council on Minority Mental Health and Health Disparities in coordination with the Division of Education to include proposed frameworks, resource documents and instructional video modules available to APA members and the public.

That the video modules be crafted to meet criteria for CME eligibility.

That the video modules be included in the Supplemental Education and Training (SET) for Success coursework that benefits resident and fellow members.

That the developed web-based toolkit and its components be publicized through APA Communications and *Psychiatric News*.

That the instructional video modules be offered as a free Member Course of the Month.

That the APA explore funding sources for research, such as the APA Foundation, to support efforts to further characterize the prevalence, incidence and characterization of racial discrimination against psychiatry trainees & practicing psychiatrists.

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Jessica Abellard, M.D., APA Member

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Constance Dunlap, M.D., Representative, Washington Psychiatric Society

ESTIMATED COST:
Author: $2,607
APA: $4,740

ESTIMATED SAVINGS: TBD

ESTIMATED REVENUE GENERATED: none

ENDORSED BY: Caucus of Black Psychiatrists, Assembly Committee on Access to Care, Caucus of Women Psychiatrists, Area 1 Council, Assembly Committee of Resident-Fellow Members (ACORF), Assembly Committee of Early Career Psychiatrists, Assembly Committee on Public & Community Psychiatry, Assembly Committee of Representatives of Minority/Underrepresented Groups, Washington Psychiatric Society

KEY WORDS: bias, discrimination, diversity, workforce

APA STRATEGIC PRIORITIES: Education, Diversity, Supporting Research

REVIEWED BY RELEVANT APA COMPONENT: Council on Medical Education and Lifelong Learning, Council on Minority Mental Health and Health Disparities
References:

Appendix 1. Attachment on Prevalence
A Stanford University study of graduate medical education trainees revealed that fifteen percent of residents personally experienced or witnessed mistreatment and more than half included discrimination by patients' families (2). Nearly half of the respondents did not know how to react to these instances, and one-quarter believed no action would be taken if they alerted hospital leadership.

A study of nearly 250 family medicine residents in Canada found that the most frequent type of discrimination while in training occurred in the form of verbal assaults with patients representing over one-third of the perpetrators and these verbal assaults included inappropriate comments perceived to be based on ethnicity (16.2%) and culture (9.5%). (3) Another study of pediatric residents similarly found race (42%) and ethnicity (38%) were included in the highest witnessed forms of targeted discrimination (4).

Finally, a study of nearly 2,000 medical residents revealed that one-quarter reported being the target of racial/ethnic discriminatory behaviors predominantly perpetrated by patients. The medical residents reporting discriminatory experiences included 13.6% of the white residents,
37.2% of the Hispanic residents, 62.9% of the Asians/Pacific Islanders, 68% of those from the Indian Subcontinent, 77.4% of the African Americans and 77.8% of those from the Middle East. In summary, all represented groups described at least one discriminatory experience based on racial/ethnic identity.

Appendix 2. Attachment on Existing APA Commentary
The mission of the APA includes serving the professional needs of its membership while valuing lifelong professional learning and collegial support.
The goals of the APA include the improvement of psychiatric education and training. As outlined in Topic 3.3.3 in the APA Commentary of Ethics of Practice, responsibilities in teaching and in supervising psychiatrists-in-training include fostering a positive, respectful learning environment. The APA has expressed a commitment to the diversification of the psychiatric workforce (position statement 2017) which must be accompanied by specific support in addressing discrimination from members of the patient population it serves. Namely, the APA commitment supports a focus on addressing discrimination in the form of racial aggressions as its workforce continues to benefit from expanded numbers of racial/ethnic minorities.
The revised Position Statement on Bias Related Incidents (2015) states that the APA opposes bias-related incidents and recognizes that these incidents occur in our nation’s communities, institutions, organizations and throughout all levels of society. This same position statement encourages APA members to take appropriate actions to prevent such incidents as well as actively respond when such bias-related incidents occur.

Appendix 3. Attachment on Existing Guidance

Appendix 4. Attachment on Existing Guidance
The tool kit development would be a collaboration between the Division of Education and CMELL with support from the CMMHD. Task force members number estimate of 10 total.

The task force charged with its creation can be comprised of volunteer members with one staff in a supporting role for coordination of activities.

The task force will collaborate on how to craft the materials, however, the ideal components would include a video module with taped role plays (spoken narratives with text), archived web materials and written materials.

The cost of creating the webpage for the materials underneath the relevant section should be included.

Research estimates should consider the time necessary for conducting as well as the level of expertise. Please advise on this line item.
Action Paper Worksheet
2018 Action Paper Budget Estimate

Action Paper Author(s): Jessica Isom, M.D., MPH, RFM Representative, Area 1
Phone/email: 704-726-6615; jessica.isom@yale.edu
APA Admin. Name: Vabren Watts, PhD, Division of Diversity and Health Equity
Phone/email: 202-559-3445/ vwatts@psych.org

Attendance Summary:

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Non-Staff Costs:
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- Screen
- Flipchart
- Microphones

Total Non-Staff Costs: 

Staff Costs:

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<td>3 Exploration of funding sources for research, such as the APA Foundation, to support efforts to further characterize the prevalence, incidence and characterization of racial discrimination against psychiatry trainees &amp; practicing psychiatrists.</td>
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Total Staff Costs: 2,607

Other Costs not included above: 

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Total Staff Costs: 4,740

Other Costs not included above: 

Total Administration Estimate: 4,740

APA Administration Feedback:

DEPARTMENT: Division of Diversity and Health Equity (DDHE)
DDHE will work will enlist members from the Council on Minority Mental Health and Health Disparities (CMMH/HD) to review the web-based video module before it is sent to the Division of Education for further review and completion.

EXPLANATION OF COST: We estimate 60 hours of total staff time to execute this duty.
TITLE: Suicide Prevention Work Group

WHEREAS:

When considering the epidemiology of suicide, the World Health Organization continues to address the phenomenon of suicide as a worldwide issue affecting a diverse array of individuals. Suicide is the second greatest cause of premature death in individuals ages 15-29, and the third greatest in those ages 15-44 worldwide.¹

On June 7, 2018, the Centers for Disease Control and Prevention (CDC) issued a press release stating that suicide rates were rising across the United States. According to the CDC, almost every State saw a rate increase of at least 6%. Suicide is currently the 10th leading cause of death in the U.S.²

Older adults are increasingly becoming high-risk population. According to the CDC, in 2015 there were 11,193 deaths attributed to suicide of individuals between the ages 60 and 85+, approximately 17% of the total population within that age range.³

Among sexes, both men and women of most racial and ethnic groups have seen an increase in suicide rates in 2014.⁴ American Indian and White women are the two leading groups, with an 89% and respectively 60% increase. Similarly, the largest rate increase among men was found in American Indian (38%) and White (28%).⁶

Adolescence suicidal ideation rate is at approximately 15–25% with a wide range of severity. Lifetime estimates of suicide attempts among boys ranges from 1.3–3.8%, and 1.5–10.1% among girls. It is speculated that the number of adolescent suicide attempts may be underestimated due to treatment avoidance or inaccurate documentation.⁵

Drug addiction is closely tied to suicide. Approximately 40% of patients seeking assistance with substance dependence have reported at least one suicide attempt. Addiction and suicide have been found to co-occur with major life stressors, such as marital discord, loss of employment, and financial stress. Such factors, in combination with personality traits and major mental illnesses (i.e., depression, bipolar, PTSD), contribute to the fatality of suicide.⁷

Those with less education, less social support, and fewer jobs are at higher risk. A number of specific groups are found to be at increased risk: First responders, military service members, those with a history of trauma, individuals who are incarcerated, those in locked hospital units, minorities, the homeless, and refugees. In addition to the demographics involved, there are biological, hereditary, and cognitive risk factors. Suicide is therefore a global problem affecting individuals from a variety of socio-economic, cultural, and genetic backgrounds with complex risk factors.⁸
BE IT RESOLVED:

That the American Psychiatric Association will develop a Suicide Prevention Work Group.

That the Suicide Prevention Work Group will be comprised of one designated council member from each of the thirteen councils to reflect the various population that a council represents.

That the role of the Suicide Prevention Work Group will be the development of a suicide prevention strategic plan. In order to develop this plan, the Suicide Prevention Work Group can consult external expertise, not limited to APA members, and decide in what capacity such consultation should be effectuated.

That the Suicide Prevention Work Group would take in consideration the following when developing the suicide prevention strategic plan:

1. Identify and examine data on issues related to suicide within each population that each council represents
2. Understand the barriers and incentives to suicide prevention care of each population that each council represents
3. Consider suicide prevention strategies targeted to the nuances of each population that each council represents
4. Identify strategies to enhance existing and foster new long-term partnerships among both the for-profit and non-profit sectors

That the suicide prevention strategic plan will be at the behest of the Suicide Prevention Work Group to ensure flexibility and self-management.

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Cristina Secarea, M.D., RFM Representative, Area 3

SPONSORS:
James LePage, M.D., RFM Deputy Representative, Area 5

ESTIMATED COST:
Author: $5,410
APA: $7,110

ESTIMATED SAVINGS: TBD

ESTIMATED REVENUE GENERATED: TBD

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

KEY WORDS: suicide prevention, suicide taskforce, media campaign, education

APA STRATEGIC PRIORITIES: Advancing Psychiatry, Education
References:
4. 2015, United States Suicide Injury Deaths and Rates per 100,000. https://webappa.cdc.gov/cgi-bin/broker.exe.
Action Paper Title: 12.N: Suicide Prevention Work Group
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Attendance Summary:
Number of Component Members: 13
Number of Staff: 1
Number of Non-Staff: 2
Total: 16

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Total Travel Budget: $2,646

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Total Non-Staff Costs: $1,500

Staff Costs:

Description:

1 Support for development and finalization of suicide prevention strategic plan: 1,264

2

3 Total Staff Costs: 1,264

Other Costs not included above:
The suicide prevention work group will convene during the council and/or components meeting that regularly takes place, therefore it will not be any additional meeting/costs necessary for the 13 representatives from each council, unless determined by the suicide prevention work group itself. The other two persons added to the list as the non-APA staff to attend the meeting -

Total Author Estimate: 5,410

APA Administration Estimate:

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Total Travel Budget: -

Non-Staff Costs:

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Total Non-Staff Costs: -

Staff Costs:

Description:

1 Staffing the workgroup: 7,110

2

3 Total Staff Costs: 7,110

Other Costs not included above: 7,110

Total Administration Estimate: 7,110

Rvd. Jan. 2018

APA Administration Feedback:

DEPARTMENT: Department of Practice Management and Delivery Systems Policy & the Department of Government Relations

Suicide prevention is a top priority for the APA, and the Administration will work with membership to develop an official Suicide Prevention Work Group and assist in the development of a strategic plan. The APA Administration is also working with other stakeholder organizations to identify areas for collaboration.

EXPLANATION OF COST:
The APA Administration projects 90 hours of staff time to coordinating the work group.
TITLE: Position Statement on Immigrant Children Detained at US/Mexico Border

WHEREAS:
1. Whereas there are more than 2,000 children who have been forcibly separated from their parents at the United States and Mexico border.
2. Whereas families from Central America are fleeing crime and life-threatening situations and seeking asylum in the United States.
3. Whereas these forcible separations are traumatic and bound to psychologically affect the detained children.
4. Whereas emotional traumatic events will remain with the affected subjects long past the initial detention process.

BE IT RESOLVED:
That the APA advocates for the necessity of keeping the family units together while they are going through the asylum-seeking process.

AUTHORS:
Edmundo Rivera, M.D., Deputy Representative, Hispanic Psychiatrists
Oscar Perez, M.D., Representative, Hispanic Psychiatrists

ESTIMATED COST:
Author: $0
APA: $4,345

ESTIMATED SAVINGS:

ESTIMATED REVENUE GENERATED:

ENDORSED BY: Caucus of Hispanic Psychiatrists

KEY WORDS: Separation, Children

APA STRATEGIC PRIORITIES: Advancing Psychiatry

REVIEWED BY RELEVANT APA COMPONENT: Caucus of Hispanic Psychiatrists
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### Non-Staff Costs:

- LCD Projector -
- Laptop -
- Screen -
- Flipchart -
- Microphones -

**Total Non-Staff Costs:**

### Staff Costs:

- Description: APA Administration lobbying and advocacy efforts
  - 1
- Description: DDHE liaise with experts from the Child Council
  - 2
- Description: 
  - 3

**Total Staff Costs:** $4,345

**Other Costs not included above:**

| - | - | - | - | - | - |

**Total Author Estimate:**

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### APA Administration Estimate:

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### Non-Staff Costs:

- LCD Projector -
- Laptop -
- Screen -
- Flipchart -
- Microphones -

**Total Non-Staff Costs:**

### Staff Costs:

- Description: APA Administration lobbying and advocacy efforts
  - 1
- Description: DDHE liaise with experts from the Child Council
  - 2
- Description: 
  - 3

**Total Staff Costs:** $4,345

**Other Costs not included above:**

| - | - | - | - | - | - |

**Total Administration Estimate:** $4,345

Rsvd. Jan. 2018

APA Administration Feedback:

DEPARTMENT: Department of Government Relations
In response to the recent actions by the Administration, the APA released several public communications concerning its opposition to the separation of children from their parents and/or families at the border. In addition, APA joined other mental health organizations to emphasize the trauma-related issues that could develop as a result of these separations. The Department will continue to evaluate existing or proposed legislation and maintain their advocacy efforts.

EXPLANATION OF COST: Once a position has been identified, the staff time to continue lobbying and advocacy efforts associated with addressing the issue will be approximately 30 hours.

DEPARTMENT: Division of Diversity and Health Equity (DDHE)
DDHE is working with experts from the Council on Children, Adolescents, and Their Families (Child Council) to develop educational resources on providing mental health services to immigrant children who have been detained at the US/Mexico borders or seeking asylum from other foreign countries.

EXPLANATION OF COST: Should DDHE liaise with experts from the Child Council on this issue, we estimate 25 hours of staff time to execute this duty.
TITLE: Efficient Communication at the Assembly

WHEREAS:
- The Assembly is continually challenged to be more effective and efficient.
- Distributing materials with printed copies is costly and wasteful.
- A majority of Assembly Members and guests have access to a computer or eReader at the meeting.

BE IT RESOLVED:
- All information updates, changes and proposed changes in Action Papers made at the reference committee or proposed amendments typically presented as printed packets or other printed material should be distributed in real time using the APA Drop Box account and the Assembly Listserv.
- Staff would be responsible for distributing and maintaining the information, just as they do currently.
- A modest, albeit reduced, number of printed copies would be available on site, in the hall that hosts the Assembly.

AUTHORS:
Peter Forster, M.D., Representative, Northern California Psychiatric Society
Jessica Thackaberry, M.D., ECP Representative, Area 6
Adam Nelson, M.D., Representative, Northern California Psychiatric Society

ESTIMATED COST:
Author: $0
APA: $0

ESTIMATED SAVINGS: $500-$2000 annually

ESTIMATED REVENUE GENERATED: $0

ENDORSED BY: N/A

KEY WORDS: efficient, electronic communication

APA STRATEGIC PRIORITIES: Advancing Psychiatry

REVIEWED BY RELEVANT APA COMPONENT: N/A
### Action Paper Worksheet
#### 2018 Action Paper Budget Estimate

**Action Paper Title:** 12.P: Efficient Communication at the Assembly  
**Action Paper Author(s):** Adam Nelson, M.D., Representative, Northern California Psychiatric Society  
**Phone/email:** (415) 460-6710 / info@adamnelsonmd.com  
**APA Admin. Name:** Allison Moraske, Association Governance  
**Phone/email:** amoraske@psych.org

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

**Author Estimate:**  

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

**Staff Costs:**  
- Description: 
  1. Upload digital copies of printed materials during the Assembly meeting to the APA Drop Box account and distribute via listserv -  
  2 -  
  3 -  
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**Other Costs not included above:** 
- none -

**APA Administration Estimate:**  

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

**Other Costs not included above:** 
- none -

**Total Author Estimate** -

**Total Administration Estimate** -

Rvsd. Jan. 2018
Action Paper 12.P: Efficient Communication at the Assembly

APA Administration Feedback:

DEPARTMENT: Association Governance
The action paper asks that,

- All information updates, changes and proposed changes in Action Papers made at the reference committee or proposed amendments typically presented as printed packets or other printed material should be distributed in real time using the APA Drop Box account and the Assembly Listserv.
- Staff would be responsible for distributing and maintaining the information, just as they do currently.
- A modest, albeit reduced, number of printed copies would be available on site, in the hall that hosts the Assembly.

Governance, at the request of the Assembly Executive Committee, has limited the amount of printed meeting materials provided onsite at the Assembly meetings for both environmental and budgetary reasons and uses electronic platforms to distribute meeting materials. Currently, only those action papers that are revised by the Assembly Reference Committees are copied and distributed, along with the written reports of the Reference Committees, Saturday morning at the Assembly Committee and Area Council meetings.

While this request would decrease overall printing costs of the meeting, there are some areas of concern. It should be noted that not all members of the Assembly bring laptop computers/tablets to the Assembly meeting and may not be able to access the revised papers. Additionally, given the variability of internet access at the various meeting locations (convention centers, hotels), the meeting may experience unexpected connectivity issues which may prevent or delay members from downloading the materials. Funds are not available for additional power sources in the plenary meeting room. Hard copies of the revised papers would have to be significantly reduced and potentially even phased out should the Assembly choose to move to electronic platforms for such a distribution.
ACTION PAPER

TITLE: Psychiatric Facility Construction

WHEREAS:
1. In the 19th century, psychiatric hospitals were designed by those who would be on-site and run them. The best-known example was Thomas Kirkbride, MD, a founder of the Association of Medical Superintendents of American Institutions for the Insane (a precursor to the APA). (1-4)
2. Over the course of the 20th century, psychiatrists and others with experience working in psychiatric hospitals were progressively excluded from the process of designing psychiatric facilities. (1)
3. Psychiatrists offer unique and crucial expertise regarding evaluation, treatment, and care of persons with mental illness, and
4. The inpatient, emergency department, and outpatient settings (whether free-standing or embedded in larger facilities) in which psychiatric evaluation, treatment, and care occurs can have a critical impact on safety, effectiveness, and quality of the experiences of both persons receiving these services and those providing the services.

BE IT RESOLVED:
1. That the APA shall convene a joint Board of Trustees and Assembly Work Group to draft a Position Statement regarding the need for psychiatrists’ input into the process of psychiatric facility design, construction, and renovation.
2. That the Work Group shall consider whether to include the importance of patient input in the Position Statement.
3. That the Position Statement shall be presented to the Assembly at its November 2019 meeting.

AUTHORS:
Isabel Norian, M.D., Representative, New Hampshire Psychiatric Society
Jeffrey Geller, M.D., MPH, Representative, American Association of Community Psychiatrists
Anita Rao, M.D., RFM Representative, Area 4

SPONSORS:
Judy Glass, M.D., Representative, Quebec & Eastern Canada District Branch
Mary Anne Albaugh, M.D., DFAPA, Representative, Pennsylvania Psychiatric Society

ESTIMATED COST:
Author: $8,650
APA: $3,160

ESTIMATED SAVINGS: $ 0

ESTIMATED REVENUE GENERATED: $ 0

ENDORSED BY: Area 1 Council, Assembly Committee on Public and Community Psychiatry
KEY WORDS: Psychiatric Facility, Design, Construction

APA STRATEGIC PRIORITIES: Advancing Psychiatry

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

References:
Action Paper Worksheet
2018 Action Paper Budget Estimate

Action Paper Title: 12.Q: Psychiatric Facility Construction
Action Paper Author(s): Isabel Norian, M.D., Representative, New Hampshire Psychiatric Society
Phone/email: belle_note@yahoo.com
APA Admin. Name: Michelle Dirst, Director, Practice Management and Delivery Systems Policy
Phone/email: mdirst@psych.org

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Non-Staff Costs:

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Other Costs not included above:

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Staff Costs:

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Other Costs not included above:

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Rvst. Jan. 2018

APA Administration Feedback:

COMPONENT: Council on Healthcare Systems and Financing: We support.

EXPLANATION OF COST:
Staffing of a workgroup to develop a position statement would take approximately 40 hours.
ACTION PAPER

TITLE: Reducing the Burden of Treatment Plan Documentation

WHEREAS:
1. The requirement of formalized “Treatment Plan” documentation in psychiatric care settings arose in the 1970s for good reason, including the issue of persons with mental illness being warehoused in state mental health institutions without documented evidence of adequate treatment, and the expansion of Medicaid funding to community behavioral health services. (1)
2. In over 40 years, there has been no formal review of this regulatory process by stakeholders. (1)
3. Treatment Plan documentation requirements are built into Centers for Medicare and Medicaid Services (CMS) and Joint Commission regulations for inpatient and outpatient “behavioral health” services (1).
4. In May 2017, The American College of Physicians published a paper addressing the need to reduce administrative tasks in health care, advising that “Administrative tasks that cannot be eliminated from the health care system must be regularly, reviewed, revised, aligned, and/or streamlined in a transparent manner, with the goal of minimizing burden, by all stakeholders involved.” (2)
5. There is a distinction between clinically driven, meaningful treatment planning and the documentation requirement known as a “Treatment Plan.” (1)
6. There is no currently available published evidence that “Treatment Plan” documentation, in its current state, improves patient care. (1)
7. Documentation of the “Treatment Plan” places unnecessary administrative burden on psychiatrists and other members of psychiatric care teams, which in turn negatively impacts access to quality psychiatric care, including by detracting from available physician time for direct patient care activities and contributing to physician burnout. (1)
8. In March 2018, the American Association of Community Psychiatrists (AACP) published a Position Statement addressing the need to reduce burdens associated with “Treatment Plan” documentation, noting that “the current regulatory requirement of treatment plan documentation as a mechanism for determining reimbursement is additional undue burden for mental health providers when compared to reimbursement policies for chronic medical conditions.” (1)
9. In June 2018, the APA sent a letter to CMS regarding the “Patients over Paperwork Initiative” and specifically identified “Interdisciplinary Treatment Plans” as an issue of concern. (3)

BE IT RESOLVED:
1. That the APA endorse “Positions” (#1 through 4) of the attached AACP Position Statement, “Putting Patients First by Improving Treatment Planning and Reducing Administrative and Clinical Burden of Treatment Plan Documentation.”
2. That the APA shall convene a joint Board of Trustees and Assembly Work Group to address this issue, with the intent of having the APA take a leadership role in engaging CMS, the Joint Commission, SAMHSA, and other relevant stakeholders in addressing this issue.
3. That actions and progress of the Work Group shall be reported to the Assembly at its May and November 2019 meetings.
AUTHORS:
Isabel Norian, M.D., Representative, New Hampshire Psychiatric Society
Jeffrey Geller, M.D., MPH, Representative, American Association of Community Psychiatrists
Kenneth Minkoff, M.D., APA Member
Dianna Dragatsi, M.D., APA Member
Michael Flaum, M.D., APA Member

SPONSORS:
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Annya Tisher, M.D., Representative, Maine Association of Psychiatric Physicians
Daniel Neff, M.D., Representative, Pennsylvania Psychiatric Society
David Fogelson, M.D., Representative, Southern California Psychiatric Society
Leslie Hartley Gise, M.D., Representative, Hawaii Psychiatric-Medical Association
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Elisabeth J. Kunkel, M.D., DFAPA, APA Member
Marianne Marsh, M.D., APA Member
Miriam Tepper, M.D., APA Member
Tony Carino, M.D., APA Member
Jeanie Tse, M.D., APA Member
Mehdi Qalbani, M.D., APA Member
Dale Svendsen, M.D., MS, DLFAPA, APA Member
Anthony T. Ng, M.D., DFAPA, APA Member
Leigh Nathan, M.D., APA Member

ESTIMATED COST:
Author: $13,726
APA: $23,700

ESTIMATED SAVINGS: $0

ESTIMATED REVENUE GENERATED: $0

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

KEY WORDS: Treatment Plans, Treatment Planning, Administrative Burden

APA STRATEGIC PRIORITIES: Advancing Psychiatry

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

REFERENCES:

AACP Position Statement:
Putting Patients First by Improving Treatment Planning and Reducing Administrative and Clinical Burden of Treatment Plan Documentation

This paper represents a position statement of the American Association of Community Psychiatrists (AACP), regarding treatment plans. We regard treatment plans, a documentation requirement, in this position statement, as distinct from the process of treatment planning. The AACP is concerned that treatment plan documentation in its current state, creates unnecessary administrative burden for physicians, without evidence of benefit for patients, reducing direct patient contact time, thereby negatively impacting quality of care. In this position, we echo the statements made by the American College of Physicians in their position paper entitled “Putting Patients First by Reducing Administrative Tasks in Health Care”. We recommend a review of the treatment plan documentation requirement across the nation, engaging consumers, providers, regulatory agencies in all states, as well as national reimbursement and regulatory agencies, in order to promote the process of quality driven care and documentation.

Background
In May 2017, the American College of Physicians published a seminal position paper in the Annals of Internal Medicine. The Position Paper was entitled: Putting Patients First by Reducing Administrative Tasks in Health Care. The first two recommendations in this position paper included the following language:

1. *(Administrative) tasks that are determined to have a negative effect on quality and patient care, unnecessarily question physician and other clinician judgment, or increase costs should be challenged, revised, or removed entirely.*

2. *Administrative tasks that cannot be eliminated from the health care system must be regularly, reviewed, revised, aligned, and/or streamlined in a transparent manner, with the goal of minimizing burden, by all stakeholders involved.* (1)

The American Association of Community Psychiatrists (AACP) applauds the American College of Physicians’ Position Statement and its emphasis on changing the extent to which well-intentioned administrative regulations accumulate to the point that they interfere with good clinical care in spite of a lack of evidence that they produce the results they are intended to ensure.

This issue is of tremendous relevance in behavioral health, particularly in community behavioral health organizations. Administrative burden in community behavioral health services is especially concerning in services that are already extremely stretched for resources. Further, excessive administrative burden directly affects community psychiatrists, contributing substantially to the burnout of, as well as to barriers to recruitment and retention of, psychiatrists in public behavioral health settings. Most importantly, excessive administrative burden interferes with the ability of community psychiatrists and community behavioral health organizations to “put patients first” and provide the most effective possible clinical care.
Focus on Treatment Plan Documentation as Distinct from Treatment Planning

In this position statement, we aim to build on the thrust of the argument made by the American College of Physicians and focus specifically on one important area of regulation that is of significance to community psychiatrists, which is the documentation of “Treatment Plans” in order to meet regulatory requirements.

In this document, we are explicitly distinguishing the essential clinical process of treatment planning, which is especially important when working with individuals who have complex care needs or who are receiving complex team-based services, from the specifically prescribed regulatory documentation requirement known as the “Treatment Plan.”

Describing all the elements of appropriate clinical treatment planning is beyond the scope of this position paper. Clinical treatment planning in community psychiatry has been well described in the literature (2) and is continually being studied and improved. Effective treatment planning includes elements such as person/family-centered collaboration with shared decision-making, recovery/resiliency-oriented goals, integrated service delivery, team-based interventions, achievable and realistic objectives, and measurable results.

Further, effective clinical treatment planning must be documented in such a way that it can be useful to people receiving services and all members of the treatment team, as well as to funding and regulatory organizations. However, current documentation requirements do not appear to be an effective and efficient way of meeting that goal.

Assertions

- We assert that there is no clear evidence that the current requirements for treatment plan documentation and attestation (signature) meet the needs of service recipients, service providers, and funders/regulatory organizations in the most effective and efficient manner.
- We assert that regulatory requirements for provision of behavioral health services in community behavioral health organizations are imposed in a manner that is excessive compared to the requirements for provision of comparable behavioral health services in health clinics.
- We assert that the utilization of treatment plan documentation as the mechanism for determining whether services are eligible for payment interferes with the quality of treatment planning and with the quality of services delivered.
- We assert that the current regulatory requirement of treatment plan documentation as a mechanism for determining reimbursement is additional undue burden for mental health providers when compared to reimbursement policies for chronic medical conditions
- We assert that because the current administrative requirements for documenting treatment plans very commonly “have negative effects on quality and patient care” and unnecessarily “increase costs” without demonstrable value in improving the quality of clinical treatment planning, that these treatment planning documentation requirements need to be “reviewed, revised, aligned, and/or streamlined in a transparent manner, with the goal of minimizing burden, by all stakeholders involved.” (1)
History

Requirements for documentation of “Treatment Plans” originally arose many decades ago for good reasons.

One reason was the serious issue of people being warehoused in state mental health institutions without evidence of adequate treatment, and federal courts subsequently requiring that state institutions provide treatment, and concomitantly requiring written documentation of both the individualized treatment plan and of actual care being provided (3).

Another reason was associated with the expansion of Medicaid funding to community behavioral health services, also in the 1970s. When Medicaid became an important funding stream for public and community behavioral health services, state Medicaid authorities required documentation of “Treatment Plans” and associated treatment interventions as a way of initially establishing mechanisms for confirming “medical necessity” to justify payment.

Since that time, the documented “Treatment Plan” has become entrenched in public and community behavioral health care service delivery. The reach of the “Treatment Plan” has extended to the point that in almost all care settings, community psychiatrists and treatment team members experience such documentation exercises as a detraction from more actual, meaningful treatment planning and direct care activities. After forty years, a regulatory process such as this is long overdue for critical analysis and reconsideration.

Challenges

To summarize: The process of meaningful treatment planning is an essential aspect of care delivery in public and community behavioral health care settings. Unfortunately, that process is typically not well-captured or well-served by the current regulatory “Treatment Plan” documentation requirement, which:

1. **Lacks sufficient data to justify its continuation as a regulatory requirement.** While there is no doubt that the original concept of the “Treatment Plan” was reasonably intentioned, literature search finds no formal review of the current treatment plan documentation process nor definitive findings that indicate that the process is producing clinically effective treatment planning in all the treatment settings to which it is applied. A review of the literature reveals that numerous publications detail how to write a Treatment Plans (2, 4). Treatment Plan documentation is embedded into CMS and JCAHO regulatory requirements for inpatient and outpatient services (5). Yet there is no convincing published data suggesting that perpetuation of the currently implemented Treatment Plan requirement improves clinical outcomes or reduces health care costs.

2. **Is a requirement unique to behavioral health care services.** Comparable services (e.g., a physician evaluation and medication visit) for psychiatric conditions in other medical settings, such as primary care, do not have a comparable administrative documentation requirement, with its regulatory and reimbursement implications. The Mental Health Parity and Addiction Equity Act (“MHPAEA”) states that Plans may not apply any financial requirement or treatment limitation to Mental Health/Substance Use Disorders benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification. (6). Requiring – as a condition of payment - treatment plans that are substantially longer and more burdensome for mental illnesses and
substance use disorders in a mental health clinic than for either psychiatric conditions or medical conditions in a health clinic (where documentation of treatment plans and interventions in a progress note is adequate) is a potential violation of at least the spirit if not the letter of MHPAEA.

3. **Conflates clinical treatment planning with payment authorization creating direct and indirect barriers to access to care.** In most states, counties, and jurisdictions, services that are not specifically delineated on “Treatment Plans” are not reimbursed. The assumption by regulatory entities (such as JCAHO, state Medicaid agencies) is that failure to precisely document the so-called “medical necessity” of each intervention in the required Treatment Plan format is an indication that a service was either not indicated (not medically necessary) or not supposed to be delivered. In some instances, lack of timely completion of the “Treatment Plan” can disqualify consumers from receiving real-time, necessary services (such as functional support services). In many states and in many types of services, unless the “Treatment Plan” is meticulously and perfectly completed, then a given service will not be paid for, or may be subsequently denied. As a consumer’s care needs may quickly change, and often expand, the process of keeping the “Treatment Plan” updated in real time before a specific service can be rendered presents a barrier to timely service delivery, while exposing an agency to risk of nonpayment or recoupment.

4. **Targets a payor, rather than a consumer/provider, audience.** The “Treatment Plan” is initiated, updated, and completed with regulatory reviewers and auditors in mind. By contrast, good clinical treatment planning entails a comprehensive process of engagement between the service recipient, family members and treatment team members, is done in language understandable to all involved, and honors the service recipient’s unique circumstances and needs. In contrast to formulaic and constrictive regulatory template completion, useful treatment planning in community behavioral health settings is an interactive process that is recovery-oriented, collaborative (engaging consumer and team members in development and follow-through), concise, current and relevant to the consumer’s current condition and circumstances, and transferrable across care settings. Good treatment often involves standard monitoring of treatment outcomes, through scales and measures supported in the scientific literature, that both providers and consumers can utilize to track treatment outcomes. Documentation of treatment planning for measurement-based care, as well as the associated monitoring of progress, often takes place and should take place real time in progress notes or a similarly dedicated area in the record, rather than in cumbersome forms that are designed for auditor review rather than for patient care.

5. **Presents undue administrative burden to providers.** “Treatment Plans” demand detailed information entry, including “measurable” “goals” and “objectives.” These documents must be signed by the consumer, staff, sometimes family, and a physician. The process of initiating, completing, and updating a Treatment Plan is time- and resource-intensive. Documenting “Treatment Plan” requirements that meet “audit standards” stands to detract from actual quality treatment planning and execution. Furthermore, the accepted standard of care in health care in general is that treatment planning is documented as an integral component of strong progress notes by those providing care, and so the requirement to separately document a “Treatment Plan” potentially represents duplication of effort and information. Despite the mandate for “meaningful use” electronic health records (EHRs) (7), providers utilizing EHRs may face challenges in the integration of the required “Treatment Plan” into other areas of clinical documentation, yielding replication of documentation in disparate areas of the medical record.
6. **Impacts the role of the psychiatrist in the health care team.** At a time when physician shortages are a widespread problem in the workforce, it is critical that physicians practice at the top of their expertise and licensure and limit their involvement in unnecessary administrative tasks as referenced above. The “Treatment Plan” requirement that has been imposed upon the treatment team structure can shift the physician into role of “attestor” and “authorizer” of service, often spending hours signing hundreds of charts of patients that often have not been directly seen and evaluated. This detracts from the community psychiatrist’s ability to engage in the role of healer, collaborator, and partner in care delivery. Meaningful physician engagement positively impacts outcomes. Therefore, regulatory requirements that result in physician disengagement from care, without demonstrable value, result in poorer outcomes, and potentially increased burnout and turnover of providers.

**Position**

1. The AACP endorses the Position Statement of the American College of Physicians: “Putting Patients First by Reducing Administrative Tasks in Health Care” (1), including the statement that “Administrative tasks that cannot be eliminated from the health care system must be regularly reviewed, revised, aligned, and/or streamlined in a transparent manner, with the goal of minimizing burden, by all stakeholders involved.”

2. The AACP calls for the immediate elimination of the requirement that provision of a psychiatric visit in a behavioral health clinic necessitates documentation of a formal “Treatment Plan,” while provision of a comparable service in other medical settings (such as a primary care clinic) does not have a comparable requirement and requires only documentation in an assessment and progress note. Any similar additional examples of differential documentation requirements for treatment plans, whether for psychiatrists or other behavioral health practitioners, should be immediately identified and eliminated.

3. The AACP calls for elimination of the utilization of elaborate documentation of “treatment plans” as the major vehicle for determining whether services are authorized for payment. Documentation of medical necessity for payment authorization must be simplified and disconnected from clinical treatment planning documentation whenever feasible.

4. The AACP calls for a national collaborative effort - including, but not necessarily limited to, organizations such as CMS, DOJ, SAMHSA, NASMHPD, NACBHD, National Association of State Medicaid Directors, The Joint Commission, CARF, Council on Accreditation, the National Council, and national professional organizations to formally review the pervasive “Treatment Plan” documentation requirements in the delivery of behavioral health care services. Such an effort would include collection and analysis of data about financial, time, and quality of care impact statements of such requirements, and data on correlation (if any) between such requirements and successful clinical treatment planning and service delivery outcomes. Finally, such an effort must include specific recommendations for how to make changes in current documentation requirements, disconnect such requirements from micromanagement by payers, and propose pilot studies or field testing of new standards to determine whether any recommended changes improve clinical efficiency and outcomes while maintaining appropriate levels of clinical and financial accountability.
References


5. The Joint Commission. TJC PC 4.40, 4.10, PC.01.03.01, CTS.03.01.09.


**Action Paper Title:** 12.R: Reducing the Burden of Treatment Plan Documentation  
**Action Paper Author(s):** Isabel Norian, M.D., Representative, New Hampshire Psychiatric Society  
**Phone/email:** belle_note@yahoo.com  
**APA Admin. Name:** Michelle Dirst, Director of Practice Management and Delivery Systems Policy  
**Phone/email** 202-599-3716/mdirst@psych.org

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- LCD Projector: 850
- Laptop: 300
- Screen: 180
- Flipchart: -
- Microphones: -

**Total Non-Staff Costs:** 1,330

### Staff Costs:

1. Support for development and finalization of Position Statement draft: 3,160

2. -

3. -

**Total Staff Costs:** 3,160

### Other Costs not included above:

- 0

**Total Author Estimate:** 13,726

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### Staff Costs:

1. Staff time for workgroup convening and administrative tasks: 9,480

2. Staff time for advocacy efforts: 14,220

3. -

**Total Staff Costs:** 23,700

### Other Costs not included above:

- 0

**Total Administration Estimate:** 23,700

Rvsd. Jan. 2018
Action Paper 12.R: Reducing the Burden of Treatment Plan Documentation

APA Administration Feedback:

DEPARTMENT: Practice Management and Delivery Systems Policy
We support developing a workgroup to review the treatment plan documentation. We previously advocated for addressing the issue as noted.

EXPLANATION OF COST:
Staff time for workgroup convening and administrative tasks: 120
Staff time for advocacy efforts: 180
ACTION PAPER

TITLE: American Psychiatric Association Elections

WHEREAS:
WHEREAS, the APA is the professional organization that represents the interests and wellbeing of both psychiatric physicians and their patients; and

WHEREAS, such organizations should be structured to, in fact, be representative of the concerns and opinions of its members; and

WHEREAS, this is most likely to occur when the leadership of the organization is selected by a truly representative sample of the membership; and

WHEREAS, this imperative is not met when the leadership is consistently selected by an extremely small percentage of eligible voters; and

WHEREAS, only 18.25 percent of the eligible APA voting membership voted in the most recent election, a percentage that has been shrinking and skewing over several elections cycles; and

WHEREAS, the members of the APA Assembly are elected by their local colleagues and the cumulative vote for the APA Assembly representatives exceeds the vote in the APA national elections – thus providing a group of potential electors who are more representative of the membership than are the small and skewed number of members who, in fact, cast ballots in national APA elections; and

WHEREAS, the AMA years ago recognized this dilemma and instituted House of Delegates election of AMA leadership, and

WHEREAS, this proposal is presented as an action paper because the APA no longer has a workable referendum process.

BE IT RESOLVED:
That the Board implement procedural changes in the election process that would stipulate that if less than 25 percent of the APA eligible voting membership, in fact, vote in an APA election, the selection of such leadership will pass to the Assembly for nationally selected offices and to the Area Councils for Area selected offices and members of the Board. The Assembly voting mechanism would be one vote per representative with a vote by strength if a chosen candidate gets less than 60% of the initial vote.

Alternatively, the officer election ballot could be sent out to all voting members with the yearly dues statement which also contains a request for contributions to the PAC and Foundation, so it would go to both dues paying and non-dues paying voting members. The implementation of this
second alternative should ensure that the first alternative would never need to be utilized and is therefore preferred.

AUTHOR:
John P. D. Shemo, M.D., DLFAPA, Representative, Psychiatric Society of Virginia

ESTIMATED COST:
Author: $0
APA: $158

ESTIMATED SAVINGS: Second Alternative: Should be some savings from one “mailing” per year rather than two.

ESTIMATED REVENUE GENERATED: DNA

ENDORSED BY:

KEY WORDS: APA elections, Governance

APA STRATEGIC PRIORITIES: Diversity

REVIEWED BY RELEVANT APA COMPONENT: Submitted to Elections Committee
### Action Paper Worksheet

#### 2018 Action Paper Budget Estimate

**Action Paper Title:** 12S: American Psychiatric Association Elections

**Action Paper Author(s):** John P.D. Shemo, M.D., DLFA, Representative, Psychiatric Society of Virginia

**Phone/email:** 434-984-6777 / shemojohn@pabrcrc.com

**APA Admin. Name:** Chiharu Tobita, Association Governance

**Phone/email:** 202 609-7228 / ctobita@psych.org

### Attendance Summary:

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- LCD Projector
- Laptop
- Screen
- Flipchart
- Microphones

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#### Staff Costs:

1. Description:

2. Description:

3. Description:

**Total Staff Costs:**

### APA Administration Estimate:

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- LCD Projector
- Laptop
- Screen
- Flipchart
- Microphones

**Total Non-Staff Costs:**

#### Staff Costs:

1. Description: Apa administration will provide assistance to the tellers during the vote count

2. Description:

3. Description:

**Total Staff Costs:**

**Other Costs not included above:**

**Total Administration Estimate:** 158

---

**APA Admin. Name:** Chiharu Tobita, Association Governance

**Phone/email:** 202 609-7228 / ctobita@psych.org

**Action Paper Author(s):** John P.D. Shemo, M.D., DLFA, Representative, Psychiatric Society of Virginia

**Phone/email:** 434-984-6777 / shemojohn@pabrcrc.com

**Rvd Jan. 2018**
DEPARTMENT: Association Governance

The Elections Committee chaired by Dr. Josepha Cheong reviewed the Action Paper and submitted the following feedback to the author:

The Elections Committee does not support the Action Paper for the following reasons:

1. *Deferment of selection of elected officials to the Assembly and the Area Councils does not necessarily guarantee representation of the wishes of the general membership. The only certainty is a circular argument: the selections of the Assembly and Area Councils reflects the selections of the Assembly and the Area Councils.

2. *It's not clear why a low turnout of general members voting is "skewing" the elections. If the ones who vote are the most engaged - are their individual votes less valid because there are fewer total votes?

3. *"One member, one vote" is an essential component of the APA. It is not certain how this Action Paper with its proposal to allow the Assembly/Area Councils select in event of low voter turnout addresses engagement of the general member. It is more likely to be perceived as a potential "power grab" by the Assembly and Area Councils.

DEPARTMENT: Membership Department

The action paper requests that: “...the officer election ballot could be sent out to all voting members with the yearly dues statement which also contains a request for contributions to the PAC and Foundation, so it would go to both dues paying and non-dues paying voting members. The implementation of this second alternative should ensure that the first alternative would never need to be utilized and is therefore preferred.”

Membership sends out material to dues paying members that includes 1 invoice, 1 letter, 1 payment plan sign-up form, 1 flyer, and 1 return envelope (5 total pieces). Dues-exempt life members and members on a scheduled payment plan are not part of the invoice mailing process and include about 8,000 members. More than half of members who receive the invoice pay their memberships online and, consequently, do not return the dues statement. Therefore, the ballot would likely be discarded along with the dues statement.

For those roughly 25% that mail checks, the inclusion of two return envelopes, one addressed to APA and the other to the third-party vendor facilitating the elections, would likely result in members confusing the ballot and dues envelopes. This would disrupt both the processing of ballots and dues for the APA and the District Branches/State Associations.

Membership would prefer not to be responsible for the management of incoming ballots either through one envelop with dues or by receiving the wrong envelop from members given the confidential and political sensitivity of the process. The increase in hard and soft costs are difficult to calculate until additional clarity pertaining to the above factors are better known.
EXPLANATION OF COST:  Association Governance

The implementation of the author’s second suggested alternative ("Alternatively, the officer election ballot could be sent out to all voting members with the yearly dues statement which also contains a request for contributions to the PAC and Foundation, so it would go to both dues paying and non-dues paying voting members.") would involve a higher cost estimate than proposed, as it would require APA to hire contractors to implement the mailings of the ballots and dues statements. Please note that it was not included in the administration cost estimate.