May 2023 Assembly Action Papers

The action papers from the May 2023 Assembly meeting are listed below. Please click on the item number to view the action paper. To receive a report (or reports) submitted for the November Assembly meeting, please contact Association Governance at apagov@psych.org.

Item Number	Action Paper Title
2023A1 12.A	Incorporation of Medications for the Treatment for Opioid Use Disorder by Opioid Treatment Programs into Controlled Substance Databases **[APPROVED]**
2023A1 12.B	Interference with Psychiatry Resident, Physician-in-Training **[APPROVED]**
2023A1 12.C	Exemption to the Crack House Statute (21 U.S.C. S856) for Overdose Prevention Centers **[APPROVED]**
2023A1 12.D	Banning Stigma Against People Living with Mental Illness Beyond Health Insurance Parity **[TABLED]**
2023A1 12.E	Making Prescribing Easier: Eliminating Inappropriate Prescribing Policies and Limitation **[FAILED]**
2023A1 12.F	Expanding Post-Graduate Opportunities for Unmatched Psychiatry Residency Applicants **[APPROVED]**
2023A1 12.G	Adding a Trauma Specifier to DSM-5 Oppositional Defiant Disorder Diagnostic Criteria **[WITHDRAWN BY THE AUTHOR]**
20231 12.H	Expanding Noncriminal Behavior Inclusivity of DSM-5 Antisocial Personality Disorder Diagnostic Criteria **[WITHDRAWN BY THE AUTHOR]**
2023A1 12.I	Dismantling Racist Policies in Black Mental Health: APA to Repudiate the Moynihan Report **[APPROVED]**
2023A1 12.J	Improving the Public and Healthcare Professionals' Perceptions of Psychiatry and Psychiatrists **[APPROVED]**
2023A1 12.K	DEA Registration in Different States **[WITHDRAWN BY THE AUTHOR]**
2023A1 12.L	Text Communication to Improve APA National Election Participation **[APPROVED]**
2023A1 12.M	Making the Nomination and Election Process Fair for Petition Nominees for APA Officer Positions **[APPROVED]**
2023A1 12.N	Furthering our APA's Initiative on the Collaborative Care Model **[APPROVED]**
2023A1 13.A	OLD BUSINESS: Addressing Structural Racism in the APA: Replacing Minority and Underrepresented (MUR) Terminology **[APPROVED]**

Item 2023A1 12.A
Assembly
May 19-21, 2023

ACTION PAPER
FINAL

TITLE: Incorporation of Medications for the Treatment for Opioid Use Disorder by Opioid Treatment Programs into Controlled Substance Databases

WHEREAS:

Whereas: Over 300,000 individuals receive Methadone through an Opioid Treatment Program (OTP), also known as a Methadone Treatment Program (MTP). An OTP is governed by Federal rules, state laws, and state administrative rules.

Whereas: Methadone has the potential to interact with a number of medications, and some of the interactions have the potential for serious consequences, including death.

Whereas: Physicians and other healthcare providers report that they regularly encounter patients in emergency departments, hospitals and other healthcare settings who divulge that they receive Methadone through an OTP, but the patient is not privy to their dose of Methadone. The physicians and other healthcare providers are dependent on urgent confirmation of the dose of Methadone from the OTP, risking under-dosing, opioid withdrawal, or providing a Methadone dose which is higher than needed.

Whereas: Patients may be reluctant to reveal that they are on Methadone for an Opioid Use Disorder.

Whereas: Most states require physicians to query their state's PDMP (Prescription Drug Monitoring Program) to analyze prescription history prior to writing a prescription for opioids or other controlled substances. Studies have shown that states that have implemented a PDMP and that have required prescribers of controlled substances to perform patient queries have seen declines in overall opioid prescribing, drug-related hospitalizations, and overdose deaths. More robust PDMP programs have been associated with greater reductions in prescription opioid overdoses. However, any physicians and other health care professionals are not aware that PDMPs do not currently contain comprehensive information on patient medications, particularly medications for OUD from an OTP.

Whereas: Pharmacies and other dispensers are not required to obtain patient consent before submitting information to the state PDMP about controlled substances which have been dispensed to patients.

Whereas: Previous guidance from SAMHSA in 2011 encouraged OTP staff to access PDMPs, but stated that OTPs could not disclose patient identifying information to a PDMP unless an exception applied, consistent with the federal confidentiality requirements.

Whereas: According to published advice in the Federal Register, in August 2019, SAMHSA published a Notice of Proposed Rulemaking (NPRM) that proposed changes to the Part 2 regulations that SAMHSA believed would better align with HIPPA, “the needs of individuals with SUD and of those who treat these

patients in need, and help facilitate the provision of well-coordinated care, while ensuring appropriate confidentiality protection for persons in treatment through Part 2 programs."

Whereas: SAMHSA underscored the risks of Methadone treatment non-disclosure when it published amendments and comments to 42 CFR Part 2 in July 2020- "The omission of OTP data from a PDMP can lead to potentially dangerous adverse events for patients who may receive duplicate or potentially contraindicated prescriptions as part of medical care outside of an OTP, thereby placing them at risk for adverse events, including possible overdose or even fatal drug interactions." Also, that the amendments to 42 CFR Part 2 were "essential for improving patient care and safety, particularly for individuals receiving MAT,"

Whereas: SAMHSA also published the statement in July 2020 that "increasing care coordination and information access within an individual's care team will reduce stigma by giving providers accurate and comprehensive information about a patient's medical needs."

Whereas: In July 2020, the Final Rule amending 42 CFR Part 2 through the addition of § 2.36 created new permissions to allow OTPs to disclose dispensing and prescribing data, as required by applicable state law, to PDMPs, subject to patient consent. ("A part 2 program or other lawful holder is permitted to report any SUD medication prescribed or dispensed by the part 2 program to the applicable state prescription drug monitoring program if required by applicable state law. A part 2 program or other lawful holder must obtain patient consent to a disclosure of records to a prescription drug monitoring program under § 2.31 prior to reporting of such information.")

Whereas: Prescriptions written for the treatment of Opioid Use Disorder by prescribers outside of OTPs are already submitted to state PDMP through pharmacies or other dispensing entities. As such, PDMPs which are operated by law enforcement agencies are already receiving some patient data related to SUD treatment. While the reporting of patient data to a PDMP by an OTP would make it possible for law enforcement, prescribers, and pharmacies with access to a PDMP to determine that a specific patient had received services at a specific OTP, law enforcement would still require a court order meeting the requirements of 42 CFR § 2.65 to access these records for patients receiving treatment from the OTP.

Whereas: Many Opioid Treatment Programs are owned and/or managed by for-profit corporations, and these corporations vehemently resist state's attempts to further regulate them. Such resistance would make it extremely difficult for states to require the OTPs to submit information about Methadone use to the state PDMP. Incorporating this recommendation into any relevant APA Practice Guidelines, having an APA Position Statement about Methadone treatment and PDMP reporting, and changing § 2.36 of 42 CFR Part 2 to require OTPs to submit information to their state PDMP about Methadone dosing would greatly assist states in enacting equivalent legislation.

BE IT RESOLVED:

1. That the APA develop a position statement for the inclusion of Methadone, or any other controlled substance dispensed from an Opioid Treatment Program be included in controlled substance databases.

2. That the APA encourage SAMHSA to amend § 2.36 of 42 CFR Part 2 to require (not just allow) reporting of any controlled substance medication dispensed or administered to a patient by an OTP to the applicable state prescription drug monitoring program if allowed or required by applicable state law. Further, that this disclosure would not require patient consent.

AUTHOR:
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ESTIMATED COST:
APA: $251,566

ENDORSED BY:

KEY WORDS: Methadone, PDMP, Opioid, OUD, Opioid Use Disorder, MOUD, MAT, OTP, MTP

APA STRATEGIC PRIORITIES: Advancing Psychiatry

REVIEWED BY RELEVANT APA COMPONENT:

Item 2023A1 12.B
Assembly
May 19-21, 2023

ACTION PAPER
FINAL

TITLE: Interference with Psychiatry Resident, Physician-in-Training

WHEREAS:

Psychiatry Resident and Fellow physician didactic education requires fundamental knowledge acquired during medical school;

Guidelines for this didactic education in psychiatry residency programs is agreed upon by Accreditation Council of Graduate Medical Education (ACGME); ACGME develops standards including educational guidelines, milestones, and assessments, along with graduated patient care responsibility; ACGME updates these standards regularly for excellent trainee education; ACGME annually reviews all psychiatry residency programs for compliance regularly;

ACGME requirements address non-physicians' roles in resident education, both from the perspective of teaching faculty as well as the impact of non-physician learners on resident education; these requirements state[1],

> "the presence of other learners and other care providers, including, but not limited to, residents from other programs, subspecialty fellows, and advanced practice providers, must enrich the appointed residents' education;"

ACGME states[2],

> "The program must report circumstances when the presence of other learners has interfered with the residents' education to the DIO and Graduate Medical Education Committee;"

ACGME standardized education is unfavorably altered or diluted to assist students with less foundational science education in some residency training programs; this hinders the intended advanced medical and psychiatric education required for the psychiatry resident physicians-in-training;

The American Psychiatric Association (APA) has current position statements related to infringement upon psychiatric scope of practice and other elements of education including non-physician supervision during training[3];

At the AMA, a position statement[4] was developed by the section on residents and fellows in 2021 that resolved that the AMA study and report on the "curriculum, accreditation requirements, accrediting bodies, and supervising boards for undergraduate, graduate, and postgraduate clinical training programs for non-physicians and the impact on undergraduate and graduate medical education" and that the AMA "oppose non-physician healthcare providers from holding a seat on the board of an organization that regulates and/or provides oversight of physician undergraduate and graduate medical education, accreditation, certification, and credentialing when these types of non-physician healthcare providers either possess or seek to possess the ability to practice without physician supervision as it represents a conflict of interest;" this action was passed to the AMA Council on Medical Education;

The AMA Council on Medical Education produced a report[4], which emphasizes several of the same concerns in this APA Action Paper:

- Physician training can be adversely affected if the presence of multiple learners results in decreased opportunities for patient or procedural exposures;
- Enrolling [NPPs] into "resident" positions can lead to reduction in the number of MD/DO graduate positions available;

The American Academy of Emergency Medicine (AAEM) have similarly stated[5]:

- "[NPP training] programs must be clear to the public by prohibiting the use of the following terms: doctor, intern, internship, resident, residency, fellow, and fellowship. The recommended term is postgraduate training program;"
- "[NPP postgraduate training programs] must be structured, intended, and advertised as to prepare its participants to practice *only* as members of a physician-led team;"
- "[NPP postgraduate training programs] must not interfere with the educational opportunities of emergency medicine residents and medical students. Potential detriment to resident and student education must be monitored in a comprehensive and meaningful way throughout the existence of the NPP program;"
- "[NPP postgraduate training programs] must be initiated with the consultation and approval of the emergency medicine residents and physician faculty;"

The American Academy of Dermatology (AAD)[6] has also noted that,

> "[the] education of physicians and non-physician clinicians is entirely different…this labeling [of advanced practice residencies or fellowships] is misleading to the general public as it portrays a level of training that has not been established."

Non-physician practitioners (NPPs) should be taught and trained primarily by clinicians with their same or higher degree/license in order to receive the knowledge they need to work within a collaborative model recommended by the APA; these practitioners need to ensure adequate and appropriate training for themselves within their own specialty;

While most programs who are combining the education of NPPs with psychiatry residents are likely doing so to preserve resources without considering the ramifications, this practice of combining education should not occur as there are a number of negative consequences to psychiatrists and to the field of psychiatry, that can occur:

Commingling the training of NPPs alongside Psychiatry Residents inadvertently gives the appearance of a false equivalency and of NPPs completing a residency training education;

Integrating training undermines the differential benefits of all, and further risks reducing the clinical competencies of psychiatric trainees; the learning and training objectives and program intent are different for each;

Having NPPs in the same didactic training programs decreases the space and availability for psychiatrists-in-training due to a finite number of attending physicians; this practice of coeducation is in conflict with the APA's stated goal to increase the number of psychiatrists in training[7];

For the purpose of interprofessional education and collaborative care education, psychiatrists should assist in training of NPPs in certain forums, but the training of psychiatry residents and fellows should not be superseded by interprofessional education including NPPs.

BE IT RESOLVED:

1. That the APA create a Position Statement in the service of patients and the field of Psychiatry concerning the training of Psychiatry residents and non-physician practitioners.

2. That the Position Statement clarifies the appropriate relationships for interdisciplinary education, recognizing and emphasizing only physician-led, team-based collaborative care models with education for non-physician practitioners.

3. That the APA work with the AMA, ACGME, AAEM, AAD and other medical societies to preserve the training of physicians as the head of collaborative care models, make the physician education the priority in any combined post-graduate interprofessional education, and work to assess and ensure in such settings where non-physician trainees are integrated into the program their inclusion does not diminish the institutional expectations of the role of the physician expert.

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ESTIMATED COST:
APA: $1,044

ENDORSED BY: RFM Committee

KEY WORDS: education, collaborative care, residents, fellows, training, mid-level practitioners, non-physician practitioners

APA STRATEGIC PRIORITIES: Advancing Psychiatry, Education

REVIEWED BY RELEVANT APA COMPONENT:

REFERENCES:

1. ACGME Resident Survey/Common Program Requirements Crosswalk, 2021. https://www.acgme.org/globalassets/pfassets/programresources/residentfellow-survey-common-program-requirements-crosswalk.pdf
2. ACGME Common program requirements (Residency), 2022. https://www.acgme.org/globalassets/pfassets/programrequirements/cprresidency_2022v3.pdf
3. APA Action Paper: Supervision of Psychiatric Mental Health Nurse Practitioners and Physician Assistants in Psychiatry by Psychiatrists, Item 2018A1 12.C, May 2018.
4. The American Medical Association Council on Medical Education report, June 2021. https://www.ama-assn.org/system/files/a22-cme05.pdf
5. The American Academy of Emergency Medicine (AAEM), September 2020. https://www.aaem.org/resources/statements/position/updated-advanced-practice-providers

6. American Academy of Dermatology (AAD), May 2019. https://server.aad.org/Forms/Policies/Uploads/PS/PS-Dermatology%20Residency%20and%20Fellowship%20Training.pdf
7. *Workforce development*. Psychiatry.org - Workforce Development. (2022, July 29). https://www.psychiatry.org/psychiatrists/advocacy/federal-affairs/workforce-development

Item 2023A1 12.C
Assembly
May 19-21, 2023

ACTION PAPER
FINAL

TITLE: Exemption to the Crack House Statute (21 U.S.C. S856) for Overdose Prevention Centers

WHEREAS:
There were 100,521 reported overdose deaths as of September 2022, with 75,862 (75%) being opioid overdose deaths.

Overdose prevention center (OPC), aka Supervised Injection Facility (SIF) or Supervised Injection Site (SIS) allow people who inject drugs (PWID) to use in a supervised setting where staff can intervene if an overdose occurs. Data from other countries show that OPCs lead to significant reductions in non-fatal overdose and mortality, with no reported overdose deaths.

The Crack House Statute is a federal law from 1986 that deems it illegal for organizations to open a place and knowingly allow use of controlled substances.

Hence, OPCs operate in a legal gray area that make them vulnerable to legal challenges and prohibit federal funding.

The first OPCs in the US opened in November 2021 in NYC. As of March 2023, they had nearly 66,000 engagements and intervened 819 times to address overdose symptoms. Meanwhile, other cities such as Denver, Philadelphia and Maine have not been able to open OPCs due to legal barriers on the local and federal level.

Amending the Crack House Statute to include exemptions for organizations providing overdose prevention services would remove a significant barrier to providing lifesaving treatment.

BE IT RESOLVED:

- That the APA supports the development of overdose prevention centers as a harm reduction strategy to reduce overdose deaths in the US, and it be further
- Resolved that the APA, through the Council on Advocacy and Government Relations, seek federal legislation or regulation to provide exemptions to 21 U.S.C. S856 for Overdose Prevention Centers, and be it further
- Resolved, that the APA share educational information on the benefits of Overdose Prevention Centers with members of the US House of Representatives and the US Senate, and be it further
- Resolved, that this resolution be referred to the AMA HOD for adoption and partnership in advocacy on the national level.

AUTHOR:
Alan T. Rodríguez Penney, MD, ECP Deputy Representative, Area 2

ESTIMATED COST:
APA: $9,396

ENDORSED BY: New York State Psychiatric Association

KEY WORDS: Harm reduction, overdose prevention

APA STRATEGIC PRIORITIES: Advancing Psychiatry

REVIEWED BY RELEVANT APA COMPONENT:

REFERENCES:

Evidence base for OPCs: https://icer.org/wp-content/uploads/2020/10/ICER_SIF_Final-Evidence-Report_010821.pdf

Overdose deaths/opioid overdoses: https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm

Data first 2 months OnPoint NYC:
https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2794323

Item 2023A1 12.D
Assembly
May 19-21, 2023

ACTION PAPER
TABLED

TITLE: Banning Stigma Against People Living with Mental Illness Beyond Health Insurance Parity

WHEREAS:

1. The federal Mental Health Parity Addiction Equity Act (MHPAEA) and states' parity laws serve to correct inequity in the treatment of people living with mental illness only through regulation of private health insurance and state Medicaid agencies.
2. Systemic stigma against mental illness beyond health insurance and public health coverage is caused by laws, policies, procedures, and practices of private and publicly held companies and government entities within the United States.
3. Systemic stigma represents bias and prejudice against people living with mental illness and is based on unscientific fears and assumptions about mental illness.
4. This systemic stigma can further limit access to quality mental health treatment beyond the scope of MHPAEA.
5. This systemic stigma creates unfair, unethical, and immoral impediments to other basic human and civil rights that people without mental illness do not face.
6. Innumerable laws, policies, procedures, and practices that are based on fear of prejudice against mental illness and not based on clinical science already exist that are not impacted by MHPAEA or states' parity laws, , thereby causing this systemic stigma.
7. Examples of such laws, policies, procedures, and practices include
    a. the delineation of Institutions of Mental Disease (IMDs) by the Centers for Medicare and Medicaid Services (CMS) that applies to the hospital-based care only for mental illness; and
    b. the Joint Commission (JCAHO) utilizing different standards for credentialling inpatient and outpatient behavioral health institutions on behalf of CMS; and
    c. regulations by the Drug Enforcement Agency (DEA) necessitating specialized waivers and certification for prescribing opiates in the treatment of opioid addiction, i.e., preventing the pain of opioid withdrawal, but not for the treatment of other pain conditions; and
    d. the Air Carrier Access Act, which regulates psychiatric service animals differently than other medical service animals; and
    e. differences between mental illness and other medical conditions in the process for application, considerations and limitations placed on short- and long-term disability decisions; and
    f. questions on job applications and licensure applications that ask about mental health and/or substance abuse, but not about other medical limitations; and
    g. many more examples too numerous to list of laws, polices, procedures, and practices of federal, state, and local government agencies; public and corporate enterprises; and other organizations lawfully operating within the United States.
8. The APA has previously issued a Position Statement on Discrimination Against Persons with Previous Psychiatric Treatment[1], last in 2019 before the Public Health Emergency
9. The issue of stigma and discrimination on the basis of mental health and mental disorders has become even more discordant with the needs of society.

BE IT RESOLVED:

1. That the APA will develop, guide and support federal legislation
    a. establishing that the rights and privileges of those living with mental illness shall not be diminished or inhibited on the basis of having a mental illness by the laws, polices, processes, and practices of any government agency, any public or corporate enterprise, or other entity operating within the United States, and
    b. immediately outlawing any current laws, polices, processes, and practices that diminish or inhibit such rights and privileges
2. That the APA revise, if necessary, and re-issue a position statement
    a. defining Mental Health Stigma as any prejudice or bias against mental illness, mental health, mental healthcare, or people living with mental or psychiatric disease that is not based on clinical or scientific fact
    b. demanding basic human rights in society for all people living with mental illness, and that no person's constitutional, civil, ethical, or moral rights should be diminished on the basis of having medically diagnosed condition when there is no scientific, or health related reason to do so.
    c. declaring support for any endeavor that focused on establishing equitable and fair treatment and access to all rights and privileges in public and private life for those living with mental illness

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Arden Barnett, MD, Representative, Illinois Psychiatric Society
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ESTIMATED COST:
APA: $43,500

ENDORSED BY: Illinois Psychiatry Society

KEY WORDS: Stigma

APA STRATEGIC PRIORITIES: Advancing Psychiatry

REVIEWED BY RELEVANT APA COMPONENT:

REFERENCES:

1. APA "Position Statement on Discrimination Against Persons with Previous Psychiatric Treatment, approved by Board of Trustees", Dec. 2019

Item 2023A1 12.E
Assembly
May 19-21, 2023

ACTION PAPER
FAILED

TITLE: Making Prescribing Easier: Eliminating Inappropriate Prescribing Policies and Limitation

WHEREAS:

1. Dealing with insurance coverage, pharmacy benefit manager (PBM), and pharmacy dispensing policies that limit medication choices and quantities cause burdensome, uncompensated, and sometimes futile administrative time and effort for physicians and other prescribing healthcare workers
2. Such burdensome and uncompensated administrative work contributes to physician burnout.
3. Examples of such policies include, are not limited to, the following.
    a. Health insurers' medication Step Therapy policies, also known as "fail first" policies, which require patients to fail - due to ineffectiveness or adverse reactions - certain medications, chosen based on financial but not clinical factors, before the insurers will cover the one recommended by the patient's physician.
    b. Health insurers' arbitrary drug quantity and prescription duration policies, which limit monthly pill quantities or require 90-day prescriptions in order cover prescribed medication and serve only a financial benefit for the insurer without regard to clinical appropriateness or patient convenience.
    c. Pharmacy policies to request 90-day prescriptions - sometimes sent to physicians worded as, "Your patient has requested a 90-day prescription," when no such request has been made by the patient – and which serve only a financial benefit for the pharmacy without regard to clinical appropriateness or patient convenience.
4. Such policies are utilization management and financial controls meant only to maximize insurers' or pharmacies' profits with no existing evidence demonstrating clinical benefits.
5. Such policies create burdensome, uncompensated, and sometimes futile administrative time and effort for physicians to respond to.
6. Such policies ultimately extend patients' suffering due to delays in starting the appropriate treatment or due to trying and failing a clinically inappropriate treatment, thus profiting the insurer or pharmacy at the expense of members' and physicians' health
7. Many states have enacted Step Therapy legislation to curb step therapy polices,[1] but no Federal legislation or policy currently exists to curb Federal health insurance or ERISA-regulated plans currently exist.
8. The Federal "Safe Step Act"[2] has not progressed in either chamber of Congress since being introduced in spring of 2021 and has many shortcoming
9. Neither existing state step therapy laws nor the "Safe Step Act" address health insurers' drug quantity and prescription duration polices, nor pharmacies' 90-day prescription requests.

BE IT RESOLVED:

1. The APA modify, update, and broaden its earlier positions statements related to pharmacy benefit managers and prescribing restrictions to oppose any policies or procedures - including but not limited to quantity limitations or requirements, step therapy or fail first policies, or prior authorization - by health insurance, pharmacy benefit managers, pharmacies, and any other

health care organizations that delay, or otherwise interfere with, the immediate filling of prescriptions by patients for any non-clinical reason.

2. That the APA will advocate for changes to URAC accreditation to prohibit health insurance, pharmacy benefit managers, pharmacies, and any other health care organizations from having policies that delay, or otherwise interfere with, the immediate filling of prescriptions by patients for any reason not based on clinical or medical science.
3. That APA will, in coordination with other medical societies as necessary, develop and pursue federal legislation seeking to ban any policies and procedures for health insurance, pharmacy benefit manager, pharmacy, and all other health care organization that regulate a prescriber's medication choice and quantity, or that otherwise delay timely filling of prescriptions by patients, when such policies are not based medical evidence or treatment standards.
4. That APA will create related model legislation for state level advocacy.

AUTHOR:
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ESTIMATED COST:
APA: $39,150

ENDORSED BY:

KEY WORDS: Step Therapy, prescribing, quantity limits, quantity requirements, health insurance, pharmacy

APA STRATEGIC PRIORITIES:
Advancing Psychiatry

REVIEWED BY RELEVANT APA COMPONENT:

REFERENCES:

1. www.steptherapy.com
2. Safe Step Act, S. 464, 117th Cong. (2021-2022), or Safe Step Act, H.R. 2163, 117th Cong. (2021-2022)

Item 2023A1 12.F
Assembly
May 19-21, 2023

ACTION PAPER
FINAL

TITLE: Expanding Post-Graduate Opportunities for Unmatched Psychiatry Residency Applicants

WHEREAS:
The COVID-19 pandemic has increased the frequency, severity, and complexity of psychiatric symptoms, necessitating more care led by psychiatrists.[1,2]

The gap between available and needed US psychiatrists continues to grow and is projected to be around 25% by 2025.[3]

In the 2023 Main Residency Match, there were over 3,000 applicants for about 2,100 available psychiatry residency positions.[4]

The chance of matching as a psychiatry reapplicant decreases with every attempt. In the year 2023, only 45 out of 2,143 of those who matched into psychiatry were US MD/DO reapplicants.[4]

Reapplicants are advised that they can improve their chances of matching into psychiatry by engaging in research or mental health-related work, or by working in a clinical setting.[5,6,7]

APA currently does not educate its medical student members through listserv communication or provide information on their website regarding specific opportunities that might bolster the resume of a reapplicant.

BE IT RESOLVED:
That APA expand its webpage of residency/fellowship vacancies to host, and continually update, opportunities for paid/unpaid research, clinical rotations or observerships, or other clinical work.

That APA work with relevant stakeholders/organizations such as the American Association of Directors of Psychiatric Residency Training (AADPRT) and the Association of Directors of Medical Student Education in Psychiatry (ADMSEP), to populate said webpage with these opportunities.

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ESTIMATED COST:
APA: $5,220

ENDORSED BY: Area 1 Council, Area 6 Council, Assembly Committee of Area Resident-Fellow Members (ACORF)

KEY WORDS: Match; NRMP; residency; AADPRT; ADMSEP

APA STRATEGIC PRIORITIES: Education

REVIEWED BY RELEVANT APA COMPONENT:

REFERENCES:

1. Jonikas, J. A., Cook, J. A., Swarbrick, M., Nemec, P., Steigman, P. J., Boss, K. A., & Brice, G. H. (2021). The impact of the COVID-19 pandemic on the mental health and daily life of adults with behavioral health disorders. *Translational Behavioral Medicine*, *11*(5), 1162–1171.
2. Ettman, C. K., Abdalla, S. M., Cohen, G. H., Sampson, L., Vivier, P. M., & Galea, S. (2020). Prevalence of Depression Symptoms in US Adults Before and During the COVID-19 Pandemic. *JAMA Network Open*, *3*(9), 1–12.
3. Steinberg Institute. (2017, August). *Fact Sheet: How Primary Care Providers Can Help Solve Our Psychiatrist Shortage (August 2017)*. https://steinberginstitute.org/fact-sheet-primary-care-providers-can-help-solve-psychiatrist-shortage/
4. National Residency Matching Program. (2023). *Advance Data Tables for the 2023 Main Residency Match*. https://www.nrmp.org/wp-content/uploads/2023/03/2023-Advance-Data-Tables-FINAL.pdf
5. American Psychiatric Association. (2022). *A Roadmap to Psychiatric Residency*. https://www.psychiatry.org/File%20Library/Residents-MedicalStudents/MedicalStudents/Roadmap-to-Psychiatric-Residency.pdf
6. Balon, R., Morreale, M. K., Coverdale, J., Guerrero, A. P. S., Aggarwal, R., Louie, A. K., Beresin, E. V., & Brenner, A. M. (2020). Medical Students Who Do Not Match to Psychiatry: What Should They Do, and What Should We Do? *Academic Psychiatry*, *44*(5), 519–522.
7. Bumsted, T., Schneider, B. N., & Deiorio, N. M. (2017). Considerations for Medical Students and Advisors After an Unsuccessful Match. *Academic Medicine*, *92*(7), 918.

Item 2023A1 12.G
Assembly
May 19-21, 2023

ACTION PAPER
WITHDRAWN BY THE AUTHOR

TITLE: Adding a Trauma Specifier to *DSM-5* Oppositional Defiant Disorder Diagnostic Criteria

WHEREAS:
Oppositional defiant disorder (ODD) refers to a childhood pattern of disruptive symptoms involving irritability, argumentative behavior, and/or retaliatory behavior.[1]

Both normative, adaptive responses to trauma and posttraumatic stress disorder symptoms can include irritability and reactively angry outbursts.[2,3]

The current *DSM-5*'s Criterion C for ODD states that diagnosable behaviors must "not occur exclusively during the course of a psychotic, substance use, depressive, or bipolar disorder," nor meet criteria for disruptive mood dysregulation disorder. However, trauma- and stressor-related disorders, such as PTSD, are not currently mentioned among these exclusionary conditions.[4]

Based on the aforementioned, current *DSM-5* criteria, labeling patients with ODD risks them being overlooked for alternative, trauma reaction-related etiologies for irritability and argumentative behaviors. This can preclude children from receiving indicated treatment for a trauma disorder.[5]

This issue is exacerbated for African American, Latinx, and indigenous male youths who already face disproportionately higher rates of violence, racism, and other trauma-inducing factors, and have been suggested to be over-diagnosed with ODD.[6,7,8]

BE IT RESOLVED:
That APA's *DSM* Committee explore the possibility of adding an exclusionary specifier of trauma disorders to the aforementioned Criterion C for ODD.

AUTHORS:
Richard Zhang, MD, MA, RFM Deputy Representative, Area 1
Brett Kramer, DO, RFM Deputy Representative, Area 3
Anthony Kulukulualani, MD, RFM Deputy Representative, Area 5
Akshita Lalendran, MD, RFM Deputy Representative, Area 2

ESTIMATED COST:
APA: $9,570

ENDORSED BY: Area 1 Council , Assembly Committee of Area Resident-Fellow Members (ACORF)

KEY WORDS: Oppositional defiant disorder; *DSM-5*; PTSD; trauma; child and adolescent psychiatry

APA STRATEGIC PRIORITIES: Advancing Psychiatry; Diversity

REVIEWED BY RELEVANT APA COMPONENT:

REFERENCES:

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4. American Psychiatric Association. (2022). Disruptive, Impulse-Control, and Conduct Disorders. In *Desk Reference to the Diagnostic Criteria from DSM-5-TR* (pp. 181–186). American Psychiatric Association Publishing.
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Item 2023A1 12.H
Assembly
May 19-21, 2023

ACTION PAPER
WITHDRAWN BY THE AUTHOR

TITLE: Expanding Noncriminal Behavior Inclusivity of *DSM-5* Antisocial Personality Disorder Diagnostic Criteria

WHEREAS:
Antisocial personality disorder (ASPD) refers to disruptive, characterologically perpetuated antipathy towards societal norms, ethics, and the rights of others.[1]

ASPD is a useful diagnosis for understanding, and accordingly tailoring appropriate boundary-setting and interviewing style to, applicable patients.

Current *DSM-5* criteria explicitly refer, sometimes with exclusionary prepositional phrasings, to criminogenic or physically violent behaviors such as:
"...1. Failure to conform to social norms with respect to **lawful** behaviors, **as indicated by** repeatedly performing acts that are **grounds for arrest.**"
"...4. Irritability and aggressiveness, **as indicated by** repeated **physical** fights or assaults."
"...5. Reckless disregard for **safety** of self or others."[2]

Much of the seminal research contributing to the *DSM's* formulation of ASPD criteria interacted specifically with incarcerated populations. Incarcerated people comprise a proportionately limited subset of the general population.[3,4]

People with psychopathic temperaments, especially of higher socioeconomic backgrounds, can recurringly perform norm-violating behaviors that cause not physical, but instead significant financial, emotional, and/or psychological damage, which may not always be technically unlawful.[5,6,7]

It has been suggested that *DSM-5* criteria for ASPD overrepresent criminogenic features while blurring out noncriminal manifestations that still involve characterologically driven, persistent cruelty.[8]

BE IT RESOLVED:
That APA's DSM Committee explore rephrasing the aforementioned diagnostic criteria of ASPD, to expand inclusivity of noncriminal and non-physically violent, but intentionally norm-violating, harmful behaviors.

AUTHORS:
Richard Zhang, MD, MA, RFM Deputy Representative, Area 1
Christian Moser, MD, RFM Representative, Area 3

ESTIMATED COST:
APA: $9,570

ENDORSED BY: Area 1 Council, Assembly Committee of Area Resident-Fellow Members (ACORF)

KEY WORDS: Antisocial personality disorder; personality disorders; *DSM-5*; psychiatry and law

APA STRATEGIC PRIORITIES: Advancing Psychiatry, Diversity

REVIEWED BY RELEVANT APA COMPONENT:
A draft of this Action Paper was presented to and received feedback from the Assembly DSM Committee and then underwent a minor revision. The DSM Committee's chair, Dr. Kruse, reviewed this Action Paper again and gave permission to mention his support for this Action Paper to be presented at the May 2023 Assembly Meeting.

REFERENCES:

1. *Antisocial Personality Disorder: Causes, Symptoms & Treatment*. (2021, May 12). Cleveland Clinic. https://my.clevelandclinic.org/health/diseases/9657-antisocial-personality-disorder
2. American Psychiatric Association. (2022). Personality Disorders. In *Desk Reference to the Diagnostic Criteria from DSM-5-TR* (pp. 269–278). American Psychiatric Association Publishing.
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Item 2023A1 12.I
Assembly
May 19-21, 2023

ACTION PAPER
FINAL

TITLE: Dismantling Racist Policies in Black Mental Health: APA to Repudiate the Moynihan Report

WHEREAS:

1. The 1965 Moynihan report "The Negro Family: The Case For National Action," created as the theoretical framework to guide Federal strategies for the "War on Poverty," left largely unaddressed the role of harsh and pervasive racial discrimination and gross inequalities of educational and occupational opportunities in causing higher rates of poverty among Blacks relative to the general US population, and instead concluded that Black poverty was primarily caused by a "tangle of pathology" in Black family structure "capable of perpetuating itself without assistance from the white world;"

2. The Moynihan Report by pointing to cultural deficiencies among Blacks explains without recourse to now-discredited notions of biological inferiority how racial inequality persists even if race supposedly no longer matters. Its call to go "beyond civil rights," intended to highlight economic inequality, misleadingly implied that full legal and political equality had already been achieved.

3. The Moynihan Report perpetuates the dominant American ideology of the post-civil rights era: a willfully naïve color-blindness that suggests that racism no longer significantly factors in American life. The illusion of color-blindness allows Americans to overlook such contemporary realities that disproportionately affect Blacks as mass incarceration, blatantly unjust police violence, and even disenfranchisement.

4. The continued presence of unresolved sociopolitical and economic issues mentioned in the Moynihan Report continue to promote racism via racist policies that result in health care disparities for the Black community.

5. Structural racism negatively impacts Black individuals including psychiatric patients, psychiatric staff, families, and communities.

6. The conclusions of the Moynihan Report influenced for several generations American psychiatric training related to the assessment and treatment of mental health issues in Black patients and families with emphasis on tangles of pathologies instead of racist policies;

7. The legacy of this psychiatric training, never explicitly addressed by the APA, continues today to negatively impact the quality of care received by Black psychiatric patients and their families;

8. Generations of psychiatric trainees whose institutions had responsibility for providing psychiatric services to Blacks, were indoctrinated with the idea that the core problems of this community stemmed from family psychopathology, as opposed to racism;
9. The APA has remained silent regarding the fallacious content of the Moynihan Report which upholds that the core problems of the Black community and roots of Black poverty stem from dysfunctional family structure and culture;

10. A public repudiation by the APA of the methodologies and conclusions of the Moynihan Report would have an immediate, powerful, and beneficial impact on psychiatric training and practice and the perceptions of psychiatric leadership, and mental health treatment by the Black community;

BE IT RESOLVED:
The Board of Trustees of the American Psychiatric Association will issue a statement on the APA website as well as publications in the editorials of the *American Journal of Psychiatry* and *Psychiatric News* that:

1. acknowledges the fallacies of the Moynihan Report and its multigenerational negative impact upon Black mental health,

2. repudiates all misguided psychotherapeutic theory and practices based upon it, primarily the fallacy of "tangle of pathologies" as being direct consequences of dysfunctional family structure.

3. That the APA consider drafting a Position Statement on this topic.

AUTHORS:
Ijeoma Ijeaku, MD, MPH, Representative, Southern California Psychiatric Society
Rod Shaner, MD, APA Member

ESTIMATED COST:
APA: $2,610

ENDORSED BY: Southern California Psychiatric Society, Area 6 Council

KEY WORDS: Black Mental Health, Equity, Social Justice, Structural Racism, Anti-Racist Policies

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

REVIEWED BY RELEVANT APA COMPONENT:

Item 2023A1 12.J
Assembly
May 19-21, 2023

ACTION PAPER
FINAL

TITLE: Improving the Public and Healthcare Professionals' Perceptions of Psychiatry and Psychiatrists

WHEREAS:

1. The World Psychiatric Association (WPA) Task Force on stigmatization of psychiatry and psychiatrists, concluded (1) that:
   A. Public opinion about psychiatric facilities and psychiatrists has been consistently negative;
   B. Medical students perceived psychiatry as the object of bashing by other medical disciplines and as lacking a solid, authoritative, scientific foundation;
   C. Patients and their relatives listed the fear of mental illness stigma as the most frequent reason to not see a psychiatrist;
   D. The general depiction of psychiatry in the news and entertainment media was predominantly negative and derogatory, and stereotyped psychiatrists as unhelpful, not providing therapy, and boundary-violating.

2. A recent multisite survey of teaching medical faculty members from several medical teaching centers found 90% of respondents considered psychiatrists as not good role models for medical students (2).

3. There is a lack of clarity in the public mind about what psychiatrists do. One survey found psychiatrists were perceived as more authoritative and medication-focused, and psychologists as friendlier and having better rapport (3). Even more troubling is a frequent public misunderstanding that psychiatrists are not medical doctors (4). There is also a frequent public confusion between a psychiatrist and a psychologist as to who can prescribe medication.

4. A recent meta-analysis of population surveys found that general practitioners (GPs) were preferred for the treatment of depression, psychiatrists and psychologists/psychotherapists are equally recommended for the treatment of schizophrenia, while psychologists and psychotherapy were the most preferred mental healthcare givers for the treatment depression (5).

5. In 2019, an Action Paper titled " IMPROVING PUBLIC UNDERSTANDING OF PSYCHIATRY" was approved by the Assembly and moved to JRC. Unfortunately, the Joint Reference Committee (JRC) advised to the Board of Trustees to accept the Council on Communications recommendations for alternatives such as low-cost videos and in-house productions to be posted on social media, instead of the proposed public information campaign from the original Action Paper; now four years later, these efforts have produced limited results to improve the image and understanding of psychiatry and psychiatrists.

6. The American Psychiatric Association (APA) vision is to be the premier psychiatric organization that advances mental health as part of general health and well-being.

7. The APA's mission is to advance and represent the profession of psychiatry and serve the professional needs of the membership.

8. The psychiatric profession needs help with its self-image and the world's perception of the profession.

9. APA's active role in improving the image of psychiatry and psychiatrists can result in increased recruitment of medical students into psychiatric residencies, better recruitment and retention of APA members and enhancement of the value of the APA for its members.

10. Improving the image of psychiatry and psychiatrists will facilitate the removal of the stigma and irrational fear fostered by the media and improve access to psychiatric care for those in need.

11. Clearly demarcating the differences between psychologists, psychotherapists, counselors, mid-level medical practitioners and psychiatrists will reduce confusion among the public, healthcare professionals, payors, insurers, legislators and other policy makers as to what psychiatrists do.

BE IT RESOLVED:

1. The APA shall embark upon the creation of a comprehensive and strategic public relations campaign with both short and long-term strategies that improve the public and healthcare professionals' perception and understanding of psychiatry and psychiatrists.

2. To this effort, and in coordination with the APA Council on Communications, the APA shall identify and utilize an outside public relations firm to assist in developing this campaign, with the following specific considerations:
    * Informing the public about the more rigorous training and greater capabilities of psychiatrists compared to other disciplines that treat psychiatric disorders
    * Dispelling the false equivalency of psychiatrists with advanced practice nurses, prescribing psychologists, and other disciplines that seek to expand their scope of practice to be equal to that of psychiatrists
    * Targeting the general public, government officials, and healthcare industry leaders with messages specific to their relationship with the profession of psychiatry
    * Effectively leveraging and integrating the current efforts within the APA, including the Council on Communications and Public Relations Department, to support these aims
    * Including methods to assess the effectiveness of such strategies.

3. The Assembly review the strategies and recommendations from the public relations consulting firm at its 2024 spring meeting.

4. That the Assembly receive yearly reports on the progress of this campaign.

AUTHORS:
Sudhakar Madakasira, MD, Representative, Mississippi Psychiatric Association
Jack Bonner, MD, Representative, Senior Psychiatrists
Michelle Cochran, MD, Representative, Transcranial Magnetic Stimulation (TMS) Society
Harold Kudler, MD, Representative, American Psychoanalytic Association
Scott Monteith, MD, Representative, Michigan Psychiatric Society
Jerry Trotter, MD, APA Member

Shree Vinekar, MD, Representative, Oklahoma Psychiatric Physicians Association
James West, MD, Deputy Representative, Area 5
ESTIMATED COST:
APA: $1,679,840

ENDORSED BY:

KEY WORDS: Perceptions, image, stigma, public, public relations, health professionals, psychiatry, psychiatrists, psychologists, psychotherapists

APA STRATEGIC PRIORITIES: Advancing Psychiatry

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

REFERENCES:

1. WPA guidance on how to combat stigmatization of psychiatry and psychiatrists. Sartorius N, Gaebel W, et al., *World Psychiatry*, 9 (3), 2010.
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Item 2023A1 12.K
Assembly
May 19-21, 2023

ACTION PAPER
WITHDRAWN BY THE AUTHOR

TITLE: DEA Registration in Different States

WHEREAS:
Whereas: most physicians believe that their DEA registration is a national authorization, and is good for whatever state in which the physician chooses to practice, and

Whereas: current DEA regulation requires a separate DEA registration number for each state in which a physician practices, including telehealth, and

Whereas: the Public Health Emergency waived this requirement for telehealth for the duration of the emergency, in order to provide continued care for patients requiring controlled substances, and

Whereas: when the Public Health emergency ends, physicians will be at risk of violation of DEA regulations if they continue to prescribe via telehealth for patients resident in a state where the physician does not have a DEA registration, and

Whereas: most physicians are unaware of this DEA requirement, therefore

BE IT RESOLVED:
That the American Psychiatric Association alert its members to this current requirement, while awaiting new telehealth rules from the DEA, and be it further

That the American Psychiatric Association advocate for the DEA and other agencies with jurisdiction to permit physicians with a valid DEA registration in their home state to prescribe controlled substances to patients via telehealth, without the requirement to get a DEA registration in the state where the patient is located.

AUTHORS:
Robert Wilson, MD, PhD, Representative, Pennsylvania Psychiatric Society
Kenneth M. Certa, MD, APA Member
Mary Anne Albaugh, MD, Representative, Pennsylvania Psychiatric Society

ESTIMATED COST:
APA: $27,405

ENDORSED BY: Pennsylvania Psychiatric Society

KEY WORDS: telehealth, DEA

APA STRATEGIC PRIORITIES: Advancing Psychiatry, Education

REVIEWED BY RELEVANT APA COMPONENT: referred to CAGR, Addiction, and Healthcare Systems and Financing

Item 2023A1 12.L
Assembly
May 19-21, 2023

ACTION PAPER

FINAL

TITLE: Text Communication to Improve APA National Election Participation

WHEREAS:

Each year individual American Psychiatric Association members have the opportunity to select representation through a vote for the executive members of the board of directors; the APA needs member input and engagement;

The current communication attempts (email and mail) to encourage voting by members is not working, as the percentage of members who vote in the APA national officer elections has continued to decrease in recent years; this is not unexpected as field studies have shown similar poor results with email and mail campaigns for elections (1, 2, 3);

Most physicians own a smartphone and text messaging is a common communication tool and has better click-thru and response times than emails and some studies have shown that improvement in voter turnout can be achieved by texting reminders and FaceBook instant messaging (4, 5, 6);

Text reminders are specifically beneficial when a colleague or friend instigates the encouraging message and includes a link; when a positive response to a personalized conversational thread text is received, click-thru participation improves (7); the APA District Branches (DBs) often have a more personal relationship with members than the APA organization as a whole;

Customer Relationship Management (CRM) Software is easy to use, readily available and can inexpensively (<$1000) be purchased for large organizations; CRM software can customized to be used by both the APA and District Branches (DB) in a coordinated way to improve voting in the national election via text and instant messaging, and can assist in tracking and customizing specific communication (click-thru percentages).

BE IT RESOLVED:

In addition to its other communications (email and mail announcements), the APA should pilot a text-to-vote in cooperation with the district branches, to send texts to APA members during the four weeks prior to the APA National Officer Elections~~.~~;

The opt-in to receive texts to vote in the national APA officer election should be added to the annual membership renewal process, the annual meeting registration as well as other membership communication opportunities;

The texts or messaging should be limited during the four weeks prior to the election, have a conversational style, include a link to vote in the APA National Election, and not exceed more than seven reminders;

That the APA and the Council on Communication re-evaluate this program after two election cycles to see if the percentage of voters in the national election improves;

That this Action Paper be sent directly to the APA Board of Trustees so that they may approve sufficient funding, at their next meeting, to allow the pilot to be organized by the Council on Communications in time for the 2024 APA National Officer Elections.

AUTHORS:
Michelle Cochran, MD, Representative, Clinical TMS Society
L. Lee Tynes, MD, PhD, Louisiana Psychiatric Medical Association
Kaylee Davis-Bordovsky, MD, RFM Representative, Area 5

ESTIMATED COST:
APA: $1,670

ENDORSED BY: Tennessee Psychiatric Association, Assembly Committee of Resident-Fellow Members

KEY WORDS: APA National Election

APA STRATEGIC PRIORITIES: Advancing Psychiatry

REVIEWED BY RELEVANT APA COMPONENT:

REFERENCES:

1. Bennion, E. A., & Nickerson, D. W.. The Cost of Convenience: An Experiment Showing E-Mail Outreach Decreases Voter Registration. *Political Research Quarterly*, *64*(4), 858–869. (2011)
2. Bennion, Elizabeth A and David W Nickerson. 2016. "I will register and vote, if you teach me how: A field experiment testing voter registration in college classrooms." PS: Political Science & Politics 49(4):867–871.
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7. Schein, Aaron and Vafa, Keyon and Sridhar, Dhanya and Veitch, Victor and Quinn, Jeffrey and Moffet, James and Blei, David M. and Green, Donald P., A Digital Field Experiment Reveals Large Effects of Friend-to-Friend Texting on Voter Turnout (September 21, 2020).

Item 2023A1 12.M
Assembly
May 19-21, 2023

ACTION PAPER
FINAL

TITLE: Making the Nomination and Election Process Fair for Petition Nominees for APA Officer Positions

WHEREAS:

1. APA Election Principles define the laudable goals of The Equity of Access and Economic Principle, The Fairness Principle, The Collegiality Principle and The Membership Engagement Principle, all to be applied and honored in the election of APA officers.
2. APA by Laws in Section 3.2 state that the Nominating Committee shall report its nominations to the Board by November 1 and the nominating petitions must be filed with the Secretary within 15 days of the announcement of the final slate, for the petition nominee to be included on the ballot.
3. APA By Laws in Sections 3.4, 3.5, 3.6 and 4.7 state that candidates for various offices shall be nominated either (a) by the Nominating Committee, which shall nominate at least two candidates for each position to be filled; or by (b) a petition signed by 400 or more members eligible to vote (only 100 signatures needed for Area Trustee and Resident Fellow Trustee petition nominations per Section 3.3 and 3.7).
4. In order for a petition nominee to obtain the required number of signatures, the APA Election Committee has declared that “a petition nominee is not permitted access to the membership through easily available resources at the APA such as member to member email or APA listservs” and that “ a petition nominee must refrain from using APA or DB resources, including online membership directory, for petitioning or campaigning purposes but a petition nominee may use one’s own personal email lists to send requests to other members”. No such language, however, is found in any APA document relating to the collection of signatures for petition nominations.
5. Quite simply, the Bylaws require the signatures of 400 members on a petition for most APA officer positions to be obtained in a very short period of time, when an otherwise qualified member of the APA has not had the good fortune of being selected by the Nominating Committee; a petition nominee must, recreate private data bases, possibly at great expense, to seek the signatures of fellow members and is subjected to undue burden and restrictions, particularly considering current virtual environment and voter apathy.
6. The nomination process by petition for APA officer positions is not in accordance with the four Election Principles as it is not equitable or economic, not fair to every qualified member, not congenial or fostering more open communication and not engaging with the membership.

BE IT RESOLVED:

1. The APA evaluate the nominating and election rules and procedures for petition nominations for various APA officer positions to make them more in line with the pronounced goals of The Equity of Access and Economic Principle, The Fairness Principle, The Collegiality Principle and The Membership Engagement Principle.

2. The APA submit a report on its evaluation for a review by the Assembly at the May 2024 meeting.

AUTHORS:
Sudhakar Madakasira, MD, Representative, Mississippi Psychiatric Association
Michelle Cochran, MD, Representative, Transcranial Magnetic Stimulation (TMS) Society
Harold Kudler, MD, Representative, American Psychoanalytic Association
Shree Vinekar, MD, Representative, Oklahoma Psychiatric Physicians Association

ESTIMATED COST:
APA: $1,740

ENDORSED BY:

KEY WORDS: Nomination, election, by laws, Petition candidate, signatures

APA STRATEGIC PRIORITIES: Advancing Psychiatric Care

REVIEWED BY RELEVANT APA COMPONENT:

Item 2023A1 12.N
Assembly
May 19-21, 2023

ACTION PAPER
FINAL

TITLE: Furthering our APA's Initiative on the Collaborative Care Model

WHEREAS:
Access to Psychiatric services remains a daunting issue in our healthcare delivery system, and

Whereas, this has dominated the Psychologists prescribing debate albeit without merit, and
Whereas, Collaborative Care Model (CoCM)offers a real solution and has become a flagship initiative for our APA, and

Whereas, despite encouraging States to develop model legislation only 9 State have laws paying for CoCM, and

Whereas, even in the States that have such laws, payment for CoCM has continued to be stalled, and

Whereas, there are CPT codes for CoCM that Primary Care groups use to get payments for such services, and

Whereas, the reimbursement for the Psychiatric Consultants services are not clearly defined (except anecdotally), even though APA staff has come up with helpful model contracts, and

Whereas, the subject of Assembly-District branch relationships has become increasingly important in our communications, therefore

BE IT RESOLVED:
That our Assembly leadership convene a meeting with Assembly Representatives and District Branch Presidents in each of the State District Branches that have not passed APA's State Collaborative Care Model (CoCM) legislation to encourage them to aggressively pursue enactment in their States, and

Be it further resolves, that APA Administration make available CoCM materials for advocacy and practice on the APA members only area of the web site, including advocacy talking points, lessons learned in states, contracts for psychiatric consultants and reimbursement mechanisms.

AUTHOR:
Shastri "Swami" Swaminathan, MD, Representative, Illinois Psychiatric Society

ESTIMATED COST:
APA: $5,220

ENDORSED BY:

KEY WORDS: Collaborative Care Model

APA STRATEGIC PRIORITIES: Advancing Psychiatry

REVIEWED BY RELEVANT APA COMPONENT:

Item 2023A1 13.A
Item 2021A2 12.L
Assembly
November 6-7, 2021

ACTION PAPER
FINAL

TITLE: Addressing Structural Racism in the APA: Replacing Minority and Underrepresented (MUR) Terminology

WHEREAS:

APA identified MUR groups include American Indian/Alaska Native/Native Hawaiians; Asian Americans; blacks; Hispanics; lesbians, gays, and bisexuals; international medical graduates; and women.

The purpose of MUR positions per the Assembly procedural code and APA bylaws is to provide opportunities to raise issues of concern to minority psychiatrists and minority patients. Further, the MUR Assembly positions were created to address the underrepresentation of such members within APA's governing bodies and committee structures, with such underrepresentation related to their characteristics as a minority and to represent patients and other citizens with similar minority characteristics who have had interests, rights, and needs repeatedly neglected, ignored, or violated within the society, such that their mental health has been adversely affected in a significant way."

The MUR terminology makes invisible the root of under-representation in the organization.

The MUR terminology is ahistorical and revisionist in that it implies the lack of group representation is not historically intentional, structural in nature and an issue that requires inclusionary policies, practices and norms.

The root of racial under-representation in the organization is structural racism that manifests in the organizational culture, policies, practice and norms.

BE IT RESOLVED:
That the APA, through the ongoing efforts of the Structural Racism Accountability Committee (SRAC), collaborate with the Council on Minority Mental Health and Health Disparities, the MUR Committee and its representative caucuses, over the next six months, but before the next Assembly meeting, to identify a replacement for the M/UR term, which is a historically informed and culturally progressive term that has been identified as inclusive and representative of the diverse history, experience, and membership of the individuals in the groups.

AUTHORS:
Jessica Isom, MD, MPH, ECP Representative, Area 1
Constance E. Dunlap, MD, DFAPA Deputy Representative, Area 3

ESTIMATED COST:
APA: $3,480

ENDORSED BY: Assembly Committee of Minority/Underrepresented Groups, Caucus of Black Psychiatrists, Caucus of International Medical Graduate (IMG) Psychiatrists, Caucus of American Indian, Alaska Native and Native Hawaiian Psychiatrists

KEY WORDS:

APA STRATEGIC PRIORITIES: Advancing Psychiatry, Diversity

REVIEWED BY RELEVANT APA COMPONENT:

REFERENCES

1. Structural Racism in American Psychiatry and APA: Part 7 (https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2020.10a33)

2. Procedural Code of the Assembly of the APA (https://www.psychiatry.org/File%20Library/About-APA/Organization-Documents-Policies/procedural-code.pdf)

3. Walden, S. E., & Trytten, D. A., & Shehab, R. L., & Foor, C. E. (2018, April), Critiquing the "Underrepresented Minorities" Label Paper presented at 2018 CoNECD - The Collaborative Network for Engineering and Computing Diversity Conference, Crystal City, Virginia. https://peer.asee.org/29524