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From the Practice Directorate

At its July 2004 meeting, the Council of Representatives adopted as APA policy The Resolution on Outpatient Civil Commitment.

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APA Resolution on Outpatient Civil Commitment

At its July 2004 meeting, the Council of Representatives adopted as APA policy The Resolution on Outpatient Civil Commitment.

The purpose of the resolution was to develop an APA policy that supports humane and psychologically informed preventative alternatives that favor choice and least restrictive interventions over forced treatment. Among the recommendations were incorporating input from psychologists in assessing and shaping the treatment, lessening the use of forced psychotropic medications, enabling recipients and their families/significant others to have maximal input into treatment decisions, and implementing effective community interventions to reduce the need for involuntary outpatient commitment and to provide services and support after such treatment.

APA Resolution on Outpatient Civil Commitment

Adopted by the Council of Representatives July 28, 2004

WHEREAS Outpatient civil commitment (OCC) is increasingly used in courts and civil commitment venues across the country (Swartz & Monahan, 2001);

WHEREAS People with serious mental illness and resulting psychological disabilities are the individuals most subject to imposition of involuntary mental health services, including OCC (Swartz & Monahan, 2001);

WHEREAS People with such disabilities have the same rights to personal liberty as other citizens (Stefan, 2001);

WHEREAS Psychological disabilities may impair the ability of individuals to appreciate threats to their well-being, placing them at risk for homelessness, incarceration, premature death, suicide, and vulnerability to violence (Swartz & Monahan, 2001);

WHEREAS There is heated controversy about the legitimacy of OCC, the criteria by which it should be applied, the relevant clinical methods and standards of professional practice, and the relative value of alternatives (Petrlia, Ridgely & Borum, 2003);

WHEREAS People with behavior disorders severe enough to reach the dangerousness criterion should have access to psychological and behavioral interventions designed to treat the specific behaviors (Spaulding, Sullivan & Poland, 2003);

WHEREAS Key issues concerning OCC can be effectively addressed through application of the principles of psychological science and the findings of psychological and psycholegal research (Spaulding, Poland, Elbogen & Ritchie, 2000);

WHEREAS People with serious mental illness have a right to the resources and services generated by psychological research and practice (Van Houton, Axelrod, Bailey & Favell, 1988);

WHEREAS All people have a right to the opportunity for recovery, namely, full participation in society to the best of their ability (Stefan, 2001);

WHEREAS Issues regarding OCC, and broader issues of services for people with serious mental illness, will only be resolved in the context of a comprehensive, accessible, and responsive system of care that focuses on improved quality of life rather than mere symptom reduction (Petrlia, Ridgely & Borum, 2003);

WHEREAS A key ingredient in recovery from serious mental illness is making choices for oneself and developing skills necessary to make those choices (Anthony and Liberman, 1992);

WHEREAS Clinical application of psychological methods (including neuropsychological, behavioral, sociocognitive, and functional assessments and interventions) hold substantial promise for enhancing skill development, including skills relevant to recovery from serious mental illness and skills relevant to making competent personal choices (Spaulding, Sullivan & Poland, 2003);

WHEREAS Resolution of controversies regarding OCC will require consideration of people's rights; their uniqueness and diversity; the disabilities associated with serious mental illness; and the sometimes competing values of personal liberty, public safety, and the public's interest in providing for those who cannot provide for themselves (Petrlia, Ridgely & Borum, 2003);

WHEREAS Women and members of minority racial and ethnic groups are especially vulnerable to discrimination in adjudication and treatment related to involuntary incarceration and treatment (Stefan, 1996);

WHEREAS Women and members of minority racial and ethnic groups tend to receive less or lower quality mental health services (Thornicroft, Davides & Leese, 1999);

WHEREAS Members of other stigmatized groups may also be vulnerable to discrimination in adjudication and treatment related to involuntary incarceration and treatment;

WHEREAS Involuntary treatment raises special concerns about gender, ethnic or minority status, or membership in other stigmatized groups for the practitioner (Mindell, 1993; Baker, 1999);

WHEREAS It is the role of mental health scientists and practitioners to advocate for due process and appropriate legal representation and counsel, to advise the court through briefs or testimony, and to seek therapeutic benefits in application of the law (Daicoff & Wexler, 2003);

WHEREAS Mandating involuntary mental health services is a legal, not a clinical process; except in cases of dire emergency, it is never the role of any mental health practitioner, of any discipline, acting in the role of caregiver, to make decisions that infringe upon a person's right to consent to services. Moreover, as specified in the APA Ethics Code, psychologists are required to respect the rights of individuals to self-determination and autonomy, and to act in accordance with the requirements for informed consent to therapy and related procedures.

THEREFORE BE IT RESOLVED that psychologists should continue to promote and engage in development of evidence-based clinical methods for determining risk and dangerousness, including risk associated with accepting or not accepting mental health services.

BE IT FURTHER RESOLVED that psychologists should continue to promote and engage in development of clinical methods for determining competence to make specific judgments and decisions, including decisions about whether to accept and/or participate in mental health services.

BE IT FURTHER RESOLVED that psychologists should continue to promote and engage in development of clinical methods for reversing the disabilities of serious mental illness and enhancing recovery, including those disabilities that incur risk and dangerousness, as well as those disabilities that compromise competent decisions and choices about accepting and/or participating in mental health services.

BE IT FURTHER RESOLVED that when people with mental illness exhibit dangerous behavior, psychologists trained in the direct treatment of behavioral dysfunction can enhance positive outcomes by providing consultation and treatment for the specific behaviors.

BE IT FURTHER RESOLVED that psychologists should continue to promote and engage in development of clinical methods that help people participate to the maximum extent in legal processes that affect their lives.

BE IT FURTHER RESOLVED that psychologists should continue to promote and conduct rigorous research on the interaction of clinical and legal processes, with the objective of making those processes maximally accessible to and beneficial for people with serious mental illness.

BE IT FURTHER RESOLVED that psychologists should continue to promote and conduct rigorous research on the various forms of and alternatives to involuntary commitment, including OCC, limited guardianship, and advance directives, to determine their relative costs, outcomes, and benefits.

BE IT FURTHER RESOLVED that psychologists should continue to promote and engage in development of clinical assessment methods that address and inform the legal processes that mandate involuntary mental health services, and should promote development of legal processes that make optimum use of information generated by psychological assessments.

BE IT FURTHER RESOLVED that psychologists should continue to support and promote social policy that ensures accessibility of services that enhance recovery, including comprehensive biopsychosocial rehabilitation, for all people, regardless of gender or membership in racial, ethnic or other stigmatized and vulnerable groups.

BE IT FURTHER RESOLVED that psychologists should continue to support and promote professional training and education in the treatment of serious mental illness, including the ethical, clinical, and legal considerations involved in involuntary services, and the impact of gender or membership in racial, ethnic or other stigmatized and vulnerable groups.

BE IT FURTHER RESOLVED that psychologists should continue to support and promote public education and other strategies for

eliminating the prejudice and stigmatization of serious mental illness, including public attitudes related to involuntary services.

BE IT FURTHER RESOLVED that psychologists should continue to support and promote consumer empowerment, citizen advocacy, collaboration, and other strategies for enhancing the role of people with serious mental illness in mental health services, policy, and law.

BE IT FURTHER RESOLVED that psychologists should continue to participate, as scientists, practitioners, educators and citizens, in the ongoing public discourse that weighs competing values and imperatives in formulation of law and social policy about involuntary mental health services.

BE IT FURTHER RESOLVED that psychologists should continue to vigorously promote the view that involuntary services and related infringements on individual liberty can only be mandated through legal processes, not by mental health professionals acting as caregivers. However, psychologists also should assertively provide professional expertise and consultation to legal and judicial authorities in order to ensure that legal processes and decisions are appropriately informed by scientific and clinical considerations.

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The Resolution is posted on the APA Website at [http://www.apa.org/practice \(/practice/index.aspx\)](http://www.apa.org/practice (/practice/index.aspx) and on the Practitioner Portal.

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HIPAA Security Rule Primer

The APA Practice Organization has created a document that provides a preliminary overview of the Health Insurance Portability and Accountability Act (HIPAA) Security Rule. The HIPAA Security Rule Primer is available on the APA Practice site. The HIPAA Security Rule seeks to assure the security of confidential electronic patient information. For psychologists, this usually means addressing administrative, physical and technical procedures such as access to offices, files and computers, as well as the processes a psychologist uses to keep electronic health information secure. The compliance date: April 20, 2005. In spring 2005, the directorate will offer more detailed tools and information about the Security Rule.

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Another First: New Mexico Implements Prescriptive Authority Law

New Mexico recently became the first state to implement a law allowing licensed psychologists with the appropriate training and certification to prescribe psychotropic medications. The regulations to activate the law were filed with the state's record center in December 2004 and took effect on January 7. When the regulations were filed, psychology advocates said work remained in clarifying the scope of medications that qualified psychologists would be allowed to prescribe-the "formulary."

"This is an historic day in the sense that for the first time in the country's history, rules and regulations have been filed allowing appropriately trained psychologists to prescribe psychotropic medications," said E. Mario Marquez, PhD, the legislative chair of the New Mexico Psychological Association (NMPA). "New Mexico prescribing psychologists are paving the way for the other states to provide a new means of offering quality mental health care."

The new regulations

The regulations were developed by a joint committee of physicians and psychologists. To receive a prescribing certificate in New Mexico, psychologists must complete at least 450 hours of coursework, an 80-hour practicum in clinical assessment and pathophysiology, and a 400-hour, 100-patient practicum under physician supervision. They also must pass a national certification examination, the Psychopharmacology Examination for Psychologists. The academic component includes psychopharmacology, neuroanatomy, neurophysiology, clinical pharmacology, pathophysiology, pharmacotherapeutics, pharmacoepidemiology and physical and lab assessments.

After completing these requirements, psychologists licensed to practice in New Mexico are eligible for a two-year conditional prescription certificate allowing them to prescribe under supervision of a physician. At the end of two years, if the supervisor approves and the psychologist's prescribing records pass an independent peer review, the psychologist can apply to prescribe independently. Only at that point will prescribing psychologists work independently, albeit in close collaboration with the patient's physician.

"There are more than 40 psychologists in New Mexico who already have completed the training or are currently enrolled in a training program," says Elaine LeVine, PhD, director of the Southwestern Institute for the Advancement of Psychotherapy/New Mexico State University Collaborative, a New Mexico psychopharmacology training program for psychologists. "These psychologists are very experienced practitioners who also completed seven years of doctoral training including two years of supervised practice in order to become licensed as psychologists before undertaking the extensive training in psychopharmacology."

The collaboration provisions of the regulations codify good clinical practice, said Russ Newman, PhD, JD, APA's executive director for professional practice. For example, the regulations call not only for psychologist-prescribers to initiate contact with patients' physicians when medication is warranted, but also for physicians to contact patients' psychologists when changes in the patients' medical condition might affect psychologists' treatment.

Psychology advocates say the prescriptive authority law represents an important step toward providing comprehensive mental-health care to New Mexico residents, who face serious access-to-care challenges; seeing a psychiatrist can take up to five months and a lengthy commute.

Pressing for Clarification

At press time, psychology advocates of the legislation were working to clarify the statutory definition of formulary included in the regulations. Advocates planned to ask the New Mexico legislature to approve a revised definition of psychotropic medication that would allow psychologists to prescribe off-label drugs that are in common and proper use for mental health conditions when appropriate. This plan did not delay the regulations taking effect on January 7.

Proponents assert that the revision would clearly allow prescribing psychologists to follow usual and customary best practices by allowing them access to the full complement of medications necessary to manage mental disorders. As currently written, the formulary only allows prescribing psychologists to prescribe those psychotropics specifically approved by the Food and Drug Administration for mental health disorders, thereby excluding any "off-label" uses that have become customary practice in the treatment of these disorders. Psychology anticipates opposition in the upcoming legislative session as psychiatry reportedly has spent \$100,000 on a lobbying campaign in New Mexico to undermine implementation of the law and to ultimately repeal it.

New Mexico was the first state to pass a prescribing law for psychologists in March 2002, following the passage of similar legislation by the U.S. territory of Guam in 1998. Louisiana passed similar legislation in 2004. At press time, the regulations to implement the Louisiana law had been published for review and comment and were the subject of a public hearing by the Louisiana State Board of Examiners of Psychologists.

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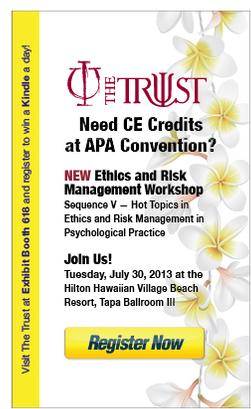
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