Meeting of the Virginia Board of Medicine

October 17, 2019
8:30 a.m.

Virginia Department of Health Professions

Board of Medicine

Thursday, October 17, 2019 @ 8:30 a.m.
Perimeter Center
9960 Mayland Drive, Suite 201
Board Room 2
Henrico, VA 23233

Call to Order and Roll Call

Emergency Egress Procedures/Shake Out Earthquake Drill i

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====No motion needed to adjourn if all business has been conducted====

PERIMETER CENTER CONFERENCE CENTER
EMERGENCY EVACUATION OF BOARD AND TRAINING ROOMS
(Script to be read at the beginning of each meeting.)

PLEASE LISTEN TO THE FOLLOWING INSTRUCTIONS ABOUT EXITING THESE PREMISES IN THE EVENT OF AN EMERGENCY.

In the event of a fire or other emergency requiring the evacuation of the building, alarms will sound.

When the alarms sound, leave the room immediately. Follow any instructions given by Security staff

Board Room 2

Exit the room using one of the doors at the back of the room. (Point) Upon exiting the room, turn **RIGHT.** Follow the corridor to the emergency exit at the end of the hall.

Upon exiting the building, proceed straight ahead through the parking lot to the fence at the end of the lot. Wait there for further instructions.

You may also exit the room using the side door **(Point)**, turn **Right** out the door and make an immediate **Left**. Follow the corridor to the emergency exit at the end of the hall.

Upon exiting the building, proceed straight ahead through the parking lot to the fence at the end of the lot. Wait there for further instructions.

Get Ready to ShakeOut.

October 17, 2019 Register Now at www.ShakeOut.org

The Great South East Shake Out Earthquake Drill

Will Take Place

Thursday, October 17th at 10:17a.m.

During the Drill, Participants Should Practice doing the following:

DROP where you are, onto your hands and knees. This position protects you from being knocked down and also allows you to stay low and crawl to shelter if nearby.

COVER your head and neck with one arm and hand

- If a sturdy table or desk is nearby, crawl underneath it for shelter
- If no shelter is nearby, crawl next to an interior wall (away from windows)
- Stay on your knees; bend over to protect vital organs

HOLD ON until shaking stops

- Under shelter: hold on to it with one hand; be ready to move with your shelter if it shifts
- No shelter: hold on to your head and neck with both arms and hands.

Agenda Item: **Approval of Minutes of the June 13, 2019**

Staff Note: Draft minutes that have been posted on Regulatory Townhall and the Board's website are presented. Review and revise if necessary.

Action: Motion to approve minutes.

==DRAFT UNAPPROVED==

VIRGINIA BOARD OF MEDICINE
FULL BOARD MINUTES

June 13, 2019 **Department of Health Professions** **Henrico, VA 23233**

CALL TO ORDER: Dr. O'Connor called the meeting to order at 8:36 AM.

ROLL CALL: Ms. Opher called the roll. A quorum was established.

MEMBERS PRESENT:
Kevin O'Connor, MD, President
Ray Tuck, DC, Vice-President
Lori Conklin, MD, Secretary-Treasurer
Syed Ali, MD
David Archer, MD
James Arnold, DPM
Manjit Dhillon, MD
Alvin Edwards, PhD
David Giammittorio, MD
Jane Hickey, JD
L. Blanton Marchese
Jacob Miller, DO
Karen Ransone, MD
Brenda Stokes, MD
David Taminger, MD
Svinder Toor, MD
Kenneth Walker, MD
Martha Wingfield

MEMBERS ABSENT: None

STAFF PRESENT:
William L. Harp, MD-Executive Director
Jennifer Deschenes, JD-Deputy Executive Director for Discipline
Colanthia M. Opher-Deputy Executive Director for Administration
Barbara Matusiak, MD-Medical Review Coordinator
Cheryl Clay-Administrative Assistant
Leslie van den Berg-Administrative Assistant
Barbara Allison-Bryan, MD-DHP Deputy Director
Erin Barrett, JD-Assistant Attorney General

OTHERS PRESENT:
Scott Johnson, JD-HDJN & MSV
Amy Stewart-VCU HPMP
Peggy Wood-DHP Liaison for HPMP
Caitlin Carnell, MD-Chief Resident, VCU Department of Psychiatry
Janet Knisely, PhD-VCU HPMP Program Director

==DRAFT UNAPPROVED==

EMERGENCY EGRESS

Dr. Tuck provided the emergency egress procedures for Conference Room 2.

APPROVAL OF THE FEBRUARY 14, 2019 MINUTES

Dr. Miller moved to approve the minutes as presented; the motion was properly seconded and carried unanimously.

ADOPTION OF THE AGENDA

Dr. Ransone moved to accept the agenda as presented; the motion was properly seconded and carried unanimously.

PRESENTATION BY THE HEALTH PRACTITIONERS' MONITORING PROGRAM (HPMP) – Janet Knisely, PhD, Program Director

Dr. Knisely presented an overview of HPMP to the Board members. She described HPMP's structure and processes to include eligibility criteria, the intake process, case management, and how a practitioner's readiness to return to practice is assessed. She said that a citizen member has been added to the Program Committee. After the presentation, Dr. Knisely and Ms. Wood fielded several questions from the members.

Dr. Harp shared with the Board that Dr. Knisely was retiring in a few weeks. He said that over the years, Dr. Knisely has been a valuable resource and an important stabilizing force at HPMP, especially since 2008. He then read an inscription to be placed on a plaque, expressing the Board's appreciation for the work she has done.

PUBLIC COMMENT ON AGENDA ITEMS

There was no public comment; however, Dr. O'Connor referred to information in the packet that had been received from Sydney Rab and Kristen Ogden regarding the pain care crisis.

DHP DIRECTOR'S REPORT- Barbara Allison-Bryan, MD

Dr. Allison-Bryan provided the Board with an update on the CBD oil program and fielded questions about the processes.

Some of the concerns expressed by the Board members were:

1) The practitioner being responsible for writing for CBD oil, but the pharmacist having discretion in dispensing.

2) The practitioner being required to monitor the patient with no control over the prescribing.

3) The compatibility of CBD oil and THC-A oil with other drugs, particularly anesthesia medications.

4) The possibility of "pill mills" cropping up with the regulatory scheme.

Dr. Ali said that the Board of Medicine is not a good fit with the regulatory scheme for cannabis-based oils. The request for CBD oil comes up often with cancer patients. If the General Assembly wants to do something, they should legalize the product, so what is purchased can be used for anything. Dr. Ali stated that we should not take on the responsibility of tracking what patients purchase elsewhere. He noted that a weak law creates a black market.

Dr. Allison-Bryan said that although there are many places that CBD oil can currently be purchased in Virginia, it is not manufactured to the specifications that the processors under the Board of Pharmacy must use. Not only might some products be ineffective, but they may also contain contaminants.

Dr. Toor said that CBD oil has been touted as safe, but that is not what is being found. It is now a significant issue that there can be adverse drug interactions. In some instances, toxic levels have occurred.

Dr. Allison-Bryan thanked everyone for their comments and said that she would keep them informed on the progress of CBD oil program.

REPORT OF OFFICERS AND EXECUTIVE DIRECTOR

PRESIDENT

Dr. O'Connor provided a synopsis of his attendance at the FSMB Annual Meeting in Fort Worth, TX. Accompanying him were Dr. Walker, Dr. Tuck, Dr. Conklin, Mr. Marchese, and Mrs. Opher. He noted that when attending these functions, he is always struck by how well Virginia is doing in relation to some other states.

VICE-PRESIDENT'S REPORT

Dr. Tuck had no report.

SECRETARY-TREASURER'S REPORT

Dr. Conklin had no report.

EXECUTIVE DIRECTOR'S REPORT

Dr. Harp briefly reviewed the Board's updated revenue and expenditures report, the Enforcement and APD hours, HPMP Participation report and FCLB's letter to Governor Northam commending Dr. Tuck for his participation at their 93rd Annual Congress meeting.

This report was for informational purposes only and did not require any action.

Dr. Harp said that Dr. Brown has indicated the Board should consider a reduction of renewal fees for all its professions for the next biennium. Ms. Yeatts added that the reduction, if approved, would be for the 2020-2021 cycle. The percent of the reduction will be on the agenda for the Executive Committee meeting August 2, 2019, at which time the vote to approve will occur.

Dr. Toor asked how the number of impaired physicians in Virginia compares to other states. Has it been stable over the years or is it climbing? Also, what are some preventative measures?

Dr. Harp advised that he was not aware of any available statistics capturing this information. From 1998 to 2009, the program was called the Health Practitioners' Intervention Program (HPIP). During that time, the Program had more outreach capability, and Medicine's number of participants was about 150. Then the funds were trimmed back, and it became a monitoring program. It would be up to the Department to decide if it wanted to add services to the contract.

Dr. O'Connor stated that he had become aware of a national monitoring program run out of FSMB; one of the components of the program is physician wellness.

Dr. Allison-Bryan agreed that there are more physicians who can benefit from the program. HPMP is investing funds in marketing so that more practitioners will self-refer, get the assistance they need, yet stay below the radar. A practitioner could enter the Program and complete 5 years without the Board knowing, as long as the practitioner is compliant with the Program and remains safe to practice.

Dr. Ali noted that an article in the *New York Times* reports that the physician suicide rate is the highest it has been this century.

As an aside, Dr. O'Connor recommended that the members read a *Fortune* magazine article "Death by a Thousand Clicks: Where Electronic Health Records Went Wrong", published March 18, 2019.

COMMITTEE and ADVISORY BOARD REPORTS

Dr. Harp pointed out that the existing committee assignments will be updated after the new President is named. Anyone with interest in serving on a particular committee can let Dr. Harp know.

Dr. Toor moved to accept all the minutes en bloc. The motion was seconded and carried.

OTHER REPORTS

Board Counsel

Erin Barrett, AAG provided an update on the status of the following cases:

- Clowdis v. Virginia Board of Medicine
- Merchia v. Virginia Board of Medicine

Board of Health Professions

Dr. O'Connor referred to Dr. Brown's report on page 63 of the agenda packet regarding a new law that will stagger board member terms to prevent the loss of historical knowledge and experience. He pointed out that licensure of art therapists is under study by the Board of Health Professions. He also said a workgroup is being convened to look at the practice of telemedicine.

Podiatry Report

Dr. Arnold had no report.

Chiropractic Report

Dr. Tuck announced that at the FCLB Annual Meeting in Mission Bay, CA, Dr. Brown was presented the George W. Arvidson Award for meritorious service. Dr. Tuck said that it was distinct honor for Dr. Brown, as few Arvidson awards had been presented previously. He said Dr. Brown's speech was "wonderful" and was well-received.

Committee of the Joint Boards of Nursing and Medicine

Dr. O'Connor highlighted the implementation of HB793 and the regulations for nurse practitioner autonomous practice. The application for autonomous practice is now on the Board of Nursing website. Dr. O'Connor has asked for data that captures the geographical distribution of autonomous nurse practitioners.

Break

Dr. O'Connor called for a 15-minute break; the meeting reconvened at 10:12 a.m.

Presentation on Physician Boundary Violations – Caitlin Carnell, MD

Dr. Carnell provided a very informative presentation on boundaries. She began by addressing the definition of a boundary violation. During her presentation, she described who is at risk and what types of violations are most common. Dr. Carnell also briefed the members on individual risk factors that could play a part in physician behavior, such as childhood trauma and maladaptive beliefs. After her presentation, Dr. Carnell fielded questions from the Board members.

New Business:

1) Regulatory and Legislative Issues

- **Chart of Regulatory Actions**

Ms. Yeatts provided an update on the emergency regulations for physician assistants that will eliminate the term supervision and HB2559 – Waiver for electronic prescribing which will go into effect in 2020. This report was for informational purposes only and did not require action.

- **Response to petition for rulemaking**

Ms. Yeatts spoke to the petition for rulemaking submitted by Dr. Luke Vetti. He requested to add the American Board of Podiatric Medicine to the Regulations Governing the Practice of Medicine, Osteopathy, Podiatry, and Chiropractic, 18 VAC 85-20-10 et seq., specifically 17 VAC 85-20-141 "Licensure by Endorsement, " section 4 and 18 VAC85-20-350 "Informed consent", section B. She noted that the 3 comments received were in support of this proposed amendment. The Legislative Committee's recommendation to the Board was to accept the petition.

MOTION: After a brief discussion, Dr. Ali moved to accept the recommendation of the Legislative Committee to initiate rulemaking and adopt amendments by a fast-track action. The motion was properly seconded and carried unanimously.

- **Legislative Proposal**

Ms. Yeatts explained that this proposal is to remove outdated language in §54.1-2909 that references an agreement for an Impaired Physicians Program and include updated language that references the Health Practitioners' Monitoring Program. Ms. Yeatts also said that the reporting requirement for presidents of all professional societies is redundant of language found in 54.1-2908, so it can be deleted from 2909.

MOTION: After discussion, this proposal was approved by acclamation.

- **Legislative Proposal – Athletic Trainers**

Ms. Yeatts reported that the Advisory Board on Athletic Trainers identified the need to amend the Drug Control Act to gain authority for athletic trainers to possess and administer naloxone in emergencies involving opioid overdoses.

Dr. Archer asked if athletic trainers could be added to section 54.1-3408 X.

Ms. Yeatts said that section X was amended by the 2019 General Assembly to include authorization for naloxone. In section X, practitioners and non-health care providers are authorized to administer and dispense. The athletic trainers are asking to possess and administer. Since athletic trainers are already listed in section F, amending F would be practical choice.

Dr. Archer stated that it is redundant to place it in F. He believed athletic trainers should be added to the list of those authorized in X. Additionally, he asked what training do athletic trainers have?

Ms. Yeatts stated that all non-professionals need training, and they can get it from CVS. There is little rationale that athletic trainers may need training when they already have the knowledge to administer epinephrine.

Dr. Stokes added that the athletic trainer administering the naloxone will be working with a physician.

Ms. Deschenes reiterated that anyone can obtain naxolone. Some of the athletic trainers were individually obtaining it to help with life-saving issues that occur in the schools. However, because of personal liability and liability of the school that employs them, they thought it best to have naloxone added to 54.1-3408(F).

MOTION: With no further discussion, Dr. Walker moved to adopt the legislative proposal as presented. The motion was properly seconded and carried unanimously.

2) Licensing Report

Dr. Harp introduced the licensing specialists to the Board and acknowledged them for the work done this year while understaffed and without a Deputy for Licensure. He announced that as of June 12th, 7,000 initial applications had been issued in the past 12 months.

Dr. Harp also announced that Michael Sobowale, the new Deputy Executive Director for Licensure, will be joining the Board on July 25th. Mr. Sobowale is coming from another state health regulaotry board with licensing experience and a law degree. Mr. Sobowale will be a tremendous asset to the Board.

Dr. Harp then reviewed the licensure by endorsement process and provided information on the average number of days to licensure by the Interstate Medical Licensure Compact. He is confident that the Board will be able to provide expeditious licensure to all applicants that qualify. He explained that the BOM has been allowing applicants to switch tracks from traditional to endorsement within 30 days of the traditional application being filed. Dr. Harp asked the Board to approve that switching of paths no longer be an option at the end of June. The Board agreed with the plan as described.

Dr. Harp presented information on the training programs for radiologic technologists-limited and the number of hours reported by the programs to cover competency. He recommended that, for now, applicants should be asked to attest to the number of training hours rather than having the hours reported by the program. The Board agreed with this approach.

3) Discipline Report

Ms. Deschenes presented the numbers for Discipline and reviewed the change to the mandatory suspension statute (54.1-2409) that will allow the agency "to not suspend" licensees who fall under a reciprocal action cycle. Presently, a licensee suspended in another state based on disciplinary action imposed by the Virginia Board of Medicine has to then be suspended by Virginia. The change in the law allows DHP "to not suspend" when the other state is acting solely on an action taken by the Virginia Board of Medicine.

4) Comment on the Opioid Regulations and PMP

Dr. Harp provided the following background information in the agenda packet.

The Centers for Disease Control and Prevention published its Guideline for Prescribing Opioids for Chronic Pain in March 2016. An outline of the principles in the Guideline was sent to Virginia prescribers in May 2016. The Board began to get questions from its licensees about the prescribing of opioids. In March 2017, the Board of Medicine regulations for the prescribing of opioids and buprenorphine became effective. Since that time, the Board has gotten communications from patients and physicians about proper prescribing. Patients would express concern that their dose that had them stable and functional for years was being cut. Board staff that attended medical meetings became aware that the majority of physicians had not read the regulations to understand the great latitude that prescribers have with the dosing of opioids. The Board's Continuing Education Committee met in the fall of 2018 to determine who would be required to obtain opioid continuing education for the next biennium. It also considered what continuing education would be required. Two suggestions to address the mythology around opioids and provide education on effective tapering were offered—1) read the regulations, and 2) the Stanford University course on tapering chronic opioids. This 2-hour "package" was provided to all the Board's licensees, including nurse practitioners. Still the Board gets communications from patients. Two recent communications are included for your review. The first is a request from Sydney Rab that the Board reconsider its regulations, followed by a response from Dr. Harp, and an advocacy blog. The second is commentary on the Prescription Monitoring Program's thresholds for identifying unusual patterns of prescribing from Kristen Ogden. Ms. Ogden's e-mail follows the material related to the first request. The Board of Medicine does have input into the thresholds.

==DRAFT UNAPPROVED==

Dr. Harp noted this issue had been before the Legislative Committee on May 15th, and it recommended to the Board that no change in the regulations be made.

After a brief discussion, Dr. Edwards moved that the Board take no action; the motion was seconded and carried unanimously.

5) Report of the Nominating Committee

Dr. Walker presented the recommended slate of officers: President-Ray Tuck; Vice-President-Lori Conklin; Secretary/Treasurer-Blanton Marchese. No nominations arose from the floor. The vote to approve the slate of officers was unanimous.

6) **Announcements**

Next meeting date of the Full Board is October 17-19, 2019.

Travel vouchers for today's meeting should be submitted no later than July 15, 2019.

7) Adjournment

With no other business to discuss, Dr. O'Connor adjourned the meeting of the Full Board at approximately 11:45 AM.

Ray Tuck, Jr., DC
President, Chair

William L. Harp, MD
Executive Director

Colanthia Morton Opher
Recording Secretary

Agenda Item: **Director's Report**

Staff Note: None.

Action: Informational presentation. No action required.

Agenda Item: **Report of Officers**

Staff Note:

- President
- Vice-President
- Secretary-Treasurer
- Executive Director

Action: Informational presentation. No action required.

Agenda Item: **Executive Director's Report**

Staff Note: All items for information only

Action: None.

		102- Medicine
Board Cash Balance as June 30, 2019	$	9,382,219
YTD FY20 Revenue		536,108
Less: YTD FY20 Direct and Allocated Expenditures		1,617,510
Board Cash Balance as Augsut 31, 2019	$	8,300,817

Virginia Department of Health Professions
Input of Case Hours by Department
For Use in Allocation of Department 305- ***Enforcement*** Costs
For the Fiscal Year Ended June 30, 2019

	Fiscal Month No.	1	2	3	4	5	6	7	8	9	10	11	12	Annual	YTD
	Month Name	July	August	September	October	November	December	January	February	March	April	May	June	Total	%
Dept. No.	Dept. Name														
101	Nursing	1,729.00	1,758.25	1,716.50	1,952.13	1,552.25	1,445.75	1,857.50	1,633.75	1,912.50	1,883.95	1,793.50	1,540.00	20,775.08	25.9%
102	Medicine	1,881.00	2,274.33	1,606.30	1,640.00	1,575.50	1,392.50	1,786.75	1,833.00	1,827.75	1,750.15	1,930.03	2,008.75	21,506.06	26.8%
103	Dentistry	421.00	632.75	500.05	479.25	439.50	417.00	439.50	438.50	418.50	548.50	567.30	565.65	5,867.50	7.3%
104	Funeral Directors and Emba	138.00	154.00	103.00	133.03	87.00	60.75	137.35	129.70	134.25	212.30	132.00	118.75	1,540.13	1.9%
105	Optometry	46.75	12.25	45.50	10.00	11.25	19.75	8.50	6.25	17.75	18.33	37.25	23.50	257.08	0.3%
106	Veterinary Medicine	345.25	341.58	273.00	392.38	308.25	258.00	326.75	943.25	359.75	318.00	288.25	241.75	4,396.21	5.5%
107	Pharmacy	1,236.65	1,549.13	1,163.35	1,446.68	914.50	793.05	1,020.20	374.45	1,188.50	1,181.50	1,055.08	1,190.00	13,113.09	16.3%
108	Psychology	52.00	41.75	46.00	104.25	60.50	103.75	65.25	75.75	95.50	146.20	94.75	75.75	961.45	1.2%
109	Professional Counselors	191.50	216.25	179.50	201.99	136.75	190.00	279.75	257.75	255.25	438.00	249.05	235.25	2,831.04	3.5%
110	Social Work	121.50	118.00	76.75	66.25	58.50	70.50	65.00	108.00	122.00	198.20	99.25	134.25	1,238.20	1.5%
112	Cerified Nurse Aids (State	612.50	480.50	388.70	374.75	401.25	403.25	360.50	397.00	498.00	486.40	599.00	537.50	5,539.35	6.9%
114	Nursing Home Administrator	105.75	108.75	136.50	116.00	99.75	87.75	134.75	93.00	141.75	174.75	122.00	71.50	1,392.25	1.7%
115	Audiology and Speech Lang	13.50	18.00	32.00	30.50	2.50	4.75	10.75	20.25	19.00	25.75	20.75	14.25	212.00	0.3%
116	Physical Therapy	21.75	36.25	55.00	68.00	30.25	36.25	62.00	56.25	78.25	37.95	48.25	37.75	567.95	0.7%
118	Va. Pharm Processor Pgm	-	-	-	-	-	-	-	-	-	7.75			7.75	0.0%
	Total	6,916.15	7,741.79	6,322.15	7,015.21	5,677.75	5,283.05	6,554.55	6,366.90	7,068.75	7,427.73	7,036.460	6,794.650	80,205.140	

Description of Allocation Method

Sources & Notes
Note: Number of hours = Investigative Hours + Manpower Analysis Hours (#'s come from monthly statistical reports from Enforcment (Tamika))
The source for these numbers is a VDHP spreadsheet titled *Allocation 305 & 306.xls*

Maximus report of April 11, 2002 recommended using the average of the current and two prior months in computing the allocation factor.

Commonwealth of Virginia

Harp, William <william.harp@dhp.virginia.gov>

RE: [EXTERNAL] VA Regulations on Telehealth

1 message

Galpin, Kevin MD <Kevin.Galpin@va.gov> Sun, Sep 8, 2019 at 1:53 PM
To: "Harp, William" <william.harp@dhp.virginia.gov>, Robin Lisa <lrobin@fsmb.org>, Ray Tuck <raytuck@tuckclinic.com>, "Brown, David" <david.brown@dhp.virginia.gov>, "Conklin, Lori D *HS" <LDC5D@hscmail.mcc.virginia.edu>
Cc: "Massarsky, Sallie N." <Sallie.Massarsky@va.gov>, "Isern, Rebeca" <Rebeca.Isern@va.gov>

Good afternoon Dr. Harp,

We appreciate the Virginia Board of Medicine's support for our Veterans. We also appreciate and thank you for the thoughtful recommendation.

I have copied our regulatory affairs team working on this proposal so they can help capture the recommendation.

Thank you again,

Kevin

Kevin Galpin, M.D.

Executive Director, VHA Telehealth Services

From: Harp, William <william.harp@dhp.virginia.gov>
Sent: Saturday, September 7, 2019 11:03 AM
To: Galpin, Kevin MD <Kevin.Galpin@va.gov>; Robin Lisa <lrobin@fsmb.org>; Ray Tuck <raytuck@tuckclinic.com>; Brown, David <david.brown@dhp.virginia.gov>; Conklin, Lori D *HS <LDC5D@hscmail.mcc.virginia.edu>
Subject: [EXTERNAL] VA Regulations on Telehealth

Dear Dr. Galpin:

The Virginia Board of Medicine appreciates the opportunity to provide comment on the proposed amendments to the Veterans' Administration Regulations on Telehealth.

Please know that the Board fully supports expanded access to care for our veterans, and anything that can be done to provide that care is applauded.

Members of the Board have discussed the proposed amendments and have only one suggestion. In regards to medical trainees that might provide telemedicine services, the Board suggests that the authorization begin with residents that are at the PGY-2 level or beyond.

The Board reasoned that trainees are eligible for a full and unrestricted Virginia license after one year of supervised postgraduate training. An unrestricted license authorizes independent practice. Allowing PGY-1's to provide telemedicine services may inadvertently create a 2-tiered system of care. Our veterans deserve care from physicians that have proven their knowledge, clinical acumen, and skills to be sound.

Again, thank you for the opportunity to provide comment on this important issue, and thanks for all you do for our veterans and our nation.

With kindest regards,

William L. Harp, MD

Executive Director

Virginia Board of Medicine

Commonwealth of Virginia

Harp, William <william.harp@dhp.virginia.gov>

DOH Clarification of opioid prescribing rules letter

1 message

Washington Medical Commission <WAMedicalCommission@public.govdelivery.com> Thu, Sep 26, 2019 at 7:02 PM
Reply-To: WAMedicalCommission@public.govdelivery.com
To: william.harp@dhp.virginia.gov

Having trouble viewing this email? View it as a Web page.

Clarification Letter on Opioid Prescribing Rules

Washington State Boards, Commissions and the Department of Health have composed a letter to clarify the current opioid prescribing rules. We have received reports of patients on chronic opioid therapy whose opioids have been rapidly tapered or discontinued. We are also hearing reports of patients on chronic opioid therapy who are unable to find providers willing to care for them. The purpose of this letter is to help you better understand the existing rules around prescribing opioids and managing existing patients on chronic opioid therapy so that you feel comfortable continuing to care for these individuals. Read the letter in its entirety here and contact us is you have any questions.

GOVDELIVERY

STATE OF WASHINGTON

DEPARTMENT OF HEALTH

Olympia, Washington 98504

September 20, 2019

Re: Clarification of opioid prescribing rules

Dear Provider,

The Washington State Department of Health and its partner boards and commissions have received reports of patients on chronic opioid therapy whose opioids have been rapidly tapered or discontinued. We are also hearing reports of patients on chronic opioid therapy who are unable to find providers willing to care for them. The appropriate treatment of pain is an integral part of clinical medicine. The purpose of this letter is to help you better understand the existing rules around prescribing opioids and managing existing patients on chronic opioid therapy so that you feel comfortable continuing to care for these individuals.

Dose Restrictions

The Washington State opioid prescribing rules do **not** set a regulatory limit on the daily dosage of opioids that can be prescribed in the state. When opioids are started, the Centers for Disease Control and Prevention (CDC) recommend that providers prescribe the lowest effective dose, use caution when prescribing opioids at any dosage, and avoid **escalating new chronic pain patients** to doses greater than 90 mg MME per day or carefully justify a decision to do so based on an assessment of benefits and risks. While we support these recommendations, we do not use the CDC opioid prescribing guideline to determine if a violation of the opioid rules has occurred. Under Washington State rules, if a healthcare provider believes a patient being treated for chronic pain needs more than 120 mg MME per day to adequately address their pain, the healthcare provider is generally required to consult with a pain specialist. There are multiple mechanisms for accomplishing the consult requirement described in the rules, and the rules provide an exception to this consult requirement, described below.

Patients on High-Dose Chronic Opioid Therapy

Neither the Washington State opioid prescribing rules nor the CDC opioid prescribing guideline support rapidly tapering or discontinuing opioids for patients on existing opioid doses exceeding 90 mg MME per day under most circumstances. Abruptly tapering or discontinuing opioids in a patient who is physically dependent may cause serious patient harms including severe withdrawal symptoms, uncontrolled pain, psychological distress, and in rare instances, suicide.

Healthcare providers accepting new patients on chronic opioid therapy that exceeds 120 mg MME per day should not feel pressured to change a patient's current opioid dose until an appropriate assessment suggests that a change is indicated. Under Washington's rules, patients with chronic pain new to your practice and on high-dose opioids are exempt from mandatory pain specialist consultation requirements for the **first three months** of newly established care if the patient is being treated for the same condition(s); is on a stable and non-escalating opioid dose; has been compliant with written agreements and treatment plans; and has improved or stable function at the presenting dose. During this time period, the healthcare provider should evaluate the benefits and risks of chronic opioid therapy and determine if any tapering can or should be done. This critical time of re-evaluation of their opioid regimen is an opportunity to develop a stronger therapeutic rapport with your patient and to integrate non-opioid and non-pharmacologic therapies into a treatment plan offering valuable tools and skills for your patient to more safely self-manage pain and improve their quality of life.

According to Washington State opioid prescribing rules, tapering would be expected for patients on chronic opioid therapy when one or more of the following occurs:

- The patient requests tapering;
- The patient experiences a deterioration in function or pain;
- The patient is noncompliant with the written agreement;
- Other treatment modalities are indicated;
- Evidence of misuse, abuse, substance use disorder, or diversion;
- The patient experiences a severe adverse event or overdose;
- Unauthorized escalation of doses; or
- An authorized escalation of dose with no improvement in pain or function.

After the assessment period, if the patient is following a tapering schedule or the patient's pain and function are stable on a non-escalating dosage of opioids, a consultation is not required regardless of opioid dose. Tapering schedules should be slow enough to minimize withdrawal symptoms.

This letter is not intended to be a comprehensive review of the Washington State opioid prescribing rules. Instead, we have focused on the parts of the rules that seem to be causing the most confusion or apprehension. We encourage you all to take the time to read the new opioid prescribing rules in their entirety at: https://www.doh.wa.gov/OpioidPrescribing/HealthcareProviders. Reading the rules counts towards continuing education credits required as part of the rule.

Thank you for your serious efforts to address our opioid crisis and provide comprehensive, patient-centered care. We recognize that the myriad federal, state, and local policies and recommendations have created a complex working environment for you. We hope this letter helps to alleviate any remaining confusion around opioid prescribing rules in Washington. If you have further questions, feel free to contact your appropriate board or commission (https://www.doh.wa.gov/OpioidPrescribing/ContactUs).

Thank you again for the work you do every day to care for the residents of Washington State!

Sincerely,

Kathy Lofy, MD
State Health Officer
Washington State Department of Health

Alden W. Roberts, MD
Chair
Medical Commission

Tracy D. Rude, LPN
Chair
Nursing Care Quality Assurance Commission

John Finch, Jr., DO
Chair
Board of Osteopathic Medicine and Surgery

Julia Richman, DDS
Chair
Dental Quality Assurance Commission

Randolph Anderson, DPM
Chair
Podiatric Medical Board

Additional Resources:

Medical Commissions Interpretative Statement on Opioid Prescribing and Monitoring for Patients (March 2019):
https://wmc.wa.gov/sites/default/files/public/documents/OpioidINS2019-01.pdf
https://wmc.wa.gov/sites/default/files/public/documents/Opioid-PatientsINS2019-02.pdf

CDC Advises Against Misapplication of the Guideline for Prescribing Opioids for Chronic Pain (April 2019): https://www.cdc.gov/media/releases/2019/s0424-advises-misapplication-guideline-prescribing-opioids.html

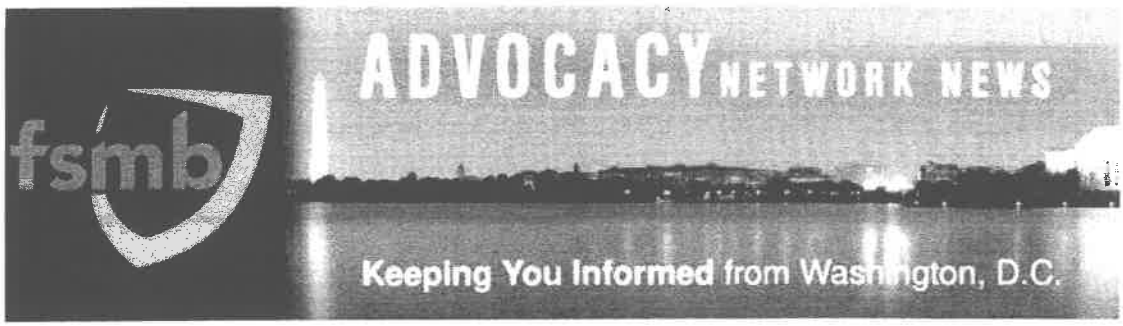
Commonwealth of Virginia

Harp, William <william.harp@dhp.virginia.gov>

FSMB Advocacy Network News

1 message

Federation of State Medical Boards, D.C. <jknickrehm@fsmb.org> Wed, Oct 2, 2019 at 11:32 AM
Reply-To: jknickrehm@fsmb.org
To: william.harp@dhp.virginia.gov



Articles of Interest

Medscape: Rule Buried in Proposed Medicare Fee Schedule Could Have 'Chilling Effect' (Free login required)

DOJ: $2.1 Billion Health Care Fraud Takedown

Contact Us

Lisa Robin
Chief Advocacy Officer

FSMB
1300 Connecticut Avenue NW
Suite 500
Washington, D.C. 20036

Phone: (202) 463-4000
lrobin@fsmb.org

October 2, 2019

Congress Returns to Washington - What We're Watching

Congress returned to Washington last month after a six-week recess and began work on a number of pressing issues including: drug pricing, surprise medical billing, gun control, trade, and appropriations. With only a short amount of time remaining on the legislative calendar this year, the Senate will focus on getting its spending bills finalized in the coming weeks.

Several other pieces of legislation are expected to be introduced before year's end - below is an overview of what we're watching as the session gets back into full swing:

Telehealth Legislation

- **Senator Marsha Blackburn (R-TN)** introduced the Telehealth Across State Lines Act of 2019 (S. 2408), as part of her rural health package, which would:
  - Bring together a group of stakeholders to create uniform best practices for the use of telehealth under the title "National Telehealth Program"
  - Create a grant program for expanding telehealth programs into rural areas and provide for a study of the results of the program
  - Direct the Center for Medicare and Medicaid Innovation (CMMI) to create a model to provide incentives for the adoption of telehealth for increased access to care in rural areas
- **Rep. John Curtis (R-UT)** introduced the Telehealth Innovation and Improvement Act of 2019 (H.R. 4013), which would require CMMI to test the effect of including telehealth services in Medicare health care delivery reform models, including:
  - Testing non-applications of certain restrictions, including services furnished without regard to originating site and geographic location
  - Evaluating these enhanced service models - including identifying any impediments, such as "licensing or credentialing barriers,"

- **Rep. Richard Neal (D-MA)** introduced the Beneficiary Education Tools, Telehealth, and Extenders Reauthorization Act of 2019 (H.R. 3417), which includes a provision that would remove Medicare geographic location restrictions on mental telehealth services without waiving any applicable state law requirements.

- **Sen. Cory Booker (D-NJ)** introduced the MOMMIES Act (S.1343) and **Rep. Ayanna Pressley (D-MA)** introduced the Healthy MOMMIES Act (H.R. 2602), both of which would require a "General Accountability Office (GAO) report on state Medicaid programs' use of telemedicine to increase access to maternity care." As part of the study, the GAO would assess health outcomes, cost savings, patient satisfaction and barriers to use.

Veterans Affairs

- **Rep. Bobby Carter (R-GA)** introduced the VA Mission Telehealth Clarification Act (H.R. 3228), that would clarify which health care professionals and ***health professional trainees*** may provide treatment via telemedicine within the VA.

- **Rep. Mark Meadows (R-NC)** introduced the Brian Tally VA Medical Care and Liability Improvement Act (H.R. 3813), which would ensure that Federal tort claim laws apply to specified health care contractors at the VA and require reporting of judgements from such claims to state licensing entities.

Background Checks

- **Sen. Cory Booker (D-NJ)** introduced the Next Step Act of 2019 (S. 697), which contains several criminal justice reform efforts, including the **REDEEM Act (Title IX)** and the **Fair Chance Licensing Act.** Specifically, the **Fair Chance Licensing Act (Title VIII)** would curtail licensing boards' use of background checks.

  The FSMB is actively tracking and engaging on the **Next Step Act of 2019**, which combines several pieces of stand-alone legislation and has the potential to impact state medical boards' use of criminal background checks during the licensure process.

Opioids

- The **Department of Health and Human Services (HHS) announced $1.8 billion for combating the opioid crisis**, which will be divided between the Centers for Disease Control (CDC) and the Substance Abuse and Mental Health Services Administration (SAMSHA). SAMSHA's $932 million will go to all 50 states as part of its "State Opioid Response" grants. For more information on the funding announcement, click here

- **Rep. Doris Matsui (D-CA)** introduced the Improving Access to Remote Behavioral Health Treatment Act of 2019 (H.R. 4131), which would clarify that qualified community mental health centers may be eligible to register to provide controlled substances via telemedicine. The bill would allow the Attorney General to deny an application for registration if it determines that it would be inconsistent with the public interest, which can be based on several factors, including:
  - "Any recommendation by the licensing board or professional disciplinary authority of the state in which the applicant is located..."

- **Sen. Pat Roberts (R-KS)** introduced a similar bill - the Modernizing Eligible Treatment centers for Healing (METH) Addiction Act of 2019 (S. 2244) - which would allow community addiction treatment facilities and community mental health facilities to register to dispense controlled substances via telemedicine.

- **Sen. Ed Markey (D-MA)** introduced the CREATE Opportunities Act (S. 1983), which wouldexpand programs for providing medication assisted treatment for incarcerated individuals with opioid use disorder.

- **Sen. Maggie Hassan (D-MA)** introduced the Mainstreaming Addiction Treatment Act of 2019 (S. 2074), which would eliminate the requirement for practitioners to obtain a DATA 2000 waiver to prescribe buprenorphine. **Rep. Paul Tonko (D-NY)** introduced its companion bill (H.R. 2482) in the House.

Marijuana

- **Sens. Chuck Grassley (R-IA) and Dianne Feinstein (D-CA)** introduced the Cannabidiol and Marihuana Research Expansion Act (S. 2032), which would encourage research of, and allow for, increases in the amount of Schedule I substances used in approved research.

Stem Cells

- **Sen. Roger Wicker (R-MS)** introduced the Patients First Act of 2019 (S. 2308), which would require the National Institutes of Health (NIH) to support human stem cell research and therapy, with certain limitations.

State Legislative News

Interstate Medical Licensure Compact

During 2019, the Interstate Medical Licensure Compact (IMLC) added four additional states to its membership - Georgia, Kentucky, North Dakota, and Oklahoma - bringing the total number of Member States to twenty-nine states, the District of Columbia and Guam. The Compact legislation remains pending in New Jersey (**A 5406/S 3821**) and South Carolina (**H 3101**).

As of August 31, 2019, the Interstate Medical Licensure Compact Commission (IMLCC) has processed 4,890 applications, resulting in 6,990 medical licensees being issued by Member States.

With state legislatures beginning to pre-file legislation for the 2020 legislative session, the FSMB is willing and able to provide support and advocate on behalf of state medical boards wishing to join the Compact. The model Compact legislation can be found on the IMLCC's website at www.imlcc.org. Additional resources can be obtained by contacting John Bremer, Director of State Legislation & Policy, at jbremer@fsmb.org or (202) 432-4021.

FSMB Advocacy Network

Working from offices in Texas and Washington, D.C., the FSMB provides advocacy services ranging from monitoring of legislation to liaison with key federal agencies. Contact us to learn more about our work on state and federal legislative issues, administration initiatives and the legislative process.

Agenda Item: **Committee and Advisory Board Reports**

Staff Note: Please note Committee assignments and minutes of meetings since June 13, 2019.

Action: Motion to accept minutes as reports to the Board.

VIRGINIA BOARD OF MEDICINE

Committee Appointments

2019-2020

EXECUTIVE COMMITTEE (8)
Ray Tuck, DC, **President**
Syed Salman Ali, MD
David Archer, MD
Lori Conklin, MD, **Vice-President**
Alvin Edwards, PhD
L. Blanton Marchese, **Secretary/Treasurer**
Karen Ransone, MD
Kenneth Walker, MD

LEGISLATIVE COMMITTEE (7)
Lori Conklin, MD, **Vice-President, Chair**
David Giammittorio, MD
Jane Hickey, JD
Jacob Miller, DO
Kevin O'Connor, MD
Brenda Stokes, MD
Svinder Toor, MD

CREDENTIALS COMMITTEE (9)
Kenneth Walker, MD, Chair
James Arnold, DPM
Jane Hickey, JD
L. Blanton Marchese, **Secretary/Treasurer**
Jacob Miller, DO
Brenda Stokes, MD
Ray Tuck, DC, **President**
David Taminger, MD
Martha Wingfield

FINANCE COMMITTEE
Ray Tuck, DC, **President**
Lori Conklin, MD, **Vice-President**
L. Blanton Marchese, **Secretary/Treasurer**

BOARD BRIEFS COMMITTEE
William L. Harp, M.D., Ex Officio

CHIROPRACTIC COMMITTEE
Ray Tuck, Jr., DC - **President**

BOARD OF HEALTH PROFESSIONS
Kevin O'Connor, MD

COMMITTEE OF THE JOINT BOARDS OF NURSING AND MEDICINE
Lori Conklin, MD, **Vice-President**
Ray Tuck, DC, **President**
Kenneth Walker, MD

--- DRAFT UNAPPROVED --

VIRGINIA BOARD OF MEDICINE
EXECUTIVE COMMITTEE MINUTES

Friday, August 2, 2019 | Department of Health Professions | Henrico, VA

CALL TO ORDER: Dr. Tuck called the meeting of the Executive Committee to order at 8:36 a.m.

ROLL CALL: Ms. Opher called the roll; a quorum was established.

MEMBERS PRESENT:
Ray Tuck, DC - President
Blanton Marchese - Secretary-Treasurer
David Archer, MD
Alvin Edwards, MDiv, PhD
Karen Ransone, MD

MEMBERS ABSENT:
Syed Salman Ali, MD
Lori Conklin, MD - Vice-President
Kenneth Walker, MD

STAFF PRESENT:
William L. Harp, MD - Executive Director
Jennifer Deschenes, JD - Deputy Director for Discipline
Colanthia Morton Opher - Deputy Director for Administration
Michael Sobowale, LLM - Deputy Director for Licensure
Barbara Matusiak, MD - Medical Review Coordinator
Barbara Allison-Bryan, MD - DHP Chief Deputy Director
Elaine Yeatts - DHP Senior Policy Analyst
Erin Barrett, JD - Assistant Attorney General

OTHERS PRESENT:
W. Scott Johnson, JD - MSV
Jennie Wood - Board of Medicine

EMERGENCY EGRESS INSTRUCTIONS

Mr. Marchese provided the emergency egress instructions.

APPROVAL OF MINUTES OF DECEMBER 7, 2018

Dr. Edwards moved to approve the meeting minutes from December 7, 2018 as presented. The motion was seconded and carried unanimously.

ADOPTION OF AGENDA

Dr. Edwards moved to adopt the agenda as presented. The motion was seconded and carried unanimously.

PUBLIC COMMENT

There was no public comment.

DHP DIRECTOR'S REPORT

Dr. Allison-Bryan began by informing the Committee of the events surrounding the passing of Dr. Hughes Melton. Dr. Melton was the Commissioner of the Department of Behavioral Health and Developmental Services and was very active in the medical community. He taught and inspired many practitioners and was a big contributor to her interest in substance use disorders. The Committee members observed a moment of silence for Dr. Melton and his family and the young woman who was tragically killed in the crash and her family.

Dr. Allison-Bryan also provided an overview of two workgroups generated by the 2019 General Assembly.

1. Telemedicine - This workgroup is looking at ways to enhance a physician's ability to provide care through telemedicine, thereby creating greater access for patients in need. It is also looking to maintain the principle that the practice of medicine occurs where the patient is located. Dr. Brown will be leading the group, and Dr. O'Connor will be a participant.

2. International Medical Graduates Work Group: Barriers to Licensure and Opportunities for the Commonwealth - Dr. Allison-Bryan said that at least 63 individuals in Virginia were physicians in their home country but have been unable to get a license in the Commonwealth. This workgroup is hoping to level the playing field for international graduates.

Dr. Archer recalled that the current requirement for IMG's is one year of residency.

Dr. Allison-Bryan said that, prior to 2016, the regulations required two years of postgraduate training for IMG's. Then the Board reduced it to one year for both US and Canadian graduates. A significant issue is that there are not a lot of residency slots to go around. Some IMG's have had full residencies overseas and practiced in another country. However, such training and experience does not meet the licensure requirements in Virginia. It is anticipated that the workgroup will have some recommendations regarding how to help IMG's clear some of the hurdles to licensure.

PRESIDENT'S REPORT

Dr. Tuck had no report and invited Dr. Edwards to provide a report on his attendance at FSMB's Education Committee meeting. The Committee is responsible for planning next year's Annual Meeting.

Dr. Edwards stated that he was on the Committee to bring the perspective of a non-physician. He noted that the Virginia Board was well regarded by the members of the Committee. One of his suggestions was a glossary of terms for non-physician fellows. FSMB said such a tool already exists. The 2019 Annual Meeting was evaluated along with discussion of potential speakers for next year's meeting, which will be in San Diego. The Committee is looking for best practices and new ways of doing things in medical regulation.

EXECUTIVE DIRECTOR'S REPORT

Dr. Harp introduced Michael Sobowale, the new Deputy for Licensure, and provided the Committee a little about his experience in health care regulation and supervision of staff.

Mr. Sobowale told the Committee that he was pleased to be a part of Board staff. He noted that he has worked in the regulatory field for over 18 years and brings his experience and understanding of the healthcare regulatory environment.

NEW BUSINESS

Chart of Regulatory Actions

Ms. Yeatts provided a brief overview of the regulatory actions as of July 19, 2019. She noted that all actions are moving along very well.

Board Action on Fee Reduction

Ms. Yeatts referred to the financial report showing the Board's current surplus and reviewed the proposed reduction of 20% in renewal fees for all professions in 2020-2021. She noted that the amended regulations fall under an exemption from the Administrative Process Act. The regulations should be in effect prior to the time that renewal notices for January 2020 are sent.

MOTION: Dr. Edwards moved to approve the amended regulations as presented; the motion was properly seconded. Mr. Marchese stated that, in discussing this matter with Dr. Harp, he understands that Dr. Brown fully supports this action.

The motion carried unanimously.

DHP-Medicine Regulatory/Policy Actions – 2019 General Assembly

Ms. Yeatts provided a brief overview of the regulatory and policy actions affecting the Board of Medicine. She fielded questions about HB2457 – Retiree license, and advised that this item will be on the Legislative Committee meeting September 6, 2019. This report was for informational purposes only.

Adoption of exempt action – Physician Assistants

Ms. Yeatts presented the draft proposed amendment to 18 VAC85-50-50 – Regulations Governing the Practice of Physician Assistants, noting that the amendment will authorize the issuance of a license by endorsement to a physician assistant who is the spouse of an active duty military member.

MOTION: Dr. Edwards moved to adopt the amended regulation as an exempt action. The motion was properly seconded and carried unanimously.

Adoption of Regulations for Waiver of Electronic Prescribing by Emergency Action

Ms. Yeatts reviewed the amendments to §54.1-3408.02, and 18 VAC85-21-21, which require electronic prescribing of opioids by July 1, 2020. She stated that the General Assembly decided to grant a one-year exemption to those physicians who provided proof of hardship for not being able to meet the deadline. She also noted that the Board will need to delegate authority to Dr. Harp to grant an exemption. She then informed the members that the enactment clause requires adoption of regulations within 280 days, so the Board must accomplish this by an emergency action.

MOTION: After a brief discussion, Dr. Edwards moved to adopt the emergency regulations and a Notice of Intended Regulatory Action (NOIRA) to replace the emergency regulations as presented. The motion was properly seconded and carried unanimously.

Adoption of Regulations for Physician Assistants by Emergency Action

Ms. Yeatts reviewed the amendments to §§54.1-2900, 54.1-2951.1 through 54.1-2952.1, 54.1-2957 and 18 VAC85-50-10 et. seq – Regulations Governing the Practice of Physician Assistants

Ms. Yeatts advised that the amendments would change supervision of physician assistants to practice with a patient care team physician.

Ms. Yeatts also stated that the enactment clause on HB1952 requires adoption of regulations within 280 days, so the Board must amend the regulations by an emergency action.

MOTION: Dr. Archer moved to adopt the emergency regulations as presented. The motion was properly seconded and carried unanimously.

MOTION: Dr. Edwards then moved to adopt a Notice of Intended Regulatory Action (NOIRA) to replace the emergency regulations as presented. The motion was properly seconded and carried unanimously.

2. Licensure by Endorsement

Dr. Harp provided the Committee with the following staff notes:

Since the application for Licensure by Endorsement was posted in December 2018, Board staff has been able to take note of steps in the process that work, don't work, or need further clarification.

At the June Board meeting, Board staff reported that it had provided the option to applicants that had started in the traditional pathway to switch to the endorsement pathway if they qualified, and if it had been less than 30 days since they submitted the traditional application. Over time, this became somewhat burdensome. Board staff asked the Board to make it a policy that such switching would cease as of July 1, 2019. The Board agreed.

In regulation, the first 5 requirements of Licensure by Endorsement are essentially YES or NO. However, the 6th requirement reads:

6. Have no grounds for denial based on provisions of § 54.1-2915 of the Code of Virginia or regulations of the board.

The instructions for the applicant to read prior to submitting an application by Endorsement include:

6) Provide answers to the questions in the online application. NOTE: FOR ANY "YES" ANSWERS FOR QUESTIONS 4-17, you must provide a narrative in the space provided.

Board staff asks that the language above "you must provide a narrative in the space provided" be replaced with "you do not qualify for Licensure by Endorsement and must file through the traditional pathway."

Ms. Barrett spoke in support of this change and stated that the endorsement pathway is meant to be the express train with no stops, so the application should be clean.

Ms. Hickey inquired as to whether question #9 was sufficient for capturing necessary information to deem the applicant eligible for endorsement. She suggested that "or past" be inserted after pending.

MOTION: Dr. Edwards moved to accept the changes presented by staff, and the amendment to question #9. The motion was properly seconded and carried unanimously.

3. Proposed 2020 Board Meeting Dates

The Committee unanimously agreed to accept the dates as presented with the following changes:

- Full Board – February 20-21 amended to February 20-22
- Legislative – September 4th – possibly moving meeting date (Ms. Opher will check room availability)

--- DRAFT UNAPPROVED --

ANNOUNCEMENTS

Dr. Harp announced that Dr. Matusiak would like the Board members to review some disciplinary cases after adjournment.

The next meeting of the Committee will be December 6, 2019 at 8:30 a.m.

ADJOURNMENT

With no additional business, the meeting adjourned at 9:36 a.m.

Ray Tuck, Jr., DC
President, Chair

William L. Harp, MD
Executive Director

Colanthia M. Opher
Recording Secretary

---DRAFT UNAPPROVED---

VIRGINIA BOARD OF MEDICINE

LEGISLATIVE COMMITTEE MINUTES

Friday, September 6, 2019 Department of Health Professions Henrico, VA

CALL TO ORDER: Dr. Conklin called the meeting of the Legislative Committee to order at 8:34 a.m.

ROLL CALL: Ms. Opher called the roll; a quorum was established.

MEMBERS PRESENT:
Lori Conklin, MD, Vice-President & Chair
David Giammittorio, MD
Jane Hickey, JD
Jacob Miller, DO

MEMBERS ABSENT:
Kevin O'Connor, MD
Brenda Stokes, MD
Svinder Toor, MD

STAFF PRESENT:
William L. Harp, MD, Executive Director
Jennifer Deschenes, JD, Deputy Director for Discipline
Colanthia Morton Opher, Deputy Director for Administration
Michael Sobowale, LLM, Deputy Director for Licensing
Barbara Matusiak, MD, Medical Review Coordinator
David Brown, DC, DHP Director
Barbara Allison-Bryan, MD, DHP Chief Deputy Director
Elaine Yeatts, DHP Senior Policy Analyst
Erin Barrett, JD, Assistant Attorney General

OTHERS PRESENT:
Ken Olshansky, MD
W. Scott Johnson, Esq., MSV
Ben Traynham, MSV
Clark Barrineau, MSV
Casey Pick – The Trevor Project
Adam Trimmer – Born Perfect
Vee Lamneck, Equality Virginia
Tom Intorcio – Virginia Catholic Conference

EMERGENCY EGRESS INSTRUCTIONS

Dr. Conklin provided the emergency egress instructions.

---DRAFT UNAPPROVED---

APPROVAL OF MINUTES OF MAY 17, 2019

Ms. Hickey moved to approve the meeting minutes of May 17, 2019 as presented. The motion was seconded and carried unanimously.

ADOPTION OF AGENDA

Dr. Miller moved to accept the agenda as presented. The motion was seconded and carried unanimously.

PUBLIC COMMENT

- Ken Olshansky, MD – spoke in favor of banning conversion therapy
- Casey Pick – spoke in favor of banning conversion therapy
- Adam Trimmer – spoke in favor of banning conversion therapy
- Vee Lamneck – spoke in favor of banning conversion therapy
- Tom Intorcio – spoke against banning conversion therapy

DHP DIRECTOR'S REPORT

Dr. Brown informed the members that the agency has transitioned to a new website and individual boards will be moving to it soon. He also reported that, at the request of the General Assembly, two work groups were formed and had recently met. The first, led by Dr. Brown, reviewed the laws, regulations, and other parameters concerning telemedicine in Virginia. The second, led by Dr. Allison-Bryan, identified the barriers to licensure for international medical graduates (IMG's).

Dr. Allison-Bryan said that Virginia had already done well by IMG's with the Board's leveling of the playing field in 2017. The Board now requires 1 year of postgraduate training for all medical graduates. Her report is due this fall and will reflect that Virginia has been a leader in facilitating the licensure of IMG's. She added that IMG's now represent 25% of the physicians practicing in the Commonwealth.

EXECUTIVE DIRECTOR'S REPORT

Dr. Harp introduced Michael Sobowale as the new Deputy Executive Director for Licensing at the Board. Mr. Sobowale said he appreciated the greetings of the Committee members and is pleased to be part of the Virginia Board of Medicine.

NEW BUSINESS

1. Chart of Regulatory Actions

Ms. Yeatts reviewed the Board's regulatory activity as of August 22nd.
This report was for informational purposes only and did not require any action.

---DRAFT UNAPPROVED---

2. Committee Recommendation on Retiree License

Ms. Yeatts briefly reviewed the legislation passed by the General Assembly requiring the Board to create a "retiree" license.

She pointed out that this license would allow a practitioner to provide charity care and health care to patients in their residences, for whom travel is a barrier to receiving care.

The question, "what problem are we trying to solve by creating this license?" was asked and discussed.

Ms. Yeatts said that the patron of the bill is of the opinion that there are untapped medical resources in the community that could enhance access to care. He believes that physicians who are retired from full-time practice, but want to remain engaged in medicine and be helpful, could add to community resources. Ms. Yeatts also stated that the patron was made aware of the existing temporary licenses issued by the Board, but he did not think they met the intent of his bill.

Some of the concerns discussed at length by the members were:

- the confusion between the existing temporary licenses and restricted licenses.
- the exemption from civil liability of the retiree license.
- how is retiree defined; by age or number of years in practice?
- the appearance that the Board is lowering the standard of care to patients that are housebound.

Dr. Conklin spoke to the concern about the exemption from civil liability. She suggested that the Committee's recommendation to the Full Board require those practicing on a retiree license for compensation to carry their own medical malpractice.

Ms. Deschenes pointed out that practitioners in the Commonwealth of Virginia are not currently required under law to carry medical malpractice insurance. Additionally, she noted that the way the statute is written suggests that the volunteer retiree license would only authorize charity care provided to homebound patients with restricted travel limitations. Ms. Deschenes point out that the statute uses an "and" to link "charity care" and "health care services to patients in their residence." The statute does not appear to be written to say charity care or home health services for reimbursement, although that is one interpretation that is being considered.

Ms. Barrett commented that the Board could interpret the statute to read as an "or". She will carefully review it and provide a report at the October Board meeting.

Ms. Yeatts suggested that, after Ms. Barrett's report, the Board consider developing a guidance document to list and explain all the licenses with restrictions to clear up any confusion.

Ms. Hickey said that with the population aging and a shortage of physicians, she can see a need for this license. She added that the practitioner would still need to meet the standard of care expected by the Board.

MOTION: After more discussion, Ms. Hickey moved to recommend to the Full Board that a Notice of Intended Regulatory Action on the issuance of a retiree license be adopted. The motion was seconded; the vote was 2-2. The motion and vote will be noted for the October Full Board.

3. Results of the Mixing, Diluting, or Reconstituting (MDR) Audit

Dr. Harp advised that, in late 2018, an audit was begun on 60 practitioners who indicated during the renewal process that they perform MDR of drugs for administration in their practice.

Dr. Harp noted that the audit was not complaint-based. DATA was asked to randomly select 15 physicians from each of the 4 Enforcement regions and achieve the broadest representation of specialties as possible. All told, 61 physicians were audited.

He said the first MDR audit of 44 physicians in 2011-2012 found most compliant with the requirements of the regulations. Those found non-compliant were sent advisory letters.

Dr. Harp reviewed the current audit form, the results of the 2018-2019 audit, and offered options to resolve the matter with those practitioners who were not in total compliance.

MOTION: After discussion, Ms. Hickey moved to send an advisory letter to each practitioner who was non-compliant, to publish the results of the audit in the newsletter, and for those with more than three violations, to conduct a follow-up audit in six months. The motion was not seconded.

MOTION: After additional discussion, Ms. Hickey moved that the results of the audit be published in the newsletter with a link to the regulations, the 30 physicians found to be non-complaint be sent an advisory letter, and that those with more than one violation be subject to a follow-up audit in six months. The motion was seconded, and the floor re-opened for discussion.

Dr. Giammittorio asked who judges the severity of the complaint.

Dr. Brown made the suggestion that, rather than trying to stratify who would be re-audited, the Committee could vote to send an advisory letter to all, or re-audit all those who were non-compliant.

MOTION: After more discussion, Dr. Giammittorio amended the motion on the floor. He moved that an advisory letter be sent to all the practitioners found to be non-compliant. The motion was properly seconded and carried unanimously.

Dr. Conklin called for a break at 10:11 a.m.; the meeting reconvened at 10:31 a.m.

---DRAFT UNAPPROVED---

4. Conversion Therapy

Ms. Yeatts provided the following staff note:

On October 5, 2018, the Department of Health Professions convened a Conversion Therapy Workgroup. Included were representatives from the Board of Social Work, Board of Nursing, Board of Medicine, Board of Counseling, Board of Psychology, House of Delegates, DHP staff and others. The workgroup heard testimony from the public, reviewed relevant documents, and discussed the issues thoroughly. It was determined that it would be up to the individual boards to decide whether they wanted to develop a guidance document or promulgate regulations.

Ms. Yeatts then pointed to the minutes of the October 2018 meeting, the proposed guidance document for the Board of Psychology, draft regulations for the Board of Counseling, and the position statements/publications from the American Psychiatric Association, American Academy of Child and Adolescent Psychiatry, American Academy of Pediatrics, American Medical Association, and SAMHSA.

MOTION: After some discussion, Ms. Hickey moved to recommend to the Full Board the development of a guidance document and to publish a Notice of Intended Regulatory Action to promulgate regulations. The motion was properly seconded and carried unanimously.

5. Veterans Administration (VA) Proposed Regulations to Increase Access of Telehealth to its Veterans

Dr. Harp informed the members that current federal regulation, 38 CFR 17.417, authorizes a Veterans Administration health care provider to practice telehealth in any location and within any state in which the provider or patient is physically located.

The VA is proposing to amend current regulation to include all health care professionals, including trainees, as telehealth providers. The health care professional will be held to VA policies and standards of care rather than those of the states.

Dr. Harp said that the Federation of State Medical Boards (FSMB) is asking for comment about the impact of the proposed regulations on Board processes.

MOTION: After some discussion, Ms. Hickey moved to recommend that, as a response to FSMB, PGY-1 residents be excluded as telemedicine providers in the proposed regulations. The motion was properly seconded and carried unanimously.

6. Proposed Meeting Date Change and Reminder

Ms. Opher stated that the original date of January 17, 2020 was set prior to the distribution of the state's calendar which shows January 17th will be a holiday. The new date of January 31st was proposed as an alternate date.

The Committee agreed to the new date.

---DRAFT UNAPPROVED---

ANNOUNCEMENTS

Committee members were reminded to stay for probable cause review

NEXT MEETING

January 30, 2020

ADJOURNEMENT

With no other business to conduct, the meeting adjourned at 11:05 a.m.

Lori Conklin, MD
Vice-President, Chair

William L. Harp, MD
Executive Director

Colanthia Morton Opher
Recording Secretary

---DRAFT UNAPPROVED---

VIRGINIA BOARD OF MEDICINE
SPECIAL CONFERENCE COMMITTEE MINUTES SEPTEMBER 25, 2019
Department of Health Professions
Perimeter Center
9960 Mayland Drive, Suite 201
Henrico, VA

Wednesday, September 25, 2019 Department of Health Professions Henrico, VA

CALL TO ORDER: A special conference committee meeting of the Board was called to order at 9:01 a.m.

MEMBERS PRESENT: James Arnold, D.P.M., Chair
Brenda Stokes, M.D.
Martha Wingfield

STAFF PRESENT: William Harp, Executive Director
Michael Sobowale, LL.M., Deputy Executive Director
Deborah J. Greenberg, J.D., LL.M., Adjudication Specialist, APD

OTHERS PRESENT: Lawrence Katz (Witness of Dr. Wentt)

MATTER: **Allan Wentt, M.D.** **License No.: 0101-232617**
Case No.: 195583

Dr. Arnold provided the emergency egress instructions prior to proceeding with the informal conference.

DISCUSSION: Dr. Wentt appeared before the committee in person in accordance with a Notice of the Board dated August 6, 2019 to respond to the Board's inquiry regarding the possible refusal to reinstate his license to practice as a medical doctor pursuant to Virginia Code Sections § § 54.1-2915(A)(4) and (14). Dr. Wentt appeared without counsel. Mr. Lawrence Katz appeared as a witness for Dr. Wentt.

The committee fully discussed the allegations in the Notice with Dr. Wentt.

CLOSED SESSION: Upon conclusion of the open session with Dr. Wentt, Dr. Arnold moved to convene a closed session pursuant to section §2.2-3711.A (15) of the Code of Virginia, for the purpose of consideration and discussion of medical and mental health records of Dr. Wentt.

Additionally, he moved that Dr. Harp and Mr. Sobowale attend the closed meeting because their presence in the closed meeting was deemed necessary and would aid the Committee in its deliberations. The motion was duly seconded by Martha Wingfield and carried.

RECONVENE: Having certified that the matters discussed in the preceding closed session met the requirements of Virginia Code Section 2.2-3712, upon a motion by Dr. Arnold, the Committee passed the motion by a voice vote, to re-convene in open session and continue its discussion with Dr. Wentt regarding the allegations.

CLOSED SESSION: Upon a motion by Dr. Stokes, and duly seconded by Martha Wingfield, the Committee voted to convene a closed meeting pursuant to §2.2-3711.A (27) of the Code of Virginia, for the purpose of deliberation to reach a decision in the matter of Dr. Wentt. Additionally, she moved that Dr. Harp and Mr. Sobowale attend the closed meeting because their presence in the closed meeting was deemed necessary and would aid the Committee in its deliberations.

RECONVENE: Having certified that the matters discussed in the preceding closed session met the requirements of Virginia Code Section 2.2-3712, the Committee re-convened in open session and announced its decision.

DECISION: Upon a motion by Dr. Stokes, and duly seconded by Martha Wingfield, the committee made certain findings of fact and conclusions of law and voted unanimously to deny Dr. Wentt's application for reinstatement of licensure to practice medicine.

ADJOURNMENT: The Committee adjourned at 11:03 a.m.

James Arnold, D.P.M., Chair

William L. Harp, M.D., Executive Director

Date

Date

----DRAFT UNAPPROVED---

VIRGINIA BOARD OF MEDICINE
SPECIAL CONFERENCE COMMITTEE MINUTES SEPTEMBER 25, 2019
Department of Health Professions
Perimeter Center
9960 Mayland Drive, Suite 201
Henrico, VA

Wednesday, September 25, 2019 Department of Health Professions Henrico, VA

CALL TO ORDER: A special conference committee meeting of the Board was called to order at 1:00 p.m.

MEMBERS PRESENT: James Arnold, D.P.M., Chair
Brenda Stokes, M.D.
Martha Wingfield

STAFF PRESENT: William Harp, Executive Director
Michael Sobowale, LL.M., Deputy Executive Director, Licensure
Shevaun Roukos, Adjudication Specialist, APD

MATTER: **Peter Greene, M.D.**
Case No.: 190948

Dr. Arnold provided the emergency egress instructions prior to proceeding with the informal conference.

DISCUSSION: Dr. Greene appeared before the committee in person in accordance with a Notice of the Board dated August 6, 2019 to respond to the Board's inquiry regarding the possible refusal to issue a license to practice as a medical doctor pursuant to Virginia Code Section 54.1-2915(A)(5). Dr. Greene appeared without counsel.

The committee fully discussed the allegations in the Notice with Dr. Greene.

CLOSED SESSION: Upon conclusion of the open session with Dr. Greene, Dr. Stokes moved to convene a closed session pursuant to section §2.2-3711.A (27) of the Code of Virginia, for the

purpose of deliberation to reach a decision in the matter of Dr. Greene. Additionally, she moved that Dr. Harp and Mr. Sobowale attend the closed meeting because their presence in the closed meeting was deemed necessary and would aid the Committee in its deliberations. The motion was duly seconded by Martha Wingfield. Motion carried.

RECONVENE: Having certified that the matters discussed in the preceding closed session met the requirements of Virginia Code Section §2.2-3712, the Committee re-convened in open session and announced its decision.

DECISION: Upon a motion by Dr. Stokes, and duly seconded by Martha Wingfield, the committee made certain findings of fact and conclusions of law and voted unanimously to approve Dr. Greene's application for licensure to practice medicine and subject his license to terms and conditions.

ADJOURNMENT: The Committee adjourned at 2:17 p.m.

As provided by law this decision shall become a Final Order thirty (30) days after service of such Order on Dr. Greene, unless a written request to the Board for a formal hearing on the allegations made against him is received from Dr. Greene, within such a time. If service of the Order is made by mail three (3) additional days shall be added to that period. Upon such timely request for a formal hearing, the decision of the Special Conference Committee shall be vacated.

James Arnold, D.P.M., Chair

William L. Harp, M.D., Executive Director

Date

Date

---DRAFT APPROVED---

VIRGINIA BOARD OF MEDICINE
NOMINATING COMMITTEE MEETING MINUTES
Hearing Room 5

Thursday, June 13, 2019 @ 7:45 a.m. Perimeter Center 9960 Mayland Drive, Henrico

CALL TO ORDER Ken Walker, MD, Chair, called the meeting to order at 7:54 AM.

ROLL CALL

MEMBERS PRESENT Ken Walker, MD
Syed Ali, MD

MEMBERS ABSENT Martha Wingfield

NEW BUSINESS

1. Candidates for President

Ray Tuck, DC was the only candidate for President. He represented that he had finished his term as President of the American Chiropractic Association and would be able to give the time needed to the duties of the office. He indicated that he had a large practice and chiefly provided leadership for his team of professionals and was doing a little less clinical chiropractic.

2. Candidates for Vice-President

Lori Conklin, MD was the only candidate for Vice-President. She indicated that she would have more time now for duties at the Board. She said she would be available to stand in for the President when he was out of contact.

3. Candidates for Secretary-Treasurer

David Archer, MD indicated that he would like to serve and lend his experience to the efforts of the Board. Dr. Archer asked good questions about the processes of the Board.

Blanton Marchese provided the Committee with his medical experience over the decades, his interest in the Board and FSMB, and his license application review.

After the Committee had heard from all the candidates, it unanimously agreed to the following slate: President-Ray Tuck; Vice-President-Lori Conklin; Secretary-Treasurer-Blanton Marchese.

The meeting adjourned at 8:28 AM.

Kenneth Walker, MD, Chair

William L. Harp, MD, Executive Director

Agenda Item: **Other Reports**

- Assistant Attorney General*
- Board of Health Professions
- Podiatry Report*
- Chiropractic Report*
- Committee of the Joint Boards of Nursing and Medicine

Staff Note: *Reports will be given orally at the meeting

Action: These reports are for information only. No action needed unless requested by presenter.

Virginia Department of
Health Professions
Board of Health Professions

Board of Health Professions
Full Board Meeting
August 20, 2019 at 10:00 a.m.
Board Room 4
9960 Mayland Dr, Henrico, VA 23233
DRAFT

In Attendance	Sahil Chaudhary, Citizen Member Helene Clayton-Jeter, OD, Board of Optometry Kevin Doyle, EdD, LPC, LSATP, Board of Counseling Mark Johnson, DVM, Board of Veterinary Medicine Allen Jones, Jr., DPT, PT, Board of Physical Therapy Louis Jones, FSL, Board of Funeral Directors and Embalmers Derrick Kendall, NHA, Board of Long-Term Care Administrators Maribel Ramos, Citizen Member John Salay, MSW, LCSW, Board of Social Work Herb Stewart, PhD, Board of Psychology James Watkins, DDS, Board of Dentistry James Wells, RPh, Citizen Member
Absent	Alison King, PhD, CCC-SLP, Board of Audiology & Speech-Language Pathology Ryan Logan, RPh, Board of Pharmacy Kevin O'Connor, MD, Board of Medicine Martha Rackets, PhD, Citizen Member Vacant - Board of Nursing Vacant - Citizen Member
DHP Staff	David Brown, DC, Director DHP Elizabeth A. Carter, PhD, Executive Director BHP Laura Jackson, MSHSA, Operations Manager BHP Charis Mitchell, Assistant Attorney General Rajana Siva, MBA, Research Analyst BHP Elaine Yeatts, Senior Policy Analyst DHP
Speakers	Shelby Reynolds, Virginia State Task Force for Music Therapy
Observers	Jerry Gentile, DPB Ben Traynham, Hancock Daniel Kaycee Ensigy, Medical Society of Virginia
Emergency Egress	Elizabeth Carter, PhD
Call to Order	Dr. Jones, Jr. Time: 10:00 a.m. Quorum: Established
Public Comment	Dr. Jones, Jr. Shelby Reynolds with the Virginia State Task Force for Music Therapy thanked the Board for their time and advised that she was available to answer any questions that the Board may have in regard to the Music Therapy study.

Approval of Minutes
Motion

Dr. Jones, Jr.
Discussion: A motion to accept meeting minutes from the May 14, 2019 Full Board was made and properly seconded. All members were in favor, none opposed.

Director's Report

Dr. Brown
Dr. Brown announced that agency Board Member Training will be held October 7, 2019. The Agency will be bringing in guest speakers to discuss specific topics, such as FOIA. He asked that each board member relay this information at their next board meeting.

The Agency's website redesign is allowing for a more user friendly approach for applicants, consumers and DHP staff. He stated that the software being used allows for easier and quicker updates to each boards webpage. He requested that each board member take a look at the website and provide feedback on what they feel is working or should be changed.

The Council on Licensure, Enforcement and Regulation (CLEAR) is an organization designed to help those in professional regulation have access to resources. At the annual CLEAR meeting in September, DHP's research and analysis into the workload of the Enforcement Division staff will be presented by DHP's Enforcement Director Ms. Schmitz and Visual Research, Inc. President Neal Kauder.

DHP is working diligently to utilize our workforce data to inform the public of what the agency does. One example is the research describing how physical therapy assistants are now being utilized to assist individuals with pain management, decreasing the need for opioid prescriptions.

Reordering of Agenda
Motion

Dr. Jones, Jr. requested a reordering of the agenda. The motion to reorder the agenda was made and properly seconded.

Legislative and Regulatory Report

Ms. Yeatts

Ms. Yeatts requested board member introductions.

Ms. Yeatts provided a brief overview of the regulations provided in the meeting packet. Also provided was a handout (Attachment 1) with information regarding a bill to amend 54.1-2405, relating notification to patients of a practitioner closure, sale or relocation of professional practice.

Motion

After board discussion a motion was made and properly seconded to change the existing language in 54.1-2405 to include the language "either electronically or" to the code. All members were in favor, none opposed.

Board Chair Report

Dr. Jones, Jr. provided Dr. Clayton-Jeter with a plaque thanking her for her service as previous board Chair.

Dr. Jones, Jr. also passed out Department of Health Professions lapel pins to each board member.

Individual Board Reports	Board of Veterinary Medicine - Dr. Johnson (Attachment 2) Board of Dentistry - Dr. Watkins (Attachment 3) Board of Optometry - Dr. Clayton-Jeter (Attachment 4) Board of Psychology - Dr. Stewart (Attachment 5) Board of Long - Term Care Administrators - Mr. Kendall (Attachment 6) Board of Counseling - Dr. Doyle (Attachment 7) Board of Physical Therapy - Dr. Jones, Jr. (Attachment 8) Board of Audiology & Speech Language Pathology - Dr. Carter (Attachment 9) Board of Funeral Directors and Embalmers - Mr. Jones (Attachment 10) Board of Social Work - Mr. Salay (Attachment 11)
Committee Reports	Mr. Wells provided details regarding the Regulatory Research Committee's study review of the need to license music therapists in Virginia. Mr. Wells advised the Board that the Committee's final recommendation was for licensure of music therapists, with the best placement being under the Board of Counseling.
Motion	A motion for licensure of music therapists in Virginia, to be placed under the Board of Counseling, was made and properly seconded. 10 members were in favor, one abstained and one opposed. Dr. Carter advised of next steps as noted in the music therapist study work plan.
Break	Dr. Jones, Jr. requested a brief break at 11:04 a.m.
Reconvene	Dr. Jones, Jr. reconvened the meeting at 11:11 a.m.
Executive Director's Report	Dr. Carter reviewed the Board's budget and provided insight into the agencies statistics and performance. Dr. Carter has requested Charles Giles, DHP Budget Manager, to provide an update of the Agency's finances at the November 4, 2019 meeting. Dr. Carter also requested that a workgroup meet to discuss the Board's update to its Mission Statement. Communications Director, Ms. Powers, will be aiding the workgroup. Dr. Jones, Jr. will appoint members who will meet in person prior to the November 4, 2019 full board meeting.
Healthcare Workforce Data Center	Dr. Carter provided a PowerPoint presentation on the Healthcare Workforce Data Center. (Attachment 12) Dr. Clayton-Jeter requested that Optometry workforce information be shared with out of state schools of Optometry as there are currently no schools in Virginia.
New Business	Agenda item for November 4, 2019 meeting: Discussion of other states' approaches to placement of professions within regulatory boards and agencies. Dr. Carter will provide a briefing on these approaches.

Agenda item for November 4, 2019 meeting: Discussion of the existing telehealth/telemedicine guidance documents from the respective boards.

Dr. Jones, Jr. appointed Dr. Clayton-Jeter and Mr. Salay to the Nominating Committee. The Committee will meet prior to the November 4, 2019 Full Board meeting to provide a slate of officers for the Fall election for Chair and Vice Chair.

Next Meeting Dr. Jones, Jr. advised the Board that the next meeting is scheduled for November 4, 2019 at 10:00 a.m.

Meeting Adjourned 12:23 p.m.

Chair Allen Jones, Jr., DPT, PT

Signature _____ ____/____/____

Board Executive Director Elizabeth A. Carter, PhD

Signature _____ ____/____/____

Agenda Item: Regulatory Actions - Chart of Regulatory Actions

As of October 2, 2019

Chapter		Action / Stage Information
[18 VAC 85 - 20]	Regulations Governing the Practice of Medicine, Osteopathic Medicine, Podiatry, and Chiropractic	Result of periodic review [Action 5167] Fast-Track - *Register Date: 7/22/19* *Effective: 9/6/19*
[18 VAC 85 - 20]	Regulations Governing the Practice of Medicine, Osteopathic Medicine, Podiatry, and Chiropractic	Addition of American Board of Podiatric Medicine [Action 5316] Fast-Track - *Register Date: 9/16/19* *Effective: 11/1/19*
[18 VAC 85 - 20]	Regulations Governing the Practice of Medicine, Osteopathic Medicine, Podiatry, and Chiropractic	(E) Renewal fee reduction [Action 5353] Final - *Register Date: 9/2/19* *Effective: 10/2/19*
[18 VAC 85 - 21]	Regulations Governing Prescribing of Opioids and Buprenorphine	Waiver for e-prescribing of an opioid [Action 5355] Emergency/NOIRA - *Register Date: 9/30/19* *Effective: 9/18/19 to 3/17/21* *Comment on NOIRA: 9/30 – 10/30*
[18 VAC 85 - 50]	Regulations Governing the Practice of Physician Assistants	Practice with patient care team physician [Action 5357] Emergency/NOIRA - *Register Date: 10/14/19* *Effective: 10/1/19 to 3/31/21* *Comment on NOIRA: 10/14 – 11/13*
[18 VAC 85 - 50]	Regulations Governing the Practice of Physician Assistants	(E) Licensure by endorsement for spouses of military [Action 5356] Final - *Register Date: 9/2/19* *Effective: 10/2/19*

Board action: Amendment to fee for returned checks

Included in agenda package:

Applicable sections of the Code of Virginia

Revised Fee section

Staff note:

Auditors from the Office of the Comptroller have advised DHP that we should be charging $50 for a returned check, rather than the current $35. That amount was based on language in § 2.2-614.1. However, § 2.2-4805 (from the Va. Debt Collection Act) requires the fee for a returned check to be $50.

Board counsel for DHP boards has advised that the handling fee of $50 in Virginia Code 2.2-4805 governs. Section 2.2-614.1 states that a "penalty of $35 or the amount of any costs, **whichever is greater**," shall be imposed. By amending § 2.2-4805 in 2009, the General Assembly determined that the costs, in the form of a "handling fee," is $50, and thus greater than the $35 penalty imposed under 2.2-614.1.

Therefore, all board regulations will need to be amended to reflect the higher "handling" fee.

Code of Virginia
Title 2.2. Administration of Government
Chapter 48. Virginia Debt Collection Act

§ 2.2-4805. Interest, administrative charges and penalty fees

A. Each state agency and institution may charge interest on all past due accounts receivable in accordance with guidelines adopted by the Department of Accounts. Each past due accounts receivable may also be charged an additional amount that shall approximate the administrative costs arising under § 2.2-4806. Agencies and institutions may also assess late penalty fees, not in excess of ten percent of the past-due account on past-due accounts receivable. The Department of Accounts shall adopt regulations concerning the imposition of administrative charges and late penalty fees.

B. Failure to pay in full at the time goods, services, or treatment are rendered by the Commonwealth or when billed for a debt owed to any agency of the Commonwealth shall result in the imposition of interest at the judgment rate as provided in § 6.2-302 on the unpaid balance unless a higher interest rate is authorized by contract with the debtor or provided otherwise by statute. Interest shall begin to accrue on the 60th day after the date of the initial written demand for payment. A public institution of higher education in the Commonwealth may elect to impose a late fee in addition to, or in lieu of, interest for such time as the institution retains the claim pursuant to subsection D of § 2.2-4806. Returned checks or dishonored credit card or debit card payments shall incur a handling fee of $50 unless a higher amount is authorized by statute to be added to the principal account balance.

C. If the matter is referred for collection to the Division, the debtor shall be liable for reasonable attorney fees unless higher attorney fees are authorized by contract with the debtor.

D. A request for or acceptance of goods or services from the Commonwealth, including medical treatment, shall be deemed to be acceptance of the terms specified in this section.

1988, c. 544, § 2.1-732; 2001, c. 844;2009, c. 797.

The chapters of the acts of assembly referenced in the historical citation at the end of this section may not constitute a comprehensive list of such chapters and may exclude chapters whose provisions have expired.

Code of Virginia
Title 2.2. Administration of Government
Chapter 6. General Provisions

§ 2.2-614.1. Authority to accept revenue by commercially acceptable means; service charge; bad check charge.

A. Subject to § 19.2-353.3, any public body that is responsible for revenue collection, including, but not limited to, taxes, interest, penalties, fees, fines or other charges, may accept payment of any amount due by any commercially acceptable means, including, but not limited to, checks, credit cards, debit cards, and electronic funds transfers.

B. The public body may add to any amount due a sum, not to exceed the amount charged to that public body for acceptance of any payment by a means that incurs a charge to that public body or the amount negotiated and agreed to in a contract with that public body, whichever is less. Any state agency imposing such additional charges shall waive them when the use of these means of payment reduces processing costs and losses due to bad checks or other receivable costs by an amount equal to or greater than the amount of such additional charges.

C. If any check or other means of payment tendered to a public body in the course of its duties is not paid by the financial institution on which it is drawn, because of insufficient funds in the account of the drawer, no account is in the name of the drawer, or the account of the drawer is closed, and the check or other means of payment is returned to the public body unpaid, the amount thereof shall be charged to the person on whose account it was received, and his liability and that of his sureties, shall be as if he had never offered any such payment. A penalty of $35 or the amount of any costs, whichever is greater, shall be added to such amount. This penalty shall be in addition to any other penalty provided by law, except the penalty imposed by § 58.1-12 shall not apply.

2002, c. 719; 2004, c. 565.

go back | open in word

Project 6175 - none

BOARD OF MEDICINE

Handling fee

18VAC85-20-22. Required fees.

A. Unless otherwise provided, fees established by the board shall not be refundable.

B. All examination fees shall be determined by and made payable as designated by the board.

C. The application fee for licensure in medicine, osteopathic medicine, and podiatry shall be $302, and the fee for licensure in chiropractic shall be $277.

D. The fee for a temporary authorization to practice medicine pursuant to clauses (i) and (ii) of § 54.1-2927 B of the Code of Virginia shall be $25.

E. The application fee for a limited professorial or fellow license issued pursuant to 18VAC85-20-210 shall be $55. The annual renewal fee shall be $35. For renewal of a limited professorial or fellow license in 2018, the fee shall be $30. An additional fee for late renewal of licensure shall be $15.

F. The application fee for a limited license to interns and residents pursuant to 18VAC85-20-220 shall be $55. The annual renewal fee shall be $35. For renewal of a limited license to interns and residents in 2018, the fee shall be $30. An additional fee for late renewal of licensure shall be $15.

G. The fee for a duplicate wall certificate shall be $15; the fee for a duplicate license shall be $5.00.

H. The fee for biennial renewal shall be $337 for licensure in medicine, osteopathic medicine, and podiatry and $312 for licensure in chiropractic, due in each even-numbered year in the licensee's birth month. An additional fee for processing a late renewal application within one renewal cycle shall be $115 for licensure in medicine, osteopathic medicine, and podiatry and $105 for licensure in chiropractic. For renewal of licensure in 2018, the fee shall be $270 for licensure in medicine, osteopathic medicine, and podiatry and $250 for licensure in chiropractic.

I. The fee for requesting reinstatement of licensure or certification pursuant to § 54.1-2408.2 of the Code of Virginia or for requesting reinstatement after any petition to reinstate the certificate or license of any person has been denied shall be $2,000.

J. The fee for reinstatement of a license issued by the Board of Medicine pursuant to § 54.1-2904 of the Code of Virginia that has expired for a period of two years or more shall be $497 for licensure in medicine, osteopathic medicine, and podiatry ($382 for reinstatement application in addition to the late fee of $115) and $472 for licensure in chiropractic ($367 for reinstatement application in addition to the late fee of $105). The fee shall be submitted with an application for licensure reinstatement.

K. The fee for a letter of verification of licensure shall be $10, and the fee for certification of grades to another jurisdiction by the board shall be $25.

L. The fee for biennial renewal of an inactive license shall be $168, due in the licensee's birth month. An additional fee for late renewal of licensure shall be $55 for each renewal cycle.

M. The fee for an application or for the biennial renewal of a restricted volunteer license shall be $75, due in the licensee's birth month. An additional fee for late renewal of licensure shall be $25 for each renewal cycle. For renewal of a restricted volunteer license in 2018, the fee shall be $65.

N. The handling fee for a returned check or a dishonored credit card or debit card shall be ~~$35~~ $50.

18VAC85-40-35. Fees.

The following fees are required:

1. The application fee, payable at the time the application is filed, shall be $130.

2. The biennial fee for renewal of active licensure shall be $135 and for renewal of inactive licensure shall be $70, payable in each odd-numbered year in the license holder's birth month. For 2019, the fee for renewal of an active license shall be $108, and the fee for renewal of an inactive license shall be $54.

3. The additional fee for late renewal of licensure within one renewal cycle shall be $50.

4. The fee for reinstatement of a license issued by the Board of Medicine pursuant to § 54.1-2904 of the Code of Virginia, which has lapsed for a period of two years or more, shall be $180 and must be submitted with an application for licensure reinstatement.

5. The fee for reinstatement of a license pursuant to § 54.1-2408.2 of the Code of Virginia shall be $2,000.

6. The fee for a duplicate license shall be $5.00, and the fee for a duplicate wall certificate shall be $15.

7. The handling fee for a returned check or a dishonored credit card or debit card shall be ~~$35~~ $50.

8. The fee for a letter of good standing or verification to another jurisdiction shall be $10; the fee for certification of grades to another jurisdiction shall be $25.

9. The fee for an application or for the biennial renewal of a restricted volunteer license shall be $35, due in the licensee's birth month. An additional fee for late renewal of licensure shall be $15 for each renewal cycle.

18VAC85-50-35. Fees.

Unless otherwise provided, the following fees shall not be refundable:

1. The initial application fee for a license, payable at the time application is filed, shall be $130.

2. The biennial fee for renewal of an active license shall be $135 and for renewal of an inactive license shall be $70, payable in each odd-numbered year in the birth month of the licensee. For 2019, the fee for renewal of an active license shall be $108, and the fee for renewal of an inactive license shall be $54.

3. The additional fee for late renewal of licensure within one renewal cycle shall be $50.

4. A restricted volunteer license shall expire 12 months from the date of issuance and may be renewed without charge by receipt of a renewal application that verifies that the physician assistant continues to comply with provisions of § 54.1-2951.3 of the Code of Virginia.

5. The fee for review and approval of a new protocol submitted following initial licensure shall be $15.

6. The fee for reinstatement of a license pursuant to § 54.1-2408.2 of the Code of Virginia shall be $2,000.

7. The fee for a duplicate license shall be $5.00, and the fee for a duplicate wall certificate shall be $15.

8. The handling fee for a returned check or a dishonored credit card or debit card shall be ~~$35~~ $50.

9. The fee for a letter of good standing or verification to another jurisdiction shall be $10.

10. The fee for an application or for the biennial renewal of a restricted volunteer license shall be $35, due in the licensee's birth month. An additional fee for late renewal of licensure shall be $15 for each renewal cycle.

18VAC85-80-26. Fees.

A. The following fees have been established by the board:

1. The initial fee for the occupational therapist license shall be $130; for the occupational therapy assistant, it shall be $70.

2. The fee for reinstatement of the occupational therapist license that has been lapsed for two years or more shall be $180; for the occupational therapy assistant, it shall be $90.

3. The fee for active license renewal for an occupational therapist shall be $135; for an occupational therapy assistant, it shall be $70. The fees for inactive license renewal shall be $70 for an occupational therapist and $35 for an occupational therapy assistant. Renewals shall be due in the birth month of the licensee in each even-numbered year. For 2018, the fee for renewal of an active license as an occupational therapist shall be $108; for an occupational therapy assistant, it shall be $54. For renewal of an inactive license in 2018, the fees shall be $54 for an occupational therapist and $28 for an occupational therapy assistant.

4. The additional fee for processing a late renewal application within one renewal cycle shall be $50 for an occupational therapist and $30 for an occupational therapy assistant.

5. The fee for a letter of good standing or verification to another jurisdiction for a license shall be $10.

6. The fee for reinstatement of licensure pursuant to § 54.1-2408.2 of the Code of Virginia shall be $2,000.

7. The handling fee for a returned check or a dishonored credit card or debit card shall be ~~$35~~ $50.

8. The fee for a duplicate license shall be $5.00, and the fee for a duplicate wall certificate shall be $15.

9. The fee for an application or for the biennial renewal of a restricted volunteer license shall be $35, due in the licensee's birth month. An additional fee for late renewal of licensure shall be $15 for each renewal cycle.

B. Unless otherwise provided, fees established by the board shall not be refundable.

18VAC85-101-25. Fees.

A. Unless otherwise provided, fees listed in this section shall not be refundable.

B. Initial licensure fees.

1. The application fee for radiologic technologist or radiologist assistant licensure shall be $130.

2. The application fee for the radiologic technologist-limited licensure shall be $90.

3. All examination fees shall be determined by and made payable as designated by the board.

C. Licensure renewal and reinstatement for a radiologic technologist or a radiologist assistant.

1. The fee for active license renewal for a radiologic technologist shall be $135, and the fee for inactive license renewal shall be $70. For 2019, the fees for renewal shall be $108 for an active license as a radiologic technologist and $54 for an inactive license. If a radiologist assistant holds a current license as a radiologic technologist, the renewal fee shall be $50. If a radiologist assistant does not hold a current license as a radiologic technologist, the renewal fee shall be $150. For renewal of a radiologist assistant license in 2019, the fee shall be $40 for a radiologist assistant with a current license as a radiologic technologist and $120 for a radiologist assistant without a current license as a radiologic technologist.

2. An additional fee of $50 to cover administrative costs for processing a late renewal application within one renewal cycle shall be imposed by the board.

3. The fee for reinstatement of a radiologic technologist or a radiologist assistant license that has lapsed for a period of two years or more shall be $180 and shall be submitted with an application for licensure reinstatement.

4. The fee for reinstatement of a license pursuant to § 54.1-2408.2 of the Code of Virginia shall be $2,000.

D. Licensure renewal and reinstatement for a radiologic technologist-limited.

1. The fee for active license renewal shall be $70, and the fee for inactive license renewal shall be $35. For 2019, the fees for renewal shall be $54 for an active license as a radiologic technologist and $28 for an inactive license.

2. An additional fee of $25 to cover administrative costs for processing a late renewal application within one renewal cycle shall be imposed by the board.

3. The fee for reinstatement of a license that has lapsed for a period of two years or more shall be $120 and shall be submitted with an application for licensure reinstatement.

4. The fee for reinstatement of a license pursuant to § 54.1-2408.2 of the Code of Virginia shall be $2,000.

E. Other fees.

1. The application fee for a traineeship as a radiologic technologist or a radiologic technologist-limited shall be $25.

2. The fee for a letter of good standing or verification to another state for licensure shall be $10; the fee for certification of scores to another jurisdiction shall be $25.

3. The handling fee for a returned check or a dishonored credit card or debit card shall be ~~$35~~ $50.

4. The fee for a duplicate license shall be $5.00, and the fee for a duplicate wall certificate shall be $15.

18VAC85-110-35. Fees.

Unless otherwise provided, the following fees shall not be refundable:

1. The application fee for a license to practice as an acupuncturist shall be $130.

2. The fee for biennial active license renewal shall be $135; the fee for biennial inactive license renewal shall be $70. For 2019, the fee for renewal of an active license shall be $108, and the fee for renewal of an inactive license shall be $54.

3. The additional fee for processing a late renewal within one renewal cycle shall be $50.

4. The fee for reinstatement of a license which has expired for two or more years shall be $180.

5. The fee for a letter of good standing or verification of a license to another jurisdiction shall be $10.

6. The fee for reinstatement of a license pursuant to § 54.1-2408.2 of the Code of Virginia shall be $2,000.

7. The fee for a duplicate wall certificate shall be $15.

8. The fee for a duplicate renewal license shall be $5.00.

9. The handling fee for a returned check or a dishonored credit card or debit card shall be ~~$35~~ $50.

10. The fee for an application or for the biennial renewal of a restricted volunteer license shall be $35, due in the licensee's birth month. An additional fee for late renewal of licensure shall be $15 for each renewal cycle.

18VAC85-120-35. Fees.

A. Unless otherwise provided, fees listed in this section shall not be refundable.

B. The following fees have been adopted by the board:

1. The application fee shall be $130.

2. The fee for renewal of licensure shall be $135 and shall be due in the licensee's birth month, in each odd-numbered year.

3. A fee of $50 for processing a late renewal within one renewal cycle shall be paid in addition to the renewal fee.

4. The fee for reinstatement of a license that has expired for two or more years shall be $180 and shall be submitted with an application for reinstatement.

5. The fee for reinstatement of a license pursuant to § 54.1-2408.2 of the Code of Virginia shall be $2,000.

6. The fee for a duplicate renewal license shall be $5.00, and the fee for a duplicate wall certificate shall be $15.

7. The handling fee for a returned check or a dishonored credit card or debit card shall be ~~$35~~ $50.

8. The fee for a letter of verification to another jurisdiction shall be $10.

9. The fee for an inactive license shall be $70, and the fee for a late renewal shall be $25.

10. For 2019, the fee for renewal of an active license shall be $108, and the fee for renewal of an inactive license shall be $54.

18VAC85-130-30. Fees.

Unless otherwise provided, the following fees shall not be refundable:

1. The application fee for a license to practice as a midwife shall be $277.

2. The fee for biennial active license renewal shall be $312; the additional fee for late renewal of an active license within one renewal cycle shall be $105.

3. The fee for biennial inactive license renewal shall be $168; the additional fee for late renewal of an inactive license within one renewal cycle shall be $55.

4. The fee for reinstatement of a license that has expired for a period of two years or more shall be $367 in addition to the late fee. The fee shall be submitted with an application for licensure reinstatement.

5. The fee for a letter of good standing or verification of a license to another jurisdiction shall be $10.

6. The fee for an application for reinstatement if a license has been revoked or if an application for reinstatement has been previously denied shall be $2,000.

7. The fee for a duplicate wall certificate shall be $15.

8. The fee for a duplicate renewal license shall be $5.00.

9. The handling fee for a returned check or a dishonored credit card or debit card shall be ~~$35~~ $50.

10. For 2019, the fee for renewal of an active license shall be $250, and the fee for renewal of an inactive license shall be $125.

18VAC85-140-40. Fees.

The following fees are required:

1. The application fee, payable at the time the application is filed, shall be $130.

2. The biennial fee for renewal of active licensure shall be $135 and for renewal of inactive licensure shall be $70, payable in each odd-numbered year in the license holder's birth month. For 2019, the renewal fee for an active license shall be $108, and the renewal fee for an inactive license shall be $54.

3. The additional fee for late renewal of licensure within one renewal cycle shall be $50.

4. The fee for reinstatement of a license that has lapsed for a period of two years or more shall be $180 and must be submitted with an application for licensure reinstatement.

5. The fee for reinstatement of a license pursuant to § 54.1-2408.2 of the Code of Virginia shall be $2,000.

6. The fee for a duplicate license shall be $5.00, and the fee for a duplicate wall certificate shall be $15.

7 The handling fee for a returned check or a dishonored credit card or debit card shall be $35 $50.

8. The fee for a letter of good standing or verification to another jurisdiction shall be $10.

18VAC85-150-40. Fees.

A. The following fees have been established by the board:

1. The initial fee for the behavior analyst license shall be $130; for the assistant behavior analyst license, it shall be $70.

2. The fee for reinstatement of the behavior analyst license that has been lapsed for two years or more shall be $180; for the assistant behavior analyst license, it shall be $90.

3. The fee for active license renewal for a behavior analyst shall be $135; for an assistant behavior analyst, it shall be $70. The fees for inactive license renewal shall be $70 for a behavior analyst and $35 for an assistant behavior analyst. Renewals shall be due in the birth month of the licensee in each odd-numbered year. For 2019, the renewal of an active license as a behavior analyst shall be $108, and the renewal fee for an inactive license shall be $54; the renewal fee for an active license as an assistant behavior analyst shall be $54, and the renewal fee for an inactive license shall be $28.

4. The additional fee for processing a late renewal application within one renewal cycle shall be $50 for a behavior analyst and $30 for an assistant behavior analyst.

5. The fee for a letter of good standing or verification to another jurisdiction for a license shall be $10.

6. The fee for reinstatement of licensure pursuant to § 54.1-2408.2 of the Code of Virginia shall be $2,000.

7. The handling fee for a returned check or a dishonored credit card or debit card shall be ~~$35~~ $50.

8. The fee for a duplicate license shall be $5.00, and the fee for a duplicate wall certificate shall be $15.

B. Unless otherwise provided, fees established by the board shall not be refundable.

18VAC85-160-40. Fees.

A. The following fees have been established by the board:

1. The fee for registration as a surgical assistant or surgical technologist shall be $75.

2. The fee for renewal of registration shall be $70. Renewals shall be due in the birth month of the registrant in each even-numbered year. For 2018, the renewal fee shall be $54.

3. The additional fee for processing a late renewal application within one renewal cycle shall be $25.

4. The handling fee for a returned check or a dishonored credit card or debit card shall be ~~$35~~ $50.

B. Unless otherwise provided, fees established by the board are not refundable.

18VAC85-170-40. Fees.

The following fees are required:

1. The application fee for licensure, payable at the time the application is filed, shall be $130.

2. The application fee for a temporary license, payable at the time the application is filed, shall be $50.

3. The biennial fee for renewal of active licensure shall be $135 and for renewal of inactive licensure shall be $70, payable in each odd-numbered year in the license

holder's birth month. For 2019, the renewal fee for an active license shall be $108, and the renewal fee for an inactive license shall be $54.

4. The additional fee for late renewal of licensure within one renewal cycle shall be $50.

5. The fee for reinstatement of a license that has lapsed for a period of two years or more shall be $180 and shall be submitted with an application for licensure reinstatement.

6. The fee for reinstatement of a license pursuant to § 54.1-2408.2 of the Code of Virginia shall be $2,000.

7. The fee for a duplicate license shall be $5.00, and the fee for a duplicate wall certificate shall be $15.

8. The handling fee for a returned check or a dishonored credit card or debit card shall be ~~$35~~ $50.

9. The fee for a letter of good standing or letter of verification to another jurisdiction shall be $10.

Project 6167 - none

BOARDS OF MEDICINE AND NURSING

Handling fees - NP regs

18VAC90-30-50. Fees.

A. Fees required in connection with the licensure of nurse practitioners are:

1. Application	$125
2. Biennial licensure renewal	$80
3. Late renewal	$25
4. Reinstatement of licensure	$150
5. Verification of licensure to another jurisdiction	$35
6. Duplicate license	$15
7. Duplicate wall certificate	$25
8. ~~Return check charge~~ Handling fee for returned check or dishonored credit card or debit card	~~$35~~ $50
9. Reinstatement of suspended or revoked license	$200

B. For renewal of licensure from July 1, 2017, through June 30, 2019, the following fee shall be in effect:

Biennial renewal	$60

18VAC90-40-70. Fees for prescriptive authority.

A. The following fees have been established by the boards:

1. Initial issuance of prescriptive authority	$75
2. Biennial renewal	$35
3. Late renewal	$15
4. Reinstatement of lapsed authorization	$90
5. Reinstatement of suspended or revoked authorization	$85
6. Duplicate of authorization	$15
7. ~~Return check charge~~ Handling fee for returned check or dishonored credit card or debit card	~~$35~~ $50

B. For renewal of licensure from July 1, 2017, through June 30, 2019, the following fee shall be in effect:

Biennial renewal	$26

Agenda Item: Recommendation on Retiree License

Included in agenda package:

Legislation passed by 2019 General Assembly (HB2457)

Information relating to discussion of a Notice of Intended Regulatory Action

Letter from the Medical Society of Virginia

Staff note:

The Board will need to discuss whether to adopt a Notice of Intended Regulatory Action (NOIRA).

Board action:

The Board may: 1) adopt a NOIRA to initiate rulemaking on creation of a retiree license; or 2) defer action for future consideration.

VIRGINIA ACTS OF ASSEMBLY -- 2019 SESSION

CHAPTER 379

An Act to amend the Code of Virginia by adding a section numbered 54.1-2937.1, relating to Board of Medicine; retiree license.

[H 2457]

Approved March 14, 2019

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding a section numbered 54.1-2937.1 as follows:

§ 54.1-2937.1. Retiree license.

A. The Board may issue a retiree license to any doctor of medicine, osteopathy, podiatry, or chiropractic who holds an unrestricted, active license to practice in the Commonwealth upon receipt of a request and submission of the fee required by the Board. A person to whom a retiree license has been issued shall not be required to meet continuing competency requirements for the first biennial renewal of such license.

B. A person to whom a retiree license has been issued shall only engage in the practice of medicine, osteopathy, podiatry, or chiropractic for the purpose of providing (i) charity care, as defined in § 32.1-102.1, and (ii) health care services to patients in their residence for whom travel is a barrier to receiving medical care.

Information for Consideration of a "Retiree License"

Current regulations for issuance of a "restricted volunteer license"

18VAC85-20-226. Restricted Volunteer License.

A. Any doctor of medicine, osteopathic medicine, podiatry or chiropractic who held an unrestricted license issued by the Virginia Board of Medicine or by a board in another state as a licensee in good standing at the time the license expired or became inactive may be issued a restricted volunteer license to practice without compensation in a clinic that is organized in whole or in part for the delivery of health care services without charge in accordance with § 54.1-106 of the Code of Virginia.

B. To be issued a restricted volunteer license, a doctor of medicine, osteopathic medicine, podiatry or chiropractic shall submit an application to the board that documents compliance with requirements of § 54.1-2928.1 of the Code of Virginia and the application fee prescribed in 18VAC85-20-22.

C. The licensee who intends to continue practicing with a restricted volunteer license shall renew biennially during his birth month, meet the continued competency requirements prescribed in subsection D of this section, and pay to the board the renewal fee prescribed in 18VAC85-20-22.

D. The holder of a restricted volunteer license shall not be required to attest to hours of continuing education for the first renewal of such a license. For each renewal thereafter, the licensee shall attest to 30 hours obtained during the two years immediately preceding renewal with at least 15 hours of Type 1 activities or courses offered by an accredited sponsor or organization sanctioned by the profession and no more than 15 hours of Type 2 activities or courses.

Reference in Code to practice with restricted volunteer license

§ 54.1-106. Health care professionals rendering services to patients of certain clinics and administrators of such services exempt from liability.

A. No person who is licensed or certified by the Boards of/for Audiology and Speech-Language Pathology; Counseling; Dentistry; Medicine; Nursing; Optometry; Opticians; Pharmacy; Hearing Aid Specialists; Psychology; or Social Work or who holds a multistate licensure privilege to practice nursing issued by the Board of Nursing who renders at any site any health care services within the limits of his license, certification or licensure privilege, voluntarily and without compensation, to any patient of any clinic which is organized in whole or in part for the delivery of health care services without charge or any clinic for the indigent and uninsured that is organized for the delivery of primary health care services as a federally qualified health center designated by the Centers for Medicare & Medicaid Services, shall be liable for any civil damages for any act or omission resulting from the rendering of such services unless

the act or omission was the result of his gross negligence or willful misconduct. Additionally, no person who administers, organizes, arranges, or promotes such services shall be liable to patients of clinics described in this section for any civil damages for any act or omission resulting from the rendering of such services unless the act or omission was the result of his or the clinic's gross negligence or willful misconduct.

For purposes of this section, any commissioned or contract medical officers or dentists serving on active duty in the United States armed services and assigned to duty as practicing commissioned or contract medical officers or dentists at any military hospital or medical facility owned and operated by the United States government shall be deemed to be licensed pursuant to this title.

B. For the purposes of Article 5 (§ 2.2-1832 et seq.) of Chapter 18 of Title 2.2, any person rendering such health care services who (i) is registered with the Division of Risk Management and (ii) has no legal or financial interest in the clinic from which the patient is referred shall be deemed an agent of the Commonwealth and to be acting in an authorized governmental capacity with respect to delivery of such health care services. The premium for coverage of such person under the Risk Management Plan shall be paid by the Department of Health.

C. For the purposes of this section and Article 5 (§ 2.2-1832 et seq.) of Chapter 18 of Title 2.2, "delivery of health care services without charge" shall be deemed to include the delivery of dental, medical or other health services when a reasonable minimum fee is charged to cover administrative costs.

Fee for Restricted Volunteer License (in regulation)

M. The fee for an application or for the biennial renewal of a restricted volunteer license shall be $75, due in the licensee's birth month. An additional fee for late renewal of licensure shall be $25 for each renewal cycle. For renewal of a restricted volunteer license in 2018, the fee shall be $65.

Definition in Code of Charity Care – referenced in 54.1-2937.1:

"Charity care" means health care services delivered to a patient who has a family income at or below 200 percent of the federal poverty level and for which it was determined that no payment was expected (i) at the time the service was provided because the patient met the facility's criteria for the provision of care without charge due to the patient's status as an indigent person or (ii) at some time following the time the service was provided because the patient met the facility's criteria for the provision of care without charge due to the patient's status as an indigent person. "Charity care" does not include care provided for a fee subsequently deemed uncollectable as bad debt. For a nursing home as defined in § 32.1-123, "charity care" means care at a reduced rate to indigent persons.

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September 13, 2019

VIA Email: WILLIAM.HARP@DHP.VIRGINIA.GOV
William Harp, MD
Executive Director
Virginia Board of Medicine
9960 Mayland Drive, Suite 300
Richmond, VA 23233-1463

Re: House Bill 2457 - Retiree License

Dear Dr. Harp:

I trust this letter finds you doing well. I am writing to you as General Counsel for the Medical Society of Virginia (MSV) as it relates to consideration by the Virginia Board of Medicine ("Board") of Delegate Steve Landes' HB2457, which was enacted by the 2019 General Assembly Session. Given the discussion of the issues surrounding whether or not the Board will issue a retiree license that took place at the legislative committee on Friday, September 6th and in anticipation that the full Board will consider this issue at the October meeting, the MSV would like to respectfully convey several observations for the Board's consideration.

First, this legislation was not submitted at the request of the MSV. Rather, Delegate Landes introduced this on his own, as he thought it would be an opportunity for some physicians, who are approaching the end of their careers, to be issued a retiree license in order to continue to provide a certain level of care to their existing patients that may have travel barriers preventing them from seeking healthcare. Obviously, this was a laudable purpose, but in the speed of the General Assembly Session, the full ramifications of the legislation may not have been considered.

Second, we are very mindful that were the Board to decide to grant issuance of retiree licenses, that such licenses may cause confusion by some physicians when compared to the existing issuance of restricted volunteer licenses. We discussed at the legislative committee that the restrictive volunteer license is for physicians to provide care in free clinics, without compensation. In that situation, clinics routinely have medical malpractice insurance coverage that is purchased through the Virginia Division of the Treasurer. Contrary, a retiree license, as described in statute, would permit a physician to provide charity care ["a defined term"] to patients at their place of residence. There is no prohibition in the statute on physicians with a retiree license being compensated for their services, likewise, there is no mention of these individuals having to have medical malpractice insurance coverage. Of note, the General Assembly did debate whether medical malpractice insurance coverage would be a requirement of these individuals; and, Delegate Landes requested that language not be included in the statute.

Third, the issue was raised as to whether a physician could hold both a restricted volunteer license and a retiree license at the same time. In that situation, would a physician rely on a license based upon the treatment setting of the patient and might they be in the proverbial trap for providing care outside of the parameters of one or more of the licenses.

We found it persuasive, the comment raised during the legislative committee about the ability of a 35-year-old physician to retire and continue to practice for multiple years under a retiree license. Obviously, the thought at the General Assembly was along the lines of a physician approaching true retirement age (closer to receiving Medicare). However, there was no discussion of a lifetime of practice on a retiree license.

In conclusion, since the statute created in 54.1-2937.1, regarding a retiree license, provides that the Board may issue such a license, we believe the Board should exercise its discretion to not issue such a license, at this time; but instead, consider whether additional statutory consideration should first be pursued so as to minimize any physician confusion and to further consider appropriate uses and limitations, were a retiree license to be issued by the Board.

As always, MSV looks forward to working with the Board on this issue and should you have any questions, please do not hesitate to contact me.

Very truly yours,

W. Scott Johnson

cc: Clark Barrineau, Asst. Vice President of Government Affairs/MSV
Lauren Bates-Rowe, Asst. Vice President of Health Policy/MSV
Tyler Cox, Government Affairs Manager/Hancock, Daniel & Johnson
Benjamin H. Traynham, Esquire/Hancock, Daniel & Johnson

#1077337

Agenda Item: Adoption of Regulation for Waiver of Electronic Prescribing by Emergency Action –Nurse Practitioners

Included in agenda package:

Copy of HB2559 – Amendments to Code to require electronic prescribing of an opioid by July 1, 2020

Draft of amendments to prescriptive authority regulations for nurse practitioners

Staff note:

Enactment clause on HB2559 requires adoption of regulations within 280 days, so the Board must amend by an emergency action.

The Executive Committee adopted identical language for prescribers licensed by the Board of Medicine.

The Board of Nursing adopted these amendments for nurse practitioners on September 17, 2019

Action: Adoption of emergency regulations and a Notice of Intended Regulatory Action (NOIRA) to replace the emergency regs

VIRGINIA ACTS OF ASSEMBLY -- 2019 SESSION

CHAPTER 664

An Act to amend and reenact §§ 54.1-3408.02, as it shall become effective, and 54.1-3410 of the Code of Virginia, relating to electronic transmission of certain prescriptions; exceptions.

[H 2559]

Approved March 21, 2019

Be it enacted by the General Assembly of Virginia:

1. That §§ 54.1-3408.02, as it shall become effective, and 54.1-3410 of the Code of Virginia are amended and reenacted as follows:

§ 54.1-3408.02. (Effective July 1, 2020) Transmission of prescriptions.

A. Consistent with federal law and in accordance with regulations promulgated by the Board, prescriptions may be transmitted to a pharmacy as an electronic prescription or by facsimile machine and shall be treated as valid original prescriptions.

B. Any prescription for a controlled substance that contains an ~~opiate~~ *opioid* shall be issued as an electronic prescription.

C. The requirements of subsection B shall not apply if:

1. The prescriber dispenses the controlled substance that contains an opioid directly to the patient or the patient's agent;

2. The prescription is for an individual who is residing in a hospital, assisted living facility, nursing home, or residential health care facility or is receiving services from a hospice provider or outpatient dialysis facility;

3. The prescriber experiences temporary technological or electrical failure or other temporary extenuating circumstance that prevents the prescription from being transmitted electronically, provided that the prescriber documents the reason for this exception in the patient's medical record;

4. The prescriber issues a prescription to be dispensed by a pharmacy located on federal property, provided that the prescriber documents the reason for this exception in the patient's medical record;

5. The prescription is issued by a licensed veterinarian for the treatment of an animal;

6. The FDA requires the prescription to contain elements that are not able to be included in an electronic prescription;

7. The prescription is for an opioid under a research protocol;

8. The prescription is issued in accordance with an executive order of the Governor of a declared emergency;

9. The prescription cannot be issued electronically in a timely manner and the patient's condition is at risk, provided that the prescriber documents the reason for this exception in the patient's medical record; or

10. The prescriber has been issued a waiver pursuant to subsection D.

D. The licensing health regulatory board of a prescriber may grant such prescriber, in accordance with regulations adopted by such board, a waiver of the requirements of subsection B, for a period not to exceed one year, due to demonstrated economic hardship, technological limitations that are not reasonably within the control of the prescriber, or other exceptional circumstances demonstrated by the prescriber.

§ 54.1-3410. When pharmacist may sell and dispense drugs.

A. A pharmacist, acting in good faith, may sell and dispense drugs and devices to any person pursuant to a prescription of a prescriber as follows:

1. A drug listed in Schedule II shall be dispensed only upon receipt of a written prescription that is properly executed, dated and signed by the person prescribing on the day when issued and bearing the full name and address of the patient for whom, or of the owner of the animal for which, the drug is dispensed, and the full name, address, and registry number under the federal laws of the person prescribing, if he is required by those laws to be so registered. If the prescription is for an animal, it shall state the species of animal for which the drug is prescribed;

2. In emergency situations, Schedule II drugs may be dispensed pursuant to an oral prescription in accordance with the Board's regulations;

3. Whenever a pharmacist dispenses any drug listed within Schedule II on a prescription issued by a prescriber, he shall affix to the container in which such drug is dispensed, a label showing the prescription serial number or name of the drug; the date of initial filling; his name and address, or the name and address of the pharmacy; the name of the patient or, if the patient is an animal, the name of the owner of the animal and the species of the animal; the name of the prescriber by whom the prescription was written, except for those drugs dispensed to a patient in a hospital pursuant to a chart order; and such directions as may be stated on the prescription.

B. A drug controlled by Schedules III through VI or a device controlled by Schedule VI shall be dispensed upon receipt of a written or oral prescription as follows:

1. If the prescription is written, it shall be properly executed, dated and signed by the person prescribing on the day when issued and bear the full name and address of the patient for whom, or of the owner of the animal for which, the drug is dispensed, and the full name and address of the person prescribing. If the prescription is for an animal, it shall state the species of animal for which the drug is prescribed.

2. If the prescription is oral, the prescriber shall furnish the pharmacist with the same information as is required by law in the case of a written prescription for drugs and devices, except for the signature of the prescriber.

A pharmacist who dispenses a Schedule III through VI drug or device shall label the drug or device as required in subdivision A 3 of this section.

C. A drug controlled by Schedule VI may be refilled without authorization from the prescriber if, after reasonable effort has been made to contact him, the pharmacist ascertains that he is not available and the patient's health would be in imminent danger without the benefits of the drug. The refill shall be made in compliance with the provisions of § 54.1-3411.

If the written or oral prescription is for a Schedule VI drug or device and does not contain the address or registry number of the prescriber, or the address of the patient, the pharmacist need not reduce such information to writing if such information is readily retrievable within the pharmacy.

D. Pursuant to authorization of the prescriber, an agent of the prescriber on his behalf may orally transmit a prescription for a drug classified in Schedules III through VI if, in such cases, the written record of the prescription required by this subsection specifies the full name of the agent of the prescriber transmitting the prescription.

E. (Effective July 1, 2020) ~~No pharmacist shall dispense a controlled substance that contains an opiate unless the prescription for such controlled substance is issued as an electronic prescription.~~ *A dispenser who receives a non-electronic prescription for a controlled substance containing an opioid is not required to verify that one of the exceptions set forth in § 54.1-3408.02 applies and may dispense such controlled substance pursuant to such prescription and applicable law.*

2. That the Board of Medicine, the Board of Nursing, the Board of Dentistry, and the Board of Optometry shall promulgate regulations to implement the provisions of this act regarding prescriber waivers to be effective within 280 days of its enactment.

3. That the Secretary of Health and Human Resources shall convene a work group of interested stakeholders, including the Medical Society of Virginia, the Virginia Hospital and Healthcare Association, the Virginia Dental Association, the Virginia Association of Health Plans, and the Virginia Pharmacists Association, to evaluate the implementation of the electronic prescription requirement for controlled substances and shall report to the Chairmen of the House Committee on Health, Welfare and Institutions and the Senate Committee on Education and Health by November 1, 2022. The work group's report shall identify the successes and challenges of implementing the electronic prescription requirement and offer possible recommendations for increasing the electronic prescribing of controlled substances that contain an opioid.

Project 6115 - none

BOARD OF NURSING

Waiver for e-prescribing

18VAC90-40-122. Waiver for electronic prescribing.

A. Beginning July 1, 2020, a prescription for a controlled substance that contains an opioid shall be issued as an electronic prescription as consistent with § 54.1-3408.02 of the Code of Virginia.

B. Upon written request, the boards may grant a one-time waiver of the requirement of subsection A of this section, for a period not to exceed one year, due to demonstrated economic hardship, technological limitations that are not reasonably within the control of the prescriber, or other exceptional circumstances demonstrated by the prescriber.

Agenda Item: **Regulatory Action – Prescriptive Authority**

Staff note:

The comment period on this regulatory action ended on 9/20/19. There were no public comments. There are no changes to the proposed regulation recommended by staff.

Included in agenda package:

Copy of proposed amendments

Copy of applicable section of the Code

Board action:

To adopt the proposed amendments as drafted or as revised by the Board.
(Board of Nursing will adopt the final at its November meeting)

Virginia.gov Agencies | Governor

VIRGINIA REGULATORY TOWN HALL

Agency **Department of Health Professions**

Board **Board of Nursing**

Chapter **Regulations for Prescriptive Authority for Nurse Practitioners [18 VAC 90 - 40]**

Action: Elimination of separate license for prescriptive authority

Proposed Stage

Action 4958 / Stage 8458

Edit Stage | Withdraw Stage | Go to RIS Project

Documents		
Proposed Text	7/11/2019 8:45 am	Sync Text with RIS
Agency Statement	11/2/2018 (modified 1/17/2019)	Upload / Replace
Attorney General Certification	12/3/2018	
DPB Economic Impact Analysis	1/11/2019	
Agency Response to EIA	1/18/2019	Upload / Replace
Governor's Review Memo	6/14/2019	
Registrar Transmittal	6/27/2019	

Status	
Incorporation by Reference	No
Exempt from APA	No, this stage/action is subject to article 2 of the *Administrative Process Act* and the standard executive branch review process.
Attorney General Review	Submitted to OAG: 11/2/2018 Review Completed: 12/3/2018 Result: Certified
DPB Review	Submitted on 12/3/2018 Economist: Larry Getzler Policy Analyst: Jeannine Rose Review Completed: 1/17/2019 *DPB's policy memo is "Governor's Confidential Working Papers"*
Secretary Review	Secretary of Health and Human Resources Review Completed: 3/27/2019
Governor's Review	Review Completed: 6/14/2019 Result: Approved
Virginia Registrar	Submitted on 6/27/2019 **The Virginia Register of Regulations** Publication Date: 7/22/2019 **Volume: 35 Issue: 24**
Public Hearings	**08/27/2019 8:30 AM**

Comment Period	Ended 9/20/2019 0 comments

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This person is the primary contact for this chapter.
This stage was created by Elaine J. Yeatts on 11/02/2018
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go back | open in word

Project 5352 - Proposed

BOARD OF NURSING

Elimination of separate license for prescriptive authority

18VAC90-40-20. Authority and administration of regulations.

A. The statutory authority for this chapter is found in §§ 54.1-2957.01, 54.1-3303, 54.1-3401, and 54.1-3408 of the Code of Virginia.

B. Joint boards of nursing and medicine.

1. The Committee of the Joint Boards of Nursing and Medicine shall be appointed to administer this chapter governing prescriptive authority.

2. The boards hereby delegate to the Executive Director of the Virginia Board of Nursing the authority to issue the initial authorization ~~and biennial renewal~~ to those persons who meet the requirements set forth in this chapter and to grant extensions or exemptions for compliance with continuing competency requirements as set forth in subsection E of 18VAC90-40-55. Questions of eligibility shall be referred to the committee.

3. All records and files related to prescriptive authority for nurse practitioners shall be maintained in the office of the Board of Nursing.

18VAC90-40-50. ~~Renewal of prescriptive authority.~~ (Repealed.)

~~An applicant for renewal of prescriptive authority shall:~~

~~1. Renew biennially at the same time as the renewal of licensure to practice as a nurse practitioner in Virginia.~~

~~2. Submit a completed renewal form attesting to compliance with continuing competency requirements set forth in 18VAC90-40-55 and the renewal fee as prescribed in 18VAC90-40-70.~~

18VAC90-40-55. Continuing competency requirements.

A. ~~In order to renew prescriptive authority, a~~ A licensee with prescriptive authority shall meet continuing competency requirements for biennial renewal as a licensed nurse practitioner. Such requirements shall address issues such as ethical practice, an appropriate standard of care, patient safety, and appropriate communication with patients.

B. A nurse practitioner with prescriptive authority shall obtain a total of eight hours of continuing education in pharmacology or pharmacotherapeutics for each biennium in addition to the minimal requirements for compliance with subsection B of 18VAC90-30-105.

C. The nurse practitioner with prescriptive authority shall retain evidence of compliance and all supporting documentation for a period of four years following the renewal period for which the records apply.

D. The boards shall periodically conduct a random audit of ~~its~~ their licensees to determine compliance. The nurse practitioners selected for the audit shall provide the evidence of compliance and supporting documentation within 30 days of receiving notification of the audit.

E. The boards may delegate to the committee the authority to grant an extension or an exemption for all or part of the requirements for circumstances beyond the control of the licensee, such as temporary disability, mandatory military service, or officially declared disasters.

18VAC90-40-60. ~~Reinstatement of prescriptive authority.~~ (Repealed.)

~~A. A nurse practitioner whose prescriptive authority has lapsed may reinstate within one renewal period by payment of the current renewal fee and the late renewal fee.~~

~~B. A nurse practitioner who is applying for reinstatement of lapsed prescriptive authority after one renewal period shall:~~

~~1. File the required application;~~

~~2. Provide evidence of a current, unrestricted license to practice as a nurse practitioner in Virginia;~~

~~3. Pay the fee required for reinstatement of a lapsed authorization as prescribed in 18VAC90-40-70; and~~

~~4. If the authorization has lapsed for a period of two or more years, the applicant shall provide proof of:~~

~~a. Continued practice as a licensed nurse practitioner with prescriptive authority in another state; or~~

~~b. Continuing education, in addition to the minimal requirements for current professional certification, consisting of four contact hours in pharmacology or pharmacotherapeutics for each year in which the prescriptive authority has been lapsed in the Commonwealth, not to exceed a total of 16 hours.~~

~~C. An applicant for reinstatement of suspended or revoked authorization shall:~~

~~1. Petition for reinstatement and pay the fee for reinstatement of a suspended or revoked authorization as prescribed in 18VAC90-40-70;~~

~~2. Present evidence of competence to resume practice as a nurse practitioner with prescriptive authority; and~~

~~3. Meet the qualifications and resubmit the application required for initial authorization in 18VAC90-40-40.~~

18VAC90-40-70. Fees for prescriptive authority.

~~A.~~ The following fees have been established by the boards:

1. Initial issuance of prescriptive authority	~~$75~~ $35
~~2. Biennial renewal~~	~~$35~~
~~3. Late renewal~~	~~$15~~
~~4. Reinstatement of lapsed authorization~~	~~$90~~
~~5. Reinstatement of suspended or revoked authorization~~	~~$85~~
~~6. Duplicate of authorization~~	~~$15~~
~~7.~~ 2. Return check charge	$35

~~B. For renewal of licensure from July 1, 2017, through June 30, 2019, the following fee shall be in effect:~~

~~Biennial renewal $26~~

18VAC90-40-110. Disclosure.

A. The nurse practitioner shall include on each prescription ~~written~~ issued or dispensed his signature and the Drug Enforcement Administration (DEA) number, when applicable. If ~~his~~ the nurse practitioner's practice agreement authorizes prescribing of only Schedule VI drugs and the nurse practitioner does not have a DEA number, he shall include the prescriptive authority number as issued by the boards.

B. The nurse practitioner shall disclose to patients at the initial encounter that he is a licensed nurse practitioner. Such disclosure may be included on a prescription pad or may be given in writing to the patient.

C. The nurse practitioner shall disclose, upon request of a patient or a patient's legal representative, the name of the patient care team physician and information regarding how to contact the patient care team physician.

Agenda Item: Recommendation on Conversion Therapy

Included in your agenda package:

- Copy of minutes of Workgroup convened by the Department on October 5, 2018 – included representatives from Medicine, Nursing, Psychology, Counseling and Social Work
- Copies of statements from applicable medical societies/associations
- Copy of report from SAMSHA
- Draft of guidance document

Staff note:

- The 2018 Workgroup heard testimony from the public, reviewed relevant documents, and discuss the issues thoroughly. It was determined that it would be up to each regulatory boards to decide whether to develop a guidance document and/or promulgate regulations addressing the issue of conversion therapy.
- The Legislative Committee (see September 6th minutes) voted to recommend adoption of a guidance document and initiation of rulemaking by issuance of a Notice of Intended Regulatory Action.

Board options:

1) Take no action;
2) Accept recommendation of the Committee and adopt a guidance document and initiate rulemaking; or
3) Adopt only guidance.

DHP Conversion Therapy Workgroup

Friday, October 5, 2018
Perimeter Center, 2nd Floor Conference Center, Board Room 2
Henrico, Virginia

MEETING MINUTES

In Attendance:

Workgroup Convener

David E. Brown, DC
Director, Department of Health Professions

Workgroup Members

Jamie Clancey, LCSW
Member, Board of Social Work

Jay Douglas, MSM, RN, CSAC, FRE
Executive Director, Board of Nursing

Kevin Doyle, EdD, LPC, LSATP
Chairperson, Board of Counseling

William Harp, MD
Executive Director, Board of Medicine

Patrick A. Hope
Delegate, Virginia General Assembly

Jaime Hoyle
Executive Director, Boards of Counseling, Psychology and Social Work

Trula Minton
Member, Board of Nursing

Jennifer Morgan, PsyD

Kevin O'Connor, MD
President, Board of Medicine

Jennifer Phelps, BS, LPN, QMHPA
First Vice President, Board of Nursing

Jane Probst, LCSW

Herb Stewart, PhD
Chairperson, Board of Psychology

Terry Tinsley, PhD, LPC, LMFT, NCC, CSOTP
Member, Board of Counseling

Elaine Yeatts
Senior Policy Analyst, Department of Health Professions

Staff

Laura Z. Rothrock
Executive Assistant to Director David E. Brown, DC, Department of Health Professions

Opening Remarks and Approval of Agenda:

At 10:00am, prior to calling the meeting to order, Dr. Brown asked the workgroup members to take some time to review the documents that were not sent to them previously:

- Letter dated October 4, 2018 from Senator Scott Surovell re: Adding Conversion Therapy to the Standards of Practice; Unprofessional Conduct
- American Counseling Association (ACA) Resolution on Reparative Therapy/Conversion Therapy/Sexual Orientation Change Efforts (SOCE) as a Significant and Serious Violation of the ACA Code of Ethics.
- Letter dated October 4, 2018 from Alliance Defending Freedom re: Proposed Regulation to Limit Counseling and Therapeutic Freedom

NOTE: Prior to the meeting, the workgroup had been provided with a letter dated October 1, 2018 from the National Task Force for Therapy Equality.

Dr. Brown called the meeting to order at 10:07am. He welcomed everyone, provided emergency egress information, and asked the workgroup members to introduce themselves. He also provided background of events leading to formation of the workgroup and what he hopes to accomplish during the meeting.

During the 2018 General Assembly session, Delegate Hope introduced HB 363 which would prohibit a person licensed by a health regulatory board from engaging in sexual orientation change efforts with a person under 18 years of age. During discussion before a subcommittee of the House, the question arose as to why licensing boards had not addressed this issue in regulation. Subsequently, Dr. Herb Stewart, President of the Board of Psychology, made the recommendation to Dr. Brown to convene a workgroup to discuss the issue. The workgroup will discuss the big picture and will not have authority to do anything but make a recommendation to the boards (i.e., Counseling, Medicine, Nursing, Psychology, and Social Work). Each board would have to make the decision whether to promulgate regulation. The process would take approximately 1½ to 2 years to go through all of the regulatory process steps, and there will be more than one opportunity for public comment during the process. Dr. Brown emphasized that this meeting is an initial step in the process.

Call for Public Comment:

Dr. Brown indicated that he will try to enforce a three minute time limit per speaker. Twenty-eight (28) people (24 signed-up plus and an additional 4 people) provided comment, including Senator Amanda Chase. Senator Chase spoke to the events during the 2018 General Assembly session where both the House and Senate (SB 245 - Surovell) bills were passed by indefinitely, indicated that regulations should conform to the actions of the General Assembly, and told the attendees that it was important to have a constructive and respectful conversion.

The comments from the public included personal experiences of how conversion therapy either helped the individual or did more harm (e.g., feelings of helplessness, fear and low-self-esteem) that took years of healing to overcome. One individual told the workgroup that no one should have to go through therapy because of therapy. One individual noted that as far back as 1973 the APA (American Psychiatric Association) indicated that homosexuality was not to be classified as a mental disorder.

Some comments expressed concerns about potential regulations in areas such as "fluidity," freedom of speech of counselors, access to treatment, parental rights, minors' rights to treatment, religious freedom rights, suicide/suicidal thoughts among LGBTQ youths. Other comments noted issues such as science versus morals, conversion therapy is not evidence-based treatment, and need for regulations to protect a vulnerable population.

Dr. Brown thanked Senator Chase for setting a respectful tone and thanked all of the speakers for coming forward with their comments. He indicated that some comments were outside the scope of the workgroup (e.g., legislative intent, constitutionality) and the boards would have legal counsel to advise them before moving forward. He also indicated that the need to regulate would not be determined by vote in the meeting but by consensus, if there was one.

Dr. Brown announced a 10 minute break before continuing. The meeting resumed at 11:49am.

Discussion of Public Comment and Agenda Packet Materials:

Dr. Brown asked the workgroup members to provide their thoughts on what they had heard from the public.

Delegate Hope thanked Dr. Brown for convening the workgroup and indicated he wanted to clarify three items: 1) In regards to the General Assembly, the committee votes do not represent the whole General Assembly because of the makeup of the committees. 2) He has brought a bill forward in each of the past 4 years. 3) The scope of the legislation is limited to children under 18 years of age and only deals with licensed professionals. He feels the government's role is to protect children and asked the workgroup to give the following questions thought: Do these therapies work? Do they cause harm? What does science/evidence suggest?

The workgroup members found the public comment to be compelling and emotional on both sides and indicated that youths and adults need therapies that are not harmful. Dr. Stewart put together the chart of policy and position statements in the agenda packet (pages 103 – 105) and asked for regulations to be considered. Dr. O'Connor felt that it is important to separate science from emotion. Dr. Doyle asked if the regulations currently offer adequate protection.

Several of the board representatives concurred with the need to regulate, as the mission of the boards is to protect the public; and they also reported that they do not recall receiving any complaints related to conversion therapy. Ms. Clancey felt that the public may need to be educated about filing complaints and suggested reevaluating accessibility to the public possibly through use of social media. Ms. Yeatts stated the expectation of getting complaints from a child/youth is unrealistic.

Dr. Tinsley brought up concern with the title "conversion" which could bring up issues and deflect from options parents have in seeking treatment. Other common terms were discussed by the workgroup: reparative therapy and Sexual Orientation Change Efforts (SOCE). Ms. Yeatts indicated that the legislation defines what conversion therapy is and is not and that the workgroup should look at the total definition.

Dr. Stewart discussed a recent Williams Institute Study based on a national survey which showed that more than 20,000 LGBT youths will receive conversion therapy from a licensed health care professional in 41 states that don't ban the practice. He asked that this information be included with the meeting materials.

Ms. Phelps spoke to the freedom of speech issue and indicated that conversion therapy is only one side of freedom of speech. Ethics practices say to put religious beliefs aside in professional practice. Other workgroup members indicated that conversion therapy may be done by non-licensed therapists.

Prior to breaking for lunch, Dr. Brown invited Senator Chase to make further comments. Senator Chase indicated the Senate committee did not advance the legislation, and no floor vote was taken. The workgroup heard from the public as to where conversion therapy went wrong, and she agrees that the general public needs a reporting mechanism for complaints. She indicated there could be unintended consequences to a regulatory ban on conversion therapy in that parents may not take their children to professionals for help. She feels that more options need to be allowed for children.

The workgroup broke for lunch at 12:38pm and resumed at 1:11pm.

Dr. Brown asked for any further comments from the workgroup on the need to regulate and the ability of conversion therapy to occur under current regulations. Discussion took place as to the fact that minors would not report complaints for themselves and concerning treatment plans, consent and a child's right to confidentiality.

There was not a complete consensus among the workgroup members. Most saw the need to regulate in regards to conversion therapy, but existing regulations may be adequate; and some felt there may be some negative connotations as to the term "conversion therapy."

Review of Potential Regulatory Language:

Dr. Brown asked Ms. Yeatts to review the regulatory language that she drafted (page 107 of the agenda packet). Ms. Yeatts indicated that the draft is identical to what is in the legislation on pages 1 and 3. She referred to lines 17 – 20 in both HB 363 and SB 245. Different terms were used (HB 363 used "sexual orientation change efforts," and SB 245 used "conversion therapy"), but the rest of the language is the same.

It was noted that licensees sometimes read things differently than intended, so whatever language is used should be clearly stated.

The draft language on page 107 has three parts: 1) the first sentence related to the practitioners specified in the regulation; 2) the definition of conversion therapy; and 3) what conversion therapy does not include.

Some felt that the term used (i.e., conversion therapy) is not important, but rather describe the behavior because practitioners could call it by a different name. The wording "this practice" or something similar could be used. Others felt that a label was needed, and it was pointed out that the media uses "conversion therapy."

Another item of discussion in the draft was the word "seeks" on the third line. Patients have a right to explore, and the draft indicates in the third part that conversion therapy does not include identity exploration. Ms. Yeatts suggested using "that is aimed at changing" instead of "seeks to change."

Dr. Brown indicated that Ms. Yeatts will work on the language that will be presented to the boards.

Closing Comments:

Dr. Brown discussed the next steps. There will be a report to the boards and interested stakeholders concerning the workgroup's discussions with alternate proposed regulatory language. The boards can elect to promulgate regulations or not.

Delegate Hope thanked Dr. Brown for allowing him to be part of the process. He expressed his appreciation for everyone's diligence and indicated there was discussion that was missing from previous discussions on the topic.

Dr. Brown informed the public that the boards will post agendas for upcoming meetings on their websites.

Adjourn:

With no further business to discuss, Dr. Brown adjourned the meeting at 2:09pm.

ISSUE BRIEF

LGBTQ change efforts ("conversion therapy")

Background

"Conversion therapy" refers to any form of interventions, such as individual or group, behavioral, cognitive or milieu/environmental operations, which attempt to change an individual's sexual orientation or sexual behaviors (sexual orientation change efforts [SOCE]) or an individual's gender identity (gender identify change efforts [GICE]).[1] Practitioners of change efforts may employ techniques including:

- Aversive conditioning (e.g., electric shock, deprivation of food and liquids, smelling salts and chemically induced nausea)
- Biofeedback
- Hypnosis
- Masturbation reconditioning
- Psychotherapy or systematic desensitization[2]

Underlying these techniques is the assumption that homosexuality and gender identity are mental disorders and that sexual orientation and gender identity can be changed. This assumption is not based on medical and scientific evidence. Professional consensus rejects pathologizing homosexuality and gender nonconformity, in addition, empirical evidence has demonstrated that homosexuality and variations in gender identity are normal variants of human expression not inherently linked to mental illness. However, the unfounded misconception of sexual orientation and gender identity "conversion" persists today in some health, spiritual and religious practitioners.[3]

According to the UCLA Williams Institute on Sexual Orientation and Gender Identity Law and Public Policy, as of 2018, almost 700,000 lesbian, gay, bisexual, transgender and queer/questioning (LGBTQ) adults in the U.S. had received "conversion therapy"; in addition, an estimated 57,000 youths will receive change efforts from religious or health care providers before they turn 18 years old.[4]

Health implications for LGBTQ individuals

Evidence does not support the purported "efficacy" of SOCE in changing sexual orientation.[5] To the contrary, these practices may cause significant psychological distress.[6] One study showed that 77 percent of ex-SOCE participants reported significant long-term harm, including the following symptoms:

- Depression
- Anxiety
- Lowered self-esteem

1. John Bancroft, et al., *Peer Commentaries* on Spitzer, 32 Archives of Sexual Behavior 5, 419-68 (Oct. 2003).
2. American Psychological Association, Report of the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation (Aug. 2009).
3. Jack Drescher, *Ethical issues in treating gay and lesbian patients*, 25 Psychiatric Clinics of North America 3, 605-21 (Sep. 2002).
4. Christy Mallory, Taylor Brown & Kerith Conron, The Williams Institute on Sexual Orientation and Gender Identity Law, UCLA School of Law, Conversion therapy and LGBT youth (Jan. 2018)
5. American Psychological Association, *supra* note 2
6. *Id.*

AMA AMERICAN MEDICAL ASSOCIATION

GLMA Health Professionals Advancing LGBTQ Equality

- Internalized homophobia
- Self-blame
- Intrusive imagery
- Sexual dysfunction[7]

Participants also reported significant social and interpersonal harm such as alienation, loneliness, social isolation, interference with intimate relationships and loss of social supports.[8]

SOCE may also increase suicidal behaviors in a population where suicide is prevalent. In young adults between 15 and 24 years old, suicide has been the second leading cause of death since 2011, and LGBTQ young adults are more than twice as likely to report a history of suicide attempts in comparison to their heterosexual peers.[9] Similarly, LGB adults are three to five times more likely to have a suicidal attempt in comparison to their heterosexual counterparts.[10] Young LGBTQ adults who report higher levels of parental and caregiver rejection are 8.4 times more likely to report having attempted suicide.[11] One study found nearly 30 percent of individuals that underwent SOCE reported suicidal attempts.[12]

GICE may cause similar long-term harm as SOCE. According to the American Psychological Association Consensus on Efforts to Change Gender Identity, there is a lack of published research on efforts to change gender identity among children and adolescents. No existing research supports that mental health and behavioral interventions with children and adolescents alter gender identity.[13]

Ethical Concerns

All leading professional medical and mental health associations reject "conversion therapy" as a legitimate medical treatment. In addition to the clinical risks associated with the practice, the means through which providers or counselors administer change efforts violate many important ethical principles, the foremost of which: "First, do no harm."

A health care provider's nonjudgmental recognition of and respect for patients' sexual orientations, sexual behaviors and gender identity are essential elements in rendering optimal patient care in health, as well as in illness. This recognition is especially important to address the specific health care needs of people who are or may be LGBTQ, as these patients often experience disparities in access to care. Yet administering change efforts is an inherently discriminatory practice often administered coercively and fraught with ethical problems, such as:

7. Ariel Shidlo & Michael Schroeder, *Changing Sexual Orientation: A Consumers' Report,* 33 Professional Psychology: Research and Practice 3, 249-59 (2002).
8. *Id.*
9. National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, *10 Leading Causes of Death by Age Group, United States,* https://www.cdc.gov/Injury/wisqars/LeadingCauses.html; Andrea Miranda-Mendizábal, et al., *Sexual orientation and suicidal behaviour in adolescents and young adults: systematic review and meta-analysis,* 211 British Journal of Psychiatry 2, 77-87 (Aug. 2017).
10. Travis Hottes, Laura Bogaert, Anne Rhodes, David Brennan & Dionne Gesink, *Lifetime Prevalence of Suicide Attempts Among Sexual Minority Adults by Study Sampling Strategies: A Systematic Review and Meta-Analysis,* 106 Am J Public Health 5, e1-e12 (May 2016).
11. Caitlin Ryan, David Huebner, Rafael Diaz, & Jorge Sanchez, *Family Rejection as a Predictor of Negative Health Outcomes in White and Latino Lesbian, Gay, and Bisexual Young Adults,* 123 Pediatrics 1, 346-52 (Jan. 2009).
12. Shidlo, supra note 7.
13. Therapy Supporting and Affirming LGBTQ Youth: Statements of professional consensus regarding sexual orientation and gender identity and expression, American Psychological Association, https://www.apa.org/advocacy/civil-rights/sexualdiversity/lgbtq-therapy.aspx.

- Uninformed consent: change efforts are often prescribed without full descriptions of risks and disclosure of lack of efficacy or evidence
- Breaches of confidentiality: content of treatment, sexual orientation and gender identity may be shared with family, school or religious leaders without proper consent
- Patient discrimination: change efforts reinforce bias, discrimination and stigma against LGBTQ individuals
- Indiscriminate and improper treatment: change efforts are recommended regardless of evidence
- Patient blaming: the failure of treatment may be blamed on the patient.[14]

It is clinically and ethically inappropriate for health care providers to direct mental or behavioral health interventions, including SOCE and GICE, with a prescriptive goal aimed at achieving a fixed developmental outcome of a child's or adolescent's sexual orientation, gender identity or gender expression.[15]

State laws

To date, 14 states (California, Connecticut, Delaware, Hawaii, Illinois, Maryland, Nevada, New Hampshire, New Jersey, New Mexico, Oregon, Rhode Island, Vermont and Washington) and the District of Columbia have enacted laws banning "conversion therapy" for minors. Importantly, these laws do not prohibit counseling and therapies that help patients struggling with sexual or gender identity to develop coping and self-acceptance skills.

Medical society and other healthcare association positions

The American Medical Association and GLMA: Health Professionals Advancing LGBTQ Equality (GLMA) oppose the use of reparative or conversion therapy for sexual orientation or gender identity. Other medical societies have policies or statements similarly opposing these policies, including the American Psychiatric Association, American Academy of Child and Adolescent Psychiatry, American College of Physicians and American Academy of Pediatrics.[16] Other health care associations including the American Association for Marriage and Family Therapy, American Counseling Association, American Psychoanalytic Association, American Psychological Association, National Association of Social Workers, Pan American Health Organization: Regional Office of the World Health Organization have similar policies.[17]

AMA policy

H-160.991 Health Care Needs of Lesbian, Gay, Bisexual and Transgender Populations

1. Our AMA: (a) believes that the physician's nonjudgmental recognition of patients' sexual orientations, sexual behaviors, and gender identities enhances the ability to render optimal patient care in health as well as in illness. In the case of lesbian, gay, bisexual, transgender, queer/questioning, and other (LGBTQ) patients, this recognition is especially important to address the specific health care needs of people who are or may be LGBTQ; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of LGBTQ Health and the need to elicit relevant gender and sexuality information from our patients;

14. *Id.*; Jack Drescher J, et al., *The Growing Regulation of Conversion Therapy,* 102 J Med Regulation 2, 7-12 (Jan 2016).
15. American Psychological Association, *supra* note 13.
16. See American Psychiatric Association, Commission on Psychotherapy by Psychiatrists, *Position Statement on Therapies Focused on Attempts to Change Sexual Orientation (Reparative or Conversion Therapies),* 157 American Journal of Psychiatry 10, 1719-21 (Oct. 2000); American Academy of Child and Adolescent Psychiatry, The AACAP Policy on "Conversion Therapies (Feb. 2018); Hilary Daniel & Renee Butkus, American College of Physicians, *Lesbian, Gay, Bisexual, and Transgender Health Disparities: Executive Summary of a Policy Position Paper From the American College of Physicians,* 163 Ann Intern Med 2, 135-7 (July 2015); American Academy of Pediatrics, Committee on Adolescence, *Homosexuality and Adolescence,* 92 Pediatrics 4, 631-4 (1993).
17. Policy and Position Statements on Conversion Therapy, Human Rights Campaign, http://www.hrc.org/resources/policy-and-position-statements-on-conversion-therapy.

these efforts should start in medical school, but must also be a part of continuing medical education; (ii) educating physicians to recognize the physical and psychological needs of LGBTQ patients; (iii) encouraging the development of educational programs in LGBTQ Health; (iv) encouraging physicians to seek out local or national experts in the health care needs of LGBTQ people so that all physicians will achieve a better understanding of the medical needs of these populations; and (v) working with LGBTQ communities to offer physicians the opportunity to better understand the medical needs of LGBTQ patients; and **(c) opposes, the use of "reparative" or "conversion" therapy for sexual orientation or gender identity.**

2. Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for sexual and gender minority individuals to undergo regular cancer and sexually transmitted infection screenings based on anatomy due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; (iii) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases; and (iv) that individuals who identify as a sexual and/or gender minority (lesbian, gay, bisexual, transgender, queer/questioning individuals) experience intimate partner violence, and how sexual and gender minorities present with intimate partner violence differs from their cisgender, heterosexual peers and may have unique complicating factors.

3. Our AMA will continue to work alongside our partner organizations, including GLMA, to increase physician competency on LGBTQ health issues.

4. Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to-date education and information to enable the provision of high quality and culturally competent care to LGBTQ people. (CSA Rep. C, I-81; Reaffirmed: CLRPD Rep. F, I-91; CSA Rep. 8 - I-94; Appended: Res. 506, A-00; Modified and Reaffirmed: Res. 501, A-07; Modified: CSAPH Rep. 9, A-08; Reaffirmation A-12; Modified: Res. 08, A-16; Modified: Res. 903, I-17; Modified: Res. 904, I-17) (emphasis added)

GLMA policy

GLMA 099-97-114 Reparative or Conversion Therapy

GLMA: Health Professionals Advancing LGBTQ Equality condemns the behavioral and psychological interventions known as "reparative" or "conversion" therapies that attempt to change sexual orientation and gender identity. (Approved 1997; Amended & Reaffirmed pending final GLMA Board approval 2018)

For additional information or assistance with legislation to ban conversion therapy in your state, please visit www.ama-assn.org/go/arc or contact Annalia Michelman, JD, Senior Legislative Attorney, AMA Advocacy Resource Center at annalia.michelman@ama-assn.org or (312) 464-4788.

AMERICAN PSYCHIATRIC ASSOCIATION

News Releases

Nov 15, 2018

APA Reiterates Strong Opposition to Conversion Therapy

Washington, D.C. – In the wake of recent popular entertainment portrayals of conversion therapy, the American Psychiatric Association (APA) today reiterates its long-standing opposition to the practice. APA made clear with its 1998 position statement that "APA opposes any psychiatric treatment, such as "reparative" or "conversion" therapy, that is based on the assumption that homosexuality per se is a mental disorder or is based on the a priori assumption that the patient should change his or her homosexual orientation."

APA expanded on that position with a statement in 2013: "The American Psychiatric Association does not believe that same-sex orientation should or needs to be changed, and efforts to do so represent a significant risk of harm by subjecting individuals to forms of treatment which have not been scientifically validated and by undermining self-esteem when sexual orientation fails to change. No credible evidence exists that any mental health intervention can reliably and safely change sexual orientation; nor, from a mental health perspective does sexual orientation need to be changed."

Conversion therapy is banned in 14 states as well as the District of Columbia. The APA calls upon other lawmakers to ban the harmful and discriminatory practice.

American Psychiatric Association

The American Psychiatric Association, founded in 1844, is the oldest medical association in the country. The APA is also the largest psychiatric association in the world with more than 37,800 physician members specializing in the diagnosis, treatment, prevention and research of mental illnesses. APA's vision is to ensure access to quality psychiatric diagnosis and treatment. For more information please visit www.psychiatry.org.

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Conversion Therapy

Approved by Council February 2018

Variations in sexual orientation and gender expression represent normal and expectable dimensions of human development. They are not considered to be pathological; therefore, they are not included in the Diagnostic and Statistical Manual of Mental Disorders, and other accepted nosological systems (1). Health promotion for all youth encourages open exploration of all identity issues, including sexual orientation, gender identity, and/or gender expression according to recognized practice guidelines (2). This fosters healthy development, especially for sexual and gender diverse youth, as they integrate their sexual orientation, gender identity, and/or gender expression, into their overall identity without any pre-determined outcome.

"Conversion therapies" (or "reparative therapies") are interventions purported to alter same-sex attractions or an individual's gender expression with the specific aim to promote heterosexuality as a preferable outcome (3, 4). Similarly, for youth whose gender identity is incongruent with their sex anatomy, efforts to change their core gender identity have also been described and more recently subsumed under the conversion therapy rubric (5). These interventions are provided under the false premise that homosexuality and gender diverse identities are pathological. They are not; the absence of pathology means there is no need for conversion or any other like intervention. Further, there is evidence that "conversion therapies" increase risk of causing or exacerbating mental health conditions in the very youth they purport to treat (2-5).

Comprehensive assessment and treatment of youth that includes exploration of all aspects of identity, including sexual orientation, gender identity, and/or gender expression is not "conversion therapy" (2). This applies whether or not there are unwanted sexual attractions and

when the gender role consistent with the youth's assigned sex at birth is non-coercively explored as a means of helping the youth understand their authentic gender identity. In the presence of gender dysphoria (distress related to the incongruence between gender identity and sex assigned at birth), the standard of care may involve exploration of living in a different gender role (appropriate to the child or adolescent's developmental understanding of gender) and/or potential use of affirming gender transition interventions to align anatomical features with one's gender identity for appropriately assessed pubertal adolescents (6, 7). This follows recognized standards of care and is not considered "conversion therapy."

The AACAP Policy on "Conversion Therapies"

The American Academy of Child and Adolescent Psychiatry finds no evidence to support the application of any "therapeutic intervention" operating under the premise that a specific sexual orientation, gender identity, and/or gender expression is pathological. Furthermore, based on the scientific evidence, the AACAP asserts that such "conversion therapies" (or other interventions imposed with the intent of promoting a particular sexual orientation and/or gender as a preferred outcome) lack scientific credibility and clinical utility. Additionally, there is evidence that such interventions are harmful. As a result, "conversion therapies" should not be part of any behavioral health treatment of children and adolescents. However, this in no way detracts from the standard of care which requires that clinicians facilitate the developmentally appropriate, open exploration of sexual orientation, gender identity, and/or gender expression, without any pre-determined outcome.

Developed by AACAP's Sexual Orientation and Gender Identity Issues Committee

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H629-A/17 LGBTQ+ CONVERSION THERAPY OR REPARATIVE THERAPY – OPPOSITION TO THE PRACTICE OF

The American Osteopathic Association (AOA) affirms that individuals who identify as lesbian, gay, bisexual, transgender, questioning, identifying as queer, or other than heterosexual (LGBTQ+) are not inherently suffering from a mental disorder.

The AOA strongly opposes the practice of conversion therapy, reparative therapy, or other techniques aimed at changing a person's sexual orientation or gender identity.

The AOA supports potential legislation, regulations, or policies that oppose the practice of conversion therapy, reparative therapy, or other techniques aimed at changing a person's sexual orientation or gender identity.

The AOA opposes the use of Sexual Orientation Change Efforts (SOCE), which is based on the assumption that homosexuality is a mental disorder that should be changed and that any effort by an osteopathic physician to participate in any SOCE activity is considered unethical. 2017

POLICY STATEMENT Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of all Children

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents

Jason Rafferty, MD, MPH, EdM, FAAP, COMMITTEE ON PSYCHOSOCIAL ASPECTS OF CHILD AND FAMILY HEALTH, COMMITTEE ON ADOLESCENCE, SECTION ON LESBIAN, GAY, BISEXUAL, AND TRANSGENDER HEALTH AND WELLNESS

As a traditionally underserved population that faces numerous health disparities, youth who identify as transgender and gender diverse (TGD) and their families are increasingly presenting to pediatric providers for education, care, and referrals. The need for more formal training, standardized treatment, and research on safety and medical outcomes often leaves providers feeling ill equipped to support and care for patients that identify as TGD and families. In this policy statement, we review relevant concepts and challenges and provide suggestions for pediatric providers that are focused on promoting the health and positive development of youth that identify as TGD while eliminating discrimination and stigma.

abstract

FREE

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Dr Rafferty conceptualized the statement, drafted the initial manuscript, reviewed and revised the manuscript, approved the final manuscript as submitted, and agrees to be accountable for all aspects of the work.

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The guidance in this statement does not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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INTRODUCTION

In its dedication to the health of all children, the American Academy of Pediatrics (AAP) strives to improve health care access and eliminate disparities for children and teenagers who identify as lesbian, gay, bisexual, transgender, or questioning (LGBTQ) of their sexual or gender identity.[1,2] Despite some advances in public awareness and legal protections, youth who identify as LGBTQ continue to face disparities that stem from multiple sources, including inequitable laws and policies, societal discrimination, and a lack of access to quality health care, including mental health care. Such challenges are often more intense for youth who do not conform to social expectations and norms regarding gender. Pediatric providers are increasingly encountering such youth and their families, who seek medical advice and interventions, yet they may lack the formal training to care for youth that identify as transgender and gender diverse (TGD) and their families.[3]

This policy statement is focused specifically on children and youth that identify as TGD rather than the larger LGBTQ population, providing brief, relevant background on the basis of current available research

TABLE 1 Relevant Terms and Definitions Related to Gender Care

Term	Definition
Sex	An assignment that is made at birth, usually male or female, typically on the basis of external genital anatomy but sometimes on the basis of internal gonads, chromosomes, or hormone levels
Gender identity	A person's deep internal sense of being female, male, a combination of both, somewhere in between, or neither, resulting from a multifaceted interaction of biological traits, environmental factors, self-understanding, and cultural expectations
Gender expression	The external way a person expresses their gender, such as with clothing, hair, mannerisms, activities, or social roles
Gender perception	The way others interpret a person's gender expression
Gender diverse	A term that is used to describe people with gender behaviors, appearances, or identities that are incongruent with those culturally assigned to their birth sex; gender-diverse individuals may refer to themselves with many different terms, such as transgender, nonbinary, genderqueer,[7] gender fluid, gender creative, gender independent, or nonclsgender. "Gender diverse" is used to acknowledge and include the vast diversity of gender identities that exists. It replaces the former term, "gender nonconforming," which has a negative and exclusionary connotation.
Transgender	A subset of gender-diverse youth whose gender identity does not match their assigned sex and generally remains persistent, consistent, and insistent over time; the term "transgender" also encompasses many other labels individuals may use to refer to themselves.
Cisgender	A term that is used to describe a person who identifies and expresses a gender that is consistent with the culturally defined norms of the sex they were assigned at birth
Agender	A term that is used to describe a person who does not identify as having a particular gender
Affirmed gender	When a person's true gender identity, or concern about their gender identity, is communicated to and validated from others as authentic
MTF; affirmed female; trans female	Terms that are used to describe individuals who were assigned male sex at birth but who have a gender identity and/or expression that is asserted to be more feminine
FTM; affirmed male; trans male	Terms that are used to describe individuals who were assigned female sex at birth but who have a gender identity and/or expression that is asserted to be more masculine
Gender dysphoria	A clinical symptom that is characterized by a sense of alienation to some or all of the physical characteristics or social roles of one's assigned gender; also, gender dysphoria is the psychiatric diagnosis in the *DSM-5*, which has focus on the distress that stems from the incongruence between one's expressed or experienced (affirmed) gender and the gender assigned at birth.
Gender identity disorder	A psychiatric diagnosis defined previously in the *DSM-IV* (changed to "gender dysphoria" in the *DSM-5*); the primary criteria include a strong, persistent cross-sex identification and significant distress and social impairment. This diagnosis is no longer appropriate for use and may lead to stigma, but the term may be found in older research.
Sexual orientation	A person's sexual identity in relation to the gender(s) to which they are attracted; sexual orientation and gender identity develop separately.

This list is not intended to be all inclusive. The pronouns "they" and "their" are used intentionally to be inclusive rather than the binary pronouns "he" and "she" and "his" and "her." Adapted from Bonifacio HJ, Rosenthal SM. Gender variance and dysphoria in children and adolescents. *Pediatr Clin North Am*. 2015;62(4):1001–1016. Adapted from Vance SR Jr, Ehrensaft D, Rosenthal SM. Psychological and medical care of gender nonconforming youth. *Pediatrics*. 2014;134(6):1184–1192. DSM-5, *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*; DSM-IV, *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*; FTM, female to male; MTF, male to female.

and expert opinion from clinical and research leaders, which will serve as the basis for recommendations. It is not a comprehensive review of clinical approaches and nuances to pediatric care for children and youth that identify as TGD. Professional understanding of youth that identify as TGD is a rapidly evolving clinical field in which research on appropriate clinical management is limited by insufficient funding.[3,4]

DEFINITIONS

To clarify recommendations and discussions in this policy statement, some definitions are provided. However, brief descriptions of human behavior or identities may not capture nuance in this evolving field. "Sex," or "natal gender," is a label, generally "male" or "female," that is typically assigned at birth on the basis of genetic and anatomic characteristics, such as genital anatomy, chromosomes, and sex hormone levels. Meanwhile, "gender identity" is one's internal sense of who one is, which results from a multifaceted interaction of biological traits, developmental influences, and environmental conditions. It may be male, female, somewhere in between, a combination of both, or neither (ie, not conforming to a binary conceptualization of gender). Self-recognition of gender identity develops over time, much the same way as a child's physical body does. For some people, gender identity can be fluid, shifting in different contexts. "Gender expression" refers to the wide array of ways people display their gender through clothing, hair styles, mannerisms, or social roles. Exploring different ways of expressing gender is common for children and may challenge social expectations. The way others interpret this expression is referred to as "gender perception" (Table 1).[5,6]

These labels may or may not be congruent. The term "cisgender" is used if someone identifies and expresses a gender that is consistent with the culturally defined norms of the sex that was assigned at birth. "Gender diverse" is an umbrella term to describe an ever-evolving array of labels that people may apply when their gender identity, expression, or even perception does not conform

to the norms and stereotypes others expect of their assigned sex. "Transgender" is usually reserved for a subset of such youth whose gender identity does not match their assigned sex and generally remains persistent, consistent, and insistent over time. These terms are not diagnoses; rather, they are personal and often dynamic ways of describing one's own gender experience.

Gender identity is not synonymous with "sexual orientation," which refers to a person's identity in relation to the gender(s) to which they are sexually and romantically attracted. Gender identity and sexual orientation are distinct but interrelated constructs.[8] Therefore, being transgender does not imply a sexual orientation, and people who identify as transgender still identify as straight, gay, bisexual, etc, on the basis of their attractions. (For more information, *The Gender Book*, found at www.thegenderbook.com, is a resource with illustrations that are used to highlight these core terms and concepts.)

EPIDEMIOLOGY

In population-based surveys, questions related to gender identity are rarely asked, which makes it difficult to assess the size and characteristics of the population that is TGD. In the 2014 Behavioral Risk Factor Surveillance System of the Centers for Disease Control and Prevention, only 19 states elected to include optional questions on gender identity. Extrapolation from these data suggests that the US prevalence of adults who identify as transgender or "gender nonconforming" is 0.6% (1.4 million), ranging from 0.3% in North Dakota to 0.8% in Hawaii.[9] On the basis of these data, it has been estimated that 0.7% of youth ages 13 to 17 years (~150 000) identify as transgender.[10] This number is much higher than previous estimates, which were extrapolated from individual states or specialty clinics, and is likely an underestimate given the stigma regarding those who openly identify as transgender and the difficulty in defining "transgender" in a way that is inclusive of all gender-diverse identities.[11]

There have been no large-scale prevalence studies among children and adolescents, and there is no evidence that adult statistics reflect young children or adolescents. In the 2014 Behavioral Risk Factor Surveillance System, those 18 to 24 years of age were more likely than older age groups to identify as transgender (0.7%).[9] Children report being aware of gender incongruence at young ages. Children who later identify as TGD report first having recognized their gender as "different" at an average age of 8.5 years; however, they did not disclose such feelings until an average of 10 years later.[12]

MENTAL HEALTH IMPLICATIONS

Adolescents and adults who identify as transgender have high rates of depression, anxiety, eating disorders, self-harm, and suicide.[13–20] Evidence suggests that an identity of TGD has an increased prevalence among individuals with autism spectrum disorder, but this association is not yet well understood.[21,22] In 1 retrospective cohort study, 56% of youth who identified as transgender reported previous suicidal ideation, and 31% reported a previous suicide attempt, compared with 20% and 11% among matched youth who identified as cisgender, respectively.[13] Some youth who identify as TGD also experience gender dysphoria, which is a specific diagnosis given to those who experience impairment in peer and/or family relationships, school performance, or other aspects of their life as a consequence of the incongruence between their assigned sex and their gender identity.[23]

There is no evidence that risk for mental illness is inherently attributable to one's identity of TGD. Rather, it is believed to be multifactorial, stemming from an internal conflict between one's appearance and identity, limited availability of mental health services, low access to health care providers with expertise in caring for youth who identify as TGD, discrimination, stigma, and social rejection.[24] This was affirmed by the American Psychological Association in 2008[25] (with practice guidelines released in 2015[8]) and the American Psychiatric Association, which made the following statement in 2012:

> *Being transgender or gender variant implies no impairment in judgment, stability, reliability, or general social or vocational capabilities; however, these individuals often experience discrimination due to a lack of civil rights protections for their gender identity or expression.... [Such] discrimination and lack of equal civil rights is damaging to the mental health of transgender and gender variant individuals.*[26]

Youth who identify as TGD often confront stigma and discrimination, which contribute to feelings of rejection and isolation that can adversely affect physical and emotional well-being. For example, many youth believe that they must hide their gender identity and expression to avoid bullying, harassment, or victimization. Youth who identify as TGD experience disproportionately high rates of homelessness, physical violence (at home and in the community), substance abuse, and high-risk sexual behaviors.[5,6,12,27–31] Among the 3 million HIV testing events that were reported in 2015, the highest percentages of new infections were among women who identified as transgender[32] and were also at particular risk for not knowing their HIV status.[30]

GENDER-AFFIRMATIVE CARE

In a gender-affirmative care model (GACM), pediatric providers offer developmentally appropriate care that is oriented toward understanding and appreciating the youth's gender experience. A strong, nonjudgmental partnership with youth and their families can facilitate exploration of complicated emotions and gender-diverse expressions while allowing questions and concerns to be raised in a supportive environment.[5] In a GACM, the following messages are conveyed:

- transgender identities and diverse gender expressions do not constitute a mental disorder;
- variations in gender identity and expression are normal aspects of human diversity, and binary definitions of gender do not always reflect emerging gender identities;
- gender identity evolves as an interplay of biology, development, socialization, and culture; and
- if a mental health issue exists, it most often stems from stigma and negative experiences rather than being intrinsic to the child.[27,33]

The GACM is best facilitated through the integration of medical, mental health, and social services, including specific resources and supports for parents and families.[24] Providers work together to destigmatize gender variance, promote the child's self-worth, facilitate access to care, educate families, and advocate for safer community spaces where children are free to develop and explore their gender.[5] A specialized gender-affirmative therapist, when available, may be an asset in helping children and their families build skills for dealing with gender-based stigma, address symptoms of anxiety or depression, and reinforce the child's overall resiliency.[34,35] There is a limited but growing body of evidence that suggests that using an integrated affirmative model results in young people having fewer mental health concerns whether they ultimately identify as transgender.[24,36,37]

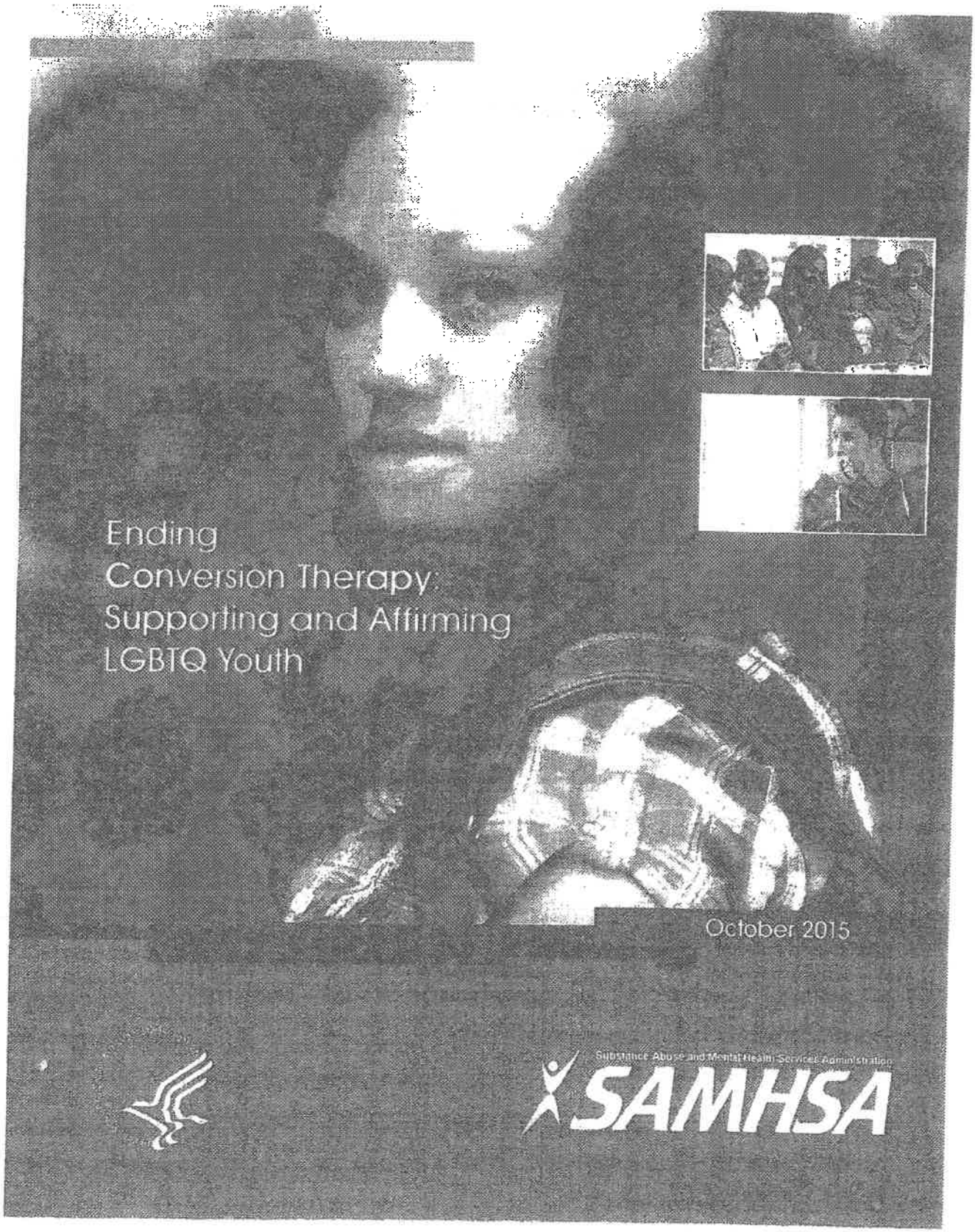
In contrast, "conversion" or "reparative" treatment models are used to prevent children and adolescents from identifying as transgender or to dissuade them from exhibiting gender-diverse expressions. The Substance Abuse and Mental Health Services Administration has concluded that any therapeutic intervention with the goal of changing a youth's gender expression or identity is inappropriate.[33] Reparative approaches have been proven to be not only unsuccessful[38] but also deleterious and are considered outside the mainstream of traditional medical practice.[29,39–42] The AAP described reparative approaches as "unfair and deceptive."[43] At the time of this writing,* conversion therapy was banned by executive regulation in New York and by legislative statutes in 9 other states as well as the District of Columbia.[44]

Pediatric providers have an essential role in assessing gender concerns and providing evidence-based information to assist youth and families in medical decision-making. Not doing so can prolong or exacerbate gender dysphoria and contribute to abuse and stigmatization.[35] If a pediatric provider does not feel prepared to address gender concerns when they occur, then referral to a pediatric or mental health provider with more expertise is appropriate. There is little research on communication and efficacy with transfers in care for youth who identify as TGD, particularly from pediatric to adult providers.

DEVELOPMENTAL CONSIDERATIONS

Acknowledging that the capacity for emerging abstract thinking in childhood is important to conceptualize and reflect on identity, gender-affirmation guidelines are being focused on individually tailored interventions on the basis of the physical and cognitive development of youth who identify as TGD.[45] Accordingly, research substantiates that children who are prepubertal and assert an identity of TGD know their gender as clearly and as consistently as their developmentally equivalent peers who identify as cisgender and benefit from the same level of social acceptance.[46] This developmental approach to gender affirmation is in contrast to the outdated approach in which a child's gender-diverse assertions are held as "possibly true" until an arbitrary age (often after pubertal onset) when they can be considered valid, an approach that authors of the literature have termed "watchful waiting." This outdated approach does not serve the child because critical support is withheld. Watchful waiting is based on binary notions of gender in which gender diversity and fluidity is pathologized; in watchful waiting, it is also assumed that notions of gender identity become fixed at a certain age. The approach is also influenced by a group of early studies with validity concerns, methodologic flaws, and limited follow-up on children who identified as TGD and, by adolescence, did not seek further treatment ("desisters").[45,47] More robust and current research suggests that, rather than focusing on who a child will become, valuing them for who they are, even at a young age, fosters secure attachment and resilience, not only for the child but also for the whole family.[5,45,48,49]

* For more information regarding state-specific laws, please contact the AAP Division of State Government Affairs at stgov@aap.org.


Ending
Conversion Therapy:
Supporting and Affirming
LGBTQ Youth
October 2015
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SAMHSA

Ending Conversion Therapy: Supporting and Affirming LGBTQ Youth

October 2015

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Executive Summary

Lesbian, gay, bisexual, and *transgender* youth, and those who are *questioning* their sexual orientation or gender identity (*LGBTQ* youth) experience significant health and behavioral health disparities. Negative social attitudes and discrimination related to an individual's LGBTQ identity can contribute to these disparities, and may result in institutional, interpersonal, and individual stressors that affect mental health and well-being. (Bockting, Miner, Swinburne Romine, Hamilton, & Coleman, 2013; Meyer, 2003). This stress, as well as limited opportunities for support, are encountered by *sexual and gender minority*[1] youth in their families, communities, and school settings. Additionally, some transgender youth experience gender dysphoria – psychological distress due to the incongruence between one's body and gender identity (Coleman et al., 2012).

SAMHSA is committed to eliminating health disparities facing vulnerable communities, including sexual and gender minority communities. One key factor to preventing these adverse outcomes is positive family (including guardians and caregivers) and community engagement and appropriate interventions by medical and behavioral health care providers. Supporting optimal development of children and adolescents with regard to sexual orientation, gender identity, and gender expression is vital to ensuring their health and well-being.

The purpose of this report, *Ending Conversion Therapy: Supporting and Affirming LGBTQ outh*, is to provide mental health professionals and families with accurate information about effective and ineffective therapeutic practices related to children's and adolescent's sexual orientation and gender identity. Specifically, this report addresses the issue of conversion therapy for minors. The conclusions in this report are based on professional consensus statements arrived at by experts in the field. Specifically, conversion therapy—efforts to change an individual's sexual orientation, gender identity, or gender expression[2]—is a practice that is not supported by credible evidence and has been disavowed by behavioral health experts and associations. Conversion therapy perpetuates outdated views of gender roles and identities as well as the negative stereotype that being a sexual or gender minority or identifying as LGBTQ is an abnormal aspect of human development. Most importantly, it may put young people at risk of serious harm.

Key Findings

This report and its recommendations are based on consensus statements developed by experts in the field after a careful review of existing research, professional health association reports and summaries, and expert clinical guidance. The consensus statements highlight areas of the ethical and scientific foundations most relevant to the practice of conversion therapy with minors. A full list of the consensus statements is found in the body of this report; key statements that form the underpinnings of the guidance in this report are provided here.

- Same-gender sexual orientation (including identity, behavior, and attraction) and variations in gender identity and gender expression are a part of the normal spectrum of human diversity and do not constitute a mental disorder.
- There is limited research on conversion therapy efforts among children and adolescents; however, none of the existing research supports the premise that mental or behavioral health interventions can alter gender identity or sexual orientation.
- Interventions aimed at a fixed outcome, such as gender conformity or heterosexual orientation, including those aimed at changing gender identity, gender expression, and sexual orientation are coercive, can be harmful, and should not be part of behavioral health treatment. (American Psychiatric Association, 2013b; American Psychological Association, 2010; National Association of Social Workers, 2008).

Understanding Sexual Orientation and Gender Identity in Children and Youth

Behavioral health providers, parents, schools, and communities can best provide support to children, adolescents, and their families when they have access to the most current information about sexual orientation, gender identity, and gender expression in youth. The following overview presents the best current evidence regarding understandings of child and adolescent sexual orientation, gender identity, and gender expression.

Sexuality occurs across a continuum; same-gender attraction and relationships are normal variations of human sexuality (Diamond, 2015; Vrangalova & Savin-Williams, 2012). Similarly, a gender identity that is incongruent with assigned sex at birth, as well as a gender expression that diverges from stereotypical cultural norms for a particular gender, are normal variations of human gender (American Psychological Association, 2015a; Knudson, De Cuypere, & Bockting, 2010). Being a sexual or gender minority, or identifying as LGBTQ, is not pathological (American Psychological Association, 2015a; APA Task Force on Gender Identity and Gender Variance, 2009; Coleman et al., 2012).

There is not a single developmental trajectory for either sexual minority or gender minority youth. Compared to the 20th century, in the 21st century, youth started realizing and disclosing a minority sexual orientation and/or identifying as lesbian, gay, or bisexual at younger ages than in previous generations (Diamond & Savin-Williams, 2000; Floyd & Bakeman, 2006; Grov, Bimbi, Nanín, & Parsons, 2006; R. C. Savin-Williams, 2001). Though aspects of sexuality are displayed beginning in infancy, little is known about sexual orientation among pre-pubertal children (Adelson & American Academy of Child and Adolescent Psychiatry (AACAP) Committee on Quality Issues (CQI), 2012). Children are rarely if ever distressed about their current or future sexual orientation; more commonly, parents and guardians are distressed about a child's perceived current or future sexual orientation and seek the assistance of behavioral health providers (American Psychological Association, 2009). Sexual minority adolescents face the same developmental tasks that accompany adolescence for all youth, including sexual orientation identity development. Unlike those with a heterosexual orientation, however, adolescents with a minority sexual orientation must navigate awareness and acceptance of a socially marginalized sexual identity; potentially without family, community, or societal support. In comparison with their heterosexual counterparts, sexual minority adolescents are at increased risk for psychological distress and substance use behaviors, including depressive symptoms, increased rates of substance use and abuse, suicidal ideation and attempts, as well as increased likelihood of experiencing victimization, violence, and homelessness (Corliss et al., 2010; Friedman et al., 2011; Goldbach, Tanner-Smith, Bagwell, & Dunlap, 2014; Hatzenbuehler, 2011; Institute of Medicine, 2011; Kann et al., 2011; Marshal et al., 2011; Russell, 2003). Supportive families, peers, and school and community environments are associated with improved psychosocial outcomes for sexual minority youth (Bouris et al., 2010; Kosciw, Greytak, Palmer, & Boesen, 2014; Lease, Horne, & Noffsinger-Frazier, 2005).

Gender development begins in infancy and continues progressively throughout childhood. Gender diversity or signs of gender dysphoria may emerge as early as a child's preschool years, or as late as adolescence (Cohen-Kettenis, 2005). For many gender minority children, gender dysphoria will not persist, and they will develop a *cisgender* identity in adolescence or adulthood; a majority of these children will identify as lesbian, gay, or bisexual in adulthood (Bailey & Zucker, 1995; Drescher, 2014; Leibowitz & Spack, 2011; Wallien & Cohen-Kettenis, 2008). Whether or not these individuals continue to have a diverse gender expression is unknown. For other gender minority children, gender dysphoria will persist and usually worsen with the physical changes of adolescence; these youth generally identify as transgender (or another gender identity that differs from their assigned sex at birth) in adolescence and adulthood

(Byne et al., 2012; Coleman, et al., 2012). For still another group, gender dysphoria emerges in post-puberty without any childhood history of gender dysphoria gender diversity (Edwards-Leeper & Spack, 2012). Gender dysphoria that worsens with the onset of puberty is unlikely to remit later in adolescence or adulthood, especially among youth with a childhood onset, and long-term identification as transgender is likely (American Psychological Association, 2015a; American Psychological Association, 2008; Byne, et al., 2012).

While most adolescents with gender dysphoria score within normal ranges on psychological tests (Cohen-Kettenis & van Goozen, 1997; de Vries, Doreleijers, Steensma, & Cohen-Kettenis, 2011; Smith, van Goozen, & Cohen-Kettenis, 2001), some gender minority children and adolescents have elevated risk of depression, anxiety, and behavioral issues. These psychosocial issues are likely related to if not caused by negative social attitudes or rejection (Vance, Ehrensaft, & Rosenthal, 2014). As with sexual minority adolescents, other issues of clinical relevance for gender minority adolescents include increased risk of experiencing victimization and violence, suicidal ideation and attempts, and homelessness (Coleman, et al., 2012; Garofalo, Deleon, Osmer, Doll, & Harper, 2006; Institute of Medicine, 2011; Mustanski, Garofalo, & Emerson, 2010; Simons, Leibowitz, & Hidalgo, 2014). Improved psychosocial outcomes are seen among youth when social supports are put in place to recognize and affirm gender minority youth's gender identities (Vance, et al., 2014).

Therapeutic Efforts with Sexual and Gender Minority Youth[4]

Given the professional consensus that conversion therapy efforts are inappropriate, the following behavioral health approaches are consistent with the expert consensus statements and current research, and are recommended by professional associations (American Psychological Association, 2015a; APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009; Byne, et al., 2012). When providing services to children, adolescents, and families, appropriate therapeutic approaches include: providing accurate information on the development of sexual orientation and gender identity and expression; increasing family and school support; and reducing family, community, and social rejection of sexual and gender minority children and adolescents. Approaches should be client-centered and developmentally-appropriate with the goal of treatment being the best possible level of psychological functioning, rather than any specific gender identity, gender expression, or sexual orientation. Appropriate therapeutic approaches with sexual and gender minority youth should include a comprehensive evaluation and focus on identity development and exploration that allows the child or adolescent the freedom of self-discovery within a context of acceptance and support. It is important to identify the sources of any distress experienced by sexual and gender minority youth and their families, and work to reduce this distress. Working with parents and guardians is important as parental behaviors and attitudes have a significant effect on the mental health and well-being of sexual and gender minority children and adolescents. School and community interventions may also be necessary and appropriate.

In addition to the appropriate therapeutic approaches described above – comprehensive evaluation, support in identity exploration and development without an *a priori* goal of any particular gender identity or expression, and facilitation of family and community support – social transition and medical intervention are therapeutic approaches that are appropriate for some gender minority youth. Careful evaluation and developmentally-appropriate informed consent of youth and their families, including a weighing of potential risks and benefits are vital when considering medical intervention with gender minority youth.

Eliminating the practice of conversion therapy with sexual and gender minority minors is an important step, but it will not alleviate the myriad of stressors they experience as a result of interpersonal, institutional, and societal bias and discrimination against sexual and gender minorities.

LGBTQ youth still need additional support to promote positive development in the face of such stressors. Supportive family, community, school, and health care environments have been shown to have great positive impacts on both the short- and long-term health and well-being of LGBTQ youth. Families and others working with LGBTQ children and adolescents can benefit from guidance and resources to increase support for sexual and gender minority minors and to help facilitate the best possible outcomes for these youth.

Ending the Use of Conversion Therapy for Minors

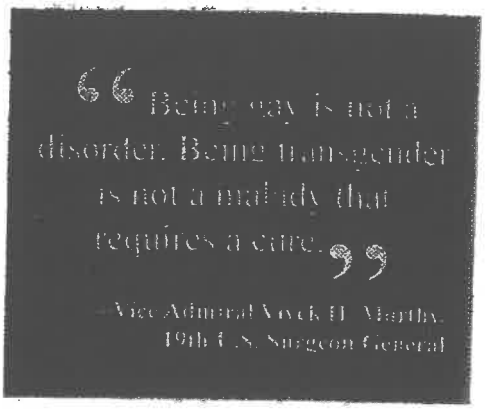
Given that conversion therapy is not an appropriate therapeutic intervention; efforts should be taken to end the practice of conversion therapy. Efforts to end the practice have included policy efforts to reduce the negative attitudes and discrimination directed at LGBTQ individuals and families; affirmative public information about LGBTQ individuals, particularly directed at families and youth; resolutions and guidelines by professional associations to inform providers that conversion efforts are inappropriate and to provide guidance on appropriate interventions; and, state and federal legislation and legal action to end the practice of conversion therapy. Future efforts may include improved provider training, federal regulatory action, advancement of legislation at the state and federal level, and additional activities by the Administration, which issued a public statement supporting efforts to ban the use of conversion therapy for minors in the spring of 2015.

Introduction

This report, *Ending Conversion Therapy: Supporting and Affirming LGBTQ outh*, provides an overview of the current state of scientific understanding of the development of sexual orientation and gender identity in children and adolescents as well as the professional consensus on clinical best practices with these populations. Specifically, this report addresses the issue of conversion therapy for minors. Conversion therapy—efforts to change an individual's sexual orientation, gender identity, or gender expression[5]—is a practice that is not supported by credible evidence, and has been disavowed by behavioral health experts and associations. Importantly, this report also provides a nuanced overview of appropriate supportive interventions to assist families in exploring the sometimes difficult issues associated with sexual orientation, gender identity, and gender expression.

This work is the result of a collaboration between the Substance Abuse and Mental Health Services Administration (SAMHSA) and the American Psychological Association (APA), which convened a panel of behavioral health professionals (e.g., psychologists, researchers and clinicians from psychology, social work, and psychiatry) with expertise in the fields of gender development, gender identity, and sexual orientation in children and adolescents in July 2015. That convening, which is discussed in greater depth below, aimed to establish consensus with respect to conversion therapy for minors, based on the best available research and scholarly material available, as well as the clinical experience of experts in the field. The resultant statements of professional consensus are printed in their entirety in the following section.

In addition, this report highlights areas of opportunity for future research, and provides an overview of mechanisms to eliminate the use of harmful therapies. In an effort to provide useful tools for families, practitioners, and educators, the report also provides resources on several topics, including: *Family and Community Acceptance*, *School-Based Issues*, *Pediatric Considerations*, and *Affirmative Exploratory Therap* . In addressing these four topics, SAMHSA aims to enable families, providers, educators, and community members to take actions that will reduce the health risks and disparities facing this vulnerable population.



SAMHSA is committed to eliminating health disparities facing vulnerable communities, including sexual and gender minority communities. In addressing the issues included in this report that have a significant impact on the lives and well-being of sexual and gender minority youth, SAMHSA aims to enable families, providers, and educators to take actions that will reduce the health risks and disparities facing this vulnerable population

SAMHSA's mission is to improve the behavioral health of the nation. As such, SAMHSA endeavors to improve public health and eliminate health disparities facing all vulnerable communities, including sexual and gender minority populations.[6]As will be addressed in detail below, conversion therapy perpetuates outdated gender roles and negative stereotypes that being a sexual or gender minority or identifying as LGBTQ is an abnormal aspect of human development. Most importantly, it may put young people at risk of serious harm. This report is one of many steps SAMHSA is taking to improve the health and well-being of sexual and gender minority children and youth.

Professional Consensus Process

In early April 2015, representatives from SAMHSA and APA agreed to collaborate to address the concerns of professional associations, policy makers, and the public regarding efforts to change gender identity and sexual orientation in children and adolescents (also referred to as conversion therapy). Through the support of the Federal Agencies Project, APA hosted an expert consensus convening on this topic in July 2015, which significantly informed this report. The research overview and clinical expertise highlighted throughout serve as the foundation from which the consensus statements were developed. Both the process of achieving consensus and the results of the meeting are published below.

APA initially developed a list of the areas of expertise to be used in identifying potential experts to participate in the consensus panel based on existing professional guidelines and resolutions related to sexual orientation, gender identity, and gender expression, as well as published research. APA solicited nominations from specialists in the field with expertise in gender, sexuality and sexual orientation, child and adolescent development and mental health, and the psychology of religion. Additionally, APA solicited nominations from professional associations representing the major mental health and health professions. Using the input received from these sources, APA extended invitations to a short list of highly recommended group of experts. This initial expert pool nominated additional experts based on their assessment of the expertise needed to achieve the goals of the meeting. The final panel of 13 experts consisted of ten psychologists, two social workers, and one psychiatrist. These individuals included researchers and practitioners in child and adolescent mental health with a strong background in gender development, gender identity, and sexual orientation in children and adolescents. The panel also included experts with a background in family therapy, ethics, and the psychology of religion. Among others, the panel included: Sheri Berenbaum, PhD; Celia B. Fisher, PhD; Laura Edwards-Leeper, PhD; Marco A. Hidalgo, PhD; David Huebner, PhD; Colton L. Keo-Meier, PhD; Scott Leibowitz, MD; Robin Lin Miller, PhD; Caitlin Ryan, PhD, ACSW; Josh Wolff, PhD; and Mark Yarhouse, PsyD. APA activities were coordinated by Clinton W. Anderson, PhD and Judith Glassgold, PsyD.

Based on published literature on consensus methods, APA developed an iterative process that culminated in a two-day meeting in Washington, DC on July 7 and 8, 2015. During the meeting, panelist-led discussions considered the relevant research, professional guidelines and clinical knowledge-base for each of the topics. The panel developed consensus statements on sexual orientation change efforts as well as gender identity change efforts in children and adolescents for each of the relevant developmental stages: pre-pubertal children, peri-pubertal adolescents, and pubertal and post-pubertal adolescents.

Panelists agreed that unanimous consensus was a strong priority, but that if unanimity could not be reached, 80 percent support would consitute consensus. The panelists also agreed that minority opinions should be reflected in the record if any dissenting expert wished to issue such an opinion. Unanimous consensus was reached in nearly all instances. No dissenting opinions were formally registered. The statements of professional consensus are printed in *Section 3* of this report.

Observers from interested federal agencies, health and human services professional organizations, foundations, and LGBTQ human rights organizations also attended the meeting. These observers were offered an opportunity to submit written questions, which the panel addressed throughout the course of the meeting.

Statements of Professional Consensus

The following are the statements of professional consensus regarding sexual orientation and gender identity and expression that were developed during the July 2015 APA consensus convening. After initially developing separate statements regarding issues relating to the development of sexual orientation and gender identity and gender expression, the panel developed a set of three key summary statements. The panel also developed a statement regarding the guiding human rights and scientific principles that provide a foundation for behavioral health professionals' work in this area.

Guiding Principles

Behavioral health professionals respect human dignity and rights. The foundational ethical principle of "self-determination" requires that children and adolescents be supported in their right to explore, define, and articulate their own identity. The principles of "justice" and "beneficence and nonmaleficence" require that all children and adolescents have access to behavioral health treatments that will promote their health and welfare. Children and adolescents have the right to participate in decisions that affect their treatment and future. Behavioral health professionals respect human diversity and strive to incorporate multicultural awareness into their work.

These guiding principles are based upon the codes of ethics for the professional fields of Psychology, Psychiatry, and Social Work (American Psychiatric Association, 2013b; American Psychological Association, 2010; National Association of Social Workers, 2008).

Professional Consensus on Conversion Therapy with Minors

1. **Same-gender[7]sexual orientation (including identity, behavior, and/or attraction) and variations in gender identity and gender expression are a part of the normal spectrum of human diversity and do not constitute a mental disorder.**
2. **There is limited research on conversion therapy efforts among children and adolescents; however, none of the existing research supports the premise that mental or behavioral health interventions can alter gender identity or sexual orientation.**
3. **Interventions aimed at a fixed outcome, such as gender conformity or heterosexual orientation, including those aimed at changing gender identity, gender expression, and sexual orientation are coercive, can be harmful, and should not be part of behavioral health treatments. Directing the child to be conforming to any gender expression or sexual orientation, or directing the parents to place pressure for specific gender expressions, gender identities, and sexual orientations are inappropriate and reinforce harmful gender and sexual orientation stereotypes.**

Professional Consensus on Sexual Orientation in Youth

1. Same-gender sexual identity, behavior, and attraction are not mental disorders. Same-gender sexual attractions are part of the normal spectrum of sexual orientation. Sexual orientation change in children and adolescents should not be a goal of mental health and behavioral interventions.
2. Sexual minority children and adolescents are especially vulnerable populations with unique developmental tasks who lack protections from involuntary or coercive treatment, and whose parents and guardians need accurate information to make informed decisions about behavioral health treatment.
3. There is a lack of published research on efforts to change sexual orientation among children and adolescents; no existing research supports that mental health and behavioral interventions with children and adolescents alter sexual orientation. Given the research on the secondary outcomes of such efforts, the potential for risk of harm suggests the need for other models of behavioral health treatment.
4. Behavioral health professionals provide accurate information on sexual orientation, gender identity, and expression; increase family and school support; and, reduce rejection of sexual minority youth. Behavioral health practitioners identify sources of distress and work to reduce distress experienced by children and adolescents. Behavioral health professionals provide efforts to encourage identity exploration and integration, adaptive coping, and family acceptance to improve psychological well-being.

Professional Consensus on Gender Identity and Gender Expression in Youth

Consensus on the Overall Phenomena of Gender Identity and Gender Expression

1. Variations in gender identity and expression are normal aspects of human diversity and do not constitute a mental disorder. Binary definitions of gender may not reflect emerging gender identities.
2. Pre-pubertal children and peri-pubertal adolescents who present with diverse gender expressions or gender dysphoria may or may not develop a transgender identity in adolescence or adulthood. In pubertal and post-pubertal adolescents, diverse gender expressions and transgender identity usually continue into adulthood.

Consensus on Efforts to Change Gender Identity

3. There is a lack of published research on efforts to change gender identity among children and adolescents; no existing research supports that mental health and behavioral interventions with children and adolescents alter gender identity.
4. It is clinically inappropriate for behavioral health professionals to have a prescriptive goal related to gender identity, gender expression, or sexual orientation for the ultimate developmental outcome of a child's or adolescent's gender identity or gender expression.
5. Mental health and behavioral interventions aimed at achieving a fixed outcome, such as gender conformity, including those aimed at changing gender identity or gender expression, are coercive, can be harmful, and should not be part of treatment. Directing the child or adolescent to conform to any particular gender expression or identity, or directing parents and guardians to place pressure on the child or adolescent to conform to specific gender expressions and/or identities, is inappropriate and reinforces harmful gender stereotypes.

Consensus on Appropriate Therapeutic Intervention for Youth with Gender-Related Concerns

6. Children and adolescents experiencing gender-related concerns are an especially vulnerable population with unique developmental tasks. Parents and guardians need accurate scientific information to make informed decisions about appropriate mental health and behavioral interventions, including whether or not to initiate a social gender transition or, in the case of peri-pubertal, pubertal, and post-pubertal adolescents, medical intervention. Treatment discussions should respect the child's and adolescent's developing autonomy, recognizing that adolescents are still transitioning into adult decision-making capacities.
7. Approaches that focus on developmentally-appropriate identity exploration, integration, the reduction of distress, adaptive coping, and family acceptance to improve psychological well-being are recommended for children and adolescents of all ages experiencing gender-related concerns.

Pre-Pubertal Children

8. Gender expression and gender identity are interrelated and difficult to differentiate in pre-pubertal children, and are aspects of identity that develop throughout childhood. Therefore, a detailed psychological assessment should be offered to children and families to better understand the present status of a child's gender identity and gender expression, as well as any associated distress.

Peri-Pubertal Adolescents

9. For peri-pubertal adolescents, the purpose of pubertal suppression is to provide time to support identity exploration, to alleviate or avoid potential distress associated with physical maturation and secondary sex characteristics[4], and to improve future healthy adjustment. If pubertal suppression is being considered, it is strongly recommended that parents or guardians and medical providers obtain an assessment by a licensed behavioral health provider to understand the present status of a peri-pubertal adolescent's gender identity or gender expression and associated distress, as well as to provide developmentally-appropriate information to the peri-pubertal adolescent, parents or guardians, and other health care professionals involved in the peri-pubertal adolescent's care. The purpose of the assessment is to advise and inform treatment decisions regarding pubertal suppression after sharing details of the potential risks, benefits, and implications of pubertal suppression, including the effects of pubertal suppression on behavioral health disorders, cognitive and emotional development, and future physical and sexual health.

Pubertal and Post-Pubertal Adolescents

10. Decision-making regarding one's developing gender identity is a highly individualized process and takes many forms. For pubertal and post-pubertal adolescents, if physical gender transition (such as hormone therapy or gender affirming surgeries) is being considered, it is strongly recommended that adolescents, parents, and providers obtain an assessment by a licensed behavioral health provider to understand the present status of an adolescent's gender identity and gender expression and associated distress, as well as to provide developmentally-appropriate information to adolescents, parents or guardians, and other health care professionals involved in the pubertal or post-pubertal adolescent's care. If physical transition is indicated, the potential risks, benefits, and implications of the transition-related procedures being considered – including the effects on behavioral health disorders, cognitive and emotional development, and potentially irreversible effects on physical health, fertility, and sexual health – are presented to the adolescent and parents or guardians.

    Withholding timely physical gender transition interventions for pubertal and post-pubertal adolescents, when such interventions are clinically indicated, prolongs gender dysphoria and exacerbates emotional distress.

Research Overview

Sexual Orientation

Sexual orientation is a multidimensional construct that consists of sexual identity, sexual and romantic attraction, and sexual behavior. Great shifts in the understanding of sexual orientation have occurred over the past century (Herek, 2010). Though a minority sexual orientation was once considered abnormal or a medical problem, scientists now understand that sexuality occurs on a continuum and variations in sexual orientation are part of the normal range of human sexuality (American Psychological Association, 2009; Diamond, 2015; Vrangalova & Savin-Williams, 2012). In 1973, homosexuality was removed as a diagnostic category in the Diagnostic and Statistical Manual of Mental Disorders with a declaration of support for the civil rights of lesbian, gay, and bisexual people from the American Psychiatric Association. Many health organizations followed suit in passing resolutions that affirmed their support for the civil rights of lesbian, gay, and bisexual people, including the American Psychological Association, the National Association for Social Workers, the American Counseling Association, the American Medical Association, the American Psychoanalystic Association, and the American Academy of Pediatrics. In 1992, the World Health Organization removed homosexuality from the International Classification of Diseases (Nakajima, 2003; World Health Organization, 1992)[9].

Gender

Gender is a ubiquitous and multi-faceted social category. When discussing the concept of gender, scientists distinguish between biological sex, gender identity, and gender expression. Biological sex refers to one's physical sex characteristics (Hughes, Houk, Ahmed, & Lee, 2006). Infants' biological sex is labeled at birth, almost always based solely on external genital appearance; this is referred to as one's assigned sex at birth[10]. Gender identity refers to a person's deeply felt, inherent sense of being a girl, woman or female; a boy, a man or male; a blend of male or female; or an alternative gender (Bethea, 2013; Institute of Medicine, 2011). Gender expression refers to the ways a person communicates their gender within a given culture, including clothing, communication patterns, and interests; a person's gender expression may or may not be consistent with socially prescribed gender roles or assigned sex at birth, and may or may not reflect his or her gender identity (American Psychological Association, 2008).

Similar to sexual orientation, significant changes have occurred over time in the scientific understanding of gender. Though one's biological sex, gender identity, and gender expression are distinct constructs, society expects that they will align, and for most individuals this is true – that is, most individuals who are assigned female at birth identify as girls or women and adopt a feminine gender expression, while most individuals who are assigned male at birth identify as boys or men and adopt a masculine gender expression[11](American Psychological Association, 2015a). However, for some individuals, these constructs do not align. The term transgender refers to individuals whose gender identity is not consistent with their sex assigned at birth. The term gender diverse (or gender nonconforming) refers to individuals whose gender expression does not conform to the stereotypical norms in their culture for their assigned sex at birth. Research in recent decades has also challenged the perception of gender as a binary construct with mutually exclusive categories of male or female, boy or girl, man or woman (American Psychological Association, 2015a; Steensma, Kreukels, de Vries, & Cohen-Kettenis, 2013). It has also often been assumed that one's gender identity – that is, the deeply felt, inherent sense of one's gender – always aligns with sex assigned as birth (American Psychological Association, 2015a). Scientists now recognize that a wide spectrum of gender identities and gender expressions exist (and have always existed), including people who identify as either man or woman, neither man nor woman,

a blend of man and woman, or a unique gender identity (Harrison, Grant, & Herman, 2012; Kuper, Nussbaum, & Mustanski, 2012).

Furthermore, scientists and clinicians now understand that identifying with a gender that does not align with sex assigned at birth, as well as a gender expression that varies from that which is stereotypical for one's gender or sex assigned at birth, is not inherently pathological (American Psychological Association, 2015a; Coleman, et al., 2012; Knudson, De Cuypere, & Bockting, 2010) and does not always require clinical attention (Steensma, Kreukels, et al., 2013). However, people may experience distress associated with discordance between their gender identity and their body or sex assigned at birth (i.e., gender dysphoria) as well distress associated with negative social attitudes and discrimination (Coleman, et al., 2012). This paradigmatic shift in the understanding of diverse gender identities and expressions was reflected in the replacement of Gender Identity Disorder with Gender Dysphoria in the 2013 edition of the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2013a). The diagnosis of Gender Dysphoria, which is marked in children and adolescents by clinically significant distress encountered by the discordance between biological sex and gender identity that disrupts school or social functioning, depathologizes diverse gender identities and expressions, instead focusing on the potential psychosocial challenges associated with gender diversity (American Psychiatric Association, 2013a; Simons, et al., 2014; Vance, et al., 2014).

Sexual Orientation and Gender in Childhood

Sexual Orientation in Childhood

Sexual orientation, as usually conceptualized, begins at or near adolescence with the development of sexual feelings (APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009). While children display aspects of sexuality from infancy, and almost universally develop sexual feelings by adolescence or earlier, the limited research focused on children's sexuality generally does not assess sexual orientation (Adelson & AACAP CQI, 2012). Therefore, little is known about sexual orientation in pre-pubertal children, and no direct research on sexual orientation in pre-pubertal children has been conducted. Studies that have retrospectively asked lesbian, gay, and bisexual adults about their childhood experiences have reported that LGB adults often describe having had same-gender emotional and sexual feelings and attractions from childhood or early adolescence; many recall a sense of being different even earlier in childhood (APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009).

Gender Identity and Gender Expression in Childhood

Gender-related development begins in infancy and continues progressively throughout childhood. Research has focused on three key concepts: gender constancy, gender consistency, and gender identity. On average, children develop gender constancy – stability across time in identification of their gender – between ages 3 to 4 (Kohlberg, 1966) and gender consistency – recognition that gender remains the same across situations – between ages 4 to 7 (Siegal & Robinson, 1987). The development of gender identity appears to be the result of a complex interplay between biological, environmental, and psychological factors (Steensma, Kreukels, et al., 2013). For most people, gender identity develops in alignment with one's sex assigned at birth. However, for some individuals, gender identity may not align with one's assigned sex at birth, and the period during which gender identity is clarified and solidified is unclear (Diamond & Butterworth, 2008; Steensma, Kreukels, et al., 2013). There is no single trajectory of gender identity development for gender minority children.

It is important to note that research on gender identity issues among children is largely clinical in nature and focuses on the treatment and intervention of Gender Dysphoria and, previously, Gender Identity Disorder[12](APA Task Force on Gender Identity and Gender Variance, 2009). Though there

have been no epidemiological studies to determine the prevalence of gender diverse and transgender children or adolescents, there has been a notable increase in the number of gender minority youth presenting to specialty gender clinics in the past decade (Vance, et al., 2014). Recent evidence indicates that as a culture becomes more supportive of gender diversity, more children are affirming a transgender identity or diverse gender expressions (Vance, et al., 2014).

Some gender non-conforming children experience significant distress, currently termed *gender dysphoria*. Signs of gender dysphoria may emerge as early as the preschool years; children as young as two years may indicate that they want to be another gender, express dislike for the gender associated with their sex assigned at birth, express anatomic dysphoria, and state that they want to be another gender as soon as they can express language (Cohen-Kettenis, 2005). For most gender minority children, gender dysphoria does not persist through adolescence. Existing research suggests that between 12 percent and 50 percent of children attending a specialty clinic for gender dysphoria may persist in their identification with a gender different than sex assigned at birth into late adolescence and young adulthood (Drummond, Bradley, Peterson-Badali, & Zucker, 2008; Steensma, McGuire, Kreukels, Beekman, & Cohen-Kettenis, 2013; Wallien & Cohen-Kettenis, 2008). These studies were based on clinical samples of youth and many of the researchers categorized youth no longer attending the clinics (whose gender identity may be unknown) as no longer gender dysphoric, and so this research likely underestimates the percentage of youth who persist with a cross-gender or transgender identity (American Psychological Association, 2015a).

The fact that a large proportion of gender minority children do eventually develop a gender identity consistent with their sex assigned at birth has been viewed as evidence of the malleability of gender identity (Zucker, 2004; Zucker & Bradley, 1995). However, this conclusion has been challenged in recent years by some scholars. These researchers and clinicians have pointed out that the diagnostic criteria for Gender Dysphoria (and, previously, Gender Identity Disorder) in Childhood includes indicators that might denote gender dysphoria or gender identity, but might also simply be markers of diverse gender expression (for example, children's play preferences; Steensma, Biemond, de Boer, & Cohen-Kettenis, 2011; Steensma, McGuire, et al., 2013). These scholars have suggested that the inclusion in study samples of many children with diverse gender expressions who may not have gender dysphoria could explain the large proportion of gender minority children who eventually do not meet the diagnostic criteria in adolescence (Hidalgo et al., 2013; Wallien & Cohen-Kettenis, 2008).

One of gender's greatest complexities is that some people never identify with the sex they were assigned at birth, some people consistently identify with the sex they were assigned at birth, and still others vary over time. Gender minority children follow two trajectories[13]: On the first, children will experience gender dysphoria through adolescence and adulthood (unless dysphoria is mitigated through social or medical transition) and will identify as transgender or as a gender different from that assigned at birth. On the other trajectory, gender minority children will develop to be cisgender individuals, i.e., they will eventually identify with a gender consistent with their sex assigned at birth (Simons, et al., 2014). Gender minority children who eventually develop a cisgender identity are more likely to identify as lesbian, gay, or bisexual in adolescence and young adulthood (Bailey & Zucker, 1995; Drescher, 2014; Leibowitz & Spack, 2011; Wallien & Cohen-Kettenis, 2008). It is unknown whether gender minority children who develop a cisgender identity continue to express their gender in ways that do not conform to stereotypical gender norms, as this has not been studied. No prospective data exist on factors that might predict for any particular child which trajectory they will follow. There is, however, recent retrospective evidence identifying factors that are more common among children who eventually identify as transgender: early cognitive ("I am a girl") rather than affective ("I feel like a girl") assertion of gender; consistent and firm gender-

fluid or gender-crossing expressions and identity; and distress about the incongruence between their physical sex characteristics and affirmed gender (Steensma, Biemond, de Boer, & Cohen-Kettenis, 2011; Steensma, McGuire, et al., 2013; Vance, et al., 2014).

Clinical Issues in Childhood

Researchers have not systematically investigated whether children experience distress related to their sexual orientation. No published research suggests that children are distressed about their sexual orientation. When pre-pubertal children are referred to behavioral health professionals for concerns related to sexual orientation, such referrals are often precipitated by a parent or guardian's concern or distress about a child's behavior – generally, a failure to conform to stereotypical gender role behaviors – and possible future sexual orientation (APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009). Research has shown that gender diverse children who develop a cisgender identity do have a higher likelihood of identifying as a sexual minority in adulthood, and that some (but not all) sexual minority adults recall gender nonconforming behaviors in childhood (APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009). It is unknown whether cisgender lesbian, gay, and bisexual adults who were treated by behavioral health providers as youth experienced distress related to their gender nonconformity (APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009).

Gender minority children are not a monolithic group: some gender diverse children are distressed; while others are not distressed, but may be referred for mental health care because of parental concerns related to their gender or perceived future sexual orientation. Among those who are distressed, the source of distress varies. Some gender diverse children are distressed by their primary sex characteristics or by the anticipation of future sex characteristics, while others are not (Coleman, et al., 2012; Vance, et al., 2014). In addition to anatomical dysphoria, children's feelings of gender typicality, gender contentedness, and pressure to conform to stereotypical gender norms also appear related to children's psychosocial adjustment. Researchers have reported on the relationships between these various components of gender identity and indicators of children's psychosocial adjustment, such as self-esteem, internalizing and externalizing problems, and social competence with peers (Carver, Yunger, & Perry, 2003; Egan & Perry, 2001; Yunger, Carver, & Perry, 2004).

Gender minority children, on average, have poorer relationships with parents (Adelson & AACAP CQI, 2012; Alanko et al., 2009) and peers (Smith & Leaper, 2006; Zucker, 2005), experience high rates of mistreatment from peers (D'Augelli, Grossman, & Starks, 2006), and are at increased risk of physical and sexual abuse in childhood, as compared to their gender conforming peers (Roberts, Rosario, Corliss, Koenen, & Austin, 2012). Clinical samples of gender minority children with gender dysphoria have increased rates of internalizing disorders, such as depression and anxiety (de Vries, et al., 2011; Spack et al., 2012) and behavioral problems (Simons, et al., 2014; Zucker, 2004), as compared to the general population of children. Behavioral issues among those with gender dysphoria increase with age; poor peer relations explain most of the variance in behavioral problems among children with gender dysphoria (Zucker, 2004). Negative social attitudes or rejection are likely related if not the direct causes of these psychological difficulties (Vance, et al., 2014). Additionally, autism spectrum disorders appear to occur more commonly among clinical samples of children with gender dysphoria than among children in the general population, though the reason for this increased co-occurrence, and whether this increased co-occurrence also occurs outside of clinic populations, is not fully understood (de Vries, et al., 2010; Edwards-Leeper & Spack, 2012).

Sexual Orientation and Gender in Adolescence

Sexual Orientation in Adolescence

Significant physical, cognitive, and social development occurs during adolescence. Sexual minority adolescents face the same developmental tasks that accompany adolescence for all youth, including sexual identity development. Unlike those with a heterosexual orientation, however, adolescents with a minority sexual orientation must navigate awareness and acceptance of a socially marginalized sexual identity; potentially without family, community, or societal support. Various factors affect the trajectory of development related to sexual orientation, and there is not a single or simple trajectory experienced by all individuals (Diamond, 2006, 2008; Diamond & Savin-Williams, 2000; Dube & Savin-Williams, 1999; Horowitz & Newcomb, 2001). In a large prospective cohort study of adolescents living throughout the U.S., 12 percent of males and 22 percent of females at one point indicated a minority sexual orientation identity (i.e., mostly heterosexual, bisexual, mostly homosexual, or completely homosexual; Ott, Corliss, Wypij, Rosario, & Austin, 2010)[14]. Compared to earlier cohorts, today's sexual minority adolescents are developing an awareness of their sexual orientation and disclosing their sexual orientation to others earlier than previous generations, frequently disclosing their sexual orientation or "coming out" as lesbian, gay, or bisexual in middle or high school (Diamond & Savin-Williams, 2000; Floyd & Bakeman, 2006; Grov, et al., 2006; R. C. Savin-Williams, 2001; R.C. Savin-Williams, 2005). This earlier disclosure means that adolescents are now often coming out while still dependent on their families and communities for emotional and instrumental support.

Gender Identity in Adolescence

Gender minority adolescents include both youth who realized a transgender identity or gender diverse presentation in childhood (i.e., early-onset individuals) and youth for whom gender dysphoria first emerges in adolescence (i.e., later-onset individuals). Adolescence is a crucial period for the consolidation of gender identity and persistence of gender dysphoria in early-onset individuals and for the initiation of gender dysphoria in later-onset individuals (Steensma, McGuire, et al., 2013). Youth for whom gender dysphoria first emerges in adolescence may have no history of a gender diverse expression or gender identity questioning in childhood (Edwards-Leeper & Spack, 2012; Wallien & Cohen-Kettenis, 2008). The onset of typical physical changes associated with puberty is often associated with worsening of anatomical dysphoria and distress in adolescents with gender dysphoria (Byne, et al., 2012; Coleman, et al., 2012). Increasing numbers of adolescents have already starting living in their desired gender role upon entering high school (Cohen-Kettenis & Pfäfflin, 2003) and many (but not all) adolescents with gender dysphoria express a strong desire for hormone therapy and gender affirming surgeries (Coleman, et al., 2012).

When gender dysphoria persists through childhood and intensifies into adolescence, the likelihood of long-term persistence of gender dysphoria and identification as transgender in adulthood increases. Two different follow up studies reported that 50-67 percent of adolescents attending a specialty clinic for gender dysphoria went on to have gender affirming surgeries, suggesting high rates of persistence (Cohen-Kettenis & van Goozen, 1997; Smith, van Goozen, & Cohen-Kettenis, 2001). Since not all individuals with gender dysphoria have gender affirming surgeries, the percentage of adolescents in these study samples who continued to experience gender dysphoria is likely higher than 50-67 percent; in fact, the Smith et al. (2001) study suggested that a considerable number of the patients who did not have gender affirming surgeries still experienced gender dysphoria four years later.

Although many sexual and gender minority youth successfully navigate the challenges of adolescence, others experience a variety of mental health and psychosocial concerns. In comparison with their heterosexual and cisgender counterparts, sexual and gender minority adolescents are at increased risk for psychological distress and substance use behaviors, including depressive symptoms, increased rates of substance use and abuse, suicidal ideation and attempts, as well as increased likelihood of experiencing victimization, violence, and homelessness (Coleman, et al., 2012; Corliss, et al., 2010; Friedman, et al., 2011; Garofalo, et al., 2006; Goldbach, et al., 2014; Hatzenbuehler, 2011; Institute of Medicine, 2011; Kann, et al., 2011; Liu & Mustanski, 2012; Marshal, et al., 2011; Mustanski, et al., 2010; S. T. Russell, 2003; Simons, et al., 2014). Sexual and gender minority youth who lack supportive environments are especially vulnerable to these negative outcomes (for example, research from Kosciw, et al., (2014), Ryan, Huebner, Diaz, & Sanchez, (2009), and Travers, et al. (2012)).

Pubertal development can be especially distressing for transgender adolescents and can set off a cascade of mental health problems during adolescence (Byne, et al., 2012; Coleman, et al., 2012). Mental health challenges are more common among adolescents with gender dysphoria than among children with gender dysphoria (Byne et al., 2012), which may be due to peer ostracism that increases with age (APA Task Force on Gender Identity and Gender Variance, 2009). Additionally, as with children, the prevalence of autism spectrum disorders appears to be higher among clinical samples of adolescents with gender dysphoria than among the general population of adolescents (de Vries, et al., 2010; Edwards-Leeper & Spack, 2012). Adolescents with autism spectrum disorders (ASD) would benefit from careful assessment distinguishing between symptomatology related to gender dysphoria and symptoms related to ASD. de Vries, et al. (2010) reported a rate of autism spectrum disorders 10 times higher among children and adolescents referred to their gender clinic in Amsterdam, Netherlands as compared to the general population. This research only examined cases of severe autism and not milder versions such as Asperger's disorder, which Edwards-Leeper and Spack (2012) reported being more commonly seen among patients in the GeMS clinic in Boston, especially among those with a late-onset of gender dysphoria. The question of whether gender dysphoria is simply a symptom of autism spectrum disorder among youth with ASD has been raised by behavioral health providers; Edwards-Leeper and Spack (2012) suggest that it is also worth questioning validity of the autism diagnosis among transgender youth, particularly those with Asperger's disorder, as it is possible that social awkwardness and lack of peer relationships are the result of feeling isolated and rejected due to gender identity and expression (Edwards-Leeper & Spack, 2012). More research is needed into appropriate treatment for sexual and gender minority children and adolescents with developmental disabilities as well; behavioral health providers should not presume that young people with developmental disabilities cannot also be sexual and gender minorities.

Influences on Health and Well-Being

The increased risks faced by sexual or gender minority youth are not a function of their identity. Rather, these risks stem from the stresses of prejudice, discrimination, rejection, harassment, and violence (Bockting et al., 2013; Harper & Schneider, 2003; Hendricks & Testa, 2012; Meyer, 1995). The presence of sexual orientation- and gender-related stressors – and opportunities for support – encompasses multiple social systems, including family, school, and religious networks (U. Bronfenbrenner, 1979; U. Bronfenbrenner, 2005; Harper, 2007); Mustanski, Birkett, Greene, Hatzenbuehler, & Newcomb, 2013)[15]. Therefore, when a distressed sexual and gender minority adolescent is evaluated by a behavioral health provider, it is imperative to assess the broader family and community systems in which the child lives, in addition to individual issues. Assessing

not only the adolescent's level of distress, but also identifying the source(s) of distress and support are vital components of a comprehensive assessment.

Family

Family response to an adolescent's sexual orientation, gender identity, or gender expression has a significant impact on the adolescent's wellbeing. Parents can serve as both a source of stress and a source of support for sexual and gender minority youth (Bouris, et al., 2010; Ryan, Russell, Huebner, Diaz, & Sanchez, 2010; Travers et al., 2012). Negative parental responses to sexual orientation or gender are associated with young people's psychological distress; however, parent-child relationships characterized by closeness and support, however, are an important correlate of mental well-being. Research by Doty, Willoughby, Lindahl and Malik (2010) has emphasized the benefits of sexuality-specific family and peer support to sexual minority adolescents' well-being.

Sexual and gender minority adolescents are at increased risk for experiencing violence and victimization, including psychological, physical, and sexual abuse from those within their families compared to adolescents from the general population (Friedman, et al., 2011; Roberts, et al., 2012). Past parental verbal and physical abuse has been associated with suicide attempts in transgender adolescents (Grossman & D'Augelli, 2007). These adolescents may also be ejected from their homes or run away, contributing to the overrepresentation of sexual and gender minority adolescents among the nation's homeless youth; 20-40 percent of all homeless youth identify as lesbian, gay, bisexual, or transgender (Durso & Gates, 2012; Ray & National Gay and Lesbian Task Force, 2006). Some data suggest that, compared to cisgender youth who conform to stereotypical gender norms, transgender and other adolescents whose gender expressions do not conform to stereotypical norms have a higher risk of abuse from family members (Roberts, et al., 2012; Roberts, Rosario, Slopen, Calzo, & Austin, 2013).

Furthermore, the level of family acceptance or rejection an adolescent experiences appears to have effects that extend into young adulthood. Data from the Family Acceptance Project have shown that sexual and gender minority young adults who experienced high levels of family rejection during adolescence fared significantly worse than those who experience low levels of family rejection in terms of depression, substance abuse, sexual risk behaviors, and suicide attempts (Ryan, Huebner, Diaz, & Sanchez, 2009); conversely, high levels of family acceptance in adolescence predicted greater self-esteem, social support, and general health status, and protected against depression, substance abuse, and suicidal ideation and behaviors in young adulthood as compared to those with low levels of family acceptance in adolescence (Ryan, et al., 2010).

Religion & Spirituality

When considering family and community influences, an adolescent's religious background is also an important factor. Religious beliefs and background are far-reaching influences that encompass multiple arenas of one's life, including: personal and family religious identity, beliefs and coping; family attitudes, beliefs and relationships; and community character and support. Religious views of homosexuality in the United States vary widely (Moon, 2014), and religion can have a large influence on sexual minority adolescents' mental health and wellbeing (cf. Ream & Savin-Williams, 2005; Page, Lindahl, & Malik, 2013). Though research on who seeks conversion therapy to change sexual orientation is lacking, it appears that such requests occur primarily among religious communities that view minority sexual orientations as undesirable or morally wrong (APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009).

Though religiosity is often associated with better psychosocial adjustment among young people in general, sexual minority youth may feel rejected by their religion or experience conflict between their sexual orientation and religious identities (Cotton, Zebracki, Rosenthal, Tsevat, & Drotar,

2006). However, various ways in which adolescents and young adults reconcile this conflict have been identified (Meanley, Pingel, & Bauermiester, 2015; Ream & Savin-Williams, 2005). Sexual minority youth growing up in more conservatively religious families are, on average, exposed to more messages that portray minority sexual orientations as undesirable or morally wrong (Schope & Eliason, 2000), which are associated with shame, guilt, and internalized homophobia (Ream & Savin-Williams, 2005). Sexual minority adolescents with religious parents may be less likely to disclose their sexual orientation to others (Schope, 2002; Stewart, Heck, & Cochran, 2015). Some research has indicated that involvement with religious or spiritual belief systems that cast rejecting or disapproving messages about sexual minorities is associated with greater psychosocial challenges, including increased internalized homophobia (Meanley, Pingel, & Bauermeister, 2015; Page, Lindahl, & Malik, 2013).

Religiosity or spirituality can be a deeply affirming and supportive aspect of identity, including for sexual minorities from faith communities. Research with adults indicates that affirming religious environments – that is, those that are inclusive and supportive of sexual minorities –may be associated with improved psychological wellbeing and reduced internalized homophobia (e.g., research from Lease, et al. (2005) and Yakushko (2005). Research from Hatzenbuehler, Pachankis, and Wolff (2012) supports the benefit of affirming religious environments for youth as well; the researchers reported that lesbian, gay, and bisexual high school students who lived in Oregon counties with a supportive religious climate (i.e., counties where the majority of religious individuals adhered to a religious denomination supportive of minority sexual orientations) had significantly fewer alcohol abuse symptoms and fewer sexual risk behaviors than those living in counties with a less supportive religious climate.

It is important not to reify categories within faiths such as "traditional", "liberal", "affirming" and "non-affirming"; religion and spirituality are complex, nuanced aspects of human diversity.

Parents from faith backgrounds have reactions that are similar in essential ways to all parents (e.g., sense of loss, desire for information, coming to terms with difference between hopes and reality; Maslowe and Yarhouse, 2015). Research indicates that families who identify superordinate goals such as unconditional love, mercy, forgiveness, and respect for all human beings can remain connected to their children in positive ways (Ryan et al, 2009; Maslowe & Yarhouse, 2015).

Given the great potential impact of religion on the lives of sexual and gender minority youth, little research has been done in this area with sexual minority adolescents and almost none has been completed with gender minority adolescents; further, almost no research has focused on sexual minority youth or adults in the United States from non-Christian religious backgrounds (cf. Harari, Glenwick, & Cecero, 2014; Siraj, 2012). It is unknown whether similar relationships between various aspects of religion and well-being would be seen among gender minority youth and among sexual and gender minority youth from non-Christian religious backgrounds.

School

Sexual and gender minority adolescents may also experience a myriad of sexual orientation and gender-related stressors in the school environment, where they spend a large portion of their time. The climates of U.S. middle and high schools are generally unsupportive and unsafe for many sexual and gender minority youth, who experience high levels of verbal and physical harassment and assault, sexual harassment, social exclusion and isolation, and other interpersonal problems with peers (Kosciw, Greytak, & Diaz, 2009). In the most recent National School Climate Survey, the Gay, Lesbian & Straight Education Network (GLSEN) found that 55.5 percent of surveyed sexual and gender minority students felt unsafe at school because of their sexual orientation and 37.8 percent felt unsafe because of their gender expression (Kosciw, et al., 2014). Most students reported hearing homophobic remarks and negative remarks about their gender expression at school

from fellow students and teachers or other school staff; a third of students reported hearing negative remarks specifically about transgender people. Of the students surveyed, 74.1 percent of surveyed students were verbally harassed, 36.2 percent were physically harassed, 16.5 percent were physically assaulted, and 49.0 percent were cyberbullied in the past year because of their sexual orientation. On average, sexual minority students of color and students who did not conform to stereotypical gender roles experienced higher frequencies of victimization. Over half of the students surveyed experienced policies that were discriminatory based on sexual orientation, gender identity, or gender expression at school. Transgender students were particularly targeted by some discriminatory policies: 42.2 percent of transgender students had been prevented from using their preferred name; 59.2 percent were required to use a bathroom or locker room of their legal sex; and 31.6 percent were not allowed to wear clothes consistent with their gender identity.

This mistreatment has a significant effect on sexual and gender minority adolescents' mental health and wellbeing. Those who experience victimization due to sexual orientation or gender expression are more likely to report depressive symptoms, suicidality, and low self-esteem (Burton, Marshal, Chisolm, Sucato, & Friedman, 2013; Kosciw, et al., 2014). Experiences of victimization and discrimination are linked to negative academic outcomes, including missing school, lower grades, and not planning to pursue post-secondary education (Kosciw, et al., 2014). Further, these effects may last into young adulthood (Russell, Ryan, Toomey, Diaz, & Sanchez, 2011). Victimization from peers and school staff, combined with discriminatory policies, likely contributes to the over-representation of sexual and gender minorities in the juvenile justice system: though sexual and gender minority youth comprise only five to seven percent of the nation's youth, it is estimated that 13 to 15 percent of youth in the juvenile justice system are sexual and gender minority youth (Majd, Marksamer, & Reyes, 2009).

School and peer networks can also be a place where sexual and gender minority youth find support. The presence of friends to whom youth can be out about their sexual orientation or gender identity has been linked to mental health and wellbeing (Doty & Brian, 2010; Elizur & Ziv, 2001). Sexual and gender minority friends may be of particular importance, as they are more likely than heterosexual and cisgender friends to provide support for sexuality-related stress, which is associated with lower levels of both emotional distress and sexuality distress (Doty, et al., 2010; Snapp, Watson, Russell, Diaz, & Ryan, 2015). Additionally, both the presence of and participation in a Gay-Straight-Alliance (GSA) – a student-led, school-based club aiming to provide a safe place for LGBTQ students – has beneficial outcomes for sexual and gender minority students (for example, research from Goodenow, Szalacha, and Westheimer (2006), Kosciw, Greytak, Diaz, and Bartkiewicz (2010), Toomey, Ryan, Diaz, and Russell (2011), and Walls, Kane, and Wisneski (2010)).

Identity Development

Sexual and gender minority adolescents may experience identity conflict when reconciling a sexual minority identity that may conflict with the expectations of their family, peers, and community. Difficulty with the identity development process, such as difficulty accepting one's sexual orientation and dissonance between one's self-image and societal beliefs about sexual minorities, can increase internalized homophobia (Page et al., 2013). Sexual orientation conflict has been linked to negative psychosocial outcomes in adolescents and young adults (Willoughby, Doty, & Malik, 2010). Furthermore, a negative self-image as a sexual minority contributes to the relationship between sexuality-specific stressors, including family rejection and victimization, to poorer mental health outcomes (Page, et al., 2013; Willoughby, et al., 2010).

Though less research has been done with gender minority adolescents overall, and especially on topics related to identity, internalized transphobia is expected to have a deleterious effect on mental health (Hendricks & Testa, 2012). Therefore,

important areas of focus for behavioral health professionals who work with sexual and gender minority adolescents include internalized homophobia, transphobia, and clients' minority identity.

Intersecting Identities

Finally, sexual and gender minority adolescents are not a single, homogenous population; individuals may hold multiple minority identities. Race, ethnicity, sex assigned at birth, social class, religion, disability, and immigration status may each confer their own unique minority identities, stressors, and strengths that interact with those related to sexual orientation and gender identity and expression. Sexual and gender minority youth have multiple, interlocking identities defined by relative sociocultural power and privilege that shape individual and collective identities and experiences (Crenshaw, 1991; Parent, DeBlaere, & Moradi, 2013; Shields, 2008; Yarhouse & Tan, 2005). Though a full review is beyond the scope of this report, research has begun to identify some of the ways that sexual and gender minority adolescents' experiences vary by race/ethnicity (Corby, Hodges, & Perry, 2007; Grov, et al., 2006; Kosciw, et al., 2014; Ryan, et al., 2009; Ryan, et al., 2010), immigration status (Daley, Solomon, Newman, & Mishna, 2008; Ryan, et al., 2009; Ryan, et al., 2010), gender (Bontempo & D'Augelli, 2002; Ryan, et al., 2009), gender expression (Hidalgo, Kuhns, Kwon, Mustanski, & Garofalo, 2015; Roberts, et al., 2012; Roberts, et al., 2013; Toomey, Ryan, Diaz, Card, & Russell, 2010), and socioeconomic status (Kosciw, et al., 2009; Ryan, et al., 2009; Ryan, et al., 2010). Behavioral health professionals working with sexual and gender minority youth should be aware of and responsive to the intersecting identities held by young people when considering the effects of minority stress on mental health and wellbeing. Given the gaps in our understanding, more research on the experiences of adolescents who hold multiple marginalized identities is needed in order to understand both the unique strengths and sources resilience, as well as the stressors youth and their families may experience.

Therapeutic Efforts with Sexual and Gender Minority Youth

Introduction[16]

Despite dramatic social changes in the recognition of same-gender relationships and families and transgender identities, sexual and gender minority children and adolescents and their families face misinformation, negative social attitudes and discrimination that can pose challenges for child development and family acceptance. Behavioral health providers may receive referrals for treatment that include requests to change a child or adolescent's actual, perceived, or future sexual orientation or same-gender sexual behaviors, gender identity, or gender expression. Requests for conversion therapy most often come from a parent or guardian, or more rarely, a child or adolescent.

In providing services to children, adolescents, and families experiencing distress related to sexual orientation or gender, behavioral health providers should consider the following as the scientific basis of treatment[17]:

- Same-gender sexual identity, behavior, and attraction do not constitute a mental disorder;
- Transgender identities and diverse gender expressions do not constitute a mental disorder;
- Same-gender sexual attractions are part of the normal spectrum of sexual orientation and occur in the context of a variety of sexual orientations and gender identities;
- Variations in gender identity and expression are normal aspects of human diversity, and binary definitions of gender may not reflect emerging gender identities;
- Gay men, lesbians, bisexual and transgender individuals can lead satisfying lives as well as form stable, committed relationships and families.

Conversion Therapy

Lesbian, gay, and bisexual orientations are normal variations of human sexuality and are not mental health disorders; therefore, treatment seeking to

change an individual's sexual orientation is not indicated. Thus, behavioral health efforts that attempt to change an individual's sexual orientation are inappropriate. In 2009, the APA Taskforce on Appropriate Therapeutic Responses to Sexual Orientation Change Efforts conducted a thorough review of peer-reviewed literature published on conversion therapy. The APA Taskforce concluded that no methodologically-sound research on adults undergoing conversion therapy has demonstrated its effectiveness in changing sexual orientation. There have been no studies on the effects of conversion therapy on children, though adults' retrospective accounts of their experiences of conversion therapy during childhood or adolescence suggests that many were harmed (American Psychological Association, 2009). No new studies have been published that would change the conclusions reached in the APA Taskforce's 2009 review.

Given the lack of evidence of efficacy and the potential risk of serious harm, every major medical, psychiatric, psychological, and professional mental health organization, including the American Psychological Association, the American Psychiatric Association, the National Association for Social Work, the Pan American Health Organization, and the American Academy of Child and Adolescent Psychiatry, has taken measures to end conversion therapy efforts to change sexual orientation. To the extent that children and adolescents experience distress related to their sexual orientation, treatment efforts should focus on identifying and ameliorating the sources of distress.

The discussion surrounding conversion therapy with gender minority youth is complicated by the fact that though diverse gender expressions and transgender identities are now understood to be part of the normal spectrum of human gender (American Psychological Association, 2015a; Coleman, et al., 2012; Knudson, De Cuypere, & Bockting, 2010), there remains a related psychiatric diagnosis: Gender Dysphoria (formerly Gender Identity Disorder (American Psychiatric Association, 2013a). Although there is much debate over whether Gender Dysphoria should remain a psychiatric diagnosis (for example, see Bockting & Ehrbar (2005)), such a discussion is beyond the scope of this report. However, the shift from Gender Identity Disorder to Gender Dysphoria in version five of the Diagnostic and Statistical Manual of Mental Disorders does reflect a shift away from a pathological view of gender diversity towards a focus on the distress experienced as a result of the incongruence between one's physical body and gender identity (American Psychiatric Association, 2013a; Simons, et al., 2014; Vance, et al., 2014). Thus, the distress remains the target of intervention, rather than gender identity. There is also scientific consensus that for many people, medical intervention in the form of hormone therapy or gender affirming surgeries may be medically necessary to alleviate gender dysphoria (American Medical Association, 2008; American Psychological Association, 2008; Anton, 2009; World Professional Association for Transgender Health, 2008).

Historically, conversion therapy efforts to make children's behaviors, dress, and mannerisms more consistent with those stereotypically expected of their assigned sex at birth (i.e., more stereotypically masculine expression for those assigned male at birth and more stereotypically feminine expression for those assigned female at birth) were the primary clinical approach used with children experiencing gender dysphoria (Vance, et al., 2014; Zucker, 2004). Efforts to change children's gender expression have been made with the goal of preventing a transgender identity, as well as with the goal of preventing a future minority sexual orientation. Such efforts were based on the belief that variations in gender identity and expression are pathological and that certain patterns of family relationships cause a transgender identity or minority sexual orientation; research has not supported these theories or interventions (American Psychological Association, 2009). Because there is scientific consensus that gender dysphoria in adolescence is unlikely to remit without medical intervention, even those who support gender identity change efforts with pre-pubertal children generally do not attempt such efforts with adolescents experiencing gender dysphoria

(Adelson & AACAP CQI, 2012; American Psychological Association, 2008). Alternative affirmative and supportive approaches to therapy with transgender and gender diverse children have been developed and are becoming increasingly common (Edwards-Leeper, Leibowitz, & Sangganjanavanich, in press; Hidalgo, et al., 2013; Lev, 2005; Menvielle & Tuerk, 2002; Menvielle, Tuerk, & Perrin, 2005).

No research has been published in the peer-reviewed literature that demonstrates the efficacy of conversion therapy efforts with gender minority youth, nor any benefits of such interventions to children and their families. Researchers have reported that these interventions are ineffective in decreasing the likelihood of a future same-gender sexual orientation or minority sexual identity (Zucker & Bradley, 1995). In addition to a lack of evidence for the efficacy of conversion therapy with gender minority youth, there are concerns about the ethics of this practice (Byne, et al., 2012; Coleman, et al., 2012) as well as the practice's potential for harm (Minter, 2012; Wallace & Russell, 2013). Although no research demonstrating the harms of conversion therapy with gender minority youth has been published, the potential harms of conversion therapy are suggested by clinicians' observations that the behavioral issues and psychological distress of many children and adolescents with gender dysphoria improves markedly when their gender identities and expressions are affirmed through social and/or medical transition (de Vries, Steensma, Doreleijers, & Cohen-Kettenis, 2011; Edwards-Leeper & Spack, 2012), as well as by the body of literature demonstrating the negative effects of both rejection and a lack of support on the health and well-being of gender minority youth (e.g., research from Kosciw, et al. (2014), Ryan, et al. (2010), and Travers, et al. (2012)).

In conclusion, given the lack of evidence for the efficacy conversion therapy and the fact that conversion therapy efforts are based on a view of gender diversity that runs counter to scientific consensus, in addition to evidence that rejecting behaviors and a lack of support have adverse effects on the psychological well-being of gender minority youth – conversion therapy, as well as any therapeutic intervention with an *a priori* goal for a child's or adolescent's gender expression, gender identity, or sexual orientation, is inappropriate. Given the potential for harm associated with conversion therapy efforts, other affirmative behavioral health interventions are recommended for individual or family distress associated with sexual orientation and gender identity.

Appropriate Interventions for Distress in Children, Adolescents, and Families[19]

Behavioral health providers are in a unique position to provide accurate information on the development of sexual orientation and gender identity and expression; to increase family and school support; and to reduce family, community and social rejection of sexual and gender minority children and adolescents. The descriptions of interventions below provide general guidance to behavioral health providers working in this area.

Client-Centered Individual Approaches

Behavioral health providers should provide children, adolescents and their families with developmentally-appropriate multiculturally-competent and client-centered interventions that emphasize acceptance, support, assessment, and understanding. A clear treatment goal is to identify sources of distress and work to reduce any distress experienced by children, adolescents and their families.

Appropriate approaches support children and adolescents in identity exploration and development without seeking predetermined outcomes related to sexual orientation, sexual identity, gender identity, or gender expression. Such approaches include an awareness of the interrelatedness of multiple identities in individual development as well an understanding of cultural, ethnic, and religious variation in families. Specific approaches can include (a) providing a developmentally-informed cognitive, emotional, mental health

and social assessment of the child and family; (b) supporting children and adolescents in their developmental processes and age-appropriate milestones and facilitating adaptive coping; (c) providing developmentally-appropriate affirmative information and education on sexual orientation, gender identity, gender expression, sexuality, and the identities and lives of *lesbian*, *gay*, *bisexual*, *transgender* people and those who are *questioning* their sexual orientation or gender identity (LGBTQ) to children and adolescents, parents or guardians and community organizations; and, (d) reducing internalized negative attitudes toward same-gender attractions, gender diversity, and LGBTQ identities in children and youth and in parents or guardians and community institutions (e.g., schools and community social groups).

Behavioral health providers should provide developmentally-sensitive interventions to children and adolescents. Such interventions include a comprehensive evaluation taking into account appropriate developmental emotional and cognitive capacities, developmental milestones, and emerging or existing behavioral health concerns. Specific evaluation procedures for children and adolescents with persistent gender concerns have been described by Leibowitz and Telingator (2012).

Behavioral health providers should not have an *a priori* goal for sexual orientation or gender expression, or identity outcomes. The goal of treatment should be the best level of psychological functioning not a specific orientation or identity. Rather, behavioral health providers should focus on identity development and exploration that allows the child or adolescent the freedom of self-discovery within a context of acceptance and support.

Behavioral health providers should strive to incorporate multicultural awareness into their treatment, considering age, ethnicity and race, gender and gender identity, sexual orientation and attraction, ability and disability issues, religion and spirituality, generation, geographic issues and other notable factors. A key aim is to dispel negative stereotypes and to provide accurate information in developmentally-appropriate terms for children and adolescents. Identity development is multifaceted and may include multiple and intersecting identities, such as ethnic and racial and religious and spiritual identities. Sexual orientation, gender identity and expression are fluid concepts and in flux, requiring the consideration of generational changes and norms. Supporting youth in age-appropriate tasks such as developing positive peer relationships, positive parent and family relations, dating, exploring gender expression, sexuality, multiple identity development and disclosure as appropriate is a critical consideration. Behavioral health providers should take into consideration potential sources of social support and community resources. Client-centered and exploratory approaches specific to gender minority youth have been discussed in numerous publications (Edwards-Leeper, et al., in press; Hidalgo, et al., 2013; Lev, 2005; Menvielle & Tuerk, 2002; Menvielle, et al., 2005; Yarhouse, 2015c).

Behavioral health providers should describe their treatment plan and interventions to children, adolescents and their families and to ensure the goals of treatment as well as potential benefits and risks are understood. Where appropriate developmentally, behavioral health providers should obtain informed consent with all parties to treatment. If informed consent is not a developmentally appropriate option (as the child cannot cognitively or legally provide consent), behavioral health providers should explain treatment in a developmentally appropriate manner and receive assent for treatment. Interventions that are involuntary, especially those in inpatient or residential settings, are potentially harmful and inappropriate. In addition, interventions that attempt to change sexual orientation, gender identity, gender expression, or any other form of conversion therapy are also inappropriate and may cause harm. Informed consent cannot be provided for an intervention that does not have a benefit to the client.

Family Approaches

Parental attitudes and behaviors play a significant role in children's and adolescents' adjustment and parents' distress often is the cause of a referral for treatment (APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009; Ryan et al., 2009, 2010). Family rejection, hostility, and violence are key predictors of negative health outcomes in LGBTQ children and adolescents (Ryan, et al., 2009; Ryan & Rees, 2012). Reducing parental rejection, hostility, and violence (verbal or physical) contributes to the mental health and safety of the child and adolescent (Ryan, et al., 2009; R. Savin-Williams, 1994; Wilbur, Ryan, & Marksamer, 2006).

Family therapy that provides anticipatory guidance to parents and guardians to increase their support and reduce rejection of children and adolescents is essential. Interventions that increase family and community support and understanding while decreasing LGBTQ-directed rejection are recommended for families. School and community interventions are also recommended to reduce societal-level negative attitudes, behaviors and policies, as well as provide accurate information and social support to children, adolescents, and families.

A key focus of treatment should be addressing parental concerns regarding current or future sexual orientation and gender identity. Behavioral health providers should provide family members with accurate developmentally-appropriate information regarding minority sexual orientations and strive to dispel myths regarding the lives, health, and psychological well-being of sexual and gender minority individuals.

Ryan, et al. (2010) recommended that behavioral health providers assess family reactions to LGBTQ children and adolescents, specifically the presence of family rejection. Further, behavioral health providers should attempt to modify highly rejecting behaviors, providing anticipatory guidance to families that include recommendations for support on the part of the family, and explaining the link between family rejection and negative health problems in children and adolescents. Behavioral health providers should seek ways to ameliorate parents' distress about their children's sexual orientation and/or gender, such as exploring parental attributions and values regarding minority sexual orientations and gender diversity. Family therapy may be helpful in facilitating dialogues, increasing acceptance and support, reducing rejection, and improving management of conflicts or misinformation that may exacerbate a child or adolescent's distress (Mattison & McWhirter, 1995; Ryan, et al., 2009; Salzburg, 2004, 2007). Such therapy can include family psychoeducation to provide accurate information and teach coping skills and problem-solving strategies for dealing more effectively with the challenges sexual and gender minority youth may face and the concerns the families and caretakers may have (Ben-Ari, 1995; Perrin, 2002; Ryan & Diaz, 2005; Ryan & Futterman, 1998; Ryan, et al., 2009; Salzburg, 2004, 2007; Yarhouse, 1998).

When working with families of young children, behavioral health providers should counsel parents who are concerned that their children may grow up to be lesbian, gay, bisexual, or transgender to tolerate the ambiguity inherent in the limited scientific knowledge of development. A two-prong approach may be helpful: (a) provide information to reduce heterosexism and cisgenderism (that is, attitudes and actions that a heterosexual orientation and gender identity and expression that conform to stereotypical norms are preferable to a same-gender sexual orientation, transgender identity, or diverse gender expression) within the family and increase the family's capacity to provide support; and (b) introduce information about sexual and gender minority issues into family discussions to increase the child's own self-awareness and self-acceptance and to counter negative attitudes directed toward the self that might reduce self-esteem. For example, consider ways in which respect and value of all persons is frequently a shared goal. Even in cases in which family members may disagree about decisions each person may make, there may be opportunity to agree on broader principles and

concepts that can lead to mutual understanding (Yarhouse, 2015b).

Families with strong beliefs who see same-gender attractions or relationships and gender diversity as undesirable and contrary to those beliefs may struggle with a child's emerging minority sexual orientation or gender. Ryan and Rees (2012) and Yarhouse (1998; Yarhouse & Tan, 2005; Maslowe & Yarhouse, 2015) have suggested that family therapy focus encouraging love of their child. This involves focusing on superordinate values such as unconditional love and changing behaviors to reduce rejection. The authors stress that these positive steps can lay a constructive foundation for communication and problem solving and reduce family discord and rejection (Yarhouse & Tan, 2005). Ryan, et al. (2009) and Ryan and Rees (2012) focus on reframing family concerns as a manifestation of care and love and focus on teaching non-rejecting ways to communicate those positive emotions. For example, providers can help the family create an atmosphere of mutual respect that ensures the safety of each person from being hurt or bullied as a natural extension of seeing each person as having intrinsic worth (Yarhouse, 2015b). One of the most important messages that can be communicated to a young person is that their safety is important to the provider and to the family. It is helpful to set an atmosphere of mutual respect for one another in the home and then to see the value of extending that to other settings, such as neighborhood, school, and places of worship. Safety in this context is not just physical safety, but also emotional safety (Yarhouse, 2015b).

Many families may feel they have to choose between competence (in a provider) and deeply held beliefs. It is ideal when a family can work with competent providers who also share their deeply held beliefs and who are affirming of sexual orientation and gender diversity. However, when such providers are not available, it is important for families to work with competent providers who will be sensitive to the family's deeply held beliefs and values while offering competent, appropriate services for sexual and gender minority minors (Yarhouse, 2015b). Thus, behavioral health providers may wish to increase their own competence in working with certain communities with deeply held beliefs and focus on viewing these beliefs through the imperative of multicultural competence and mutual respect (Bartoli & Gillem, 2008). This is includes understanding how to translate between psychology and deeply held beliefs rather than judging those beliefs. Certain language, such as acceptance, might not resonate with communities that have strongly held beliefs, whereas the concept of unconditional love might (Yarhouse, 2015a).

Providing multiculturally-sensitive anticipatory guidance to all parents to address their unique personal concerns can be helpful (Ryan & Futterman, 1998). Behavioral health providers can help the parents plan in an affirmative way for the unique life challenges that they may face as parents of a sexual or gender minority child. Also, parents must deal with their own process of "coming out" and resolve fears of discrimination or negative social reactions if they risk disclosure within their communities, at work, and to other family members (Ryan & Rees, 2012). Further, behavioral health providers can address other stresses, such as managing life celebrations and transitions and coping feelings of loss, and aid parents in advocating for their children in school situations—for example, when they face bullying or harassment. Multiple family groups led by behavioral health providers might be helpful to counter the isolation that many parents experience (Menveille & Tuerk, 2002).

School and Community Interventions

Research has illustrated the potential that school-based and community interventions have for increasing safety and tolerance of sexual and gender minorities, preventing distress and negative mental health consequences, and increasing the psychological well-being and health of sexual minority children and adolescents (American Psychological Association, 2015c; D'Augelli & Patterson, 2001; Goodenow, et al., 2006; Harper, Jamil, & Wilson, 2007; Kosciw & Diaz, 2006; Safren & Heimberg, 1999). For instance, sexual

and gender minority adolescents in schools with support groups for LGBTQ students reported lower rates of suicide attempts and victimization than those without such groups (Goodenow, et al., 2006; Kosciw & Diaz, 2006; Szalacha, 2003; Toomey, et al., 2011).

These support groups provided accurate affirmative information and social support, and the groups' presence was also related to increased school tolerance and safety for LGB adolescents (Goodenow, et al., 2006; Kosciw & Diaz, 2006; Szalacha, 2003; Toomey, et al., 2011). School policies that increased staff support and positive school climate have been found to moderate suicidality and to positively affect sexual minority children's and adolescents' school achievement and mental health (Goodenow, et al., 2006).

Additional Appropriate Approaches with Gender Minority Youth

In addition to the appropriate therapeutic approaches described above – comprehensive evaluation, support in identity exploration and development without an *a priori* goal of any particular gender identity or expression, and facilitation of family and community support – social transition and medical intervention are therapeutic approaches that are appropriate for some gender minority youth.

Social Transition

Social transition refers to adopting a gender expression, name, and pronouns consistent with one's gender identity. Over the past ten years, the age at which individuals socially transition has decreased dramatically, and it has become increasingly common for children to present to specialty gender clinics having already socially transitioned (Cohen-Kettenis & Klink, 2015; Steensma & Cohen-Kettenis, 2011). There is less controversy around social transition with adolescents, for whom gender identity is typically more stable and desistence of gender dysphoria (without social transition or medical intervention) is less common. Gender specialists recommended that adolescents socially transition at or before the time they begin medically transitioning with hormone therapy, though many adolescents will socially transition earlier (Cohen-Kettenis & Klink, 2015).

There is no research evidence on the benefits vs. risks of social transition among pre-pubertal children, and the impact of social transition on likelihood of persistence or desistence of gender dysphoria has not yet been studied (Adelson & AACAP CQI, 2012; Leibowitz & Telingator, 2012). A divergence of expert opinion exists among specialists treating gender minority children (Adelson & AACAP CQI, 2012; Leibowitz & Telingator, 2012). Given the lack of data on the risks and benefits of social transition in childhood, the American Academy of Child and Adolescent Psychiatry suggests that concerns related to social transition in school environments should be weighed against the risks of not doing so, including distress, social isolation, depression, or suicide due to lack of social support (Adelson & AACAP CQI, 2012). Edwards-Leeper and Spack (2012) outline several factors that need to be considered in determining when and if a child should socially transition, including the child's needs, the potential impact on the child's siblings, whether it is safe for the child to socially transition in his or her community, and emphasizing to the child and family the possibility that the child's gender identity and gender expression may change as development continues.

Medical Intervention

The appropriateness of medical interventions vary by the age of the child. No medical interventions are currently undertaken or recommended for children with gender dysphoria before the initial onset of puberty. Medical intervention has proven efficacious in improving the well-being of young adolescents with gender dysphoria both during and well after treatment (Cohen-Kettenis & van Goozen, 1997; de Vries, et al., 2011; Smith, et al., 2001), and most adolescents who seek medical intervention usually have extreme forms of gender dysphoria beginning in childhood (Cohen-Kettenis & Klink, 2015). Pubertal suppression and hormone

therapy are medical interventions used to treat gender dysphoria in adolescents.

Medical intervention with gender dysphoric adolescents is a multi-disciplinary endeavor including Behavioral health providers, pediatricians, and often pediatric endocrinologists (Hembree et al., 2009; Leibowitz & Telingator, 2012). A comprehensive assessment, including assessment of the degree of an individual adolescent's gender dysphoria and desire to seek gender reassignment, helps determine the risks and benefits of medical interventions (for featured examples of assessments with children and adolescents, see Leibowitz and Telingator (2012)). Importantly, not all individuals who experience gender incongruence or gender dysphoria necessarily experience a complete cross-gender identity, want hormone therapy as well as gender affirming surgeries, or want to live as the other gender permanently or completely (Coleman et al., 2012).

If a diagnosis of gender dysphoria is assigned and the adolescent desires and is eligible for treatment, readiness for medical treatment must be considered (Cohen-Kettenis & Klink, 2015). Adolescents and their parents or guardians must be informed about possibilities and limitations of pubertal suppression, hormone therapy, and other types of treatment, such as psychological interventions, in order to give full informed consent (Coleman et al., 2012; Vance et al., 2014). Taking into account developmental considerations when working with adolescents is key. Youth should realize that medical intervention or a complement of hormone therapy and gender affirming surgeries are not the only treatment option to solve gender dysphoria, and should realize that gender dysphoria may exist in many forms and intensities (Cohen-Kettenis, Delemarre-van de Waal, & Gooren, 2008). Continued mental health treatment should be offered when an adolescents' gender incongruence requires further exploration and/or when other psychological, psychiatric, or family problems exist. Adolescents receiving medical intervention without these additional concerns may also benefit from continued psychological treatment (Vance et al., 2014); given that pubertal suppression or administration of hormone therapy occurs over many years during important developmental periods, the need for psychological treatment may change with time as new questions arise (Cohen-Kettenis & Klink, 2015).

Pubertal suppression using gonadotrophin-releasing hormone (GnRH) analogues prevents the development of unwanted secondary sex characteristics in a peri-pubertal adolescent, which are irreversible and highly distressing for some adolescents with gender dysphoria (Leibowitz & Telingator, 2012). Pubertal suppression is fully reversible and serves as an extended diagnostic period, providing additional time for gender exploration as well as cognitive and emotional development that allows adolescents to become psychologically and neurologically mature enough to make decisions regarding their gender and to provide informed consent years later for the partially irreversible treatment interventions (e.g., hormone therapy) without having to experience distressful, irreversible changes of puberty (Hembree et al., 2009; Edwards-Leeper & Spack, 2012; Leibowitz & Telingator, 2012). Pubertal suppression also has therapeutic effects, often resulting in a large reduction in the distress the physical changes of puberty were producing (de Vries et al., 2011; Edwards-Leeper & Spack, 2012).

Pubertal suppression for young adolescents remains controversial, with concern over whether adolescents are able to make far-reaching decisions and understand the impact of pubertal suppression on their lives and over the lack of robust research on the long-term effects of pubertal suppression on brain and bone development in these populations (Cohen-Kettenis & Klink, 2015; Leibowitz & Telingator, 2012). However, results of preliminary research on the long-term effects of pubertal suppression are promising (Delemarre-van de Waal & Cohen-Kettenis, 2006; Cohen-Kettenis, Schagen, et al., 2011; Staphorsius et al., 2015). Abstaining from treatment in adolescence comes with risks as well: adolescents can experience refusal for treatment and the progression of secondary sex characteristic development as extremely psychologically painful, and a refusal

of medical intervention can lead to worse psychological adjustment and risky behaviors (e.g., self-mutilation, self-medication, or suicide; Cohen-Kettenis & Klink, 2015; Leibowitz & Telingator, 2012; Vance et al., 2014). Given the current evidence that diagnosis can be made reliably in adolescence, that gender dysphoria that worsens with puberty rarely subsides afterwards, and that – with careful diagnostic procedures – early pubertal suppression leads to good outcomes with young adults; withholding GnRHa is not considered a neutral option (Cohen-Kettenis & Klink, 2015). According to the Endocrine Society Guidelines, pubertal suppression with GnRH analogues is considered a medical standard of care for adolescents in Tanner stage 2 or 3 of puberty, once appropriate mental health assessments and recommendations are in place (Hembree et al., 2009). However, the importance of full informed consent for both adolescents and their parents or guardians is important and must include awareness and consideration of the risks and benefits involved, as well as an emphasis on continued exploration of gender identity.

The initiation of hormone therapy (estrogen and testosterone blocking medication for those assigned male at birth and testosterone for those assigned female at birth) around age 16 promotes the development of secondary sexual characteristics consistent with one's gender identity (Coleman et al., 2012; Hembree et al., 2009). While a minimum age of 16 was previously a requirement, the optimal time for initiation of hormone therapy is now determined by duration of GnRH analogue use (when used) and the adolescent's psychological state (Cohen-Kettenis & Klink, 2015). Unlike GnRH analogues, which are completely reversible, hormone therapy is only partially reversible. Again, once hormone therapy is indicated and an adolescent has been carefully assessed for readiness, care must be taken to get the informed consent of the adolescent and his or her parents or guardians before hormone therapy is initiated, including a full understanding of the potential risks and benefits of hormone therapy and the impact of hormone therapy on future fertility and options related to fertility (Cohen-Kettenis & Klink, 2015; Edwards-Leeper & Spack, 2012; Leibowitz & Telingator, 2012). The support of a behavioral health professional during this process can aid an adolescent in adjusting to their changing physical characteristics and the response from people in different aspects of the adolescent's life.

In addition to hormone therapy, some transgender adolescents desire and will eventually pursue gender affirming surgeries. The age of legal consent for surgery is 18, so most surgeries are not performed on adolescents, though behavioral health providers and medical providers working with adolescents may need to obtain and provide knowledge of the surgical processes in order to assist in navigating the emotional issues leading up to gender affirming surgeries; additionally, those assigned female sex at birth may be considered for virilizing mammoplasty beginning at age 16 (Edwards-Leeper & Spack, 2012; Leibowitz & Telingator, 2012).

Future Directions for Research

Areas of opportunity for future research, as well as the validity and quality of extant research are discussed in several sections of this report and were topics of conversation during the APA Consensus Panel Meeting in July, 2015. Methodologically rigorous, longitudinal, and peer reviewed research is vital to improving our understanding of the complexities of sexual orientation and gender identity and expression among children and adolescents. Several potential areas for future research are identified below.

Development of sexual orientation and gender identity

Little is known about the development of sexual orientation and gender identity in childhood and adolescence. Basic research on the developmental pathways of these fundamental issues is necessary. How these identities are embedded in cognitive and emotional development and other developmental processes would aid in the understanding of human development as well as appropriate interventions.

Culturally-specific mitigation of distress relating to sexual orientation, gender identity, and gender expression

More targeted research that acknowledges the intersections of identity, including race, ethnicity, faith, and class, among others, could shed light on positive and appropriate whole-family therapeutic approaches to addressing these issues. Researchers should evaluate these practices and integrate them into behavioral health care. Researchers should also work collaboratively with young people and families from faith communities to better understand the interplay between deeply held religious beliefs and the importance of ensuring the safety and well-being of LGBTQ young people. The work of the Family Acceptance Project, cited throughout this report, speaks to the necessity of an increased focus on approaches specific to various communities including culturally diverse communities and those with deeply held morals and values that include conversations about sexual orientation, gender identity, and gender expression.

Addressing the needs of disconnected LGBTQ youth

LGBTQ youth experiencing homelessness, in juvenile justice facilities, or otherwise in out-of-home care may lack permanent and stable family connections in part because of family distress around issues relating to their LGBTQ identity. These vulnerable populations, as well as low-income and racial and ethnic minority LGBTQ youth, are often neglected in research studies that most often recruit youth who are already connected to clinics or providers. This need for more representative sampling and better recruitment efforts should be addressed by future researchers interested in sexual orientation and gender identify among youth.

Long-term Outcomes

More research is necessary to explore the developmental trajectory of sexual orientation, gender identity, and gender expression, in addition to the long-term medical and behavioral health outcomes associated with early experiences of family and community distress due to sexual orientation and gender identity and expression. Other recommended areas of opportunity for long-term research topics include:

- A nuanced exploration of the factors that may differentiate children and adolescents who continue to experience gender dysphoria into adolescence and those who do not.
- Long-term outcomes from early social transition and pubertal suppression (including effects on brain development, sexual health function, fertility, etc.).
- Rigorous evaluation of current practices and protocols, including affirmative models, structural interventions, and culturally-specific models, among others.
- Prospective research focusing on younger children, in partnership with pediatric clinics.
- Sources of distress among sexual and gender minority youth, focusing on distinguishing between internal and external factors that may drive gender dysphoria.
- Methods of supporting positive behavioral health for LGBTQ youth, including building resiliency against suicidality, self-harm and risky behaviors, depression, anxiety, substance abuse, and other behavioral health issues.

Integration, Collaboration, and Dissemination

Researchers and clinicians should examine and evaluate the best methods of integrating and disseminating best and promising practices for addressing sexual orientation and gender identity and expression among children and youth, and

how to successfully collaborate with parents and guardians, caregivers and providers, and community leaders. This could include conducting studies with these populations focused on knowledge, attitudes, and beliefs relating to efforts to change sexual orientation, gender identity, or gender expression.

Finally, the behavioral health community can work to support community-based organizations to develop common ground and consensus on these topics and promote the health and well-being of youth. This could also include the development of treatment registries, support for sexual health research across the country, and the inclusion of LGBT-specific questions in national behavioral and mental health surveys.

Based on careful review of the research and the consensus of clinical experts in this field, conversion therapy is not an appropriate therapeutic intervention. Consequently, efforts should be taken to end the practice. The Administration has issued a public statement supporting efforts to ban the use of conversion therapy for minors, stating in part:

> *"When assessing the validity of conversion therapy, or other practices that seek to change an individual's gender identity or sexual orientation, it is as imperative to seek guidance from certified medical experts. The overwhelming scientific evidence demonstrates that conversion therapy, especially when it is practiced on young people, is neither medically nor ethically appropriate and can cause substantial harm.*
>
> *As part of our dedication to protecting America's youth, this Administration supports efforts to ban the use of conversion therapy for minors."* (Jarrett, 2015)

Approaches to Ending the Use of Conversion Therapy

Several approaches have been employed as mechanisms for eliminating the use of harmful practices, and encouraging positive and appropriate alternatives to discussing issues related to sexual orientation, gender identity, and gender expression with children and adolescents. These efforts will be reviewed in depth in this section:

1. Reducing discrimination and negative social attitudes towards LGBT identities and individuals
   - Adoption of public policies that end discrimination
   - Increasing access to health care
   - Publication of affirmative, culturally competent resources for the public on LGBT individuals and families.
2. Dissemination of information, training and education for behavioral health providers
   - Dissemination of professional association and federal agency documents and resolutions related to ending conversion therapy
   - Guidelines by professional associations on affirmative approaches to LGBTQ children and youth as well as LGBT adults
   - Inclusion of affirmative information and treatment models in professional training curriculum
   - Continuing education on elements of ethical codes and licensing laws relevant to these issues.
3. Legislative, regulatory, and legal efforts
   - State and federal legislation that bans sexual orientation and gender identity change efforts
   - Federal and state regulatory actions and additional Administration activities
   - Legal action

Reducing discrimination and negative social attitudes towards LGBT identities and individuals

Reducing the discrimination and negative social attitudes that many LGBTQ children and adolescents experience can improve health outcomes. As previously discussed, negative social attitudes are stressors that can result in poor mental health. Working with individuals, families, communities, and diverse populations to increase family acceptance and change cultural norms that are unsupportive of sexual and gender minority identities is one way to improve health and well-being overall.

The Administration has taken significant steps to reduce discrimination and negative social attitudes towards and increase support for LGBT communities,[19] including improving access to health care. Among other notable signals of social acceptance and support, the Administration has:

- Ended the "Don't Ask, Don't' Tell" policy in military service for lesbian, gay, and bisexual people, and taken steps to remove barriers to service for transgender people;
- Supported same-sex marriage and ensured that same-sex couples and their families have full access to federal benefits;
- Prevented employment discrimination by federal contractors;
- Advanced policies that expand access to quality healthcare for millions of Americans, including LGBT Americans; and
- Supported public information campaigns, such as the "It Gets Better" Project, which aims to gives LGBTQ youth hope and build public support.

Broad dissemination of supportive actions such as those outlined above serves to both mitigate negative social attitudes, and to build more

accepting ones. SAMHSA, in addition to partner organizations and professional associations, has developed targeted resources geared towards providers working with sexual and gender minority youth and their families.[20]

Dissemination of information, training and education for behavioral health providers

The major health associations have issued policy statements critical of conversion therapy including the World Health Organization, the American Medical Association, the American Academy of Pediatrics, the American Academy of Child and Adolescent Psychiatry, the American Psychological Association, American Counseling Association, American Psychoanalytic Association, and the National Association of Social Workers, among others. Other Association publications include professional guidelines on affirmative practices for this population (APA, 2011; APA 2015a).

In addition, some professional associations, including the American Academy of Child and Adolescent Psychiatrists, American Psychiatric Association, and the American Psychological Association, have published reports and professional practice guidelines on appropriate therapeutic efforts for this population. These documents provide important resources for providers on the types of interventions that are appropriate for sexual and gender minority children and youth as well as for LGBT adults.[21]

Professional mental health, medical, and social services organizations can require training that includes appropriate interventions for this population. For example, The American Association of Medical Colleges (AAMC) produced a report on *Implementing Curricular and Institutional Climate Changes to Improve Health Care for Individuals Who are LGBT, Gender Nonconforming, or Born with DSD.* As part of this publication, the association indicates that "doctors should be able to demonstrate an investigatory and analytic approach to clinical situations by [...] identifying various harmful practices (e.g., historical practice of using 'reparative' therapy to attempt to change sexual orientation; withholding hormone therapy from transgender individuals) that perpetuate the health disparities for [LGBT] patients."

Professional health and mental health associations also have ethical codes (American Psychiatric Association, 2013; American Psychological Association, 2010; National Association of Social Workers, 2008). These codes include provisions that stress aspirational principles and standards for practice that can be applied to sexual and gender minority youth and LGBT individuals broadly. Many of these codes are integrated into state licensing laws and thus govern standards of professional practice.

Experts have suggested that the use of conversion therapy to change the sexual orientation or gender identity of clients may be inconsistent with the aspirational principles of behavioral health professions. For example, conversion therapy might violate the principle of "*Do No Harm*" through techniques that are deleterious rather than beneficial to mental health. Additionally, conversion therapy may be inconsistent with professional standards that treatment be based on the best scientific knowledge and standards of professional competence, in its use of treatments that cannot be justified by established scientific and clinical knowledge in the field, and which imply that variations in sexual orientation and gender identity are not normative. Experts have also suggested that conversion therapy is inconsistent with principles of non-discrimination and justice that guarantee all clients, including sexual and gender minorities, equal access to the benefits of psychology and to equal quality of services. Finally, by denying the inherent worth of LGBT individuals and engaging in an intervention based on negative social or cultural attitudes, practitioners of conversion therapy could potentially violate principles that dictate respect for people's dignity.

Legislative, regulatory, and legal efforts

Many individuals, organizations, and several state legislatures have taken steps to regulate and eliminate the practice of conversion therapy. Efforts to end the practice of conversion therapy have included legislative bans and causes of action alleging consumer fraud, among others. Future efforts may include federal regulatory action, advancement of legislation at the state and federal level, and additional activities by the Administration.

As of August 2015, four states and the District of Columbia have passed laws banning the practice of conversion therapy for minors, and 21 other states have introduced similar legislation. All of the bills bar mental health providers from practicing conversion therapy on minors; some also include protections for vulnerable adults, restrictions on the use of state funds, and consumer protection provisions.

There is currently no federal ban on conversion therapy. Several bills and resolutions have been introduced in 2015, including H.R. 2450: Therapeutic Fraud Prevention Act; S.Res. 184: Stop Harming Our Kids Resolution of 2015; HR 3060 Stop Child Abuse in Residential Programs for Teens Act of 2015; and H.Con.Res. 36: Expressing the sense of Congress that conversion therapy, including efforts by mental health practitioners to change an individual's sexual orientation, gender identity, or gender expression, is dangerous and harmful and should be prohibited from being practiced on minors. These efforts discourage or ban conversion therapy or require non-discrimination in the provision of services to sexual and gender minority minors.

Stakeholders have also suggested the following as potential federal actions to end conversion therapy:

- Restrictions on the use of federal or state funding for conversion therapy by federal programs, by recipients of such funding, or through health insurance reimbursements.
- Policies for institutions that house out-of-home youth (such as juvenile justice and foster care programs) that prohibit conversion therapy efforts on minors in care. These entities are often licensed by states or receive federal funding.
- Clarification of existing non-discrimination policies to extend to prohibitions on conversion therapy

In addition to legislative and regulatory action, legal action has been explored as a mechanism for ending the use of conversion therapy. Most notably, a jury found in favor of a claim brought under New Jersey's consumer fraud law, finding that a "conversion therapy" program that offered services purported to change people from gay to straight was fraudulent and unconscionable.[23]

In addition, potential claims of discrimination have been raised under the theory that the provision of ineffective and potentially harmful therapy is due solely to an individual's sexual orientation or gender identity.

Notably, the American Bar Association also passed a resolution urging "all federal, state, local, territorial, and tribal governments to enact laws that prohibit state-licensed professionals from using conversion therapy on minors," as well as "to protect minors, particularly minors in their care, from being subjected to conversion therapy by state-licensed professionals."[24]

Guidance for Families, Providers, and Educators

Being a sexual or gender minority, or identifying as LGBTQ, does not constitute a mental disorder. Sexual or gender minority status, however, is associated with increased risk of psychosocial issues such as psychological distress, mistreatment, and discrimination. Social support, as well as a lack of rejection, in family, community, school, and health care environments has been shown to have great positive impacts on both the short- and long-term health and well-being of LGBTQ youth (see *Research Overview Section 3.2*). Beyond eliminating the practice of conversion therapy with sexual and gender minority minors, LGBTQ youth need additional support to promote resilience and positive development in the spite of the still-pervasive interpersonal, institutional, and societal bias and discrimination against sexual and gender minorities. The following portions of this report provide families and others working with LGBTQ children and adolescents with guidance and additional resources to help facilitate the best possible outcomes for these youth. The information in these sections is based on research findings as well as clinical expertise.

Promoting Family and Community Acceptance and Support

As children and adolescents increasingly experience and integrate LGBTQ and gender diverse identities during childhood and adolescence, it is critical to provide support to reduce risk and promote well-being across social institutions and systems. This includes families, peers, schools, religious institutions, health and social systems and community services.

Over the past decade, the concept of "connectedness" has been seen by researchers and clinicians as an essential aspect in helping to protect against risk and promote wellness for individuals in families and communities. For LGBTQ youth, family, peer and community support have been shown to be important sources of support, and among these, family support and acceptance during adolescence were found to have the strongest influence on overall adjustment and well-being in young adulthood. Because most young people are nurtured through diverse family, caregiver and kinship systems, LGBTQ and gender diverse children and adolescents need support in the context of their families, cultures and faith communities. Access to accurate information about sexual orientation and gender identity development is critical for families and caregivers who often have limited and inaccurate information about these core aspects of human development. This is particularly important for families and caregivers who believe that LGBTQ identities and gender diversity may be at odds with or disavowed by their religious and cultural values and beliefs.

In 2014, SAMHSA worked with the Family Acceptance Project to publish a resource guide to help practitioners to provide support for families with LGBTQ children. The Family Acceptance Project has developed a family support model and research-based resources to help diverse families, including conservative families, to support their LGBTQ children in the context of their values and beliefs.

Key Points:

- Family reactions to learning that a child is lesbian, gay, bisexual or transgender range from highly rejecting to highly accepting. The largest proportion of families are ambivalent about having an LGBTQ or gender diverse child, and rejecting families become less rejecting over time. Families can learn to support their LGBTQ children – and do so more quickly – when guidance and services are provided in ways that resonate for them, including education presented in the context of cultural and deeply held values.

- All families and caregivers need to receive accurate information about sexual orientation and gender identity and expression in children and adolescents, and they need to understand that how they respond to their LGBTQ children matters. For example, family rejecting behaviors during adolescence – including attempts to change an adolescent's sexual orientation – have been linked with health risks, including suicidal behavior and risk for HIV, during young adulthood. In addition, family supportive and accepting behaviors during adolescence, which include supporting a child's gender expression, have been found to help protect against health risks and to help promote well-being for LGBTQ young adults. As family rejecting and supportive behaviors increase, so, too, does the level of health risks and protective role of family acceptance in promoting an LGBTQ child's overall health and well-being.
- Parents and families with LGBTQ and gender diverse children need to be heard and understood by providers, educators and others who provide services and support for their children and family. This means meeting parents and families where they are, supporting their need to express their feelings, perceptions, hopes and concerns for their LGBTQ child in the context of their cultural and religious perspectives, and being sensitive to how deeply held values shape reactions and responses to having an LGBTQ or gender diverse child.
- Parents and caregivers who are perceived as rejecting their LGBTQ children and who engage in rejecting behaviors (such as trying to change their child's sexual orientation or gender expression, using deeply held values and morals to prevent or change an adolescent's identity or preventing them from participating in LGBTQ support groups) are typically motivated by trying to help their LGBTQ child "fit in," have a good life and be accepted by others. The Family Acceptance Project's research-informed approach to providing services and care for LGBTQ children and adolescents uses a strengths-based framework that views families and caregivers as potential allies in reducing risk, promoting well-being, and creating healthy futures for their LGBTQ children. The family's cultural values, including deeply-held morals and values, are viewed as strengths. Research findings related to family accepting and rejecting behaviors are aligned with underlying deeply held morals and cultural values (such as supporting an individual's dignity and self-worth) to help families understand that it is specific family reactions and communication patterns that contribute to both their LGBTQ child's risk and their well-being.
- Families that are struggling with having an LGBTQ or gender diverse child don't have to choose between their LGBTQ child and their culture or their morals and values. Many parents who are struggling believe that responding with positive reactions such as expressing affection once they learn that a child is LGBTQ will condone or encourage a behavior or identity that is at odds with their beliefs. However, expressing affection for an LGBTQ child is a key supportive behavior that helps protect their child against health risks and increases connectedness. In addition, parents that are struggling can respond with other supportive behaviors that help increase parent-child connectedness and have been identified in research to help protect against risk and help promote an LGBTQ child's well-being - without "accepting" an identity they believe is wrong. This includes behaviors such as talking with their child and listening respectfully to understand their child's experiences; requiring that other family members treat their child with respect even if they disagree; ensuring their child's safety by standing up for their child when others hurt, mistreat or discriminate against their LGBTQ or gender diverse child because of who they are. These behaviors also reflect the key values of dignity, mercy, and compassion.

Resources

Family Acceptance Project: http://familyproject.sfsu.edu/

Gender Spectrum: www.genderspectrum.org

Institute for the Study of Sexual Identity: www.sexualidentityinstitute.org

PFLAG: www.pflag.org

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Bullying, Harassment, and Other School-Based Issues

Children and adolescents spend the vast majority of their time in schools and other institutional settings. Research has shown that students with positive school experiences achieve healthier outcomes across a range of variables. Conversely, negative experiences in school can have a detrimental impact on educational attainment, in addition to numerous health-related outcomes. LGBTQ young people in schools experience disproportionately high levels of bullying, harassment, and discrimination. This puts them at higher risk of depression, anxiety, suicidal ideation and attempt, substance use, and other mental health problems, in addition to negative educational outcomes. Families, guardians, and school-based professionals can and should take steps to mitigate issues that arise because students are, or are perceived to be, LGBTQ. Safe and supportive school environments are an important factor in ensuring the health and well-being of all students, including LGBTQ students.

Key points:

- Much of the distress that LGBTQ children and adolescents experience is not the result of their gender non-conformity or LGBTQ identity – in other words, it is not *being* LGBTQ that causes the distress, but rather the way they are *treated* for being LGBTQ that does. This can include being bullied, harassed, or otherwise

mistreated, in addition to experiences with structural barriers such as the lack of access to an appropriate restroom for a transgender student. School-based professionals can help minimize mental health issues for LGBTQ students by taking steps to eliminate structural barriers and proactively working to create a positive school climate, which can include measures such as LGBTQ-inclusive curriculum and intervening to stop bullying and harassment.

- School-based mental health professionals may often be one of the few trusted adults with whom young people can be open about who they are and what barriers they are facing as a result. Some LGBTQ young people may not be in a position to discuss their sexual orientation or gender identity with their families, whether because their family has already made it clear that such conversations are not welcome, or because of fears of family rejection if they come out. In addition to providing a safe and welcoming atmosphere, school-based mental health professionals can equip themselves with LGBTQ-related resources, know the warning signs for identity-based mistreatment, and be prepared to serve as one of the primary adults with whom LGBTQ youth can discuss these issues.
- It is important to understand that confidentiality is essential; students should not be outed to their parents or to their peers, and professionals should not assume that the name, pronouns, or manner of dress that a student uses in school is the same at home; often times, school may be the only place where a young person feels comfortable being out or expressing their gender in a certain way. Students should be asked how they would like to be addressed and in which context. Safety and support should be of paramount concern.
- Students should never be asked to change gender non-conforming behavior as a means of resolving issues arising in school. Beyond the potential for increasing psychological distress, such requests occur within the context of a system that already frequently penalizes LGBTQ youth. This population is disproportionately disciplined in schools, and is over-represented in the juvenile justice system. While five to seven percent of youth are estimated to be LGBTQ, they represent 15 percent of the juvenile justice population, and up to 40 percent of homeless youth. Helping to ensure that LGBTQ youth can be who they are *and* stay in school is a life-changing and potentially life-saving intervention.
- One of the most important steps that families and schools can take is to ensure that schools have inclusive and supportive policies for LGBTQ youth that are implemented effectively. Numerous resources have been developed (several are listed below) that walk through all of the ways in which a school can make system-wide changes that benefit all students, including LGBTQ students. Beyond simply being in the best interest of LGBTQ students and their behavioral health, Title IX of the Education Amendments of 1972 protects transgender and gender nonconforming students from discrimination. Proactive adoption of inclusive policies can prevent costly and time-consuming efforts to remedy issues after damage has already occurred.

Resources:

Centers for Disease Control, Division of Adolescent and School Health (DASH): www.cdc.gov/HealthyYouth/

GLSEN: www.glsen.org

Human Rights Campaign, Welcoming Schools Initiative: www.welcomingschools.org

National Center for Lesbian Rights, Youth Project: www.nclrights.org/our-work/youth

National Association for School Psychologists, Committee on GLBTQ Issues: www.nasponline.org/advocacy/glb.aspx

PFLAG : www.pflag.org

Safe & Supportive Schools Project: http://www.apa.org/pi/lgbt/programs/safe-supportive/default.aspx

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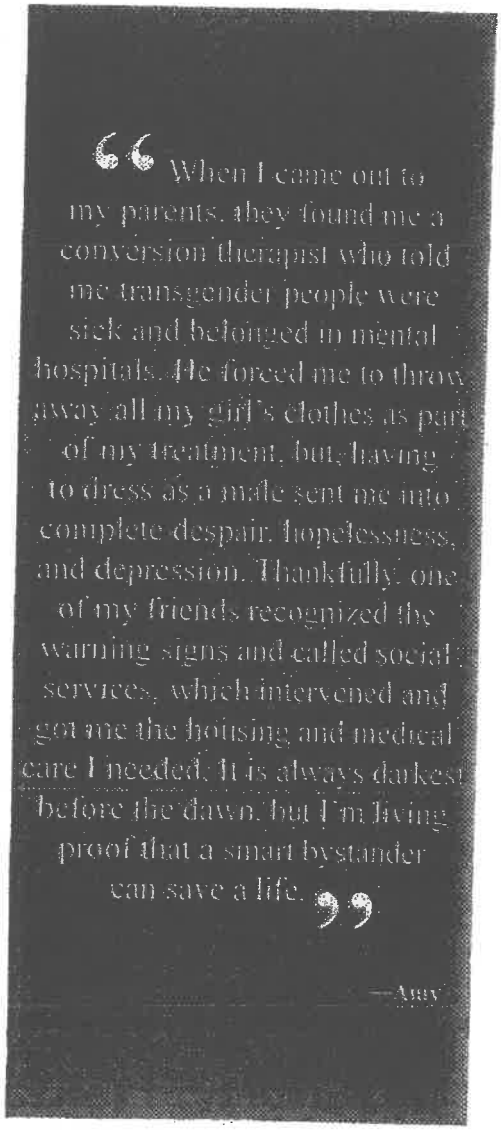

Pediatric Care Considerations for LGBTQ Children and Adolescents

Pediatricians are often the first health professional that families turn to when they need help addressing issues that have arisen because their child is, or is perceived to be, LGBTQ. Families often develop a longstanding, trusting relationship with their family pediatrician and may feel more comfortable discussing issues with them before reaching out to a behavioral health professional. They may rely also on them for referrals to other appropriate professionals. Consequently, it is important for pediatricians to understand appropriate therapeutic approaches when working with LGBTQ children and their families.

In 2014, the Association of American Medical Colleges (AAMC) published a set of thirty gender, sex anatomy, and sexuality competencies that physicians should be able to demonstrate in their practices (Association of American Medical Colleges, 2014). Additionally, the American Academy of Child and Adolescent Psychiatry published a set of practice parameters pertaining to the care of LGBTQ youth that speaks to the importance of addressing family dynamics when working with families with LGBTQ youth (Adelson & AACAP CQI, 2012). Specifically for eligible transgender adolescents who meet criteria for gender dysphoria (GD), the World Professional Association of Transgender Health Standards of Care, 7th Edition, recommends that family involvement in the consent process is crucial for physical interventions that are prescribed by health professionals who are not behavioral health professionals. The following key principles can be drawn from these resources as they apply to pediatricians and family practice physicians when youth who are, or are perceived to be, LGBTQ present in clinical practice.

Key points:

- *Families need accurate information about LGBTQ identities as being normal variants of the human experience*. Specifically, this is important in helping pediatricians respond to family and parent questions about the healthiness or normality of their child's or adolescent's behavior or identity is inherently pathological and whether these behaviors or identities can or should be changed. This can be particularly important for transgender and gender nonconforming youth, who may be seeking medical interventions to help mitigate the effects of untreated gender dysphoria, as some parents might hold the belief that their youth's gender identity is inherently pathological. In fact, it is the associated gender identity-sex anatomy discrepancy that characterizes gender dysphoria, and which is the treatable phenomena, not the gender identity itself. This information is readily available (several resources are listed below), and sharing it may be the most important way a pediatrician can support the healthy development of sexual and gender minority youth.
- *Practices should provide office climates that allow all youth to feel comfortable disclosing their gender identity or sexual orientation, whether it differs from societal expectations and cultural norms or not.* Steps to do so can include a number of things, ranging from changing intake forms to include both gender identity and sex assigned at birth, routinely asking about pronoun preferences when with youth alone, training frontline staff to use youths' preferred name and pronoun (and when it is safe and appropriate to do so), to forming partnerships with local LGBTQ organizations and building relationships with LGBTQ community providers to whom they can refer youth and families to when appropriate.
- *Family dynamics are particularly important to address as they pertain to attitudes and beliefs about gender identity and sexual orientation.* Research has shown that LGBTQ youth who come from highly rejecting families are nearly nine times more likely to engage in suicidal behavior when compared to their LGBTQ youth counterparts who come from accepting families (Ryan, et al., 2009). Pediatricians should be aware of the various types of

reactions from family members towards their child or adolescent which can range from subtle forms of rejection (e.g., calling their child's identity a "phase") to more overt forms of rejection (e.g., kicking their youth out of the home or physical abuse). Pediatricians should encourage whole-family resolutions of issues with which they are confronted, including referral to mental health professionals who can work with young people as well as for individual family members who may be struggling with the idea that their child or adolescent is or may be LGBTQ. Partnering with parents or family members who are struggling with their youths' gender identity or sexual orientation may sometimes be necessary in order to gain family members' trust, increasing adherence and reducing resistance to the pediatrician's future recommendations.

- *Pediatricians should be careful not to reinforce gender stereotypes when working with LGBTQ and gender nonconforming youth and their families.* This can require recognizing your own implicit biases and working to change ingrained patterns, such as giving certain stereotypically masculine toys to boys and others to girls, or asking adolescents specifically whether they have a boyfriend or a girlfriend instead of determining the information in a manner that does not presuppose the gender of their romantic or sexual interest or attraction.
- *Pediatricians should be aware of the situations when it is necessary to enlist an interdisciplinary team of providers to address the health of some LGBTQ youth.* While some issues may be resolved through the simple provision of information, it may be necessary to establish an interdisciplinary team that includes qualified behavioral health professionals and ongoing collaboration. For all LGBTQ youth, recognizing and detecting signs of emotional distress and psychiatric co-occurring diagnoses (such as depression, anxiety, substance abuse), requires astute screening (particularly in the case of suicide), detection of psychiatric conditions, and prompt referral to a behavioral health provider. As is addressed in depth in the *Affirmative Care* section, for adolescents with gender dysphoria, it is important to coordinate the care with a qualified behavioral health provider and endocrinologist in determining eligibility and readiness for physical interventions such as pubertal suppression or cross-gender hormone therapy. In some situations, coordination of care with the behavioral health provider and surgeon may be necessary as well when considering surgical interventions for eligible adolescents with gender dysphoria as described in the WPATH standards of care (Coleman et al., 2012).

Resources:

American Academy of Pediatrics. (2013). Policy Statement: Office-based care for lesbian, gay, bisexual, transgender, and questioning youth. *Pediatrics, 132*(1), 198 -203 doi: 10.1542/peds.2013-1282

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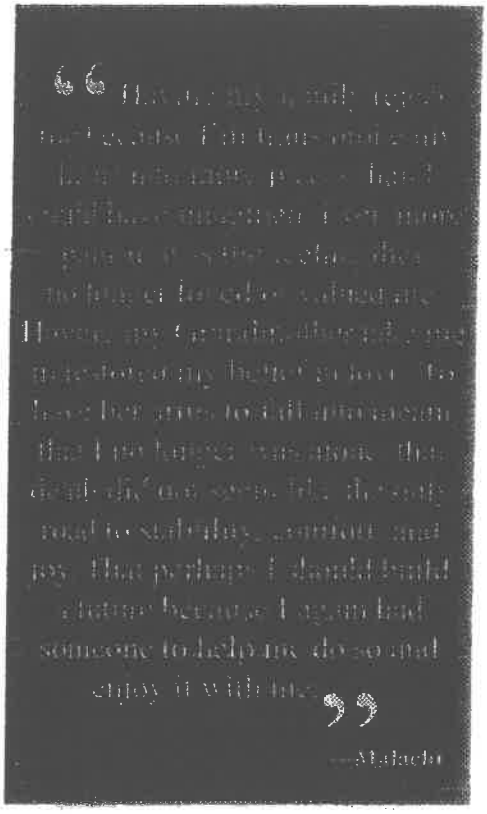

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Affirmative Care for Gender Minority Youth

Increasingly, families, providers, and researchers alike are realizing that providing supportive, affirmative care to transgender children and adolescents results in better outcomes for youth. This positive development has resulted in a significant increase in the number of families and providers seeking accurate information about appropriate treatment protocols for working with gender minority (transgender and gender diverse) youth, including information about socially transitioning youth, and about medical interventions for adolescents.

It is important to ensure that supportive behavioral health and medical care take an affirmative approach which aims to facilitate in children and adolescents the time and space they need to develop and transition in whatever way that might make sense for them, whenever they are ready.

In this approach, children and adolescents are encouraged to actively explore their gender identity and gender expression at home, with peers, and within the context of supportive therapy. This approach encourages children, adolescents, and families to move away from the gender binary and accept the child's developing gender identity and sexual orientation at whatever point they are in their own trajectory. With young children, this may include exploring all options related to social transitioning. For example, perhaps the child is assigned male at birth and prefers feminine clothing and toys but is not pushing for a female name and pronouns. Rather than assume the child should undergo a full social transition, an affirmative approach would allow the child to continue sorting out their gender identity over time. For an adolescent uninterested in medical interventions, an affirmative approach might include encouraging them to consider non-body altering ways of living in their affirmed gender and helping them explore the variety of ways to live in their individualized gender identity.

Here are a few key points to keep in mind when considering a supportive and balanced approach for transgender and gender diverse, or gender minority, youth:

- Affirmative work with gender non-conforming young children should consider the option of socially transitioning for each child individually, carefully exploring the pros and cons in a client-centered approach. The existing research should be discussed with parents, with acknowledgement that many gender non-conforming children do not persist to become transgender adolescents and adults.
- Affirmative work with gender minority adolescents involves offering puberty blocking medication (at Tanner Stage 2-3) and cross-sex medical interventions (generally offered around the age of 16). However, the research showing positive effects for these interventions are based on protocols that require supportive, gender-clarifying therapy and a psychological/ readiness evaluation. Offering these medical interventions in the absence of an interdisciplinary team that provides the mental health component does not have empirical support and carries risks (e.g., greater chance of regret).
- While lowering the age requirement for hormone treatment may be in the best interest of some adolescent patients, this decision carries risks as most adolescents prior to age 16 are still solidifying their identities and have underdeveloped neurological and cognitive functioning that allows for mature long-term decision making. Mental health involvement, most importantly a formal readiness evaluation, is always recommended in these cases.
- Research shows that gender minority children and adolescents are most likely to thrive when they have the support of their parents. For this reason, an affirmative approach should involve parents in the process.
- Medical interventions (puberty blockers and cross-sex hormone therapy) have been shown to be helpful in decreasing gender dysphoria and improving quality of life for transgender and gender minority youth when the youth treated follow a specific protocol that involves two important steps: (1) gender exploring therapy with a qualified mental health provider, and (2) a comprehensive evaluation to determine readiness for a medical intervention.
- Because of the potential impact that hormone therapy may have on fertility, this topic should be discussed at length with any adolescent seeking medical interventions and should occur with both their mental health and medical providers. Parents should also be made aware of these potential side effects. Additionally, because many gender minority young adolescents who are prescribed puberty blocking medication eventually pursue hormone treatment, the conversation about fertility should happen prior to starting blockers as well.
- Although many young adolescents who are prescribed puberty blockers will eventually pursue hormone treatment, blockers are not intended as the first step in the physical/medical transition process. The affirmative client-centered approach reminds parents, youth (and providers) that the primary purpose of the blockers is to give the adolescent more time to continue exploring their gender identity in an effort to help them make the best decision for themselves regarding initiation of other medical interventions in the future. Adults that are unable to or are uncomfortable with the possibility that an adolescent on blockers could change their mind may explicitly or inexplicitly make an adolescent feel "stuck" in a gender identity.
- Affirmative care encourages providers, patients, and families to critically examine their own values and beliefs about gender and the gender binary specifically. Providers and parents are encouraged to accept a more fluid expression of gender and allow their child or adolescent the freedom to explore their developing gender identity without pressure to select one of two options.

- Due to the complexity that exists for most transgender and gender diverse youth, due to their evolving gender identity and sexual orientation, their rapidly changing and developing bodies and brains, along with a rapidly shifting societal landscape around acceptance of and treatment for transgender and gender diverse people, an affirmative approach recognizes the importance of providing care within an interdisciplinary team, wherein each provider's input is valued and perceived as equally critical to the care of the individual patients served.

Resources

TransYouth Family Allies: www.imatyfa.org/

Trans Youth Equality Foundation: www.transyouthequality.org

PFLAG Transgender Network: http://community.pflag.org/transgender

Gender Spectrum: www.genderspectrum.org

Brill, S. A., & Pepper, R. (2008). *The transgender child: A handbook for families and professionals*. Berkeley, CA: Cleis Press.

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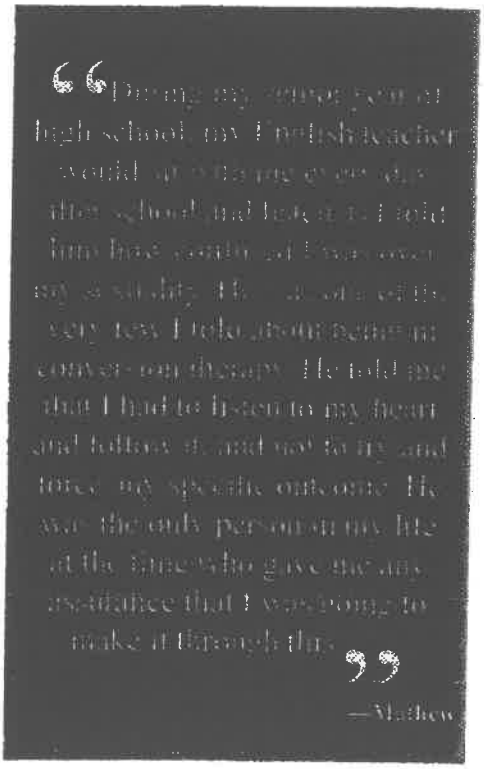

Summary and Conclusion

SAMHSA is committed to eliminating health disparities facing vulnerable communities, including sexual and gender minority children and youth. To build a healthy and supportive environment for all children and adolescents, families and providers need resources and accurate information to help inform healthy decision making. Two key strategies that can help prevent adverse outcomes and support healthy development for LGBTQ youth are: strong and positive family and community engagement, and appropriate and supportive therapeutic interventions by health and behavioral health care providers.

These strategies are grounded in psychological research. Being a sexual or gender minority, or identifying as LGBTQ, is not a mental disorder. Variations in sexual orientation, gender identity, and gender expression are normal. Sexual and gender minority children have unique health and behavioral health needs, and may experience distress related to their sexual orientation or gender, as well as others' responses to their current, future, or perceived sexual orientation, gender expression, or gender identity. In addition, gender minority youth may experience distress caused by the incongruence between their gender identity and physical body.

The research, clinical expertise, and expert consensus make it clear that conversion therapy efforts to change a child's or adolescent's gender identity, gender expression, or sexual orientation are not an appropriate therapeutic intervention. No evidence supports the efficacy of such interventions to change sexual orientation or gender identity, and such interventions are potentially harmful. Appropriate therapeutic approaches to working with sexual and gender minority youth include: providing accurate information on the development of sexual orientation and gender identity and expression, increasing family and school support, and reducing family, community, and social rejection of sexual and gender minority children and adolescents. Social transition and medical interventions, including pubertal suppression and hormone therapy, are additional therapeutic approaches that are appropriate for some gender minority youth. Careful evaluation, developmentally-appropriate informed consent of youth and their families, and a weighing of potential risks and benefits are vital when considering interventions with gender minority youth.

Beyond ending potentially harmful practices, it is important to also build greater social acceptance of LGBTQ youth; to adopt appropriate and supportive therapies; and to provide targeted resources and accurate information for children, adolescents, their families, and their providers. Building better supportive environments and working to eliminate negative social attitudes will reduce health disparities and improve the health and well-being of all LGBTQ youth.

> "It is nearly impossible to describe walking into a therapist's office after surviving conversion therapy. The problem is that we need help from a system we have only known to hurt us. Hearing that I would be okay and that my new therapist could help me learn to cope with the pain of my conversion therapy experience was like getting a second chance at life."
>
> —Sam

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Appendix A: Glossary of Terms

Cisgender: A person whose gender identity, gender expression, and sex assigned at birth all align.

Conversion therapy: Efforts to change an individual's sexual orientation, gender identity, or gender expression through behavioral health or medical interventions. Any effort with an *a priori* goal of a gender expression that aligns with stereotypical norms, cisgender identity, and/or heterosexual orientation, identity, and sexual behaviors.

Gender dysphoria: Psychological distress due to the incongruence between one's body and gender identity.

Gender expression: The way a person expresses their gender identity (e.g., through dress, clothing, body movement, etc.). Young children express their gender through choices for personal items such as toys and clothes, as well as hairstyle, colors, etc.

Gender identity: A person's internal sense of being male, female, or something else. Gender identity is internal, so it is not necessarily visible to others. Gender identity is also very personal, so some people may not identify as male or female while others may identify as both male and female.

Gender nonconforming, gender diverse: A person whose gender expression differs from how their family, culture, or society expects them to behave, dress, and act.

Intersex: Individuals with medically defined biological attributes that are not exclusively male or female; frequently "assigned" a gender a birth which may or may not differ from their gender identity later in life.

Questioning: Individuals who are uncertain about their sexual orientation and/or gender identity. Also used as a verb to describe the process of exploring ones sexual orientation and/or gender identity.

Sex assigned at birth: The sex designation given to an individual at birth.

Sexual orientation: A person's emotional, sexual, and/or relational attraction to others. Sexual orientation is usually classified as heterosexual, bisexual, or homosexual (lesbian and gay), and includes components of attraction, behavior, and identity (Laumann et al., 1994). Sexual orientation is expressed in relationship to others to meet basic human needs for love, attachment, and intimacy (Institute of Medicine, 2011). Thus, young people can be aware of their sexual orientation as feelings of attachment and connection to others before they become sexually active. Sexual orientation identity is how someone labels and identifies their sexual orientation either publicly or privately. Sexual orientation, sexual orientation identity, and sexual behaviors are not always congruent.

Transgender: A person who feels that their gender identity does not match their physical body and diffets from the gender that others observed and gave them at birth (assigned or birth gender).

Transition: A term used to describe the process of moving from one gender to another; in adolescents and adults, can be characterized by medical intervention such as the use of cross-sex hormone therapy or gender affirming surgeries. For all people, can include social transition, which is the process of outwardly beginning to present as a different gender, which can include changes in name, pronouns, and appearance.

Endnotes

1. The term "sexual and gender minority" is an umbrella term. "Sexual minority" refers to individuals who have a same-gender (i.e., gay or lesbian) or bisexual orientation. "Gender minority" refers to individuals whose gender identity differs from their assigned sex at birth or whose gender expression does not conform to stereotypical cultural norms. Sexual and gender minority populations are also referred to as lesbian, gay, bisexual, and transgender (LGBT) populations, as many (though not all) sexual and gender minority individuals identify as lesbian, gay, bisexual, or transgender. At times, the phrase LGBTQ - lesbian, gay, bisexual, transgender, and questioning – is used to be inclusive of individuals who are questioning aspects of their gender or sexual orientation, and is particularly common when youth are the population of focus, as here.
2. Conversion therapy consists of any efforts to change an individual's sexual orientation, gender identity, or gender expression through behavioral health or medical interventions. Any effort with an *a priori* goal of a gender expression that aligns with stereotypical norms, cisgender identity, and/or heterosexual orientation, identity, and sexual behaviors. For a full glossary of terms, see Appendix A.
3. To be inclusive of transgender populations, the term "same-gender" (as opposed to "same-sex") is used throughout this report in order to clearly distinguish between the constructs of gender and assigned sex and to recognize that individuals generally label their sexual orientation with regard to their gender identity as opposed to assigned sex at birth.
4. This section is based on the consensus statements developed by an expert panel convened by the American Psychological Association, July 2015. These statements are based on the best available research and scholarly material available.
5. Efforts to change an individual's sexual orientation, gender identity, or gender expression through behavioral health or medical interventions. Any effort with an *a priori* goal of a gender expression that aligns with stereotypical norms, cisgender identity, and/or heterosexual orientation, identity, and sexual behaviors. For a full glossary of terms, see Appendix A.
6. The term "sexual and gender minority" is an umbrella term. "Sexual minority" refers to individuals who have a same-gender (i.e., homosexual) or bisexual orientation. "Gender minority" refers to individuals whose gender identity differs from their assigned sex at birth or whose gender expression does not conform to stereotypical cultural norms. Sexual and gender minority populations are also referred to as lesbian, gay, bisexual, and transgender (LGBT) populations, as many (though not all) sexual and gender minority individuals identify as lesbian, gay, bisexual, or transgender. At times, the phrase LGBTQ - lesbian, gay, bisexual, transgender, and questioning – is used to be inclusive of individuals who are questioning aspects of their gender or sexual orientation, particularly common when youth are the population of focus.
7. To be inclusive of transgender populations, the term "same-gender" (as opposed to "same-sex") is used throughout this report in order to clearly distinguish between the constructs of gender and assigned sex and to recognize that individuals generally label their sexual orientation with regard to their gender identity as opposed to assigned sex at birth.
8. Secondary sex characteristics refer to sexually dimorphic phenotypic traits that develop due to increased sex hormones in puberty. Changes due to increase in androgens includes growth of the testicles and penis, increased height, increased muscle mass, changes in body shape and weight distribution (e.g., broadening of the shoulders and chest), growth of facial and body hair, and enlargement of the larynx and deepening of the voice. Changes due to increase in estrogens includes breast development, changes in body shape and weight distribution (e.g., widening of the hips and narrowing of the waist), growth of underarm and pubic hair, and the onset of menses (Lee 1980).
9. Homosexuality per se was removed from the International Classification of Diseases and it is explicitly stated that "sexual orientation by itself is not to be considered a disorder." Certain homosexuality-related diagnoses remain in the ICD, although there is some movement underway to remove them in the next edition of ICD (Cochran, S. D., Drescher, J., Kismödi, Giami, García-Moreno, Atalla, …, & Reed, 2014).
10. Biological sex is itself a multidimensional construct, as the chromosomal, gonadal, and anatomical indicators of biological sex do not always align, such as in intersex individuals/individuals with disorders of sex development (Hughes et al., 2006).
11. It should be noted that what behaviors, activities, and appearances are considered feminine or masculine, as well as the expected degree of conformity to gender expressions stereotypically associated with one's assigned sex at birth, varies by culture and over time. The alignment of assigned sex at birth, gender identity, and gender expression has been assumed in many, but not all, cultures and religious traditions. Historically several different cultures have recognized, accepted, and sometimes revered diversity in gender identity and gender expression (American Psychological Association, 2015b). This includes Two Spirit individuals within American Indian communities.

12. The diagnosis of Gender Identity Disorder was eliminated and replaced with the diagnosis of Gender Dysphoria in the Diagnostic and Statistical Manual of Mental Disorders in 2013. Though no longer the current diagnosis, almost all existing research includes participants who were diagnosed using the earlier criteria for Gender Identity Disorder. In addition to the diagnostic category of Gender Dysphoria (capitalized), the term "gender dysphoria" (lowercase) is used to broadly describe the discomfort or distress caused by the discrepancy between a person's gender identity and that person's sex assigned at birth and/or primary or secondary sex characteristics. We will use the term "individuals with gender dysphoria" throughout the report as inclusive of individuals diagnosed under both current and earlier diagnostic criteria, while recognizing that future research findings focused on individuals with Gender Dysphoria may differ from that focused on individuals previously diagnosed with Gender Identity Disorder.
13. There is a third trajectory, in which individuals do not experience gender dysphoria or a diverse gender expression in childhood, but experience the onset of gender dysphoria in adolescence or later. This trajectory is discussed in the section on Gender in Adolescence.
14. Scientists now understand that while sexual orientation is not malleable to external pressures to change (American Psychological Association, 2009), some individuals experience internal changes in sexual attraction and/or changes in what sexual orientation identity label they use (e.g., straight, bisexual, gay) throughout adolescence and adulthood; this concept is referred to as sexual fluidity (Diamond & Butterworth, 2008; Savin-Williams & Ream, 2006). For findings related to the stability of sexual orientation identity in adolescence and young adulthood, refer to research by Ott et al. (2010).
15. Though opportunities for sexuality- and gender-related stressors and supports also occur throughout these social systems within the lives of sexual and gender minority children, research in these areas has generally not included pre-pubertal children.
16. This section is based on the statements of professional consensus developed by an expert panel convened by the American Psychological Association, July 2015 at the request of the US Substance Abuse and Mental Health Services Administration. These statements, listed in *Section 2*, are based on the best available research and scholarly material available.
17. See American Psychological Association (2009, 2012, and 2015a)
18. This section is based on reports by American Psychological Association (2012 and 2015a) and APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation (2009).
19. For more information see White House sources Strengthening Protection against Discrimination.
20. For example, "A Practitioner's Resource Guide: Helping Families to Support Their LGBT Children" http://store.samhsa.gov/product/A-Practitioner-s-Resource-Guide-Helping-Families-to-Support-Their-LGBT-Children/PEP14-LGBTKIDS. Another helpful resources is "Helping Families Support Their Lesbian, Gay, Bisexual, and Transgender (LGBT) Children" http://nccc.georgetown.edu/documents/LGBT_Brief.pdf.
21. See for instance, American Psychological Association (2011), Guidelines for Psychological Practice with Lesbian, Gay, and Bisexual Clients.
22. Association of American Medical Colleges, 2014. Implementing Curricular and Institutional Climate Changes to Improve Health Care for Individuals Who are LGBT, Gender Nonconforming, or Born with DSD. Available at https://www.aamc.org/download/414172/data/lgbt.pdf.
23. Ferguson v. JONAH, Law Div., Hudson Cy. (Barlso, J.S.C.), HUD-L-5473-12, February 5, 2015.
24. American Bar Association, 2015. Resolution 112., available at https://www.americanbar.org/content/dam/aba/images/abanews/2015annualresolutions/112.pdf.

The Washington Post

Religion

Conversion therapy center founder who sought to turn LGBTQ Christians straight says he's gay, rejects 'cycle of self shame'

By Marisa Iati
September 3

McKrae Game wants people to know that he was wrong about all of it.

He was wrong to found Hope for Wholeness Network, a faith-based conversion therapy program that seeks to rid people of their LGBTQ identities. He was wrong to create a slogan promoting the idea of "freedom from homosexuality through Jesus Christ." He was wrong to tell people they were doomed for all eternity if they didn't change their ways.

After 20 years working in that field, Game said he realizes the harm he has caused and that he, himself, is gay. Conversion therapy encompasses a widely discredited range of methods that purport to change someone's sexual orientation or gender identity. The practice is illegal in 18 states and the District.

"It's all in my past, but many, way TOO MANY continue believing that there is something wrong with themselves and wrong with people that choose to live their lives honestly and open as gay, lesbian, trans, etc.," Game, 51, wrote on Facebook last week. "The very harmful cycle of self shame and condemnation has to stop."

Hope for Wholeness, based in South Carolina and known as one of the nation's most prominent conversion therapy centers, did not respond Tuesday to requests for comment.

Game is among many founders and leaders of conversion therapy programs to disavow the practice later. In 2014, nine former "ex-gay" leaders signed an open letter denouncing conversion therapy as "ineffective and harmful" and calling for an end to it. A Latter-day Saint counselor who practiced conversion therapy said in January that he is gay and that he "unequivocally renounces" ex-gay ministry.

Game announced in June that he was gay, almost two years after Hope for Wholeness's board of directors fired him, the Post and Courier reported. In his Facebook post, he said all conversion therapy programs should be closed, but that he would support them becoming support groups for people who believe being LGBTQ is incongruous with their faith.

"I was a religious zealot that hurt people," Game told the Post and Courier. "People said they attempted suicide over me and the things I said to them. People, I know, are in therapy because of me. Why would I want that to continue?"

In a Facebook Live video posted Tuesday, Game said he decided to tell people he was gay because he was scared that someone would "out" him — reveal his sexual orientation — and he wanted to control his own story. He said he slowly hinted on Facebook that he was attracted to men.

Game said he is currently doing yard work and that his wife has been

"ridiculously understanding" of his coming out. The couple has two children. He said some people, including Christians and LGBTQ advocates, have expressed anger against him.

"I can see how my life could have been used manipulatively, and I'm very sorry for that," Game said. "How can I count all the ways I did wrong? I don't know that I can. But I've tried, and I'm trying."

Leaders of conversion therapy programs rarely renounce the practice publicly because doing so involves turning their backs not just on the ex-gay community, but also on conservative faith as a whole, said Alan Chambers, the former president of Exodus International. Exodus was the world's largest conversion therapy ministry until Chambers shut it down in 2013 and apologized to the LGBTQ community.

"Oftentimes, not only do you lose the relationships of people in the community that you've been in, but you lose your church," Chambers told The Washington Post. "Sometimes you lose your family. Sometimes you lose everything."

Chambers, who said he is "a gay man married to a straight woman," said his decision to reject conversion therapy developed slowly over decades. He said he was particularly struck by the devastated reactions he saw to California's passage of the now-defunct Proposition 8, a constitutional amendment that in 2008 banned same-sex marriage there. Chambers now advocates for an end to conversion therapy for minors and for including LGBTQ people in faith communities.

Mel White, a former ghostwriter for high-profile evangelical Christians, describes himself as "a victim of the ex-gay movement." White said that when he was married to a woman and believed his same-sex attractions were sinful, he tried every kind of conversion therapy in the book: He took cold showers, subjected himself to electric therapy and got an exorcism. He and his wife paid more than $1,000 for the treatment, he said, and none of it worked.

Eventually, White said he couldn't live that way anymore. He and his wife divorced, and he has been married to a man for 37 years. He said he eventually came to believe that God loves him exactly as he was created, and he stopped ghostwriting autobiographies for the likes of Jerry Falwell and Billy Graham.

White said he believes Christianity is the greatest source of suffering for LGBTQ people, and he co-founded the organization Soulforce to combat what he sees as this oppression. The organization promotes nonviolent resistance to religious fundamentalism.

After spending years working with the conservative Christian right, White said he has "spent the rest of my life trying to redeem myself from having anything to do with that ex-gay system."

Read more:

Agenda Item: Consideration of Guidance Document for Nurse Practitioners

Included in the agenda package:

Guidance Document 90-53 – Treatment by Women's Health Nurse Practitioners of Male Clients for Sexually Transmitted Diseases

Staff Note:

- The Committee of the Joint Boards reviewed and reaffirmed 90-53. It was approved by Board of Medicine in February, but subsequently there were questions so it was not considered by the Board of Nursing in March.
- Jt. Boards reconsidered document on October 16th; draft from that meeting agenda is attached

Action: Board adoption of 90-53 as recommended by the Committee of the Joint Boards

Guidance document: 90-53

Revised: Board of Nursing -
Board of Medicine –

VIRGINIA BOARDS OF NURSING AND MEDICINE

Treatment of Male Clients for Sexually Transmitted Diseases by Women's Health Nurse Practitioners and Certified Nurse Midwives

The Committee of the Joint Boards of Nursing and Medicine determined that the management and treatment of sexually transmitted diseases by Women's Health Nurse Practitioners and Certified Nurse Midwives may include treatment of male partners or male clients as an extension of care of female clients under the requirements of 18 VAC 90-30-120 (B), Regulations Governing the Practice of Nurse Practitioners.

Women's Health Nurse Practitioners and Certified Nurse Midwives who treat male clients for sexually transmitted diseases must have authorization for and have received specific training in such practice, as documented in the written or electronic practice agreement between the nurse practitioner and the collaborating patient care team physician. In addition, any prescription written for sexually transmitted diseases shall be issued for a medicinal therapeutic purpose to a person with whom the practitioner has a bona fide practitioner-patient relationship, in accordance with § 54.1-3303 of the Code of Virginia.

Agenda Item: Audit of Practitioners Performing MDR

Staff Note: In late 2018, an audit was begun on 60 practitioners who indicated during the renewal process that they perform mixing, diluting, or reconstituting of drugs for administration in their practice. In the following pages, you will find a copy of the audit tool, the results of the audit, communications that were in the Board Briefs, and possible options for resolving the audit results with non-compliant licensees.

Action: After a thorough discussion, the Legislative Committee recommended sending advisory letters to all those who were non-compliant with 1 or more elements of the audit tool. The Board can approve the recommendation or discuss and choose another option.

OPTIONS TO RESOLVE MDR CASES

You have noted the advance communications to licensees in 2011 and 2018.

The first audit was accomplished in 2012. Advisory Letters were sent to all licensees found to be non-compliant with some aspect of the regulations.

The current audit is the second, and the same options apply to the resolution of the findings with the licensees.

The 61 licensees audited this time were selected randomly by DATA and did not involve any complaints. The only parameters for selection were geographic scatter and the broadest range of specialties possible.

Options for Resolution

First Option

Send the 30 non-compliant licensees an Advisory Letter based upon the requirement(s) on the audit form with which the licensee was not compliant. This will be the most expeditious way to get feedback to the licensees

Second Option

If the Board deems non-compliance minor misconduct, send Confidential Consent Agreements to licensees that demonstrated some non-compliance with the regulations to ensure that it will be corrected. This approach will take considerably more time than an Advisory Letter. Further investigation may also be necessary.

Third Option

Public discipline in the form of a Consent Order that specifies allegations of violating some requirement in the regulations. Again, not as expeditious as an Advisory Letter, and more investigation would need to occur prior to issuing a Consent Order.

Fourth Option

A hybrid of the above options or any other approach.

Virginia Department of
Health Professions
Board of Medicine www.dhp.virginia.gov

MIXING, DILUTING OR RECONSTITUTING OR DRUGS OR ADMINISTRATION

Physician's Name: _____ **License Number:** _____
Practice Name: _____ **Phone Number:** _____
Address: _____ **???** _____
Inspection Date: _____ **License Number:** _____

C	NC	NA	REQUIREMENTS FOR IMMEDIATE STERILE MIXING, DILUTING OR RECONSITITUING 10VAC85-20-400 et. seq.
☐	☐	☐	The mixing, diluting, or reconstituting of sterile manufactured drug products when there is no direct contact contamination and administration begins within 10 hours of the completion time of preparation shall be considered immediate-use. If manufacturers' instructions or any other accepted standard specifies or indicates an appropriate time between preparation and administration of less than 10 hours, the mixing, diluting or reconstituting shall be in accordance with the lesser time.
☐	☐	☐	No direct contact contamination means that there is no contamination from touch, gloves, bare skin or secretions from the mouth or nose.
☐	☐	☐	Emergency drugs used in the practice or anesthesiology and administration of allergens may exceed 10 hours after completion of the preparation, provided administration does not exceed the specified expiration date of a multiple use vial and there is compliance with all other requirements of this section.

C	NC	NA	IMMEDIATE USE MIXING, DILUTING OR RECONSITITUING Doctors of medicine or osteopathic medicine who engage in immediate-use mixing, diluting or reconstituting shall:
☐	☐	☐	Utilize the practices and principles of disinfection techniques, aseptic manipulations and solution compatibility in immediate-use mixing, diluting or reconstituting.
☐	☐	☐	Ensure that all personnel under their supervision who are involved in immediate-use mixing, diluting or reconstituting are appropriately and properly trained in and utilize the practices and principles of disinfection techniques, aseptic manipulations and solutions compatibility.
☐	☐	☐	Establish and implement procedures for verification of the accuracy of the product that has mixed, diluted, or reconstituted to include a second check performed by a doctor or medicine or osteopathic medicine or a pharmacist, or by a physician assistant or a registered nurse who has been specifically trained pursuant to subdivision 2 of 18VAC85-20-400 in immediate-use mixing, diluting and reconstituting. NOTE: Mixing, diluting or reconstituting that is performed by a doctor of medicine or osteopathic medicine, a pharmacist, or by a specifically trained physician assistant or registered nurse or mixing, diluting or reconstituting of vaccines does not require a second check.

C: Compliant NC: Not Compliant NA: Not Applicable

☐	☐	☐	Provide a designated, sanitary work space and equipment appropriate for aseptic manipulations.
☐	☐	☐	Document or ensure that personnel under his supervision documents in the patient record or other readily retrievable record that identifies the patient; the name of drugs mixes, diluted or reconstituted; and the date of administration.
☐	☐	☐	Develop and maintain written policies and procedures to be followed in mixing, diluting or reconstituting of sterile products and for the training of personnel.
☐	☐	☐	Any mixing, diluting or reconstituting of drug products that are hazardous to personnel shall be performed consistent with requirements of all applicable federal and state laws and regulations for safety and air quality, to include but not be limited to those of the Occupational Safety and Health Administration. (OSHA)

C	NC	NA	REQUIREMENTS FOR LOW, MEDIUM OR HIGH-RISK STERILE MIXING, DILUTING OR RECONSTITUTING
☐	☐	☐	Any mixing, diluting or reconstituting of sterile products that does not meet the criteria for immediate-use as set forth in 18VAC-20-400 A shall be defined as low-, medium-, or high-risk compounding under the definitions of Chapter 797 of the U.S. Pharmacopeia (USP)
☐	☐	☐	Doctors of medicine or osteopathic medicine who engage in low-, medium-, or high-risk mixing, diluting or reconstituting of sterile products shall comply with all applicable requirement of the USP Chapter 797. Subsequent changes to the USP Chapter 797 shall apply within one year of the official announcement by USP.
☐	☐	☐	A current copy, in any published format, of USP Chapter 797 shall be maintained at the location where low-, medium-, or high-risk mixing, diluting or reconstituting of sterile products is performed.

C	NC	NA	RESPONSIBILITIES OF DOCTORS WHO MIX, DILUTE OR RECONSTITUTE DRUGS IN THEIR PRACTICES
☐	☐	☐	Doctors of medicine or osteopathic medicine who delegate the mixing, diluting or reconstituting of sterile drug products for administration retain responsibility for patient care and shall monitor and document any adverse responses to the drugs.
☐	☐	☐	Doctors who engage in the mixing, diluting or reconstituting of sterile drug products in their practices shall disclose this information to the board in a manner prescribed by the board and are subject to unannounced inspections by the board or its agents.

Inspector Signature: _____

Physician Signature: _____

C: Compliant NC: Not Compliant NA: Not Applicable

Board Briefs-November 2011

Mixing, Diluting or Reconstituting Regulations

The Board has regulations regarding how mixing, diluting or reconstituting of drugs for administration in your practice must occur. These regulations establish standards for medical practice insofar as requirements for training, second checks, documentation, and time to administration. Mixing, diluting or reconstituting that is performed by a doctor of medicine or osteopathic medicine, a pharmacist, or by a specially trained physician assistant or registered nurse or mixing, diluting or reconstituting of vaccines does not require a second check; however, preparation by anyone else requires a second check by a physician, pharmacist, or specially trained PA or RN. At some point, the Board will begin a random inspection program to assess compliance with the regulation. Here is a draft inspection form that the Board anticipates using to review compliance with the regulations in a physician's practice. For those without internet access, the form may be found at the end of the newsletter.

Mixing, Diluting or
Reconstituting of Drugs

Board Briefs-September 2018

Mixing, Diluting or Reconstituting Audits

In the near future, you may be contacted by an investigator/inspector from the Department of Health Professions Enforcement Division regarding compliance with the Regulations for Mixing, Diluting or Reconstituting (MDR) Drugs for Administration. As you may recall, MDR occurring in physicians' practices was carved out of compounding under the Board of Pharmacy and placed under the jurisdiction of the Board of Medicine. In the initial 2005 legislation was a mandate to do periodic audits to assess compliance with the regulations. Now is the time for another audit. The Board wanted to make the audit tool available to you in advance of this effort as a reminder of what is required by the regulations.

MDR Audit Tool

Agenda Item: **Update on Licensure by Endorsement**

Staff Note: Ms. Opher will provide information on note-worthy licensing matters.

Action: None anticipated.

Agenda Item: **Discipline Report**

Staff Note: Ms. Deschenes will provide information on discipline matters.

Action: Consent orders may be presented for consideration.

Agenda Item: **Finance Presentation on submitting Travel Vouchers**

Staff Note: Finance will stress the importance of submitting travel vouchers in a timely fashion.

Action: Very important information!

Virginia Board of Medicine
Amended - 2020 Board Meeting Dates

Full Board Meetings

February 20-22, 2020	DHP/Richmond, VA	Board Rooms TBA
June 18-20, 2020	DHP/Richmond, VA	Board Rooms TBA
October 22-24, 2020	DHP/Richmond, VA	Board Rooms TBA

Times for the above meetings are 8:30 a.m. to 5:00 p.m.

Executive Committee Meetings

April 10, 2020	DHP/Richmond, VA	Board Rooms TBA
August 7, 2020	DHP/Richmond, VA	Board Rooms TBA
December 4, 2020	DHP/Richmond, VA	Board Rooms TBA

Times for the above meetings are 8:30 a.m. to 5:00 p.m.

Legislative Committee Meetings

January 31, 2020	DHP/Richmond, VA	Board Rooms TBA
May 22, 2020	DHP/Richmond, VA	Board Rooms TBA
September 4, 2020	DHP/Richmond, VA	Board Rooms TBA

Times for the above meetings are 8:30 a.m. to 1:00 p.m.

Credentials Committee Meetings

January 8, 2020	February 12, 2020	March 11, 2020
April 15, 2020	May 13, 2020	June 10, 2020
July 8, 2020	August 12, 2020	September 25, 2020
October 23, 2020	November (TBA), 2020	December (TBA), 2020

Times for the Credentials Committee meetings - TBA

Advisory Board on:

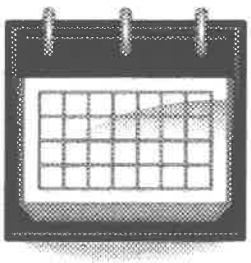
Behavioral Analysts			10:00 a.m.
February 3	June 1	October 5	
Genetic Counseling			1:00 p.m.
February 3	June 1	October 5	
Occupational Therapy			10:00 a.m.
February 4	June 2	October 6	
Respiratory Care			1:00 p.m.
February 4	June 2	October 6	
Acupuncture			10:00 a.m.
February 5	June 3	October 7	
Radiological Technology			1:00 p.m.
February 5	June 3	October 7	
Athletic Training			10:00 a.m.
February 6	June 4	October 8	
Physician Assistants			1:00 p.m.
February 6	June 4	October 8	
Midwifery			10:00 a.m.
February 7	June 5	October 9	
Polysomnographic Technology			1:00 p.m.
February 7	June 5	October 9	

Joint Boards of Medicine and Nursing

TBA

Next Meeting Date of the Full Board is

February 20-22, 2020



Please check your calendars and advise staff of any known conflicts that may affect your attendance.

The travel regulations require that "travelers must submit the Travel Expense Reimbursement Voucher with 30 days after completion of their trip". (CAPP Topic 20335, State Travel Regulations, p.7)

In order for the agency to be in compliance with the state travel regulations, please submit your request for today's meeting no later than

November 18, 2019