IN THE UNITED STATES DISTRICT COURT

FOR THE EASTERN DISTRICT OF MISSOURI

EASTERN DIVISION

JAMES L. RADTKE, JR.,	)	**JURY TRIAL DEMANDED**
	)	
Plaintiff,	)	
	)	
v.	)	
	)	
REBECCA WINZEN, et al,	)	Case No. 4:13-00213-ERW
	)	
	)	
Defendants.	)	

PLAINTIFF'S RESPONSE IN OPPOSITION TO THE MOTIONS TO DISMISS BY DEFENDANTS APA AND FRANCES

Defendant APA moves the Court to dismiss Counts V, VI and VIII of Plaintiff's Amended Complaint pursuant to Rule 12(b)(1) of the Federal Rules of Civil Procedure, to protect their First Amendment rights. They also move to dismiss under Rule 12(b)(6). Defendant Frances, *pro se*, incorporates APA's motion without separate argument. Plaintiff opposes the motions.

1. The purported "First Amendment Issue" is a red herring.

Defendant APA, repetitively but inappropriately, presents "freedom of speech" and "freedom to publish" as bars to Plaintiff's claims against them. However, Plaintiff's allegations against APA and Frances are not based solely on the Defendants' creation and publication of the *DSM*. Plaintiff actually has no interest in preventing or

suppressing any speech at all, including publication and public discussion of theories or ideas in the *DSM* regarding mental illness with which he may or may not disagree. If these defendants had merely published a book and engaged in activities which are protected by their right to free speech, the Plaintiff would not have suffered the damages and indignities which he did. Plaintiff's lawsuit is consistent with, and he believes it will predictably enable, *more speech, not less*.[1]

Plaintiff alleges that APA and Frances encouraged and helped create, for their private advantage, omnipresent legal/bureaucratic machinery to force people to become psychiatric patients. For two decades APA and Frances allowed and actively worked to aid and abet the clear *misuse* – according to *their own* stated parameters – of their *DSM* diagnostic system. Precisely this *misuse* has justified widespread violations and restrictions of individuals' rights to liberty and privacy. APA and Frances profited enormously from doing this. Whether their activity is understood (as Plaintiff has alleged it) to be conspiracy, production of a faulty product for which they are strictly liable, negligence and/or failure to warn, it is a serious wrong, and it caused those harms which Plaintiff has suffered.

The Plaintiff reasonably believes and adequately alleges in his Amended Complaint that Defendants Winzen, Taca and Mercy would never have "admitted" him to the Behavioral Health Unit or forced him to become a psychiatric patient, except that thanks to the systematic incorporation of APA's and Frances' *DSM* into state law and insurance regulations, they knew how to get paid even when the Plaintiff never wanted

[1] This phrase is the title of a 1997 book by Defendant APA's counsel. It has since appeared in case law, including several U.S. Supreme Court decisions, most recently *United States v. Alvarez*, 132 S.Ct. 2537, 2545. Plaintiff's counsel respects Mr. Sableman's impressive expertise in the area of First Amendment law, but believes it hardly applies to this case, which is not really a dispute within the "realm of discourse and expression". *Id.*

or agreed to any hospitalization or treatment. Defendants Wilhelm and St. Louis County would have no routine practice of forcibly removing people from their homes at 5:30 AM and delivering them to hospital emergency rooms under police guard, if they did not know that hospitals *want* involuntary "patients" whose insurance likely covers *DSM* mental disorders, and if they had no legalized excuse of "mentally ill" as defined by reference to the *DSM*. Plaintiff named APA and Frances as defendants in this case because they are an inseparable part of the *whole* proximate cause of his damages, not because they are located anywhere in a linear series of causes.

Plaintiff also alleges that Defendants APA and Frances purposefully conspired, long and hard, to set things up to work precisely as the events on which his specific case is based developed, with law and public policy profitably dependent upon and securely attached to their own copyrighted property. More people in more walks of life must either buy the *DSM* or hire a psychiatrist who owns one, so this larger setup has been worth a lot of money to APA and Frances over many years, and secured much social and political influence. Money and influence are not illegitimate objectives in themselves, but when acquired by damaging or violating others' rights, they are traditionally accompanied by liability.

APA disingenuously characterizes Plaintiff's allegations as "inflammatory and erroneous" and inserts in their Memorandum in Support of their Motion a section entitled BACKGROUND ON THE DSM. Their citation of information, warnings and disclaimers from introductory sections of *DSM-IV* and *DSM-IV-TR* serves precisely but ironically as an admission: APA and Frances knew very well in 1994, and still knew in 2000, that their diagnostic system was neither valid nor appropriate and should never be used as

an excuse, for police to forcibly remove people from their own homes or for hospitals to imprison people against their will.

The Defendants' admission goes further: APA and Frances clearly knew or believed in 1994, and in 2000, that there was a substantial probability of *the DSM being used inappropriately* (exactly as Plaintiff alleges in Paragraph 12 of his Amended Complaint) to provoke widespread deprivation of individuals' civil rights. If the defendants had not *intended* and *wanted* such inappropriate uses to occur, they should have taken some measures to discourage it, commensurate with their marketing and lobbying for the widest possible inappropriate uses of the *DSM*. Those pro forma disclaimers, published once with the 1994 book (*DSM*-IV) and once with the 2000 revision (*DSM-IV-TR*), and rarely if ever elaborated upon or repeated in any of a large number of critically relevant contexts, contrast much too dramatically with the continued and consistent *actions and omissions* of these defendants between 1994 and 2011.

On one hand, as APA notes, the *DSM* states no real facts and lacks any operational definition of mental disorder, such that the concept actually has no precise boundaries. This may be why *DSM* has contributed to several false epidemics and captured patients (Plaintiff himself being one) who would have been far better off never entering the mental health system, as alleged in the Amended Complaint, Paragraph 12. If APA's "inflammatory and erroneous" characterization is directed at Paragraph 12, it certainly creates more irony, because the wording was taken directly from widely published statements by Defendant Frances, wherein he arguably admits the Plaintiff's basic allegations. (See Attachment 1.)

On the other hand, the *DSM* – this limited, risky and vague "consensus"

supposedly intended only for clinicians at a limited historical moment -- has become a widely institutionalized set of rules, referenced, relied upon and incorporated by police, courts, schools, all manner of government regulatory agencies, and insurance companies. The *DSM* is incorporated into Missouri and federal statutes and regulations to define mental illness, making it the effective evaluator of both competence and culpability in criminal trials. Likewise, it determines who is entitled to many educational and social services, as incorporated to define disability from mental illness. It even regulates such disparate professional practices as dentistry and marriage counseling. (See Attachment 2.) Defendant APA engages in advertizing and promotional activities hyping the critical implications of the *DSM* for insurance coverage, which APA's legal department also litigates to enforce. (See Attachments 3 and 4.)

There is an appropriate larger perspective, of the reasons *why* we protect freedom of speech to begin with. Goodman Professor of Media Law at University College, London, Eric Berendt, in his classic work, *Freedom of Speech* (Second Edition, Oxford University Press, 2005), presents four arguments: 1) free speech enables discovery of valuable truth; 2) free speech is necessary to an autonomous person's self-development and fulfillment; 3) public discussion is a political duty of citizens; and 4) free speech is a bulwark against corrupt power. (Berendt, pp. 6-23.)

In their Motion and Memorandum, the Defendants can only assert a version of the first of these four arguments, essentially: all aspects of their communications and behavior in any way connected with the *DSM* are vital to the advancement of psychiatric science and must therefore be absolutely indemnified against the Plaintiff's claims. Even if this wildly egotistical view were reasonable, the other three of Berendt's

arguments cut in the opposite direction, in the Plaintiff's favor.

The APA is not an individual interested in self-fulfillment, the Plaintiff is. When the Plaintiff was told in no uncertain terms by the forensic mental health machine, for which APA provided key theoretical justifications and a vital administrative framework, that he could not trust himself to know what was in his own best interests, that he had to be imprisoned and guarded and "treated" against his will, that he was "dangerous to himself" – that was a violent strike *against* individual autonomy and self-fulfillment.

The *DSM* does not serve to encourage public discussion about mental illness, but rather limits it to an approved cloister of experts. As the "explicit warnings" cited by the Defendants in their Memorandum state, *DSM* categories, criteria and textual descriptions can only be used by people with special training, not by laymen.

Pursuant to the fourth argument, we have to ask a rhetorical question: Who is more likely to be, or to be connected to, any corrupt power – a private individual, father and small businessman with no political connections or aspirations and no criminal record (i.e., the Plaintiff); or a wealthy professional guild with tens of thousands of dues-paying members, full-time private lobbyists in Washington, D.C. and every state capital, and authority over the basic definitions and concepts written into state and federal law and regulations (i.e., Defendant APA)?

The *DSM*, whatever its merits or shortcomings for psychiatric medicine and clinical practice, can thus be seen to be far, *far* more than any protected expression of scientific opinion or speech. It is not the book itself or any ideas or opinions in it, which are an issue in this case. It is rather the Defendants' actions and inactions. Plaintiff alleges that Defendants Frances and APA created and are responsible for a the linchpin

among those conceptual gears and wheels and levers, which have become a vast legal/bureaucratic system, or mechanism, for restraining and altering the behavior of individuals and forcing people to undergo psychiatric treatment against their will. To his everlasting shock and severe harm, the Plaintiff's own body was thrown onto that machine in February, 2011. Now he wants simple justice from making the machine stop. He nevertheless remains perfectly content for the Defendants to *publish* whatever they like, and to *speak* their opinions and their minds freely. The Plaintiff makes no claim in this case against the Defendants' actual First Amendment rights.

The *DSM as a book* is evidence of what the Defendants did or neglected to do which harmed the Plaintiff. However, the Plaintiff does not ask for such award of damages, and would not demand such settlement terms, as could ever prevent APA from continuing to publish the *DSM* from now until doomsday, or discourage them in the slightest way from speaking freely as advocates for the genuine interests of psychiatric physicians and patients. Plaintiff only intends that APA and Frances should stop causing such harm as happened to him, through their aiding and abetting the omnipresent *misuse* of their diagnostic system.

2. The *DSM*, being explicitly incorporated in Missouri statutes, regulations and Supreme Court Rules, is itself prima facie evidence of Plaintiff's §§ 1983 and 1985 claims against Defendants APA and Frances.

Regardless of any complex procedures or circumstantial variations, Missouri law allows an individual to be taken to a mental health facility and admitted against his or her will based upon reasonable belief that: 1) the individual has a mental illness or disorder, and 2) the mental illness or disorder makes the individual dangerous to him or

herself or others. Thus, what exactly a mental illness or disorder is, and how to determine whether an individual has one, are critical questions in the law. *The only answer* to these critical questions includes the *Diagnostic and Statistical Manual of Mental Disorders*, or *DSM*, of Defendants APA and Frances. Without the *DSM* the law of involuntary psychiatric detention would be incomprehensible or meaningless.

The Revised Statutes of Missouri contain several explicit incorporations of the *DSM* to define mental illness under state law. Under Title 24, §376.810 specifies certain definitions for purposes of life, health and accident insurance policy requirements throughout Missouri. It states in relevant part:

> (10) "Recognized mental illness", those conditions classified as "mental disorders" in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders…

In another example mandating a *DSM* definition for insurance requirements, §376.1224 specifies:

> (3) "Autism spectrum disorders", a neurobiological disorder, an illness of the nervous system, which includes Autistic Disorder, Asperger's Disorder, Pervasive Developmental Disorder Not Otherwise Specified, Rett's Disorder, and Childhood Disintegrative Disorder, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association…

Directly on the same point, §376.1550 also mandates a *DSM* definition for coverage requirements:

> 2.(4) "Mental health condition", any condition or disorder defined by categories listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders except for chemical dependency…

Missouri Supreme Court Rules explicitly incorporate the *DSM*:

> 5.285 Consideration of mental disorder in determining discipline and reinstatement (a) For purposes of this Rule 5.285, the following terms mean:(1) "Mental disorder" is a condition, found in the current Diagnostic and Statistical Manual**,** that more than minimally impairs judgment, cognitive ability, or volitional or emotional functioning in

relation to performance of professional duties and commitments…

The Missouri Code of State Regulations widely and thoroughly enshrines the *DSM* of Defendants APA and Frances in the official legal framework affecting every citizen. There are no fewer than seventeen specifications, including: a core rule for psychiatric and substance abuse programs requiring all individuals screened for state services in the Department of Mental Health to be assessed according to the *DSM* diagnostic system, 9 CSR 10-7.030(2)(A)12.; a rule requiring that the definitions of "co-occurring disorders" and "substance abuse" must follow the *DSM*, 9 CSR 10-7.140(2)(N) and 7.140(2)(KKK); a rule specifically linking eligibility for state substance abuse services to diagnosis strictly in accordance with the *DSM*, 9 CSR 30-3.100(7); a rule specifically linking eligibility for state compulsive gambling treatment to diagnosis strictly in accordance with the *DSM*, 9 CSR 30-3.134(3); a rule specifying that to be eligible for substance abuse treatment in correctional institutions inmates must meet *DSM* diagnostic criteria, 9 CSR 30-3.160(2)(A); a rule that ties admission to community psychiatric rehabilitation program services to a primary *DSM* diagnosis, and specifying no fewer than 27 particular diagnostic codes directly from the *DSM*, 9 CSR 30-4.042(4)(B)1-12; and even a regulation concerning dental/orthodontic services under Missouri HealthNet which incorporates the *DSM* to define "mental, emotional and/or behavioral problems, disturbances or dysfunctions", 13 CSR 70-.010(5)(C)3.

It is disingenuous, given the above facts of law and state regulation, and in light of the high probability that Missouri is not at all unique or unusual, for the defendants to pretend that the *DSM* is an innocent book of ideas deserving blanket First Amendment protection. The omnipresence and omnipotent authority of the *DSM* in connection with

any and all issues of mental health, in virtually every sphere of commercial and professional activity, public or private, necessarily forces a conclusion that any person hospitalized and/or treated against his or her will has been directly impacted by the *DSM* system of defining and diagnosing mental disorders. It would be incredible for Defendants APA and Frances to pretend that the St. Louis County Police and the hospital personnel involved in the incident on which this case is based, in acting as they did, are not conversant with, and primarily thinking in terms of the diagnostic system of the *DSM*, when they assess whether any individual is mentally ill and dangerous.

Thus, unlike the plaintiff in *Miller v. Redwood Toxicology Lab* (ECF No. 35-1, pp.5, 6 &7), James Radtke does not allege that his "injury is the result of actions by some third party (i.e. here, Winzen, Taca, Mercy, Wilhelm and Police), not the defendant (i.e. here, APA and Frances)." Radtke alleges a direct causal connection between the violation of the Plaintiff's rights to liberty and privacy and the behavior of APA and Frances in aiding and abetting, justifying and encouraging the creation of legal/bureaucratic machinery to lock up people who have committed no crime, and to force them to be psychiatric patients. Radtke alleges that this behavior by APA and Frances consisted of particular acts, both commissions and omissions, continuing over the years from 1994 to 2011. *Publishing* the *DSM* was not one of those acts. Actively and continuously persuading health care professionals, states and municipalities (i.e. here, Missouri, St. Louis County, Mercy Hospital, Dr. Taca, Ms. Winzen) to treat individuals with *DSM*-diagnosed mental disorders as public health threats, is one such act. Purposefully neglecting to ever refer law enforcement, courts and legislatures back to the pro forma disclaimers in *DSM-IV* and *DSM-IV-TR*, despite definite knowledge that

the books were being misused is another.

These alleged wrongful acts by APA and Frances were not attenuated or "remote" (as in *Springall v. Fredericksburg Hospital and Clinic*, ECF No. 35-1, p.6) to those of the other defendants, but rather concurrent and fully in concert with them. None of the defendants could have done what they did to the Plaintiff without the related actions of the others. Plaintiff's injuries were proximately caused by a masterful symphony of all seven Defendants' actions, not by single instruments playing alone. The test of common experience might not validate any single Defendant's actions as sufficiently causative, and no sharp line can be drawn to separate them. But, common empirical and intuitive sense attests that what happened to James Radtke in February, 2011, was wrong, and that he was injured, and that the seven Defendants named in the Amended Complaint, together, did it to him. The Plaintiff in *Miller v. Redwood* fatally neglected or elected not to bring everyone who caused his injuries before the court, which clearly distinguishes that case from this one. 688 F.3d 928 at 936. Here, the court is not asked to avoid a "proverbial elephant in the room". *Id.,* 935.

The *DSM* itself, as used or abused, is the best lens for viewing, and the most immediate evidence of a *whole* proximate cause of Plaintiff's injuries. That cause is not an expression of ideas, but rather coordinated actions, omissions and justifications by the several Defendants, adding up to a highly developed *system* for forcing people to become psychiatric patients. (See Attachment 5.)

3. Plaintiff argues against the entire outline, and each specific argument in the Defendants' Memorandum of Law.

APA's arguments are largely repetitive (especially of the purported "First

Amendment problem"), but presented under many sections, subsections and sub-subsections. Therefore Plaintiff will employ APA's outline to briefly reiterate, clarify or add any arguments in opposition which are not fully covered above.

I. LACK OF CONSTITUTIONAL STANDING

This is their Rule 12(b)(1) argument. Our point, supra, is that we do not challenge, or threaten in any way, APA's right or ability to publish the *DSM* or to speak as advocate for the legitimate interests of psychiatric physicians and patients. The whole "freedom of speech issue" is misdirection. These Defendants are all sued for what they have done together, not for what they have published or for any opinion.

II. GENERAL TORT PRINCIPLES AND THE FIRST AMENDMENT

A. Product liability, ideas and content of the *DSM*

Again, we simply are not suing because of the book or any information which it delivers. Plaintiff alleges that Defendants APA and Frances have, in systematic collusion and coordination with the other Defendants over many years, sold and delivered a *product* , namely a complex and technical legal, administrative and bureaucratic system, which locks people up and forces them to be psychiatric patients through a "diagnosis of mental disorder". All the cases cited by APA in this argument were instances where plaintiffs alleged that *specific false ideas in publications* caused their injuries. Here we allege no such thing. Rather, the Plaintiff here claims that APA acted contrary to the ideas in the *DSM* to actually encourage and facilitate the inappropriate (per their own disclaimers) use of the book as a linchpin for the system of forced psychiatry. That *system* is the product; it is defective and dangerous, APA knew it as the *DSM* books demonstrate, they did nothing to correct it, the Plaintiff was injured

and the Defendants are liable.

In *Winter v. G.P. Putnam's Sons*¸ 938 F.2d 1033, 1036 (9th Cir. 1991), the court noted that, "…under products liability law … the injury does not have to result because a compass explodes in your hand, but can result because the compass malfunctions and leads you over a cliff." As APA points out in their Memorandum, the Ninth Circuit declined to extend product liability law to embrace ideas and expression in a book. No such extension is required here, because it was *not the book or the ideas expressed in it* which harmed the Plaintiff. It was the system of coercing people to be psychiatric patients which harmed him. The *DSM* is merely the most specific (pre-discovery) evidence of the Defendants' vital participation in assembling that system between 1994 and 2011. It is their product, not speech or ideas. It has corporeal form, in emergency rooms with door locks to keep "patients" in, or behavioral health centers and state psychiatric hospitals around the country with guard stations, desks, security cameras and monitors, and even steel bars[2], to ensure "patients" do not escape.

The court in *Winter* suggested that computer software which fails to yield the result for which it is designed could be analogous to aeronautical charts, as highly complex tools containing technical, mechanical data. 938 F.2d at 1036 . The combined justifications, rules, informal customs, procedures, habits and rituals of a large, decades-old bureaucracy are precisely such "software". The fact that the Defendants' *DSM* is a linchpin in this machine and always has been, since the modern mental health system was invented, shows that these Defendants made this product and sold it. Now

[2] The most dramatic example with which Plaintiff's counsel is personally acquainted is the Illinois Department of Human Services' Chester Mental Health Center, located barely an hour's drive from this Court. It is not only corporeal but massive with physical security apparatus, including double steel bar gates to open and close electronically in front and behind any family member or friend who ventures in to visit a "patient".

their product proves to be defective, because it roughly swallowed up a person against whom it would not have had been used, without the defect. Product liability is therefore appropriate, and should apply.

B. Negligence and APA's/Frances' duty to this Plaintiff

1 & 2. Plaintiff does not claim APA or Frances owes any duty as publisher or author, nor as standards setting authorities. Paragraph 45 of the Amended Complaint explains the duty to warn which is owed. Defendants appear to simply ignore this.

C. The First Amendment bar

1 & 2. This is discussed extensively, supra. We do not allege liability based upon expressive content or ideas, nor do we threaten or wish for any content-based speech restrictions; the *DSM* is evidence of actions and omissions. Precisely how any conceivable result of this case could impede APA's/Frances' publishing or advocacy activities in the slightest degree is a mystery. Nevertheless, even if some hypothetical result could do so, it is clear that the government has a compelling interest in protecting the fundamental rights of citizens to liberty and privacy. This Plaintiff was forcibly removed from his home, locked up, degraded and drugged for no good reason, and he had absolutely no prayer of stopping it by "counterspeech". *U.S. v. Alvarez*, 132 S.Ct. 2537, 2549 (2011).

III. THE CONSPIRACY COUNT AND CIVIL RIGHTS CLAIM

A. Conspiracy involvement

Reading the Amended Complaint fairly, Plaintiff clearly does assert that APA manufactured false evidence against him – by creating the "diagnoses" in the *DSM* which are entirely subjective and applicable to any person under many circumstances,

and then convincing legislators, law enforcement, medical emergency practitioners, etc., that such "diagnoses" justify locking a person up as "dangerous" and forcing psychiatric treatment on them, and most of all by facilitating the profitability of such violations of liberty and privacy. Without a "diagnostic" form, the police and the hospital would have had no evidence, either against the Plaintiff or for purposes of billing him and his insurance company. Plaintiff also reasonably believes that one or more individuals involved with the police or at Mercy Hospital actually are or were members of APA, or have been advised by members of APA on the subject of involuntary psychiatric hospitalization and treatment.

B. Pleading a claim under 42 U.S.C. § 1985

Plaintiff's Amended Complaint does adequately allege elements (1) through (4) per *Davis v. Jefferson Hospital Association*, 685 F.3d 675, 684 (8th Cir. 2012). Although we expect to discover a preponderance of evidence proving those elements, we believe the fact of the *DSM* itself, incorporated as it is into the laws and regulations of Missouri, is sufficient for pleading at this stage.

1. Plaintiff alleges that APA, Frances and other Defendants conspired and acted out of invidiously discriminatory animus against him as a member of a class of psychiatrically untreated persons, or too-reluctant customers of their specialty.

2. The Amended Complaint alleges that there was a meeting of the minds, and that all defendants reached agreement, embodied by the *DSM* itself, its omnipresent incorporation in the law, and in the bureaucratic processes followed as well as the specific notes and chart entries written about the Plaintiff, when he was taken from his home at 5:30 AM to be imprisoned at Mercy, which was the overt act.

C. The claim under § 1983

1. Clearly, as we have argued and adequately pled in the Amended Complaint, the violations of Plaintiff's rights could not have occurred without, and were caused by, the APA's and Frances' linchpin contributions to the legal/bureaucratic machinery for imprisoning and forcibly treating individuals described as dangerous to themselves or others necessarily (under the law) due to "mental disorders". The fundamental concepts here would not exist to be considered without the work of these Defendants.

2. The private actors in the forced recruiting of the Plaintiff as a psychiatric patient certainly participated willfully with state officials. Plaintiff does allege that they reached a mutual understanding for precisely that unlawful objective. The three factors from *Ciambriello v. County of Nassau*, 292 F.3d 307 (2d Cir. 2002) are alleged.

4. Conclusion

The Plaintiff can acknowledge that his case may present an unusual but perhaps fundamental and necessary challenge, to involuntary psychiatry as practiced for two generations in Missouri and across the United States. However it seems impossible to argue that the issue is anything but an important question of fundamental rights under the U.S. Constitution; and the time for this issue to be newly considered has come.

WHEREFORE, Plaintiff respectfully asks the Court to deny the Motion to Dismiss by Defendants APA and Frances. Alternatively, if the Court decides that it must dismiss the Amended Complaint or any count in it, Plaintiff asks that it do so without prejudice, allowing him to further amend and plead with more specificity.

Respectfully submitted,

__/s/_S. Randolph Kretchmar_____
Attorney for the Plaintiff

S. RANDOLPH KRETCHMAR
ATTORNEY AT LAW
1170 MICHIGAN AVENUE
WILMETTE, IL 60091
(847) 853-8106 voice
(847) 853-0114 fax
s_randolph@earthlink.net

CERTIFICATE OF SERVICE

I, S. Randolph Kretchmar, certify that on June 24, 2013, I electronically filed Plaintiff's **RESPONSE IN OPPOSITION TO THE MOTIONS TO DISMISS BY APA AND FRANCES** with the Clerk of the Court using the CM/ECF system, which will send notification of the filing to the following:

Kenneth W. Bean kbean@sandbergphoenix.com, jlicavoli@sandbergphoenix.com
(for Defendant Arturo Taca)

Mark Sableman msableman@thompsoncoburn.com, sstoeckel@thompsoncoburn.com
(for Defendant American Psychiatric Association)

Michael E. Hughes mhughes2@stlouisco.com
(for Defendants St. Louis County and Amanda Wilhelm)

James C. Thoele jthoele@brinkerdoyen.com
(for Defendants Mercy and Rebecca Winzen)

I further certify that on June 24, 2013, a true and correct copy of the foregoing was served on Defendant Allen Frances, M.D., by mail to:

Dr. Allen Frances, M.D.
1820 Avenida Del Mundo
Coronado, CA 92118
allenfrances@vzw.blackberry.net

/s/ *S. Randolph Kretchmar*

Los Angeles Times

Opinion

It's not too late to save 'normal'

Psychiatry's latest DSM goes too far in creating new mental disorders.

March 01, 2010 | By Allen Frances

As chairman of the task force that created the current Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), which came out in 1994, I learned from painful experience how small changes in the definition of mental disorders can create huge, unintended consequences.

Our panel tried hard to be conservative and careful but inadvertently contributed to three false "epidemics" -- attention deficit disorder, autism and childhood bipolar disorder. Clearly, our net was cast too wide and captured many "patients" who might have been far better off never entering the mental health system.

The first draft of the next edition of the DSM, posted for comment with much fanfare last month, is filled with suggestions that would multiply our mistakes and extend the reach of psychiatry dramatically deeper into the ever-shrinking domain of the normal. This wholesale medical imperialization of normality could potentially create tens of millions of innocent bystanders who would be mislabeled as having a mental disorder. The pharmaceutical industry would have a field day -- despite the lack of solid evidence of any effective treatments for these newly proposed diagnoses.

The manual, prepared by the American Psychiatric Assn., is psychiatry's only official way of deciding who has a "mental disorder" and who is "normal." The quotes are necessary because this distinction is very hard to make at the fuzzy boundary between the two. If requirements for diagnosing a mental disorder are too stringent, some who need help will be left out; but if they are too loose, normal people will receive unnecessary, expensive and sometimes quite harmful treatment.

Where the DSM-versus-normality boundary is drawn also influences insurance coverage, eligibility for disability and services, and legal status -- to say nothing of stigma and the individual's sense of personal control and responsibility.

What are some of the most egregious invasions of normality suggested for DSM-V? "Binge eating disorder" is defined as one eating binge per week for three months. (Full disclosure: I, along with more than 6% of the population, would qualify.) "Minor neurocognitive disorder" would capture many people with no more than the expected memory problems of aging.

Grieving after the loss of a loved one could frequently be misread as "major depression." "Mixed anxiety depression" is defined by commonplace symptoms difficult to distinguish from the emotional pains of everyday life.

The recklessly expansive suggestions go on and on. "Attention deficit disorder" would become much more prevalent in adults, encouraging the already rampant use of stimulants for performance enhancement. The "psychosis risk syndrome" would use the presence of strange thinking to predict who would later have a full-blown psychotic episode. But the prediction would be wrong at least three or four times for every time it is correct -- and many misidentified teenagers would receive medications that can cause enormous weight gain, diabetes and shortened life expectancy.

A new category for temper problems could wind up capturing kids with normal tantrums. "Autistic spectrum disorder" probably would expand to encompass every eccentricity. Binge drinkers would be labeled addicts and "behavioral addiction" would be recognized. (If we have "pathological gambling," can addiction to the Internet be far behind?)

The sexual disorders section is particularly adventurous. "Hypersexuality disorder" would bring great comfort to philanderers wishing to hide the motivation for their exploits behind a psychiatric excuse. "Paraphilic coercive disorder" introduces the novel and dangerous idea that rapists merit a diagnosis of mental disorder if they get special sexual excitement from raping.

Defining the elusive line between mental disorder and normality is not simply a scientific question that can be left in the hands of the experts. The scientific literature is usually limited, never easy to generalize to the real world and always subject to differing interpretations.

Experts have an almost universal tendency to expand their own favorite disorders: Not, as alleged, because of conflicts of interest -- for example, to help drug companies, create new customers or increase research funding -- but rather from a genuine desire to avoid missing suitable patients who might benefit. Unfortunately, this therapeutic zeal creates an enormous blind spot to the great risks that come with overdiagnosis and unnecessary treatment.

This is a societal issue that transcends psychiatry. It is not too late to save normality from DSM-V if the greater public interest is factored into the necessary risk/benefit analyses.

Allen Frances is professor emeritus and former chairman of the department of psychiatry at Duke University.

LEXIS SEARCH OF REVISED STATUTES OF MISSOURI, CONSTITUTION, COURT RULES & ALS, COMBINED; TERMS "DIAGNOSTIC AND STATISTICAL MANUAL" OR "AMERICAN PSYCHIATRIC ASSOCIATION" (JUNE 20, 2013)

1. § 337.500 R.S.Mo. (2013), TITLE 22. OCCUPATIONS AND PROFESSIONS (Chs. 324-346) , CHAPTER 337. PSYCHOLOGISTS--PROFESSIONAL COUNSELORS--SOCIAL WORKERS, PROFESSIONAL COUNSELORS, § 337.500. Definitions , LEXISNEXIS (TM) MISSOURI ANNOTATED STATUTES

... master of education in counseling, and further testified that she used the Diagnostic and Statistical Manual written by the American Psychiatric Association in determining what disorders the victim of an alleged sodomy was suffering from, the ...
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2. § 376.810 R.S.Mo. (2013), TITLE 24. BUSINESS AND FINANCIAL INSTITUTIONS (Chs. 361-385) , CHAPTER 376. LIFE, HEALTH AND ACCIDENT INSURANCE, INDIVIDUAL ACCIDENT AND SICKNESS INSURANCE, § 376.810. Definitions for policy requirements for chemical dependency , LEXISNEXIS (TM) MISSOURI ANNOTATED STATUTES

... mental illness", those conditions classified as "mental disorders" in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders, but shall not include mental ...

3. § 376.1224 R.S.Mo. (2013), TITLE 24. BUSINESS AND FINANCIAL INSTITUTIONS (Chs. 361-385) , CHAPTER 376. LIFE, HEALTH AND ACCIDENT INSURANCE, AUTISM SPECTRUM DISORDERS, § 376.1224. Definitions -- insurance coverage required -- limitations on coverage -- maximum benefit amount, adjustments -- reimbursements, how made -- applicability to plans -- waiver, when -- report , LEXISNEXIS (TM) MISSOURI ANNOTATED STATUTES

... Disintegrative Disorder, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association; (4) "Diagnosis of autism spectrum disorders", medically necessary ...

4. § 376.1550 R.S.Mo. (2013), TITLE 24. BUSINESS AND FINANCIAL INSTITUTIONS (Chs. 361-385) , CHAPTER 376. LIFE, HEALTH AND ACCIDENT INSURANCE, MENTAL HEALTH COVERAGE, § 376.1550. Mental health coverage, requirements -- definitions -- exclusions , LEXISNEXIS (TM) MISSOURI ANNOTATED STATUTES

... by categories listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders except for chemical dependency; (5) " ...

5. Mo. Sup. Ct. R. 5.285 (2013), SUPREME COURT RULES, RULES GOVERNING THE MISSOURI BAR AND THE JUDICIARY, RULE 5. COMPLAINTS AND PROCEEDINGS THEREON , 5.285. Consideration of mental disorder in

determining discipline and reinstatement , MISSOURI COURT RULES Copyright (c) 2013 by Matthew Bender and Company, Inc., a member of the LexisNexis Group All rights reserved.

... Mental disorder" is a condition, found in the current Diagnostic and Statistical Manual, that more than minimally impairs judgment, cognitive ability, or volitional or ...
... dependence or abuse, delirium, and dementia. Some conditions included in the Diagnostic and Statistical Manual as conditions that may be quite serious and in need of professional ...

LEXIS SEARCH OF MISSOURI CODE OF STATE REGULATIONS;
TERMS "DIAGNOSTIC AND STATISTICAL MANUAL"
OR "AMERICAN PSYCHIATRIC ASSOCIATION"
(JUNE 20, 2013)

1. 9 CSR 10-7.030 (2013), TITLE 9 - DEPARTMENT OF MENTAL HEALTH, DIVISION 10 - DIRECTOR, DEPARTMENT OF MENTAL HEALTH, CHAPTER 7 - CORE RULES FOR PSYCHIATRIC AND SUBSTANCE ABUSE PROGRAMS, 10-7.030 Service Delivery Process and Documentation, MISSOURI CODE OF STATE REGULATIONS

... diagnosis or diagnostic impression in accordance with the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. (B) Recommendations for specialized services may require ...

2. 9 CSR 10-7.140 (2013), TITLE 9 - DEPARTMENT OF MENTAL HEALTH, DIVISION 10 - DIRECTOR, DEPARTMENT OF MENTAL HEALTH, CHAPTER 7 - CORE RULES FOR PSYCHIATRIC AND SUBSTANCE ABUSE PROGRAMS, 10-7.140 Definitions, MISSOURI CODE OF STATE REGULATIONS

... consistent with diagnostic criteria established in the current edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association; (O) Corporal punishment, purposeful infliction of physical pain ...
... in accordance with criteria established in the current edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association; (LLL) Supports, array of activities, resources, relationships and services ...

3. 9 CSR 30-3.100 (2013), TITLE 9 - DEPARTMENT OF MENTAL HEALTH, DIVISION 30 - CERTIFICATION STANDARDS, CHAPTER 3 - ALCOHOL AND DRUG ABUSE PROGRAMS, 30-3.100 Service Delivery Process and Documentation, MISSOURI CODE OF STATE REGULATIONS

... five (5) axis as defined in the current edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. (A) A face-to-face diagnostic interview shall be ...

4. 9 CSR 30-3.134 (2013), TITLE 9 - DEPARTMENT OF MENTAL HEALTH, DIVISION 30 - CERTIFICATION STANDARDS, CHAPTER 3 - ALCOHOL AND DRUG ABUSE PROGRAMS, 30-3.134 Compulsive Gambling Treatment, MISSOURI CODE OF STATE REGULATIONS

... for pathological gambling as defined in the current edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. There must be documentation of the specific behaviors and circumstances demonstrating how the ...
... following material is incorporated into this rule by reference: 1) American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders 4th Edition. (Washington, D.C., American Psychiatric Association, 1994). In accordance with section 536.031(4), RSMo, the ...

5. 9 CSR 30-3.160 (2013), TITLE 9 - DEPARTMENT OF MENTAL HEALTH, DIVISION 30 - CERTIFICATION STANDARDS, CHAPTER 3 - ALCOHOL AND DRUG ABUSE PROGRAMS, 30-3.160 Institutional Corrections Treatment Programs, MISSOURI CODE OF STATE REGULATIONS

... substance abuse or dependence as described in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association; or (B) Have been ordered by a court of jurisdiction or by the ...

6. 9 CSR 30-4.042 (2013), TITLE 9 - DEPARTMENT OF MENTAL HEALTH, DIVISION 30 - CERTIFICATION STANDARDS, CHAPTER 4 - MENTAL HEALTH PROGRAMS, 30-4.042 Admission Criteria, MISSOURI CODE OF STATE REGULATIONS

... physician or licensed psychologist shall certify a primary Diagnostic and Statistical Manual (DSM) diagnosis as defined in 9 CSR 10-7.140(2)(OO) ...

7. 9 CSR 45-2.015 (2013), TITLE 9 - DEPARTMENT OF MENTAL HEALTH, DIVISION 45 - DIVISION OF DEVELOPMENTAL DISABILITIES, CHAPTER 2 - ELIGIBILITY FOR SERVICES, 45-2.015 Prioritizing Access to Funded Services, MISSOURI CODE OF STATE REGULATIONS

... recent edition of the Diagnostic and Statistics Manual of Mental Disorders, American Psychiatric Association. (Includes autistic disorder, Asperger's syndrome, pervasive developmental ...

8. 9 CSR 50-2.010 (2013), TITLE 9 - DEPARTMENT OF MENTAL HEALTH, DIVISION 50 - ADMISSION CRITERIA, CHAPTER 2 - MENTAL HEALTH SERVICES, 50-2.010 Admissions to Children's Supported Community Living, MISSOURI CODE OF STATE REGULATIONS

... under Chapter 630, RSMo; (C) DSM IV, Diagnostic and Statistical Manual of Mental Disorders (Fourth Edition) of the American Psychiatric Association; (D) Supported Community Living, an office which is responsible for the ...
... following material is incorporated into this rule by reference: 1) American Psychiatric Association, DSM IV Diagnostic and Statistical Manual of Mental Disorders (Fourth Edition) (Washington, D.C.: American Psychiatric Association, 1994). In accordance with section 536.031(4), RSMo, the ...

9. 9 CSR 50-2.510 (2013), TITLE 9 - DEPARTMENT OF MENTAL HEALTH, DIVISION 50 - ADMISSION CRITERIA, CHAPTER 2 - MENTAL HEALTH SERVICES, 50-2.510 Admissions to Adult Placement Program, MISSOURI CODE OF STATE REGULATIONS

... Chapter 630, RSMo. (E) DSM-IV-TR, Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, (2000), by the American Psychiatric Association, 1400 K Street NW, Washington, DC 20005, which is ...

10. 13 CSR 70-35.010 (2013), TITLE 13 - DEPARTMENT OF SOCIAL SERVICES, DIVISION 70 - MO HEALTHNET DIVISION, CHAPTER 35 - DENTAL PROGRAM, 70-35.010 Dental Benefits and Limitations, MO HealthNet Program, MISSOURI CODE OF STATE REGULATIONS

... disturbances or dysfunctions, as defined in the most current edition of the Diagnostic Statistical Manual of the American Psychiatric Association, and which may be caused by the participant's daily functioning as it relates to ...

11. 13 CSR 70-98.015 (2013), TITLE 13 - DEPARTMENT OF SOCIAL SERVICES, DIVISION 70 - MO HEALTHNET DIVISION, CHAPTER 98 - PSYCHIATRIC/PSYCHOLOGY/COUNSELING/CLINICAL SOCIAL WORK PROGRAM, 70-98.015 Psychiatric/Psychology/Counseling/Clinical Social Work Program Documentation, MISSOURI CODE OF STATE REGULATIONS

... diagnosis or diagnostic impression in accordance with the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association or the International Classification of Diseases, Ninth Revision. Clinical Modification (...

12. 13 CSR 70-98.020 (2013), TITLE 13 - DEPARTMENT OF SOCIAL SERVICES, DIVISION 70 - MO HEALTHNET DIVISION, CHAPTER 98 - PSYCHIATRIC/PSYCHOLOGY/COUNSELING/CLINICAL SOCIAL WORK PROGRAM, 70-98.020 Prior Authorization Process for Non-Pharmaceutical Mental Health Services, MISSOURI CODE OF STATE REGULATIONS

... services when they are determined medically necessary when using diagnostic criteria from the Diagnostic and Statistical Manual of Mental Disorders-- Fourth Edition (DSM-IV), published by the American Psychiatric Association, or the most currently published version of the DSM manual. The services ...

13. 20 CSR 400-2.165 (2013), TITLE 20 - DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION, DIVISION 400 - LIFE, ANNUITIES AND HEALTH, CHAPTER 2 - ACCIDENT AND HEALTH INSURANCE IN GENERAL, 400-2.165 Access to Providers for Treatment of Mental Health Conditions, MISSOURI CODE OF STATE REGULATIONS

... condition or disorder defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders except for chemical dependency. (K) " ...

14. 20 CSR 2095-2.010 (2013), TITLE 20 - DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION, DIVISION 2095 - COMMITTEE FOR PROFESSIONAL COUNSELORS, CHAPTER 2 - LICENSURE REQUIREMENTS, 2095-2.010 Educational Requirements, MISSOURI CODE OF STATE REGULATIONS

... psychodiagnostics using classification systems with an emphasis on the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). Course content regarding the DSM ...

15. 20 CSR 2233-2.010 (2013), TITLE 20 - DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION, DIVISION 2233 - STATE COMMITTEE OF MARITAL AND FAMILY THERAPISTS, CHAPTER 2 - LICENSURE REQUIREMENTS, 2233-2.010 Educational Requirements, MISSOURI CODE OF STATE REGULATIONS

... psychodiagnostics using classification systems with an emphasis on the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). Course content regarding the DSM ...

16. 22 CSR 10-2.055 (2013), TITLE 22 - MISSOURI CONSOLIDATED HEALTH CARE PLAN, DIVISION 10 - HEALTH CARE PLAN, CHAPTER 2 - STATE MEMBERSHIP, 10-2.055 Medical Plan Benefit Provisions and Covered Charges, MISSOURI CODE OF STATE REGULATIONS

... diagnostic criteria as described in the most recent edition of the American Psychiatric Association Diagnostic and Statistical Manual (DSM). If outside of the United States, the member's mental health ...

17. 22 CSR 10-3.057 (2013), TITLE 22 - MISSOURI CONSOLIDATED HEALTH CARE PLAN, DIVISION 10 - HEALTH CARE PLAN, CHAPTER 3 - PUBLIC ENTITY MEMBERSHIP, 10-3.057 Medical Plan Benefit Provisions and Covered Charges, MISSOURI CODE OF STATE REGULATIONS

... diagnostic criteria as described in the most recent edition of the American Psychiatric Association Diagnostic and Statistical Manual (DSM). If outside of the United States, the member's mental health ...

LEXIS SEARCH OF UNITED STATES CODE SERVICE – TITLES 1-51;
TERMS "DIAGNOSTIC AND STATISTICAL MANUAL"
OR "AMERICAN PSYCHIATRIC ASSOCIATION"
(JUNE 21, 2013)

1. 18 USCS § 3621, TITLE 18. CRIMES AND CRIMINAL PROCEDURE, PART II. CRIMINAL PROCEDURE, CHAPTER 229. POSTSENTENCE ADMINISTRATION, SUBCHAPTER C. IMPRISONMENT, § 3621. Imprisonment of a convicted person , UNITED STATES CODE SERVICE

... legitimately qualified for program; and (2) BOP's reliance on Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV), to help ...

2. 18 USCS Appx § 5K2.13, TITLE 18. CRIMES AND CRIMINAL PROCEDURE, SENTENCING GUIDELINES FOR THE UNITED STATES COURTS. 18 USCS APPENDIX, CHAPTER FIVE. DETERMINING THE SENTENCE, PART K. DEPARTURES, 2. OTHER GROUNDS FOR DEPARTURE, § 5K2.13. Diminished Capacity (Policy Statement) , UNITED STATES CODE SERVICE

... often spoke with defendant about his problem, and standard text of the American Psychiatric Association which lists pathological gambling as an impulse control disorder, even ...

3. 21 USCS § 823, TITLE 21. FOOD AND DRUGS, CHAPTER 13. DRUG ABUSE PREVENTION AND CONTROL, CONTROL AND ENFORCEMENT, REGISTRATION OF MANUFACTURERS, DISTRIBUTORS, AND DISPENSERS OF CONTROLLED SUBSTANCES, § 823. Registration requirements , UNITED STATES CODE SERVICE

... Psychiatry, the American Medical Association, the American Osteopathic Association, the American Psychiatric Association, or any other organization that the Secretary determines is appropriate for purposes of this ...

4. 29 USCS § 1132, TITLE 29. LABOR, CHAPTER 18. EMPLOYEE RETIREMENT INCOME SECURITY PROGRAM, PROTECTION OF EMPLOYEE BENEFIT RIGHTS, REGULATORY PROVISIONS, ADMINISTRATION AND ENFORCEMENT, THE CASE NOTES SEGMENT OF THIS DOCUMENT HAS BEEN SPLIT INTO 3 DOCUMENTS. THIS IS PART 3. USE THE BROWSE FEATURE TO REVIEW THE OTHER PART(S)., § 1132. Civil enforcement [Caution: See prospective amendment note below.] , UNITED STATES CODE SERVICE

... 197N. 968.--Limitations on coverage Plan administrator's reliance on American Psychiatric Association's compendium of mental disorders to find bipolar disorder to be mental (...

5. 38 USCS § 1155, TITLE 38. VETERANS' BENEFITS, PART II. GENERAL BENEFITS, CHAPTER 11. COMPENSATION FOR SERVICE-CONNECTED DISABILITY OR DEATH, SUBCHAPTER VI. GENERAL COMPENSATION PROVISIONS, § 1155. Authority for schedule for rating disabilities , UNITED STATES CODE SERVICE

... affd (1998, CA FC) 136 F3d 1300. American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, as revised in 1994, fourth edition (...
... 38 USCS § 1155, that symptoms listed in Diagnostic and Statistical Manual of Mental Disorders, 4th edition, (DSM-IV), do not ...

6. 38 USCS § 5103A, TITLE 38. VETERANS' BENEFITS, PART IV. GENERAL ADMINISTRATIVE PROVISIONS, CHAPTER 51. CLAIMS, EFFECTIVE DATES, AND PAYMENTS, SUBCHAPTER I. CLAIMS, § 5103A. Duty to assist claimants , UNITED STATES CODE SERVICE

... findings were based on lack of verification of stressors, or on other criteria of Diagnostic and Statistical Manual of Mental Disorders (4th ed. 1994); moreover, it was unclear whether ...

7. 38 USCS § 7104, TITLE 38. VETERANS' BENEFITS, PART V. BOARDS, ADMINISTRATIONS, AND SERVICES, CHAPTER 71. BOARD OF VETERANS' APPEALS, § 7104. Jurisdiction of the Board , UNITED STATES CODE SERVICE

... Axis III condition may have prognostic or treatment implications; Diagnostic and Statistical Manual of Mental Disorders (4th ed.1994) (DSM-IV) at ...
... warranting remand, because Board's analysis was inconsistent with guidance in Diagnostic and Statistical Manual of Mental Disorders 32, which provided that global assessment of functioning (...
... various VA' examinations by multiple examiners, revealed that Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) criteria for diagnosis of ...

8. 38 USCS § 7261, TITLE 38. VETERANS' BENEFITS, PART V. BOARDS, ADMINISTRATIONS, AND SERVICES, CHAPTER 72. UNITED STATES COURT OF APPEALS FOR VETERANS CLAIMS, SUBCHAPTER II. PROCEDURE, § 7261. Scope of review , UNITED STATES CODE SERVICE

... various VA' examinations by multiple examiners, revealed that Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) criteria for diagnosis of ...
... warranting remand, because Board's analysis was inconsistent with guidance in Diagnostic and Statistical Manual of Mental Disorders 32, which provided that global assessment of functioning (...

9. 42 USCS § 405, TITLE 42. THE PUBLIC HEALTH AND WELFARE, CHAPTER 7. SOCIAL SECURITY ACT, TITLE II. FEDERAL OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE BENEFITS, THE CASE NOTES SEGMENT OF THIS DOCUMENT HAS BEEN SPLIT INTO 4 DOCUMENTS. THIS IS PART 1. USE THE BROWSE FEATURE TO REVIEW THE OTHER PART(S)., § 405. Evidence, procedure, and certification for payments , UNITED STATES CODE SERVICE

... physician did not consider malingering as possibility as required by Diagnostic and Statistical Manual of Mental Disorders before making his diagnosis; there was no evidence ...

10. 42 USCS § 423, TITLE 42. THE PUBLIC HEALTH AND WELFARE, CHAPTER 7. SOCIAL SECURITY ACT, TITLE II. FEDERAL OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE BENEFITS, THE CASE NOTES

SEGMENT OF THIS DOCUMENT HAS BEEN SPLIT INTO 3 DOCUMENTS. THIS IS PART 2. USE THE BROWSE FEATURE TO REVIEW THE OTHER PART(S)., § 423. Disability insurance benefit payments , UNITED STATES CODE SERVICE

... physician did not consider malingering as possibility as required by Diagnostic and Statistical Manual of Mental Disorders before making his diagnosis; there was no evidence ...
... selective mutism was recognized mental disorder listed in Diagnostic and Statistical Manual of Mental Disorders, selective mutism could be shown by medically ...

11. 42 USCS § 1396r, TITLE 42. THE PUBLIC HEALTH AND WELFARE, CHAPTER 7. SOCIAL SECURITY ACT, TITLE XIX. GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS, § 1396r. Requirements for nursing facilities , UNITED STATES CODE SERVICE

... primary or secondary diagnosis of mental disorder (as defined in the Diagnostic and Statistical Manual of Mental Disorders, 3rd edition)", and inserted "or a diagnosis (...

12. 42 USCS § 3796ii-1, TITLE 42. THE PUBLIC HEALTH AND WELFARE, CHAPTER 46. JUSTICE SYSTEM IMPROVEMENT, MENTAL HEALTH COURTS, § 3796ii-1. Definitions , UNITED STATES CODE SERVICE

... meet diagnostic criteria within the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association; and (B) that has resulted in functional impairment that substantially interferes with or ...

13. 42 USCS § 3797aa, TITLE 42. THE PUBLIC HEALTH AND WELFARE, CHAPTER 46. JUSTICE SYSTEM IMPROVEMENT, ADULT AND JUVENILE COLLABORATION PROGRAM GRANTS, § 3797aa. Adult and juvenile collaboration programs , UNITED STATES CODE SERVICE

... meet diagnostic criteria within the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association; and (B) (i) that, in the case of an adult, has resulted in

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LEXIS SEARCH OF CFR – CODE OF FEDERAL REGULATIONS; TERMS "DIAGNOSTIC AND STATISTICAL MANUAL" OR "AMERICAN PSYCHIATRIC ASSOCIATION" (JUNE 21, 2013)

1. 10 CFR 73.56, TITLE 10 -- ENERGY, CHAPTER I -- NUCLEAR REGULATORY COMMISSION, PART 73 -- PHYSICAL PROTECTION OF PLANTS AND MATERIALS, PHYSICAL PROTECTION REQUIREMENTS AT FIXED SITES, § 73.56 Personnel access authorization requirements for nuclear power plants. , CODE OF FEDERAL REGULATIONS

... conducting such assessments established by the American Psychological Association or American Psychiatric Association. (3) At a minimum, the psychological assessment must include the ...

2. 10 CFR 712.3, TITLE 10 -- ENERGY, CHAPTER III -- DEPARTMENT OF ENERGY, PART 712 -- HUMAN RELIABILITY PROGRAM, SUBPART A -- ESTABLISHMENT OF AND PROCEDURES FOR THE HUMAN RELIABILITY PROGRAM, GENERAL PROVISIONS, § 712.3 Definitions. , CODE OF FEDERAL REGULATIONS

... expertise in the area of psychological assessment for the HRP. Diagnostic and Statistical Manual of Mental Disorders means the current version of the American Psychiatric Association's manual containing definitions of psychiatric terms and diagnostic criteria of ...

3. 10 CFR 712.14, TITLE 10 -- ENERGY, CHAPTER III -- DEPARTMENT OF ENERGY, PART 712 -- HUMAN RELIABILITY PROGRAM, SUBPART A -- ESTABLISHMENT OF AND PROCEDURES FOR THE HUMAN RELIABILITY PROGRAM, PROCEDURES, § 712.14 Medical assessment. , CODE OF FEDERAL REGULATIONS

... alcohol and other substance use disorders, as described in the Diagnostic and Statistical Manual of Mental Disorders; (3) Use of illegal drugs or the abuse of ...

4. 14 CFR 382.117, TITLE 14 -- AERONAUTICS AND SPACE, CHAPTER II -- OFFICE OF THE SECRETARY, DEPARTMENT OF TRANSPORTATION (AVIATION PROCEEDINGS), SUBCHAPTER D -- SPECIAL REGULATIONS, PART 382 -- NONDISCRIMINATION ON THE BASIS OF DISABILITY IN AIR TRAVEL, SUBPART H--SERVICES ON AIRCRAFT, § 382.117 Must carriers permit passengers with a disability to travel with service animals? , CODE OF FEDERAL REGULATIONS

... passenger has a mental or emotional disability recognized in the Diagnostic and Statistical Manual of Mental Disorders--Fourth Edition (DSM IV); (2) The ...

5. 20 CFR 404, TITLE 20 -- EMPLOYEES' BENEFITS, CHAPTER III -- SOCIAL SECURITY ADMINISTRATION, PART 404 -- FEDERAL OLD-AGE, SURVIVORS AND DISABILITY INSURANCE (1950-), Part 404 Note , CODE OF FEDERAL REGULATIONS

... § 12.05(C), which indicates that 12.05(C) accommodates the American Psychiatric Association's analysis of mental retardation, which looks to an individual's ability to function ...

6. 26 CFR 54.9812-1T, TITLE 26 -- INTERNAL REVENUE, CHAPTER I -- INTERNAL REVENUE SERVICE, DEPARTMENT OF THE TREASURY, SUBCHAPTER D -- MISCELLANEOUS EXCISE TAXES, PART 54 -- PENSION EXCISE TAXES, § 54.9812 Parity in mental health and substance use disorder benefits (temporary). , CODE OF FEDERAL REGULATIONS

... medical practice (for example, the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), the most current version of the ICD, or ...

7. 28 CFR 550.53, TITLE 28 -- JUDICIAL ADMINISTRATION, CHAPTER V -- BUREAU OF PRISONS, DEPARTMENT OF JUSTICE, SUBCHAPTER C -- INSTITUTIONAL MANAGEMENT, PART 550 -- DRUG PROGRAMS, SUBPART F -- DRUG ABUSE TREATMENT PROGRAM, § 550.53 Residential Drug Abuse Treatment Program (RDAP). , CODE OF FEDERAL REGULATIONS

... criteria for substance abuse or substance dependence under the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision. The Presentence ...

8. 28 CFR 550.56, TITLE 28 -- JUDICIAL ADMINISTRATION, CHAPTER V -- BUREAU OF PRISONS, DEPARTMENT OF JUSTICE, SUBCHAPTER C -- INSTITUTIONAL MANAGEMENT, PART 550 -- DRUG PROGRAMS, SUBPART F -- DRUG ABUSE TREATMENT PROGRAM, § 550.56 Community Transitional Drug Abuse Treatment Program (TDAT). , CODE OF FEDERAL REGULATIONS

... criteria for substance abuse or dependence indicated in the Diagnostic and Statistical Manual of the Mental Disorders, Fourth Edition. This diagnostic impression must be ...

9. 29 CFR 2590.712, TITLE 29 -- LABOR, SUBTITLE B -- REGULATIONS RELATING TO LABOR, CHAPTER XXV -- EMPLOYEE BENEFITS SECURITY ADMINISTRATION, DEPARTMENT OF LABOR, SUBCHAPTER L -- GROUP HEALTH PLANS, PART 2590 -- RULES AND REGULATIONS FOR GROUP HEALTH PLANS, SUBPART C -- OTHER REQUIREMENTS, § 2590.712 Parity in mental health and substance use disorder benefits., CODE OF FEDERAL REGULATIONS

... medical practice (for example, the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), the most current version of the ICD, or ...

10. 32 CFR 199.4, TITLE 32 -- NATIONAL DEFENSE, SUBTITLE A -- DEPARTMENT OF DEFENSE, CHAPTER I -- OFFICE OF THE SECRETARY OF DEFENSE, SUBCHAPTER M -- MISCELLANEOUS, PART 199 -- CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES (CHAMPUS), § 199.4 Basic program benefits. , CODE OF FEDERAL REGULATIONS

... according to the criteria listed in the most current edition of the Diagnostic and Statistical Manual of Mental Disorders which may be purchased from the American Psychiatric Press, ...
... latest revision of the International Classification of Diseases Clinical Modification, or the Diagnostic and Statistical Manual of Mental Disorders; (ii) Meet at least one of the following: (...

11. 32 CFR 199.5, TITLE 32 -- NATIONAL DEFENSE, SUBTITLE A -- DEPARTMENT OF DEFENSE, CHAPTER I -- OFFICE OF THE SECRETARY OF DEFENSE, SUBCHAPTER M -- MISCELLANEOUS, PART 199 -- CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES (CHAMPUS), § 199.5 TRICARE Extended Care Health Option (ECHO). , CODE OF FEDERAL REGULATIONS

... retardation made in accordance with the criteria of the current edition of the "Diagnostic and Statistical Manual of Mental Disorders" published by the American Psychiatric Association. (ii) Serious physical disability. A serious physical ...

12. 32 CFR PART 199 APPENDIX A, TITLE 32 -- NATIONAL DEFENSE, SUBTITLE A -- DEPARTMENT OF DEFENSE, CHAPTER I -- OFFICE OF THE SECRETARY OF DEFENSE, SUBCHAPTER M -- MISCELLANEOUS, PART 199 -- CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES (CHAMPUS), APPENDIX A TO PART 199 -- ACRONYMS , CODE OF FEDERAL REGULATIONS

... Doctor of Osteopathy DoD -- Department of Defense DSM-III -- Diagnostic and Statistical Manual of Mental Disorders (Third Edition) ECHO -- Extended Care ...

13. 38 CFR 3.304, TITLE 38 -- PENSIONS, BONUSES, AND VETERANS' RELIEF, CHAPTER I -- DEPARTMENT OF VETERANS AFFAIRS, PART 3 -- ADJUDICATION, SUBPART A -- PENSION, COMPENSATION, AND DEPENDENCY AND INDEMNITY COMPENSATION, RATINGS AND EVALUATIONS; SERVICE CONNECTION, § 3.304 Direct service connection; wartime and peacetime. , CODE OF FEDERAL REGULATIONS

... 38 C.F.R. § 3.304(f) (2008). Pursuant to the Diagnostic and Statistical Manual of Mental Disorders (4th ed. 1994) (DSM-4), ...
... a current diagnosis for that condition in accordance with the Diagnostic and Statistical Manual of Mental Disorders (4th ed.). 38 C.F.R. § ...
... evidence shows to the contrary) to have been made in accordance with the applicable Diagnostic and Statistical Manual of Mental Disorders criteria as to both the adequacy of the symptomatology and the sufficiency of the ...

14. 38 CFR 3.384, TITLE 38 -- PENSIONS, BONUSES, AND VETERANS' RELIEF, CHAPTER I -- DEPARTMENT OF VETERANS AFFAIRS, PART 3 -- ADJUDICATION, SUBPART A -- PENSION, COMPENSATION, AND DEPENDENCY AND INDEMNITY COMPENSATION, RATING CONSIDERATIONS RELATIVE TO SPECIFIC DISEASES, § 3.384 Psychosis. , CODE OF FEDERAL REGULATIONS

... term "psychosis" means any of the following disorders listed in Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, of the American Psychiatric Association (DSM-IV-TR): (a) Brief Psychotic Disorder; (...

15. 38 CFR 4.125, TITLE 38 -- PENSIONS, BONUSES, AND VETERANS' RELIEF, CHAPTER I -- DEPARTMENT OF VETERANS AFFAIRS, PART 4 -- SCHEDULE FOR RATING DISABILITIES, SUBPART B -- DISABILITY RATINGS, MENTAL DISORDERS, § 4.125 Diagnosis of mental disorders. , CODE OF FEDERAL REGULATIONS

... a diagnosis of a mental disorder does not conform to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) or is not ...
... post-traumatic stress disorder is made in accordance with the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). 38 C.F.R. § 4.125(a) (2010) ...
... presumed to have made a diagnosis in accordance with the requirements of the Diagnostic and Statistical Manual of Mental Disorders (4th ed. 1994) (DSM or DSM- ...
... a diagnosis of a mental disorder does not conform to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) or is not ...
... post-traumatic stress disorder is made in accordance with the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). 38 C.F.R. § 4.125(a) (2010) ...
... clinical treatises. The diagnostic criteria set forth in the Diagnostic and Statistical Manual of Mental Disorders (4th ed. 1994) for mental ...
... disability. If the diagnosis of a mental disorder does not conform to the Diagnostic and Statistical Manual of Mental Disorders or is not supported by the findings on the examination ...
... a diagnosis of a mental disorder does not conform to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) or is not ...
... post-traumatic stress disorder is made in accordance with the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). 38 C.F.R. § 4.125(a) (2010) ...
... disorders, there must also be medical evidence of a diagnosis that conforms to the Diagnostic and Statistical Manual of Mental Disorders. 38 C.F.R. § 4.125(a) (2010) ...
... traumatic stress disorder diagnoses be stated in terms of the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) criteria, 38 C.F.R. § 4.125(a) (2009) ...
... PTSD), mental health professionals are presumed to know the requirements of the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV), applicable to their ...
... a mental disorder cannot be accepted if it does not conform to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) or is not supported by ...
... a diagnosis of a mental disorder does not conform to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) or is not ...
... loss. If the diagnosis of a mental disorder does not conform to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) or is not supported by the ...
... presumed to have made a diagnosis in accordance with the requirements of the Diagnostic and Statistical Manual of Mental Disorders (4th ed. 2000) (DSM-IV), where ...
... presumed to have made a diagnosis in accordance with the requirements of the Diagnostic and Statistical Manual of Mental Disorders (4th ed. 1994) (DSM or DSM- ...
... disorders, there must also be medical evidence of a diagnosis that conforms to the Diagnostic and Statistical Manual of Mental Disorders. 38 C.F.R. § 4.125(a) (2010) ...
... clinical treatises. The diagnostic criteria set forth in the Diagnostic and Statistical Manual of Mental Disorders (4th ed. 1994) for mental ...

... presumed to have made a diagnosis in accordance with the requirements of the Diagnostic and Statistical Manual of Mental Disorders (4th ed. 1994) (DSM or DSM- ...
... provides that if the diagnosis of a mental disorder does not conform to the Diagnostic and Statistical Manual of Mental Disorders (4th ed., 1994) or is not supported ...
... PTSD), mental health professionals are presumed to know the requirements of the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV), applicable to their ...
... presumed to have made a diagnosis in accordance with the requirements of the Diagnostic and Statistical Manual of Mental Disorders (4th ed. 1994) (DSM or DSM- ...
... disability. If the diagnosis of a mental disorder does not conform to the Diagnostic and Statistical Manual of Mental Disorders or is not supported by the findings on the examination ...

16. 38 CFR 4.126, TITLE 38 -- PENSIONS, BONUSES, AND VETERANS' RELIEF, CHAPTER I -- DEPARTMENT OF VETERANS AFFAIRS, PART 4 -- SCHEDULE FOR RATING DISABILITIES, SUBPART B -- DISABILITY RATINGS, MENTAL DISORDERS, § 4.126 Evaluation of disability from mental disorders. , CODE OF FEDERAL REGULATIONS

... occupational and social impairment, including, if applicable, those identified in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, as revised in the 1994, fourth edition. ...

17. 38 CFR 4.130, TITLE 38 -- PENSIONS, BONUSES, AND VETERANS' RELIEF, CHAPTER I -- DEPARTMENT OF VETERANS AFFAIRS, PART 4 -- SCHEDULE FOR RATING DISABILITIES, SUBPART B -- DISABILITY RATINGS, MENTAL DISORDERS, § 4.130 Schedule of ratings -- mental disorders. , CODE OF FEDERAL REGULATIONS

... employed in this portion of the rating schedule is based upon the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, of the American Psychiatric Association (DSM-IV). Rating agencies must be thoroughly familiar with this ...
... 4.130 of the Code of Federal Regulations adopted the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as the basis for the nomenclature of the rating ...
... occupational and social impairment, including, if applicable, those identified in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition. The symptoms listed in ...
... occupational and social impairment, including, if applicable, those identified in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition. The symptoms listed in ...
... functioning (GAF) scores, other symptoms listed in the Diagnostic and Statistical Manual of Mental Disorders 32 (4th ed. 1994), and the enumerated ...
... Assessment of Functioning scores, other symptoms listed in the Diagnostic and Statistical Manual of Mental Disorders 32 (4th ed. 1994), and the enumerated ...
... mental disorders was revised. Go To Headnote Symptoms in the Diagnostic and Statistical Manual of Mental Disorders, 4th edition, do not replace, but ...
... nomenclature employed in the rating schedule is based upon the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, as revised in the 1994, fourth edition (...
... occupational and social impairment, including, if applicable, those identified in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, as revised in the 1994, fourth edition. 38 C.F.R. § 4.126 (2001) ...
... occupational and social impairment, including, if applicable, those identified in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition. The symptoms listed in ...
... employed in this portion of the rating schedule is based upon the Diagnostic and Statistical Manual of Mental Disorders-IV (DSM-IV). Rating agencies ...
... in 38 C.F.R. § 4.130 (1999), not the Diagnostic and Statistical Manual of Mental Disorders-IV, are for application to establish the appropriate ...
... in 38 C.F.R. § 4.130, not in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, will be for application to establish the appropriate ...
... occupational and social impairment, including, if applicable, those identified in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition. The symptoms listed in ...

... functioning (GAF) scores, other symptoms listed in the Diagnostic and Statistical Manual of Mental Disorders 32 (4th ed. 1994), and the enumerated ...
... service related PTSD condition was severe. Symptoms in the Diagnostic and Statistical Manual of Mental Disorders, 4th edition, do not replace, but ...

18. 42 CFR 8.12, TITLE 42 -- PUBLIC HEALTH, CHAPTER I -- PUBLIC HEALTH SERVICE, DEPARTMENT OF HEALTH AND HUMAN SERVICES, SUBCHAPTER A -- GENERAL PROVISIONS, PART 8 -- CERTIFICATION OF OPIOID TREATMENT PROGRAMS, SUBPART B -- CERTIFICATION AND TREATMENT STANDARDS, § 8.12 Federal opioid treatment standards. , CODE OF FEDERAL REGULATIONS

... determined, using accepted medical criteria such as those listed in the Diagnostic and Statistical Manual for Mental Disorders (DSM-IV), that the person is currently ...

19. 42 CFR 34.2, TITLE 42 -- PUBLIC HEALTH, CHAPTER I -- PUBLIC HEALTH SERVICE, DEPARTMENT OF HEALTH AND HUMAN SERVICES, SUBCHAPTER C -- MEDICAL CARE AND EXAMINATIONS, PART 34 -- MEDICAL EXAMINATION OF ALIENS, § 34.2 Definitions. , CODE OF FEDERAL REGULATIONS

... A currently accepted psychiatric diagnosis, as defined by the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, or by other authoritative sources. (o) Panel physician. ...

20. 42 CFR 412.27, TITLE 42 -- PUBLIC HEALTH, CHAPTER IV -- CENTERS FOR MEDICARE & MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES, SUBCHAPTER B -- MEDICARE PROGRAM, PART 412 -- PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES, SUBPART B -- HOSPITAL SERVICES SUBJECT TO AND EXCLUDED FROM THE PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT OPERATING COSTS AND INPATIENT CAPITAL-RELATED COSTS, § 412.27 Excluded psychiatric units: Additional requirements. , CODE OF FEDERAL REGULATIONS

... diagnosis that is listed in the Fourth Edition, Text Revision of the American Psychiatric Association's Diagnostic and Statistical Manual, or in Chapter Five ("Mental Disorders") of the International Classification of ...

21. 42 CFR 483.102, TITLE 42 -- PUBLIC HEALTH, CHAPTER IV -- CENTERS FOR MEDICARE & MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES, SUBCHAPTER G -- STANDARDS AND CERTIFICATION, PART 483 -- REQUIREMENTS FOR STATES AND LONG TERM CARE FACILITIES, SUBPART C -- PREADMISSION SCREENING AND ANNUAL REVIEW OF MENTALLY ILL AND MENTALLY RETARDED INDIVIDUALS, § 483.102 Applicability and definitions. , CODE OF FEDERAL REGULATIONS

... individual has a major mental disorder diagnosable under the Diagnostic and Statistical Manual of Mental Disorders, 3rd edition, revised in 1987. Incorporation of the 1987 edition of the Diagnostic and Statistical Manual of Mental Disorders, 3rd edition, was approved by the Director of the ...
... govern the use of incorporation by reference. n1 n1 The Diagnostic and Statistical Manual of Mental Disorders is available for inspection at the Centers for ...
... St. NW., Washington, DC. Copies may be obtained from the American Psychiatric Association, Division of Publications and Marketing, 1400 K Street, NW., ...
... dementia if he or she has a primary diagnosis of dementia, as described in the Diagnostic and Statistical Manual of Mental Disorders, 3rd edition, revised in 1987, or ...

22. 45 CFR 146.136, TITLE 45 -- PUBLIC WELFARE, SUBTITLE A -- DEPARTMENT OF HEALTH AND HUMAN SERVICES, SUBCHAPTER B -- REQUIREMENTS RELATING TO HEALTH CARE ACCESS, PART 146 -- REQUIREMENTS FOR THE GROUP HEALTH INSURANCE MARKET, SUBPART C -- REQUIREMENTS

RELATED TO BENEFITS, § 146.136 Parity in mental health and substance use disorder benefits. , CODE OF FEDERAL REGULATIONS

... medical practice (for example, the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), the most current version of the ICD, or ...

23. 45 CFR PART 1355 APPENDIX A, TITLE 45 -- PUBLIC WELFARE, SUBTITLE B -- REGULATIONS RELATING TO PUBLIC WELFARE, CHAPTER XIII -- OFFICE OF HUMAN DEVELOPMENT SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES, SUBCHAPTER G -- THE ADMINISTRATION ON CHILDREN, YOUTH AND FAMILIES, FOSTER CARE MAINTENANCE PAYMENTS, ADOPTION ASSISTANCE, AND CHILD AND FAMILY SERVICES, PART 1355 -- GENERAL, Appendix A to Part 1355--Foster Care Data Elements , CODE OF FEDERAL REGULATIONS

... unless it is determined that they are also seriously emotionally disturbed. The diagnosis is based on the Diagnostic and Statistical Manual of Mental Disorders (Third Edition) (DSM III) or the most ...

24. 45 CFR PART 1355 APPENDIX B, TITLE 45 -- PUBLIC WELFARE, SUBTITLE B -- REGULATIONS RELATING TO PUBLIC WELFARE, CHAPTER XIII -- OFFICE OF HUMAN DEVELOPMENT SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES, SUBCHAPTER G -- THE ADMINISTRATION ON CHILDREN, YOUTH AND FAMILIES, FOSTER CARE MAINTENANCE PAYMENTS, ADOPTION ASSISTANCE, AND CHILD AND FAMILY SERVICES, PART 1355 -- GENERAL, Appendix B to Part 1355--Adoption Data Elements , CODE OF FEDERAL REGULATIONS

... unless it is determined that they are also seriously emotionally disturbed. Diagnosis is based on the Diagnostic and Statistical Manual of Mental Disorders (Third Edition) (DSM III) or the most ... ...

Insurance Implications of DSM-5

American Psychiatric Publishing
A Division of American Psychiatric Association

The fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) was developed to facilitate a seamless transition into immediate use by clinicians and insurers to maintain continuity of care. The new manual represents a step forward in more precisely identifying and diagnosing mental disorders.

To help ensure ease of use, DSM-5 continues to use statistical codes contained in the U.S. Clinical Modifications (CM) of the World Health Organization's (WHO's) International Classification of Diseases (ICD). The ICD-9-CM contains the internationally approved statistical codes for all medical diseases or disorders but does not contain detailed descriptions of how to diagnose these conditions. Below are frequently asked questions especially pertinent to insurers and clinicians.

Frequently Asked Questions

When can DSM-5 be used for insurance purposes?
Since DSM-5 is completely compatible with the HIPAA-approved ICD-9-CM coding system now in use by insurance companies, the revised criteria for mental disorders can be used immediately for diagnosing mental disorders (approval for use in the US by CMS is located here). However, the change in format from a multi-axial system in DSM-IV-TR may result in a brief delay while insurance companies update their claim forms and reporting procedures to accommodate DSM-5 changes.

How will the previous multi-axial conditions be coded?
DSM-5 combines the first three DSM-IV-TR axes into one list that contains all mental disorders, including personality disorders and intellectual disability, as well as other medical diagnoses. Although a single axis recording procedure was previously used for Medicare and Medicaid reporting, some insurance companies required clinicians to report on the status of all five DSM-IV-TR axes.

Contributing psychosocial and environmental factors or other reasons for visits are now represented through an expanded selected set of ICD-9-CM V-codes and, from the forthcoming ICD-10-CM, Z-codes. These codes provide ways for clinicians to indicate other conditions or problems that may be a focus of clinical attention or otherwise affect the diagnosis, course, prognosis, or treatment of a mental disorder (such as relationship problems between patients and their intimate partners). These conditions may be coded along with the patient's mental and other medical disorders if they are a focus of the current visit or help to explain the need for a treatment or test. Alternatively, they may be entered into the patient's clinical record as useful information on circumstances that may affect the patient's care.

On October 1, 2014, the United States adopts ICD-10-CM as its standard coding system. How will diagnoses be coded then?
DSM-5 contains both ICD-9-CM codes for immediate use and ICD-10-CM codes in parentheses. The inclusion of ICD-10-CM codes facilitates a cross-walk to the new coding system that will be implemented on October 1, 2014 for all U.S. health care providers and systems, as recommended by the Centers for Disease Control and Prevention's National Center for Health Statistics (CDC-NCHS) and the Centers for Medicare and Medicaid Services (CMS). This feature will eliminate the need for separate training

on ICD-10-CM codes for mental disorders that is now being offered for all other diseases/disorders by other medical societies and vendors to prepare for the 2014 implementation.

With the removal of the multiaxial system in DSM-5, how will disability and functioning be assessed?
The DSM-5 includes separate measures of symptom severity and disability for individual disorders, rather than the Global Assessment of Functioning (GAF) scale that combined assessment of symptom severity, suicide risk, and social functioning into a single global assessment. This change is consistent with WHO recommendations to move toward a clear conceptual distinction between the disorders contained in the ICD and the disabilities resulting from disorders, which are described in the International Classification of Functioning, Disability, and Health (ICF).

The World Health Organization Disability Assessment Schedule (WHO-DAS 2.0) is provided in Section III of DSM-5 as the best current alternative for measuring disability, and various disorder-specific severity scales are included in Section III and online. The WHO-DAS 2.0 is based on the ICF and is applicable to patients with any health condition, thereby bringing DSM-5 into greater alignment with other medical disciplines. While the WHO-DAS was tested in the DSM-5 field trials and found to be reliable, it is not yet being recommended by APA until more data are available to evaluate its utility in assessing disability status for treatment planning and monitoring purposes.

Sometimes different disorders or subtypes share the same diagnostic code. Is this an error?
No. It is occasionally necessary to use the same code for more than one disorder. Because the DSM-5 diagnostic codes are limited to those contained in the ICD, some disorders must share codes for recording and billing purposes. For example, hoarding disorder and obsessive-compulsive disorder share the same codes (ICD-9-CM 300.3 and ICD-10-CM F42).

Because there may be multiple disorders associated with a given ICD-9-CM or ICD-10-CM code, the DSM-5 diagnosis should be always be recorded by name in the medical record in addition to listing the code.

The names of some DSM-5 disorders do not match the names of the ICD disorders, even though the code is the same. Can you explain this?
Because the DSM-5 diagnostic codes are limited to those contained in the ICD, new DSM-5 disorders were assigned the best available ICD codes. The names connected with these ICD codes sometimes do not match the DSM-5 names. For example, DSM-5 disruptive mood dysregulation disorder (DMDD) is not listed in the ICD. The best ICD-9-CM code available for DSM-5 use was 296.99 (other specified episodic mood disorder). For ICD-10-CM the code will be F34.8 (other persistent mood [affective] disorders). Please refer to the table below for other examples. APA will be working with CDC-NCHS and CMS to include new DSM-5 terms in the ICD-10-CM, and will inform clinicians and insurance companies when modifications are made.

Because DSM-5 and ICD disorder names may not match, the DSM-5 diagnosis should always be recorded by name in the medical record in addition to listing the code.

DSM-5 Disorder	DSM-5/ICD-9-CM Code (in use through September 30, 2014)	CD-9-CM Title	DSM-5/ICD-10-CM Code (in use starting October 1, 2014)	ICD-10-CM Title
Social (pragmatic) communication disorder	315.39	Other developmental speech or language disorder	F80.89	Other developmental disorders of speech and language
Disruptive mood dysregulation disorder	296.99	Other specified episodic mood disorder	F34.8	Other persistent mood [affective] disorders
Premenstrual dysphoric disorder	625.4	Premenstrual tension syndromes	N94.3	Premenstrual tension syndrome
Hoarding disorder	300.3	Obsessive-compulsive disorders	F42	Obsessive- compulsive disorder
Other specified obsessive compulsive and related disorder	300.3	Obsessive-compulsive disorders	F42	Obsessive- compulsive disorder
Unspecified obsessive compulsive and related disorder	300.3	Obsessive-compulsive disorders	F42	Obsessive- compulsive disorder
Excoriation (skin picking) disorder	698.4	Dermatitis factitia [artefacta]	L98.1	Factitial dermatitis
Binge eating disorder	307.51	Bulimia nervosa	F50.8	Other eating disorders

How are DSM-5 and ICD related?
DSM-5 and the ICD should be thought of as companion publications. DSM-5 contains the most up-to-date criteria for diagnosing mental disorders, along with extensive descriptive text, providing a common language for clinicians to communicate about their patients. The ICD contains the code numbers used in DSM-5 and all of medicine, needed for insurance reimbursement and for monitoring of morbidity and mortality statistics by national and international health agencies. The APA works closely with staff from the WHO, CMS, and CDC-NCHS to ensure that the two systems are maximally compatible.

The CMS response to a Frequently Asked Question (FAQ) about the relationship between DSM and ICD-9-CM can be found here.

How is information from DSM-5 used?
DSM-5 is the handbook used by health care professionals in the United States and much of the world as the authoritative guide to the diagnosis of mental disorders. Clinicians use DSM-5 diagnoses to communicate with their patients and with other clinicians, and to request reimbursement from insurance organizations. DSM-5 diagnoses may also be used by public health authorities for compiling and reporting morbidity and mortality statistics.

Another important role of DSM is to establish diagnoses for research on mental disorders. Only by having consistent and reliable diagnoses can researchers determine the risk factors and causes for specific disorders, and determine their incidence and prevalence rates.

Can clinicians continue to use the DSM-IV-TR diagnostic criteria?
Clinicians may use DSM-5 in their practices immediately. However, there may be brief delays while

insurance companies update their claim forms and reporting procedures to accommodate DSM-5 changes, and clinicians should use DSM-IV-TR diagnoses and codes when required by a specific company. Transition details are still being developed with CDC-NCHS, CMS, and private insurance agencies. The APA is working with these groups with the expectation that a transition to DSM-5 by the insurance industry can be made by December 31, 2013.

As part of the transition to DSM-5, there will also need to be updates of questions in board certification examinations and quality assessments for medical record reviews. APA will be providing periodic updates of agreements with federal agencies, private insurance companies, and medical examination boards as they become available.

DSM is the manual used by clinicians and researchers to diagnose and classify mental disorders. The American Psychiatric Association (APA) will publish DSM-5 in 2013, culminating a 14-year revision process. For more information, go to www.DSM5.org.

APA is a national medical specialty society whose more than 36,000 physician members specialize in the diagnosis, treatment, prevention and research of mental illnesses, including substance use disorders. Visit the APA at www.psychiatry.org. For more information, please contact Eve Herold at 703-907-8640 or press@psych.org.

http://psychnews.psychiatryonline.org/newsarticle.aspx?articleid=1691401

PSYCHIATRIC NEWS

FROM THE AMERICAN
PSYCHIATRIC ASSOCIATION

Legal News

May 23, 2013

Court to Hear Case Alleging Parity-Law Violation

Mark Moran

A federal court in Vermont rules that a lawsuit charging a health insurance provider with violating the parity law can go forward.

If insurance companies are going to treat mental and physical illnesses differently, they must justify the disparities using clinically appropriate standards.

That's what the U.S. District Court for the District of Vermont said in the case *C. M. v. Fletcher Allen Health Care, Inc.*—one of the first legal opinions to address interpretation of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). The court's ruling in the case was in response to a motion to dismiss the case filed by the defendant insurer, Fletcher Allen Health Care. The effect of the ruling is to ensure that the plaintiff's case can go forward.

But the court's decision is important, said APA General Counsel Colleen Coyle, because it "squarely puts the burden on the insurance plan to demonstrate that treatment of mental health benefits in a manner that is not comparable to treatment of

medical/surgical benefits is justified by recognized and clinically appropriate standards of care."

The insurer had argued that the federal parity law requires patients to prove not just that mental health benefits were treated differently from other medical benefits, but to demonstrate that "no clinically appropriate standard of care would permit a difference." That is, the insurer was arguing that the case should be dismissed because it is the patient's responsibility to prove that the insurer's action was not justified by clinically appropriate standards of care.

Not so, said the court, which ruled instead that it is the insurer that bears the burden of proof for explaining its treatment decisions. "[T]he Parity Act was promulgated to eliminate impermissible disparity in the benefits afforded for mental health and substance abuse disorders when compared to those afforded medical/surgical conditions," the federal court said. "It stands to reason that plan administrators would also bear the burden of establishing under the
Parity Act, why mental health and medical benefits are treated differently based upon divergent clinical standards."

Coyle told *Psychiatric News*, "Mental health and substance disorder patients have a right to know whether they are being treated differently than patients with other physical or surgical issues, and if so, on what clinical grounds the insurance companies justify that difference."

In the Vermont case, the plaintiff patient—identified only as "C.M."—alleges that the insurer violated the MHPAEA by requiring preapproval for routine mental health services but not for other medical services; by conducting concurrent reviews of mental health services but not requiring such reviews for other medical services; and by initiating automatic review processes triggered by a fixed number of visits for mental health services but not for other services.

The court denied Fletcher Allen's motion to dismiss the claim, and therefore C.M. will have the opportunity to prove that these differences in handling mental health claims violated federal law. If the patient does so, the court should find that the insurer violated the MHPAEA unless the insurer can demonstrate that these disparities are justified by recognized and clinically appropriate standards of care, Coyle said.

APA assisted the plaintiff's counsel in developing the MHPAEA-based arguments in this case. APA has filed another lawsuit against insurers Anthem and WellPoint in Connecticut and is in the process of challenging several other insurance carriers it believes are violating mental health parity laws or improperly using CPT codes for services provided by psychiatrists (*Psychiatric News*, April 5.

The lead attorney representing C.M., Alison Bell, of the law firm Langrock Sperry & Wool, said in a statement, "Mental health parity is an important lifeline for my client, who was denied benefits for medical care desperately needed in order to live a healthy life. We are grateful for APA's assistance with MHPAEA issues."

Last month, former member of Congress Patrick Kennedy hosted a roundtable discussion in New Haven, Conn., at which the plaintiff in the Vermont case spoke—along with psychiatrists, other patients, mental health advocates, and political leaders—about mental health parity and the need for patients to speak out publicly to ensure that the vision that propelled passage of the MHPAEA is realized.

APA Medical Director James H. Scully Jr., M.D., praised the plaintiff for taking action and emphasized that the Vermont case is an important one. "APA applauds plaintiff C.M. and others who spoke at the roundtable…for having the courage to stand up for the right to care," he said in a statement. "We look forward to the day when parity is fully realized and those with a mental illness and/or substance use disorders can expend their energy and resources conquering the illness, rather than battling the insurance companies for the coverage to which they are entitled and for which they and their employer have paid." ■

CLERK MEMO

(*Sent as hard copy via express mail with referenced Attachment 5; and filed electronically with referenced Plaintiff's RESPONSE and also with Plaintiff's earlier MOTION to file in excess of 15 pages)*

4:13-CV-00213 ERW

RADTKE V. WINZEN, ET AL

JUNE 22, 2013

Dear Clerk of Court,

Please file the enclosed copy of the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Test Revision, DSM-IV-TR*, as Attachment 5 with the Plaintiff's RESPONSE IN OPPOSITION TO THE MOTIONS TO DISMISS BY APA AND FRANCES, which will be filed electronically along with its Attachments 1 - 4, by June 24, 2013.

Yours very truly,
S. Randolph Kretchmar
Attorney for the Plaintiff