State of California
Office of Administrative Law

In re:
Department of State Hospitals

Regulatory Action:

Title 09, California Code of Regulations

Adopt sections: **4700, 4710, 4711, 4712, 4713, 4714, 4715, 4716, 4717**
Amend sections:
Repeal sections:

NOTICE OF APPROVAL OF EMERGENCY REGULATORY ACTION

Government Code Sections 11346.1 and 11349.6

OAL Matter Number: 2017-0315-01

OAL Matter Type: Emergency Readopt (EE)

The Department of State Hospitals (Department) submitted this emergency readoption action to keep in effect emergency regulations that pertain to admissions to state hospitals from court-ordered commitments under Penal Code section 1370, which are made when a criminal defendant is determined by a court to be incompetent to stand trial (IST). The regulations are intended to streamline the admissions process and provide uniform rules for all counties regarding the admissions process for IST individuals. The emergency action was prompted by *In re Loveton* (2016) 244 Cal.App.4th 1025, where the court reaffirmed a trial court standing order for the Department to admit IST individuals within 60 days of a court-ordered commitment.

OAL approves this emergency regulatory action pursuant to sections 11346.1 and 11349.6 of the Government Code.

This emergency regulatory action is effective on 3/15/2017 and will expire on 6/14/2017. The Certificate of Compliance for this action is due no later than 6/13/2017.

Date: March 15, 2017

Richard L. Smith
Senior Attorney

For: Debra M. Cornez
Director

Original: Pamela Ahlin
Copy: Dennalee Folks

EMERGENCY

STATE OF CALIFORNIA—OFFICE OF ADMINISTRATIVE LAW

NOTICE PUBLICATION/REGULATIONS SUBMISSION

(See instructions on reverse)

For use by Secretary of State only

STD. 400 (REV. 01-2013)

OAL FILE NUMBERS	NOTICE FILE NUMBER	REGULATORY ACTION NUMBER	EMERGENCY NUMBER
	Z-		2017-0315-01EE

For use by Office of Administrative Law (OAL) only

2017 MAR 15 A 9:44

OFFICE OF ADMINISTRATIVE LAW

NOTICE | REGULATIONS

ENDORSED - FILED
in the office of the Secretary of State
of the State of California
MAR 15 2017
4:06 PM

AGENCY WITH RULEMAKING AUTHORITY: Department of State Hospitals

AGENCY FILE NUMBER (if any):

A. PUBLICATION OF NOTICE (Complete for publication in Notice Register)

1. SUBJECT OF NOTICE	TITLE(S)	FIRST SECTION AFFECTED	2. REQUESTED PUBLICATION DATE

3. NOTICE TYPE	4. AGENCY CONTACT PERSON	TELEPHONE NUMBER	FAX NUMBER (Optional)
☐ Notice re Proposed Regulatory Action ☐ Other			

OAL USE ONLY	ACTION ON PROPOSED NOTICE	NOTICE REGISTER NUMBER	PUBLICATION DATE
	☐ Approved as Submitted ☐ Approved as Modified ☐ Disapproved/ Withdrawn		

B. SUBMISSION OF REGULATIONS (Complete when submitting regulations)

1a. SUBJECT OF REGULATION(S): Incompetent to Stand Trial Admissions Process

1b. ALL PREVIOUS RELATED OAL REGULATORY ACTION NUMBER(S): 2016-0906-03E

2. SPECIFY CALIFORNIA CODE OF REGULATIONS TITLE(S) AND SECTION(S) (Including title 26, if toxics related)

SECTION(S) AFFECTED (List all section number(s) individually. Attach additional sheet if needed.)

ADOPT: 4700, 4710, 4711, 4712, 4713, 4714, 4715, 4716, 4717

AMEND:

TITLE(S): 9

REPEAL:

3. TYPE OF FILING

- ☐ Regular Rulemaking (Gov. Code §11346)
- ☐ Resubmittal of disapproved or withdrawn nonemergency filing (Gov. Code §§11349.3, 11349.4)
- ☐ Emergency (Gov. Code, §11346.1(b))
- ☐ Certificate of Compliance: The agency officer named below certifies that this agency complied with the provisions of Gov. Code §§11346.2-11347.3 either before the emergency regulation was adopted or within the time period required by statute.
- ☐ Resubmittal of disapproved or withdrawn emergency filing (Gov. Code, §11346.1)
- ☒ Emergency Readopt (Gov. Code, §11346.1(h))
- ☐ File & Print
- ☐ Other (Specify)
- ☐ Changes Without Regulatory Effect (Cal. Code Regs., title 1, §100)
- ☐ Print Only

4. ALL BEGINNING AND ENDING DATES OF AVAILABILITY OF MODIFIED REGULATIONS AND/OR MATERIAL ADDED TO THE RULEMAKING FILE (Cal. Code Regs. title 1, §44 and Gov. Code §11347.1)

5. EFFECTIVE DATE OF CHANGES (Gov. Code, §§ 11343.4, 11346.1(d); Cal. Code Regs., title 1, §100)

- ☐ Effective January 1, April 1, July 1, or October 1 (Gov. Code §11343.4(a))
- ☒ Effective on filing with Secretary of State
- ☐ §100 Changes Without Regulatory Effect
- ☐ Effective other (Specify)

6. CHECK IF THESE REGULATIONS REQUIRE NOTICE TO, OR REVIEW, CONSULTATION, APPROVAL OR CONCURRENCE BY, ANOTHER AGENCY OR ENTITY

- ☐ Department of Finance (Form STD. 399) (SAM §6660)
- ☐ Fair Political Practices Commission
- ☐ State Fire Marshal
- ☐ Other (Specify)

7. CONTACT PERSON	TELEPHONE NUMBER	FAX NUMBER (Optional)	E-MAIL ADDRESS (Optional)
Dennalee Folks	916-651-8544	916-651-3090	dennalee.folks@dsh.ca.gov

8. **I certify that the attached copy of the regulation(s) is a true and correct copy of the regulation(s) identified on this form, that the information specified on this form is true and correct, and that I am the head of the agency taking this action, or a designee of the head of the agency, and am authorized to make this certification.**

SIGNATURE OF AGENCY HEAD OR DESIGNEE: Pam Ahlin

DATE: 3/15/17

TYPED NAME AND TITLE OF SIGNATORY: Pam Ahlin, Director

For use by Office of Administrative Law (OAL) only

ENDORSED APPROVED
MAR 15 2017
Office of Administrative Law

INCOMPETENT TO STAND TRIAL ADMISSIONS PROCESS

TITLE 9. REHABILITATIVE AND DEVELOPMENTAL SERVICES
DIVISION 1. DEPARTMENT OF MENTAL HEALTH
CHAPTER 16. STATE HOSPITAL OPERATIONS

Adopt ARTICLE 7. ADMISSIONS

Adopt Sections 4700, 4710, 4711, 4712, 4713, 4714, 4715, 4716 and 4717

4700. Definitions.

(a) "Low/moderate security risk" means any individual who has no escape/escape attempt(s) history from a locked facility, state hospital, locked psychiatric facility, or correctional facility.

(b) "High security risk" means an individual with a history of escape/escape attempt(s) from a locked facility or a successful escape from a state hospital, locked psychiatric facility, or correctional facility.

(c) "Psychiatric acuity" means an individual's condition that is evidenced by the fact that an individual's mental illness is leading to complications which put the individual at risk of death or serious injury while awaiting admission. For purposes of assessing psychiatric acuity, the individual would need to exhibit more than aggressive behavior alone.

Note: Authority cited: Sections 4005.1 and 4027, Welfare and Institutions Code. Reference: Section 1370, Penal Code; and Sections 7228 and 7230, Welfare and Institutions Code.

4710. Admission of Individuals Found Incompetent to Stand Trial.

(a) When scheduling admission of individuals committed by the courts to the Department of State Hospitals pursuant to Penal Code section 1370, the department will admit such individuals in relation to the individuals' respective commitment date, such that the order of admission will be determined by the earlier of the individuals' respective commitment dates. This order of admission by commitment date may be changed by the department under any of the following circumstances:

(1) Bed availability at the facility under consideration for the individual's placement;

(2) Whether the psychiatric acuity of the individual indicates the need for a priority admission to a facility;

(3) Whether the medical needs of the individual can presently be clinically accommodated by the facility under consideration for the individual's placement;

(4) The transportation ability or timing of the committing county to the facility under consideration for the individual's placement; or the committing county's inability to transport the committed individual for any other reason.

(b) For individuals committed and/or admitted by the courts to the Department of State Hospitals who are placed in a jail-based competency program pursuant to Penal Code section 1370, if that jail-based competency program determines that it cannot appropriately serve the individual, the individual shall be admitted to a state hospital in the order of admission that reflects the individual's original commitment date to the Department of State Hospitals.

Note: Authority cited: Sections 4005.1 and 4027, Welfare and Institutions Code. Reference: Section 1370, Penal Code; and Sections 7228 and 7230, Welfare and Institutions Code.

4711. Admissions Documentation for Individuals Found Incompetent to Stand Trial.

(a) A county committing an individual to the Department of State Hospitals under Penal Code section 1370 shall submit a commitment packet to the department for review and approval prior to the admission of the individual.

(b) The commitment packet shall include:

(1) The commitment order, including a specification of the charges.

(2) A computation or statement setting forth the maximum term of commitment.

(3) A computation or statement setting forth the amount of credit for time served, if any, to be deducted from the maximum term of commitment.

(4) The state summary criminal history information.

(5) Any arrest report(s) from police departments or other law enforcement agencies.

(6) Any court-ordered psychiatric examination or evaluation reports.

(7) The placement recommendation report prepared by the community program director of the forensic conditional release program.

(8) Records of any finding of mental incompetence pursuant to this chapter arising out of a complaint charging a felony offense specified in Penal Code section 290 or any pending Penal Code section 1368 proceeding arising out of a charge of a Penal Code section 290 offense.

(9) Any medical records as described in section 4712.

Note: Authority cited: Sections 4005.1 and 4027, Welfare and Institutions Code. Reference: Sections 1370 and 1370.01, Penal Code; Section 7228, Welfare and Institutions Code; Title 45, Code of Federal Regulations, Section 164.508; *and In re Loveton* (2016) 244 Cal.App.4th 1025.

4712. Medical Records Documentation.

(a) The following medical documentation of the individual shall be supplied in the individual's commitment packet, if available;

(1) Any progress notes by a nurse, psychiatrist, medical doctor, or that pertain to behavioral incidents, within the last 10 days;

(2) Current medications and dosages;

(3) Medication compliance documentation;

(4) Lab results/work and consultations;

(5) Recent admission psychiatric evaluation;

(6) Safety cell usage or suicide watch records or incidences of self-injurious behavior;

(7) Any recent physical exams or medical history notes;

(8) Any advance health care directive;

(9) Any consent forms for treatment; and

(10) Any other court-ordered medical treatment.

(b) Other medical documentation, including treatment plans, will be required for the following conditions, if available:

(1) Renal dialysis (hemodialysis or peritoneal dialysis);

(2) Non-ambulation, or where the individual needs prosthetics, walkers, or assistance to ambulate;

(3) Pregnancy, near term (last two months), or any prenatal care information or complications;

(4) Continuous oxygen, continuous respiratory monitoring such as pulse oximetry, ventilator devices such as CPAP for sleep apnea, or nebulizer for airway treatment;

(5) Cancer;

(6) Congestive heart failure;

(7) Blood or spinal fluid shunt in place, such as Prot-o-cath, or shunt for hydrocephalus;

(8) Any required injections;

(9) Any open wound not yet healed or untreated;

(10) Ostomy;

(11) Cirrhosis of the liver;

(12) Active inflammatory bowel diseases, complications by intestinal obstruction, subocclusion, severe fistulas, or active rectal bleeding;

(13) Inability to provide basic self-care or any other condition requiring skilled nursing level of care;

(14) HIV/AIDS;

(15) Tuberculosis; and

(16) Any other significant medical condition.

Note: Authority cited: Sections 4005.1 and 4027, Welfare and Institutions Code. Reference: Section 1370 and 1370.01, Penal Code; Section 7228, Welfare and Institutions Code; Title 45, Code of Federal Regulations, Section 164.508; *and In re Loveton* (2016) 244 Cal.App.4th 1025.

4713. Medical Records Review.

(a) The Department of State Hospitals shall use the medical records provided in the commitment packet to determine the medical needs of an individual.

(b) A department admissions unit's triage nurse shall review all documents related to an individual's medical condition(s).

(c) The department's admissions unit's triage nurse shall consult with the department's admissions unit's physician or the chief physician and surgeon to address whether the particular facility, proposed for the individual's placement, is able to provide the necessary care or services needed by the patient's medical condition(s).

Note: Authority cited: Sections 4005.1 and 4027.
Reference: Sections 1370 and 1370.01, Penal Code; and Sections 7228 and 7230, Welfare and Institutions Code.

4714. Security Risk Assessment for Placement of Individuals Found Incompetent to Stand Trial.

(a) The Department of State Hospitals shall conduct a security risk assessment of each individual committed to the department pursuant to Penal Code section 1370 prior to admission.

(b) The security risk assessment shall include:

(1) The individual's prior history of escape or attempted escapes at any locked facility;

(2) Whether, within 30 days prior to the completion of the department's assessment, the department receives new information about the individual, such as a change in commitment status, divorce by spouse, death of a family member, or birth of a child;

(3) The individual's age;

(4) Whether the individual has been diagnosed with an antisocial, borderline, and/or narcissistic personality disorder based on the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (May 18, 2013), hereby incorporated by reference;

(5) The number of the individual's prior felony convictions;

(6) The individual's current length of sentence at the time of assessment; and

(7) The individual's current medical condition.

Note: Authority cited: Sections 4005.1 and 4027, Welfare and Institutions Code. Reference: Sections 7228 and 7230, Welfare and Institutions Code.

4715. Placement of Individuals Found Incompetent to Stand Trial.

The Department of State Hospitals may not admit an individual under Penal Code section 1370 until the commitment packet specified in section 4711 is received, reviewed, and approved by the department in order to determine the proper placement within the department. The department may admit a committed individual whose commitment packet is incomplete when the department determines, pursuant to section 4716, that the individual's psychiatric acuity indicates the need for an immediate admission to a state facility.

Note: Authority cited: Sections 4005.1 and 4027, Welfare and Institutions Code. Reference: Section 1370, Penal Code; Section 7228, Welfare and Institutions Code.

4716. Psychiatric Acuity Review.

(a) If an individual committed to the department pursuant to Penal Code section 1370 is psychiatrically acute, the individual may be reprioritized in the order of commitment in the admission process.

(b) The committing county's clinician responsible for the individual's clinical assessment shall contact the Department of State Hospitals' medical director, or designee, about an individual's psychiatric acuity and the psychiatric acuity needs of the individual.

(c) The committing county shall provide the medical director, or designee, the medical information and documentation that supports the psychiatric acuity. Such documentation may include, but is not limited to:

(1) Safety cell notes;

(2) Current medications or lack of medication;

(3) Medical lab work; or

(4) Any additional treatment records from local health care providers.

(d) The medical director of the Department of State Hospitals, or designee, is the final authority for determining psychiatric acuity of an individual for purposes of expediting admission to a state facility.

(e) The medical director of the Department of State Hospitals, or designee, will make a decision on whether to expedite admission of an individual due to his or her psychiatric acuity within 72 hours of contact by the committing county's clinician and when the department receives sufficient documentation.

Note: Authority cited: Sections 4005.1, 4027 and 7225, Welfare and Institutions Code.
Reference: Sections 1370 and 1370.01, Penal Code; and Sections 7228 and 7230, Welfare and Institutions Code.

4717. State Hospital Placements of Individuals Found Incompetent to Stand Trial for Security Risks,

(a) The Department of State Hospitals shall consider an individual committed to the department pursuant to Penal Code section 1370, and who the department determines is a low/moderate security risk, only for admission to Department of State Hospitals – Atascadero, Department of State Hospitals – Patton, Department of State Hospitals – Napa, or to Department of State Hospitals – Metropolitan.

(b) The Department of State Hospitals shall consider an individual committed pursuant to Penal Code section 1370, and who the department determines is a high security risk, only for admission to Department of State Hospitals – Atascadero or to Department of State Hospitals - Patton.

Note: Authority cited: Sections 4005.1, 4027 and 7225, Welfare and Institutions Code.
Reference: Sections 7228 and 7230, Welfare and Institutions Code.

DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS

FIFTH EDITION

DSM-5™

AMERICAN PSYCHIATRIC ASSOCIATION

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Section III
Emerging Measures and Models

Appendix

Preface

The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM) is a classification of mental disorders with associated criteria designed to facilitate more reliable diagnoses of these disorders. With successive editions over the past 60 years, it has become a standard reference for clinical practice in the mental health field. Since a complete description of the underlying pathological processes is not possible for most mental disorders, it is important to emphasize that the current diagnostic criteria are the best available description of how mental disorders are expressed and can be recognized by trained clinicians. DSM is intended to serve as a practical, functional, and flexible guide for organizing information that can aid in the accurate diagnosis and treatment of mental disorders. It is a tool for clinicians, an essential educational resource for students and practitioners, and a reference for researchers in the field.

Although this edition of DSM was designed first and foremost to be a useful guide to clinical practice, as an official nomenclature it must be applicable in a wide diversity of contexts. DSM has been used by clinicians and researchers from different orientations (biological, psychodynamic, cognitive, behavioral, interpersonal, family/systems), all of whom strive for a common language to communicate the essential characteristics of mental disorders presented by their patients. The information is of value to all professionals associated with various aspects of mental health care, including psychiatrists, other physicians, psychologists, social workers, nurses, counselors, forensic and legal specialists, occupational and rehabilitation therapists, and other health professionals. The criteria are concise and explicit and intended to facilitate an objective assessment of symptom presentations in a variety of clinical settings—inpatient, outpatient, partial hospital, consultation-liaison, clinical, private practice, and primary care—as well in general community epidemiological studies of mental disorders. DSM-5 is also a tool for collecting and communicating accurate public health statistics on mental disorder morbidity and mortality rates. Finally, the criteria and corresponding text serve as a textbook for students early in their profession who need a structured way to understand and diagnose mental disorders as well as for seasoned professionals encountering rare disorders for the first time. Fortunately, all of these uses are mutually compatible.

These diverse needs and interests were taken into consideration in planning DSM-5. The classification of disorders is harmonized with the World Health Organization's *International Classification of Diseases* (ICD), the official coding system used in the United States, so that the DSM criteria define disorders identified by ICD diagnostic names and code numbers. In DSM-5, both ICD-9-CM and ICD-10-CM codes (the latter scheduled for adoption in October 2014) are attached to the relevant disorders in the classification.

Although DSM-5 remains a categorical classification of separate disorders, we recognize that mental disorders do not always fit completely within the boundaries of a single disorder. Some symptom domains, such as depression and anxiety, involve multiple diagnostic categories and may reflect common underlying vulnerabilities for a larger group of disorders. In recognition of this reality, the disorders included in DSM-5 were reordered into a revised organizational structure meant to stimulate new clinical perspectives. This new structure corresponds with the organizational arrangement of disorders planned for ICD-11 scheduled for release in 2015. Other enhancements have been introduced to promote ease of use across all settings:

- **Representation of developmental issues related to diagnosis.** The change in chapter organization better reflects a lifespan approach, with disorders more frequently diagnosed in childhood (e.g., neurodevelopmental disorders) at the beginning of the manual and disorders more applicable to older adulthood (e.g., neurocognitive disorders) at the end of the manual. Also, within the text, subheadings on development and course provide descriptions of how disorder presentations may change across the lifespan. Age-related factors specific to diagnosis (e.g., symptom presentation and prevalence differences in certain age groups) are also included in the text. For added emphasis, these age-related factors have been added to the criteria themselves where applicable (e.g., in the criteria sets for insomnia disorder and posttraumatic stress disorder, specific criteria describe how symptoms might be expressed in children). Likewise, gender and cultural issues have been integrated into the disorders where applicable.
- **Integration of scientific findings from the latest research in genetics and neuroimaging.** The revised chapter structure was informed by recent research in neuroscience and by emerging genetic linkages between diagnostic groups. Genetic and physiological risk factors, prognostic indicators, and some putative diagnostic markers are highlighted in the text. This new structure should improve clinicians' ability to identify diagnoses in a disorder spectrum based on common neurocircuitry, genetic vulnerability, and environmental exposures.
- **Consolidation of autistic disorder, Asperger's disorder, and pervasive developmental disorder into autism spectrum disorder.** Symptoms of these disorders represent a single continuum of mild to severe impairments in the two domains of social communication and restrictive repetitive behaviors/interests rather than being distinct disorders. This change is designed to improve the sensitivity and specificity of the criteria for the diagnosis of autism spectrum disorder and to identify more focused treatment targets for the specific impairments identified.
- **Streamlined classification of bipolar and depressive disorders.** Bipolar and depressive disorders are the most commonly diagnosed conditions in psychiatry. It was therefore important to streamline the presentation of these disorders to enhance both clinical and educational use. Rather than separating the definition of manic, hypomanic, and major depressive episodes from the definition of bipolar I disorder, bipolar II disorder, and major depressive disorder as in the previous edition, we included all of the component criteria within the respective criteria for each disorder. This approach will facilitate bedside diagnosis and treatment of these important disorders. Likewise, the explanatory notes for differentiating bereavement and major depressive disorders will provide far greater clinical guidance than was previously provided in the simple bereavement exclusion criterion. The new specifiers of anxious distress and mixed features are now fully described in the narrative on specifier variations that accompanies the criteria for these disorders.
- **Restructuring of substance use disorders for consistency and clarity.** The categories of substance abuse and substance dependence have been eliminated and replaced with an overarching new category of substance use disorders—with the specific substance used defining the specific disorders. "Dependence" has been easily confused with the term "addiction" when, in fact, the tolerance and withdrawal that previously defined dependence are actually very normal responses to prescribed medications that affect the central nervous system and do not necessarily indicate the presence of an addiction. By revising and clarifying these criteria in DSM-5, we hope to alleviate some of the widespread misunderstanding about these issues.
- **Enhanced specificity for major and mild neurocognitive disorders.** Given the explosion in neuroscience, neuropsychology, and brain imaging over the past 20 years, it was critical to convey the current state-of-the-art in the diagnosis of specific types of disorders that were previously referred to as the "dementias" or organic brain diseases. Biological markers identified by imaging for vascular and traumatic brain disorders and

specific molecular genetic findings for rare variants of Alzheimer's disease and Huntington's disease have greatly advanced clinical diagnoses, and these disorders and others have now been separated into specific subtypes.

- **Transition in conceptualizing personality disorders.** Although the benefits of a more dimensional approach to personality disorders have been identified in previous editions, the transition from a categorical diagnostic system of individual disorders to one based on the relative distribution of personality traits has not been widely accepted. In DSM-5, the categorical personality disorders are virtually unchanged from the previous edition. However, an alternative "hybrid" model has been proposed in Section III to guide future research that separates interpersonal functioning assessments and the expression of pathological personality traits for six specific disorders. A more dimensional profile of personality trait expression is also proposed for a trait-specified approach.
- **Section III: new disorders and features.** A new section (Section III) has been added to highlight disorders that require further study but are not sufficiently well established to be a part of the official classification of mental disorders for routine clinical use. Dimensional measures of symptom severity in 13 symptom domains have also been incorporated to allow for the measurement of symptom levels of varying severity across all diagnostic groups. Likewise, the WHO Disability Assessment Schedule (WHODAS), a standard method for assessing global disability levels for mental disorders that is based on the International Classification of Functioning, Disability and Health (ICF) and is applicable in all of medicine, has been provided to replace the more limited Global Assessment of Functioning scale. It is our hope that as these measures are implemented over time, they will provide greater accuracy and flexibility in the clinical description of individual symptomatic presentations and associated disability during diagnostic assessments.
- **Online enhancements.** DSM-5 features online supplemental information. Additional cross-cutting and diagnostic severity measures are available online (www.psychiatry.org/dsm5), linked to the relevant disorders. In addition, the Cultural Formulation Interview, Cultural Formulation Interview—Informant Version, and supplementary modules to the core Cultural Formulation Interview are also included online at www.psychiatry.org/dsm5.

These innovations were designed by the leading authorities on mental disorders in the world and were implemented on the basis of their expert review, public commentary, and independent peer review. The 13 work groups, under the direction of the DSM-5 Task Force, in conjunction with other review bodies and, eventually, the APA Board of Trustees, collectively represent the global expertise of the specialty. This effort was supported by an extensive base of advisors and by the professional staff of the APA Division of Research; the names of everyone involved are too numerous to mention here but are listed in the Appendix. We owe tremendous thanks to those who devoted countless hours and invaluable expertise to this effort to improve the diagnosis of mental disorders.

We would especially like to acknowledge the chairs, text coordinators, and members of the 13 work groups, listed in the front of the manual, who spent many hours in this volunteer effort to improve the scientific basis of clinical practice over a sustained 6-year period. Susan K. Schultz, M.D., who served as text editor, worked tirelessly with Emily A. Kuhl, Ph.D., senior science writer and DSM-5 staff text editor, to coordinate the efforts of the work groups into a cohesive whole. William E. Narrow, M.D., M.P.H., led the research group that developed the overall research strategy for DSM-5, including the field trials, that greatly enhanced the evidence base for this revision. In addition, we are grateful to those who contributed so much time to the independent review of the revision proposals, including Kenneth S. Kendler, M.D., and Robert Freedman, M.D., co-chairs of the Scientific Review Committee; John S. McIntyre, M.D., and Joel Yager, M.D., co-chairs of the Clinical and Public Health Committee; and Glenn Martin, M.D., chair of the APA Assem-

bly review process. Special thanks go to Helena C. Kraemer, Ph.D., for her expert statistical consultation; Michael B. First, M.D., for his valuable input on the coding and review of criteria; and Paul S. Appelbaum, M.D., for feedback on forensic issues. Maria N. Ward, M.Ed., RHIT, CCS-P, also helped in verifying all ICD coding. The Summit Group, which included these consultants, the chairs of all review groups, the task force chairs, and the APA executive officers, chaired by Dilip V. Jeste, M.D., provided leadership and vision in helping to achieve compromise and consensus. This level of commitment has contributed to the balance and objectivity that we feel are hallmarks of DSM-5.

We especially wish to recognize the outstanding APA Division of Research staff—identified in the Task Force and Work Group listing at the front of this manual—who worked tirelessly to interact with the task force, work groups, advisors, and reviewers to resolve issues, serve as liaisons between the groups, direct and manage the academic and routine clinical practice field trials, and record decisions in this important process. In particular, we appreciate the support and guidance provided by James H. Scully Jr., M.D., Medical Director and CEO of the APA, through the years and travails of the development process. Finally, we thank the editorial and production staff of American Psychiatric Publishing—specifically, Rebecca Rinehart, Publisher; John McDuffie, Editorial Director; Ann Eng, Senior Editor; Greg Kuny, Managing Editor; and Tammy Cordova, Graphics Design Manager—for their guidance in bringing this all together and creating the final product. It is the culmination of efforts of many talented individuals who dedicated their time, expertise, and passion that made DSM-5 possible.

David J. Kupfer, M.D.
DSM-5 Task Force Chair

Darrel A. Regier, M.D., M.P.H.
DSM-5 Task Force Vice-Chair
December 19, 2012