AMERICAN PSYCHIATRIC ASSOCIATION

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August 28, 2017

Joaquin Alexander Maza Martelli, President, United Nations Human Rights Council
Dainius Puras, United Nations Special Rapporteur
Office of the High Commissioner for Human Rights
United Nations Office at Geneva
CH-1211 Geneva 10
Switzerland

Dear Mr. Maza Martelli and Mr. Puras:

The American Psychiatric Association (APA) is submitting a response to the report of Mr. Dainius Puras, Special Rapporteur on the **right of everyone to the enjoyment of the highest attainable standard of physical and mental health** (A/HRC/35/21), submitted to the Thirty-fifth session of the United Nations (UN) Human Rights Council, 6-23 June 2017.

We wish to express concern regarding the attenuated depiction of mental health care and concepts misattributed to the practice of psychiatry and psychiatrist physicians.

While the report focuses on the concept of the global burden of obstacles in psychiatry as responsible for inadequate mental health care around the world, the greater issue is the prevailing lack of parity between physical and mental health and the lack of access to adequate mental health services. The report misrepresents psychiatry in unproven statements as a 'discipline marked by rights violations, characterized by a reductionist approach, and enslaved to the pharmaceutical industry' and does not take into consideration the life-saving aspects and increased quality of life achievable through psychiatric care and treatment.

Further, the report undermines the alliance among psychiatrist physicians, patients, and families by casting doubts on the intent of psychiatrist physicians and the efficacy of psychiatric evaluation and treatment. Such misrepresentation and mischaracterization of psychiatry and psychiatrist physicians is detrimental to improving advocacy and collaboration efforts among all stakeholders.

According to reports of the World Health Organization (WHO) regarding the increase in disability adjusted life years (DALYs) and years lived with disability (YLDs), it is predicted that depression will be the lead cause of DALY's in the next decade. With the release of the WHO Comprehensive Mental Health Action Plan (2013-2020), national psychiatric physician organizations, such as the APA, have acted in accordance by focusing on strengthening effective leadership and governance for mental health through parity, including the development of policy and legislation, and through increased stakeholder collaboration. Rather than cast dispersion on a healthcare profession, the goal should be collaboration, as reflected in the WHO Mental Health Action Plan.

As a non-governmental organization (NGO) with special consultative status with the UN Economic and Social Council, APA recently coordinated a panel discussion on the integrated healthcare model during the 10th session of the Conference on States Parties to the Convention

on the Rights of Persons with Disabilities (CRPD), 13-15 June 2017, which included four psychiatrist physicians, one patient, and one peer counselor on the panel.

We are providing some additional information that addresses, in greater detail, the concepts and claims raised in the report for your consideration (see attachment). We welcome the opportunity to provide additional information and participate in further discussions to facilitate a greater understanding of the issue.

Thank you for your consideration.

Sincerely,

Anita Everett, M.D.
President
American Psychiatric Association

Saul Levin, M.D., M.P.A.
CEO and Medical Director
American Psychiatric Association

Cc

Ambassador Nikki Haley, U.S. Permanent Representative to the United Nations
Ambassador Michele J. Sison, U.S. Deputy Permanent Representative to the United Nations

ATTACHMENT 1: Detailed Response to A/HRC/35/21

1) The report focuses on the concept of the **global burden of obstacles** in psychiatry, including the **dominance of the biomedical model**, the existence of **power asymmetries**, and the **biased use of evidence in mental health**, as responsible for inadequate mental health care around the world**.** It characterizes mental health services as "useless" and ignores the large population of individuals who have been successfully treated and enabled to live a meaningful life. It also unfairly attributes gender orientation discrimination to psychiatry, despite the work of psychiatrist physicians and their organizations to combat cultural norms promoting discrimination in parts of the world directed to women. The report also does not discuss the importance of the quantification of the global burden of diseases attributable to mental and substance use disorders in terms of disability-adjusted life years (DALYs), years of life lost to premature mortality (YLLs), and years lived with disability, as it provides a basis for understanding the human, social, and economic costs of mental illness and the importance of supporting mental health parity.

2) While the report indicates a **dominance of biomedical interventions** in psychiatry, it portrays treatment with psychotropic medications as useless, if not harmful, and ignores evidence of its effectiveness. This misrepresentation undermines the efforts of mental health professionals and families to promote treatment adherence with treatment discontinuation representing the leading cause of relapse and hospitalization. Rather than being seen as complementary approaches, psychiatric interventions aimed at improving public mental health and the provision of care for those suffering from mental disorder are presented as incompatible approaches and posits a dangerous dichotomy between biological and psychosocial approaches.

Psychiatric interventions are determined only after careful and comprehensive psychiatric evaluation and assessment which involves diagnosis formulation through an evaluation and assessment of clinical history and contributing social, psychological, biological, and cultural factors. Manuals, such as the Diagnostic and Statistical Manual of Mental Disorders (DSM), developed with the participation of a diverse group of expert clinicians and researchers across multiple disciplines, are intended as tools for the assessment and diagnosis of mental disorders and do not include guidelines for the treatment of any disorder. It is the clinical expertise of the psychiatrist physician, achieved through extensive clinical training, which determines the appropriate course of care and treatment, requiring monitoring and follow up, which can incorporate psychosocial and psychopharmacologic interventions, though maintaining psychotherapy as a central treatment option (APA, *Psychotherapy*, 2015).

Persons with serious mental illness should have access to psychiatric services that are person-centered and recovery oriented and foster self-sufficiency, independence, and positive self-worth (APA, *Accountability*, 2016). It is the nature of the initial psychiatric evaluation that helps establish the doctor-patient relationship, which is critical to the entire treatment process and, when done properly, gathers the necessary data to arrive at the correct diagnosis and appropriate intervention, rather than any pre-determined biomedical intervention corresponding to a diagnosis.

3) The **power asymmetries** attributed to psychiatry in the report, with respect to involuntary treatment, does not take into consideration, that in medically necessary cases, involuntary treatment can restore the functional and decisional capacity of persons with severe psychiatric disorders and protect them and others from the behavioral

consequences of their conditions. Medical necessity is a cornerstone of insuring that involuntary treatment is only used when appropriate and when other interventions are not likely to be successful. Most persons with psychiatric disorders, of course, are not and should not be subject to involuntary interventions. They retain the capacity to make treatment decisions and pose no serious risk to themselves or to other people. However, for the minority of persons who are sufficiently disabled by their disorders to be unable to protect their own interests and/or who endanger themselves or others, the existence of involuntary interventions may be life-saving and hold the prospect of restoring them to a fully functional and independent life (APA, *Involuntary*, 2015).

The report considers all long-term care facilities as incompatible with respect to human rights and offers no alternatives for people requiring long-term housing and daily assistance, such as elderly people with dementia. In America, many children and adolescents who suffer from mental health and behavioral disorders are not able to access appropriate mental health care due to the nationwide shortage of inpatient mental health services for their age group. Inpatient psychiatric hospitalization is often necessary to evaluate, acutely stabilize, treat and transition children and adolescent patients who present to emergency facilities in crisis (APA, Psychiatric Hospitalization, 2016). However, APA recognizes that the abuse and misuse of psychiatry (APA, *Abuse and Misuse*, 2014) continues to be an issue in different parts of the world and asserts that such incidences are an abuse of an individual's human rights (APA, *Human Rights*, 2014) and supports the involvement of involvement of international humanitarian organizations.

With regards to the influence of the pharmaceutical industry, in the United States, psychiatry has taken steps to monitor the relationship between physicians and the pharmaceutical industry through the *Physicians Payment Sunshine Act*. This legislation requires manufacturers of drugs, medical devices, and biologicals to report payments give to physicians and teaching hospitals and making the information publicly available.

4) With regards to the **biased use of evidence in mental health**, diversification in research and a balance between neurobiological and psychosocial approaches to psychiatric interventions is necessary. Research plays a vital role in the understanding of the causes of mental illnesses, the development of treatments and preventive strategies, and the promotion of mental health. Research also provides information about how to effectively organize and structure the delivery of services for mental disorders, including substance abuse. To a greater extent than ever before, research informs public and private sector policies that affect persons with mental disorders and their families, as well as mental health care providers, insurers, and agencies at all levels of government. In the most recent strategic planning report from the National Institute of Mental Health (NIMH), an emphasis was placed on accelerating therapeutics especially as industry has backed away from investing in research and development for new medications and payers have raised questions about the evidence base for nonpharmacological treatments. In response, NIMH has begun shifting its clinical trials portfolio toward studies with defined targets and milestones in an attempt to reveal more about the mechanisms of disorders that can serve as a foundation for better biomedical and psychosocial interventions (NIMH, *Strategic Plan*, 2015).

Position Statement: The Call to Action: Accountability for Persons with Serious Mental Illness

(Adapted from the Position Statement: A Call to Action for the Chronic Mental Patient)

Approved by the Board of Trustees, July 2016
Approved by the Assembly, May 2016

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Issue: Failure to meet the needs of persons with serious mental illness, including persistent mental illness, early presentation of mental illness, and comorbid substance use disorders, remains a national crisis.

Serious mental illness spans all ages, genders, and sociocultural groups. It includes a wide variety of diagnoses, including psychotic disorders, mood disorders, anxiety disorders, neurodevelopmental disorders, neurodegenerative disorders, traumatic brain injury, and substance-related syndromes. Obstacles to recovery are everywhere. State hospital closures, community hospital downsizing, and the absence of essential community systems are driving forces behind poor outcomes, homelessness, and increasing social costs. Poor quality of care, social disadvantage, and adverse health behaviors lead to premature mortality in this population. Life expectancy of persons with serious mental illness is decreased by as much as 20 years compared with otherwise similar groups without mental illness.

Ensuring appropriate treatment, rehabilitation, and opportunities for recovery of persons with serious mental illness is ***a public health responsibility***. Federal, state, and local governments must be accountable for ensuring access to comprehensive assessment and evidence-based treatments. Psychiatrists have a unique role and responsibility for developing strategies to address these challenges.

Position:
The American Psychiatric Association shall work with psychiatrists, other physicians, and professionals, communities, and partners to achieve the best possible clinical outcomes, functioning, and quality of life for persons with serious mental illness. Priorities and strategies include:

1. **Ensuring access to all levels of effective and efficient care and treatment.**

   Services shall be:
   - Person-centered and recovery oriented, fostering self-sufficiency, independence, and positive self-worth.
   - Culturally and linguistically sensitive.
   - Available to persons across the lifespan.
   - Available to persons of all social, cultural, ethnic, racial, gender, sexual orientation, economic backgrounds, and population densities.
   - Provided in the least restrictive setting appropriate to the person's needs.

- Overseen in a meaningful way by a physician, preferably a psychiatrist.
- Reimbursed by all health insurances (including Medicare and Medicaid) and provided by all health systems (including the Veteran's Administration).
- Adequately funded.

Services shall include but not be limited to:

- Comprehensive diagnostic assessments of psychiatric, substance use, and physical health, taking into consideration the impacts of psychosocial factors (such as homelessness, poverty, trauma, gender, and sexual orientation).
- Comprehensive plans of care and treatment based upon comprehensive and timely assessments.
- Follow-up assessments of sufficient frequency and duration.
- 24-hour emergency assessment and care, inpatient care, transitional care, respite care, clinic-based outpatient care, and therapeutic day care.
- Proactive crisis prevention with prompt and appropriate crisis intervention and stabilization, available and accessible at all times.
- Integrated psychiatric and substance use disorder care and treatment.
- Evidence based treatments (such as Assertive Community Treatment, supported employment, peer support, ECT, and DBT).
- Access to a comprehensive formulary of psychotropic medications.
- Comprehensive case management and functional support services.
- Support for education, socialization, and rehabilitation.
- Home-based, school-based, and community-based programs.
- Prevention and early recognition and intervention programs.
- Engagement of family and other primary supports, including the financial, social, and behavioral health resources to do so.
- Full spectrum housing from structured residential care to independent living.
- Full spectrum employment from supported employment to long-term, independent, and sustainable employment.
- Benefits counseling and coordination including assistance to the uninsured and underinsured.
- Review of social security eligibility to better reflect disability and to foster transition to sustainable employment.

2. **Coordinating and integrating medical and psychiatric care.**

   Care and treatment shall be coordinated with primary care providers to alleviate the burden of medical illness, so the life spans of persons with serious mental illness will not be compromised or shortened because of inadequate or inadequately integrated services. Coordination shall include comprehensive care management services.

3. **Ensuring interagency coordination of federal, state, and local: human service, health, and criminal justice agencies.**

   An individual's transition between levels, locations, and jurisdictions of care and treatment shall be seamless. Funding shall follow individuals through transitions.

4. **Enhancing education and training at every level of potential intervention.**

Elements shall include but not be limited to:

- Family engagement and participation in education.
- Peer support knowledge and skill development.
- Educational opportunities for students and trainees in all relevant fields.
- Interdisciplinary and cross-discipline training.
- Medical student and resident training in primary care, specialty care, and emergency care.
- Reaching out to community partners and other interested stakeholders.
- Opportunities for academic career development.
- Partnerships of state health authorities, medical schools, and academic medical centers.
- Training of psychiatric residents and early career psychiatrists regarding administrative and leadership roles in the public/community sector.
- Availability and accessibility of adequately trained and supervised psychiatrists and other practitioners, at all levels of education and training, to meet clinical and social service needs.

5. **Increasing research about serious mental illness and the individuals it affects.**

   Research shall include epidemiology, etiologies, treatments, comorbidities, prevention, outcomes, interdisciplinary management, and service delivery.

6. **Eliminating discrimination against persons with serious mental illness by informing the public, elected leaders, and community leaders that any individual with serious mental illness may be meaningfully integrated into their community**.

   Individuals with serious mental illness, family members, professionals, paraprofessionals, and interested others shall inform the public, elected leaders, and community leaders about what must be done to overcome the discrimination, stigma, and obstacles of meaningful community acceptance and integration of persons with serious mental illness.

Authors: Laurence Miller, MD, Isabel Norian, MD (Primary), APA Assembly Committee on Public and Community Psychiatry, in consultation with the APA BOT Workgroup on Healthcare Reform, American Association of Community Psychiatrists, and the Council on Healthcare Systems and Financing and its Workgroup on Integrated Care.

Adoption Date: July 2016

Position Statement on Psychotherapy as an Essential Skill of Psychiatrists

Retained by the Board of Trustees, December 2015
Approved by the Board of Trustees July 2014
Retained by the Assembly, November 2015
Approved by the Assembly, May 2014

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Issue

Psychiatrists are uniquely positioned to provide comprehensive, integrated treatment either by providing medication alone, psychotherapy alone, or combined treatment. Importantly, psychotherapy and prescribing medication flourish on the same foundation—confidentiality, trust, and active patient participation—which readily allows psychiatrists to change or add treatment modalities e.g., switch from psychotherapy to medications or add medication to psychotherapy, while keeping a clear focus on the complex interplay of patient, practitioner, pharmacotherapy, and psychotherapy. Even when a psychiatrist provides "only" medication, psychotherapeutic elements in the therapeutic alliance enhance the effectiveness of any medication. Indeed, although cost per session is higher for psychiatrists, integrated psychiatric care (as compared to split treatment by a psychiatrist and non-MD therapist) may lead to lower total costs and decreased patient suffering.

Position Statement

The APA advocates for psychotherapy to remain a central treatment option for all patients and for psychotherapy (alone or as part of combined treatment) by psychiatrists to be reimbursed by payers in a manner that integrates care and does not provide financial incentives for isolating biological treatments from psychosocial interventions, e.g., isolated use of medication management without consideration of psychosocial issues requiring essential psychotherapy. The APA supports the Accreditation Council for Graduate Medical Education (ACGME)/ Residency Review Committee (RRC) in their continued accreditation requirement that psychiatry resident training programs provide comprehensive training in evidence-based psychotherapies, as well as in collaborative treatment models. It collaborates with AADPRT and AACDP to address the increasing difficulty programs face in supporting the time and money required for teaching and supervising psychotherapy.

Authors: Mantosh Dewan, M.D., Michele T. Pato, M.D., Nicole Del Castillo, M.D. (Council on Research and Quality Care)

APA Official Actions

Position Statement on Involuntary Outpatient Commitment and Related Programs of Assisted Outpatient Treatment[1]

Approved by the Board of Trustees, December 2015
Approved by the Assembly, November 2015

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APA Position:
The American Psychiatric Association recognizes that there is a substantial population of persons with severe mental illness whose complex treatment and human service needs go unmet by community mental health programs. For many persons so affected, their course is frequently complicated by non-adherence with treatment and as a result, they frequently relapse, are hospitalized or incarcerated. They also interact with a variety of human service agencies— substance use disorder treatment programs, civil and criminal courts, police, jails and prisons, emergency medical facilities, social welfare agencies, and public housing authorities. The pressing need to improve treatment adherence and patient outcomes, has led policymakers to consider court-ordered treatment as a way to improve treatment adherence. In this document the term 'involuntary outpatient commitment' is used to refer to outpatient treatment mandated under state involuntary commitment statutes.

Involuntary outpatient commitment is a civil court procedure wherein a judge orders a person with severe mental illness to adhere to an outpatient treatment plan designed to prevent relapse and dangerous deterioration. Persons appropriate for this intervention are those who need ongoing psychiatric care owing to severe illness but who are unable or unwilling to engage in ongoing, voluntary, outpatient care. It can be used on release from involuntary hospitalization, an alternative to involuntary hospitalization or as a preventive treatment for those who do not currently meet criteria for involuntary hospitalization. It should be used in each of these instances for patients who need treatment to prevent relapse or behaviors that are dangerous to self or others.

Involuntary outpatient commitment programs have demonstrated their effectiveness when *systematically implemented*, *linked to intensive outpatient services* and *prescribed for extended periods of time*. Based on empirical findings and on accumulating clinical experience, involuntary outpatient commitment can be a useful tool in the effort to treat patients with severe mental illness with clinical histories of relapse and re-hospitalization. It is important to emphasize, however, that all programs of involuntary outpatient commitment must include these elements of well-planned and executed implementation, intensive, individualized services and sustained periods of outpatient commitment to be effective. There is also clear evidence that involuntary outpatient commitment programs help focus the attention and effort of the providers on the treatment needs of the patients subject to involuntary outpatient commitment.

Involuntary outpatient treatment raises an ethical tension between the principles of autonomy and beneficence. Therefore states should make every effort to dedicate resources to voluntary outpatient treatment and only if such treatment fails resort to involuntary treatment. Psychiatrists must be aware of the conflict between the patient's interest in self-determination and promotion of the patient's medical best interest. In any system of treatment, including involuntary

[1] Outpatient court-ordered treatment may be referred to as 'assisted outpatient treatment', 'involuntary outpatient commitment', 'mandated community treatment', or 'community treatment orders'. Some regard the term 'assisted outpatient treatment' as a euphemistic term for treatment under coercion. In this document the term 'involuntary outpatient commitment' is used to refer to these programs.

outpatient treatment, principles of non-maleficence—doing no harm—and justice must be considered. Involuntary treatment, like any intervention, must not be discriminatory, and must be fairly applied and respectful of all persons.

The APA supports the following positions and principles regarding involuntary outpatient commitment.

1. Involuntary outpatient commitment, if systematically implemented and resourced, can be a useful tool to promote recovery through a program of intensive outpatient services designed to improve treatment adherence, reduce relapse and re-hospitalization, and decrease the likelihood of dangerous behavior or severe deterioration among a sub-population of patients with severe mental illness.

2. The goal of involuntary outpatient commitment is to mobilize appropriate treatment resources, enhance their effectiveness and improve an individual's adherence to the treatment plan. Involuntary outpatient commitment should not be considered as a primary tool to prevent acts of violence.

3. Involuntary outpatient commitment should be available in a preventive form and should not be exclusively reserved for patients who meet the criteria for involuntary hospitalization. The preventive form should be available to help prevent relapse or deterioration for patients who currently may not be dangerous to themselves or others (and therefore are not committable to inpatient treatment) but whose relapse would likely lead to severe deterioration and/or dangerousness.

4. Assessment of the likelihood of relapse, deterioration, and/or future dangerousness to self or others should be based on a clearly delineated clinical history of such episodes in the past several years based on available clinical information.

5. Involuntary outpatient commitment should be available to assist patients who, as a result of their mental illness, are unlikely to seek or voluntarily adhere to needed treatment.

6. Studies have shown that involuntary outpatient commitment is most effective when it includes a range of medication management and psychosocial services equivalent in intensity to those provided in assertive community treatment or intensive case management programs. States adopting involuntary outpatient commitment statutes should assure that adequate resources are available to provide such intensive treatment to those under commitment.

7. States authorizing involuntary outpatient commitment should provide due process protections equivalent to those afforded patients subject to involuntary hospitalization.

8. Data have shown that involuntary outpatient commitment is likely to be most successful when it is provided for a sustained period of time. Statutes authorizing involuntary outpatient commitment should consider authorizing initial commitment periods of 180 days, permitting extensions of the commitment period based on specified criteria to be demonstrated at regularly scheduled hearings. Based on clinical judgement, such orders may be terminated prior to the end of a commitment period as deemed appropriate.

9. A thorough psychiatric and physical examination should be a required component of involuntary outpatient commitment, because many patients needing mandated psychiatric treatment also suffer from other medical illnesses and substance use disorders that may be causally related to their symptoms and may impede recovery. Clinical judgment should be employed in determining when, where and how these examinations are carried out.

10. Clinicians who are expected to provide the court-ordered treatment must be involved in decision-making processes to assure that they are able and willing to execute the proposed treatment plan. Before treatment is ordered, the court should be satisfied that the recommended course of treatment is available through the proposed providers.

11. Efforts to engage patients and, where appropriate, their families in treatment should be a cornerstone of treatment, even though court-ordered. Patients and their families should be consulted about their treatment preferences and should be provided with a copy of the involuntary outpatient commitment plan, so that they will be aware of the conditions to which

the patient will be expected to adhere.

12. Involuntary outpatient commitment statutes should contain specific procedures to be followed in the event of patient non-adherence and should ensure maximum efforts to engage patients in adhering to treatment plans. In the event of treatment non-adherence, provisions to assist with adherence may include empowering law enforcement officers to assume custody of non-adherent patients to bring them to the treatment facility for evaluation. In all cases there should be specific provisions for a court hearing when providers recommend involuntary hospitalization or a substantial change in the court order.

13. Psychotropic medication is an essential part of treatment for most patients under involuntary outpatient commitment. The expectation that a patient take such medication should be clearly stated in the patient's treatment plan when medication is indicated. However, involuntary administration of medication should not be authorized as part of the involuntary commitment order without separate review and approval consistent with the state's process for authorizing involuntary administration of medication on an outpatient basis.

14. Implementation of a program of involuntary outpatient commitment requires critical clinical and administrative resources and accountability. These include administrative oversight of and accountability for involuntary outpatient commitment program operations, the ability to monitor patient and provider adherence with treatment plans, the ability to track involuntary outpatient commitment orders and to report program outcomes.

15. There is limited research to evaluate the possible disproportionate use of involuntary outpatient commitment among minority and disenfranchised groups. As a result, independent evaluation of involuntary outpatient commitment programs should be conducted at regular intervals and reported for public comment and legislative review, especially in view of concerns about its appropriate use. Among several outcomes that should be assessed is any evidence of disproportionate use of involuntary outpatient commitment among minority groups and disenfranchised groups, inadequate due process protections and the diversion of clinical resources from patients seeking treatment voluntarily. Any indications of findings in these areas should be followed by program improvement plans and corrective action.

Position Statement on Psychiatric Hospitalization of Children and Adolescents

Approved by the Board of Trustees, July 2016
Approved by the Assembly, May 2016

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Issue:

In America today, many children and adolescents who suffer from mental health and behavioral disorders are not able to access appropriate mental health care due to the nationwide shortage of inpatient mental health services for their age group. Inpatient psychiatric hospitalization is often necessary to evaluate, acutely stabilize, treat and transition children and adolescent patients who present to emergency facilities in crisis. The CDC approximates that, each year, approximately one in five children in the United States experiences a seriously debilitating mental illness described as "serious deviations from expected cognitive, social, and emotional development". It is estimated that up to 12 million children in the U.S. under the age of 18 suffer from mental illnesses that include depression, anxiety, PTSD, mood disturbances, eating disorders, substance use, psychosis and suicidal ideation.

The nationwide shortage of inpatient mental health services for children and adolescents can be attributed to several factors including the overall decrease in psychiatric hospitals and long-term facilities from the 1960s to the present. Ninety five percent of public psychiatry beds available in 1955 were no longer available as of 2005. Currently, the majority of states in America have less than half the number of public psychiatry beds needed to serve community mental health needs due to the continued closing of inpatient units triggered by cost cutting measures by hospital systems. As a result, children and adolescents are often kept for long periods of time in Emergency Departments awaiting placement for long term or inpatient care. If an inpatient bed is found, these individuals may be sent to distant hospitals making it difficult for parents and families to visit, provide support and participate in the treatment process. More often, due to lack of facilities, children and adolescents are sent home with their families to wait for outpatient follow up. It is estimated that only 21% of children and adolescents receive care for their symptoms due to the lack of appropriate mental health facilities, and waittimes often range from three months up to one year for assessment and treatment. Without appropriate inpatient psychiatric hospitals and adequate treatment facilities, many children and families do not receive appropriate intervention and treatment and are left to suffer from untreated andunder-treated mental illness.

The consequence of untreated mental health illness in children and adolescents can be devastating for patients and their families. More adolescents die by suicide than all other natural causes combined. According to The Academy of Child and Adolescent Psychiatry, approximately 50% of students aged 14 and older with mental illness drop out of high school—the highest dropout rate of any disability group. 70% of youth in state and local juvenile justice systems have mental illness, with at

least 20% experiencing severe symptoms. These youth are often diverted into the juvenile justice system for treatment and management of their mental illnesses due to a lack of alternative mental health care options which, consequently, can have numerous negative repercussions including worsening of mental illness and recurrent or long-term incarceration. These statistics attest to the importance of early intervention and treatment for all children and adolescents with mental illness symptoms. With additional inpatient and hospital-based resources, providers will be able to reduce the long-term sequelae of untreated mental health in the juvenile population.

POSITION:

It is the position of The American Psychiatric Association to:

1) Advocate for the development of a full spectrum of appropriate, financially affordable, inpatient facilities and services for the diagnosis and treatment of children and adolescent in need of psychiatric care in the United States. These facilities are to include both psychiatric and general medical hospitals. Efforts should be focused on both increasing current inpatient services and also minimizing the current trend of closing existing units due to financial reasons.
2) Emphasize that the health of children and adolescents will be best served if primary treatment decisions such as admissions, medications, psychotherapy and appropriate disposition planning are the responsibility of a psychiatrist specialized in child and adolescent psychiatry whenever available.
3) Emphasize that, when possible, inpatient psychiatric hospitalization of children and adolescents should be provided close to their homes, so that their families may be included and participate during the treatment process.
4) Work to provide parity in mental health treatment for all age groups by increasing mental health resources for children and adolescents and subsequently providing opportunities for early treatment and intervention to benefit young patients suffering from mental illness.
5) Work to educate the public and health care community that inpatient psychiatric care is necessary and justified when psychiatric illness severely affects a young person's safety or ability to function.
6) Address the shortage in Child and Adolescent Psychiatrists by recruiting psychiatrists-in-training and early career psychiatrists into specialized training.

AUTHORS:

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Position Statement on Identification of Abuse and Misuse of Psychiatry

Approved by the Board of Trustees, December 1998

"Policy documents are approved by the APA Assembly and Board of Trustees…These are…position statements that define APA official policy on specific subjects…" – *APA Operations Manual*.

Background

In May, 1994 the APA approved the following position statement developed by the Committee on Abuse and Misuse in Psychiatry in the U.S.:

> "The American Psychiatric Association supports the use of psychiatric knowledge, practice and institutions only for purposes consistent with ethical evaluation and treatment, research, consultation, and education. Abuse and misuse of psychiatry occur when psychiatric knowledge, assessment, or practice is used to further illegitimate organizational, social, or political objectives." (Amer J Psych 151:1399 (1994))

Abuse and misuse of psychiatry may occur when psychiatry is used to advance organizational purposes or the purposes of a system and not for the benefit of the patient. There may be overlap between abuse and misuse of psychiatry and ethical considerations, but there are broader concerns as well.

Psychiatrists function in their work with patients within a social, cultural and political milieu. Situations will inevitably arise in which there is tension among the interests of the individual patient, the interests of the psychiatrist, and the interest of the systems in which psychiatrists do their work. Sensitivity to what is in the best interests of the patient and how the patient's interests are affected by these forces must be understood and considered. Also, we need to be aware of how the psychiatrist and psychiatry are influenced by these external forces.

The Committee on Abuse and Misuse of Psychiatry in the U.S. and the Committee on International Abuse of Psychiatry and Psychiatrists are charged with reviewing allegations of abuse and misuse and fulfilling an educational function. In an attempt to develop guidelines by which the Committees will pursue allegations, and to develop a better consensus within the APA as to what constitutes abuse and misuse of psychiatry, the following principles are presented in keeping with medical ethics (*The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry*):

The Principles

1. The use of psychiatric knowledge, practice and institutions is only for purposes consistent with ethical evaluation and treatment, research, consultation, and education. Abuse and misuse of psychiatry occur when psychiatric knowledge, assessment, or practice is used to further morally illegitimate organizational, social, or political objectives.
2. It is psychiatrists' primary responsibility to use their clinical skills and knowledge for the benefit of their patients. External social, political, management and economic forces should not be the primary consideration.
3. Psychiatrists shall not allow their professional opinions to be inappropriately influenced by illegitimate outside factors. It is essential for psychiatrists to consider biopsychosocial factors in their assessment of patients.
4. In certain situations (e.g. forensic evaluations, disability evaluations) the primary responsibility of a psychiatrist may not be for the benefit of the evaluee per se. The evaluee must be informed of the purpose of the evaluation or service, and any lack of confidentiality, as well as the reality that the psychiatrist may not know how the information will be used. This information may require repetition. The responsibility to provide clinically sound and scientifically based consultation is still the case.
5. Psychiatrists shall always be mindful of patients' rights. In their role of treating psychiatrist, they should resist and attempt to counteract forces interfering with patient-focused, humane treatment. A psychiatrist should not be a participant in a legally authorized execution. Psychiatrists shall not detain or incarcerate persons for political reasons, use medical knowledge for interrogation, persuasion or torture, or provide unsubstantiated diagnoses for use against political dissidents, whistleblowers or others.
6. It is the psychiatrist's responsibility when working in the context of an organization or social or political environment to advocate for the mental health needs of the community or population in which he/she is working.
7. Since confidentiality is critical to patient care, psychiatrists must be sure the information and/or records they provide are sensitive to the mental health interests of the persons and/or populations with whom they are working. It is important to release the least amount of information possible to accomplish the desired function.
8. All psychiatrists are encouraged to speak to egregious issues which adversely affect them and/or the mentally ill, and to bring forward perceived misuses of their function or role as psychiatrist for review by the Committee on Abuse and Misuse of Psychiatry in the U.S. and the Committee on International Abuse of Psychiatry and Psychiatrists.

Position Statement on Human Rights

Approved by the Board of Trustees, December 1992

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The American Psychiatric Association is concerned about the psychiatric consequences of human rights violations—violations such as unjust incarceration and cruel or unusual punishment, including terror and torture. The World Psychiatric Association goals include: to educate psychiatrists and other professionals about human rights abuses and the persecution of physicians who speak out against their governments; to encourage psychiatrists to use all their efforts against the use of torture and for the rehabilitation of torture victims; to promote research on the effects of human rights violations; and to prevent human rights violations.