Protecting Youth in the Mental Health Service Settings

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Abstract

The authors present the development of the field of psychiatry with the evolution of patient safeguards. They address the recent publicized events involving sexual harassment and abuse perpetrated by mental health service providers who have harmed youth who were under their direct psychiatric care. Recommendations are provided for primary care physicians and parents and legal guardians to further ensure patient safety.

Keywords

Adolescents, boundaries, children, mental health, patient safety, professional standards, resources

Abbreviations

APA = American Psychiatric Association
CWS = Child Welfare Services
PCP = primary care physician
RICO = Regulated Industries Complaints Office
YRBS = Youth Risk Behavior Survey

Introduction

The issues of sexual harassment and sexual abuse have become very prominent in social media and the popular press. Professions and institutions that were trusted and revered in the past have been shown to be complicit to varying degrees. Practitioners working with children and adolescents have not been immune, including those working in the fields of education and mental health. For example, school officials, teachers, and mental health practitioners have crossed ethical, professional, and legal boundaries. In the case of physicians, they take the Hippocratic Oath, which explicitly prohibits such conduct: "In every house where I come I will enter only for the good of my patients, keeping myself far from all intentional ill-doing and all seduction, and especially from the pleasures of love with women or with men …"[1]

When instances of sexual misconduct have occurred, children and youth have been significantly harmed, and people are then, rightfully, less likely to trust and seek out help from practitioners in these professions. Not seeking professional help for mental health services would be very unfortunate given the already underserved children and adolescents who have mental health needs, the proven effectiveness of evidence-based mental health interventions, and the current reasonable safeguards already in place and courses of action that can be taken.

Within this context, this article addresses the issue of mental health practitioners who work with children and adolescents, with particular focus on child and adolescent psychiatry. This study first delineates the progress of patient safety, particularly as this applies to the mental health field, summarizes current needs and concerns, and finally highlights future directions to safeguard patients.

Historical Perspective

To understand what current safeguards are present in child-adolescent psychiatry, one has to review the developmental stages of general and child-adolescent psychiatry. In 1946, The National Mental Health Act was passed, resulting in the establishment of the National Institute of Mental Health—a new federal agency to sponsor research and training in psychiatry to encourage the development of improved mental health care methods. This act made mental health care a federal priority. It was inspired by alarm at the poor mental health of some draftees and veterans and was demanded by veterans and their families. This amendment to the Public Health Service Act provided for research relating to psychiatric disorders and the development of more effective methods of prevention, diagnosis, and treatment of such disorders, and for other purposes.[2]

In 1955, the Joint Commission of Mental Illness and Health was created to seek ways to increase support of mental health services, training, and research; evaluate the role of hospitalization in patient treatment; and promote mental health.[3] In 1961, this Joint Commission submitted a report, *Action for Mental Health*, advocating a shift of care away from the institutional, or "paternalistic" care model to a community-based mental healthcare model.[4]

Subsequently, legislation from the administration of President John F. Kennedy, the Community Mental Health Act, also known as the Mental Retardation and Community Mental Health Centers Construction Act of 1963, was passed by the United States (US) Congress. This act mandated the appointment of a commission to make recommendations for "combating mental illness in the United States."[5] A growing body of evidence at that time demonstrated that mental illnesses could be treated more effectively and in a more cost-effective manner in community settings than in traditional psychiatric hospitals. It was the beginning of the shift away from the "paternalistic" patient-physician relationship to a "patient-centered" relationship. The "paternalistic" relationship had the physician as sole decision-

maker for the patient's care with the belief that the physician was the only one who could make choices of interventions that best promoted the patient's health and well-being. The physician used his or her knowledge and skills to determine the patient's medical condition and stage of disease process and identified the medical tests and treatments most likely to restore the patient's health or relieve discomfort.[6] In contrast, the "patient-centered" relationship provides care that is respectful of, and responsive to, individual patient preferences, needs, and values, and ensures that patient values guide all clinical decisions.[7]

The 1969 National Joint Commission on the Mental Health of Children found that millions of children and youth were not receiving needed mental health services.[8] Many of the children who were served received inappropriate, unnecessarily restrictive care, often in state mental hospitals. Then, in 1978, under President Jimmy Carter, the President's Commission on Mental Health echoed the Joint Commission's conclusions, finding that few communities provided the volume or continuum of programs necessary to meet children's mental health needs.[9] Both Commissions recommended that an integrated network of services be developed in communities to meet the needs of severely emotionally disturbed children and youth.

Progress

The US Congress appropriated funds in 1984 for the Child and Adolescent Service System Program. This endeavor envisioned a comprehensive mental health system of care for children, adolescents, and their families. Since 1985, the mental health field has shifted from viewing parents as the cause of their child's issues to active participants in treatment, policy development, and system-reform efforts. Overall, research demonstrated that better outcomes are achieved when family members and youth have meaningful roles in their treatment.[10]

In 1991, Trupin, et al, found that children with behavioral health conditions were in need of a variety of mental health services.[11] Significant differences in the needs of boys versus girls, and of different-aged children, were present and had serious implications for service system development. Thus, families and surrogate families of children with behavioral health conditions should be full participants in all aspects of the planning and delivery of services.[12] The system-of-care concept was the foundation of the Federal Comprehensive Community Mental Health Services for Children and Their Families Program, also referred to as "the Federal children's mental health initiative." Since 1992, this program provided more than $1 billion in resources to build systems of care nationwide under the auspices of the Substance Abuse and Mental Health Services Administration within the Center for Mental Health Services.[13] One expectation from the establishment of this program was heightened awareness of the concepts of boundaries, boundary crossings, and boundary violations would improve patient care and contribute to effective risk management.[14] Since the early 1990s, this change in approach to pediatric mental health care, has demonstrated significant benefits as evidenced by improvements in systems and in the social and emotional functioning of children, youth, and families. The updated concept and philosophy were intended to assist the field to continue this progress to improve the lives of children and families.[15]

In 2001, with awareness of the high mortality rates (eg, up to 98 000 deaths per year among US hospitalizations) associated with preventable medical errors, the Institute of Medicine recommended 6 aims to improve the quality of a health care system, namely making it safe, timely, effective, efficient, equitable, and patient-centered.[16] This report was initiated in the same year that the American Psychiatric Association (APA) appointed a group of prominent members to create the APA Task Force on Patient Safety. This task force developed recommendations for psychiatric residency programs to include patient safety in the curriculum. These recommendations were in response to issues at the time in which graduates of these programs gained extensive experience in various psychiatry subspecialties but were often naïve to patient safety and the quality of care rendered through improved systems of care.[17]

Contemporary Child-Adolescent Psychiatry

Current Mechanisms to Reduce Patient Harm and Optimize Safety in Psychiatry

The mere fact that patients have been harmed by boundary transgressions indicates that, like all other medical specialties, psychiatry must optimize its processes to ensure patient safety, quality of care, and public accountability. Certain specialties have been leaders in this regard and may serve as role models. Anesthesiology was the first medical discipline to advance internal safety standards. At the turn of the 20th century, there was an international controversy over the precise dosing and delivery of chloroform. For the next 50 years, anesthesiologists witnessed a disproportionate number of patient deaths despite a growing body of knowledge in the field. As international research began to accrue in the area, it became evident that inconsistent and poor data were inadequate to explain widely divergent mortality rates.[18] In 1985, the Anesthesia Patient Safety Foundation was launched. With its momentum and influence, it served as a model for cutting-edge, cost-effective patient safety and clinical-culture research, design, and simulation. Anesthesiology adopted safeguards that involved national standards, monitoring, transparency, patient-centered focus, intradisciplinary teamwork, and inter-team member accountability.[19]

While psychiatry is different in many respects from anesthesiology, the latter being a more procedurally oriented specialty, the 2 specialties are similar in that they both take care of potentially vulnerable patients; that is, patients whose judgment may be affected by distress or other cognitive or developmental conditions, or patients who are not fully awake and who are

dependent on others for life-sustaining functions. It is hypothesized that, in contemporary practice, there are safeguards that contemporary psychiatric practices have already adopted or are working to adopt that reduce the risk of patient harm. Some of these safeguards are fundamental, similar to the way that certain safeguards in anesthesiology (eg, routine monitoring of oxygen saturation and end-tidal carbon dioxide, engineering of gas delivery equipment to prevent the patient from receiving any oxygen concentrations lower than ambient air, etc) are fundamental to significantly decrease the likelihood of patient harm. Several of these safeguards are also imperative in administrative processes. Most importantly, all patients or their guardians must provide formalized consent to evaluation and treatment, both in the initial assessment and whenever there is a meaningful change in treatment plan. It should be noted that psychotherapy, like medications or any other medical procedure, also needs to be carefully defined in terms of what it entails and its risks and benefits to patients and families.

Patient safety is also improved with greater involvement of the family. With an increasingly robust evidence base for the effectiveness of family- and systems-based treatments, it is no longer acceptable to conduct private individual sessions where none of the patient's family is in the room or otherwise readily available. Federal and state laws have more explicitly defined and improved our understanding of privacy, such that there is clearer permission for communication with guardians of minors, "circle-of-care" providers, and others directly involved in patient care. Further, psychiatry has evolved to embrace a more team-based approach. With collaborative care, there are checks and balances among the different specialties who communicate with one another, and opportunities for patients to speak with more than 1 person should there be concern about their current health care provider. The APA and the American Academy for Child and Adolescent Psychiatry have each published codes of ethics that are required readings during training and that help to more clearly define acceptable and unacceptable clinical practices for all providers.

As psychiatry becomes more integrated within large health care organizations, which in turn, are accountable to health care consumers and other stakeholders, there is higher value placed on patient-family feedback and satisfaction. Clinical processes have, therefore, evolved to include regular opportunities, often during a portion of the session, to receive feedback from patients and guardians.

Current Mental Health Needs

The current mental health needs of children and adolescents are substantial. Obtaining mental health care for children worsened in 2004 when the US Food and Drug Administration issued a warning on antidepressants, indicating they were associated with an increased risk of suicidal thinking, feeling, and behavior in young people. This warning negatively affected pediatric patients diagnosed with depression because it discouraged parents from seeking mental health care for their children and discouraged physicians who were not psychiatrists from prescribing antidepressants when these medications were clinically indicated.[20,21]

By 2005, a comprehensive, simultaneous, and integrated approach was needed to achieve real progress in children's mental health.[22] Data collected from the Youth Risk Behavior Survey (YRBS) helped defined the mental health needs of children and adolescents. The YRBS was created in the early 1990s to monitor the leading causes of death among youth and premature death in adults and progress towards protecting youth from human immunodeficiency virus (HIV) infection. Currently, the YRBS is a biennial survey of US adolescents that measures the prevalence of multiple health risk and health protective behaviors, such as smoking, drinking, drug use, diet, and physical activity. One measure of depressive symptoms from the YRBS assesses feeling of sadness and hopelessness in the question, "[Have you] felt sad or hopeless almost every day for 2 or more weeks in a row so that they stopped doing some usual activities during the 12 months before the survey." Thirty percent of our local and national youth endorsed serious depressive symptoms.[23] Additionally, YRBS data showed that 16% seriously considered attempting suicide during the past 12 months.[23] Another study, the National Survey on Drug Use and Health (2013-2014), found 9% of youth reported at least 1 episode of major depression.[24] These findings help established a baseline for the pervasive mental health needs of youth.

Current Concerns and Remedies Regarding Boundary Issues

All physicians should practice in accordance with the medical code of ethics set forth in the Principles of Medical Ethics of the American Medical Association. In brief, it states, "A physician shall… report physicians deficient in character or competence, or engaging in fraud or deception, to appropriate entities."[25] The APA incorporated many of the AMA's principles. It states, "When a person with personal knowledge believes an APA member may have violated these ethical principles, they may file a complaint with the APA District Branch to which the member belongs. Complaints are handled in accordance with APA's procedural code by the District Branch's ethics committee. Appeals from District Branch decisions are made to the APA Ethics Committee." In Hawai'i, the APA District Branch is located as part of Hawai'i Psychiatric Medical Association. In the same office is the Hawai'i Medical Association District Branch, which also receives reports of concerns or complaints. Table 1 provides recommendations for primary care physicians and parents and guardians. Primary care physicians should encourage parents and guardians who fear that their child's safety has been or is endangered by a psychiatrist to call 911 and to contact the state's Regulated Industries Complaints Office (RICO). Most people are not aware of RICO's function to investigate and prosecute possible licensing law violations by Hawai'i licensees. RICO also works to protect consumers from unscrupulous and unqualified individuals by investigating and prosecuting unlicensed activity.

Table 1. Recommendations for the Primary Care Physician (PCP) and Parents and Guardians of Your Patients
For PCPs:
1. Solicit from your colleagues a list of tried and trusted therapists
2. Professionally get to know the psychotherapists to whom your patients are referred
3. Ask for feedback from your patients and parents/guardians about their experience with the therapist
4. Concerns or complaints of a psychiatrist: Hawai'i Psychiatric Medical Association, 1360 S. Beretania St., Suite 200, Honolulu, Hawai'i 96814; Phone: (808) 536-7705; Email: office@hawaiipsychiatry.org Hawai'i Medical Association, 1360 S. Beretania St., Suite 200, Honolulu, Hawai'i 96814; Phone: (808) 536-7705; Email: office@hawaiimedicalassociation.org Regulated Industries Complaints Office (RICO) of the State of Hawai'i ; Phone: (808) 587-4272; Website: http://cca.hawaii.gov/rico/
For parents and guardians:
When faced with your child's need to be seen by a therapist, the following are recommendations to ensure your child's protection:
1. Ask for a referral from your child's PCP, if not already done
2. Use "When to Seek Help for Your Child" at "Facts-For-Families" by the American Academy of Child and Adolescent Psychiatry (www.aacap.org.)
3. Find references about the referred therapist from: • Hawai'i Psychiatric Medical Association's Psychiatrist Finder (www.hawaiipsychiatry.org) • American Academy of Child and Adolescent Psychiatry's Child and Adolescent Psychiatrist Finder (www.aacap.org) • Hawai'i Psychological Association Find a Psychologist (www.hawaiipsychology.org) • Psychology Today Find a Therapist (www.psychologytoday.com) • Hawai'i's Therapy Directory (www.hawaiitherapist.com) • Parents/Guardians' Health Insurance Plans Websites
4. Once an appointment is set, expect and ensure the following: • At least 1 or more parent(s)/guardian(s) is/are involved with the initial evaluation and ongoing therapy. • Be involved at the beginning and end of every session to ensure communication of the proposed treatment plan, safeguard your child's protection and comfort, and monitor the progress of your child's condition with the therapist.
5. When parents and guardians have founded fears that their child's safety is endangered by a psychiatrist, support him or her with the following: • Call 911 • Call the child's PCP • Contact RICO Complaint History Search of the State of Hawai'i of the Department of Commerce and Consumer Affairs at (808) 587-4272 or www.cca.hawaii.gov/rico

For parents and guardians, when to seek help may be a difficult decision. However, they are usually the first to recognize that their child has a problem with emotions or behaviors (Table 2). The first step is to try to gently talk to the child. An honest and open talk about feelings can often help. They may choose to check with the child's physicians, teachers, members of the clergy, or other adults who know the child well. These steps may resolve the problems for the child and family. If the problems are not resolved, then there are sources available to find help (Table 3). If difficulty arises in finding a therapist, there are steps to work with the health insurer (Figure 1). For families that do not have health insurance, parents and guardians may contact their nearest Family Guidance Center, which is sponsored by the Child and Adolescent Mental Health Division of the Hawai'i State Department of Health. Table 3 provides a list of Family Guidance Centers by island and region.[26]

Child Abuse or Neglect Reporting

Any mandated reporter who has reason to believe that child abuse or neglect will occur in the reasonably foreseeable future, must immediately report the matter to Child Welfare Services (CWS) or to their local police department.[27] CWS is a social service provided to children and their families when children are reported to have been harmed, or are at risk of being harmed. Child Protective Service is 1 of several child welfare programs in the Social Services Division of the Hawai'i Department of Human Services. Local CWS offices created a guide for potential reporters that offers important information about key aspects of child abuse or neglect reporting, including what legally defines child abuse or neglect, who is mandated to report, when to report, how to report, and what pertinent information should be sent to the designated CWS office. It also encourages the potential reporter to discuss questionable cases to decide whether or not a case should be referred.[28] For example, reporters who suspect Munchausen syndrome by proxy,[29] a type of medical child abuse, should contact CWS for consultation.

Future Directions to Safeguard Patients

Along with psychiatry's adoption of processes to optimize safety, quality, and accountability, other efforts to improve public awareness of sexual boundary crossings and to improve the culture of children's safety must continue. It remains very important to educate all children, starting at an early age, about safe and unsafe touching, and the need to always tell parents and guardians, regardless of what they might be told to the contrary, should anyone be engaging in unsafe touching. This type of education should include role-play scenarios involving ostensibly benevolent people like physicians and counselors and should include a discussion on how to respond assertively to threats not to tell anyone. All professionals who work with

Table 2. Signs That a Child and Adolescent Psychiatric Evaluation Would Be Useful[a,b]
Preschool and Elementary School Children
• Marked fall in school performance
• Poor grades in school despite trying very hard
• Severe worry or anxiety, as shown by regular refusal to go to school, go to sleep or take part in activities that are normal for the child's age
• Frequent physical complaints
• Hyperactivity, fidgeting, constant movement beyond regular playing with or without difficulty paying attention
• Persistent nightmares
• Persistent disobedience or aggression (longer than 6 months) and provocative opposition to authority figures
• Frequent, unexplainable temper tantrums
• Threats to harm or kill oneself
Middle School and High School Children
• Marked decline in school performance
• Inability to cope with problems and daily activities
• Marked changes in sleeping and/or eating habits
• Extreme difficulties in concentrating that get in the way at school or at home
• Sexual acting out
• Depression shown by sustained, prolonged negative mood and attitude, often accompanied by poor appetite, difficulty sleeping or thoughts of death
• Severe mood swings
• Strong worries or anxieties that get in the way of daily life, such as at school or socializing
• Repeated use of alcohol and/or drugs
• Intense fear of becoming obese with no relationship to actual body weight, excessive dieting, throwing up or using laxatives to lose weight
• Persistent nightmares
• Threats of self-harm or harm to others
• Self-injury or self-destructive behavior
• Frequent outbursts of anger, aggression
• Repeated threats to run away
• Aggressive or non-aggressive consistent violation of rights of others; opposition to authority, truancy, thefts, or vandalism
• Strange thoughts, beliefs, feelings, or unusual behaviors

[a] If problems persist over an extended period of time or if others involved in the child's life are concerned, consider speaking with or seeking a consultation with a child and adolescent psychiatrist or a trained mental health professional.
[b] American Academy of Child and Adolescent Psychiatry, "When to Seek Help for Your Child" at "Facts-For-Families". https://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/When-To-Seek-Help-For-Your-Child-024.aspx. Accessed December 14, 2019.

children should reinforce these messages. During physical examinations, they should remind children that no one should be touching their private parts, and that even the provider needs permission to touch them and should only do so with a parent or guardian present. Finally, for children receiving mental healthcare services, providers should help to debunk the myth that these services are shrouded in secrecy and obligatorily exclude parents and other concerned adults.

Child and adolescent psychiatrists hold sacred the trust of our patients, families, and communities. This trust extends to avoiding harm and making our services fully available, without stigma or barrier, for all those in need. All psychiatrists have sworn to an oath to uphold this scared trust.

Conclusion

This review and guidance offer accurate information about important developments in psychiatric and other mental health care services for children and adolescents, including higher attention to safety, advancement of transparency with treatments, and a clearer understanding of the behavioral health status of our youth. It is hoped that, with this information, providers and other stakeholders will help patients and families to make informed choices about mental health care.

Conflict of Interest

None of the authors identify any conflict of interest.

Table 3. State of Hawai'i Family Guidance Centers Contact Information[a]

Island	Region	Contact information
O'ahu	Honolulu	3627 Kīlauea Avenue, Room 401, Honolulu, Hawai'i 96816 Main Line: (808) 733-9393; Fax: (808) 733-9377
	Pearl City	860 Fourth Street, 2nd Floor, Pearl City, Hawai'i 96782 Main Line: (808) 453-5900; Fax: (808) 453-5940
	Leeward	601 Kamokila Boulevard, Suite 355, Kapolei, Hawai'i 96707 Main Line: (808) 692-7700; Fax: (808) 692-7712
	Kāne'ohe	45-691 Kea'ahala Road, Kāne'ohe, Hawai'i 96744 Main Line: (808) 233-3770 Fax: (808) 233-5659
Maui (County)	Wailuku	270 Waiehu Beach Road, Suite 213, Wailuku, Hawai'i 96793 Main Line: (808) 243-1252; Fax: (808) 243-1254
	Lāhainā	1830 Honoapi'ilani Highway, Lāhainā, Hawai'i 96761 Main Line: (808) 662-4045; Fax: (808) 661-5450
	Lāna'i	C/O Lāhainā Office, 1830 Honoapi'ilani Highway, Lāhainā, Hawai'i 96761 Main Line: (808) 662-4045; Fax: (808) 661-5450
	Lāna'i High and Elementary Schools	555 Fraser Avenue, Lāna'i City, Hawai'i 96763 Main Line: (808) 565-7900; Fax: (808) 565-7904
	Moloka'i	65 Makaena Place, Kaunakakai, Hawai'i 96748 Phone: (808) 553-7878; Fax: (808) 553-7874
Hawai'i	Kamuela	65-1230 Māmalahoa Highway, Suite A-1, Kamuela, Hawai'i 96743 Main Line: (808) 933-0610; Fax: (808) 933-0558
	Hilo	88 Kanoelehua Avenue, Suite A-204, Hilo, Hawai'i 96720 Main Line: (808) 933-0610; Fax: (808) 933-0558
	Kona	81-980 Haleki'i Street, Room 101, Kealakekua, Hawai'i 96750 Main Line: (808) 322-1534; Fax: (808) 322-1543
	Waimea	65-1230 Māmalahoa Highway, Suite A-1, Kamuela, Hawai'i 96743 Main Line: (808) 887-8100; Fax: (808) 887-8113
Kaua'i	Līhu'e	3059 'Umi Street, Room A014, Līhue, Hawai'i 96766 Main Line: (808) 274-3883; Fax: (808) 274-3889

[a] Adapted from the State of Hawai'i, Department of Human Services, Child Welfare Services, "A Guide for Mandated Reporters" November, 2007.

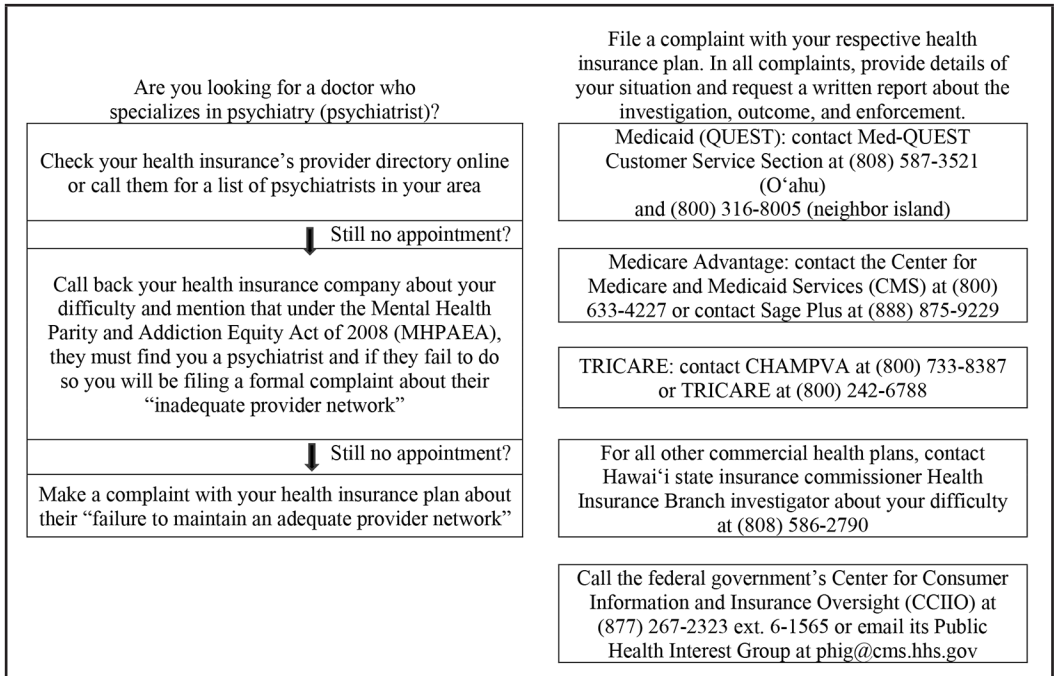

Figure 1. Psychiatrist Finder Template[a]

[a] Adapted from the Hawai'i Psychiatric Medical Association, Psychiatrist Finder Template.

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