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## FROM THE EDITOR

### Clinical and Social Contexts of Ethical Issues in Mental Health Care

Psychiatry is a critical yet often neglected area of medicine. Although mental health and substance use disorders are the leading cause of disability worldwide [1], World Health Organization (WHO) statistics from 2014 indicate that the median number of practicing psychiatrists worldwide is 0.1 per 10,000 people [2]. In the United States, we have more than ten times that number—1.2 psychiatrists per 10,000 people [2]—and yet federal statistics suggest that more than half the counties in this country do not have a single practicing behavioral health worker [3]. One recent study found that the average wait time for a first outpatient psychiatry visit in large urban areas is 25 days [4].

The value of investment needed to scale up care for depression and anxiety in 36 countries over the next 15 years is estimated to be $147 billion in present-day dollars [5]. It makes sense, then, that access to and parity for mental health care have remained critical issues for discussion during this presidential election season in the United States. Yet this huge unmet need also represents an area of tremendous potential. For example, the WHO estimates that in the United States, the return on investment for improving mental health care delivery is roughly 4 to 1 [5].

Psychiatry has always been an area of medicine with unique ethical challenges. Indeed, the very nature of psychiatric illnesses can raise challenging questions about patient autonomy. How do we best address decision making in complex psychiatric cases, when failures of reality testing and insight can sometimes be the primary symptoms of disease? Do patients have "the right to be crazy" if they do not have insight into their illnesses or, perhaps for another reason, wish to refuse treatment that members of their care team deem medically necessary? These challenging questions are addressed by James Sabin in his commentary on a case of a man with schizophrenia who wishes to discontinue taking antipsychotic medication.

Psychiatric diagnosis is another area with unique challenges, as the vast majority of diagnoses in the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*) [6] have no objective tests to confirm the clinical impression of an evaluator. To deal with the challenges of diagnostic imprecision, the National Institute of Mental Health has launched an initiative called the Research Domain Criteria (RDoC) that attempts to take a more dimensional approach to the scientific classification of the mental disorders by separating human mental functions into broad categories called "domains" and preferentially supporting research into the biological correlates of these

functions across diagnostic categories [7]. Until this work yields more precise biological characterizations of mental illness, physicians and other mental health practitioners must continue to make diagnoses using the standard criteria in *DSM-5* [6] and the "International Statistical Classification of Diseases and Related Health Problems" [8]. The limitations of diagnostic categories and the ways we might address a patient's resistance to being labeled with a specific diagnosis are discussed in Julie M. Aultman's commentary on a case of a college student who does not clearly meet the criteria for bipolar II disorder but demands a prescription—and that her diagnosis not be recorded in her medical record.

Ethical challenges also arise in connection with the choice of psychiatric treatments. Since the pathophysiology of mental illnesses remains incompletely understood, it's inevitable that there are similar gaps in our knowledge regarding mechanisms of action of pharmacological treatments. Such incomplete knowledge can lead to misinformation or uncertainty regarding the appropriate use of psychotropic medications, which in turn can have adverse effects on patients and their families. Andrea L. Kalfoglou thoughtfully addresses this challenge in her article weighing the risks and benefits of the use of antidepressant medication during pregnancy.

Given significant overlap in symptom and medication response profiles between psychiatric diagnoses, off-label medication use is particularly common in psychiatric practice [9]. Katrina Furey and Kirsten Wilkins thoughtfully address the appropriateness of off-label prescribing and its ethical and legal implications in their commentary on a case about informed consent for off-label use of an antipsychotic to control an elderly patient's agitation and paranoia.

Challenges of treatment selection are not unique to pharmacological interventions. Annette Mendola and Richard L. Gibson evaluate the effectiveness of widely used programs for substance use and addiction treatment and the ways a clinician might ethically operate in light of the limited evidence available. Challenges also might arise from patients' attitudes toward treatment. In a case commentary, Constance E. George discusses the ethical challenges that psychiatrists face when all treatments fail; she wonders whether and when depression should ever be considered a terminal illness and considers the nature, scope, and appropriateness of a physician's role in fostering hope for patients with refractory depression.

Stigma—even for patients who do not yet have psychosis but are at high risk for it—remains a significant challenge in mental health care. Dominic A. Sisti and Monica E. Calkins discuss the lexical complexities of the psychosis risk label and its implications for social and self-stigma. Cheryl M. Corcoran also evaluates evidence of potential harms of the psychosis risk label.

Finally, we must remember that mental health is an issue that physicians face not only as practitioners but also as patients and human beings. A recent meta-analysis estimated that almost 30 percent of resident physicians met criteria for clinical depression [10], and statistics show that we lose between 300 and 400 physicians each year to suicide [11, 12]. The existence and treatment of depression, suicidality, and burnout in medical trainees and next steps to limit the toll that stress takes on physicians-in-training are discussed in an article by Kathryn Baker and Srijan Sen and in the podcast with Srijan Sen. From a more personal perspective, pediatrician and memoirist Mark Vonnegut provides insight into his decision to publically acknowledge his history of mental illness and how that disclosure has influenced his interactions with patients and colleagues.

The future of the field of psychiatry is a bright one, and I am excited to be joining such a dynamic field at this time in its development. Certainly the ethical issues associated with psychiatric practice will change as knowledge progresses and treatments become more precise. In a recent interview with *NPR*, Shekhar Saxena of the World Health Organization underscored the importance of continued improvements in mental healthcare: "[W]hen it comes to mental health, all countries are developing countries" [13]. As a future psychiatrist, I agree.

Furthermore, the severe shortage of mental health practitioners means that anything approaching universal access to mental health care will likely need to involve primary care, emergency care, and women's health practitioners who also respond to patients' mental health care needs. When all clinicians strive to meet those needs, we can all look forward to the health and social benefits. Responding to ethical and justice issues in mental health care is an obligation for all of us.

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