



October 2019

Dear Member of Congress:

During the last half century, the branch of medicine focused on treating behavioral healthcare conditions has made tremendous progress. Clinicians and professionals—working together with patients and families—have expanded access to care, improved the quality of behavioral healthcare treatment, and increased rates of recovery for Americans experiencing mental health and substance use disorders.

Despite this progress, for decades there has been a segment of the population that has questioned the legitimacy of psychiatric categories, diagnostic practices, and common forms of treatment. This group does not engage in thoughtful debate. Rather, it makes unscientific objections — often amplified by social media messages — meant to erode public confidence in the clinicians and other health professionals who treat these chronic diseases.

The most overt example of this practice comes from the benignly named Citizens Commission on Human Rights (CCHR), founded in 1969 in order “to expose the evils of psychiatry.” While the name suggests the group is a citizen activist organization, or perhaps even an officially appointed investigative committee, CCHR is a front group for the Scientology movement and the teachings of Scientology founder L. Ron Hubbard.

As you may know, news outlets have reported for years that the Scientology movement’s goal is to replace all mental health treatment with homeopathic rituals that adhere to Scientology’s beliefs and practices. L. Ron Hubbard once said “Psychiatrists are simply outright murders”ⁱ and “Our error was in failing to take over total control of all mental healing in the West. Well, we’ll do that too.”ⁱⁱ In 1995, Scientology leader David Miscavige, proclaimed: “Objective one: place Scientology at the absolute center of society. Objective two: eliminate psychiatry in all its forms.”ⁱⁱⁱ

CCHR’s overarching goal is to discredit the mental health field and undermine public faith in this field of medicine. To achieve this goal, CCHR’s common strategy is to identify an isolated incident, sensationalize it in public, and then draw unsupported conclusions from that incident to criticize the overall quality of care and patient safety across all types of mental healthcare settings.

These efforts have exacerbated the existing stigma associated with mental health and addiction, which, in turn, has discouraged patients who need care from seeking professional treatment in inpatient and residential settings that provide critical and often life-saving services to millions of patients.

Addressing the Objections of the Brain Disease Skeptics

The first step in addressing the claims from brain disease skeptics is to recognize behavioral healthcare providers’ rightful place within the full healthcare continuum. CCHR discounts and dismisses the field of psychiatry by asserting false claims against those who are trained in this field and those who provide this type of medical care.

Some of these false and potentially damaging claims include referring to psychiatry as “an industry of death”^{iv} and a pseudoscientific practice of limited value in helping people recover^v, or claiming that “the covert mission of the mental health system... is social control.”^{vi}

Scientific research from the nation’s federal agencies — including the Substance Abuse and Mental Health Services Administration, the Centers for Disease Control and Prevention, and the Centers for Medicare &



Medicaid Services — have long recognized that mental illness exists. We also know that behavioral health professionals, similar to their counterparts in medical-surgical care, enter the field to help people.

Rather than viewing treatment as “punishment,” we know treatment is the most effective way people with severe mental health and substance use disorders can achieve recovery and live healthy, fulfilling lives. With this as our foundation, we will respond to the more common misconceptions and falsehoods regarding behavioral healthcare treatment. These misconceptions and myths include:

- I. Medication used for mental health and substance use disorders are dangerous and do not work.
- II. Relapse rates for behavioral healthcare conditions are higher than those for other healthcare conditions.
- III. Psychiatric care is a coercive model that relies on force.

Medications

Mental health medications are frequently reported in the media as “mind-altering” drugs and suggest, often in an alarming way, that the increased use of such drugs is a problem.^{vii}

There are effective medication options for the treatment of most major mental health conditions, including mood disorders such as depression and bipolar disease; anxiety disorders; and psychotic disorders such as schizophrenia. As an article published in the *British Journal of Psychiatry*^{viii} noted that medications for mental health conditions were more effective than some general health medications; less effective than a small number of highly effective general health medications; and, on average, slightly more effective than the median general health medications.

Relapse Rates

Historically, patients and behavioral healthcare providers have been blamed for high readmission rates, treatment failures and “relapses.” That impression is based on comparisons between behavioral healthcare outcomes and outcomes for acute healthcare conditions. However, behavioral healthcare conditions are not acute conditions. They are chronic conditions and should be compared with other chronic conditions when considering the quality of treatment provided.

When behavioral healthcare conditions are compared with other chronic conditions, behavioral healthcare outcomes are similar, and, in some cases, slightly better. Consider these statistics: 30 percent to 50 percent of adults with type 1 diabetes (a chronic condition) will experience recurrence of symptoms each year, and approximately 50 percent to 70 percent of adults with hypertension or asthma will have a recurrence requiring additional medical care each year. By comparison, “40% to 60% of patients treated for alcohol or other drug dependence return to active substance use within a year following treatment discharge.”^{ix} Major depressive disorder is also seen as condition with high relapse rates, however, only “50% of those who recover from a first episode of depression have one or more additional episodes in their lifetime.”^x

Physical Restraint or Seclusion Use

A longstanding and persistent misconception about mental healthcare is that treatment today mirrors the treatment provided in state psychiatric hospitals during the first half of the 20th century. That system was defined

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by overcrowding, underfunding, and poor treatment. Mental health and addiction treatment today have improved tremendously, and those perceptions are outdated.

In 2019, a system made up of not-for-profit and for-profit hospitals has replaced the old system of state-run facilities, and this change has brought a redesigned and more effective care model with it. The former so-called “asylums” did not track certain patient-related measures to assess quality of care as today’s hospitals and treatment centers do. Today, our nation’s behavioral healthcare providers have the education, resources, and staff to monitor patients in danger of harming themselves, or to place certain patients in restraints or in seclusion from other patients to protect themselves or others.

Providers throughout the country have worked for many years on strategies to minimize using restraint and seclusion and also to ensure that, when used, these forms of treatment are used safely. To help with this effort, the Centers for Medicare & Medicaid Services (CMS) has included an *Hours of Physical Restraint Use* measure and *Hours of Seclusion Use* measures in the Inpatient Psychiatric Facility Quality Reporting Program (IPFQR) for psychiatric hospitals participating in the Medicare care program.

In the Fiscal Year 2019 proposed rule for the IPF Prospective Payment System (IPF PPS), CMS proposed removing the *Hours of Physical Restraint Use* and *Hours of Seclusion Use* measures from the IPFQR Program because “measure performance among IPFs is so high and unvarying that meaningful distinctions and improvements in performance can no longer be made.” This means seclusion and restraints were used so infrequently among Medicare-certified psychiatric providers that CMS thought it was appropriate to eliminate the measure. Later, some commenters, including NABH, urged CMS to keep the measures and CMS obliged to ensure that restraint and seclusions continues to be used in very rare instances.

Conclusion

Behavioral healthcare providers engage daily with the most complex aspects of human behavior and the brain. Too often skeptics dismiss the tremendous advancements in the field that could do much to break down the stigma that still exists surrounding mental health and addiction in the United States. We welcome the opportunity to serve as a trusted resource for interested parties including policymakers, journalists, clinicians, patient advocates, and the general public to help debunk myths and ensure that our country’s most vulnerable patients can access the high quality, evidence-based behavioral healthcare they need.

For additional information and/or questions, please contact nabh@nabh.org.

Sincerely,

National Association for Behavioral Healthcare

Mental Health America

National Alliance on Mental Illness



ⁱ Hubbard, L. Ron illegal PCs, Acceptance of [...] High Crime Bulletin', Hubbard Communications Office Bulletin (December 6, 1976)

ⁱⁱ Hubbard L.R. The war. Executive Directive from L. Ron Hubbard. November 29, 1968.

ⁱⁱⁱ *Scientology's war on psychiatry* Salon, Katharine Mieszkowski. July 2, 2005 https://www.salon.com/2005/07/01/sci_psy/

^{iv} <https://www.cchr.org/about-us/cchr-industry-of-death-museum.html>

^v *Press Release: Coalition of Individuals with Psychiatric Labels Supports Protestors' Efforts to "Occupy" the American Psychiatric Association Convention*, National Coalition for Mental Health Recovery (May 3, 2012)

<https://www.ncmhr.org/press-releases/5.3.12.htm>

^{vi} *The Challenge of Implementing a PACE (Recovery) Philosophy in the Public Mental Health System* NARPA 2001 -- Full program November 2001

^{vii} <https://www.newyorker.com/tech/annals-of-technology/the-psychiatric-drug-crisis>

^{viii} Leucht, S., Hierl, S., Kissling, W., Dold, M., & Davis, J. (2012). Putting the efficacy of psychiatric and general medicine medication into perspective: Review of meta-analyses. *British Journal of Psychiatry*, 200(2), 97-106.

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^{ix} McLellan AT, Lewis DC, O'Brien CP, Kleber HD. Drug Dependence, a Chronic Medical Illness: Implications for Treatment, Insurance, and Outcomes Evaluation. *JAMA*. 2000;284(13):1689–1695. doi:10.1001/jama.284.13.1689

^x Burcusa, S. L., & Iacono, W. G. (2007). Risk for recurrence in depression. *Clinical psychology review*, 27(8), 959–985.

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