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Avoiding the Politicization of Mental Health Care Reform

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Once again, in response to the Parkland shooting, America is hearing calls for mental health care reform. Yet much like progressive-led efforts to promote "commonsense" gun control, Americans should be very wary about how much power they're willing to concede to "well-meaning" government officials.

First, some history. "Much of the motivation to build more mental institutions was to provide a remedy for the maltreatment of mentally ill people in our prisons," explains columnist Walter Williams. "According to professor William Gronfein at Indiana University-Purdue University Indianapolis, by 1955 there were nearly 560,000 patients housed in state mental institutions across the nation. By 1977, the population of mental institutions had dropped to about 160,000 patients."

That precipitous drop was engendered by "deinstitutionalization." Releasing the mentally ill from institutions and allowing them to live among normal people, while treating them with new psychotropic drugs at community centers, was deemed preferable to keeping them confined.

Much of the bipartisan push for deinstitutionalization was driven by good intentions. "Many psychiatric facilities at the time weren't much more than warehouses, offering little real treatment," Cato Institute senior fellow Michael Tanner notes. "Others were literal houses of horrors, utilizing shock treatment and other discredited approaches, while confining patients in squalor and neglect. The abuses and concerns that sparked deinstitutionalization were real and justified."

Thus in 1963, John F. Kennedy proposed federal funding for community mental health centers (CMHCs) to replace state mental hospitals.

In a 2013 article for The Wall Street Journal, Dr. E. Fuller Torrey revealed that the program was little more than an exorbitant disaster because the CMHCs were not fulfilling their intended role. Instead of taking care of those discharged from state hospitals, they turned their focus to people with less severe problems, often referred to as "the worried well." In the meantime, the feds were also founding and funding Medicaid and Medicare, and the Supplemental Security Income and Social Security Disability Insurance programs were modified. All of it resulted in the federal government's takeover of nation's the mental illness treatment system.

Fifty years after this JFK-proposed approach, multiple studies summarized by the Treatment Advocacy Center revealed that half the people released, including many who had family support and sought outpatient treatment, had done well.

The other, largely untreated half — as in the approximately 3.5 million Americans with severe psychiatric disorders who are receiving no treatment at all? They have committed 10% of all homicides, and comprise 20% of the jail and prison population, and at least 30% of the homeless population. The same homeless who have become an intractable part of many urban landscapes.

Moreover, spending on treatment for the mentally ill has exploded. When Torrey wrote his article, total expenditures on mental health treatment were $173.5 billion. Last year that total stood at $203.6 billion. Thus the politically correct assertion that not enough money is being spent addressing mental illness rings exceedingly hollow.

Torrey proposed shifting mental health treatment for the federal government to the states, but a 1999 U.S. Supreme Court ruling in the case of *Olmstead v. L.C.* remains problematic. It held that unjustified segregation of persons with disabilities violates the Americans with Disabilities Act, and that public entities must provide community-based services in an "integrated community setting," defined by the Justice Department as one "that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible."

What about the aforementioned psychotropic drugs? A double-edged sword. No doubt many individual Americans truly benefit from medications that mitigate the deleterious effects of anxiety disorders, bipolar disorder, OCD, ADHD and schizophrenia.

Society as a whole is another story. According the Citizens Commission on Human Rights, which describes itself as a mental health industry watchdog, from 1988 through 2017, at least "36 school shootings and/or school-related acts of violence have been committed by those taking or *withdrawing from* psychiatric drugs resulting in 172 wounded and 80 killed." CCHR notes these stats only include shooters whose drug use information was made public.

Why aren't *all* the stats made public? As columnist David Kupelian reveals, pharmaceutical companies "are by far the biggest sponsors of TV news," and they don't want any publicity "connecting their highly lucrative drugs to murderous violence." He further notes that the legal teams employed by companies such as GlaxoSmithKline and Eli Lily "have quietly and skillfully settled hundreds of cases out-of-court, shelling out hundreds of millions of dollars to plaintiffs."

Those settlements often include non-disclosure agreements. In the case of the Parkland shooter, all that has been reported is that he suffered from ADHD, depression and autism, and that he received the "necessary medication" to treat those conditions.

What medications, exactly? Since the Democrat/Media Complex has turned that atrocity into a crusade for gun control, anything that distracts from that particular narrative will likely remain under the radar.

What about voluntary versus involuntary commitment to a mental facility? Patient-rights advocates often claim court-ordered treatment is ineffective. And that's when patients can get treatment at all. "Half the counties in the U.S. have no psychiatrist or psychologist," explains columnist Tim Murphy. "Many doctors have waiting lists or may not see patients with serious mental illness such as schizophrenia or bipolar disorder or those with

violence risk. There is a nationwide shortage of 30,000 child and adolescent psychiatrists, and patients wait on average 7.5 weeks for a first appointment if the child psychiatrist is even taking new patients."

Murphy warns the shortage will continue largely because of low Medicaid reimbursements that precipitate a vicious cycle. Psychiatrists "have the lowest percentage of doctors accepting Medicaid," while "a person with serious mental illness is three times more likely to live in poverty," and "a person living in poverty is three times more likely to suffer a mental illness," he notes.

Ergo, Medicaid presents a *barrier* to timely care.

What to do? Murphy suggests Congress act on a number of fronts. They include incentivizing psychiatrists and psychologists with student loan forgiveness for a commitment to treat mentally ill patients; reforming HIPAA (Health Insurance Portability and Accountability Act) to allow a "compassionate communication" exception to patient privacy laws; increasing the number of psychiatric beds; raising Medicaid reimbursements; and closing the involuntary-commitment loopholes that prevent seriously ill Americans from having their names placed on the National Instant Criminal Background Check System (NICS).

All well and good — until one remembers the Left's penchant for excess, amply demonstrated by the Obama administration's attempt to automatically define *any* elderly American incapable of managing their own finances as "mentally defective," with the nefarious aim of placing their names on NICS.

Moreover, a federal government allowed to define mental illness — while the former standard-bearer of one party serving in that government asserted many Americans are "deplorables" — opens the door to rampant abuse.

That abuse is far more likely when the cries of "do something!" are the loudest.

"Mental illness should not be stigmatized," asserts columnist Christine Flowers. Neither should the NRA nor law-abiding gun owners. And until the coordinated hysteria dies down, politicians should tread very cautiously — in both arenas.