Inquiring Minds topic – 29 June 2018

Ed Thomson, Moderator

WHAT TO DO WITH PEOPLE WHO ARE MENTALLY ILL

Bad things happen to good people. When bad things happen who should provide help? I opened that subject with a discussion on disasters. Although we did not resolve who should pay how much for what, a consensus appeared that each person ought to have insurance. Another appeared that there exists a political issue that "government" should help people devastated such as the victims of hurricanes Irma and Maria.

Attached is an editorial from the New York Times of June 3, 2018: The Crazy Talk About Asylums.

In the bad old days people were put into asylums not only because they were ill but also because they were inconvenient. Abuse was rife. Consider the Andrew Carnegie case where his heirs attempted to have him declared insane when he announced his intent to give away over 900 million dollars (a sum then greater than the assets of Bill and Melinda Gates today). Other people were "put away" because they were old or embarrassing.

Consider also the "homeless" many of whom are "mentally ill" but many of whom do not wish to be in an institution where their lives would be controlled by the staff. When asylums were closed many of the people who had been housed became homeless.

Consider also that the Sheriff of Cook County Illinois said last month that the county jail he runs has more people suffering from "mental illness" than any other institution in the United States and lacks the capacity to treat them. His situation is not unique.

When is a homeless person a danger to others or to herself or himself? Who should decide? Who should pay?

Can we agree that taxpayers, i.e. all of us, have as obligation to help? Who should be excluded?

The Crazy Talk About Bringing Back Asylums

nytimes.com/2018/06/02/opinion/trump-asylum-mental-health-guns.html

By The Editorial BoardJune 2, 2018

Opinion

When President Trump mused that the mass shooting at a high school in Parkland, Fla., in February might have been prevented if the United States had more mental institutions, he revived a not-quite-dormant debate: Should the country bring back asylums?

Psychiatric facilities are unlikely to prevent crimes similar to the Parkland shooting because people are typically not committed until after a serious incident. Still, a string of news articles, editorials and policy forums have noted that plenty of mental health experts agree with the president's broader point.

The question of whether to open mental institutions tends to divide the people who provide, use and support mental health services — let's call them the mental health community — into two camps. There are just 14 or so psychiatric beds per every 100,000 people in the United States, a 95 percent decline from the 1950s. One camp says this profound shortage is a chief reason that so many people suffering from mental health conditions have ended up in jail, on the streets or worse. The other argues that large psychiatric institutions are morally repugnant, and that the problem is not the lack of such facilities but how little has been done to fill the void since they were shut down.

Neither side wants to return to the era of "insane asylums," the warehouselike hospitals that closed en masse between the 1960s and 1980s. Nor does anyone disagree that the "system" that replaced them is a colossal failure. Nearly 10 times as many people suffering from serious mental illnesses are being kept in jails and prisons as are receiving treatment in psychiatric hospitals.

What's more, both sides broadly agree that mental institutions alone would not be the solution. "Bring back the asylums" sounds catchy, but here are some more useful slogans to help steer the conversation:

1. DEMAND SENSIBLE COMMITMENT STANDARDS Exact wording varies by state, but commitment standards in general dictate that people cannot be hospitalized against their will unless they pose a clear and significant danger to themselves or others. That sounds reasonable, but with so few inpatient facilities,

mental health workers have a strong incentive to determine that even someone who needs to be committed — perhaps someone dangerously delusional — does not meet that standard.

2. CREATE A CONTINUUM OF CARE Deinstitutionalization was predicated on the 1963 Community Mental Health Act, which was supposed to create well-staffed, well-funded community mental health centers in about 1,500 catchment areas across the country. These centers were supposed to provide clinical care, housing and employment support, and community outreach. When President John F. Kennedy announced the legislation, he estimated that it would ultimately return about half of the 500,000 or so people then living in state psychiatric hospitals to be "treated in their own communities and returned to a useful place in society."

If only the law had been given a chance to work. States failed to devote their savings from the closure of large institutions to community-based care, and few communities were willing to host the centers in their backyards. In the end, only about 750 centers were ever built, and zero were ever fully funded. Today, less than half of all adults suffering from mental health conditions receive help, and mental illness is the leading cause of lost workdays in the United States, costing about $193 billion in lost earnings a year.

People who suffer from behavioral and psychiatric disorders need and deserve a wide range of care options: community mental health centers, short-term care facilities, and — yes — longer-term arrangements for the small portion of people who can't live safely in the community. The pro-asylum camp is right that the number of people needing those longer-term placements is greater than zero. But the figure is also small enough to avoid the need for the thousand-plus-bed facilities that were once the sites of so much abuse.

3. STAND UP FOR INSURANCE PARITY This October marks 10 years since Congress passed the Mental Health Parity and Addiction Equity Act, which requires health insurers to provide the same level of benefits for mental health treatments and services as they provide for medical and surgical care. On paper at least, both the Affordable Care Act and the 21st Century Cures Act bolstered that 2008 statute by requiring plans on the health insurance exchange to cover a list of essential behavioral health benefits and by enacting greater enforcement of the parity rules.

In practice, though, the three laws have yet to create true equity. "In some situations, you still can't get into a psychiatric facility unless you are suicidal or otherwise near death," says Ellen Weber, vice president for health initiatives at the

Legal Action Center, a nonprofit that is fighting parity violations in several states. “That’s an abhorrent double standard. We don’t do that for medical or surgical need.”

And because regulators at the federal Departments of Labor and Health and Human Services are required to investigate complaints, not prevent them from happening, the burden of proving a parity violation falls on the consumer. “This is a law that’s almost impossible to enforce as it stands,” Ms. Weber says. “It requires a tremendous amount of information gathering and sophisticated analysis that most consumers are not equipped to take on, especially in the middle of a medical crisis.”

Why not have regulators certify that plans meet parity rules before they go to market? Officials at H.H.S. and the Department of Justice could then step in to police insurers for violations — before problems become clear. While we’re at it, Medicaid ought to lift its longstanding exclusion of inpatient psychiatric care.

Because “asylum” is a loaded term, it can draw attention to crucial issues facing vulnerable Americans, but it also tends to foreclose discussion of real solutions. Most of those solutions aren’t even controversial. There just needs to be the collective will, and basic decency, to act.