Disastrous Public Policies that Followed Psychologization of Cerebral Illness

After emergent enlightened understanding and progress was curtailed and concepts of so-called mental disorders regressed, public policies soon followed.

Once grave neurologic conditions had become psychologized, and medical no more, anyone can be an authority on what's best for the so-called mentally ill. Anyone waging a war on the so-called medical model can commandeer allies, recruits, and proxies to propagate an agenda to remodel public policies.

Deinstitutionalization

Deinstitutionalization was a government policy that turned patients out of state hospitals. The goal was for this population to be integrated back into the community where they would receive treatment in community-based health centers. Most sources mark the beginning of this movement in the mid-1950s prior to the advent of pharmaceuticals that were found to alleviate symptoms for some people. This period was followed by net increases in admissions, then the beginning of declining patient populations in the early 1960s. However, some scholarly sources report that the idea of deinstitutionalization started to percolate as far back as the era in which asylums were being built.

The purported aims were to improve the lives of the "mentally ill" but there was also a fiscal motive of trimming government spending. Between 1955 and 1994, roughly 487,000 patients with serious cerebral illnesses were discharged from state hospitals.

Today, in a perverse turnabout on the impetus behind the Dorothea Dix campaign to establish these institutions, many state hospitals function almost as clients of the criminal justice system, preparing so-called incompetent people charged with crimes for prosecution.

The carnage of this misguided policy is in the statistics:

In 2005, over half of all incarcerated individuals had some type of mental health condition — over 705,000 in state prisons, 78,000 in federal prisons, and 479,000 in local jails. Just four years later, an estimated twenty percent of jail inmates nationally and fifteen percent of inmates in state prisons had a serious mental illness, amounting to about 383,000 people with severe psychiatric disease in U.S. prisons and jails. In the majority of states there are more individuals with mental illness in prisons and jail than there are in the largest state psychiatric facilities. — Georgetown Journal on Poverty Law and Policy

The assumption of deinstitutionalization was that with medication to correct chemical imbalances, these re-integrated citizens would function just like anyone needing medical services. These "freed" patients, later known as consumers, would live in "the community" whatever that meant (typically back to live with their families, independently, or in smaller congregate settings) and electively go to these community "mental health" centers to receive treatment (whatever that meant to people that fundamentally misunderstood the nature of these psychologized neurologic disorders). This idea of self-

directed engagement with treatment is still being promoted today by the recovery movement ideology that is operationalized in State Departments of Health policies.

Dr. E. Fuller Torrey wrote about the systematic, misguided dismantling of a flawed, yet functioning system that housed people with serious “mental illness” and kept them free from homelessness and unjust transinstitutionalization in the book titled “*American Psychosis: How the Federal Government Destroyed the Mental Illness Treatment System*

What legislators failed to understand is that these were cerebral illnesses that severely impaired self-auditing and regulatory control over executive functioning in critical domains. The symptom most relevant to self-directed treatment seeking is the neurological symptom known as anosognosia (the anti-medical model critics hate that word being applied to people with so-called mental illness).

Anosognosia is universally described in the context of cerebral illness as the afflicted person “not knowing he or she or the preferred pronoun is sick”. That is an abstract deficient definition. What it means is that the person has a neurological blockade to awareness that their thinking and reasoning is severely impaired, and that their behaviors are disordered, sometimes dangerously so. Another determinant is the degree of exacerbation of illness. Untreated “psychosis” can advance into a consciousness disorder, i.e. neurological detachment from reality, which can be a potentially deadly medical status in which a person is unable to negotiate care of their most basic needs, let alone making and keeping clinic appointments.

Those state hospitals were not just large institutional domiciliary care centers, they were housing. Federal and state governments to this day still do not comprehend the housing needs of people with serious cerebral illness. HUD programs like the Housing First and Rapid Rehousing Model appear to regard the housing needs of the so-called mentally illness as being no different from a person without a severe brain function disorder that happens to become homeless due to financial distress. States have a paucity of housing 24/7 onsite support and monitoring — and moreover, much of it is privatized. No one is suggesting that sprawling asylum-like campuses be re-instituted, but government-funded housing is desperately needed.

Many of the police-involved shootings of people said to have “mental illness” are people who are much too ill, even if under community-based treatment, AOT programs, or adhering to prescribed medications, to be living with their families and certainly not independently, sometimes propped by a team of social service providers. We often hear people with this severity of illness described as “unstable” or “emotionally disturbed”. Those are not terms that would be applied to someone with advanced dementia, living in a family home on the razor’s edge of commitment to a memory care facility. People with dementia can have behavioral problems that are indistinguishable from those with so-called mental illness.

Activists for police reform are calling for social workers to respond to these crisis calls instead of police. They mean well, but they do not understand the essential nature of these grave illnesses anymore than the civil rights advocates who fought to free people from large institutions. Many activists conceptualize what they call "mental health" crises as people that have become distraught in a psychological and emotional sense. They think that social workers or therapists can respond with a therapeutic approach to 'calm people down' and alleviate their distress. What they do not understand is that people who they see as "emotionally disturbed" are having a neurological crisis. The person may be in a state of consciousness where everything around them, including family members present a horrifying mortal

danger to them. A person in that state of consciousness may put up a valiant effort to defend themselves and that could make the person dangerous.

Some people may have discontinued medication (the side-effects can be terrible), the medication may have lost its efficacy, or something about the person's neurobiological status may have exacerbated. The media often refers to people with so-called mental illness as being "unstable", but their concept of unstable is not in the medical sense, it is in a psychological sense - this is a misperception. Some people are too unstable medically to be living in the community with family or independently with social supports.

Many people with severe cerebral illness need institutional housing. The word 'institution' has been made a dirty word by misguided civil liberties crusaders but any facility outside a family home or independent living unit can be considered an institution. An institution can be a small group home, an LTSR (long term structured residence, locked or unlocked units), or a personal care home.

Deinstitutionalization was premised on ideology instead of medical science, false hopes about the promise of pharmaceuticals, and false promises that resources would follow patients from state hospitals out to communities. That said, the resource that was never promised but needed the most was long-term to permanent supported housing with 24/7 onsite staff.

The steadfast refusal of federal and state government to provide this housing has costs hundreds of thousands of lives, destroyed by homelessness, premature death, unjust jail detention and incarceration, and death to people who have been killed by those who became a danger to themselves and others.

The IMD Exclusion

The Medicare bill was signed into law in 1965. It established Medicare, and Medicaid, a health insurance program for the poor. The Medicaid Institutions for Mental Disease (IMD) exclusion is a section of the bill that prohibits payments with respect to care or serves for any individual who has not attained 65 years of age and who is a patient in an institution for "mental diseases" that more than 16 beds. In 1972, the exclusion was amplified to ex excludes patients under 21.

An IMD is defined as any “hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with so-called mental diseases, including medical attention, nursing care and related services.”

The IMD Exclusion not only saved federal dollars, it also served the interests of the politicized Mental Hygiene and Consumer/Recovery movements by disincentivizing treatment of the so-called mentally ill in large institutions. It further shifted the costs for psychiatric treatment from the federal government to the states after the reprehensible assault on this class of American citizens that was in progress under deinstitutionalization.

The result of this exclusion is that desperately ill people are cut off from acute care treatment and congregate care residency for those who are sick enough to require it on a long-term to permanent

basis. The article preceding this one made clear what the potentially deadly consequences are when someone with a severe cerebral illness is living in the community without access to medical care or is too ill to be living in the family home or independently,

Congress has repeatedly rebuffed appeals from advocates calling for the repeal of the discriminatory IMD exclusion.

The IMD exclusion, which provides disincentives for psychiatric care facilities to grow, fuels the nationwide shortage of psychiatric beds and has proved disastrous for people with severe mental illness. The United States has closed almost 97% of its state hospital beds since the mid-1950s and today has fewer psychiatric beds per capita than it did in 1850. The trend, known as "deinstitutionalization," accelerated with enactment of the IMD exclusion, while the promised alternative of community behavioral health centers to provide care was never realized. — Treatment Advocacy Center

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By the mid-1990s, 3 decades had passed since the IMD exclusion had exacted compound damage upon people living and dying with serious cerebral illnesses. In 1994 there was a Senate hearing on "Deinstitutionalization, Mental Illness, and Medications" in which there is a wealth of testimony on the catastrophic consequences of these policies. In this hearing the concept of Parity was introduced into testimony.

People that were formerly living in large state hospitals did not have to grapple with seeking medical care in the community under private insurance. So now, they've been turned out of these facilities, have restricted access to critical care under the IMD exclusion, and now face discrimination in the form of reduced reimbursement from insurers based on the de-medicalization of their illnesses. The idea of parity was a flimsy patch on a system that was (in some sense out of ignorance) made dysfunctional, cruel, and unjust by design. There were some legislative acts that did very little to correct the injustice because the foundational problem was the demedicalization of cerebral illnesses as the medical establishment continued to privilege the troubled faction of Psychiatry and their cohorts in psychology to hurt people by psychologizing these medical conditions.

The ACA plugged some holes in coverage requirements, but still exempts grandfathered plans from the requirement to provide "mental health" coverage.

There was testimony in the hearing that:

The current health plan as proposed by President Clinton discriminates against people with schizophrenia in that they are only eligible for a certain number of days of hospitalization, wheras people with Parkinsons disease do not have that limit. The people with schizophrenia have a higher co-payment, 50 percent of outpatient visits. People with Parkinsons do not have that.

There is further testimony from various witnesses speaking to the fact that serious mental illness are brain disorders just like Parkinson, Alzheimers, and MS.

A more sinister plot could not have been designed to drive people with so-called mental illnesses into premature death and unjust incarceration than these legislative acts. And remember, before someone lands in jail or prison, (the only "housing" that exists for the "mentally ill" in many states) someone has to be harmed first and that's what this article is all about.

Intentional Misapplication of the Supreme Court Olmstead Ruling

This 1999 United States Supreme Court decision was based on the Americans with Disabilities Act. The Supreme Court held that people with disabilities have a qualified right to receive state funded supports and services in the community rather than institutions when the following three-part test is met:

The person's treatment professionals determine that community supports are appropriate, the person does not object to living in the community; and, the provision of services in the community would be a reasonable accommodation when balanced with other similarly situated individuals with disabilities.

The Olmstead case was propelled by Sue Jamieson, an Atlanta Legal Aid Society attorney that served as the lead attorney in the Olmstead case. According to an attorney involved in the case, speaking of Jamieson's pursuit to identify institutionalized prospects for a lawsuit: [Sue] walked the halls once a week to meet people and to bring release and commitment proceedings — which translates to: There was an agenda and vulnerable people were solicited to use as complainants.

The two women that Jamieson tagged to sign onto the case are described in the court's decision as: Respondents L. C. and E. W. are mentally retarded women; L. C. has also been diagnosed with schizophrenia, and E. W., with a personality disorder. Both women were voluntarily admitted to and confined for treatment in a psychiatric unit.

How interesting that the two women described as having what would be called "mental illnesses" are identified as mentally retarded, very interesting. The needs of people with intellectual disabilities are very different than those with cerebral illnesses such as "schizophrenia" or the suspect diagnosis of "personality disorder". One has to wonder which class of disability the Legal Aid Society was truly interested in advocating for and if the case might have been weaker had the respondents been described as having "mental illness".

The paradox of these two women with "mental illness" being used to further the cause of deinstitutionalization for all disabled persons is that advocacy groups dedicated to intellectual disability, autism, and other disabilities are nowhere to be found when allies are needed to challenge the unjust public policies that hurt people with serious cerebral illness.

They have a fixed ideological vision and even small congregate settings do not satisfy their demands.

STATEMENT ON RECENT PROPOSALS TO INSTITUTIONALIZE PEOPLE WITH MENTAL HEALTH DISABILITIES The Judge David L. Bazelon Center for Mental Health Law condemns President Trump's recent claim that the forced institutionalization of people with mental health disabilities will promote community safety. This statement must be recognized for what it is: an uninformed and discriminatory policy proposal that ignores the uncontroverted evidence that addressing mental illness has virtually no impact on gun violence ***February 23, 2018 - Bazelon Center for Mental Health Law***

(note: insertion this statement that makes reference to the previous administration is not an endorsement of that administration. This series condemns all administrations, including the present one if their policies promoted or promote mass transinstitutionalization in jails and prisons, homelessness, and premature death by neurogenic suicide, from lack of access to medical care, by officer-involved shootings. This paper asserts that mass shootings involving person with serious cerebral illnesses could be prevented in many cases if people with serious brain disorders (cerebral illnesses) were properly housed dignified, caring institutional settings and competently cased managed.)

While there are many positives that came of litigation over the decades to improve the lives of people living with disabilities, including the Olmstead case, at least one disability rights organization has a position statement that criticizes the way the decision has been applied:

"Since 1999, however, federal agencies and some advocacy organizations have lost sight of the individual when considering the rights established by the Olmstead decision. A thoughtful decision which balanced individual need, choice, and the state's resources against a statute that also required consideration of individual needs, has been discarded for an interpretation that the ADA, as interpreted by Olmstead, allows only community placement.

In sharp contrast, both the Olmstead decision and the ADA eschew absolutes. Neither support only community care or only institutional care….The Olmstead decision and the law are so clear that persistent misinterpretation by federal agencies can only be described as purposeful"…VOR

Over 20 years later, people with intellectual disabilities, people with cerebral illness, and other disabilities, continue to be adversely impacted by one-size-fits-all, agenda-driven misapplications of Olmstead, primarily in the form of homelessness and unjust incarceration for people with cerebral illnesses and according to VOR 'Journalists have time and again documented the high rates of abuse and mortality for our most disabled citizens who have been forced out of congregate care facilities into unprepared communities'.

HHS' Office of Civil Rights has been furthering the "Consumer Movement" and disability rights crusaders by deploying lawsuits against states for failure to transition people to "the community".

The HIPAA Handcuffs

Congress never intended for HIPAA to be applied this way. Consumer Movement activism's undue influence (via the administrative state in this case) has warped public policies so that they cause grievous harm to the most vulnerable of all of our citizens HIPAA even permits "mental health" professionals the privilege to hide certain observational information about patients in psychotherapy notes.

Psychotherapy is not applicable to "psychosis" in the first place. Spectrum-disordered clinicians will fiercely disagree. Some of them believe that their psychotherapeutic "treatments" can alter neural mechanisms to modify disease expression and some do not believe that so-called mental illnesses like "schizophrenia" are biological disorders (meaning, they believe the signs and symptoms are psychogenic - which is a spectrum-disordered belief). Psychotherapy, for what it

is, should be for mental health issues, which are non-medical. It makes sense that sensitive information gleaned from someone dealing with mental health issues (psychological issues) should be closely guarded. This is where the psychologization of brain function disorders introduces grossly inappropriate practices into the treatment regime.

Unlike other most other protected health information, a healthcare provider may deny a patient or their personal representative access to psychotherapy notes. Now imagine if a guardian parent requested medical records and a clinician recorded information in those notes that could reveal something dangerous or concerning that a spectrum-disordered psychiatrist or psychologist kept under wraps while trying to build a therapeutic alliance (an eccentric psychodynamic concept).

The brain's semblance of mind, slipping away into neurological detachment is typically anosognosic and "hemorrhages" bizarre unguarded thoughts. There is nothing of a sensitive nature that can be revealed in psychotherapy notes that could shock someone living in a household with a cerebral illness patient. In cases of violence, the media often reports that the shooter posted threats online or otherwise expressed their intentions. Ordinary criminals threaten their victims but not in this manner. It is the cerebral illness that strips away the guardedness and this is a facet of anosognosia. Anosognosia in cerebral illness is a horrific neurological condition. James Holmes exhibited this as he was descending into a "locked in" reality of his brain's own making.

The Office for Civil Rights of HHS enforces this corruption of HIPAA and has acted as an ideological agent for the Mental Hygiene Consumer Movement by allowing providers to use it as a cloak to conceal information rather than as a policy that is applied in the best interest of patients.

There are other destructive public policies such as the dangerousness standard for involuntary treatment, and well-intentioned but inherently unjust programs intended to help the “mentally ill” such as Mental Health courts, community crisis intervention teams, and AOT programs that only act as rickety patchwork fixes to a system that has gaping holes that our most vulnerable citizens fall through to their deaths.

Mental Health Courts are modeled upon the notion of psychosocial factors of criminality, not on an understanding and acceptance of neurobehavioral consequences of severe brain disorders.

Remodeling the Concept of “Mental Illness”

If you think you understand psychosis enough to condemn people that commit acts of harm while in this neurological status, then imagine believing , that is, knowing without a shadow of doubt that you are dead or having an unshakable belief that your body is made of glass. You can’t imagine that. You know you can’t imagine believing without a shred of doubt that that your body is made of glass or liquid or that you are Jesus. You can only try to remodel your concept of what severe so-called mental illness is, and neurological phenomenon like Fregoli’s

Syndrome, Capgras Syndrome, and Cotard's Delusion are good conceptual primers. This is the mindspace that you need to be in to start conceptualizing severe cerebral illness.

There is a stock image that depicts "mental illness" in thousands of articles to be found on the web, on mental health-oriented websites, books, and media content in general. It is an image of a person in a seated position, with their head down, grasping their head in their hands. This image depicts mental health distress, not severe cerebral illness.

When the media reports that a "mentally disturbed" person involved in a crime believed that they were God or that their mother or father or sibling is the devil or an alien intending to harm them or inserting thoughts into their head—don't cast that off as just a crazy person for which "mental health problems" should not be an excuse. A person in the throes of psychosis not just thinks they are Jesus or that their mother is the devil, they know with absolute certainty.

Society's and the judiciary's fierce skepticism of the idea of "insanity" has doomed hundreds of thousands of people to unjust punishment, up to and including state-sponsored execution. Reforming a broken system that has been deformed by misguided ideas about the essential nature of very serious brain disorders can not only save people from homelessness, premature death and unjust incarceration, it can also save the lives of people who become victims of serious untreated cerebral illness in the community.

Psychosis can be deadly and it should be treated as a medical emergency, not as a form of criminality or a psychological existential crisis. We should not have people languishing in jail detention across this country with serious cerebral illnesses awaiting "competency restoration" (i.e. preparation for prosecution) at criminal justice service centers known as state hospitals.

We need to proactively protect people that have these serious illnesses from the harm that can come to them and others by taking their medical conditions seriously and reversing some of the disastrous public policies such as the IMD exclusion and destruction of government-funded supported housing. The only way we can protect the afflicted and promote public safety is to break free of the command and control that the Consumer, Anti-Stigma, and Mental Health movements have on our legislators and society. We have to demand that they listen to the voices of reason and stop being guided by pseudoscience and ideological agendas.

Next in the series:

A Look Back at Tragedies that Might Have Been Prevented

Relevant Content

Deinstitutionalization, IMD Exclusion, and Parity

Full text of "Deinstitutionalization, mental illness, and medications : hearing before the Committee on Finance, United States Senate, One Hundred Third Congress, second session, May 10, 1994" (archive.org)

HIPAA Handcuffs

https://www.jdsupra.com/legalnews/hipaa-psychotherapy-notes-and-other-42359/

https://mentalillnesspolicy.org/national-studies/hippa_handcuffs.html

https://www.salemnews.com/opinion/columns/column-handcuffed-by-hipaa/article_66b526e1-8dbd-5b55-b705-87db4b583ac2.html

The Dangerousness Standard for Involuntary Treatment

https://www.brown.edu/Courses/BI_278/Other/Clerkship/Didactics/Readings/INVOLUNTARY%20TREATMENT.pdf