Negative: Mental Health Care

By “Coach Vance” Trefethen

***Resolved: The United States Federal Government should significantly reform its policies regarding convicted prisoners under federal jurisdiction.***

Case Summary: The AFF plan increases access to mental health care in federal prisons, under the theory that federal prisoners are under-served and suffering with lack of care.

Note #1: In this context (and in the literature in general) “jail” refers to small local city and county facilities where prisoners are kept before trial or for short sentences after conviction. “Prison” refers to bigger state or federal facilities where convicted prisoners serve longer sentences.

Note #2: “DSM” refers to Diagnostic and Statistical Manual of Mental Disorders, considered the “bible” of the psychiatric profession, it’s an official definition of the diagnosis and symptoms of mental illness.

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Negative: Mental Health Care

INHERENCY

1. Increased capacity

Mental health capacity has been increased, staff increased, and services are widely available

Michael Carvajal 2020 (DIRECTOR, FEDERAL BUREAU OF PRISONS) Statement BEFORE THE COMMITTEE ON THE JUDICIARY SUBCOMMITTEE ON CRIME, TERRORISM, AND HOMELAND SECURITY U.S. HOUSE OF REPRESENTATIVES FOR A HEARING ON OVERSIGHT OF THE FEDERAL BUREAU OF PRISONS AND THE U.S. MARSHALS SERVICE 2Dec 2020 <https://www.congress.gov/116/meeting/house/111100/witnesses/HHRG-116-JU08-Wstate-CarvajalM-20201202.pdf> (accessed 11 July 2021) (brackets added)

The Bureau has a variety of programs, the most robust of which are Cognitive Behavioral Therapy (CBT) interventions for mental health and substance use disorders, anger management, and criminal thinking elimination. Literacy and occupational training programs are also widely available, and reentry-focused programs, such as parenting, are offered at all sites. Because the agency has such a large menu of programs covering all need areas, the Bureau has put forth considerable effort to ensure adequate capacity in our existing programs, and has been able to give access to more inmates by hiring staff into the positions authorized by Congress under FSA. [First Step Act]

HARMS / SIGNIFICANCE

1. A/T “Problems in federal prisons” – Impacts are exaggerated

Federal Bureau of Prisons has better track record on violence and recidivism than most state prisons

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As the Subcommittee recognizes, it is imperative that we effectively reintegrate individuals back into the community following release from prison to reduce the likelihood of future criminal behavior and associated victimization. To that end, the mission of the Bureau is to confine offenders in prisons and community-based facilities that are safe, humane, cost-efficient, and secure, and to assist inmates in becoming productive, law-abiding citizens when they return to our communities. The Bureau has had great success with respect to both parts of our mission: we have low rates of inmate on staff and inmate on inmate assaults, disturbances, and escapes, and our recidivism rate is lower than that found in most studies of state prisons using comparable definitions and methodologies.

All prisons have higher suicide rates than regular society. But federal prisons are only slightly higher, and far lower than state prisons and jails

Kristiana J. Dixon PhD, Allison M. Ertl PhD, Rachel A. Leavitt MPH, Kameron J. Sheats PhD, Katherine A. Fowler PhD, Shane P. D. Jack PhD 2020. (all are with 1Division of Violence Prevention, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, Atlanta) <https://stacks.cdc.gov/view/cdc/94033/cdc_94033_DS1.pdf> (accessed 12 July 2021)

Suicide rates are higher among incarcerated than nonincarcerated persons (Konrad et al., 2007; Snow et al., 2002). In 2014, the suicide rate was 50 per 100,000 jail inmates (Noonan, 2016a), 20 per 100,000 state prisoners, and 14 per 100,000 federal prisoners (Noonan, 2016b), while the age-adjusted suicide rate for the entire U.S. population was 12.9 per 100,000 (Centers for Disease Control and Prevention [CDC], 2017).

2. A/T “Crisis of mental illness” – Crisis is exaggerated

Definitions of mental illness have been massively and improperly expanded. It’s over-diagnosed

Dr. Christopher Lane 2018. (PhD; teaches medical humanities and the history of medicine at Northwestern University. A former Guggenheim fellow, awarded the Prescrire Prize for Medical Writing; has held Northwestern’s Pearce Miller Research Professorship and is a member of the Center for Bioethics and Medical Humanities in the Feinberg School of Medicine) “Creating “Mental Illness” – An Interview with Christopher Lane“ quoted by Francesco Bellafante <https://www.madinamerica.com/2018/03/creating-mental-illness-interview-christopher-lane/> (accessed 12 July 2021)

The struggle to name something precisely is clearly a medical necessity, for physicians and patients alike, and one spanning centuries not just recent decades. But to answer your question better, just consider the example you cited earlier of Sir Aubrey Lewis, editor of ICD-8 (the basis for DSM-II), single-handedly deleting the word “reaction” from diagnoses such as “paranoid reaction” and “schizophrenic reaction.” In both cases, the term “reaction” indicates that the situation is dynamic, possibly short-lived, and tied to context or particular stressors (environmental, income-related, doubtless exacerbated by job-loss, homelessness, and so on). With the renaming of those conditions as “paranoia” and “schizophrenia,” all sense of reaction is lost at the stroke of a pen, it becomes much easier to imply that the conditions are innate and potentially lifelong; their recurrence will also seem closer to relapse than the repetition of a particular stressor. And with the rise of the term “disorder”—e.g., “depressive disorder,” “social anxiety disorder,” even “passive-aggressive personality disorder”—the not-so-hidden implication is that the root of the problem is biological/genetic rather than social/environmental. In short, how we describe something—especially in psychiatry—is profoundly deterministic.

“Mental illness” diagnoses and “diseases” are magically increasing out of thin air, without justification

Dr. Christopher Lane 2013. (PhD; teaches medical humanities and the history of medicine at Northwestern University. A former Guggenheim fellow, awarded the Prescrire Prize for Medical Writing; has held Northwestern’s Pearce Miller Research Professorship and is a member of the Center for Bioethics and Medical Humanities in the Feinberg School of Medicine ) How Shyness Became an Illness and Other Cautionary Tales about the DSM <https://cpb-us-e1.wpmucdn.com/sites.northwestern.edu/dist/2/790/files/2018/05/Lane-Shyness-as-a-Cautionary-Tale-about-the-DSM-Berlin-2013-z7a7ud.pdf> (accessed 12 July 2021) (article is undated but references material written in 2013 and none after)

When the American Psychiatric Association decided in 1980 to update its official list of mental disorders, it cited the existence of more than eighty new ones, many of them a source of ongoing controversy (American Psychatric Association: 1980). Among the new disorders were Social Phobia and Avoidant Personality Disorder, preludes to modified illnesses such as Social Anxiety Disorder, with descriptions so broad and open-ended they gave rise to charges that the APA was turning widespread traits into treatable conditions. The effect of such moves, scholars and fellow psychiatrists warned, was not merely to redefine norms of social interaction, itself a dangerous move, but also to medicalize large swaths of behavior with no previous relation to psychiatry or medicine (see for example Karp 1997, Kutchins and Kirk 1997, Horwitz 2003, Conrad 2007, Horwitz and Wakefield 2007 and Lane 20071 ). In 1968, to give weight to such charges, the association’s Diagnostic and Statistical Manual of Mental Disorders (DSM for short), to which I’m referring, cited 180 categories of mental disorders. By 1987, that number had grown to 292 and, by 1994, with the publication of DSM-IV, to over 350. In just twenty-six years, that is, the number of official mental disorders almost doubled, an outcome occurring nowhere else in the history of medicine.

Mental illness diagnoses are unreliable and inflated. Current standards could prove half the human population is mentally ill

Prof. Joel Paris 2020. (Professor of Psychiatry at McGill Univ. in Canada, where he served as Department Chair between 1997 and 2007 and Research Associate in the Dept of Psychiatry at the Jewish General Hospital. He is a former editor-in-chief of the *Canadian Journal of Psychiatry) Overdiagnosis in Psychiatry: How Modern Psychiatry Lost Its Way While Creating a Diagnosis for Almost All of Life's Misfortunes, 2nd edition* <https://books.google.com/books?id=EbvyDwAAQBAJ&pg=PR15&lpg=PR15&dq=%22Diagnoses+are+made+rapidly+%E2%80%93+and+often+inaccurately.+Instead+of+listening%22&source=bl&ots=Hwv7N6jSGb&sig=ACfU3U2Ma3Xxbq28ZQMpJ4jURRkIUiCgPw&hl=en&sa=X&ved=2ahUKEwiB-LbcheHxAhW0KVkFHfIzDZIQ6AEwAnoECAoQAw#v=onepage&q=%22Diagnoses%20are%20made%20rapidly%20%E2%80%93%20and%20often%20inaccurately.%20Instead%20of%20listening%22&f=false> *(accessed 13 July 2021)*



All mental illness diagnoses are subjective opinions: There are zero physical indicators (biomarkers) that can indicate or measure it

**[Analysis: You can diagnose someone with high blood pressure by attaching a cuff to their arm and measuring it. You can diagnose diabetes by sampling their blood and measuring glucose levels. You cannot measure or diagnose ANY psychiatric “illness” in any such way because there are no “biomarkers” like these to indicate someone is “ill.” Mental illness is a set of symptoms subject to various interpretations and opinions, not a measurable pathology in the human body.]**

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Federal prison data confirms subjective diagnosis problem: How many mentally ill prisoners there are. 12%? 19%? 40%? 45%? 50%?

Justice Department, Office of the Inspector General 2017. “Review of the Federal Bureau of Prisons’ Use of Restrictive Housing for Inmates with Mental Illness” July 2017 <https://oig.justice.gov/reports/2017/e1705.pdf> (accessed 15 July 2021) (brackets added)

BOP [federal Bureau of Prisons] data showed that, as of 2015, only 3 percent of the BOP’s sentenced inmate population was being treated regularly for mental illness. Yet, the BOP’s FY 2016 Performance Budget Congressional Submission cited an internal BOP study, which suggested that approximately 19 percent of federal inmates had a history of mental illness. Moreover, a 2006 Bureau of Justice Statistics report concluded that 45 percent of federal inmates had symptoms or a recent history of mental illness. We found that the BOP cannot accurately determine the number of inmates who have mental illness because institution staff do not always document mental disorders. The BOP’s FY 2014 data estimates that approximately 12 percent of inmates have a history of mental illness; however, in 2015, the BOP’s Chief Psychiatrist estimated, based on discussions with institutions’ Psychology Services staffs, that approximately 40 percent of inmates have mental illness, excluding inmates with only personality disorder diagnoses. Similarly, one institution’s Deputy Chief Psychologist estimated that 50 percent of that institution’s inmates may have Antisocial Personality Disorder; nevertheless, we found that this disorder was documented for only about 3.3 percent of the BOP’s total inmate population.

3. Financial motives for over-diagnosing mental illness: #1 - The Drug Companies

SmithKline Beecham recommended their drug Paxil for “Social Anxiety Disorder” because you could be mentally ill if you’re afraid of public speaking!

SmithKline Beecham 1998. (British pharmaceutical company, makers of the drug Paxil; now known as GSK or Glaxo Smith Kline) Seroxat/Paxil Fact File <https://cpb-us-e1.wpmucdn.com/sites.northwestern.edu/dist/2/790/files/2016/01/PaxilFactFile.Section2.Social.Anxiety-2459v5l.pdf>



SmithKline Beecham, also known as “GSK”, got caught and penalized by the US government for illegally promoting Paxil and other psych drugs to inflate their profits

US Dept of Justice, Office of Public Affairs 2012. “GlaxoSmithKline to Plead Guilty and Pay $3 Billion to Resolve Fraud Allegations and Failure to Report Safety Data” 2 July 2012 <https://www.justice.gov/opa/pr/glaxosmithkline-plead-guilty-and-pay-3-billion-resolve-fraud-allegations-and-failure-report>

“This case demonstrates our continuing commitment to ensuring that the messages provided by drug manufacturers to physicians and patients are true and accurate and that decisions as to what drugs are prescribed to sick patients are based on best medical judgments, not false and misleading claims or improper financial inducements,” said Carmen Ortiz, U.S. Attorney for the District of Massachusetts. “Patients rely on their physicians to prescribe the drugs they need,” said John Walsh, U.S. Attorney for Colorado. “The pharmaceutical industries’ drive for profits can distort the information provided to physicians concerning drugs.  This case will help to ensure that your physician will make prescribing decisions based on good science and not on misinformation, money or favors provided by the pharmaceutical industry.”
**Civil Settlement Agreement**As part of this global resolution, GSK has agreed to resolve its civil liability for the following alleged conduct: (1) promoting the drugs Paxil, Wellbutrin, Advair, Lamictal and Zofran for off-label, non-covered uses and paying kickbacks to physicians to prescribe those drugs as well as the drugs Imitrex, Lotronex, Flovent and Valtrex; (2) making false and misleading statements concerning the safety of Avandia; and (3) reporting false best prices and underpaying rebates owed under the Medicaid Drug Rebate Program.

4. Financial motives for over-diagnosing mental illness: #2 – The Doctors

Doctors give everyone a mental illness “diagnosis” so that insurance will reimburse for it

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Doctors and drug companies both profit from over-diagnosis (often inaccurate) of mental illness

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5. Not parallel to (physical) medical care

Lacking an etiology (a known physical cause), “mental illness” is a set of symptoms, not a disease, and may ultimately lack reality

**[Analysis: To put it more simply, the fact that someone has a set of symptoms doesn’t mean they have a disease. In physical medicine, for example, someone might have the symptom of thirst. It could be caused by eating salty foods, exercising a lot, or having uncontrolled diabetes. A doctor would run some tests to find out if their blood sugar was elevated [that’s the etiology], and if it was, they could diagnose diabetes. The doctor wouldn’t just listen to the symptom, diagnose them with “thirst syndrome” and prescribe medication. But that’s how psychiatry works: the symptom is labeled as the disease, and there is no search for the cause, we just go straight to medication.]**

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SOLVENCY

1. No doctors available

Remote prisons facilities can’t recruit mental health staff – they don’t want to live in rural areas

WASHINGTON POST 2018 (journalists Christie Thompson and Taylor Elizabeth Eldridge) 21 Nov 2018 “‘NO ONE TO TALK YOU DOWN’” (accessed 7 July 2021) <https://www.washingtonpost.com/news/national/wp/2018/11/21/feature/federal-prisons-were-told-to-improve-inmates-access-to-mental-health-care-theyve-failed-miserably/>

Although hiring and retaining mental-health staff is a challenge for all prisons, it can be especially difficult for remote facilities. A [recent study](https://www.ajpmonline.org/article/S0749-3797%2818%2930005-9/fulltext) published in the American Journal of Preventive Medicine found that about half of rural communities in the United States don’t have access to a psychologist, and 65 percent don’t have a psychiatrist. “Most people who have gone through the time and expense to become a psychologist . . . do not want to live in a really rural area,” said Doug Lemon, a former chief psychologist at two federal prisons in Kentucky.

2. “More treatment” doesn’t mean more success

“Number of patients receiving treatment” is not the measure of success. Could be the measure of fraud

John Schwade 2017 (retired prison psychologist, formerly stationed at Polk Correctional Institution in Butner, a North Carolina state prison) Feb 2017 “Full report: ‘Every supposed reform has been harmful’ to inmates“ <https://www.charlotteobserver.com/news/local/article134506394.html> (accessed 13 July 2021)

Of course, the fact that more inmates are receiving prescriptions for psychiatric medications does not mean that either (a) those inmates most in need of treatment are receiving it or (b) those receiving treatment are receiving appropriate treatment, or even need treatment. It is impossible to conceive of another area of medicine where the number of patients receiving a type of treatment would be construed as a measure of success without regard for whether patients receiving that treatment actually needed it or whether all of those who needed that treatment were receiving it. Indeed, this is a hallmark of fraud, as in the recent case of a Palm Beach dermatologist who falsely diagnosed skin cancers in hundreds of patients and subjected them to unnecessary and very profitable treatments.

3. Already tried & failed

The 2014 policy AFF blames for causing the mental health crisis is basically the AFF plan: They tried to guarantee mental health treatment for all inmates

Justice Department, Office of the Inspector General 2017. “Review of the Federal Bureau of Prisons’ Use of Restrictive Housing for Inmates with Mental Illness” July 2017 <https://oig.justice.gov/reports/2017/e1705.pdf> (accessed 15 July 2021)

In May 2014, the BOP issued a national policy requiring that all inmates receive mental health care commensurate with their needs, even while they are in restrictive housing. The policy seeks to ensure that inmates with mental illness are identified and receive treatment to assist their progress toward recovery and to reduce or eliminate the frequency and severity of symptoms and associated negative outcomes of mental illness, such as placement in restrictive housing. According to the policy, any BOP staff member who observes unusual behavior that may indicate mental illness must report such observations to the institution’s Chief Psychologist or Mental Health Treatment Coordinator.

DISADVANTAGES

1. Resources spread too thin

Link: Mental illness is over-diagnosed

Cross apply Significance evidence above

Link: Accepting and trying to meet the over-diagnosed “needs” of mental illness distracts us from focusing on the truly ill

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Impact: Turn the harms. The seriously ill can’t get treated when resources are spread thin trying to treat everyone. The impacts of “lack of treatment” in the AFF plan get worse.

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2. Over-medicating

Link: Epidemic of over-diagnosing mental illness leads to incorrect and unnecessary treatment

Prof. Joel Paris 2020. (Professor of Psychiatry at McGill Univ. in Canada, where he served as Department Chair between 1997 and 2007 and Research Associate in the Dept of Psychiatry at the Jewish General Hospital. He is a former editor-in-chief of the *Canadian Journal of Psychiatry) Overdiagnosis in Psychiatry: How Modern Psychiatry Lost Its Way While Creating a Diagnosis for Almost All of Life's Misfortunes, 2nd edition* <https://books.google.com/books?id=EbvyDwAAQBAJ&pg=PR15&lpg=PR15&dq=%22Diagnoses+are+made+rapidly+%E2%80%93+and+often+inaccurately.+Instead+of+listening%22&source=bl&ots=Hwv7N6jSGb&sig=ACfU3U2Ma3Xxbq28ZQMpJ4jURRkIUiCgPw&hl=en&sa=X&ved=2ahUKEwiB-LbcheHxAhW0KVkFHfIzDZIQ6AEwAnoECAoQAw#v=onepage&q=%22Diagnoses%20are%20made%20rapidly%20%E2%80%93%20and%20often%20inaccurately.%20Instead%20of%20listening%22&f=false> *(accessed 13 July 2021)*



Link: Lots of discrepancies in determining the effect of psych medications. And sometimes placebo is more effective

[Koustuv Saha](https://www.ncbi.nlm.nih.gov/pubmed/?term=Saha%20K%5BAuthor%5D&cauthor=true&cauthor_uid=32280562), [Benjamin Sugar](https://www.ncbi.nlm.nih.gov/pubmed/?term=Sugar%20B%5BAuthor%5D&cauthor=true&cauthor_uid=32280562), Dr. [John Torous](https://www.ncbi.nlm.nih.gov/pubmed/?term=Torous%20J%5BAuthor%5D&cauthor=true&cauthor_uid=32280562), Prof. [Bruno Abrahao](https://www.ncbi.nlm.nih.gov/pubmed/?term=Abrahao%20B%5BAuthor%5D&cauthor=true&cauthor_uid=32280562), [Emre Kıcıman](https://www.ncbi.nlm.nih.gov/pubmed/?term=K%26%23x00131%3Bc%26%23x00131%3Bman%20E%5BAuthor%5D&cauthor=true&cauthor_uid=32280562) and Prof. [Munmun De Choudhury](https://www.ncbi.nlm.nih.gov/pubmed/?term=De%20Choudhury%20M%5BAuthor%5D&cauthor=true&cauthor_uid=32280562) 2019 (Saha and Sugar – PhD candidate in computer sci. at Ga. Tech. Torous – MD; director of the digital psychiatry division, in the Department of Psychiatry at Beth Israel Deaconess Medical Center. Abrahao -  Assistant Professor of Information Systems and Business Analytics at NYU Shanghai. Kiciman - Senior Principal Researcher at Microsoft Research. Choudhury – PhD; Associate Professor in the [School of Interactive Computing](http://www.ic.gatech.edu/) at [Georgia Tec](http://www.gatech.edu/)h Univ.) “A Social Media Study on the Effects of Psychiatric Medication Use” June 2019 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7152507/> (accessed 14 July 2021)

As highlighted earlier, there are complexities in determining the effects of psychiatric medications in individuals; but at the same time, there are discrepancies in the claims made by clinical studies. For example, Geddes et al. found no major differences in the efficacy of SSRIs and TCAs, whereas other studies found one kind to perform better than others (Cipriani et al. 2018). Other studies found placebos or non-pharmacological care to have outperformed certain antidepressants (Szegedi et al. 2005).

Impact: Unnecessary or incorrect psych medication can exacerbate (make worse) mental illness

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Given the pervasiveness of their use, psychiatric medications can either alleviate or exacerbate mental illness burden on both personal and societal levels ([Rosenblat et al. 2016](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7152507/%22%20%5Cl%20%22R56)). One reason behind the mixed success of psychiatric medications stems from the fact that the mechanisms by which they modify the brain operation are poorly understood. In practice, their effects vary across individuals, and often do not achieve the intended result. Without any biological markers to match patients with the most appropriate medication, the selection of drug treatments is based primarily on trial-and-error ([Cipriani et al. 2018](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7152507/#R12); [Trivedi et al. 2006](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7152507/#R68)). Un-surprisingly, frustration with treatment and side effects often causes treatment discontinuation ([Bull et al. 2002](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7152507/#R6)).

Impact: Anti-depressants can worsen depression, suicide risk, hostility and violence in individuals facing stress

Dr. Peter R. Breggin 2010 (MD, a psychiatrist in private practice) Witness Testimony of Peter R. Breggin, M.D., Ithaca, NY (Psychiatrist and Author) [Hearing on 02/24/2010: Exploring the Relationship Between Medication and Veteran Suicide](https://web.archive.org/web/20121018101836/https%3A/veterans.house.gov/hearing/exploring-the-relationship-between-medication-and-veteran-suicide) [https://web.archive.org/web/20121018101836/https://veterans.house.gov/witness-testimony/peter-r-breggin-md/](https://web.archive.org/web/20121018101836/https%3A//veterans.house.gov/witness-testimony/peter-r-breggin-md/)

The Black Box Warning provides additional information.  Then the label continues with an elaborate WARNINGS section subtitled, Clinical Worsening and Suicide Risk, which contains the following statement:
There has been a long-standing concern, however, that antidepressants may have a role in inducing worsening of depression and the emergence of suicidality in certain patients during the early phases of treatment. Pooled analyses of short-term placebo-controlled trials of antidepressant drugs (SSRIs and others) showed that these drugs increase the risk of suicidal thinking and behavior (suicidality) in children, adolescents, and young adults (ages 18-24) with major depressive disorder (MDD) and other psychiatric disorders.
This section continues with a specific warning about the increased risk of medication-induced suicidality during “the initial few months of a course of drug therapy, or at times of doses changes, either increases or decreases.”  It then describes an activation or stimulant-like array of adverse effects:
The following symptoms, anxiety, agitation, panic attacks, insomnia, irritability, hostility aggressiveness, impulsivity, akathisia (psychomotor restlessness), hypomania, and mania, have been reported in adult and pediatric patients being treated with antidepressants for major depressive disorder as well as for other indications, both psychiatric and nonpsychiatric.
Note the specific mention of “irritability, hostility, aggressiveness, impulsivity”—a virtual prescription for causing suicide and violence, especially in an already stressed individuals, including soldiers.