Recommendations of
Sylvia Thompson, BA, CMC
President, NAMI Westside Los Angeles
Daughter of someone with serious mental illness
to
US House of Representatives Committee on Energy and Commerce Subcommittee on Health
In SUPPORT of HR-3717: Helping Families in Mental Health Crisis Act
April 4, 2014

I recommend passing HR 3717 and especially support the following provisions which will help get treatment to the most seriously ill.

1. Implement IMD Reform: The Institutes for Mental Disease Exclusion prevents states from receiving Medicaid reimbursement for the mentally ill who are so ill they need to be hospitalized for an extended period. So states kick the seriously mentally ill out of hospitals to make them Medicaid eligible. Many wind up incarcerated. HR3717 makes small revisions in Medicaid so those who need hospital care can receive it.

2. Require states to have AOT as a condition to receive block grants and fund pilot AOT programs: AOT is exclusively for those who have a history of multiple arrests, violence, incarcerations or hospitalizations due to going off treatment. It allows judges to order them into mandated and monitored treatment and order the mental health system to provide the care. AOT reduces homelessness, arrest, hospitalization and incarceration over 70% each. It saves 50% by providing an off-ramp before more expensive and restrictive inpatient commitment or incarceration become needed. 75% of those in the program say it helps them get well and stay well. DOJ certified it as an effective crime prevention program.

3. HIPAA/FERPA Reform: This alone would help the lives of so many people I try to help. HIPAA and FERPA require doctors to keep families in the dark absent a specific waiver by the mentally ill individual. Neither James Holmes nor Jared Loughner gave the waiver, hence their parents did not know school authorities identified them as needing help. Families need the information about their mentally ill loved ones so they can ensure they have prescriptions filled, transportation to appointments, and stay in treatment. HR 3717 writes limited exclusions into HIPAA law so family/caregivers get the same information paid caretakers would receive.

4. Eliminate anti-treatment activities at SAMHSA/CMHS: Congress created SAMHSA to "target ... mental health services to the people most in need". SAMHSA fails to focus on the seriously ill and funds programs and groups that make care more difficult. Only four of the 288 programs in the SAMHSA National Registry of Evidence Based Practices are for people with serious mental illness. SAMHSA uses block grant funds to coerce states to replace the medical model with SAMHSA's recovery model, which requires people self-direct their own care. The most seriously ill, who are psychotic and delusional, cannot self-direct their own care. SAMHSA suggests everyone recovers, thereby ignoring those so ill they do not.

5. Reform PAIMI: PAIMI was founded with the noble purpose of helping to improve the quality of care received by the most seriously ill. It now focuses on 'freeing' them from treatment. It has evolved into a lobbying machine that discourages states from spending on the most seriously ill. HR 3717 returns Protection and Advocacy for Individuals with Mental Illness to their original mission of helping persons with mental illness access care and reigns in their ability to use funds lobbying against treatments (ex. hospitals) needed by some of the seriously ill.

6. Create Assistant Secretary to focus federal efforts on the most seriously ill: HR 3717 creates an Assistant Secretary for Mental Health to distribute block grants formerly distributed by SAMHSA and help the system address the elephant in the room: getting treatment to people known to have untreated serious mental illness. The Secretary would eliminate non-evidenced based practices, provide better coordination of federal resources, reduce duplication, and require the prioritization of the seriously ill.

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Thank you Mr. Chairman, members of the Committee and my own Representative Waxman. My name is Sylvia Thompson and I am a professional client advocate and Care Manager as well as the President of the National Alliance on Mental Illness, Westside Los Angeles affiliate. But that is not why I am here today.

Today I am my mother's daughter. I never knew anything other than a life surrounded by serious mental illness. My mother was seriously mentally ill from as far back as I can remember. Growing up in our family was like living in a combat zone where my mother's serious mental illness terrorized every one of us. It never felt safe because you didn't know when the other boot was going to drop. The drastic mood changes, intense paranoia, grandiose ideas, impulsivity, delusions, depression, and inappropriate anger created a frightening environment for a child who depended on her. This led to emotional and physical neglect, as well as emotional, verbal, and, at times, physical abuse. And yet, I loved my mother. I watched as my father, and later my siblings and I, were powerless to help her.

My mother had zero insight into her illness. She did not believe she was ill. We call that anosognosia[1]. It affects up to 40% of those with schizophrenia and bipolar. Because she didn't believe she was ill, she would not stay in treatment and as a result could not take care of herself, let alone me. She had suicidal ideation, delusions I was possessed, multiple hospitalizations, and would disappear for spells of time...sometimes hours, sometimes weeks and we were powerless to do anything but watch her deteriorate.

I went to college and got a degree in Psychology, became a patient advocate for the most vulnerable population, and now President of NAMI Westside LA. I know what would have helped my mother and what would help the countless faces of serious mental illness I see day after day. Much of that is in HR 3717. It is the first bill to address the needs of the most seriously ill as opposed to the many bills that focus on helping the much higher functioning.

I believe in self-determination for those who are capable but **we must recognize** that there is a small group of people, like my mother, who are too ill to self-direct their own care. To take the extreme case, John Hinckley was self-directing his own care when he decided the best way to get a date with Jodi Foster was to shoot President Reagan. We can't pretend these people don't exist because by doing so, we marginalize them. They are our loved ones. Our helpline gets calls everyday from parents, children, siblings, and spouses of individuals who are so ill they can't acknowledge it and so refuse treatment. They cower in their rooms believing the FBI planted a transmitter in their head. They refuse to eat for fear

of being poisoned. They believe their young daughter is the child of the devil and will kill them in a great battle. The mental health system won't help them because they are not well enough to volunteer for treatment. The police can't help until after they become dangerous. Laws should prevent dangerous behavior not require it. How I wish everyone was well enough to take care of themselves and use voluntary services but some are not.

We need Assisted Outpatient Treatment. (AOT)
What would have helped my mother and would help some of those who call our helpline would be to have Assisted Outpatient Treatment as provided for in HR 3717. While some opponents cite old research on this (Appendix: Myths about Laura's Law) I have reviewed the recent research for New York (Appendix: Recent Kendra's Law Studies) and California (Appendix: Laura's Law Results in two counties) and the results are exceedingly clear: AOT reduces homelessness, incarceration, suicide, arrest, and yes, violence. It is for very few of the most seriously ill, only those with a past history of multiple incidents of arrest, violence or hospitalization caused by refusing to stay in treatment. By providing an off-ramp before involuntary commitment and incarceration it saves money and, more importantly, it saves lives.

We need enough hospital beds for the most seriously ill who need hospitalization.
We are in dire need of more hospital beds, something HR 3717 addresses. I deal with calls from families wondering what they have to do to help get a loved one who needs hospital care into a hospital. California has only 5 state hospitals with less than 7,000 beds[2]. 90% of those who get into California psychiatric hospitals do so through the criminal justice system not the mental health system[3]. In California individuals with serious mental illness are four times more likely to be incarcerated as hospitalized.[4] Admission, without becoming a danger to self or others, is virtually impossible. That is criminalizing an illness. Can you imagine that for Cancer or Alzheimer's Disease? Even if California had a perfect community based mental health system, we are still short over 10,000 hospital beds to help the seriously ill get stabilized well enough for release. Again, we can't pretend that hospitals are not needed by anyone. Some with a serious mental illness **do need** hospitalization to get stabilized.

We have to free family caretakers from HIPAA Handcuffs so they can provide care to loved ones.
HIPAA and FERPA prevent families from getting information they need to provide care to seriously mentally ill loved ones. The information is readily available to programs that are paid to provide case management services or paid to provide housing for the mentally ill, but is withheld from parents who do it out of love. Again, to take an extreme case, while authorities identified both James Holmes and Jared Loughner as needing help, as a result of HIPAA and FERPA their parents were kept in the dark. How can a family member, or in my case a daughter, ensure my loved one has transportation to an appointment if I don't know when the appointment is; or ensure she stays on medications if I am not told what the medicines are? Families are given the responsibility to provide care for mentally ill loved ones, but not the information needed to do so and so we watch helplessly as our loved one spirals into madness while our hands are tied. HR 3717 writes limited exclusions into HIPAA law so family/caregivers get the same information paid caretakers would receive.

We have to have community services that will let the most seriously ill into them.
We have to ensure that community services are in place to help the most seriously ill. Period. Right now, the ability to get into a program is inversely related to severity of illness. The least seriously ill go to the front of the line while the most seriously ill are sent to jails, prisons, the streets, and morgues. HR 3717 creates a secretary of mental health who can help insure that when community services are introduced, they focus on the most seriously ill. SAMHSA provides guidance to states on how to use Mental Health Block Grants. That direction often includes limiting resources to only those who can self-direct their own care, leaving the most seriously ill unserved...that excludes an entire population of people who need our help the most.

We have to stop funding non-evidence based programs and groups that impede care for the most seriously ill.
We have to ensure that programs are evidence based to improve a meaningful outcome in people with serious mental illness. Too many programs are measured by the claims of those who run them rather than independent investigators. Dr. Sally Satel testified that only four of the 288 programs in SAMHSA's National Registry of Evidence Based Practices focus on serious mental illness[5]. Further, SAMHSA seems to focus on soft measures for people much higher functioning like 'hope' and 'empowerment'. Those are very important, but we should also be measuring drops in suicide, homelessness, incarceration and other harder outcomes. SAMHSA is funding groups in California that are working to prevent implementation of policies that help the most seriously ill: opposing reforms of HIPAA, opposing implementation of Laura's Law, opposing preservation of adequate hospital beds. It is very hard for us to improve care for the most seriously ill in California when SAMHSA is providing funds to groups that oppose our efforts.

I urge you to pass HR 3717. It is wonderful and noble for Congress to want to improve the mental health of everyone, to help the higher functioning, but by doing so, we cannot ignore the most seriously ill and for too long we have. They are the **most vulnerable** and they need your help.

For over thirty years, my mother struggled with delusional ideas, grandiose thinking, paranoia, anxiety, and depression. She had left the family home and lived in an apartment in a state of total squalor, surrounded by stacks of newspapers and magazines dating back 15 years, rotten food, human feces, dead rodents. She continued to lash out and alienate herself from us even though we had always tried to do what was best for her.

I've spoken quite graphically about my mother today but you should also know she spoke 7 languages fluently, knew every opera libretto, and was a gifted pianist.....she was passionate, creative, and loving....she was someone's daughter, someone's sister, someone's wife...and mother to 6 amazing children who were desperate for her presence and her love.

Her inability to acknowledge her illness **was not a choice**. It was a symptom that robbed us all of her amazing qualities...that robbed me of my mother. I am proud to be my

mother's daughter. I inherited her passion, her creativity, her musicality, her outside the box thinking.

As her daughter who loved her, it was never easy as we were abandoned by an inadequate mental health system. My mother was failed by this system, my family was failed by this system, I was failed by this system.

Thank you.

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[1] Anosognosia is lack of awareness that an individual is ill. Anosognosia is the single largest reason why individuals with schizophrenia and bipolar disorder do not take their medications. It is caused by damage to specific parts of the brain, especially the right hemisphere. It affects approximately 50 percent of individuals with schizophrenia and 40 percent of individuals with bipolar disorder. The person believes that their delusions are real (e.g. the woman across the street really is being paid by the CIA to spy on him/her) and that their hallucinations are real (e.g. the voices really are instructions being sent by the President). Source: Dr. E. Fuller Torrey, Author, Surviving Schizophenia. Studies on anosognosia at http://mentalillnesspolicy.org/medical/anosognosia-studies.html

[2] The Shortage of Public Hospital Beds for the Mentally Ill, Report of the Treatment Advocacy Center, Arlington, VA 2005. Available at http://mentalillnesspolicy.org/imd/shortage-hosp-beds.pdf

[3] Governor Jerry Brown State Budget 2014. ""The composition of the patients served by DSH has changed greatly over time, with over 90 percent currently coming from the criminal justice system. In addition, the class action lawsuit (Coleman v. Brown) involving mental health care in state prisons has increased referrals from the Department of Corrections and Rehabilitation to DSH for inpatient treatment. The inmates referred to DSH tend to have a more violent history." Available at http://www.calnewsroom.com/wp-content/uploads/2014/01/FullBudgetSummary.pdf

[4] More Mentally Ill are in Jails and Prisons than Hospitals: A survey of the states. Treatment Advocacy Center. May 2010. Available at http://mentalillnesspolicy.org/NGRI/jails-vs-hospitals.html

[5] Testimony to House Energy and Commerce Subcommittee on Oversight and Investigations. Available at http://mentalillnesspolicy.org/samhsa/satel.5.22.13.samhsa.testimony.pdf

Reduction in harmful events when Laura's Law implemented in Nevada County

Key Indicator	Pre-AOT	Post-AOT	Improvement
Hospitalization	1404 days	748 days	46.7%
Incarceration	1824 days	637 days	65.1%
Homelessness	4224 days	1898 days	61.9%
Emergency Contacts	220 contacts	123 contacts	44.1%

Reduction in costs when Laura's Law implemented in Nevada County

Key Indicator	Pre-AOT	Post-AOT	Improvement
Hospitalization	$346,950	$133,650	$213,300
Incarceration	$78,150	$2,550	75,600

Summary: Nevada County gave individuals under court order access to services and found Laura's Law implementation saved $1.81-$.2.52 for ever dollar spent

Reduction in harmful events when Laura's Law implemented in Los Angeles County

Key Indicator	Percentage Decrease
Incarceration	Reduced 78%
Hospitalization	Reduced 86%
Hospitalization after AOT ended	Reduced 77%
Milestones of Recovery Scores	Increased

Reduction in costs when Laura's Law implemented in Los Angeles County

Laura's Law cut taxpayer costs 40 percent in Los Angeles.

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Source for Nevada County Data: Michael Heggarty, Behavioral Health Director, Nevada County. "The Nevada County Experience," Nov. 15, 2011.

Source for Los Angeles County Data: County of Los Angeles. "Outpatient Treatment Program Outcomes Report" April 1, 2010 – December 31, 2010. Cost data from: Michael D. Antonovich, Los Angeles County Fifth District Supervisor, Los Angeles Daily News, December 12, 2011.

Prepared by Mental Illness Policy Org.
3/2012 http://lauras-law.org

10 Independent Kendra's Law Studies Show it works

Independent Study	Findings
May 2011 Arrest Outcomes Associated With Outpatient Commitment in New York State Bruce G. Link, et al. Ph.D. Psychiatric Services	For those who received AOT, the odds of any arrest were 2.66 times greater (p<.01) and the odds of arrest for a violent offense 8.61 times greater (p<.05) before AOT than they were in the period during and shortly after AOT. The group never receiving AOT had nearly double the odds (1.91, p<.05) of arrest compared with the AOT group in the period during and shortly after assignment."
October 2010: Assessing Outcomes for Consumers in New York's Assisted Outpatient Treatment Program Marvin S. Swartz, M.D., Psychiatric Services	Consumers who received court orders for AOT appeared to experience a number of improved outcomes: reduced hospitalization and length of stay, increased receipt of psychotropic medication and intensive case management services, and greater engagement in outpatient services.
February 2010 Columbia University. Phelan, Sinkewicz, Castille and Link. Effectiveness and Outcomes of Assisted Outpatient Treatment in New York State Psychiatric Services, Vol 61. No 2	Kendra's Law has lowered risk of violent behaviors, reduced thoughts about suicide and enhanced capacity to function despite problems with mental illness. *Patients given mandatory outpatient treatment - who were more violent to begin with - were nevertheless four times less likely than members of the control group to perpetrate serious violence* after undergoing treatment. Patients who underwent mandatory treatment reported higher social functioning and *slightly less stigma*, rebutting claims that mandatory outpatient care is a threat to self-esteem.
March 2005 N.Y. State Office of Mental Health "Kendra's Law: Final Report on the Status of Assisted Outpatient Treatment. "	**Danger and Violence Reduced** • 55% fewer recipients engaged in suicide attempts or physical harm to self • 47% fewer physically harmed others • 46% fewer damaged or destroyed property • 43% fewer threatened physical harm to others. • Overall, the average decrease in harmful behaviors was 44%. **Consumer Outcomes Improved** • 74% fewer participants experienced homelessness • 77% fewer experienced psychiatric hospitalization • 56% reduction in length of hospitalization. • 83% fewer experienced arrest • 87% fewer experienced incarceration. • 49% fewer abused alcohol • 48% fewer abused drugs **Consumer participation and medication compliance improved** • Number of individuals exhibiting good adherence to meds increased 51%. • The number of individuals exhibiting good service engagement increased 103%. **Consumer Perceptions Were Positive** • 75% reported that AOT helped them gain control over their lives • 81% said AOT helped them get and stay well • 90% said AOT made them more likely to keep appointments and take meds. • 87% of participants said they were confident in their case manager's ability. • 88% said they and case manager agreed on what is important to work on. **Effect on mental illness system** · **Improved Access to Services.** AOT has been instrumental in increasing accountability at all system levels regarding delivery of services to high need individuals. Community awareness of AOT has resulted in increased outreach to individuals who had previously presented engagement challenges to mental health service providers. · **Improved Treatment Plan Development, Discharge Planning, and Coordination of Service Planning.** Processes and structures developed for AOT have resulted in improvements to treatment plans that more appropriately match the needs of individuals who have had difficulties using mental health services in the past. · **Improved Collaboration between Mental Health and Court Systems.** As AOT processes have matured, professionals from the two systems have improved their working relationships, resulting in greater efficiencies, and ultimately, the conservation of judicial, clinical, and administrative resources. o There is now an organized process to prioritize and monitor individuals with the greatest need;

February 2010 Columbia University. Phelan, Sinkewicz, Castille and Link. Effectiveness and Outcomes of Assisted Outpatient Treatment in New York State Psychiatric Services, Vol 61. No 2	• Kendra's Law has lowered risk of violent behaviors, reduced thoughts about suicide and enhanced capacity to function despite problems with mental illness. • Patients given mandatory outpatient treatment - who were more violent to begin with - were nevertheless four times less likely than members of the control group to perpetrate serious violence after undergoing treatment. • Patients who underwent mandatory treatment reported higher social functioning and slightly less stigma, rebutting claims that mandatory outpatient care is a threat to self-esteem.
October 2010: Changes in Guideline-Recommended Medication Possession After Implementing Kendra's Law in New York, Alisa B. Busch, M.D Psychiatric Services	In all three regions, for all three groups, the predicted probability of an M(edication) P(ossesion) R(atio) ≥80% improved over time (AOT improved by 31–40 percentage points, followed by enhanced services, which improved by 15–22 points, and "neither treatment," improving 8–19 points). Some regional differences in MPR trajectories were observed.
October 2010 Robbing Peter to Pay Paul: Did New York State's Outpatient Commitment Program Crowd Out Voluntary Service Recipients? Jeffrey Swanson, et al. Psychiatric Services	In tandem with New York's AOT program, enhanced services increased among involuntary recipients, whereas no corresponding increase was initially seen for voluntary recipients. In the long run, however, overall service capacity was increased, and the focus on enhanced services for AOT participants appears to have led to greater access to enhanced services for both voluntary and involuntary recipients.
June 2009 D Swartz, MS, Swanson, JW, Steadman, HJ, Robbins, PC and Monahan J. New York State Assisted Outpatient Treatment Program Evaluation. Duke University School of Medicine, Durham, NC, June, 2009	We find that New York State's AOT Program improves a range of important outcomes for its recipients, apparently without feared negative consequences to recipients. • **Racial neutrality**: We find no evidence that the AOT Program is disproportionately selecting African Americans for court orders, nor is there evidence of a disproportionate effect on other minority populations. Our interviews with key stakeholders across the state corroborate these findings. **Court orders add value:** The increased services available under AOT clearly improve recipient outcomes, however, the AOT court order, itself, and its monitoring do appear to offer additional benefits in improving outcomes. • **Improves likelihood that providers will serve seriously mentally ill:** It is also important to recognize that the AOT order exerts a critical effect on service providers stimulating their efforts to prioritize care for AOT recipients. • **Improves service engagement:** After 12 months or more on AOT, service engagement increased such that AOT recipients were judged to be more engaged than voluntary patients. This suggests that after 12 months or more, when combined with intensive services, AOT increases service engagement compared to voluntary treatment alone. • **Consumers Approve**: Despite being under a court order to participate in treatment, current AOT recipients feel neither more positive nor more negative about their treatment experiences than comparable individuals who are not under AOT.
1999 NYC Dept. of Mental Health, Mental Retardation and Alcoholism Services. H. Telson, R. Glickstein, M. Trujillo, Report of the Bellevue Hospital Center Outpatient Commitment Pilot	• Outpatient commitment orders often assist patients in complying with outpatient treatment. • Outpatient commitment orders are clinically helpful in addressing a number of manifestations of serious and persistent mental illness. • Approximately 20% of patients do, upon initial screening, express hesitation and opposition regarding the prospect of a court order. After discharge with a court order, the majority of patients express no reservations or complaints about orders. • Providers of both transitional and permanent housing generally report that outpatient commitment help clients abide by the rules of the residence. More importantly, they often indicate that the court order helps clients to take medication and accept psychiatric services. • Housing providers state that they value the leverage provided by the order and the access to the hospital it offers.
1998 Policy Research Associates, Study of the NYC involuntary outpatient commitment pilot program.	• Individuals who received court ordered treatment in addition to enhanced community services spent 57 percent less time in psychiatric hospitals.

MYTHS ABOUT LAURA'S LAW (AB1421)

Prepared by Mental Illness Policy Org

http://mentalillnesspolicy.org

MYTH: If there were more voluntary services, Laura's Law would not be needed.

REALITY: Voluntary programs and AOT currently serve two mutually exclusive populations. Voluntary programs serve those who 'voluntarily' accept services. Laura's Law by definition is for those won't accept voluntary services. Laura's Law does not preclude anyone from accepting voluntary services.

MYTH: Existing community programs serve the same people who would be served by Laura's Law

REALITY: Laura's Law is the *only* community program that serves people who refuse treatment.

MYTH: Laura's Law does not confer any benefits beyond those of LPS (5150)

REALITY: LPS only allows for inpatient commitment. Laura's Law allows for court ordered outpatient treatment, a less restrictive, less expensive, more humane alternative.

MYTH: Court orders do not provide any benefit

REALITY: The 2009 study of NY's version of Laura's Law found

"The increased services available under AOT clearly improve recipient outcomes, however, the AOT court order, itself, and its monitoring do appear to offer *additional benefits* in improving outcomes."

- ✓ The likelihood of a hospital admission over six months was "highly statistically significant" and lower among AOT recipients than among voluntary recipients.
- ✓ AOT patients were less likely to be arrested than their voluntary counterparts
- ✓ Persons receiving AOT for 12 months or more had a substantially higher level of personal engagement in treatment than those receiving services voluntarily.

MYTH: Laura's Law doesn't work.

REALITY: Nevada County's experience with Laura's Law found it works. Per Judge Anderson it saves people from severe mental health deterioration, increases voluntary participation in mental health care, increases stability, decreases crisis. Studies of the NYS version of Laura's Law show it

- ✓ Helps the mentally ill by reducing homelessness (74%); suicide attempts (55%); and substance abuse (48%)
- ✓ Keeps the public safer by reducing physical harm to others (47%) and property destruction (43%)
- ✓ Saves money by reducing hospitalization (77%); arrests (83%); and incarceration (87%).

MYTH: AOT will lead to a roundup of mentally ill individuals who will be forced into treatment.

REALITY: Laura's Law's narrowly-focused eligibility criteria, stringent multi-layer administrative requirements, independent judicial review and strong due process protections protect against misuse. Nevada County and Orange County estimate less than .003% of the population would be allowed into the program. This is consistent with NYS findings.

MYTH: AOT is unconstitutional and infringes on civil liberties.

REALITY: AOT has survived constitutional challenges in multiple states. A 2009 NYS study found:

"(I)t is now well settled that Kendra's Law is in all respects a constitutional exercise of the states police power, and its parens *patriae* power. Further, the removal provisions of the law have withstood constitutional scrutiny.

AOT also cuts the need for incarceration, restraints, and involuntary inpatient commitment, allowing individuals to retain more liberties.

MYTH: Laura's Law will frighten consumers away from seeking voluntary services

REALITY: A study in *Psychiatric News* of involuntarily treated discharged psychiatric patients found that 60 percent retrospectively favored having been treated against their will. A 2005 NYS study of consumers in their version of Laura's Law found:

- ✓ 75% reported that AOT helped them gain control over their lives;
- ✓ 81% said that AOT helped them to get and stay well;
- ✓ 90% said AOT made them more likely to keep appointments and take medication.

The 2009 independent study found:

"On the whole, AOT recipients and non-AOT recipients report remarkably similar attitudes and treatment experiences. That is, despite being under a court order to participate in treatment, current AOT recipients feel neither more positive nor more negative about their mental health treatment experiences than comparable individuals who are not under AOT."

MYTH: Assisted Outpatient Treatment is not racially neutral.

REALITY: A 2009 NYS study researched this issue and found:

"(N)o evidence that the AOT Program is disproportionately selecting African Americans for court orders, nor is there evidence of a disproportionate effect on other minority populations. Our interviews with key stakeholders across the state corroborate these findings."

MYTH: Assisted Treatment forces people to take medications.

REALITY: There is no provision for forced medication in Laura's Law.

MYTH: There is wide opposition to Laura's Law

REALITY: Laura's Law has wide support from constituencies as diverse as the National Alliance on Mental Illness, National Sheriff's Association, California Psychiatric Association, National Crime Prevention Council and consumers in AOT.

MYTH: Mental Health Commissioners support Laura's Law

REALITY: Many (not all) mental health commissioners oppose Laura's Law because they fear losing the ability to cherry-pick the easiest to treat for admission to their programs. Currently mental health policy is to send the most severely ill individuals to shelters and jails and use the 'savings' to fund services to a larger number of people ("mission-creep")

MYTH: Prop 63/Mental Health Services Act money can not be used to fund Laura's Law

REALITY: Both Los Angeles and Nevada County use MHSA money (plus Medicare, Medicaid, private insurance, and patient fees) to fund Laura's Law.

MYTH: Voluntary programs have to be cut to fund Laura's Law

REALITY: Per California Department of Mental Health, voluntary programs that provide services (ex., medication, case management, housing, CSS, etc.) may also serve individuals under court orders. There is no need to close these programs, merely open them up to people under court orders.

Myth: Laura's Law is expensive.

REALITY: Nevada County found they saved $1.81 for every $1.00 invested. The Mental Health Director found it decreases hospitalizations, length of hospitalizations, and use of 911, arrest, trial, incarceration and parole; and can be funded with existing sources.

Uncivil liberties

Far from respecting civil liberties, legal obstacles to treating the mentally ill limit or destroy the liberty of the person

by HERSCHEL HARDIN
... a West Vancouver author and consultant. He was a director of the B.C. Civil Liberties Association from 1965 to 1974, and has been involved in defence of liberty and free speech through his work with Amnesty International. One of his children has schizophrenia.

THE PUBLIC is growing increasingly confused by how we treat the mentally ill.

More and more, the mentally ill are showing up in the streets, badly in need of help. Incidents of illness-driven violence are reported regularly — incidents which common sense tells us could easily have been avoided. And this is just the visible tip of the greater tragedy — of many more sufferers deteriorating in the shadows and, often, committing suicide.

People ask in perplexed astonishment: "Why don't we provide help and treatment, when the need is so obvious?" Yet every such cry of anguish is met with the rejoinder that unrequested intervention is an infringement of civil liberties.

This stops everything. Civil liberties, after all, are a fundamental part of our democratic society.

The rhetoric and lobbying results in legislative obstacles to timely and adequate treatment, and the psychiatric community is cowed by the anti-treatment climate produced.

Here is the Kafkaesque irony. Far from respecting civil liberties, legal obstacles to treatment limit or destroy the liberty of the person.

The best example concerns schizophrenia. The most chronic and disabling of the major mental illnesses, schizophrenia involves a chemical imbalance in the brain, alleviated in most cases by medication. Symptoms can include confusion; inability to concentrate, to think abstractly, or to plan; thought disorder to the point of raving babble; delusions and hallucinations; and variations such as paranoia.

Untreated, the disease is ravaging. Its victims cannot work or care for themselves. They may think they are other people — usually historical or cultural characters such as Jesus Christ or John Lennon — or otherwise lose their sense of identity. They find it hard or impossible to live with others, and they may become hostile and threatening. They can end up living in the most degraded, shocking circumstances, voiding in their own clothes, living in rooms overrun by rodents — or in the streets. They often deteriorate physically, losing weight and suffering corresponding malnutrition, rotting teeth and skin sores. They become particularly vulnerable to injury and abuse.

TORMENTED by voices, or in the grip of paranoia, they may commit suicide or violence upon others. (The case of a Coquitlam boy who killed most of his family is only one well-publicized incident of such delusion-driven violence.) Becoming suddenly threatening or bearing a weapon, say a knife — because of a delusionally perceived need for self-protection — the innocent schizophrenic may be shot down by police.

Depression from the illness, without adequate stability — often as the result of premature release — is also a factor in suicides.

Such victims are prisoners of their illness. Their personalities are subsumed by their distorted thoughts. They cannot think for themselves and cannot exercise any meaningful liberty.

The remedy is treatment — most essentially, medication. In most cases, this means involuntary treatment because people in the throes of their illness have little or no insight into their own condition. If you think you are Jesus Christ or an avenging angel, you are not likely to agree that you need to go to hospital.

Anti-treatment advocates insist that involuntary committal should be limited to cases of imminent physical danger — instances where a person is going to do serious bodily harm to himself or somebody else.

But the establishment of such "dangerousness" usually comes too late — a psychotic break or loss of control, leading to violence, happens suddenly. And all the while, the victim suffers the ravages of the illness itself, the degradation of life, the tragic loss of individual potential.

The anti-treatment advocates say: "If that's how people want to live (babbling on a street corner, in rags), or if they wish to take their own lives, they should be allowed to exercise their free will. To interfere — with involuntary committal — is to deny them their civil liberties." As for the tragedy that follows from this dictum, well, "That's the price that has to be paid if society is to maintain its civil liberties."

Whether or not anti-treatment advocates actually voice such opinions, they seem content to sacrifice a few lives here and there to uphold an abstract doctrine. Their intent, if noble, has a chilly, Stalinist justification — the odd tragedy along the way is warranted to ensure the greater good.

THE NOTION that this doctrine is misapplied escapes them. They merely deny the nature of the illness.

Health Minister Elizabeth Cull appears to have fallen into the trap of this juxtaposition. She has talked about balancing the need for treatment and civil liberties, as if they were opposites. It is with such a misconceptualization that anti-treatment lobbyists promote legislation loaded with administrative and judicial obstacles to involuntary committal.

The result, inadvertently for Cull, Attorney-General Colin Gabelmann (as regards guardianship legislation) and the government, will be a certain number of illness-caused suicides every year, just as surely as if those people were lined up annually in front of a firing squad. Add to that the broader ravages of the illness, and keep in mind the manic-depressives who also have a high suicide rate.

A doubly ironic downstream effect: the inappropriate use of criminal prosecutions against the mentally ill, and the attendant cruelty of committal to jails and prisons rather than hospitals. B.C. Corrections once estimated that almost one-third of adult offenders and close to one-half of young offenders in the provincial corrections system have a diagnosable mental disorder.

Clinical evidence has now indicated that allowing schizophrenia to progress to a psychotic break lowers the possible level of future recovery, and subsequent psychotic breaks lower that level further — in other words, the cost of withholding treatment is permanent damage.

Meanwhile, bureaucratic roadblocks, such as time-consuming judicial hearings, are passed off under the cloak of "due process" — as if the illness were a crime with which one is being charged and hospitalization for treatment is a punishment. Such cumbersome restraints ignore the existing adequate safeguards — the requirement for two independent assessments and a review panel to check against overlong stays.

How can so much degradation and death — so much inhumanity — be justified in the name of civil liberties? It cannot.

The opposition to involuntary committal and treatment betrays a profound misunderstanding of the principle of civil liberties. Medication can free victims from their illness — free them from the Bastille of their psychoses — and restore their dignity, their free will and the meaningful exercise of their liberties. ❑