U.S House of Representatives Committee on Energy and Commerce
Subcommittee on Oversight and Investigations
"Where Have All the Patients Gone? Examining the Psychiatric Bed Shortage."
March 26, 2014

Testimony of Chief Michael C. Biasotti

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Chairman Murphy and Ms. DeGette: I am the Immediate Past President of the New York State Association of Chiefs of Police, and Chief of Police, in New Windsor N.Y. My wife, Barbara, who is a psychologist, is here with me. We have a daughter with schizophrenia who has been involuntarily hospitalized more than 20 times. Barbara and I met when she, like many moms, turned to the police for help, when her, now our daughter became psychotic, disruptive and threatening. She was self-medicating, unemployed, and deteriorating despite my wife's heroic efforts to help her. Then she went into Assisted Outpatient Treatment. It saved her life.[1]

In 2011, while at the U.S. Naval Postgraduate School's Center for Homeland Defense and Security, I published a survey of over 2400 senior law enforcement officers titled "*Management of the Severely Mentally Ill and its Effect on Homeland Security.*"[2] It found that the mentally ill consume a disproportionate percentage of law enforcement resources. Many commit low-level crimes.[3] 160,000 attempt suicide[4], 3 million become crime victims[5], and 164,000 are homeless.[6]

The survey essentially found we have two mental health systems today, serving two mutually exclusive populations: Community programs serve those who seek and accept

treatment. Those who refuse, or are too sick to seek treatment voluntarily, become a law enforcement responsibility. Officers in the survey were frustrated that mental health officials seemed unwilling to recognize or take responsibility for this second more symptomatic group. Ignoring them puts patients, the public and police at risk and costs more than keeping care within the mental health system.

As an example, there are fewer than 100,000 mentally ill in psychiatric hospitals[7] but over 300,000[8] in jails and prisons. The officers I surveyed pointed out the drain on resources it takes to investigate, arrest, fill out paperwork and participate in the trials of all of them. Add to that the sheriffs, district attorneys, judges, prisons, jails and correction officers it takes to manage each of them and you see the scope of the problem.[9] Many more related incidents, like suicides, fights and nuisance calls take police time, but don't result in arrest or incarceration.

Overly restrictive commitment standards and the shortage of hospital beds are major sources of frustration for officers. Hospitals are so overcrowded they often can't admit new patients and discharge many before they are stable. They become what we call 'round-trippers' or 'frequent flyers', one officer referred to it as a human "Catch and Release Program". Anyone who asks for help, is generally not sick enough to be admitted, so involuntary admission, that is, being a "danger to self or others" becomes the main pathway to treatment. Officers are called to defuse the situation and then have to drive in some cases hours to transport the individual to a hospital, wait hours in the ER, only to find the hospital refuses admission because there are no beds or the commitment standard is so restrictive. The only remaining solution for our officers

is to arrest people with serious mental illness for whatever minor violation exists, something we are loathe to do to sick people who need medical help, not incarceration.

Finally, while everyone knows your everyday mental illness is not associated with violence, untreated serious mental illness clearly is.[10] The officers in the survey deal with that reality every day. You in Congress dealt with it when Ronald Reagan and Gabrielle Giffords were shot; two guards in the Capitol building were killed, and the Navy Yard shootings happened. Representatives DeGette, Gardner and Griffiths' have experienced the worst of the worst in their states.

We have to stop pretending that violence is not associated with untreated serious mental illness. We have to stop pretending that everyone is well enough to volunteer for treatment and self-direct their own care. Some clearly are not.

As I wrote in the intro to the survey, police and sheriffs are being overwhelmed "dealing with the unintended consequences of a policy change that in effect removed the daily care of our nation's severely mentally ill population from the medical community and placed it with the criminal justice system." ...This policy change has caused a spike in the frequency of arrests of severely mentally ill persons, prison and jail populations as well as the homeless population...(and) has become a major consumer of law enforcement resources nationwide."

If I could make one recommendation, it would be to prevent individuals from deteriorating to the point where law enforcement becomes involved. Return care and

treatment of the most seriously ill back to the mental health system. Make the seriously mentally ill first in line, rather than last. As a law enforcement officer and father, I know treatment before tragedy is a better policy than tragedy before treatment.

Thank you.

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[1] A front page New York Times story July 30, 2013 on AOT, featured my wife and I. The story was timed to the release of a study, "The Cost of Assisted Outpatient Treatment: Can It Save States Money?" which found AOT cut costs in half by reducing the use of more expensive (and liberty infringing) inpatient commitment, hospitalization, and incarceration. See appendix B for other studies.

[2] Biasotti, Michael C., Management of the severely mentally ill and its effects on homeland security. Naval Postgraduate School, Monterey, CA, September, 2011. Key findings and quotes from officers surveyed attached as appendix. Full report available at http://mentalillnesspolicy.org/crimjust/homelandsecuritymentalillness.pdf. (Accessed 3/16/14.)

[3] Crime: A 1991 survey of 1,401 members of the National Alliance for the Mentally Ill (NAMI), an advocacy group for families of individuals with serious mental illnesses, reported that 40 percent of the mentally ill family members had been in jail at some point in their lives. Donald M. Steinwachs, Judith D. Kasper, Elizabeth A. Skinner, *Final Report: NAMI Family Survey* (Arlington, Va.: National Alliance for the Mentally Ill, 1992).

[4] Suicide: There are 38,000 suicides a year. NIMH estimates 90% are mental illness related. We conservatively estimate that half of those are related to untreated serious mental illness (16,000). NIMH says (http://www.nimh.nih.gov/health/publications/suicide-in-the-us-statistics-and-prevention/index.shtml) there are 11 attempts for every one suicide. They rely on Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS): www.cdc.gov/ncipc/wisqars

[5] Victimization: Hiday, Virginia Aldigé, Ph.D.; Swartz, Marvin S., M.D.; Swanson, Jeffrey W., Ph.D.; Borum, Randy, H. Ryan, Psy.D., Criminal Victimization of Persons With Severe Mental Illness. Psychiatric Services. American Psychiatric Association. January 1, 1999, Vol 50. Issue 1.

[6] Homelessness: Estimates of homeless mentally ill vary. In January 2012, the Annual Homeless Assessment Report determined 633,782 people were homeless on a single night in the United States. Sixty-two percent of them (390,155) were sheltered (living in

emergency shelter or transitional housing) and thirty-eight percent (243,627) were unsheltered (living in places not meant for human habitation, such as the streets, abandoned buildings, vehicles, or parks. (Alvaro Cortes, et al. 2012) These estimates do not include homeless "couch-surfers" who camp out on the sofas of friends and families, move every few days and have no permanent address. Estimates of the percentage of homeless who have mental illness range from 25% to 46% (National Alliance to End Homelessnes n.d.). Depending on the age group in question, and whether it includes all mental illness or just serious mental illness, the consensus estimate seems to be that at minimum 26% of homeless are seriously mentally ill. (U.S. Department of Housing and Urban Development 2010) Therefore, 164,783 seriously mentally ill are homeless at any given point in time as are 291,539 with any mental illness.

[7] E. Fuller Torrey, M.D, The Shortage of Public Hospital Beds for Mentally Ill Persons: A Report of the Treatment Advocacy Center. Available at http://mentalillnesspolicy.org/imd/shortage-hosp-beds.pdf

[8] More than 50% of those in jails and prisons have a mental health problem (James and Glaze 2006). However only about 16 or 17% of individuals in federal prisons and 17% of those in jails have serious mental illness. (Osher, et al. 2012) There were 1,504,150 in prisons and 735,601 in jail. (Glaze and Parks 2012) Therefore there were 240,664 seriously mentally ill in prisons and 125,052 seriously mentally ill in jails, or 365,716 adults with serious mental illness in jails and prisons.

[9] Police were involved in arresting, processing paperwork, investigating and testifying at the trials of the 365,000 seriously mentally ill in jails and prisons, and the 770,000 under probation and parole. There are 4,814,200 individuals under probation or parole. (Glaze and Parks 2012) If the same 16% (Footnote 8) holds true then 770,000 individuals with serious mental illness are under probation and parole.

[10] As NIMH Director Dr. Thomas Insel told the Institute of Medicine earlier this month, "I'd like to say something which I think is unpopular many people in the mental health community. But the data I believe are fairly unambiguous…. An active psychotic illness is associated with irrational behavior--and violence can be part of that."

- The Epidemiological Catchment Area (ECA) surveys carried out 1980–1983 reported much higher rates of violent behavior among individuals with severe mental illness living in the community compared to other community residents. For example, individuals with schizophrenia were 21 times more likely to have used a weapon in a fight. Swanson JW, Hozer CD, Ganju VK et. al. Violence and psychiatric disorder in the community: evidence from the Epidemiologic Catchment Area surveys. Hospital and Community Psychiatry 1990;41:761–770.

- A review of 22 studies published between 1990 and 2004 "concluded that major mental disorders, per se, especially schizophrenia, even without alcohol or drug abuse, are indeed associated with higher risks for interpersonal violence."

Major mental disorders were said to account for between 5 and 15 percent of community violence. Joyal CC, Dubreucq J-L, Gendron C et al. Major mental disorders and violence: a critical update. Current Psychiatry Reviews 2007;3:33–50.

- A study of 331 individuals with severe mental illness in the United States reported that 17.8 percent "had engaged in serious violent acts that involved weapons or caused injury." It also found that "substance abuse problems, medication noncompliance, and low insight into illness operate together to increase violence risk." Swartz MS, Swanson JW, Hiday VA et. al. Violence and severe mental illness: the effects of substance abuse and nonadherence to medication. American Journal of Psychiatry 1998;155:226–231.

- In a carefully controlled study comparing individuals with severe mental illness living in the community in New York with other community residents, the former group was found to be three times more likely to commit violent acts such as weapons use or "hurting someone badly." The sicker the individual, the more likely they were to have been violent. Link BG, Andrews H, Cullen FT. The violent and illegal behavior of mental patients reconsidered. American Sociological Review 1992;57:275–292.

ATTACHMENT A

Excerpts from

Management of the Severely Mentally Ill and its Effect on Homeland Security: A survey of 2400 senior law enforcement officials

By
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U.S. Naval Postgraduate School's Center for Homeland Defense and Security
September 2011

Selected Findings

Police and sheriffs are being overwhelmed "dealing with the unintended consequences of a policy change that in effect removed the daily care of our nation's severely mentally ill population from the medical community and placed it with the criminal justice system." "This policy change has caused a spike in the frequency of arrests of severely mentally ill persons, prison and jail population and the homeless population…(and) has become a major consumer of law enforcement resources nationwide."

84.28% (or 1,866) of respondents said there been an increase in the mentally ill population over the length of their career

63.03% (n=1,391) of respondents reported that the time spent on mental illness related calls has increased (during their career). An additional 17.72 percent reported that the time spent had substantially increased, totaling 70.7 percent (n=1,782) of respondents reporting an increase

When asked what the officers' attribute the increase in calls to, 56% said inability to refer mentally ill to treatment and 61% said more persons with mental illness are being released to the community,

The officers claimed that mental illness related calls take significantly longer than larceny, domestic dispute, traffic, and other calls.

When asked, "What obstacles affect the ability of law enforcement to make referrals for persons with mental illness", the inability to refer people unless they are danger to safe or others was cited by 77%; limited availability of services was cited by 57% and procedures required for mandated treatment were cited by 44% (Officers were allowed more than one response).

Selected Quotes from Senior Law Enforcement Officers

Problems Getting Admission to Hospitals

"The problems are not so much the obstacles but rather when we get them to the hospital we have to sit with them, depending on the incident that occurred, and we have a limited number of officers on duty. And once they are committed, it's only a matter of time before they are released and we end of dealing with them again in another situation."

“No support from the mental health doctors. You take them into the hospital and it takes four to six hours to admit to the ward if you are able to at all.”

“In Nevada, the Sheriff is required to transport mentally ill subjects to the State hospitals. These trips can take five to eight hours one way due to the great distances we have to travel.”

“The closest state mental health facility is approximately 300 miles from my jurisdiction. The closest private mental health facility is 100 miles. The private facility is quite difficult to work with.”

“Our jurisdiction is extremely rural. If a person requires in-patient treatment, then it is a four-hour drive to the hospital, and our ambulance service will not transport. Given that most evaluations take two hours at a minimum that leaves an officer out of service for a minimum of ten hours. Because we have only eight officers including the Chief, it also means calling someone in on their days off to make the transport.”

“The whole process is too long. It takes too long to have the patient evaluated. Takes too long to have the committal paper filed with the court. Takes too long to find a facility. Takes too long to have the paper obtained once a judge signs it. Then when the individual makes it to the next facility we get to go through the same thing and length of time on the other end. On average it takes approximately 10 hours. With a small department we have 2 or 3 people working. Basically one of my officers is tied up in this process and I have another officer at time working without backup.”

“No mandate for mental health services to accept a person brought in by law enforcement unless they are willing to self-commit. To get a commitment there has to be a plan in place to harm themselves or others and the mental health officer has to work out a hold and make sure there is a bed free. There are far too many people who are off their medication for a number of reasons encounter by law enforcement and in need of assistance getting back on track.”

“We refer them to facilities such as Emergency Mental Health (EMH) because they attempt to commit suicide and then for whatever reason are let out six to twelve hours later. I have questioned this as a Police Chief and have been told that it is difficult to predict if a person will actually ever commit suicide. What the hell do we bother bringing them to the hospital for then? I could say the same thing in their living room and save the trip to the hospital.”

“After forming the Crisis Intervention Team local facilities found out we knew the regulations related to their responsibilities and they started working with us. There are still some obstacles related to some E.R. doctors, for those we that are not a danger to themselves. For others there are limited beds available and the state continues to cut funding to the support agencies.”

Problems getting mental health departments to help the most seriously ill

“In the past, if an officer could articulate to the crisis counselor that a mental subject was a danger to him or others then they would respond and make arrangements for bed space. Now, they rarely come out unless it is an uncontrolled violent person. In some cases, a crisis counselor has asked to speak to the mental subject over the officer's cell phone and "diagnosed' the mental subject based on that short phone conversation. The problem here is that the officer has made observations and noted the comments made by the mental subject. Most officers would not ever release a dangerous person despite whatever diagnosis is made over the phone. So, the mental subject either gets arrested or goes to a local hospital for evaluation. This wastes resources and takes more of the officer's time—all in the name of protecting one's self from liability.”

“Police seem to be the only resource that is mandated to be trained and deal with these individuals in the field, usually because there is a disturbance that prompts the call for these individuals. However, EMS, local hospitals, etc., are not required the same level of participation in the de-escalation of a mental event as the police are.”

“(Problem is) Catch and Release attitude of mental health professionals, i.e. anti-suicide contracts, promise not to do it again, etc.”

“When subjects suffering from mental illness are confronted by law enforcement in the community if they have been abusing alcohol or illegal drugs most mental health practitioner will not assess these individuals regardless of behavior or symptoms until they are “sober.” This requires prolonged periods of police officers and jails having to hold these individuals or protect them in medical facilities until mental health practitioners provide an assessment.”

“Our system here requires a medical evaluation before acceptance, consequently its easier to arrest and put into jail since they don’t need a medical / physical exam prior to acceptance.”

“While no obstacles exist, referring to mental health services does little to protect the public safety. Mental health professional simply coaxed the client into taking their medications while at the facility and then sends them back home. Often times we will just have to deal with them again the next day.”

Problems caused by lack of ‘need for treatment’ standard or “grave disability” standard

“We can get them to the psych unit, but the doctors let them go due to the “dangerous to self or others” criteria.”

“The biggest problem does not lie with law enforcement. The problem is found when citizens can't get assistance due to the “danger” requirement. When they have nowhere else to turn they call the police to handle the issue. This takes a large amount of time to then pull strings to try and get help for the citizens.”

“Although referrals are easily made, the voluntary involvement of the mental health patient is necessary. If they are not voluntary, and not a danger to themselves there is little that can be done with them.”

“We are a small department and often only have one officer on duty at a time. This is VERY dangerous to have only one officer handle a mental health case. When possible, we have more officers’ respond.”

“We must call a metal health case worker, for OK to commit or county will not pay for it...they will listen to what we have to say...but it’s their call if they find a bed for the person.”

Attachment B: 10 Independent Kendra's Law (AOT) Studies

(Researched by Mental Illness Policy Org. http://mentalillnesspolicy.org)

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 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; o AOT ensures greater access to services for individuals whom providers have previously been reluctant to serve; o Increased collaboration between inpatient and community-based providers.

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.

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. ❑