Mary Ellen-

Here is some info on Mental Health that an intern prepared for Nicole a while back. Should be helpful for your Mental Health memo draft. ——— Ruby

July 2, 1999

MEMORANDUM

TO: **NICOLE RABNER**

FROM: **JOY WARREN**

SUBJECT: **CARING FOR PEOPLE WITH MENTAL ILLNESS**

Recent high profile acts of violence committed by individuals with mental illness have focused public attention on state mental health policies and practices. The New York *Times* has devoted significant coverage to New York's failures in caring for its mentally ill population. The May 23, 1999 New York *Times Sunday Magazine* ran a lengthy article that highlighted New York's shortcomings through an investigation of the psychiatric history of Andrew Goldstein, a man with untreated schizophrenia accused of pushing a young woman to her death on the subway tracks in New York this past January. [1]

Goldstein's records show that he was often turned away from psychiatric care facilities despite his requests for treatment and his documented history of violent and assaultive behavior. When he was admitted, he was typically discharged after just a few days. According to the article, hospitals are under pressure from both the Pataki administration and managed care plans to discharge patients early. Managed care plans typically consider patients with mental illness to be "stabilized' after they have been on medications for two to three weeks, and insurance coverage drops from $700 per day to $175 per day.

The author cites three reasons why states fail people with mental illness:

1. **Deinstitutionalization:** Advocates originally supported deinstitutionalization because they wanted to integrate people with mental illness into their communities. Today advocates often regard deinstitutionalization as a landmark failure in the evolution of mental health policy. Deinstitutionalization failed because patients were released into the community but were not given adequate support and services to function outside of an institution. People with severe mental illness have significant treatment needs and they require a great deal of community services to help them safely live in their own communities. Although there are community programs that have great success treating people with mental illness, they typically have long waiting lists.

   *The Pataki administration is pressuring state hospitals to discharge patients by giving them annual census reduction goals.

[1] Michael Winerip, "Bedlam on the Streets," New York *Times*, May 23, 1999.

*The number of patients with mental illness in New York state hospitals dropped from 93,000 in 1953 to the current population of 6,000 people.

2. **Decreased state spending on mental health services.**

*The *Times* reports that Governor Pataki did not provide financing for any new supervised community residences for the mentally ill during his first four-year term.

*According to the *Times,* Governor Pataki's 1999 budget proposes a $40 million increase in spending for the mentally retarded and a $27 million cut in funding for the mentally ill.

*New York state officials say that New York spends more than $2 billion on supportive housing for the mentally ill, more than any other state.[2]

*The Bazelon Center for Mental Health estimates that state spending is down by 30% since the 1950s (after adjusting for inflation and population growth).

3. **Managed care puts financial pressure on hospitals to discharge patients early.[3]**

In April, another man with untreated schizophrenia is alleged to have pushed an unsuspecting victim into the path of an oncoming subway train. The New York *Times* reported that the accused, Juan Perez had a history of failed treatment and services in New York that was disconcertingly similar to Andrew Goldstein's experience in the state's mental health system.[4]

"Kendra's Law"

The New York Legislature is considering a bill, sponsored by state Attorney General Eliot Spitzer, which would authorize outpatient commitment (OPC). OPC is a practice in which mentally ill individuals can be civilly committed to a treatment facility if they refuse to comply with a court ordered treatment plan.[5] This bill has been called "Kendra's Law", in honor of Kendra Webdale, who was pushed to her death by Andrew Goldstein. The bill seems to have the support of a wide range of organizations, including the Alliance for the Mentally Ill of New York, the National Alliance for the Mentally Ill, and approximately 25 other groups. (See attached for complete list of supporters).

Attorney General Spitzer has characterized "Kendra's Law" as a bill that would protect people with mental illness, saying, "We must have compassion for the mentally ill. And part of compassion is knowing when people are just not competent to make their own decisions about treatment."

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[2] Nina Bernstein, "Frightening Echo in Tales of Two in Subway Attacks," New York *Times*, June 28, 1999.
[3] Michael Winerip, "Bedlam on the Streets," New York *Times*, 5-23-99.
[4] Nina Bernstein, "Frightening Echo in Tales of Two in Subway Attacks," New York *Times*, 6-28-99.
[5] New York recently experimented with OPC in a pilot program in Manhattan. This pilot was authorized in 1994 and was set to expire on June 30, 1999.

The irony of "Kendra's Law" is that Andrew Goldstein did not need a court to order treatment for him; he had been committed to psychiatric facilities *voluntarily* 13 times during the two years prior to Kendra's death. The *Times* reports that Goldstein's problems were caused by: 1) the pressure to discharge patients early and 2) the shortage of treatment beds and community services available to people with severe mental illnesses. After he was discharged from the hospital, he went back to living on his own because of the waiting lists for long-term care at state hospitals, for supervised group homes, and for intensive case managers who would have visited Goldstein on a daily basis to ensure he was taking his medications.

Use of Outpatient Commitment in the United States

Forty states use some form of outpatient commitment (sometimes referred to as "assisted treatment") for people with schizophrenia, manic depression, and other severe mental illnesses. States use different sets of criteria for determining whether or not an individual should be subject to outpatient commitment. Some states require the person to have a previous hospitalization or a history of violence or of refusing medication. Many states require that a person be "dangerous to himself or others" before a judge can order outpatient commitment, a standard that is very difficult to meet. Other states have less strict standards: Wisconsin authorizes OPC for those who are "unable to provide for basic needs" and South Carolina permits OPC for an individual who "lacks sufficient insight or capacity to make responsible decisions with respect to his treatment." OPC practices can also vary among regions within a state because different judges may use varying standards in applying the law.

Severe mental illness can render individuals incapable of making rational decisions about their own treatment. People with brain disorders often experience delusional and distorted thought processes that impair their judgment about taking medications.[1] Schizophrenics and people in a manic state will often refuse medication because their thinking is so disordered that they don't realize they are sick. OPC, when used as part of a comprehensive treatment plan, can be an important tool for helping those individuals with the most serious mental illnesses. However, outpatient commitment involves very serious civil liberties issues that must be carefully considered when crafting statutory language.

Support for Outpatient Commitment

The Treatment Advocacy Center (TAC), based in Virginia and the National Alliance for the Mentally Ill both support OPC in general. TAC asserts that stronger OPC laws, if implemented properly, would allow more people to safely remain in their communities. TAC also asserts that requiring severely mentally ill people to comply with medication and treatment orders by way of outpatient commitment actually frees severely mentally ill people from the grip of their delusions so that they can better exercise their civil liberties. TAC often quotes former director of the British Columbia Civil Liberties Union, Herschel Hardin, on the topic of restricting civil liberties:

> The opposition to involuntary committal and treatment betrays a profound misunderstanding of the principle of civil liberties. Medication can free victims from their illness...and restore their dignity, their free will and their

ability to engage in a meaningful exercise of their liberties.[6]

TAC emphasizes that OPC must be used in conjunction with appropriate treatment, services, and supervision.

Opposition to Outpatient Commitment

The Bazelon Center for Mental Health and the ACLU oppose outpatient commitment and all civil commitments unless an individual meets the "danger to himself or others" standard. The American Psychiatric Association only supports involuntary treatment in "very unusual circumstances, such as when patients are very likely to kill or harm themselves or other people, and hospitalization is necessary to keep them safe." (See attached for position statements).

Alternatives to Outpatient Commitment

Conservatorships and conditional release are two alternatives to outpatient commitment. California has had success with conservatorships, in which a court appointed third party acts as a conservator for a person who has a serious mental illness. The conservator has the legal authority to make decisions about the individual's treatment. A conservator may commit the individual to a treatment facility and require the person to take prescribed medications.

Conditional release gives hospitals (not courts) the discretion to make decisions regarding a patient's disharge. Under conditional release, the hospital administrator can condition a patient's release on certain conditions such as taking medications and refraining from drinking.

Studies of Outpatient Commitment

Generally, studies show that use of outpatient commitment reduces hospital stays and increases the likelihood that patients will comply with their treatment plans after they are released from a facility.

*A study of the Bellevue OPC pilot project in New York found that individuals who received court orders for treatment in addition to enhanced community services spent 57% less time in psychiatric hospitals than individuals who had enhanced services alone without a court order.[7]

*In Arizona, 71% of patients committed under OPC voluntarily maintained treatment contacts six months after their court orders expired compared to almost none of the patients who had not been put on outpatient commitment.

*According to one study, 60% of people who were treated against their will approved of the practice in retrospect.[8]

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[6] D.J. Jaffe, "Mental Illness Causes Pataki and Silver to Agree", Albany *Times Union*, 5-30-99.

[7] "Bellevue Program Successfully Reduces Hospitalization for Individuals with Severe Psychiatric Disorders", Treatment Advocacy Center News Release, 1-5-99.

[8] D.J. Jaffe, "Mental Illness Causes Pataki and Silver to Agree", Albany *Times Union*, 5-30-99.

General Statistics

*One third of the nation's 600,000 homeless people have schizophrenia or manic-depression.[9]

*There are far more people with mental illness incarcerated in the United States (200,000) than there are in state hospitals (61,700).

*The Urban Justice Center reports that 15,000 prisoners in Rikers are treated for serious mental illness over the course of a year.

*A California study found that police spend more time responding to mental health crises than to robbery calls.[10]

*People with manic depression are 10-15 times more likely to commit suicide.

* A National Institute of Mental Health study finds that less than half of schizophrenic patients receive proper treatment. (Up to 2 million people are treated for schizophrenia each year, and up to 100,000 are in public mental health hospitals on any given day.)

Useful Websites

American Civil Liberties Union	www.aclu.org
American Psychiatric Association	www.apa.org
National Alliance for Mental Health	www.namh.org
National Alliance for the Mentally Ill	www.nami.org
Treatment Advocacy Center	www.psychlaws.org

[9] E. Fuller Torrey, "How Freedom Punishes the Severely Mentally Ill", USA *Today*, 6-7-99.
[10] E. Fuller Torrey, "...and Getting Treatment Shouldn't Be This Hard", LA *Times*, 5-27-99.

Organizations that support"Kendra's Law":

Greater NY Hospital Association
Center for the Community Interest
Victim Services Agency
Visiting Nurses Service
Alliance for the Mentally Ill of New York State
Office of the New York State Attorney General
Kenmore Residence
St. Francis Residence
Project for Psychiatric Outreach to the Homeless
NY Society for the Deaf
Concerned Citizens for Creedmoore
The Bridge, Inc.
NY Center for Neuropsychology and Forensic
Behavioral Science
NAMI/Buffalo and Erie County
NAMI/Familya (Rockland County)
NYS Public Employees Federation
Treatment Advocacy Center
Schizophrenia.com
National Alliance for the Mentally Ill
National Alliance for the Mentally Ill/Metro-New York City

JUDGE DAVID L BAZELON CENTER FOR MENTAL HEALTH LAW

Position Statement on Involuntary Commitment

The United States Supreme Court has termed involuntary civil commitment to a psychiatric hospital "a massive curtailment of liberty."(1) The court has also emphasized that "involuntary commitment to a mental hospital, like involuntary confinement of an individual for any reason, is a deprivation of liberty which the State cannot accomplish without due process of law."(2) Moreover, the court has clearly stated that there is "no Constitutional basis for confining such persons involuntarily if they are dangerous to no one and can live safely in freedom."(3) "[T]he mere presence of mental illness," the court found, "does not disqualify a person from preferring his home to the comforts of an institution."(4)

The Bazelon Center opposes involuntary ***inpatient*** civil commitment except in response to an emergency, and then only when based on a standard of imminent danger of significant physical harm to self or others and when there is no less restrictive alternative. Civil commitment requires a *meaningful* judicial process to protect the individual's rights.

The Bazelon Center also opposes all involuntary ***outpatient*** commitment(5) as an infringement of an individual's constitutional rights.

Outpatient commitment is especially problematic when based on:

- a prediction that an individual may become violent at an indefinite time in the future;
- supposed "lack of insight" on the part of the individual, which is often no more than disagreement with the treating professional;
- the potential for deterioration in the individual's condition or mental status without treatment;
- an assessment that the individual is "gravely disabled."

The above criteria are not meaningful. They cannot be accurately assessed on an individual basis, and are improperly rooted in speculation. Neither do they constitute imminent, significant physical harm to self or others—the only standard found constitutional by the Supreme Court. As a consequence, these are not legally permissible measures of the need for involuntary civil commitment—whether inpatient or outpatient—of any individual.

The Bazelon Center supports the right of each individual to fully participate in, and approve, a treatment plan and to decide which services to accept. The Bazelon Center encourages the articulation of treatment preferences in advance through the use of advance directives and/or a legally recognized health care agent.

Outpatient commitment is a dangerous formalization of coercion within the community mental health system. Such coercion undermines consumer confidence and causes many consumers to avoid contact with the mental health system altogether. Furthermore:

- Outpatient commitment is a simplistic response that cannot compensate for a lack of appropriate and effective services in the community. In fact, the enforcement demands of outpatient commitment will divert resources away from treatment.
- Data on outpatient commitment show it confers no additional benefit above access to effective community services. (In the only yet released *controlled* study, individuals given the option of enhanced community services did just as well as those under commitment orders who had access to the same services.)(6)

- There are enormous practical problems in implementation of outpatient commitment, and potentially high costs for law enforcement.
- The threat of forced treatment, with medication that has harmful side effects, often deters individuals from voluntarily seeking treatment. At best, outpatient commitment undermines the therapeutic alliance between the provider and consumer of mental health services. Greater sensitivity is needed on the part of mental health professionals in working with consumers to find the most effective and acceptable treatment.

In short, outpatient commitment penalizes the individual for what is essentially a systems problem. Lack of appropriate and acceptable community mental health services is the issue.

NOTES

1. *Humphrey v. Cady*, 405 U.S. 504, 509 (1972).

2. *Specht v. Patterson*, 386 U.S. 605, 608 (1967).

3. *O'Connor v. Donaldson*, 422 U.S. 563, 574 (1975).

4. *Id.*

5. The term "outpatient commitment" when used in this document refers to procedures for (a) involuntary commitment to outpatient treatment and (2) hospital release conditioned on treatment compliance.

6. The preliminary findings of a North Carolina study currently pending publication confirmed the New York study in finding that overall outpatient commitment conferred no additional benefits for individuals receiving enhanced services. This study did, however, find that a small group of patients who were under commitment orders for six months or longer, and who also actually received more services, did better than those not under outpatient commitment.

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Involuntary Treatment

- Involuntary treatment is sometimes necessary, but is used *only* in unusual circumstances, such as when patients are very likely to kill or harm themselves or other people, and hospitalization is necessary to keep them safe.
- Involuntary treatment is *always* subject to reviews, which protect the patients' civil liberties.
- Involuntary treatment can be inpatient or outpatient. While most involuntary treatment is provided on an in-patient basis, some jurisdictions allow "involuntary treatment" patients to be treated in clinics or other community settings.
- Involuntary treatment procedures vary from state to state. Most states allow a physician to prescribe that a person be admitted involuntarily to a hospital for a brief evaluation period, usually three-days.* During the evaluation period, a team of psychiatrists and mental health professionals determine the person's illness and the appropriate course of treatment.
- If involuntary admission is recommended, the court issues an order for only a specific period of time. At the end of that period, the question of hospitalization must again go to a court hearing.**

Reference:

Let's Talk Facts About Psychiatric Hospitalization, brochure. Washington, D.C.: American Psychiatric Publishing Group, 1994.

Consent to Voluntary Hospitalization: Report of the American Psychiatric Association Task Force on Consent to Voluntary Hospitalization. Washington, D.C.: American Psychiatric Publishing Group, 1992.

Korpell, H. How You Can Help: A Guide for Families of Psychiatric Hospital Patients. Washington, D.C.: American Psychiatric Publishing Group, 1984.

Speaker's Tips:

* *Determine the specific number of days for your state or that state which is the topic of the interview.*

** *You may wish to add: "Then there is a court review and on site determination."*