

A NEW VISION FOR MENTAL HEALTH TREATMENT LAWS

A Report by the LPS Reform Task Force

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Executive Summary

Introduction Mental illnesses, such as schizophrenia, bipolar disorder, obsessive compulsive disorder, and clinical depression, are neurobiological diseases of the brain. Recovery is very possible. Like most medical disorders, the earlier that treatment is initiated the better the prognosis. When the disease has progressed, a period of rehabilitation, social and vocational, may have to be completed to achieve the maximum recovery. With newer medications – and the new medications that are hoped for – people with mental illness experience fewer symptoms and fewer side effects. Thus, the next generation of people with mental illness may need to recover only from the illness and not both from the illness and the effects of the illness on their life circumstances.

But, first there must be treatment.

One of the difficulties in providing continuous treatment in the community is that since these illnesses are brain disorders that affect the ill person's reasoning, some individuals do not recognize that they are ill or that the symptoms of their condition will respond to medication. Therefore, they do not seek treatment. If hospitalized, they may be unable or unwilling to comply with treatment plans after discharge. When this occurs, the person may require involuntary treatment to protect their lives and avoid tragic social and personal consequences.

The current California law regarding involuntary treatment for mental illness -- the Lanterman, Petris, Short Act (LPS Act) -- was written 30 years ago before scientific knowledge advanced recognizing mental illness as a physical disorder of the brain. Its purpose was to depopulate state hospitals. It was not fully realized at the time of its enactment the structure and support some people with mental illness would require to successfully participate in community life. Furthermore, over the years the act has been piecemeal amended to make it one of the most adversarial, costly and difficult to administer involuntary treatment systems in the United States. Lack of clear definition and common misinterpretation of its provisions have caused

inconsistent application from county to county.

The law must be revised to incorporate modern scientific knowledge regarding the nature and treatment of mental illness in the community and to streamline its efficiency in today's managed care environment.

The Process In 1995, the leadership of two organizations, the Los Angeles County Affiliates of the National Alliance for the Mentally Ill (NAMI) and the Southern California Psychiatric Society, agreed to put together a task force to explore a growing awareness of the difficulty to convey needed treatment with any consistency to people so impaired by mental illness that they required involuntary help. The group was first known as the "LPS Task Force" and later as the "LPS Reform Task Force." Early on it was decided to be very inclusive in our membership: anyone who wished to work on this problem was welcomed. We invited people we thought might be interested, others came because they had heard about our group. Our membership included, in addition to Alliance members and psychiatrists, law enforcement officers, psychologists, attorneys, nurses, the director of a conditional release program, mental health consumers, the head of an IMD, social workers and others. Minutes and meeting announcements were mailed out monthly to the growing list of attendees and perspective attendees.

It is important to understand the diverse backgrounds of the attendees. Some came from the point of view of having tried unsuccessfully to get treatment for a family member; others from the frustration of having tried unsuccessfully to provide such treatment. Still others felt strongly that a system which produced so much clearly evident suffering was wrong. Some had recovered from mental illness, but were frustrated at how long it had taken to get to that point. What all had in common was a sense that it was the California laws which had contributed to the tragedy of homelessness and criminalization of people with mental illness caused by lack of needed treatment.

Monthly meetings were held. We obtained the equivalent laws from all 50 states and read much literature on the subject of involuntary commitment. Discussions took place on a wide range of subjects from the newest scientific knowledge regarding brain function to criminal justice interaction to definitions of mental illness to effective methods of rehabilitation. Many professional people and organizations advised us and provided us with the educational structure necessary to undertake the project. We particularly would like to thank Dr. Stephen Marder; Dr. Robert Liberman, Dr. H.R. Lamb, the American Psychiatric Association Council on Psychiatry and Law and the Treatment Advocacy Center and as well as our guest speakers: David Meyer, JD, on commitment law; Dr. David Stone, on the results of an outcome study on patients impacted by the LPS procedures; and Gloria Nabrit, M.P.A., who spoke to us about Medi-Cal and financial considerations.

During the time of our meetings, on August 6, 1998, Los Angeles County

Supervisor Mike Antonovich held a public hearing on whether LPS Laws should be changed. Nearly 400 residents of Los Angeles County and neighboring vicinities packed the Los Angeles County Arboretum. This forum was the first time many people had the opportunity to discuss in public their frustration with the involuntary treatment laws and their pain at watching their loved one deteriorate without any help. One participant described the system as an upside down funnel: very hard to get into and easy to fall out of. The room was filled with the sorrow of past tragedy, but strengthened by the hope of reform. A synopsis of the testimony is included in the appendix of this report.

The Recommendations This report includes recommendations of revision to the LPS Act that are the results of three years of study. In addition to the recommendations, briefing papers have been prepared on the major mental illnesses, medication advances, the consequences of lack of treatment, the current legal system, treatment issues and a history of the implementation of the LPS Act itself. The focus of this report is the involuntary treatment law as it pertains to adults with severe persistent mental illness. There are also provisions in the codes for involuntary treatment of juveniles with mental illness and people impaired by chronic alcoholism, but those populations and procedures are beyond the scope of our current study.

With all the work that this committee has done to suggest overdue corrections in our commitment laws, it must be recognized that reform will be for naught unless the State of California commits to adequate funding to provide treatment for people with severe mental illness. We have a choice: we can shut our eyes to the sight of tragedy or we can make up our minds to give people with mental illness a community structure of compassionate care.

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Recommendations

Introduction

Treatment voluntarily embraced is always preferable to treatment given involuntarily. The goal of involuntary psychiatric services should be the provision of a caring environment where medical treatment, leading to cognitive improvement, is combined with dignified and respectful therapeutic conditions to help the patient accept and continue needed treatment willingly. Before any involuntary services are provided, the patient should be encouraged to consider those services on a voluntary basis. To be sure, mental illness is such that even when services are accessible, acceptable, and of high caliber, there will be individuals who need to be provided treatment involuntarily and given the community assistance of mandated follow-up care. The current system for providing involuntary treatment is incompatible with newer scientific knowledge regarding the fluctuating degrees of cognitive and mentation deficits caused by brain dysfunction in mental illness. Moreover, piecemeal additions to the statutes addressing involuntary treatment, as well as common practice misinterpretation of the statute over the past thirty years, have made the system cumbersome and adversarial.

The California statute regarding involuntary treatment for people with mental illness as well as diagnostic and treatment practices must be re-examined, streamlined, and re-written to be

more therapeutic and effective.

The proposed legislative changes are intended to maintain a necessary balance between individual liberties, therapeutic treatment and the state's obligation to provide safety and treatment for individuals with mental illness in the least restrictive environment. The following recommendations occur after an exhaustive review of current scientific knowledge, legal investigation and discussion with a wide variety of people involved with the mental illness system about the practical application of involuntary treatment.

Recommendation 1: Definition of Mental Illness

Discussion: Mental health and mental disease are concepts of great importance to the twentieth century legislator. The content and meaning of these terms are also matters of concern to judges and attorneys and treating professionals. The Continuum Theory of the 50s and 60s, which postulated that mental illness was the far extreme of a degeneration from a state of mental health, contributed greatly to the debate. Today, the debate is over: mental health and mental illness are not part of a continuum. Mental illnesses, such as schizophrenia, bipolar disorder, OCD, are brain-based biological diseases which impact the cognitive and affective functions of their victims' brains. They are as medical in nature as Alzheimer's, Multiple Sclerosis and Parkinson's disease.

The current LPS ACT does not define mental illness; indeed the enactment was intentionally nonspecific in terms of definition. At the time of its codification, beliefs regarding the source of mental illness were in social flux. As a result, California law provides for involuntary treatment if a person shows certain behaviors resulting from nonspecific "mental disorders." A goal of the LPS was to prevent inappropriate commitment. California's involuntary treatment laws require revision in order to insure the achievement of that goal. Behaviors of choice must be differentiated from behavioral by-products caused by symptoms of an underlying "no-fault-of-the sufferer" illness.

Recommendation: A definition of mental illness be added to the LPS Act. The recommended definition is: "Mental illness includes disorders that produce psychotic symptoms, such as schizophrenia, schizoaffective disorder, manic-depression, pervasive developmental disorders as well as severe forms of other disorders such as major depression, anxiety and panic disorder, obsessive-compulsive disorder and other organic, affective or cognitive disorders which manifest as major dysfunction in the individual's behavior or personality. Except for the purposes of this act the term does not include retardation or developmental disability, simple intoxication or conditions manifested to be antisocial behavior not caused by any of the conditions listed above."

Recommendation 2: Criteria for Treatment

Discussion: A person may be involuntarily treated only if that person meets statutory criteria. Current California law emphasized deinstitutionalization of people from long term, state-run, mental facilities. Today, as the LPS proponents proposed, state institutions are nearly a thing of the past. As of January 6, 1999, California state hospitals had a total patient population of 3943 of which only 900 patients were on civil commitments. The remaining 3043 were on a variety of forensic commitments. (Source California State Department of Mental Health).

No one advocates a return to unnecessary long-term placement; our dilemma is how to provide treatment to people who do not have the medical capacity to accept or access it themselves, but who live in an open community environment.

The criteria in California's LPS laws must be updated to incorporate current medical science regarding mental illness, correspond more closely with the Medi-Cal definition of "medical necessity", provide treatment *before* tragic social and medical detriments occur and help to destigmatize mental illness by giving recognition that people need the community support of necessary treatment when symptoms of a medical illness render them unable to obtain or utilize such treatment for themselves.

Recommendation: Criteria for involuntary treatment and hospitalization be revised to include the following: "Because of a mental illness, the individual is either a passive or an active danger to self or others; or gravely disabled, which means that the person is unable to provide for his/her basic needs (i.e., food, clothing, shelter, health or safety), or to take advantage of such resources when they are provided; or has recently substantially deteriorated from a former level of functioning, or is likely to substantially deteriorate if not provided with timely treatment and the person is unable to appreciate, or understand, or lacks *consistent* judgment to make informed decisions about his/her need for treatment, care or community living structure."

Recommendation 3: Super Gallinot Probable Cause Hearing

Discussion: The right of people with mental illness to refuse antipsychotic medication while involuntarily hospitalized is based on the belief that that person has the capacity to make an informed decision. A person with mental illness who has the insight necessary to recognize he/she has a mental illness which may respond to medical treatment, who has the *consistent* judgement necessary to weigh the risks and benefits of treatment as well as appreciate the possible consequences of refusing treatment, and chooses to refuse treatment, must be granted that right as well as responsibility for the consequences of his competent choice. Indeed, a person with this cognitive capacity should not be involuntarily hospitalized at all.

The principle governing a person with mental illness' right to participate in every step of their treatment path is sound. In responding to a court case known as Riese vs. St. Mary's (1987, 209 C.A.3d 1303), the legislature attempted to codify this principle into statute by allowing an

involuntary patient to refuse medication short of a quasi-judicial finding of his/her incompetency to refuse. The application of the statute has turned the question of an involuntary patient's right to refuse medication into an administrative nightmare as well as making treatment more adversarial than therapeutic: the doctor can be fighting the patient's lawyer in front of the patient with whom he is still expected to build a trusting relationship.

Separation of the Riese hearing from the probable cause hearing has pushed more people with mental illness into the hell of the streets and prisons. People who truly do not have the capacity to refuse medication may end up going without community help as hospitals, operating under the triage of managed care, simply release the patient who is not immediately dangerous to avoid entering the procedural labyrinth. Patients further deteriorate as they await the application for the medication hearing.

Furthermore, since the decision to allow involuntary medication is made separately and in a different hearing than the probable cause hearing -- and then only at the hospital's request -- a person who rightfully has the capacity to make competent decisions regarding medication may be detained involuntarily without treatment if the hospital does not apply for the hearing. This is a serious abridgement of that patient's civil rights. Treatment and detention should not be considered a separate issue: to solely detain a person for whom treatment is available without providing him/her with that treatment deprives the individual of more rights than a decision requiring medication. Unable to provide treatment, hospitals become merely institutions of social control.

Recommendation: During the initial 72-hour period for evaluation and treatment, the treating physician should be required to evaluate whether or not the patient who is refusing medication has the medical capacity to do so. If the patient has previously signed a Ulysses Contract/ Advance Directive assigning substitute decision making for treatment to a professional or family member of choice in the event that his or her judgement becomes impaired, and a copy of that directive has been provided to the treatment facility, medication will be administered only under the terms of the Ulysses Contract unless the person is imminently dangerous to self or others. If the person has not assigned a substitute decision-maker through a Ulysses Contract/Advance Directive, and in the treating physician's opinion the patient does not have the capacity to make medication decisions, would benefit with medication, and would most likely deteriorate further without medication, medication may be administered. Before any administration of medication, the treating clinician will make reasonable attempts to obtain the patient's agreement. Treating staff should be sensitive to all input given by the patient or his/ her family regarding complaints of side effects, previous medications used, or problems with the prescribed medication.

Both issues--detention and capacity to refuse medication -- should be reviewed through a "Super Gallinot" probable cause hearing. The hearing should be nonadversarial and automatic, utilizing the same standards of proof and procedures of the current "Gallinot" hearing. The

statute should be clear to specify that determination of capacity to refuse medication should consider more than the patient's ability to convey information about side effects of medication. The capacity determination should consider whether the person has recognition of their illness as well as the consistent judgment to weigh the benefits and detriments of medication as well as the consequences of refusal. Subsequent certification hearings and conservatorship hearings should again consider the issue of medical capacity to make an informed consent, if the patient indicates he/she wishes to change or discontinue his medication against the treating physician's advice. The patient may appeal the certification decision through a one writ entitlement which may be filed any time during the certification period. That writ can address the validity of the detention and/or the medication refusal capacity of the individual. The facility should also have a right to appeal to the Superior Court in the event the certification hearing determines the patient has met the criteria necessary for certification, but has the capacity to refuse medication and the facility and the treating clinician disagree.

Recommendation 4: Community Assisted Treatment

Discussion: Many people with mental illness can be temporarily stabilized during a relatively brief period in the hospital, but have not yet reached the level of recovery which allows them to adequately function in the community unless they receive considerable support and supervision. When such support and supervision is not provided, these people revolve through repeated hospitalizations, homelessness and jailings. "Community Assisted Treatment" allows the option of discharging a person from a restrictive, expensive inpatient setting to a lesser restrictive environment without disrupting the person's continuity of treatment and recovery. Community Assisted Treatment is less restrictive and more favorable to some patients than today's conservatorship laws as it allows a voluntary decision by the patient to agree to participate in the provisions of a mutually decided upon community treatment plan overseen by a substitute decision maker, as well as an agreement by the community to provide for the person the services necessary to develop his/her stable recovery. Clear procedures for arranging mandated outpatient treatment should be in place.

Recommendation: An "aftercare" program, Community Assisted Treatment, be legislatively required for people who are stable enough to leave the hospital with adequate community support and supervision but who have in the past failed to thrive evidenced by not maintaining in treatment services, housing or medication compliance/efficacy when previously released from involuntary hospitalization. The standards for placement in the program should be (1) the patient has received due process through the probable cause hearing that he/she meets the criteria for involuntary hospitalization because of mental illness; (2) the treating physician believes, at any time during the certification period, the patient is sufficiently stable to benefit from community placement, but needs continuing treatment and care under supervised conditions to maintain and improve his/her recovery; (3) the patient agrees, and desires to participate in such a program and is willing to be placed on "on leave" status from his/her current involuntary hold certification and be released from the hospital to a lower level of care;

(4) The patient is not an immediate harm to self or others; (5) the community mental health system (county or private) agrees with the patient and the doctor's decision, and agrees to provide services necessary to the patient as directed by the treatment plan including, but not limited to, housing placement, support treatment services, medication supervision for compliance, efficacy, and side effects, and application for any necessary fiscal supports and entitlements. An aftercare expediter responsible for helping to implement and supervise the after care plan will be appointed to act as a substitute decision-maker for the patient and named in the treatment plan to which the patient has agreed. The treatment plan will be filed with and ordered by the county Superior Court. In the event, the patient does not or cannot abide by the terms of the agreed upon treatment plan, including medication compliance or efficacy, and the person is in danger of deteriorating from his released level of functioning, or if in the expediter's view the patient will best benefit from re-hospitalization, the expediter may cause the person to be returned to a more intensive level of treatment for the remaining days of the underlying involuntary treatment certification. If the returned "on leave" patient is not expected to recovery sufficiently during the remaining period of time of their previously certified hold, the treating physician may apply for a new certification and subsequent conservatorship. The "on-leave" status may be renewed annually upon agreement by all parties and re-order by the court. If the "on leave" patient has not required treatment in an intensive setting for a one year period from their initial certification date, he/she may be unconditionally discharged from the 'on leave' status.

Recommendation 5: Length of Certification

Discussion: One reason the LPS Act allowed for tiered, short periods of hold for involuntary treatment is that the original statute eliminated initial due process previously fulfilled through the commitment court. The thought was that if a person was unnecessarily detained, that detention would be relatively short and not a serious abridgement of the individual's liberty. In 1978, the Gallinot case and subsequent legislation established an upfront due process hearing at the end of 72 hours; however, the tiered lengths for certifications based on the type of behavioral hold (gravely disabled, dangerous to self or others) remained. The multi-layered due process reviews, lengths of treatment and notice filing requirements have been referred to as "Byzantine." If not rising to the level of Byzantine, the administrative nightmare is at least cumbersome, nontherapeutic, administratively costly and constitutionally unnecessarily complex making California's procedure for involuntary treatment one of the most complex systems in the United States. Medically there is no reason for different periods of times for treatment of people who are "dangerous to self or others" or "gravely disabled" or the new criteria proposed in this paper. These criteria are nothing more than descriptions of behavioral byproducts of symptoms of the mental illnesses and have no relevancy to the amount of time needed to stabilize a person in treatment.

Today these tiered lengths of stay are empty gestures geared at preventing inappropriate long term hospitalization in state hospitals. State hospitals are virtually a thing of the past for civil patients. There is now an initial up front due process in the Gallinot hearing. By law, the

physician is required to discharge any patient who no longer meets the criteria for hospitalization. Additionally, third party payers act as a fiscal incentive to rapid release through "medical necessity" definitions. Furthermore, the patient is entitled to a writ to appeal his treatment and detention to the Superior Court. Indeed the tiered system of differing tracts for certification can be nontherapeutic to the recovering patient who is taken from treatment many times and placed into an adversarial position with the treating clinician who must testify "against" the patient with whom he/she is attempting to develop a good doctor/patient relationship.

Recommendation: After the 72 hour period, certification for treatment should be for 28 days regardless of the criteria under which the patient was initially certified.

Recommendation 6: Conservatorships

Discussion: Currently conservatorships are only available to those people with mental illness who achieve a behavioral byproduct of their illness that results in grave disability. As a result, people who remain potentially suicidal, dangerous to self or potentially dangerous to others are simply released with no guarantee of continuing treatment. It has been said that one is allowed to commit suicide in California after 31 days. Furthermore, California is one of the only states to require a standard of proof for long term civil treatment that is normally restricted to criminal cases: that of "beyond a reasonable doubt." A person with mental illness is not a criminal and should receive needed help and treatment more readily than this. A paralegal system may occur in some California counties where good people trying to do good things make a quantum leap during the conservatorship process from the criteria of "dangerous to self or others" to a finding of "gravely disabled" (as evidenced by ability to provide or utilize food, shelter, and clothing). This is done to facilitate the treatment and supervision allowable by a conservatorship. Manipulation of the law in this manner, however, forces good people to provide less than honest testimony within the judicial system. A simpler and more rational response would be to provide any person who continues to require the treatment, structure and support of a conservatorship that assistance regardless of the criteria under which they were initially detained.

Recommendation: Conservatorships be available for any person who, due to mental illness, continues to fit the criteria for involuntary treatment and is in continuing need of treatment after the initial certification period regardless of the criteria used for the original detention unless that person is a demonstrated danger to others. The standard of proof for a conservatorship should be clear and convincing evidence.

Recommendation 7: Commitment Based on Demonstrated Danger

Discussion: The only true civil commitment in California occurs under WIC 5300, which allows a person who is a "demonstrated danger to others" to be placed on a 180 day-commitment

following an initial 14 day certification for involuntary treatment. This section of the LPS Act is rarely used because it requires that during the hospitalization period or just prior to, the person posed demonstrated danger of inflicting substantial physical harm on others and that the demonstrated danger was based on actual infliction, attempt, or serious threat of harm. Danger of this level rarely occurs in a supervised hospital environment. A person who has been initially held because of danger to others, but has not reached a level of "demonstrated" danger under current law is simply released. (See recommendation regarding conservatorship.) However, even for those few patients who, because to symptoms of their illness, are demonstratedly dangerous, the procedures involved in obtaining a 180-day commitment are so stringent that they may be a barrier to needed treatment and supervision.

The person detained under WIC 5300 must be brought to trial within 10 days unless his public defender applies for an extension, granted a jury trial (if so desired) and found to be a demonstrated danger beyond a reasonable doubt. During the 180 days, which is renewable, the person may be placed in a locked psychiatric facility or placed on outpatient committal status, if the professional in charge of the facility and the county mental health director advise the court that the person will no longer be dangerous, will benefit from outpatient status, and will participate in an appropriate program of supervision and treatment. The limit of commitment -- 180 days -- may not allow sufficient time for inpatient stabilization and successful reintegration to the community through supervised outpatient committal.

Recommendation: If the person has proven to be a demonstrated danger to others during the initial certification, an additional certification period of 90 days be allowed. The patient should have the right to appeal this additional certification through a writ to the Superior Court. If at the end of 60 days of the additional certification period, the person is thought to be a continuing demonstrated danger to others, notification should be given the County District Attorney's office and Public Defender's Office of impending commitment in order to allow adequate time to prepare for trial. The finding should be based on clear and convincing evidence. Actual commitment should be extended from 180 days to 1 year to conform with the current conservatorship length of time and allow sufficient time for stability and community reintegration. Commitment should be renewable annually.

Recommendation 8: Psychiatric History

Discussion Mental illness does not exist in a vacuum of time. The severity of an individual's symptoms wax and wane, sometimes hour by hour or day by day. It is not uncommon for a person with mental illness to "present well" at a legal hearing with minimal displayed psychiatric symptoms and rational plans for self care because that person has had a few days of medication in the hospital prior to the hearing or has been "coached" as to appropriate responses. Yet, upon release, the person historically has gone off medication, drifted into homelessness or repeated hospitalizations.

It is also not uncommon for an individual to minimize or fail to disclose the severity of his/her

symptoms during the actual hearing. This is especially true of the individual who is paranoid and cautious in disclosing information to strangers. While nothing in the LPS Act precludes a hearing officer or judge from considering the past history of an individual's illness, common interpretation by some hearing officers is that they must only consider the person's presentation "at that moment in time." Without reasonable consideration of the person's psychiatric history, the individual may be inappropriately and prematurely released without sufficient stabilization. A grave disservice is thus done to the person who requires a period of stability in order to gain recovery from his/her disease.

Recommendation: Certification, conservatorship, and commitment hearings and renewals take into account not only the mental status of the patient at the time of the hearing, but also the recent and past psychiatric history of the patient including number and frequency of hospitalizations or emergency room visits, history of treatment compliance and living conditions such as repeated homelessness as well as prodromal warning signs of decompensation as may be provided by treatment professionals, friends or family.

Recommendation 9: Emergency Response

Discussion: Emergency response to mental health crisis varies throughout the state in implementation and quality of content. Some counties have mobile psychiatric response teams; others may rely heavily on private teams. In many cases, law enforcement is the only availability when a person is in medical crisis due to their illness and yet law enforcement may be least able to appropriately intervene because they are not aware of alternatives to hospitalization and lack sufficient training to evaluate components of the emergency situation that are related to mental illness.

Several vicinities in California are developing successfully law enforcement/mental health collaboratives to ascertain that appropriate disposition occur when people with mental illness are in desperate need. Examples include the Los Angeles County MET/SMART program and San Jose's developing CIT (Police Crisis Intervention Team). These projects have proven to provide humane compassionate response to the individual in a manner that assures public safety and decreases the chance of violence.

Recommendation: Each county develop an emergency response capability under a legislative framework which requires law enforcement and mental health interagency collaboration, increased law enforcement training regarding mental illness, and standardized training for response teams.

Recommendation 10: Psychiatric Mobile Response Teams (PMRT)

Discussion: Psychiatric mobile response teams (PMRT) have recently become an essential part of mental health systems. Also known as PET (psychiatric emergency teams), these

teams consist of mental health workers who are empowered by the LPS laws to place individuals on involuntary holds. They generally respond to emergent situations rather than immediate situations which are more likely to be handled by law enforcement. Current LPS legislation does not adequately regulate their operations. As a result, there is now an extraordinary variation in availability and function of teams throughout California, leaving mental health stakeholders confused and frustrated.

Current LPS statutes give no guidance as to obligations of public mental health systems to provide structure, resources, and monitoring of PMRT. Especially worrisome is the growth of relatively unregulated private PMRT composed of members of the attending staffs of various private hospitals. While these teams may augment strapped county resources, private teams may have undue financial incentives to involuntarily hospitalize individuals at their facilities.

Recommendation: Each county develop a system to ensure that psychiatric mobile response teams (PMRT) operate within a legislative framework that requires a specific administrative entity to be responsible for oversight and accountability of such operations, and that requires standardized and uniform training, credentialing, designation, and monitoring of all public and private PMRT personnel.

Recommendation 11: Uniform Standards for Voluntary and Involuntary Hospitalization

Discussion: There is general consensus that there are widespread differences among counties and providers in their implementation of various provisions of the LPS Act. This is a reflection of the vagueness of some of the legal provisions and lack of definition within the statute and the distorting impact of variable resource dedication. As a result flexibility in interpretation has evolved. Historically the concerns have been differences in the interpretation of the criteria, demarcation between substance abuse and underlying mental illness and the responsibility for treatment in emergency situations, and the utilization of conservatorships for people who are not gravely disabled but clearly in need of continuing treatment and supervision as well as uniform training and certification standards for personnel who are routinely involved in the implementation of LPS. (Lewin/ICF, Evaluation of Proposed Changes to California's Lanterman Petris Short Act, June 1988) These historic concerns are addressed and rectified in previous recommendations in this report.

Currently, since the implementation of managed care, a new problem has arisen. Much concern has been perceived among voluntary patients that they must now be "5150-able" to be hospitalized. "Medical Necessity" under Medi-Cal consolidation may not be defined consistently county to county. Real "medical necessity" does not vary between the person who voluntarily accepts hospitalization and those who need treatment involuntarily because they do not recognize their brain dysfunction. It is based on the severity of symptoms. Treatment, whether voluntarily or involuntary, must be provided to people *before* their conditions deteriorate to the point of danger.

Recommendation: The standards for both voluntary and involuntary hospitalization be uniformly implemented and monitored statewide. A person who is willing to be hospitalized voluntarily must not be required to be hospitalized involuntarily to receive services.

Recommendation 12: Funding

Discussion: There is no doubt that California's public mental health system is under funded. Yet the cost of untreated mental illness does not stay within neat budgetary lines. There are many indirect costs to society resulting from untreated mental illness including lost productivity, increased use of general medical services, crime/incarceration, and use of social welfare benefits. In 1990, the indirect cost to U.S. society because of mental illness in the United States was conservatively estimated at \$75 billion including lost productivity and earnings due to illness and premature death. If only 80% of people with mental illness obtained treatment, two thirds of premature deaths attributable to mental illness would be averted and there would be at least a 10% reduction in use of general medical care by people with mental illness. (Source NAMI Science and Treatment kit) A 1996 study by Pacific Research Institute showed that California spends between \$1.2 to \$1.8 billion a year in criminal justice costs related to untreated mental illness. The human tragedy is incalculable.

California has already recognized that mental health care is a basic human service and that a system of care for adults, as envisioned under WIC 5801, can provide greater benefit to people with severe and persistent mental illness at a lower cost than the current practices within the state. Yet, we have not directed the funding necessary for an adult system of care. While avoidance in costs is conceivable through the streamlining of procedures within the LPS Act and through the utilization of Community Assisted Treatment, for every one person now receiving treatment in California, another is not. California's mental health system will remain seriously fragmented and unable to convey recovery to individuals, as well as save the overall societal cost associated with lack of treatment, until a real dedication to the needs of mentally ill individuals is funded.

Recommendation: California fund the Adult System of Care with components to assure prioritization of services to the most seriously disabled mentally ill adults whether services are needed by them on an involuntary or voluntary basis. The recognition that some people, due to the severity of their illness, will require treatment involuntarily must be incorporated into the Adult System of Care legislation and recognized as a form of community assistance.

History of LPS - Carla Jacobs

Overview

It was an era of well-intended reform -- and much social debate about the nature of mental illness -- when in 1966, the Lanterman Petris Short Act (LPS Act) was first envisioned. The 100-year-old reform of Dorothea Dix, born from a vision of peaceful asylum in hospitals rather than a disgraceful existence in jails, had become threadbare. In many cases, the state mental hospitals themselves had become overcrowded and dingy warehouses. Psychiatric activists and their allies started promoting new policies designed to provide care and treatment in the community rather than in mental asylums. The generous spirit of the Great Society saw passage of various entitlement programs which would help states pay for treatment, but only if services were provided in the community, or on a short-term basis in general hospitals. The Federal government was committed to the historical idea that states are responsible for long-term care.¹

The human dimensions of the problem facing reformers were stunning. In California, 26,567 people lived in an antiquated and fragmented state hospital system.² Patients included people with mental illness, public inebriants, children with behavioral problems and old folks with nowhere else to go. Sixty percent of all people in state hospitals were on nonvoluntary status.³ California, however, had already pioneered some of the best practices in the nation for care of its committed patients.

Extramural Care Program

In 1939, Department of Mental Health Director Dr. Aron Rosanoff initiated an "extramural care program" to "break down the walls between the hospital and the community" and to help patients to re-integrate into the community. Patients could be either unconditionally discharged from in-patient hospitalization or placed "on leave," if it seemed that they might require help and supervision during community re-entry. The Division of Adult Protective Social Services (known as the Bureau of Social Work prior to July 1, 1966) helped patients "on leave" to find employment and to obtain welfare assistance and housing. Convalescent leave psychiatrists, working in regional bureau offices, provided consultation and dispensed medication. Workers conducted "home visits" with former patients in order to make sure that they were managing satisfactorily on their own. In 1966, approximately 20,000 people were "on leave" from state hospitals.⁴

Dr. Rosanoff's extramural care program was credited with having forestalled a far worse wartime deterioration of state hospitals than that which actually occurred. But, during the 1950s, California's population spiraled; state hospital populations grew exponentially, overtaxing existing facilities. In some hospitals, two patients shared a single bed and surplus army cots filled every nook and cranny. Poorly paid nursing staff were wont to keep up with the vast numbers of patients. Community-based services were seen as the solution for patients who might otherwise have been sent to overcrowded, and, generally, remote, hospitals. It was also thought that the provision of community-based services might reduce the need for capitol outlay for construction and reduce the expense of hospital maintenance and staffing.

Short Doyle Programs

In 1958, a community-based mental health system was established under the Short Doyle Act, a state-county matching program initially funded on a 50-50 cost sharing basis. In 1963, the matching formula was revised to the counties' advantage to 75-25 for newly-initiated programs. During 1966-67, Short Doyle programs were authorized to spend \$34 million in public money, two-thirds of which came from the state and one-third of which was provided by counties. Short Doyle programs were controlled, for the most part, by counties. (Exceptions included three programs -- one in Berkeley, one in San Jose, and one in the Greater Los Angeles area). In 1966, 41 Short Doyle programs operated in 38 of California's 58 counties, representing 96 percent of the state's total population.

Over half of these programs included both inpatient and outpatient services. In 1966, approximately 115,000 people received services from Short Doyle programs, closing the year with a caseload of nearly 33,000 people. Ten percent of Short Doyle patients were inpatients in community hospitals. The Short Doyle system, however, was not acting as a deterrent to the state hospital system; during that same year, state hospitals admitted 28,834 patients, 60% of which were first-time inpatients, while the balance were re-admits or court-ordered admissions.⁵

History of Civil Commitment ***Paul F. Stavis, JD***

Soranus of Ephesus, a 2nd Century Roman of Greek extraction, theorized that disease was caused by a disturbance or an irregularity of atoms in the human body and described two kinds of mental illness, mania and melancholy, which are what we now call schizophrenia and depression. Soranus recommended treatments that included rooms of modest light and adequate warmth, always on the ground floor to prevent suicide, a simple diet with regular exercise and restraint, only if necessary and if so, only with bonds made of wool or soft materials. Soranus thought that the patient should be engaged in intellectual activities not only for therapeutic purposes but to detect the progress of the illness; patients would be encouraged to talk to philosophers "to banish their fear and sorrow."

The words of the Declaration of Independence and the Preamble of the United States Constitution expressly incorporate these principles in the fabric of our fundamental law.

Continuum Theory

The failure of the Short Doyle system to deter entry to state hospitals can be attributed, in part, to a post war shift in psychiatric thinking toward a psychodynamic and psychoanalytical model that emphasized life experience and the role of socioenvironmental factors as key in the development of mental illness. This is known as the "Continuum Theory." The Continuum Theory postulated that mental illness was the result of social degeneration and that if social and environmental conditions were ameliorated before degeneration, mental illness could be prevented.⁶

People in Short Doyle programs, generally of higher socioeconomic status than state hospital patients, were thought to have "problems in living." Community mental health care providers, guided by the Continuum Theory, sought to prevent mental illness by intervening in such problems while the individuals were still "mentally healthy." Less generously explained, Short Doyle programs were notorious for accepting "easy" patients; people who were poor, black or psychotic generally went directly to state hospitals.⁷ Ironically, the community mental health care system is still accused by many as "putting away" more difficult patients -- this time in jails and prisons.

The Dilemma Report

By 1966, state appropriations for state hospitals totaled \$111.5 million. Overall the appropriations for the Department of Mental Health was \$190 million with a portion going to facilities and services under its auspices and the Short Doyle matching funds. The state hospital system was almost completely financed by the State General Fund. The Department was second only to the University system in terms of outlay and staffing.⁸

The dilemma posed in California was how to stem entry into the state hospital by encouraging the community system to accept more patients, hopefully improving quality of care while allowing state expense to be alleviated by the newly available federal funds. Jerome Waldie, democratic majority leader of the California Assembly, and his chief aide, Art Bolton, started searching for a conduit. Earlier that year, a Special Fact Finding Committee on the Judiciary had produced a lengthy report concluding that while commitment laws were in scattered disarray throughout the Welfare and Institutions Code, existing legislation ensured sound medical practice and adequately protected the fundamental legal rights of patients.⁹ Waldie and Bolton thought differently. In January 1965 the California Medical Association had published a report on conditions within state hospitals. The report found that without adequate staff, equipment, and space, most state hospitals were unable to provide state-of-the-art treatment. Waldie and Bolton recognized that the linchpin to the entry of the state hospital system was through the commitment process.¹⁰

To focus public and legislative interest on mental illness is a daunting task, but a necessary one in order for major legislative reform to take place. The Assembly Subcommittee on Mental Health, which Waldie chaired, set out to develop a working knowledge of contemporary

thinking about mental illness and commitment. They reviewed the legal and scientific mental health research literature available to them at that time and conducted public hearings. The Subcommittee contracted with a private research firm, Social Psychiatry Research Associates of San Francisco, which defined itself as "researchers engaged in a series of social surveys generally focused on the community careers of people labeled as deviant." The mandate of the research firm was to assist in designing and completing a survey of the courts and to process and analyze the data collected. The findings were then synthesized into a document known as "The Dilemma Report."^{11 12}

The research leader was Dorothy Miller, an adherent of Erving Goffman who postulated a phenomenological argument that denied mental illness as anything more than a condition caused by institutionalization. Goffman's theories permeated the Dilemma Report, just as they had flooded popular imagination through Ken Kesey's *One Flew over the Cuckoo's Nest*.

Another popular sociologist used as reference for the investigation was Thomas Scheff, a professor of sociology at the University of California at Santa Barbara, who esoterically promulgated a theory that while many people might exhibit symptoms of mental illness, these people are no more than residual rule breakers and mental illness only exists as a label -- or a definition -- by group culture for its "social losers." He later became known as the "father of the labeling theory."

Other influences included R.D. Laing, who argued that mental illness is a socio-political event and once compared schizophrenia to a self-enlightening acid trip, and Thomas Szasz, who published, in popular magazines, his flamboyant argument that mental illness is a myth used by totalitarian governments to gain social control.

The sociological confusion surrounding the nature of mental illness in the 1960s was well stated in The Dilemma Report which said, "The term 'mental illness' is a nonscientific, generalized popular label used to describe a wide range of behavior which is considered 'peculiar' or 'sick' or objectionable . . . it does not reveal the cause of any individual's difficulty. . . . It is also evident that when a person's behavior is labeled 'mental illness,' those who do the labeling are guided by their own concepts of what is normal and abnormal. Madness, like beauty, may exist in the eye of the beholder. . . .Despite all these uncertainties the general public, its elected representatives and civil servants have perpetuated the commitment court and mental hospital system as a means of disposing of a variety of disagreeable social problems."^{13 14}

The Dilemma Report proposed doing away with the entire commitment scheme, removing reference to "need for treatment" and replacing the criteria with strictly limited behavioral standards. However, the report observed, "Most people who believe themselves to be mentally ill, or whom others believe to be mentally ill, do have some kind of problem and may benefit from some kind of assistance."¹⁵

An Emergency Services Unit (ESU), envisioned as a replacement to the former commitment process, was proposed as a place where people could come, both voluntarily or "through the help of others," for evaluation and services. Another sociological theory popular at the time was that mental illness was a reflection of poverty biased by middle class standards which could be "cured" by financial aid. The ESU recipient would therefore be given a wide choice of community services while the ESU staff investigated and clarified the financial resources available in each case.¹⁶ Additionally, the ESU would provide short-term suicide prevention counseling and other such emergency medical, legal or social services the authors believed would ameliorate crises situations. All ESU services would be voluntary, subject to termination by the individual at any time.¹⁷

A one-day commitment court survey was conducted for the Mental Health Sub-committee by volunteers from the California Mental Health Association. Surveyors reported that only 8 percent of all people appearing before the court on that day appeared to be "dangerous to others" while 18 percent constituted some manner of "danger to themselves." The others were committed because the court found them in "need for supervision, treatment, care, or restraint."¹⁸

It was concluded that few people would require help on a nonvoluntary basis and that if community services were offered, they would be accepted. The paper acknowledged that there would be some exceptional emergency cases where individuals might be too disabled or uncontrolled to participate in planning for their own needs.¹⁹ For these people, the plan proposed non-voluntary crisis placement for a maximum of 14 days. Certification for such placement required a written affirmation by a physician, after ESU staff agreed that all other alternatives had been exhausted, that: (1) the person was gravely disabled; or (2) he/she was exhibiting destructive behavior and appeared to be an immediate threat to other people; and (3) the individual had refused voluntary treatment. There would be no due process, other than the ESU's review for this period of time, unless the individual requested a court hearing. In spite of this certification, however, the patient would be allowed to leave after 14 days if he/she did not wish to remain for voluntary treatment. If after 14 days the person remained "gravely disabled," as evidenced by his/her inability to provide food, shelter, or clothing, guardianship could then be initiated through the courts. The "dangerous" would simply be released; to keep them longer, in the minds of the authors, was simply a case of preventative jailing.

The Dilemma Report also suggested that suicidal patients should not be involuntarily treated, but should, instead, be given preventative counseling at the ESU. The Report states: "Even if the state were to hospitalize suicidal patients for their own protection, there is no evidence that it is possible to prevent people from killing themselves if they are determined to do so." The report noted that even "on leave" patients had a ten times greater suicide rate than that of the normal population and that trying to prevent suicide, when attempting to teach responsibility to the patient, might be the worse possible therapy. Suicide was not, after all, a violation of California law.²⁰

"When these steps have been taken," the Report's section on civil commitment ends, "state hospitals as we now know them, will no longer exist."²¹

In May 1966, Waldie won a special election called to fill the congressional seat vacated by death of its incumbent. His co-chairs on the subcommittee, Nicholas Petris and Frank Lanterman assumed operational responsibility for the project. Because of an election bid to the Senate for Petris, captainship fell to Lanterman.

Lanterman Petris Short Act

The Dilemma Report was released on November, 28 1966. Its draft legislation got off to a flowery start, only to be met with the usual support/opposition based on ideologies and turf wars. At a early public hearing, Dr. Warren Vaughn set the tone of both opposition and support to the bill when he praised its emphasis on community services, but gave qualm to the limitation of seventeen days (three days of observation and fourteen days commitment) for involuntary commitment. He strongly recommended that suicidal people also be included for potential nonvoluntary treatment, and that the definition of gravely disabled be broadened.

Maurice Rodgers, spokesman for the California State Psychological Association, called the plan the "Magna Carta of the Mentally Ill," while the American Civil Liberties Union (ACLU), officially in support of the legislation, raised objection to the fact that the patient had to personally petition for a due process hearing at the initial point in the commitment. (The current probable cause hearing at 72 hours was legislated after a court case in 1978, known as Doe v. Gallinot.)

Some Short Doyle administrators objected to the ESU which would have been funded through MediCal. They viewed the ESU as a potentially competing community mental health system to their own, which was limited by the amount of match given by the counties. The bill was subsequently redrafted to make it difficult for the county supervisors to bypass Short-Doyle directors for evaluation and treatment services. The California State Association of Counties (CSAC) thought the bill would add extra financial burden on the counties.²²

Frank Lanterman himself noted the inadvisability of releasing people who were potentially dangerous after the 14 days hold.

Perhaps the most colorful support came from ninety-one year old Mr. Simpson who said he had once spent seven months in Agnews State Hospital as a "political prisoner." Raising a paperback copy of Ken Kesey's *One Flew over the Cuckoo's Nest*, he said it told the truth about mental hospitals.

The commitment bill was amended nearly 300 times, and was as good as dead during the

legislative process until Frank Lanterman refused to allow another bill out of a committee he chaired unless the commitment bill was amended into it. The bill which accepted the amendment was a popular piece of legislation authored by Senator Short, which called for an increase in state financial participation in the Short Doyle system to a 90/10 ratio. As a result the new commitment scheme became known as Lanterman, Petris, Short Act (LPS).

LPS was signed into law in 1967 by Governor Ronald Reagan, the same year in which his budget act abolished 1700 hospital staff positions and closed several of the state-operated aftercare facilities. Reagan promised to eliminate even more hospitals if the patient population continued to decline. Year-end population counts for the state hospitals had been declining by approximately 2000 people per year since 1960. The LPS Act became effective January 1, 1969 giving the system a year to reconstitute itself to the new procedures.²³

The LPS Act was a seminal doctrine. Its goal was the end of inappropriate lifetime commitment for people with mental illness. The memorialization of this doctrine remains excellent. It firmly established in the mind of the state and the public that people with mental illness are entitled to civil rights, nondiscrimination, treatment and community life. However, like Dorothea Dix's good intent when she first proposed state hospitals, implementation of the act has become threadbare.

A New Dilemma

Consensus does not exist on whether most long term placements in state hospitals would have not ceased naturally with the advent of more effective medications and monetary incentives toward community placements.²⁴ An unwritten goal of the LPS Act was to prevent the Short-Doyle community system from "dumping" difficult, seriously mentally ill patients.²⁵ After the statute's passage, the community mental health system reconstituted itself to accommodate additional patients who previously had been placed in hospital because of financial or social dependence and who could accept treatment voluntarily. But, the new stringent behavioral criteria for involuntarily committing a patient to treatment applied to both state and community hospitals. How to handle the serious, hard to reach patients -- who clearly needed treatment but did not fit the new criteria or who recycled through short term stays -- became a community dilemma. For them, there was nowhere to go.²⁶

Frank Lanterman would say days before his death, "I wanted the LPS Act to help the mentally ill. I never meant for it to prevent those who need care from receiving it. The law must be changed."²⁷

Revolving Door

By the late 1970s, papers about the "new chronic patient" began to be presented at psychiatric

conferences. These individuals were often referred to as "revolving door" and "treatment resistant" patients because of their frequent admissions to, and rapid discharges from, psychiatric hospitals. This generally occurred because these patients failed to follow through with outpatient care recommendations, and suffered relapses.²⁸

Early on Senator Frank Lanterman recognized serious missing links in the system of care he envisioned through the LPS Act, which seemed to contribute to the rising number of patients recycling through short-term hospitalization. He convened a wide-spectrum task force, including law enforcement, defense attorneys, prosecutors, psychiatrists and other treatment professionals. As a result, he introduced a bill in 1974, allowing "outpatient committal" of these patients on *parens patriae* basis. The bill became subjected to the beliefs of the era which considered any form of commitment by the State for mental illness an undue use of totalitarian control and therefore suspect. The legislation was subsequently amended to allow such proceedings only if the person was an "immediate danger to others," and passed the procedural rigors of the 180-day commitment judicial process. Thus, effectively what was intended as a "safety net" for seriously ill individuals was still unavailable to the "chronic patient" -- who, like the majority of people with mental illness was not dangerous, just very ill.²⁹

By 1982, it was clearly established in the literature that California's county jails had become *de facto* institutions for people who didn't succeed in the increasingly short-term hospitalization and voluntary community treatment environment.³⁰

California is still experiencing the reality of recycling patients, a costly situation both in terms of human suffering and economic impact. Typically what happens with revolving door patients is that they stabilize during a hospital stay, but only continue their medication and outpatient therapy for a short time after discharge, if at all.³¹ Most relapses in people with mental illness who have been hospitalized occur because of medication noncompliance; noncompliance rates are significantly higher during the first few months after discharge than at any other time.³² Between July 1, 1997 and June 30, 1998, Los Angeles County had a total of 12,208 unduplicated patients who were involuntarily hospitalized. Of this group, 90% were admitted to the hospital only once or twice (9,213 and 1,844 respectively). There were 1,151 patients admitted three or more times -- ranging from 594 people admitted three times to one person who was hospitalized 20 times in that year.³³

The expense of this recidivism is shocking. If the approximate cost was \$434 per hospital day, involuntary treatment cost Los Angeles County \$86,333,450 for fiscal year 1997-1998. This figure does not include auxiliary costs, such as law enforcement and judicial expenses. The 10% of patients who recycled through the system used 25% of its involuntary hospital budget. Patients who were admitted to involuntary treatment three or more times cost the County \$20,695,724.³⁴ Significantly, the average length of stay for those who only had one or two admissions was 11.8 days; those with three or more admissions averaged 7.79 days, just slightly more than the time normally used for the evaluation period and the probable cause

hearing.

No study is available indicating how many times these recycling patients have been in jail, or on the streets on their way to rehospitalization. A study by an ad hoc group of psychiatric residents in Los Angeles, however, found that patients with schizophrenia released from nonvoluntary hospitalization by legal hearing because they did not meet the stringent behavioral criteria for involuntary treatment were likely to spend 28 days in jail mental health treatment over the next year. Those who were allowed to remain until medical decision determined release averaged one day in jail.

Over the last 30 years, the number of patients who once might have been in State hospitals, but are now on the streets, or in our jails and prisons, has risen significantly. In 1968, the year before LPS was implemented, the year-end population in State hospitals was 35,739.³⁵ Today, state hospitals are primarily forensic and house fewer than 4,000 mentally ill patients. Between 20,000 and 30,000 people with mental illness are in our jails and prisons. At least an equal number are homeless on the streets.

A significant number of people with mental illness need more structure and support than the community service system currently provides. Instead, they revolve from the hospital, to the streets, and to jail. For them, we have replaced one inadequate system of care -- keeping people institutionalized for long periods of time -- with another inadequate system of care.

The Current Legal System

Overview

In California, mental health professionals acting under authority of a state statute are authorized to make the initial decision regarding a person's placement, involuntarily, in a treatment facility. This deprivation of civil liberties is limited by a safeguard called "due process." Due process requires that reasonable procedures are taken to protect the individual from undue deprivation. The amount of process -- that is, how many safeguards -- the Constitution requires depends on a balance between an American's interest to be free and the state's interest to promote public health and to protect the safety of its citizens. In temporary civil commitment, due process can become imbalanced between the State's interest and that of civil liberties. California's current system is exemplative of that imbalance, especially considering that symptoms of mental illness can deprive the individual victim of the free will necessary to enjoy that liberty. In some cases, it appears as if the liberty is given *to the psychosis* to benefit a philosophy that values esoteric interpretations of liberty over life itself.

Specific Provisions of LPS

The statute regulating the authority of the state is codified in the Lanterman-Petris-Short Act

(LPS). Beginning in the California Welfare and Institutions Code Section 5000, the LPS Act covers a wide range of topics including voluntary and involuntary treatment, patients rights, confidentiality, and conservatorship. The heart of LPS -- the rules that govern involuntary treatment -- is the topic of this discussion.

Under Section 5150 of LPS, only certain individuals may place a person into involuntary hospitalization to initiate the first 72-hour period for evaluation and treatment. These individuals include law enforcement officers, members of the attending staff of an evaluation facility designated by the county, members of a designated mobile crisis team, or other professional persons designated by the county. A person may not be involuntarily hospitalized by family or friends.

Section 5150 of LPS also defines the circumstances under which an adult may be involuntarily placed in a psychiatric hospital designated by the county. There are two requirements for involuntary hospitalization: First that the individual has a *mental disorder* and second, as a result of that *disorder* the individual is a *danger to self or others* or *gravely disabled*. *Gravely disabled* is defined as an inability to take care of one's basic needs, such as those for food, clothing or shelter. The law does not define *mental disorder* nor does the law define what constitutes a *danger*.

Many professionals who place a person into involuntary treatment *assume* that danger must be *active*: the person is actively suicidal or making threats thereof, or threatening or actually physically injuring another party. This is not true. Danger comes in many forms, including passive danger such as endangering one's child or own health & safety through behaviors caused by untreated symptoms of mental illness. Such passive danger could include, not taking needed medication for a serious medical condition or exposing oneself to violent elements on the streets. As a result of this misinterpretation of danger, many people who don't fit the "boxed" view of grave disability or danger but who need and would benefit from medical treatment for their mental illness are unable to receive it. In other cases, the complex procedures within the LPS Act weed out people who are genuinely suffering and in need of treatment.

The Current System

If a person is considered to be a *danger to self or others*, or *gravely disabled* due to *mental disorder*, WIC Section 5150 allows 72 hours of hospitalization in a designated facility for evaluation and treatment. If at any time an individual who is involuntarily hospitalized no longer meets the criteria under LPS, he/she must be released. If at the end of the 72-hour period the person is still dangerous to self or others, or gravely disabled, Section 5250 allows certification for a 14-day period of involuntary hospitalization. Prior to certification, the patient must be given the opportunity to accept treatment on a voluntary basis. If after the initial 14-day certification, the patient continues to be dangerous or gravely disabled, additional extensions

may occur, but the extended hospitalization requires stronger showing of dangerousness than the original 14-day certification. Stays beyond the 14-day certification are sometimes referred to as postcertification holds. In the case of the gravely disabled, a temporary conservatorship might be filed to extend the length of stay pending a permanent conservatorship.

After the original 17 days (the initial 72-hour hold and the additional 14-day hold) the length of extended hospitalization depends upon which criteria the involuntary hold is based. Under Section 5260 of the Welfare and Institutions Code, individuals who threaten or attempt to take their own life during the 14-day intensive treatment period may be held for a *second* 14-day intensive treatment. The criteria for the second 14-day hold requires *suicidal behavior* (threats are considered behavior) rather than just general dangerousness to self. After the second 14 day certification, if the person remains suicidal, they must be released.

Individuals who pose a *demonstrated* danger of inflicting substantial physical harm on others may be confined for up to 180 days for further treatment after the initial 14-day period. Proof of danger must be based on actual infliction, attempt, or serious threat of harm during, or just prior to, the initial hold. Rarely are people in California placed on 180-day holds because of the procedures and costs necessary to obtain one. Additionally, danger of this level frequently requires arrest. Thus, unless a person who has been brought in as a danger to others can be "made to fit" the gravely disabled or danger to self criteria due to suicidal behavior, they will be released after 17 days unless showing demonstrated danger.

Finally, a person who is gravely disabled may be certified for an additional 30 days of intensive treatment or placed on a temporary conservatorship. The additional 30-day hold is used in only a few counties. Most often a temporary conservatorship is appointed. The temporary conservator has the authority to authorize an additional 30 days of hospitalization. Following a temporary conservatorship and a full investigation considering conservatorship, a conservatorship for one year may be established by the court. This conservatorship is renewable at the end of each one-year period.

Informal Due Process

An informal due process occurs during the initial 72-hour evaluation period in that only designated persons can place the person in hospital, and the designated person must have a reasonable belief that the person fits the criteria of the statute. Furthermore, at any time the treating physician believes the person no longer fits the criteria, the patient is to be released.

Gallinot Hearing - Probable Cause

If, at the end of the 72 hour evaluation, the person who has been detained appears to continue to fulfill the criteria, the person can be placed on a 14 day hold. A certification review hearing is conducted within 4 days of the beginning of the 14 day hold. Also known as a "Gallinot"

hearing after the court case which required its legislation (Doe v. Gallinot, 657 F.2d. 1017 (9th Cir. 1981)), this procedure is sometimes referred to as a 'probable cause' hearing. It is an automatic hearing and does not have to be applied for by the patient. Certification review hearings are non-judicial proceedings that usually take place at the treatment facility. Either a court-appointed commissioner or referee, or a certification review hearing officer, conducts the hearing. During the hearing the treating psychiatrist or his designee presents information regarding the need for continued hospitalization. The patient is entitled to assistance by an advocate. The patient or his advocate may present evidence and cross-examine opposing witnesses. Additionally the patient may request attendance of any facility staff who participated in or has knowledge of the 14-day certification.

Writ Challenges - Gallinot Hearing

Section 5275 of the Welfare and Institutions Code gives the patient possibility to challenge the Gallinot hearing decision and any additional holds by means of a judicial review known as a writ. A hearing on a writ must be conducted by a judge and held within two days of the request of the patient. In the writ proceedings, the government bears the burden of proof by a standard of preponderance of evidence.

Riese Hearings - Medication

Although Section 5152 was written to provide detention and treatment, currently under California statute medication may not be given an involuntarily hospitalized person who refuses it, except in emergency situations. An emergency is defined in WIC 5008 (m) as a situation in which action to impose treatment over the person's objection is necessary for the preservation of life or the prevention of serious bodily harm to the patient or others, and it is impracticable to first to gain consent. Thus, a person with mental illness may be involuntarily detained in a hospital for "evaluation" and "treatment", but not receive treatment.

To provide pharmacological treatment for such a patient, the treating physician must petition the court to have the patient declared unable to consent for such treatment. This petition, the Riese petition, can only be filed after the psychiatrist has made repeated efforts to obtain the patient's consent. After the petition is filed, a "Riese" or capacity hearing is held, the goal being the determination of whether or not the patient has the capacity to consent or refuse the administration of medication. During the hearing, the treating psychiatrist must present evidence to prove the patient's lack of capacity. The patient is represented by an advocate, who along with the patient, can argue for the patient's capacity. The court-appointed hearing officer, who must be an attorney, determines the patient's capacity or lack thereof. If the patient is found to lack capacity to provide informed consent, the patient can be required to take the psychotropic medication prescribed by the treating physician.

Writ Challenges - Medication Hearing

Either the patient or the hospital may appeal the hearing decision to Superior Court. If an appeal is requested by a physician whose patient is in a private facility, that facility must provide an attorney to be present on the hearing date. County Counsel generally presents cases for appeals requested by physicians in a county facility. A medication capacity hearing remains in effect only for the duration of a specific hold upon which the person is currently detained. A change in legal status necessitates a new medication capacity hearing if the person continues to refuse. Each capacity hearing has a subsequent right to appeal.

Due to the cumbersomeness of the medication hearing procedures, many hospitals and physicians working under near triage conditions in extreme budgetary and time restraints, are wont to call for a medication hearing unless the person is in extremely dire straits.

Thus, the practical application of a good idea -- allowing patients who do have medical capacity to make informed decisions regarding their medication -- becomes a procedural barrier against giving care to those who do not have capacity. At least one study found the average length of stay increased for patients for whom Riese petitions were filed, and restraints and seclusion was needed longer than for other adult inpatients.³⁶ In nearly all the cases where medication hearings were actually filed by the treating physician, the patient was found to lack capacity to refuse the prescribed antipsychotic medications.³⁷ The current application of the Riese hearings have increased the expense to the system while increasing time hospitalized and reducing the therapeutic value of hospitalization to the patient.

Conservatorships

LPS Conservatorships may be sought for patients that are gravely disabled by LPS criteria and are expected to remain so. The LPS Conservatorship provides the Conservator with limited powers over the Conservatee, *possibly* including the power to place the Conservatee in locked and unlocked psychiatric facilities and to authorize the administration of psychotropic medications. WIC 5358 requires that the Conservator have reasonable cause to believe that hospitalization is necessary before placing the person in a locked unit. "Reasonable cause" must be based on a belief that a change in the Conservatee's condition poses an immediate and substantial danger to the Conservatee or others.

The LPS Conservatorship application process, which generally begins during a 14 day hold, must be initiated by a professional person in a facility providing intensive treatment. It may not be applied for by a spouse, relative, friend or other nondesignated individual. Once the application is received by the Superior Court, the Court can appoint a Temporary Conservator who begins a 30 day period of investigation. The purpose of investigation is to determine the validity of the application with regard to the grave disability of the patient. During this investigation, the patient may challenge the Temporary Conservatorship through a writ proceeding. At the end of the 30 day investigation or allowed extensions, a hearing is held in Superior Court. The patient, the Temporary Conservator, and a psychiatrist involved in the

treatment of the patient must attend the hearing. The patient is represented by a Public Defender. The judge, taking into account the report of the Temporary Conservator, the testimony of the psychiatrist, and the defense against the conservatorship presented by the Public Defender, makes a decision regarding the appointment of a Full Conservator. The 30 day investigation period may be extended if the patient requests a jury trial instead of the hearing. The Full Conservator may be a private party, such as a relative or friend of the patient, or a member of the Public Guardian's office. If the psychiatrist is unable to appear or does not appear for the hearing, the Conservatorship will not be granted. The Conservatorship remains in place for one year. A conservatee may during any six month period of the conservatorship apply for re-hearing of both the issue or the terms of the conservatorship.

Renewal of the one year Conservatorship can occur. The Conservator must petition the Court for reappointment. A hearing will again be held in Superior Court with the patient represented by the Office of the Public Defender. The Court may require a treating psychiatrist or psychiatrist to appear. If the treatment professional is unable to appear or if the Conservator does not reapply, the Conservatorship may be discontinued. The Conservatee must also appear in court and the conservatorship not be renewed if he fails to appear.

It must be noted that LPS Conservatorships are not available to people who remain a passive danger to self due to inability to provide for medical or physical safety due to mental illness nor are they available to people who remain suicidal or have a past history of danger unless they also fit the criteria of gravely disabled as described in the statute.

A person with a psychiatric disability may also be conserved under the Probate Code. A Probate Conservatorship does not give the Conservator the authority to consent for the administration of psychotropic medications or to place the patient in a psychiatric treatment facility. Thus, Probate Conservatorships are rarely used in cases of disability due to mental illness.

Commitment for Demonstrated Danger

A 180-day hold for demonstrably dangerous mentally ill individuals requires a court trial. Furthermore, if the person asks for a jury trial, the trial must be granted within 10 days of that request. During the trial, the patient is entitled to an attorney. The State's burden of proof equates to that required for a criminal conviction: *beyond a reasonable doubt*. Because of the extreme standard of proof, and the provisions and costs of a jury trial, 180-day commitments based on dangerousness are very rarely used in California. Furthermore, danger of this level frequently results in arrest. California remains one of the only states that requires a burden of proof as high as "*beyond a reasonable doubt*" in commitment proceedings.

Outpatient Committal

There is only limited civil outpatient committal in California. Outpatient commitment occurs when the patient is required to comply with a treatment plan outside the walls of a psychiatric unit. Outpatient committal is the least restrictive form of involuntary commitment. Section 5305 of the Welfare and Institution Code allows outpatient commitment of individuals who had been previously placed on a 180-day hold because of demonstrated danger during their initial involuntary treatment certification. It does not allow outpatient committal for people who are passively dangerous to self, previously dangerous to others, gravely disabled, or suicidal. The person so committed may be placed on outpatient status if the professional in charge of the facility and the county mental health director advise the court the person will no longer be dangerous, will benefit from outpatient status, and will participate in an appropriate program of supervision and treatment. Because of the limit of 180 days, little time is allowed to utilize outpatient status as a successful mode of reintegration to the community and is another reason it is rarely used.

Summary - Jonathan Stanley, Esq.

Because of the tendency to make everything seem as if its judicial, California's system for mandatory treatment is as complex as it is ineffective. The multitudes of checkpoints that must be surmounted are redundant and wasteful. The reason for multiple judicial/due process paths for those dangerous to others, suicidal and gravely disabled is unclear and unique in comparison to other state's statutes. Judicial discretion in treatment placement and the relatively short length of treatment combined with a statutory obligation to release substantially recovered involuntary patients and a committee's right to demand judicial review of his mandated care already provide overlapping protections against inordinately long treatment terms. To offer conservatorship as an option for the long-term care of gravely disabled individuals is understandable. To make it the sole means of extended treatment for those suffering from mental illness, unless they are proven an active threat to others, is incomprehensible. California's system cries for a major overhaul or, ideally, a replacement: even if not to provide more treatment, then to maintain existing levels at greatly reduced costs.

Therapeutic Jurisprudence: The Impact of LPS on Recovery - David Stone, MD

As statutory and case law concerning the confinement and treatment of the mentally ill has evolved over the past thirty years, psychiatric research has responded with various attempts to quantify the impact of those legal changes on the citizen/patient. The majority of these studies have been critically reviewed by Paul S. Appelbaum, M.D. in his book *Almost a Revolution: Mental Health Law and the Limits of Change*.³⁸

Meanwhile, legal academia has itself responded to the law's sweeping changes. Over the past several years, a new area of enquiry in legal philosophy has emerged, namely therapeutic jurisprudence. Key thinkers in the area of therapeutic jurisprudence recognize that the weighing of only the personal and state interests is inadequate for mental health law; in

addition, lawmakers and jurists must weigh the law's therapeutic impact on patient care and outcome. Refreshingly, some authors have urged legal scholars and scientists to "audit the law's success of failure" in the criminal and civil areas of mental health law, thus proposing critical, scientific assays of the law itself.

A recent large prospective study in the Los Angeles area has done just that, focusing on the Gallinot probable cause hearing and its impact on relapse and recidivism one year after discharge from inpatient care at Harbor-U.C.L.A. Medical center.³⁹ Historically, the probable cause hearing was amended into LPS statute after the California case of *Doe v. Gallinot* (486 F. Supp. 983). The probable cause hearing determines if the person meets the current criteria for involuntary treatment. Citing "massive curtailment of liberty", "adverse social consequences" of commitment, and the "substantial risk of erroneous application" of the grave disability standard, the District Court and Appellate Judges mandated probable cause review hearings to occur within seven days of confinement in every case of involuntary treatment.

The Harbor study followed 250 consecutive admissions to the hospital's two acute care settings. One year from the original admission date, the investigators compared the treatment outcomes of those patients for whom probable cause was found to the outcomes of those patients whose treatment was terminated when probable cause was not found. The results of this study were not only striking, but showed robust statistical significance.

Patients with major depression differed significantly in the time to enter outpatient treatment after discharge, despite standardized discharge planning in both groups: those who were allowed to complete their inpatient care entered outpatient treatment within 24 days of discharge, while those patients whose treatment was interrupted by the Gallinot hearing took over 173 days to enter the outpatient setting. Another trend emerged in the depressed: patients who completed their inpatient care averaged only 1.55 days back in the hospital over the follow-up year, while those whose treatment was curtailed by the hearing relapsed for an average of 14.25 days over the follow-up year.

Among patients with bipolar affective disorder, the completers and non-completers also differed significantly: patients whose treatment was cut short by the Gallinot hearing relapsed back to the emergency or acute setting within an average of 18 days, while those patients who completed their treatment without interruption did not relapse until an average of 65 days. These findings conform with clinical experience: as psychiatrists, practitioners of mental health law, and relatives of affected family members know, bipolar affective disorder is a relapsing-remitting illness. It is episodic. Furthermore, like seizure disorders, each inadequately treated episode of bipolar affective illness is associated longitudinally with faster relapse rates and stronger intensity and duration of each subsequent episode. Each interruption of treatment condemns the patient, ultimately, to worsening outcomes.

Finally, among patients with schizophrenia, Gallinot intervention assured significantly worse

outcomes for the patient released from acute treatment. Patients who were retained in treatment spent fewer relapse days in the hospital setting compared to non-completers, and spent less than one day on average in treatment in the county jail over the following year. In contrast, those patients who were released prematurely by the probable cause hearing spent a greater amount of time back in acute treatment and an average of 28 days in treatment in the county jail mental health unit.

Clearly, the results of this study underscore the importance of considering the therapeutic jurisprudence of LPS. Moreover, the data suggest the fallacy that can result of traditional legal analysis when applied to mental health law. Over the past thirty years, the majority opinions in mental health case law have marched forward to the cadence of "least restrictive alternatives" and the "stigma of commitment", while dissenting opinions, particularly at the Supreme Court level, has often inveighed against judicial interference in the clinical decision process.

In the Gallinot case, well-intentioned appeals to least restrictive alternatives, appeals that hinge on the fear of "massive curtailment of liberty" as outlined by the Gallinot court, appear to fall flat in the face of the above data. Indeed, for the patients whose liberty the law seeks to preserve, the premature probable cause hearing release guarantees both worsened clinical morbidity and heightened restriction of personal liberties over the follow-up year. The data further suggest that the ultimate "stigma" lies not with commitment or treatment, but with the disease itself and the law's effect of severing treatment.

What Is Mental Illness?

Overview

Despite age-old myths and misinformation, mental illnesses are not caused by bad character, poor child-rearing, abuse or an individual's unwillingness to behave in a socially-acceptable manner. Like Parkinson's, Alzheimer's and epilepsy, mental illness is a biological, physical disorder of the brain. Brain chemistry, structure and functioning, as well as genetics, have been identified as among the leading biological factors causing brain disorders.

The person who develops a mental illness typically loses his or her normal capacity for receiving, filtering, sorting, or interpreting information that comes into the brain through the senses. This may result in confusion, difficulty following the ideas and opinions of others, and problems in communicating ones' own ideas and opinions. In the most severe cases, the individual may make observations about his or her environment that are incorrect or wrongly interpreted, resulting in *delusions*, or in personalized perceptions, called *hallucinations*.

Mental illness may take one of many forms, but there is a common thread running through each of these forms -- that of the *immediate* need for treatment. But, unfortunately, mental illness often brings with it impaired judgment, rendering some of its sufferers incapable of

making rational decisions about their own treatment and care.

A few of the more common disorders include:

Schizophrenia - Stephen Marder, MD

Characterized by psychotic symptoms, such as hallucinations and delusions, and impairments in social and vocational adjustment, Schizophrenia affects approximately 1% of the world population. Its onset usually occurs in the late teenage years or the twenties, but it may emerge during childhood or at any point during adulthood. Some individuals who develop schizophrenia experience a normal childhood and adolescence before the onset of active symptoms. For other individuals, the development of the illness is more gradual. These patients may have demonstrated early characteristics of the illness during childhood. They may have appeared awkward and shy, and have had few friends. Later, clear symptoms of schizophrenia, such as hallucinations and delusions, may emerge. Although hallucinations and delusions may emerge during childhood, this is uncommon.

Although the causes of schizophrenia have not been identified, it is evident that this illness is a disease of the brain. Individuals with schizophrenia often demonstrate differences in the size and shape of the brain areas that control our emotions and our higher brain functions. A number of research studies have found that when individuals with schizophrenia are asked to complete a task that is carried out by a particular area of the brain, they are unable to increase the amount of activity in that brain area.

Schizophrenia is an illness that runs in families. The risk for developing schizophrenia increase from 1% for the general population to 8-10% if the patient has a relative (i.e., sibling or parent) who suffers from schizophrenia. If the patient has a nonidentical twin with schizophrenia, the risk is similar to the risk for a sibling. However, if the twin is identical, the risk increases to as high as 50% in some studies.

Individuals with schizophrenia demonstrate remarkable differences in the severity of their illness and the nature of their symptoms. For some patients, schizophrenia can be managed with antipsychotic medications and supportive psychosocial treatments. These individuals may function normally within their communities. Other people with schizophrenia may be severely impaired continuing to experience auditory hallucinations (usually voices), delusions, and disorganized thoughts despite receiving antipsychotic medications. Others may have these symptoms adequately controlled, but will experience a lack of motivation and disinterest in social interactions. These later symptoms may or may not respond to medications, and can cause severe impairments.

The management of schizophrenia nearly always includes both antipsychotic medications and psychosocial treatments. Antipsychotic medications decrease the severity of nearly all of the

symptoms of schizophrenia. They are most effective for symptoms such as hallucinations and delusions, but they may also improve decreased motivation and disorganized thoughts. Once psychotic symptoms have been minimized with an antipsychotic, these agents must nearly always be continued to prevent symptoms from returning. Many patients with schizophrenia experience severe side effects when they receive the older antipsychotics, particularly stiffness and restlessness. Until recently, many patients found that taking antipsychotics was almost as disturbing as the disease itself. Newer antipsychotics which just became available during the 1990s are associated with much milder side effects.

Major Depressive Unipolar Disorder - Elizabeth Galton, MD

Depression is the most common psychiatric disorder, with a lifetime risk of developing it varying in prevalence, depending on the study, of 10% to 25% for women, and 5% to 12% in men. No relationship has been found between getting the disease and ethnicity, education, income or marital status. It may begin at any age. Average age of onset is in the mid-twenties. The course is variable. Some people have isolated episodes separated by years without illness; others have clusters of episodes, and others have increasingly frequent episodes as they age.

The features include: a depressed mood with loss of interest and pleasure in nearly all activities; changes in appetite or weight, sleep and activity levels; low energy; feelings of worthlessness and guilt; difficulty concentrating, thinking or making decisions; agitation; or recurrent thoughts of death, with possible plans or attempts to commit suicide.

Suicidal thoughts are common, associated with thoughts that the world would be a better place without them. They vary in intensity and lethality. Thoughts of suicide may be motivated by a desire to escape seemingly insurmountable obstacles or a wish to end an excruciatingly painful emotional state caused by the underlying depression.

In addition to the human cost of suffering from this disorder, there are other consequences of lack of treatment: for example, economic costs to the work place with missed days of work, or difficulty raising children or functioning within the family.

The disorder is treatable with a good success rate if caught early. Treatment consists of anti-depressant medication and psychotherapy. Adequate length of time devoted to treatment (usually requiring months or years) can prevent recurrence. For severe depression, hospitalization may be necessary.

Bipolar Disorder - Manic Depression - Lori Altshuler, MD

People with bipolar disorder experience severe mood swings ranging from depression (very low mood) to mania (very elevated mood). During both of these extremes, patients can lose

their ability to make rational decisions about their care.

The depressed phase of bipolar disorder is characterized by a down mood. Patients often feel fatigued and lack motivation to accomplish things they had been able to do before the depression. Depression slows people down, both literally and metaphorically. For example, patients feel like they are weighted down and find it difficult to move. On a different level, the thought process is also slowed and the patient loses the ability to think clearly. This change in the ability to think clearly is known as "cognitive impairment" and also affects decision-making. The world becomes a bleak place and the patient may have irrational thoughts about wanting to die. A person with severe depression may not be able to make rational decisions about his/her treatment because the depression can cause thinking to become biased and clouded.

At the other extreme, a patient with mania may also be unable to make sound decisions regarding his/her treatment. Mania is characterized by a mood so high that it interferes with day to day activities. Individuals who are manic usually lack insight into their condition. They sleep less than usual (sometimes not at all for days) and they are constantly on the go. They may talk rapidly in a manner that does not make sense to a normal person. People who are manic can become psychotic, meaning that they lose touch with reality. They may see or hear things that others don't, or they may think they have special powers. A patient in a manic state such as this has a distorted perception of reality and has no ability to make sound decisions grounded in reality. Because mania often feels good to the patient, he/she might refuse treatment when it is indeed necessary to stabilize the patient's mood and to prevent escalation into a more dangerous state

Today's treatment for bipolar illness are very effective. Mood stabilizer, such as lithium, divalproex sodium, and carbamazepine, as well as a variety of antipsychotic and antidepressant medications, are available to effectively treat the symptoms of depression and mania safely and effectively. Once these medications have reached a therapeutic level, the mood symptoms improve and the patient begins to regain his/her ability to function.

Obsessive Compulsive Disorder (OCD) - Barbara Silver, MD

Obsessive Compulsive Disorder (OCD) is an anxiety disorder that is potentially disabling and can persist throughout a person's life. A person with OCD becomes trapped in a pattern of repetitive thoughts and behaviors that are senseless and distressing, but extremely difficult to overcome. OCD occurs in a spectrum from mild to severe; but if severe and left untreated, it can destroy a person's capacity to function at work, school or in the home. OCD can be effectively treated through behavioral techniques as well as pharmacological interventions that have become available during the past ten years. Studies indicate that at least one-third of OCD cases in adults began in childhood. OCD affects more than 2 percent of the population. It is more common than such severe mental illnesses as schizophrenia and manic-depressive illness, and males and females are equally affected. Except in severe cases, OCD rarely

requires hospitalization.

Anorexia Nervosa and Bulimia Nervosa - Barbara Silver, MD

Anorexia nervosa and bulimia nervosa are psychiatric disorders with potentially life threatening. Bulimia nervosa is more common (4-10% of adolescent and college-aged women) than anorexia nervosa (1% of young women). Anorexia nervosa, however, has a higher risk of death. Estimates have placed 20-year mortality at 15-20% for people severely ill with anorexia. In fact, anorexia nervosa has the highest mortality rate of all psychiatric disorders. In the person with anorexia, death can result not only from suicide as with other psychiatric disorders, but also from medical complications of disordered eating habits -- such as cardiac failure.

A Consumer's View of Mental Illness by Dru Ann McCain, Yuma, Arizona, March 1994

Additionally, there is evidence of neuropsychological dysfunction in patients with anorexia; the low weight patient cannot reason enough to seek treatment.

Is Mental Illness Treatable?

Brain disorders have physiological indicators that can be diagnosed and treated as precisely as many other medical conditions. Treatment protocols have been developed to enable people with brain disorders to live healthy and productive lives. Success rates for various types of medications and other therapies are impressive. According to the National Institute of Mental Health, the success rates for treating severe forms of specific brain disorders with medications and other therapies are: 60% for treating acute symptoms of schizophrenia; 70-90% for treating panic disorder; 75% for treating obsessive-compulsive disorder (OCD); 80-90% for treating bipolar disorder (manic-depressive illness); and 70-80% for treating major depression.

These success rates are better than those of many other medical conditions, such as heart disease which has a 45-50% treatment success rate. The new generation of medications recently approved and under development can target problem areas in the brain with far more precision than their predecessors. This increased precision relieves symptoms more effectively and reduces the unintended side effects associated with many older medications.

But, figures on success rates are meaningless to people who lack the ability to understand their need to obtain treatment or to continue treatment once the severest symptoms of their illness are lessened.

The Consequences of Lack of Treatment

Overview

Up to 40% of people with brain disorders do not seek treatment. Many of these individuals are suffering needlessly.⁴⁰ For every person with mental illness in California receiving treatment, another is not.⁴¹ Instead, many lead lives of tragedy and despair.

Suicide

The Golden Gate Bridge is the number one suicide site in the world. Suicide is a major public health problem representing 1% of all deaths. Unsuccessful attempts may be 50 times the completed rate, which has averaged 12.5 per 100,000 people in the United States over the last century. In 1997, suicide represented the eighth leading cause of death in the United States.⁴²

Suicide is a multi-determined event that defies search for a single explanatory factor. The most generally accepted model of suicide risk assessment includes threshold factors, including developmental, psychological, personality, biological, genetic and social variables. Suicidal individuals are different from non-suicidal individuals in threshold variables of impulsivity, specific genetic factors, and such triggering factors as acute episodes of mental illness, alcohol and substance abuse, stress and other life events.⁴³

Suicide kills more people with mental illness than any other cause. Ninety percent of its victims have one or more psychiatric disorders at the time of their suicide. Virtually all brain disorders increase the risk of suicide except mental retardation and dementia. Severe depression, especially when comorbid with substance abuse, is the number one cause of suicide with studies showing as high as 15%, or one in six, of unipolar (depressive) patients dying by committing suicide. Post mortem studies show that the vast majority of people with unipolar disorder who committed suicide were either receiving inadequate antidepressant treatment at the time of their deaths, or none at all.

People with clinical depression often lack energy during a depressive incident. Studies indicate that the most vulnerable time for suicide is when the individual appears to be recovering. While hospitalized, it is generally obvious that "things are not right," however, just when the person seems to be getting better, and is perhaps released from the hospital, he/she is most vulnerable to a suicide attempt.⁴⁴

Between 25-50% of bipolar patients attempt suicide at least once. Mixed and delusional manic states in bipolar disorder are associated with greater risk of suicide. As with unipolar patients, substance abuse comorbidity and medication noncompliance are associated with a higher risk of suicide in bipolar patients.⁴⁵ Large scale studies have shown that lithium, adequately prescribed and continually taken, drastically reduces suicidal behavior and mortality in patients with recurrent affective disorder.⁴⁶

The lifetime suicide rate among those with schizophrenia is 10-25%.⁴⁷ Approximately 50% of people with schizophrenia who die by suicide have made previous attempts. Comorbid depression is generally present; only a small percentage of people with schizophrenia commit suicide because of hallucinated instructions or to escape persecutory delusions. An individual with paranoid schizophrenia, who is exhibiting psychotic symptoms -- including a high level of suspiciousness -- has an elevated risk of suicide. Conversely, a person with predominantly negative symptoms of schizophrenia, such as diminished drive, blunted affect or social and emotional withdrawal, has a reduced risk.⁴⁸

Suicide that is associated with mental illness is a killer of youth. It tends to occur in the first few years after the initial onset of the disease in young people with schizophrenia. Suicide is the second leading cause of death among college students, third among those aged 15-24 years, and the sixth among children under 15. Attempting suicide once comports to a high risk of attempting suicide again. Forty percent of all people who attempt suicide have made a previous attempt, and 13-45% of all people who attempt suicide will try again within the next two years; the risk is particularly high during the first year after an attempt.⁴⁹ Suicide attempts contribute to the revolving door of hospitalization and expense. The American Association of Suicidality estimates that there are 100-200 attempts for every completed suicide.⁵⁰

In a study of existing research and literature prepared for the National Suicide Prevention Strategy conference in 1998, Dr. Alex Roy concluded that suicide risk strongly correlates with lack of sufficient psychopharmacological intervention in diagnoses of unipolar and bipolar disorders, schizophrenia and other psychiatric illnesses. In all psychiatric disorders, suicide is highly related to inadequate or absent medication compliance. Studies show that discharge from an in-patient setting without adequate aftercare and medication compliance portends an elevated risk of subsequent suicide.⁵¹

Substance Abuse

Substance abuse exacerbates the symptoms of mental illness and keeps people in a destructive cycle of illness, repeated hospitalization and homelessness.

People with mental disorders are at least twice as likely to abuse drugs and alcohol as are people without mental disorders.⁵² Nearly 50% of people with schizophrenia and 60% of people with bipolar disorder had co-morbid substance abuse.⁵³ In the population with co-occurring brain disorders and substance abuse disorders, the mental illness developed first in the vast majority of cases.⁵⁴ Substance abusing behavior usually occurs several years after the initial onset of the brain disorder, as a form of "self-medication" following years of sporadic or no treatment for the underlying illness. ⁵⁵ ⁵⁶

Substance abuse spirals the mentally ill person into criminalization. In 1990, the National

Institute of Mental Health (NIMH) estimated that 82% of inmates with lifetime histories of mental disorder also had a substance abuse disorder. The growth in incarceration for women with drug-related offenses in recent years has exceeded the rate of increase for men.⁵⁷ Between 1986 and 1991, the number of women in state prisons for drug-related offenses increased 433 percent, compared with an increase of 283 percent for men. Women with mental illness are especially over-represented in the incarcerated population.⁵⁸

Although alcohol and drugs may initially be used to cope with psychopathology, patients often become dependant on these substances, acquiring addiction in the process. Both conditions (the mental illness and the substance abuse) must be treated concurrently and in an integrated manner. While drug use might start out as a choice, after prolonged use a switch in the brain is thrown which moves the individual into a state of addiction, characterized by compulsive drug seeking and use. Virtually all drugs of abuse have common effects, either directly or indirectly, on a single pathway deep within the brain, the mesolimbic reward system. Activation of this system appears to be a common element in what keeps drug users taking drugs. Prolonged drug uses causes pervasive changes in brain function that persist long after the individual stops taking the drug.

A major goal of treatment must be to reverse or to compensate for those brain changes through prescribed medication or behavioral treatments.⁵⁹ Because illegal substances have been aids in coping with aspects of mental illness, individuals with a compound substance abuse-mental illness disorder find it very difficult to become abstinent since sobriety is often associated with the dysphoric aspects of their mental illness. Requiring a period of sobriety before dually diagnosed people are eligible for mental health services is, therefore, inappropriate.

Substance-abusing mentally ill individuals are eminently treatable if their conditions are recognized and treated promptly and appropriately. Substance abuse should not be seen as a reason to reject individuals who otherwise meet criteria for hospitalization due to mental illness, but rather as an opportunity to help individuals who, in their search for relief from symptoms of mental illness, have found a less than desirable way.

Violence

The United States is generally considered a violent society; overall people with mental illness only account for a small portion of the American violence. In determining the prevalence of violence among people with mental illness, therefore, the most striking research are studies from non-violent societies. A study from Denmark found that males with a severe mental illness represented only 5% of the total male population, but accounted for thirty percent of all the violent offenses committed by males. Female Danes with mental illness comprised about 5% of the entire Danish female population but were responsible for 50% of all the violent offenses committed by females.⁶⁰ A Stockholm study revealed that men with major mental

illness were found to be 4.2 times more likely to have been convicted of a "violent" crime and women 27.5 times more likely than females in the general public.⁶¹ A Finnish study focusing on homicide found that among male murderers, schizophrenia was 6.5% times more prevalent than in the general population. Generally females are less violent than males, but in the few female murderers, mental illness was 15 times more prevalent.⁶² In England and Wales, about one in every eight murders is committed by someone who is mentally ill.⁶³

Early studies in the United States starting in the 1920s concluded that people with mental illness were no more dangerous than the general public. A fault within those studies is that they occurred primarily during a time when violent people with mental illness were locked in state hospitals.⁶⁴ Under guard or in a structured ward environment, it is difficult for a person to be dangerous. John Monahan, a professor of Law and Psychology at the University of Virginia, was one of the mental health professionals who, a decade ago, argued there was no relationship between mental illness and violent behavior. Summarizing emerging data, he later concluded, "The data that have recently become available, fairly read, suggest the one conclusion I did not want to reach: whether the measure is the prevalence of violence among the disordered or the prevalence of disorder among the violent, whether the sample is people who are selected for treatment as inmates or patients in institutions or people randomly chosen from the open community, and no matter how many social and demographic factors are statistically taken into account, there appears to be a relationship between mental disorder and violent behavior."

The 1994 US Epidemiological Catchment Area study queried more than 10,000 persons, scientifically sampled, in 3 metropolitan areas and found between 10% and 12% of persons with affective or schizophrenic disorder reported having acted violently in the past year, while only 2% of persons with no mental disorders did so. People with schizophrenia were nearly nine times more likely than the general population to have fought with others or to have hit their partner in the past year, eight times more likely to have hit their child, and nearly 22 times more likely to have used a weapon.⁶⁵ Approximately one out of every 20 homicides are committed by persons known to have a history of mental illness.⁶⁶ One in four law enforcement involved shootings is considered victim-precipitated—or 'suicide by cop'—usually involving a person with mental illness.⁶⁷

Knowing who with mental illness might be violent has until recently proven a dilemma for treating professionals. Most studies have focused on relating a particular diagnosis to violence and have noted an especial high correlation between the diagnosis of untreated paranoid schizophrenia and violence. However, having a particular diagnosis does not necessarily correlate to a prediction of future danger anymore than a diagnosis of breast cancer equates automatically to the patient's death from that disease. More recent research has furthered these studies and have pinpointed certain symptoms predictive of violence. Those symptoms include especially high levels of thinking disturbance, hostility-suspiciousness, and agitation-excitement.⁶⁸ Additionally highly predictive of violence is comorbid substance abuse.⁶⁹

Violence by people with mental illness is most frequently targeted towards family, friends, or treatment providers.^{70 71} This type of violence crosses international boundaries. An Australian study found 32% of relatives caring for their mentally ill loved ones had been struck on at least one or two occasions.⁷² One U.S. study showed 54% of hospitalized patients who had assaulted someone within two weeks of admission had attacked family members. Mothers who live with an adult offspring with mental illness are especially at increased risk of violence.⁷³ U.S. Department of Justice statistics show 25% of those who killed their parents had a known history of mental illness. The rates of other family homicides linked to untreated mental illness were: spouses killed by spouse, 12%; children killed by parent, 16%; siblings killed by sibling, 17%. When mental health treatment providers are assaulted, more incidents occur in offices and outpatient clinics than during hospitalization. Nurses who provide general care for the patient, as well as acting as 'limit-setters,' are significantly more likely to be assaulted than doctors in an inpatient setting.⁷⁴ Only in the homeless mentally ill population will acts of violence more likely be directed to strangers.⁷⁵

There is general concurrence that the primary factor in violence from people with mental illness is lack of compliance with medication. When the person is compliant with an effective medication, the risk of violence reduces to closer that of a social norm. A study by Bartels et al showed 71% of violent patients had problems involving medication compliance in comparison with only 17% of those without violent behavior.

Overall violence from people with mental illness constitutes only a small portion of the violence in U.S. society, but it is a violence that can be prevented. Reduction of such risk requires carefully targeted community interventions including integrated mental health and substance abuse treatment and intensive case management.^{76 77} The current involuntary treatment laws may actually increase the likelihood of violence from people with mental illness.⁷⁸ Current standards provide treatment based on dangerous behavior rather than escalating or severe symptoms of the underlying illness which occur prior to the overt behavior. However, intervention based on danger may be too late for the victim once the violence has been allowed to display.

Victimization

While much attention is focused on mental illness and potential violence to others, victimization of people with mental illness has rarely been studied. Yet the living circumstances and judgment deficits associated with mental illness leave its victims vulnerable to be taken advantage of and abused by others. They are manipulated and killed in cults. Skid row hotel operators have been known to take them for their disability checks. In jails and prisons, where one out of twenty inmates is raped, mentally ill inmates are generally the weakest prey.⁷⁹ Homeless women are sexually assaulted at alarming rates. A person with mental illness is thought to be ten times as likely to be murdered as a person without mental illness.

A recent study by Hilday et al of North Carolinians with mental illness referred from acute care hospitalization to out patient committal is one of the few studies of victimization towards people with mental illness available. Hilday and her associates interviewed 331 individuals with severe psychiatric disorders about victimization in the four month period immediately preceding their current psychiatric hospitalization. The fact that all 331 individuals had been referred for outpatient commitment strongly suggests that they were noncompliant with medication and other treatment services and severely impaired. Over the previous four months, 8.2% reported having been the victim of a violent crime (assault, rape or mugging) a rate 2.7 times higher than the *annual* rate of violent victimization in the United States. The authors pointed to factors that "probably caused underreporting of some victimization" and also note that the rate of violent victimization in North Carolina is lower than the rate for the United States as a whole. These facts, plus the fact that the study compared victimization for *four months* in the study population versus *one year* in the control populations, all suggest that the victimization rate of people with mental illness may even be greater. Overall those victims that were drug or alcohol users and homeless were even more likely to have been victimized than the other patients in the study group.⁸⁰

Homelessness

In cities throughout California, people who are homeless and mentally ill are a visible part of the urban landscape. Those who are not so visible are hiding in encampments under freeways or in rural parks and city alleys. Since the closing of most state hospitals, the number of people with mental illness on the streets has skyrocketed. One out of every 20 people with serious mental illness in the United States is homeless; the mentally ill individuals constitute at least one-third of all homeless adults.⁸¹

Many of these people have concurrent drug or alcohol problems, and show such active symptoms of their illness as delusions of persecution, auditory hallucinations, and beliefs that their lives are influenced by mysterious forces and unusual powers. Their tenure on the streets is generally interrupted by short-term hospitalization and subsequent medication noncompliance. Surveys suggest that people with mental illness are the most troubled and troubling of all homeless populations; they have been homeless twice as long as the rest, have used more alcohol and drugs, have had more serious criminal records, and are least likely to sleep in public shelters.⁸²

Homelessness inevitably means serious health problems. Illness that are closely associated with poverty – tuberculosis, AIDs, malnutrition, severe dental problems, parasites and infection – ravage the homeless population.⁸³ A large cross-sectional sample of homeless adults in San Francisco, demonstrated an HIV seroprevalence rate of 8.5% and a 32% rate of positive tubercular skin tests.⁸⁴ At least one-fourth to one-third of homeless mentally ill women have been raped one or more times.⁸⁵

It is indisputable that affordable public housing for people who are disabled ranges from dismal to moderately good; some people with mental illness may therefore choose to live on the streets. Economic deprivation alone does not cause homelessness among people with mental illness. A major factor is that cognitive impairment, such as lack of insight, often robs people of the ability to make use of available housing or services.

The cognitive deficits and impaired judgement that contribute to homelessness also render people with mental illness exceptionally vulnerable to assault, exploitation and life-threatening self-neglect. Homeless people have a three times greater risk of death than the general population. People with mental illness who are homeless have to obtain their food from garbage cans three times as often as homeless people who are not mentally ill.⁸⁶

Living on the streets with mental illness goes hand-in-hand with criminalization. Although arrest and incarceration rates are relatively high among homeless people who are mentally ill, most are incarcerated for crimes of survival, such as trespassing, petty theft and shoplifting.⁸⁷ A Los Angeles study found that of those charged with misdemeanors, more than half had been living on the streets, on the beach, in missions or in cheap hotels, compared with less than a fourth of those charged with felonies.⁸⁸ In New York, the rate of homelessness among arrested mentally ill was 21 times greater than the rate of homelessness among the overall population of people with mental illness in the city.⁸⁹

The mental health system is not well designed to serve homeless people suffering from mental illness, alcoholism or drug dependence. Most of these people are too depressed or disorganized to seek help for themselves. They are often so withdrawn and isolated that they are ignored until they become dangerous. Others are suspicious and hostile, as well as confused. But, the fact that people who are chronically mentally ill have been deinstitutionalized does not mean that they no longer need social support, protection and relief from their illnesses. People who are homeless and mentally ill need housing, but housing alone will not solve all -- or even most -- of their problems; many will not even remain in the housing provided for them unless they also receive supervision, medication, and social and vocational rehabilitation.

People who are homeless and mentally ill may require hospitalization, or intensive treatment and case management services in a community-based mental health care facility, in order to become stable enough to transition to permanent community housing. When treatment and medication is imposed for a sufficient period of time, symptoms of mental illness and substance abuse can often be alleviated to the point where people are able to make rational decisions about treatment and rehabilitation, as well as employment and housing.⁹⁰ Premature housing placement, without a guarantee of continued medical treatment, social support and medication compliance, is a temporary solution that only postpones relapse into homelessness or criminalization.

Criminalization

Since the implementation of current involuntary treatment laws, a growing number of people with mental illness have entered the criminal justice system. In 1972, Marc Abramson, a psychiatrist in San Mateo County who coined the term, "the criminalization of the mentally ill," published data showing that the number of mentally ill persons entering the criminal justice system doubled in the first year after the LPS Act went into effect.⁹¹ As early as 1973, county task forces were being formed to deal with the increasing number of mentally ill people in local jails attributable to the passage of the Lanterman, Petris, Short Act.⁹² After the close of Agnews State Hospital in Santa Clara County, the county jail mentally ill population increased 300%. In an eight-year study following the change in commitment laws, a five-fold increase in the arrest rate of Californians with mental illness was discovered.⁹³

Currently, 7.2-15% of county jail inmates suffer severe mental illness.⁹⁴ Los Angeles County jail is reputed to be the largest *de facto* mental institution in the United States. Eight to 15% of state prison inmates suffer severe mental illness. The overall costs to arrest, adjudicate, and punish Californians with mental illness is estimated to be between \$1.2 and \$1.8 billion a year.⁹⁵ Most individuals are jailed for minor offenses when their behavior is socially unacceptable but not necessarily dangerous -- and they fail to receive the treatment services they desperately need.⁹⁶

A California study confirmed previous national studies that the majority of crimes committed by mentally ill individuals are most often nonviolent minor misdemeanors and likely to be a consequence of the impaired judgment and reasoning associated with mental illness. These offenses include misdemeanors such as loitering or suspected public intoxication, disturbing the peace or disorderly conduct, trespassing, petty theft or vandalism. Assault and battery is also reported but to a lesser degree. The authors speculate that the assaults may also represent a disorganized and impulsive response to hallucination rather than any organized intent to engage in criminal activity or felonious crime.⁹⁷

When faced with a person who is "acting out" as a result of his/her illness, law enforcement officers usually have only three options: (1) Do nothing, which usually means leaving the person on the street with no proactive treatment linkage; (2) commit the individual to hospitalization, providing that he/she meets the current stringent behavioral criteria for involuntary treatment; or (3) arrest the individual. When the person's behavior is too openly deviant to leave in public scrutiny but he/she does not fit the stringent behavioral criteria for involuntary hospitalization, the only option available to most law enforcement officers is arrest.⁹⁸

People with mental illness who commit criminal offenses tend to be the subgroup of mentally ill people who lack insight and revolve through homelessness, hospitalization and jail.⁹⁹ In a study of male inmates in a California county jail, 90% had prior psychiatric hospitalizations and

92% had prior arrest records. Four-fifths exhibited severe, overt psychopathology. Few were actively receiving medical treatment for their mental illness at the time of their arrest. Overall, the jailed population was characterized by severe, acute and chronic mental illness resulting in poor functioning. The author of the study found the population to be a generally "uncared-for" group, arrested for minor criminal acts that were "really manifestations of their illness, their lack of treatment, and lack of structure in their lives." More than half of the group studied were currently charged with felonies, and 39% were charged with crimes of violence.¹⁰⁰

Generally, people who are charged with felonies are arrested, rather than hospitalized, regardless of their mental condition.¹⁰¹ Law enforcement officers can only divert from arrest for lower level crimes. The key factor in criminalization of people with mental illness is the current practice in California of emphasizing danger as a criterion for involuntary treatment. Most people with mental illness are not dangerous, but for those who will be charged with serious or violent crimes, waiting for danger is to be too late.

Early Death and Other Physical Health Costs - Barbara Silver, MD

Treating mental illness leads to lower medical costs in the long run because people who are mentally ill and left untreated are likely to have heightened physical health needs. While it is difficult to estimate the potential health care savings associated with the provision of mental health services, a 1984 analysis of 26 cost-effectiveness studies found that medical usage is reduced an average of 33% following mental health treatment.¹⁰² Untreated severe mental illness can lead to both lack of treatment of pre-existent physical illness and the development of new physical illness or injury.

The lack of treatment of pre-existent physical illnesses can occur for several reasons. The person with a severe mental illness may not seek treatment for physical illness due to paranoia or disorganization. Additionally, somatic delusions may prevent the person from recognizing physical illnesses, and thus seeking medical treatment. If the individual is able to seek medical treatment, he/she may be too manic, irritable and/or psychotic to follow through with appointments, or to comply with recommended treatments. Chronic medical problems, such as heart disease and diabetes, left untreated, lead to serious complications, such as heart attacks and heart failure resulting from heart disease, and renal failure and blindness resulting from diabetes.

The presence of a severe mental illness may itself lead directly to physical illness and injuries. A person with severe mental illness may develop cellulitis (infection of the skin) from poor self care and lack of attention to a minor cut. The cellulitis, left untreated, may lead to osteomyelitis (infection of the bone). Poor judgment and impulsivity may cause the person with severe mental illness to engage in high risk sexual behavior, exposing the person to HIV and other sexually transmitted diseases. New physical injuries may also occur as a result of untreated mental illness. For example, the person with mental illness may attempt suicide in response to

auditory hallucinations and delusions, using such violent means as jumping from high places, resulting in broken bones and head injuries.

It is obvious that severe mental illness, left untreated, can have many deleterious effects on the person who suffers from that illness. Common physical problems may go unrecognized and untreated, and new illnesses and injuries may occur as a direct result of the mental illness.

AIDS/HIV

People with untreated mental illness have reduced capacity to deal with such additional threats to their well-being as infection from HIV, the virus that causes AIDS. Conditions surrounding lack of treatment such as impaired judgment, homelessness and substance abuse make them particularly vulnerable to infection. When combined with secondary naivete about social realities and negligence toward personal safety and health, the risks escalate even further.

HIV/AIDS is epidemic among people with mental illness. The average HIV infection rate among adults with severe mental illness is 7.8 percent, nearly 20 times the .4 percent rate estimated for the general population.¹⁰³ Studies indicate a high prevalence of concurrent tuberculosis infection among the mentally ill victims of HIV.¹⁰⁴ Across studies, psychiatric patients with identified comorbid alcohol or other drug use disorders have a significantly higher rate of infection from HIV than those without.¹⁰⁵ Generally homeless individuals with mental illness have a greater chance of HIV infection than homeless people without mental illness.¹⁰⁶

Family Toll - Christopher Amenson, PhD

Brain disorders can be life threatening, gravely disabling and deeply traumatic in the life of a family. When relatives suffer their "first break," their bizarre behavior can be very frightening to other family members. Families worry over the possibility of suicide. Some deal with the trauma of a loved one attacking them. Additionally, the family may experience the angst of realizing that the "system" will let them down, that their loved one will be shunned and misunderstood.

It may be necessary for families to take the difficult step of having their loved one involuntarily treated, recognizing that such treatment is in the best interest of their ill family member. Too frequently, however, that traumatic step of hospitalization results in premature discharge, after which the family suffers angst from a system that fails to provide compassionate, successful intervention. Unlike most devastating illnesses in which a social network develops around the family to provide practical assistance, information and empathy, the experience of untreated mental illness is frequently one of isolation, frustration and fear. Many family caregivers border dangerously close to clinical depressions because of the stressful demands of treating and living with a person suffering from mental illness.

Treatment Issues

Overview

Thirty years since the passage of the Lanterman Petris Short Act, medications and other treatment protocols for people with severe mental illness have enabled many people to recover to the point where they do not need comprehensive intensive levels of services. This level of recovery, however, often fails to reach those who are in greatest need. "Clients in greatest need" are those who relapse frequently, have persistent symptoms and impairments, and resist or avoid involvement in usual mental health services. These people also have the highest rates of hospitalization, incarceration, homelessness, and drug and alcohol abuse.

The current mental health system generally does not tailor services to meet the needs of people least able to function in the community -- those who are most costly both in financial and human terms. Community treatment will never be completely effective until the basic needs of severely disabled people -- people who are unable to choose recovery over disability -- are met.

Early Intervention - Alex Kopelowicz, MD

Individuals with schizophrenia who receive psychiatric treatment early in the course of their illness tend to have better outcomes than patients with longer delays between symptom onset and treatment. Some examples of better outcomes include fewer admissions to psychiatric hospitals, shorter lengths of stay in inpatient facilities, and higher levels of social and community functioning.¹⁰⁷ A corollary to this viewpoint is that the longer the disease has progressed unabated, the more difficult it is for patients to benefit from rehabilitation efforts, and consequently, the more unlikely it is for the patient to achieve functional recovery to their premorbid state.

As important as early intervention in mental illness is, just as essential is the need to provide optimal treatment to individuals in a continuous and consistent manner. Like most other chronic medical diseases, treatment for mental illness usually starts with a prescription for medication that must be taken regularly for the duration of time determined by the physician. Interruptions in pharmacological treatment can have significant adverse effects on treatment response. For example, nonadherence to medication regimens can lead to repeated episodes of schizophrenic relapse, which in turn may contribute to an increasing latency of response. A study at Hillside Hospital, Glen Oaks, New York, showed that time to full therapeutic response following a first episode of schizophrenia averaged 48.8 days. After a second episode, it increased to 58.8 days, and after a third, the time to complete response was 85.4 days.¹⁰⁸ Additionally, at each time point fewer individuals achieved complete response. Eventually, the disease may become intractable, and the window of opportunity for maximizing the benefits of biopsychosocial treatments may be closed forever.

Providing antipsychotic medication and psychosocial treatments for patients early and consistently throughout the course of illness is a public health imperative. Because first episodes of psychosis are usually experienced by adolescents and young adults who are particularly vulnerable to disruption of their biological, psychological, and sociological developmental pathways, mental health initiatives that minimize exposure to the deleterious effects of psychosis will enhance the likelihood of community re-integration for many individuals with mental illness. Additionally, prompt treatment will prevent a number of other adverse consequences, including increased risk of depression and suicide, loss of self-esteem and confidence, strain on peer relationships, loss of family and social supports, disruption of patient's parenting skills (for those with children), distress and increased psychological problems within the patient's family, disruption of study or employment, increased risk of substance abuse, increased likelihood of homelessness, violence and other criminal activities, and overall increased economic and social cost to society.

Although psychiatric knowledge has not progressed to the point where serious and persistent mental illnesses, such as schizophrenia, can be prevented, technological advances have been such that every individual with mental illness can receive treatments that will significantly and dramatically improve his or her level of functioning and quality of life. The challenge for mental health practitioners, administrators, third party payors, and politicians is to facilitate the delivery of those treatments as quickly, consistently, and continuously as necessary to counteract the ravages of the disease process on the developing human being.

Barrier to Treatment: Insight - June Husted, PhD

One of the difficulties in providing continuous voluntary treatment in the community for persons with serious mental illness, such as schizophrenia and bipolar disorder, is that these illnesses are brain disorders that affect the ill person's reasoning, and consequently the individuals often do not believe that they are ill or that the symptoms of their illness will respond to medication. Therefore, they do not seek treatment, or if coerced into treatment when hospitalized, are unable or unwilling after discharge to comply with the treatment regimen, again relapse and require hospitalization.

Our insistence on a psychotic individual's freedom to voluntarily choose treatment assumes that adult individuals know when they are in need of treatment and have the ability to give informed consent and choose the treatments that will help them. The person's capacity to make those choices requires insight and an understanding of the treatments shown to reduce the symptoms. Although the community understands that a demented person with Alzheimer's Disease lacks the capacity to make such choices, and readily allows the physician to decide on treatment, society often fails to comprehend the similar chronic incapacity of many individuals with severe mental illness.

When used in the context of severe psychiatric disorders such as schizophrenia, insight relates

to the individual's understanding of his or her illness or the motivation underlying one's own behavior. Insight is considered by many mental health professionals to be a multidimensional construct that includes three major components: (1) awareness of having an illness; (2) attribution of one's symptoms to the illness; and (3) acknowledgement of a need for treatment.

While psychological "defensiveness" and denial can contribute to one's lack of insight, considerable research using brain imaging techniques and neuropsychological testing to understand the structure and the function of the brain suggest several neuropsychological factors that may provide a basis for impaired insight. Some attempts to understand the possible neuropsychology of lack of insight in schizophrenia have compared it to that found in other neurological disorders, such as those occurring after brain injury and resulting in "anosognosia", in which the patient is unaware of and denies symptoms, disease, or physical deficit. For example, a patient with hemiplegia after a stroke may deny the paralysis and insist he or she can walk normally. Researchers attribute that deficit to either diffuse brain damage or to focal brain lesions in the right hemisphere that result in a lack of knowledge of disease and an inability to be self-monitoring or to self-correct. Other researchers have related awareness of mental illness and social judgement to neuropsychological tests showing decreased functioning of the prefrontal lobes and the right and left parietal lobes of the brain.

There are certain repeated neurobiological findings in major research efforts, however. Most studies find reduced metabolism in the frontal lobes of those with a schizophrenic illness, an indication of reduced brain activity. Both brain imaging techniques and neuropsychological testing have illustrated the reduced mental activity in the frontal lobes of the brain, especially for unmedicated individuals with schizophrenia. Such deficit would result in impairment in the functions of information processing, executive planning, problem solving, judgment, working memory, and impulse control, all of which are associated with the frontal cortex. Many studies show that up to 50% of patients with schizophrenia have abnormally small hippocampi, a part of the limbic system that one researcher describes as critical to the expression of paranoid schizophrenia. Other studies show 15-30% of patients have enlarged ventricles, fluid-filled spaces in the brain tissue that become enlarged with loss of brain tissue. It has been proposed that a disturbance in communication between the hippocampus and the cerebral cortex that compares past and current experience could produce cognitive impairment, misconception of reality, or distorted connections between affect and action or thought content. The individual with schizophrenia thus cannot analyze and recognize environmental contexts for making appropriate decisions.

A major dilemma exists, therefore, in the expectation that individuals who suffer from a disorder that results in lack of insight must depend upon that insight to make reasonable decisions about their need for treatment, often when they are the most ill. All too often, the treatment chosen is *no treatment* until the person has become an immediate danger to self or others. In the interim, the individual may suffer further brain deterioration, serious health problems, victimization, or incarceration.

Impaired insight is a very common symptom of schizophrenia. In reviewing two large multinational studies, researchers found that lack of insight was the most frequently present symptom of schizophrenia, occurring in 89% of long-term patients in one study and in 81% of patients in the second study. Other authors also found 74% of long-term schizophrenic patients believed their treatment was not necessary because they were not psychiatrically ill. Studies of outpatients with schizophrenia have indicated that approximately 50% of them have at least moderately impaired insight about their illness, even when stabilized on medication. The inability of the noninsightful patients to understand they have a brain disorder or to accurately evaluate their living conditions further supports a need for objective monitoring and case management for those with schizophrenia, to assess their progress with treatment, their insight, and any life circumstances that might contribute to their relapse and deterioration.

With few exceptions, the majority of outcome studies indicate that insight is negatively correlated with illness severity and chronicity; that is, the more severe and enduring one's illness is, the less insight one has about that illness. Schizophrenic patients with good insight showed greater improvement after long-term hospitalization; those with poor insight were more frequently hospitalized. Their analysis indicated that lack of insight and denial of illness were present in 62% of the hospital readmissions; and noncompliance with medication was cited as the cause of admission in 43% of these patients, supporting the need for assertive, continuous case management to avoid noncompliance as well as stressful social crises. Noncompliers (those who continued to insist they did not have an illness or need for treatment) had almost four times as many previous psychiatric hospitalizations as compliers (14.5 compared to 3.7) and other studies confirm that the relapse rate for those with schizophrenia who are noncompliant is 3.7 times greater than for those who are compliant with medication.

Irregular compliance with medication was a significant predictor of relapse and was found in 38-68% of relapsed patients in six studies reviewed. Most studies found that poor insight was consistently associated with noncompliance, whether at admission, during hospitalization, at discharge, or post-discharge. Because of this, some authors conclude that the prevention and treatment on noncompliance *per se* are important in the care of patients who have schizophrenia.

Several recent efforts have used a variety of assessment instruments to provide increasingly valid measures of insight. Rather than condemning patients with poor insight to frequent rehospitalizations, deterioration of mental and physical health, homelessness, and incarceration, these patients can be identified with present screening methods and closely monitored. When their noncompliance is demonstrated to result in the above negative consequences, the humane action is to take legal and therapeutic steps to provide coerced and supervised treatment that will prevent their decomposition.¹⁰⁹

Medication - Stephen Marder, MD

Antipsychotic medications remain the mainstay of treatment for schizophrenia and other illnesses that can cause psychosis. These agents are effective in treating nearly all of the symptoms of schizophrenia. Their effectiveness is most pronounced for reducing dramatic symptoms such as auditory hallucinations (for example, hearing voices) or suspicious delusions, but they are also effective for reducing the lack of motivation and social withdrawal that is often present in schizophrenia as well as the disorganized thoughts. Antipsychotics are also prescribed for patients who have recovered from an episode of psychosis. In these individuals, antipsychotics are useful for preventing a recurrence of psychosis. With the aid of these agents, many individuals with schizophrenia are able to return to life in the community rather than spending their lives in psychiatric institutions.

Unfortunately, these medications -- particularly the older medications -- have serious limitations: These agents are not sufficiently effective for all psychotic patients. Research indicates that 25-35% of patients with schizophrenia do not adequately respond to older antipsychotics. In addition, antipsychotics -- particularly the older agents -- are associated with side effects that can be discomfiting for some and disabling for others. The most serious effects are neurological side effects which can result in stiffness, tremor, restlessness, or spasms. Patients who are treated for prolonged periods with some antipsychotics can develop tardive dyskinesia, a disorder with abnormal movements that may affect the face or the arms and legs. For many patients with schizophrenia, the discomfiting side effects of antipsychotics lead to poor compliance or outright drug refusal.

Fortunately, a new generation of antipsychotic medications has recently been introduced. These drugs are at least as effective as the older agents and have much milder side effects. The first of these agents to be introduced was clozapine (also called Clozaril®) in 1990. This drug has been shown to be effective for patients who fail to respond to older antipsychotics. Following the introduction of clozapine, a substantial number of patients who were severely disabled by symptoms of schizophrenia were able to return to jobs, school, or family responsibilities. Despite these advantages of clozapine, its use is limited by a number of side effects including sedation, drooling and weight gain. The most serious side effect of clozapine is agranulocytosis, a failure of the bone marrow to make a certain type of white blood cell. This potentially fatal side effect can be adequately managed by regular blood tests. When agranulocytosis is diagnosed in its early stages and clozapine is discontinued, this side effect almost always reverses.

Other new drugs have been introduced beginning in 1994. The current list includes risperidone (Risperdal®), olanzapine (Zyprexa®), and quetiapine (Seroquel®). Although there are important differences among these newer agents, all of them share certain characteristics: they are highly effective and they can manage psychosis in schizophrenia with negligible neurologic side effects. Moreover, there is some evidence suggesting that these drugs are less likely to cause tardive dyskinesia than older antipsychotics.

There is also evidence that these drugs may be more effective for certain features of

schizophrenia. The lack of drive and disinterest in social interaction that is common in schizophrenia may respond better to newer drugs compared to older drugs. There is also evidence that these drugs are more effective for the disturbances of memory, attention, and decision-making which are common in schizophrenia. Improvements in these areas may lead to better functioning in areas such as work or school. In other words, combining newer drugs with psychological and rehabilitation interventions may lead to better treatment outcomes than were previously anticipated.

These newer drugs do have side effects. To varying degrees these agents can cause sedation, weight gain, dizziness, and other side effects. However, these side effects are usually much less disturbing and patients are reporting that they are much more comfortable with these medications. Greater patient acceptance is likely to lead to more reliable medication compliance and better long-term adjustment.

Medication Compliance

Noncompliance with medication is different in people suffering from schizophrenia than those with other chronic problems (such as diabetes) who eventually figure out they need medicine. People with schizophrenia have a type of brain disorder that makes it difficult for them to learn from experiences. Noncompliance accounts for at least 40% of all episodes of schizophrenia relapse and subsequent rehospitalization and the relapses suffered by people who go off their medication are often more severe and difficult to treat.¹¹⁰

Some side effects are a valid reason for people with mental illness to refuse or change certain psychopharmacological treatment, but they are far from the most common reason given for refusal of treatment. A study of the Rockland Psychiatric Center in New York showed that 80% of refusals were found to be disease-based, characterized by delusions (e.g., paranoia) or denial of illness. People who have manic-depressive illness may prefer the feeling of mania to a medically-induced state of reality. Others experiment to see if they can stay well if they go off their medication.¹¹¹

What has been learned about insight strongly suggests several important factors in treatment. First, ongoing patient education and reliable measures of insight need to be part of all treatment plans. Second, a thorough compliance history with objective information from others is needed for deciding voluntary vs. involuntary treatment methods. Third, closer monitoring of medication compliance and patient response is needed for noninsightful patients throughout their treatment. Finally, rather than condemning this group to frequent rehospitalizations, deterioration of mental and physical health, homelessness and incarceration, a medical decision for court ordered, monitored treatment to prevent their decompensation is both essential and humane. Our treatment and commitment laws need to be appropriately modified to accomplish this.

In-patient Mental Health Services - Rosa Kaplan, D.S.W.

Public Law 188-164, October 31, 1963, the federal mental Retardation and Community Mental Health Center Construction Act and Public Law 85-105, the act authorizing assistance in meeting the initial costs of professional and technical personnel for Comprehensive Community Mental Health Centers lists in-patient services as one of the essential services for the diagnosis and treatment of mental illness. These Centers, developed as a constructive alternative to the warehousing of the mentally ill, were to be benign, healing facilities. Together with the four other community-based services (outpatient, partial hospitalization, 24-hour emergency care, and education and consultation to community caretakers), in-patient services were to assess and treat individuals who needed a more protected – but also a more restrictive – setting at certain times during their treatment. California's community mental health services did not include in-patient services routinely as an integral part of community-based services. Our experience has shown, however, that varying periods of hospitalization may be essential in the treatment of mentally ill people. Situations which may necessitate hospitalization include: person is unable to control impulses which may constitute a danger to self or others; or the person requires observation by trained personnel to clarify diagnosis, response to medication, achieve stabilization, provide basis for planning; person needs a period of interaction with caring personnel to become sufficiently at ease in a mental health setting to benefit from a less restrictive kind of treatment.

Hospitalization must not be seen – or implied to be seen – as a punishment for unacceptable behavior, including non-compliance with medication regimens. If a person needs to be re-hospitalized, the reason must be explained in terms of his condition and treatment needs. Every effort must be made to provide training, staffing patterns, and medication to enable mental health in-patient services the benign and healing settings they are meant to be.

Psychiatric Rehabilitation - Robert P. Liberman, MD

Real recovery from schizophrenia, bipolar disorder, obsessive compulsive disorder, and recurrent depressions is now a feasible goal for more than 50% of persons with mental disabilities. Recovery means absence of disabling symptoms, working or schooling in normal settings, and independent living without supervision for two years or longer. The pathway to recovery is "paved" with methods of psychiatric rehabilitation -- including training in social and independent living skills, family education and support; supported employment, education and housing; intensive case management; and regular monitoring and assessment of symptoms and functioning. Attainment of recovery can be translated into enormous savings of cost because when individuals with mental illnesses can work, they can depart the Social Security and welfare rolls and become tax paying citizens. At present, less than one percent of the mentally disabled are able to live independently without financial and social support from society.

To achieve recovery, or even less costly clinical improvements in those whose illnesses are resistant to treatment and rehabilitation, requires pharmacological and psychosocial services that are comprehensive, continuous, coordinated, and consumer-oriented. Patients also must be sufficiently stable in their illnesses to benefit from rehabilitation. Rehabilitation techniques cannot be delivered to individuals with mental disabilities who are symptomatically unstable, frequently relapsing, reluctant or negativistic about their need for treatment, or rotating in a revolving door of hospitalization-discharge-rehospitalization. These impediments to successful rehabilitation, recovery, and reduced costs to society, the patient and the family are often the result of inadequate opportunities for treating the active symptoms of the mental disorder.

While suffering from delusions, hallucinations, disorganized thinking, intrusive thoughts, ritualistic behavior, apathy, severe depression or mania, the mentally disabled are hardly capable of reasoned choice or planning regarding their treatment. Nor can they participate in consumer-oriented efforts at identifying their personal goals in life and how these goals can be achieved with treatment. In fact, the very part of the brain responsible for reasoning, choice and decision-making, initiating behavior, and problem-solving - the dorsolateral prefrontal cortex -- is severely impaired in disabling mental illnesses. Thus, to expect individuals with mental illnesses to benefit from treatment and rehabilitation is impossible until the laws governing their participation in services take into account the need for periods of involuntary treatment that can remove the key obstacles (symptoms, brain impairments) to active involvement in rehabilitation.¹¹²

Structure: The Missing Component in Community Treatment - H. Richard Lamb

There is scientific evidence that many persons with schizophrenia lack the ability to create their own internal structure. Moreover, anyone with clinical responsibility for chronically and severely mentally ill persons understands the importance of structure for these people. Family members are equally aware. That most severely mentally ill people, need some degree of structure is simply a clinical reality.

What constitutes structure? Structure is provided by such means as: (1) a high staff/patient ratio, as opposed to minimal staff supervision; (2) by the dispensing of medications by staff, as opposed to taking medications on one's own; (3) by offering therapeutic activities that may structure most of the person's day; and (4) by providing a locked setting or court-ordered community treatment for those who need it for as long as they need it.

Many people with long-term, severely disabling mental illness need little, if any, structure. Others, however, lack sufficient impulse control to cope with an open setting, such as independent living, cooperative apartments, mental health hotels, or family living. These people need a high degree of external structure and control on an ongoing basis. The number of such persons may not be great, when compared to the entire population of people with severe and disabling mental illness. However, if placed in the community in living

arrangements without structure, these persons may quickly decompensate and return to the hospital or to the streets. Structure has often been the missing ingredient of community treatment for some people.

Community Assisted Treatment - Jonathan Stanley, JD, Treatment Advocacy Center

As early as the mid-1950s, California researchers recognized that patients who were then hospitalized required a different kind of care than those who could readily avail themselves of treatment in community clinics. For these people, far greater attention had to be paid to the linkage between hospital and community. Yet the reform which would take place only ten years later failed to achieve the level of assistance some people with mental illness would require to survive and thrive in a community setting.¹¹³ Frank Lanterman himself identified that missing link in 1974 when he introduced the concept of outpatient committal.¹¹⁴ That link remains missing twenty five years later.

While California's law does have a conservatorship process, that process is only available to those people who are considered chronically "gravely disabled" under the LPS Act. People who revolve through hospitals because of "danger to self/or others" cannot be given a conservatorship. Additionally, even people who are gravely disabled may quickly reconstitute their functioning after being provided medication in the hospital; yet once released, they decompensate without medication compliance and become once more one of the thousand Californians homeless, or worse in jails.

"Community Assisted Treatment", on the other hand, ensures that individuals with neurobiological disorders so severe that they lack the awareness of their illness necessary to make treatment decisions get the medical help they would have obtained if they were free of cognitive impairment. The effects of "Community Assisted Treatment" on community tenure and functioning have been studied in a variety of states that currently offer forms of it. Patients experience significant reductions in visits to psychiatric emergency service, hospital admissions and lengths of stay compared to those who are not offered this form of structure and assistance. They are enabled to maintain residency and social functioning.¹¹⁵

Community Assisted Treatment is designed to end the "revolving door syndrome" whereby individuals who are helped by medications and treatment go off them, exhibit psychotic symptoms, get rehospitalized, and then stabilized, only to be released and go off treatment again.

Community Assisted Treatment can take many forms. Some states implement it through outpatient committal or guardianships like California's conservatorship law. Others through conditional release programs. Community Assisted treatment might also consist of a legally binding contract agreed to by a consenting patient and the mental health system as is recommended in this report. This last form of implementation is the least restrictive on the

individual's civil liberty interests as the patient agrees to the terms of the contracted treatment plan before it is court ordered.

Community Assisted Treatment is for individuals with a history of deterioration because of medication-compliance, or insufficient structure in their lives. Participation in consumer support groups, taking medications, maintaining housing, attending drug counseling programs or whatever else a particular consumer needs to stay healthy can all be required by mandated orders. Inability to comply with the plan can result in interventions designed to encourage compliance and avoid danger. Such interventions might include short-term inpatient hospitalization for treatment, or visits from a community treatment team. A Community Assisted Treatment program provides stringent due process mechanisms, yet allows intervention before individuals become a "danger to themselves or others."

Community Assisted Treatment is not an alternative to other forms of treatment; it is simply a way to ensure these treatments are utilized. Many individuals with neurobiological disorders do not recognize the need for the very medicines and treatments that allow them to function in the community and prevent their deterioration. Community Assisted Treatment can substantially cut the number of people suffering from disorders who are involuntarily hospitalized. Moreover to a consumer, living in the community while receiving treatment is a far preferable alternative to hospitalization.

By ensuring that those most in need receive treatment, the number of people with neurobiological disorders who are homeless, jailed, suicidal, violent or victims of violence can be dramatically reduced. The success of Community Assisted Treatment has been proven in several states.¹¹⁶ It gives individuals with a history of dangerous decompensation caused by medication noncompliance the opportunity to live in the community if they agree to the treatment that prevents their deterioration. Community Assisted Treatment is a much kinder, gentler, and less intrusive form of treatment than waiting until the person decompensates to the point of danger.

Assertive Community Treatment - Gil Abdalian, MS, MBA, MFCC, CRC

P/ACT (Program for Assertive Community Treatment) is a service delivery model that provides comprehensive locally-based treatment to people with serious and persistent mental illness. Unlike other community-based programs, P/ACT is not a linkage or brokerage case-management program that connects individuals on a piecemeal basis to medical treatment, housing or rehabilitation agencies or services. Instead it provides highly individualized services directly to consumers.

With an assertive, persistent practical approach, P/ACT works in teams to see that consumers receive services in a continuous manner over a number of years. The team doesn't wait until a person comes into the office, but delivers the majority of services where consumers live, work

and spend their leisure time. The P/ACT team helps consumers to manage symptoms of their illnesses, and provides practical on-site support in coping with life's day-to-day demands. Using the team approach, support is provided consistently, even when individual staff members leave.

Treatment, rehabilitation and community support are tailored to meet individual needs. P/ACT provides up-to-date medication and medication management. Staff members also help people gain employment, learn socialization skills, and carry out the tasks necessary to support independent living in regular housing -- either alone or with a roommate. Consumers are also assisted in accessing entitlements, obtaining housing, and securing non-psychiatric medical care. The P/ACT program is reminiscent of California's "on-leave" extramural care program initiated by Dr. Rosanoff in 1939, and effectively functions like a "hospital without walls" for the person severely disabled by mental illness.¹¹⁷ (See History)

Some counties in California have initiated programs similar to P/ACT, and others are expected to initiate similar programs in the future. Hospitalization can be greatly reduced by intensive case management and housing stabilization. However, some consumers still require the help, authority and structural framework of a court order in order to fully benefit from the advantages of P/ACT as well as the ability to be placed in a more intensive treatment setting, when their condition requires it.¹¹⁸ Court ordered treatment can be delivered with competence, compassion and support to those consumers needing assistance in developing the necessary internal controls so important in breaking through the barriers of mental illness.

Ulysses Contract Advance Directives - Carla Jacobs

People with mental illness who are encouraged to take a proactive stance in decisions regarding medical treatment feel empowered. Yet, mental illness by nature may impact the person's cognitive functions to varying degrees. One proactive approach is the writing of a contract, similar in intent to that of a living will. Such contracts, called Ulysses Contracts, should set out preference of treatments and assign decision making for treatment to a professional or family member of the person's choice in the event the person becomes incapacitated by their illness. This empowering approach will help with the mental health professional build a collaborative, mutually responsible relationship with the person with mental illness and avert a power struggle and noncompliance with treatment when the person suffers extreme symptoms of his illness that require hospitalization. Such contracts must be time limited to allow the person to rethink his decisions as medicine and scientific knowledge advances. Additionally due to the fluctuating capacity inherent in many mental illnesses, steps should be taken to ascertain that the person was competent when signing the document. One method would be to have the document countersigned by his treating physician. The advance directive should be counterbalanced if used during involuntary treatment by a probable cause hearing to determine if the patient's directive is the best interest considering the person's current incapacity and severity of illness.

Emergency Mental Health Mobile Teams - Rod Shaner, MD

Individuals in emotional crisis or stricken with psychosis are often marooned at home, in shelters, or in public parks or streets. Their families or friends have no way of getting them safely to an emergency facility, and the individuals themselves are incapable of making an informed decision to seek help.

Since the advent of LPS statutes, various forms of mental health emergency field response capabilities have arisen to meet this need. The original LPS mental health field response was provided by law enforcement personnel, who were empowered to place individuals on involuntary holds in order to transport them to mental health facilities. Police resources are in some ways well-suited to this task. There is 24 hour availability and a capacity to restrain individuals. The public often reflexively calls police when an individual appears to be behaving dangerously or strangely. Currently, calls for law enforcement intervention in situations involving mental illness are more common than for burglaries and robberies.

There are also serious disadvantages to relying exclusively on law enforcement personnel to evaluate and detain individuals with mental problems in the field. Law enforcement usually responds in situations involving public safety. Frequently the person in crisis is of no danger to anyone, but themselves. Law enforcement training about recognition and management of mental illnesses is generally quite limited, usually less than 4.5 hours. Too frequently, a law enforcement officer fails to recognize the underlying illness and the encounter leads to arrest rather than treatment. Additionally, certain levels of danger go beyond the discretion of the law enforcement officer to divert to the hospital and require a filing of charges.

Local public mental health systems developed mobile response teams to better address some mental health emergencies in the field. They have various names, including psychiatric emergency teams (PET), psychiatric emergency response teams (PERT), psychiatric mobile response teams (PMRT). These teams consist of public mental health workers who are empowered by the original LPS laws to place individuals on involuntary holds. These teams often receive calls transferred from law enforcement agencies, from residential facilities, or from concerned members of the public. Advantages of mobile response teams over law enforcement response include better training in evaluating and treating mental illness and potential ability to sometimes resolve crises in the field. Disadvantages include an inability to respond to dangerous or criminal situations, requiring police backup. They are also often extraordinarily expensive for public mental health systems to operate, requiring dedicated 24 hour per day staffing, communications, transportation, and assessment capabilities.

Efforts are being made to combine the best features of law enforcement and mental health responses to field emergencies. Combined law enforcement/mental health emergency teams have been extensively piloted in selected geographic districts in Los Angeles County as a collaborative effort among Los Angeles County Department of mental Health (DMH), Los

Angeles County Sheriff's Department (LACSD), LAPD, and Long Beach Police Department. It is known by the somewhat obscure acronym "MET/SMART" (Mobile Evaluation Team/Special Mobile Assessment and Response Team).

In MET/SMART a specially trained law enforcement officer and a mental health employee ride together, usually in an unmarked police car and in plain clothes, to respond to law enforcement received mental illness crisis calls. The project has proven to be a substantial savings to law enforcement. Normally up to three patrol cars respond to such calls. The one specialty team allows these calls to return to normal community patrolling. MET/SMART has been exceptional in avoiding unnecessary incarceration and violent encounters. They link the person with mental illness to community services, if possible, even drive them to the clinics or housing when possible. They have the LPS authority to involuntarily detain individuals for hospitalization when necessary. Disadvantages include the cost and close coordination of extensive interagency planning and personnel cross training as well as significant fiscal commitment.

The above mechanisms to assure safe, effective, and human responses to mental health emergencies have saved many lives. However, they are seriously hobbled by some aspects of the LPS law. The aging statutes give no real guidance as to how such teams can operate within modern mental health systems of care that consist of more than simply hospitals and clinics. Teams are forced to rely only on transport to LPS designated hospital facilities, and can not detain individuals in order to treat them in the field or to transport them to more appropriate resources than inpatient hospitals. Also the LPS statutes give no guidance on what to do when an individual remains in the field with the high probability that their condition will further deteriorate. If the individuals do not meet the restrictive LPS criteria and has not committed a crime, teams must leave the individual in danger or squalor, or in the custody of terrified friends or family.

Finally, the LPS statutes give no guidance as to obligations of public mental health systems to provide structure, resources, and monitoring of teams. As a result there is an extraordinary variation in availability and function of teams throughout California, leaving mental health stakeholders confused and frustrated. It is the high of absurdity that mobile teams often can not legally travel across a line from one vicinity to another in order to transport an individual from a home to a mental health facility half a mile away.

One result of the failure of LPS statute to adequately define and support public mental health field response teams is the growth of so-called "private PET teams." Original LPS statutes wisely granted members of attending staffs of private psychiatric facilities power to involuntarily detain individuals at their hospital when criteria for this were present, but the LPS statute did not specifically provide for monitoring of the activities of individual attending staff members. In recent years, various private psychiatric hospitals have entered into arrangements with private mobile response teams who advertise crisis services. The hospital grants members of these teams attending status and the hospital. The teams then bring involuntarily detained individuals to the hospital. Team members are often members of the attending staffs of

multiple hospitals and sell their services throughout the community. They often provide very rapid service and have an incentive to be highly responsive to requests of those hospitals and agencies that contract with them to provide assessments. This raises the potential for significant conflicts of interest. LPS statutes do not clearly define the role public agencies in monitoring the activities of such teams.

It is clear that public and private mental health systems have become more complex since the original LPS statute was crafted. Consumers of these resources are now far more scattered in the community. There are many more types of treatments and resources, and there are many more forms of fiscal arrangements. Mobile mental health emergency response has increased in importance without clear statutory guidance. LPS reform is imperative in order to assure the availability and effectiveness of the critical community resource.

LPS Reform and Patient Rights - Rod Shaner, MD

It is important to acknowledge that part of the impetus for development of the original LPS statutes was recognition of patients' rights abuses that occurred prior to LPS civil liberties protections. Perhaps the greatest contribution to community welfare made by the original landmark statutes was to create a legislative focus on the rights of individuals with mental disorders.

Reassessment of LPS statute is not designed to curtail fundamental patient rights -rights that are guaranteed to all members of the community. These rights must remain. In fact, new legislation can take advantage of 30 years of experience with identifying and correcting abuses of patient rights that continue to occur in the framework of LPS. Under current LPS statutes, decisions about when and where to allow involuntary treatment all too often are influenced by non-clinical considerations. Reform can create even stronger attention to oversight measures to ensure that the civil rights of patients are protected and that patients are allowed a continuity of treatment in the least restrictive environment suitable to their condition. Furthermore, revision can assure:

- Better determination of potential financial conflicts of interest to providers of involuntary treatment services;
- Recognition of social and economic implications of involuntary treatment which is primarily hospital-based (e.g., loss of housing, starvation of pets, loss of job or income) and requirements for mitigation of such consequences through quicker, more structured release to the community;
- Development and monitoring of better informed consent policies and procedures that encourage more effective voluntary treatment services;

- And client and family involvement in the process including use of advance directives.
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"Mental Health Laws: Is Reform Overdue"

Hearing: Los Angeles County Arboretum

August 6, 1998

On August, 6, 1998, Los Angeles County Board Supervisor Michael Antonovich and Assemblywoman Helen Thomson co-sponsored a hearing at the Los Angeles Arboretum, entitled, "Mental Health Laws: Is Reform Overdue?" Over four hundred family members, professionals, and mental health consumers attended. The ensuing five hours of testimony was passionate, wrenching, and pertinent to the study we have on hand. The original transcript of the hearing is nearly 200 pages long, too heavy and complex to be reproduced here. (A copy may be requested through the Office of Supervisor Antonovich.) We have thus edited and shortened the people's verbal testimony, attempting wherever possible to maximize the content of their speech. We attempted to use their own words except when brevity required revision. In advance we apologize for any mistakes or shortcomings in translation. Our revision cannot do justice to the eloquence and heroism represented in that room that night. For the sake of confidentiality we have not used the names of the consumers or their families, replacing them in some cases with "my son" or "my daughter" or initials. Professionals who testified are usually identified.

I trained in the 70's and 80's when our psychiatric emergency rooms were increasingly crowded with terribly ill people. Court actions often led to patients being discharged from acute beds as soon as they began to respond to treatment. Patients entered a revolving door from emergency rooms to the streets. The dismantling of the state hospital system and the creation of LPS legislation seemed a good thing at the time. But the process led to unintended consequences. People who might benefit from care did not always receive it. After the basic law was written decades ago, our ability to effectively treat serious mental illness has progressed remarkably in a few short years. Reforming LPS should not simply be a return to reliance on long term hospitalization. We must recognize today that effective treatment exists and that community based treatments offer the best hope for improved quality of life. Los Angeles DMH services are evolving to meet these new realities. However we have a long way

to go as we struggle with issues of effective treatment, safety, rights and resources. Based on new knowledge about effective treatment, modifications of LPS might best encompass three truths: 1. Involuntary treatment is not the solution for most treatment noncompliance: fear of stigmatization, medication side effects, lack of access, lack of family and community support and informed personal choice also play roles. 2. Involuntary treatment is no longer completely synonymous with inpatient hospitalization. A broader range of community based treatments may be more effective even when these new services are delivered involuntarily. 3. Any changes in the definition of grave disability should be made with careful consideration of their impact on family, the community and on civil and personal rights. We all want the same basic things for people with severe mental illness: quality care, access with parity to the best treatments, dignity and support for consumers and families and education about mental illness. . . . **Roderick Shaner, Acting Director of LA County Department of Mental Health and Medical Director**

Calculating freedom and cost is an illusive thing. Today twenty thousand people with mental illness are in our prisons and jails and countless more lost to our streets. California spends \$1.2 to \$1.8 billion a year to catch adjudicate and attempt to punish mental illness out of people. Mental illness only responds to treatment. It's time for new thought. Assisted treatment is something we all need from time to time. My husband wears a hearing aid; my father a pacemaker. Treatment is not punishment, it is help. If I had a high fever and was delirious no one would make me wait until I lashed out dangerously in that delirium before giving me help. They would pick me up, give me antibiotics, involuntarily if necessary, until I had the stable medical capacity to make my own informed decision.. That's why we live in society, to help and protect each other. Yet, by common practice danger has come to be thought of as needing to be imminent and a person can eat out of dumpsters, sleep in cardboard boxes and dress in filthy rags and still not be seen as gravely disabled. Until we make LPS work in a more patient responsive medically effective manner, we will never move away from the stigmatizing perception society reaps on people with mental illness because of acts resulting from lack of treatment. . . . **Carla Jacobs, Co-Chair, LPS Reform Task Force**

These laws form an unholy alliance with our sickest citizens' delusions. They keep families from getting their loved ones treated. They prevent doctors from giving urgently needed and effective treatment. They delight those governments bent on saving money. They keep people homeless on the streets at tremendous cost in human lives. They keep people in jails and prisons at equally tremendous cost in human lives and to county and state government. It costs far less to provide treatment and housing for one year to one person than to keep them for that same year in a jail or prison. Thirty years in these days is an eon of time when it comes to psychiatric research into the causes and treatment of schizophrenia. In this age of managed care, restricted hospital stays and closing state hospitals, we need an alternative kind of commitment. For a patient who has cycled through multiple hospitalizations, jails and homelessness, if there is appropriate case management following the patient and the patient agrees to take his medication and keep appointments, the patient may have the option of living with his family or in a place of his choosing instead of the hospital. However, should he or the

treatment fail, there is a court order for his immediate return to the hospital without having to wait for him to decompensate. This becomes true community treatment. . . . **Elizabeth Galton, MD, Co-Chair LPS Reform Task Force**

A person with schizophrenia has a broken mind. And if ignored has the potential to bring about destruction to himself and to others. And often the others are people the person loves dearly when rational. . . . **I.E., a mother whose son, profoundly ill, murdered his brother**

Waiting for danger is too late. Dangerous behavior and criminal behavior are frequently synonymous. My sister qualified for treatment and became a criminal simultaneously. For nearly two years we desperately tried to intervene, but couldn't help my sister access the treatment that could free her from the Bastille of her psychosis, restore dignity, free will, and the meaningful exercise of civil liberties. My sister did not fit the criteria for treatment until she taxied seventy five miles and brutally murdered my seventy-eight year old mother. My sister's upfront hospitalization if it had been based on symptoms, most likely would have cost about \$10,000. It is now costing the State of California \$1.5 million for her trial and incarceration. We have a decision to make. We can let people like my sister, her child, my mother and countless people with mental illness suffer and die in preventable tragedies or we can say every person with severe and persistent mental illness deserves treatment appropriate to their needs. . . . **Brian Jacobs, President LA County Affiliates of NAMI**

Under the present law people can't be treated involuntarily unless they are acutely dangerous, immediately suicidal or so mentally disabled that they can't even eat out of garbage cans. It's paradoxical that this situation has come to pass at a time when really excellent treatments are available for psychiatric patients, but legal restraints make it impossible to give them the treatment that would/could really help them. It's also curious. People who have tuberculosis can be mandated to have treatment, both on an inpatient basis and an outpatient basis if they refuse to take their medication. Why not those who have brain disorders? **Edward Titus, MD**

We have done a very good job of criminalizing mental illness over the last 20 years so that the only sustained predictable kind of care comes through the county jail system or the state penal system. Emphasis on hospitalization is what we tend to focus on. And our courts focus on hospitalization because that's what the law mandates. Judicial review of persons involuntarily detained and judicial review of issues of capacity to consent is expensive. To make hospitalization easier when community based care might prevent hospitalization is a very expensive way to go and without adequate discharge planning and predictable services in the community it's a waste of time. It builds failure into a system which has failed many people already. I have no issues with expanding grave disability or perhaps even expanding concepts of dangerousness. But I ask you to look at what it is the Court is supposed to and what it is that will be accomplished by making hospitalization easier unless we also make a commitment to making community mental health available on a consistent basis. . . . **Harold Shabo, Superior**

Court Judge, Dept. 95, Los Angeles Superior Court

I think before we make any sensible changes in inpatient or outpatient commitment legislation we have to embrace and be comfortable with the fact that no one likes to be in the hospital and no one likes to take outpatient medication. But sometimes we have to. Due process has never cured a case of chronic schizophrenia. Among patients with major depression, those released prematurely by the probable cause hearing tended to spend two weeks more back in the hospital over the following year. While those who completed treatment the first time averaged only two days over the following year. Among patients with bipolar disorder, those released at the hearing relapsed significantly faster than those who were allowed to complete treatment. Finally, among patients with chronic schizophrenia those released prematurely by the probable cause hearing spent not only more time back in the hospital over the following year, but also spent an average of thirty days in "treatment" in the LA County Jail, while their counterparts who did complete treatment had fewer hospital days and almost no jail days over the ensuing year. . . . **David Stone, MD**, *discussing a study done comparing rates of rehospitalization for people with mental illness who failed to meet the current standards of the probable cause hearing.*

Society should not wait until a severely mentally ill person is actually dangerous or gravely disabled before taking action. Severely mentally ill persons deserve treatment even though they cannot appreciate at a given time that they need it. To allow them to deteriorate to the point where they are dangerous or cannot take care of themselves or commit a crime is to allow them to stigmatize themselves and other mentally ill persons. We owe severely mentally ill persons an opportunity to improve the quality of their lives. . . . **Richard Lamb, MD**, *professor of psychiatry, USC*

It was not until my son ran wildly naked through the neighborhood that the police with dogs and pistols in tow, agreed to place him on a 72 hour hold, a 5150. After several weeks of hospitalization and every possibility of feeling well, once again he refused to comply with continued treatment and medication. Upon the advice of a courageous psychiatrist to pursue the LPS conservatorship we went to court and found ourselves in the repugnant position of having to testify against our own son. Can you imagine how my wife and I felt sitting on that stand? However, to no avail. A judge who observed my son for ten minutes, based on limitations of LPS conservator laws guiding decision, without attention to my son's extensive history and contrary to my son's psychiatrist, allowed him to walk out of court. Not only was my son out on his own but bonds of trust between an adult child and his parents were deeply frayed. We were forced by an inhumane system to become warring public enemies. After several periods of stability while on conservatorships only to be subsequently removed from the conservatorship, my son once more went off medications and decompensated. Brian was allowed to walk out of a board and care unit with \$300 in his pocket and no plan. Within 24 hrs he was talked out of the \$300 and was destitute and homeless. Within days blatantly psychotic with 24 hr a day delusions, hallucinations that say ugly destructive things, my son sought to end his suffering and pain and one early morning jumped off the Coronado Bridge. Due to a

miracle that the Navy Seals were doing one of their training sessions. They were there to rescue him. After weeks of intensive care, multiple surgeries and loss of hearing in one ear my son was able to be treated involuntarily after this very lethal suicide attempt and placed again on LPS conservatorship and stabilized quite well. By now most of us lay people would be able to see a pattern. Whenever my son's LPS conservatorship was not renewed, serious decompensation due to noncompliance taking medication followed. His next suicide attempt was by overdose. Once again after hospitalization and treatment with medication Brian stabilized and did well. Once again he was released from court ordered treatment and he decompensated. This time with the distorted thinking typical of someone with a thought disorder he devised another suicide plan. In desperation to end his suffering and anguish he walked into a jewelry store with a suicide note in his pocket and a knife and asked the manager for the money. He put the money down, asked the manager to call the police. Brian wanted the police to assist him in suicide. That's not uncommon. My son was shot three times. An enlightened judge placed him in a locked facility with court ordered treatment in a plea bargain sentencing arrangement. Through another miracle he survived his three gunshot wounds after multiple surgeries and a colostomy. After several years, now very stabilized once more again, My son moved to an unlocked facility. Two years ago my son moved into his own apartment. Due to court ordered treatment he has stayed on his regimen of new generations of medications. Now my son volunteers two times a week at the San Diego Mental Health Association and was last year honored as one of the top volunteers in San Diego City. The long journey of pain, suffering and extraordinary expense to taxpayers could have been prevented. . . . **H.B.**

As a thirty year veteran with LASD (Los Angeles County Sheriff's Department) and possessing a doctorate degree in psychology, I know the largest mental health advocacy population in California is the law enforcement community. An example is the MET/SMART law enforcement collaboration with DMH, an successful outreach program. Certainly we need more MET/SMART units, but more importantly we need legislation that places the patient's welfare first, allowing fewer discharged based on current behavior and more emphasis on health criteria. I have a report here that documents one patient's hospital history showing 53 hospitalizations between September 1994 and April 1996. It's hard to imagine that he ever made it out of the parking lot of the hospital. Law enforcement is a part of the social service system and we will never abandon that responsibility, quoting Sheriff Sherman Block, however, I personally believe we need better laws to prevent the revolving doors in our emergency psychiatric system. . . . **Sgt. Barry Perrou, LASD**

I guess I have the unique honor of being the first person here who has actually been diagnosed with schizophrenia, among other things. The LPS law should not be changed to make it easier to commit people. I was hospitalized over 20 times also put in jail 15 times and I still say that. People may not seek treatment in fear of being involuntarily hospitalized. Patient noncompliance is a problem with all serious medical problems. Let's not decontextualize people that are diagnosed with mental illness. High blood pressure is a silent killer but we do not force people to have treatment who suffer it. The empirical evidence is that schizophrenia

for most people is not a deteriorating course. People with mental illness are not just delusions. We have hopes and dreams and we hope that our human rights will not end where our psychiatric diagnosis begins. . . . **R.S.**

Specifically I would like to speak about the Riese hearings. A patient of mine who had threatened to kill a variety of people was sent into the hospital severely paranoid. I dutifully did my job trying to talk her into accepting the treatment voluntarily, unsuccessfully. To the hearing officer she said "tardive dyskensia" which is a side effect of anti-psychotic medications, she was allowed to refuse treatment. The patient was then released. Subsequently she was back in on another 72 hour and another Riese hearing again where she said the magic words, "tardive dyskensia" and again was allowed to refuse treatment being released from the hospital after 17 days during which time she could not be treated. I wasn't successful in talking this paranoid person into understanding what a nice guy I was and what a good doctor I am and how I really know what I'm going. Again, she was "72 houred" back in. Finally, luckily, the patient refused to attend the next hearing. The hearing officer sort of breathed a sign of relief and said, oh, thank God, okay, and ordered the treatment. Subsequently the patient was given anti-psychotic medication, responded well and was discharged. Now who profited from this absurdity: I did. Financially I profited from it because this was a fee for service patient who remained in hospital longer than was necessary if she could have been treated. Of course as a taxpayer I'm not very happy about that because she was a Medi-Care patient, I was also as a taxpayer paying for the treatment. . . . **Steve Hayes, MD**

I've seen people become malnourished, become anemic, and dehydrated as a result of thinking that food is poison. I've seen pregnant women who seek no prenatal care during their entire pregnancy - putting their fetuses at risk. One woman didn't believe she was pregnant. She told the obstetricians, "That's not it. I don't want fetal monitors, I don't want physical exams, I don't want checkups." When I saw her she said, 'I'm not pregnant, its just the afterbirth. I don't want people telling me I'm pregnant. I'm sick of that.' She received no prenatal care. She also had an untreated venereal disease. Another common thing that I see is infections that go untreated leading to more serous infections. Patients come in with cellulitis which is an infection of the skin, often on the feet and legs, people who are walking around and don't have proper shoes. That condition is easily treated with anitbiotics if people seek them. However, if untreated it can progress to osteomyelitis which is infection in the bone, much more difficult to treat. One man that I was asked to see had leg ulcerations infested with maggots and osteomyelitis requiring six weeks of IV antibiotics. I've seen many patients with bodily injuries, broken legs, backs, head injuries. Sometimes we say that outside of the psychiatric floor, the orthopedic floor has the most psychiatric patients at the hospital. These are things that in many cases could have been prevented if the psychiatric illness had been treated. The psychiatric law needs to be revisited. We need mandatory outpatient treatment and revision of these statutes so patients can get treated before they deteriorate to the point they do dangerous things to themselves medically. . . . **Barbara Silver, MD**

I've worked for LA DMH since 1972. From those years of experience an observation I've made

is the difficulty in getting people who need services into psychiatric facilities. Gravely disabled interpretation should include using past history as a determining factor. Further more there's been difficulty in that loving care givers who try to provide any kind of assistance to the mentally ill person run the risk that the person will therefore not be found gravely disabled, the criteria needed to provide them mental health care. Flexibility and renewal of lapsed conservatorships is needed. Patient's rights advocates and public defenders sometimes seem to be advocating and defending a mentally ill patient's civil right not to be involuntarily treated or hospitalized, even if the patient has no apparent comprehension of what is occurring or no insight into his or her mental illness. The need for treatment should be an important consideration. . . . **Eugene Kunzman , MD, former Chief Psychiatrist LA County Jail**

My mental illness onset was in 1986. I felt a big rock from the roof coming down to me and I felt very threatened. And the world was the same thing. My nephew told me that I needed treatment for mental illness. I refused treatment. And then later on I felt Dracula come to me and sucked blood from my nose, my leg. And I felt that somebody was following me. I used a knife and stabbed myself. My nephew called an ambulance to rescue me to the hospital. While in the hospital I tried to suicide by choking myself. After my third suicide attempt, people said that if I killed myself I would not go to heaven. So I tried to fast for forty days. Finally I realized that I need to take medicine and I'm doing pretty well now. I have a full time job and feel very thankful that I'm well and thankful to God and everybody who supported me. . . . **E.M. through a translator.**

We have over 40 clients and family members at this rally tonight from the Asian Pacific Clinic. I testify on behalf of my sister who tried to commit suicide the day after she was refused admission to the hospital. I do want reform. . . . **D.W.**

On several occasions I managed to persuade my son who was in a manic state to go to an emergency room. On every occasion his charm and his articulateness convinced people that his mother was the crazy one. The police were the only people who ever helped me. They got a call from a neighbor that he was screaming he had a gun and was going to kill himself. The Police Department called me and explained the concept of cop assisted suicide and that they did not want to do that: would we please come down to help intervene. When we finally walked into his door, he had a cap pistol that looked real enough so if he had threatened the police, they would have shot him. The police took him in on a 72 hour hold by the end of which he had taken medication and began to stabilize. Not enough to know that he was sick, but enough to regain that articulate charm. A little mock hearing was conducted in the hospital and he articulated ten reasons why he didn't need medication and about the side effects of the medication. The doctor said what's the point of keeping him in the hospital if they're not going to be able to give him medication. The triggering event to his episode was that his girlfriend had an abortion. He was threatening to her and her parents. Finally he was arrested and sent to county jail. I'm a strong believer in patient's rights, but I would much rather sit in the waiting room at UCLA hospital then in the waiting room at County Jail. . . . **E.B.**

When my mother-in-law had a heart attack we took her to the emergency room of a local hospital. They admitted her right away, gave her the right medication and saved her life. They didn't say go and have fifty more heart attacks and if you're still alive we'll see if your heart is damaged enough that we will give you treatment. When they dumped my son he became homeless. The week before the doctor told me my son's illness had reduced his functioning level to that of a nine year old. My son who had been the youngest student in his calculus class. He was completely incapable of making even the simplest plans and following through. He had no jacket, no wallet, no ID and no money. He was hallucinating, paranoid and delusional. It took us five months to find him and get him back home. Because the illness robbed him of insight, he was incapable of realizing that he was ill and seeking help voluntarily. He refused to see a doctor or take medication. He descended into a hell of paranoid delusions and hallucinations. Becoming a recluse, he emerged from his room only to yell at his auditory hallucinations. Finally his voices told him not to eat and he began starving himself. He was experiencing command hallucinations that told him to harm me. It took all his strength to resist them. I was finally able to get the SMART team to take him to the hospital, starting the process to get him into Metropolitan State hospital. My beloved son looked like a concentration camp survivor. He was skeletal. He was incontinent. He hadn't changed his clothing or cut his hair in many months. He was completely unable to take care of his most basic needs, even with my help. Now when I see a lost soul on the streets who is clearly ill and unable to take care of himself, I know that's some other mother's child who has fallen or been pushed through the cracks in her mental health system, thanks partly to the LPS Act. As a member of the American Civil Liberties Union and as the mother of a person with schizophrenia I understand that we as a society have to find a way to strike a better balance between the need to protect each individual's civil liberties with regard to involuntary confinement. We cannot continue to abandon our loved ones to suffer unspeakable torments risking their lives and the lives of others by withholding medical care and treatment that they so desperately need. . . . **A.Z.L.**

Mental illness is a disease of the brain, nothing more, nothing less. It is not mystical, it is not demon possession, it is not punishment from God. It is a disease like heart disease is a disease of the heart, liver disease is a disease of the liver. A significant portion of schizophrenics have what's called dementia praecox which is early onset dementia which means that they lose an average of 40 to 45 IQ points from the time they become ill so the people who are living on the street are not only sick, they are demented. And we are allowing them to wander around to make these decisions about their health care. The three most common admitting diagnosis from a study done in San Francisco for homeless mentally ill were scabies and lice; starvation; and major trauma, either beatings, stab wounds or gunshots. Had you opened a clinic at Aushwitz in 1944 the list of diagnoses would have been exactly the same. The homeless mentally are murdered at ten times the rate that normal people are murdered. A third to one-half of homeless mentally ill women have been raped. The whole system is wrong. . . . **Steve Seager, MD, author of "Street Crazy"**

For three years I tried to get help for him. I knew he was going to lose his job without help. He got unable to care for himself and his needs were great. Finally he got so hungry. He had not

had a bath from April until December. He thought he was Jesus Christ. Finally I got him in the hospital for one whole month still refusing medicine. (After getting legal authority) they gave him one shot per week for two weeks and released him to a board and care. First thing he does is refuse to take any medicine at all because he was in a different place. Well, the upstart was he stayed there for thirteen months, no medication. They got him back in the hospital. He got these two more shots. It was time now to come before the judge. He looks perfectly well and the judge says, you want your freedom, do you, and he said yes, I want out. The judge gave him his freedom and he's on the street. He's an amputee and he's not able to take care of himself."...**L.B.**

My daughter quickly used up her lifetime medical insurance as a teenager and has since been hospitalized many, many times briefly, only briefly, because she too is one of those people who is very bright and who can quickly re-stabilize and goes before a judge and says I'm okay. Each time she went psychotic which is now over 25 times, her brain got a little worse. At one point she deliberately attempted suicide by getting someone to inject her with heroin. They thought she was a user, she wasn't. It got her in jail, not treatment. She was a National Merit winner. The cost to her is that every time she's psychotic her brain gets a little sicker. She's been evicted over and over eventually I succeeded and she is now belatedly, but finally receiving treatment. I'm so grateful So what has to change is the law. This should never have been allowed to go on. The law I believe should require that they look at this history not just the present facts. In any other illness we look for early treatment. Women are urged to get mammograms so that we can be treated at the first sign of breast cancer. In mental illness, you've got to be almost gone before they finally get help and then its too late. . . . **R.K.**

For every mentally ill person there is at least one parent and that parent suffers along with the mentally ill. They have to lie to get help saying "My son is ready to kill himself, please take him to the hospital, please." It doesn't always work. Because of the criteria you almost have to do it in front of the person to get admitted. The LPS laws are a funnel upside down, very hard to get in, easy to fall out. That's why there is a revolving door syndrome. This topsy-turvy upside down kind of theories that go on and on and we the parent suffer. We have to become liars. We have to almost criminalize our children in order to get help. My son was ill with chicken pox and pneumonia, age 38. I took him to an emergency room. They took him in, they treated him well, x-rays, throat cultures, you name it, everything was done superbly. He was kept in ICU because he was very very ill. Why can't that kind of treatment go on for the mentally ill? . . . **K.P.**

I'm assistant clinical director at a day treatment program. I'm also the surviving brother of a man who for fourteen years lived with schizophrenia and ultimately suicided. In Catch-22 you could survive if you asked to be relieved of duty but the very asking for relief was ipso facto determination that you were competent and so there was no basis for relieving you. This is what LPS is at this point. As a clinician now I constantly hear stories from people who are begging my clinic to take someone in. We're not able to because this person is over twenty-one and refuses treatment. My own experience in high school was standing by the phone and

waiting to see where my brother was going to call from. From skid row, from a jail, from Mexico, from wherever he was wandering because he was not willing to take his medications. We have clinicians who actively want to do the right thing. We have a county treatment structure which is working really hard to provide the very best service it can. I'm convinced we can provide fairness to due process as well as extending the category in LPS from gravely disabled to include substantial deterioration and use this as a criteria for hospitalization. One time my brother was chased by police having stolen cheese from a market, living on the streets and looking fairly disheveled. The police asked him if he wanted them to put him out of his misery. He had the foresight to say no, but he put himself out of his misery at a later date. Please, let's put these people out of their misery in the very finest and most humane way, by giving them the help that they need. . . . **K.L.**

For twenty four years I was chief of a large psychiatric day treatment program. But I didn't learn nearly as much as I did as a parent when my brilliant young son developed a psychotic disorder. He too was hospitalized twelve times in the next six years, almost always on an involuntary basis. I worked with patients who wanted treatment and took their medication and struggled heroically to get better. But what I learned was that the sicker my son was the more impossible it was to persuade him that he needed treatment. He didn't tell me he wanted to die, but indirectly voices were telling him he should die or he should mutilate himself to prevent race wars or that formations around the moon meant he should stab himself. When he was psychotic he would give away his valuable possessions, he'd leave his car unlocked in unsafe places and it would be stolen. He would act bizarre and in one community was beat up by the police. He would travel all over the country and I would get phone calls from distant states all hours of the day and night. Finally he was arrested. And while in jail even though I phoned and sent records no one paid any attention. They placed him in a cell with someone known to be a deranged child mutilator and for making pacts with his mentally ill cellmates to commit suicide and then watching them die. My son complied and hung himself and only then was he considered a danger to himself. . . . **J. H.**

Our son is a 33 year old highly functional paranoid schizophrenic. If you were to meet him he would look and sound like any other of his age. The trouble is he too believes that. He believes he is not ill. He refuses to take medication. Our son has been involuntarily hospitalized via the MET team four times in the past five years and each time the court has released him because he did not meet the criteria of being gravely disabled. The last time we thought they would keep him since he not only threatened my wife but he talked of suicide. Again he was released because fortified with several days of medication he presented himself so well that the {hearing} officer let him go. They say my son does not meet the level of dangerousness needed for involuntary treatment yet he began by punching holes in walls and breaking doors at home. His brother's caged parrot that he threatened to kill disappeared one day. He stole and forged checks. Three years ago he was incarcerated in New Jersey for possession of a handgun. A few months ago he was convicted of a misdemeanor for pulling a knife in a squabble over a seat in a library. How dangerous must our son be in order to receive help? The archaic law must be changed so our son and others like him can be involuntarily treated.

Our son lives in hell, he's alone, he's frightened and tired because he believes people are always chasing him. Sometimes he calls to harass us and other times to hear our voices since he needs to reassure himself that he is still in the same world as we. His paranoia and delusions take him to a world full of hate and anger. He is tormented and exhausted. It is a terrible feeling when your hands are tied to watch your child suffer day by day by day. In the name of humanity please help us put an end to the suffering of the mentally ill and their families. . . . **S.Y.**

The oldest of my four sons fought schizophrenia from the day after graduation from high school with all A's at the age of 16 until his untimely death May 25, 1997. He received his master's degree between breakdowns and was in and out of Metropolitan State hospital and board and care places. He was finally placed in Camarillo until it was scheduled to be closed at which time he was sent to an IMD. In the IMD, he was almost in an incoherent stupor. He was terribly unkempt, had not made his bed, had urinated in his pants. The attendant at the unit station said he's been spitting out his medication. When Craig came out of Camarillo he was in the best mental health that he had been in for a long time. Since being transferred he deteriorated so much that we could not converse with him. Today I'd like to remember Craig through my eyes as the handsome youth with a mind that knew no boundaries for surely the way he exists today by the Lord's side in heaven. . . . **F.B.**

I have been diagnosed as manic depressive. I take an antidepressant because when I'm ill I tend to be more depressed than manic. I was in and out of psychiatric hospitals, homeless and even arrested for setting some minor fires in trash cans. Since it was in July I wasn't doing that to keep warm. To this day I don't know why I did that. In those days I was literally a different person. I really thought that I had died in a suicide attempt. I was in hell and things could only get worse. I have been mentally healthy now for about eight years. I'm retired and supplementing my income by working part time for Protection and Advocacy and was until recently the chairman of the Los Angeles County/Client Coalition. I am also a member of the board of directors of the California Alliance for the Mentally Ill. I want to make it quite clear that I am not speaking on behalf of any of the organizations I've just mentioned. I'm here expressing my own opinions based on my own experiences. But I want to emphasize that if it becomes easier to have people hospitalized involuntarily we had better make damn sure that the treatment they get is appropriate. Newer medications must be used. Also psychiatrists and hospital staff must be closely monitored. At times there is abuse and also inadequate treatment making it no wonder many former patients don't want to be hospitalized involuntarily. But, if I had not been hospitalized and given medication I would not be here today testifying before you. I would probably be really dead from malnutrition or being attacked by some other homeless person. No amount of pep talk or support could steer me away from the depressions. Finding the right medication is like fine tuning a car. Each individual patient is different. What worked for me might not work for someone else. But being homeless and perceiving the world differently from what it really is certainly does not work. Expecting someone with that kind of mindset to voluntarily agree for treatment is not realistic. . . . **B.Z.**

What we have is a combination problem here: one is the definitions that are in the statute now about involuntary treatment, another is underfunding of mental health services throughout the state. You're not going to solve the problem with just redefining what is going to be involuntary treatment laws you must also dedicate resources to provide them. Those resources should not be in jail. The mental health services in the jails are rotten. Absolutely rotten. Most jails do not or cannot provide involuntary services. These people rot in jail. They go into isolation. They don't know where they are, they don't know what they're being punished for. This is undoubtedly a violation of constitutional rights. Something really ought to get done in this area as well as to the civil involuntary laws. . . . **J.V.**

I'm going to talk about this law, it's a game, and we have to know how to play it. Make it so we can walk in and say we want help. We want it before we have to literally have a gun put to our head and have somebody threatening us to make a move. . . . **J.Z.**

I go to Verdugo Mental Health to help people out. And I was placed in a state hospital for six years for no reason. And it took a long time for my parents to get me out and they finally got me out. I got a job and I was doing very well. And thank you very much. . . . **J.S.**

I am one of the fortunate people. My son has been sick for thirty years with schizophrenia. He has from the first day he was diagnosed always taken his medication. It did not always work, but whatever was available they tried and I'm very fortunate. I could stand here for the rest of the evening and tell you stories just like what you have been hearing. I have had hundreds and hundreds of calls from families who say, "Help me. What can I do? I need help." I don't have the answers. But, before we talk about the issue I want to make a statement that I feel it's a useless gesture to change the law until we get some people in the legislature in Sacramento who have some understanding and compassion and will give us the money that we need to do what we have to do ---what we have to do—for these sick people. Tears come to my eyes when I hear about our surplus of money up there and I look at these homeless people on the streets and I get these phone calls from anguished family members saying why, why, why. Now I want to show you, I have a copy of the LPS Act and item G says one of the intents when they wrote this law in 1967 to protect mentally disordered persons from criminal acts. Yet we expect them to do a criminal act before we get them help? . . . **E.R.**

I have a bipolar son standing on my left. And I have endured all the nightmares and horrors that I've heard from these dear folks today. We have to do something about this LPS law. My son finally received involuntary treatment via a plea bargain after he was sent to LA Jail. Hence I'm gong to turn the mike over to him and his story. Why he was in jail. . . . **N.K.**

I'm bipolar and stabilized. In March of 97, after not receiving help from numerous agencies, I ended up in the LA County Jail health module. The horror experience there was either being over or under medicated or receiving medicine which I was not familiar with. When I apparently was over medicated I accidentally urinated on a fellow's clothes and he attacked me, breaking

my eardrum. My shoes were stolen during the first week while I was in jail. I was only able to see a psychiatrist for about one to two minutes. And I was unable to explain to him my background or the medications I was taking. Now I have stabilized on Depakote and Zyprexa. . . . **M.M.**

A public conservator for 23 yr., I know it is very difficult to establish a conservatorship. In the first 60 days of trying, its possible for a governmental agency to go through nine separate hearings. The standard of proof to sustain a conservatorship is beyond a reasonable doubt, a criminal standard the same as if one were a murderer. To renew a conservatorship is even more difficult because if the conservator did his job, the conservatee would have been provided food, clothing and shelter and there is no evidence to sustain gravely disabled. To sustain a conservatorship, a writ, a placement hearing, expert medical testimony is required and there is no funding within DMH for a paid position to provide this testimony. Oftentimes it is very difficult to find a psychiatrist willing to testify for three reasons: 1. An unwillingness to weaken the doctor-patient relationship particularly for the treating doctor; 2. A reluctance to testify in court by doctors who are not familiar with the court process; and 3. Difficulty for the physician in managing his own patient case load even without taking time to sit in court. Additionally better efforts must be made to coordinate the need of misdemeanants for conservatorships because who are Incompetent to Stand Trial yet fail to meet the criteria or standard of proof. If you have a client who can "pull themselves together" for the court hearing it is practically impossible to sustain a conservatorship. Lastly, with limited resources for inpatient hospitalization and long term care, even a conservator cannot access care if those services are not available. . . . **Lucille Lyon, public conservator, Los Angeles County**

I am a mother of a very sweet thoughtful 54 year old man ill with schizophrenia since age 28, he had been studying at UCLA when he became ill. 1997 brought disaster. My son and I lived together for 17 of the 25 years of his debilitating illness, but this year my son began to decompensate and not take his medication. I was just about to have my 81st birthday. His psychiatrists and others knew the extreme danger I was in, thus I made arrangements to move. My son was told to find a place to stay. A mental health professional told me to "just back off" and they would handle it. They didn't. Change or disruption in the life of a person with schizophrenia makes trouble. Weeks went by and the house was filled with packing boxes causing great stress on my son who could not find his valued possessions. As he worsened I begged the police to take him to the hospital and was told "when he hits you call 911". Its hard to call 911 when you are unconscious and on the floor. One morning he started searching for his "special rock" from his collection. My daughter came over to see me just as my son rushed toward me, the last thing I knew until I was in the hospital. Her presence caused my son to take his hands off my throat. My son fled to a town about 20 miles away searching for a mental health urgent care unit. The police found him in a muddy field. They brought him home, searched the house for the dead body he said might be there, and left him in the house. Later he was taken to the local jail where he waited until my daughter signed assault information, then was placed in a mental hospital, then back to jail. They would not let him call me. Our

lives have been irrevocably changed as we will never be able to have the close caring relationship we once had, him inquiring as to how I was feeling or taking me to the doctor. I am very proud of my son because he has hung in there. All this story could have been avoided if our laws were different. My son's hands would not have been soiled by his assault on his mother and the terrible memory of that will be with him all his life. I'm glad it was I instead of a stranger who got hurt. I love him. . . . **E.C.**

Four years ago my son re-injured his back at work and stopped taking medication for his mental illness. He isolated himself inside his house, denying he was mentally ill. Attempts to get him into treatment ended in frustration. Nov. 1996 he called my husband saying he needed a doctor. When my husband arrived at his home, my son was agitated and broke a window that shattered in pieces which cut my husband. When I called 911 I was lectured for calling when no one was seriously hurt. By January my son was harassing neighbors and they were calling police. Yet unless he was a danger to himself or others, nothing could be done. My son began looking unkempt and losing weight. He posted signs and letters in his front window, some begging for help, others obscene. He ran up his credit card, forgot to make his house payment, yet installed wooden blinds, valances, painting and plumbing in his house. In April we believe he set fire to our home. For two months I was on the phone every day pleading to get my son into mental health treatment but my son was not seen as a danger. My son started blowing an air horn late at night and neighbors became more fearful of him. On June 21 police picked my son up after a high speed pursuit which ended at the market where my son usually shopped. They found a knife taped to a four foot pole in his vehicle. He was yelling he was going to kill me, the neighbors, and the police. He pled no contest to charges of terrorist threats, possessing a weapon and resisting arrest. He will receive a sentence of 16 months in state penitentiary. Even in jail, my son cannot be involuntarily medicated because while he's incarcerated he's not a threat. So after all this heartache, he's still not receiving the mental health treatment he needs. . . . **M.G.**

In the mid 60's I was hospitalized after attempting suicide. After having the pills pumped out and recovering from a coma, I found myself hospitalized for one year. At that time patients did not have civil rights. My husband made all the decisions and he was not a loving caretaker. Released, I suffered years of depression without treatment as I was afraid of more shock treatments, heavy medications and lengthy hospitalizations. In 1992 I was injured on the job and again began sinking into severe depression. This time my treatment was better as the LPS Act gave me civil rights. I had the right to informed consent and participated in discussions about my treatment. I could refuse some treatments and approve other treatments. I am diagnosed as permanently disabled and belong to client advocacy groups for empowerment and support. I believe that involuntary treatment for physical or chemical restraints should only be for institutionalized persons who are in immediate danger of injuring themselves or others. Institutionalized passive docile persons such as I was in the 60's should not have involuntary treatment. Clients have a constitutional right to life, liberty and the pursuit of happiness. We should be free to make our own decisions regarding our care when we are out living in the community. Clients need to be empowered and supported to help themselves not to be treated

as objects. Do not reform the current laws, let's just apply our present laws first. . . . **E.D.**

I am a former senior assembly person with the California senior legislature and a regional facilitator for Support Coalition International, a network which defends human rights in psychiatry and promotes better alternatives. I would like to speak about two subjects: the right to be free in a free society and the National Bioethics Advisory Commission which is to go about the country and take testimony about violations and atrocities in human research. It is a hot political issue across the country and is being pushed by the big three money tree crowd. We should all be aware that appropriate safeguards against human subject research is not in place. . . . **F.M.**

I have lost two friends to suicide, one cousin to suicide. I have seen violence in my extended family only as a result of severe mental illness, not as a result of anything else. I do not feel protected by society as just somebody living in the community or as a potential mental health client with the present laws. Because we could wander the streets, eat out of trash cans without any help. And, Supervisor Antonovich, if it happened to you, more likely you would get treatment than somebody living on the streets in South Central because there would be a number of people who would really look after you. . . . **T.D.**

Since 1960 California has bent over backwards to protect the rights of its mentally ill citizens. Every aspect of a patient's stay in a county hospital is monitored by a state appointed patient's rights advocate. Unfortunately we have adopted a philosophical stance that every adult, including the insane, are perfectly competent to make decisions. That's not true. Consequently these same laws are working an untenable hardship on the chronically and very seriously mentally ill. These are people that are out of touch with reality and need continual case management and treatment. And they are in most cases being denied that support because of strict and inflexible legal interpretations of the LPS laws. There are some organizations in our society that would have us believe that forced medication or forced hospitalization deprives a person of his rights regardless of those circumstances surrounding that situation. That is absolutely not true. All of us have a moral and ethical obligation to help those who cannot help themselves. And in so doing hopefully bring them back to a halfway normal life in their society. That is not depriving them of their rights. Its returning those rights they have lost back to them. . . . **B.D.**

The patients I represent are pretty much homeless and without family members so they are voiceless here. Early discharge promotes only revolving door scenarios. The only thing good about a revolving door is that one gets to see the patient is still alive. Mental incapacity seriously impedes the making of sound decisions regarding treatment. I have handled calls from parents begging me to confirm their child is within our facility and confidentiality laws prohibit me from confirming that to the anguished parent. Its hospitals, not jails, that better serve patients rights. . . . **Cynthia Kerns, administrator at Edgemont Hospitals.**

The mentally ill can become mentally well and I'm a good example. I believe that the mentally disturbed most importantly need friends that really care about their wellness. It is such a relief to be well, that finally you can think and talk for yourself comfortably. I am finally almost a normal person. . . . **A.H.**

There should be a change in the commitment criteria: a treatment imperative. Simply say if a person is acting irrational or scary they should be committed: that if bizarre behavior is a case of mental illness, it will be professionally taken care of. I have some fifty years experience of mental illness. My brother-in-law was about every ten years involuntarily committed. Each old-fashioned shock treatment lasted about ten years during which time he was not only perfectly normal, I had him working for me. I have two sons that are mentally ill now and police do not understand what it means to say someone is a "danger to self or others." Its too technical. We have to translate and keep it simple. . . . **P.B.**

For nearly five years I have worked as a family advocate for a county department of mental health. The calls I get from family members go like this: my family member is ill but doesn't think she is. What can I do? I have to tell them essentially unless they are violent, there is nothing. I hope you will interject some common sense into the involuntary commitment laws and put me out of a job. . . . **Camille Callahan, a family advocate**

For 12 years I have been working with the homeless, particularly in a cold weather voluntary shelter. So for that period I've watched people go downhill. And when we make the decision that we can't help you because you are under drugs or alcohol or fighting the world, there is no other place but the street. The police try but they aren't mental health professionals; they'll bring someone to us or try to get a 5150. I don't have any solutions, but I'll help if I can. . . . **B.C.**

I am a full time staff advocate for LAMP, a psychiatric social model program for adults who are mentally ill and dually diagnosed. I work in a high tolerance wet drop in facility on skid row where we provide basic services in a clean safe place with respect and voluntary non-coercive treatment. Two days a week we walk the streets, underpasses, parks, wherever the mentally ill homeless are by attempting to get trust and offering a menu of services we try to facilitate healthy choices. The chronically and persistently mentally ill dually diagnosed consumer is usually treatment resistant, non-med compliant and usually not bothering anyone. They are just trying to survive. They are afraid of traditional mental health that has in the past forced treatment. As a diagnosed bipolar who endured misdiagnosis and involuntary treatment I speak from experience. I was homeless and ended up in institutions because my choices and the treatment available was far from appropriate. On skid row where I work, violence is a common daily occurrence. The degree of violence where I work with this population is no more significant than anywhere else,. We have no security guards at LAMP; they are not needed. The mentally ill are far more often victims of violence than perpetrators. It is my opinion that the current laws are more than adequate. New and more laws are only pandering to the

sensational events that have recently taken place. Force is always met with resistance. . . . **G.M.**

My mother is demented and my brother mentally ill for 40 years. I was a professor of law at the University of Paris and I taught constitutional history at UCLA. The burden of proof has to be changed. In proceedings where a criminal attorney defends my mother or my brother against treatment, the "reasoned" thought is that of the attorney not my mother or my brother. My mother can't do it because she has no remembrance of what she ate for lunch, let alone why she is in court. Lawyers are telling doctors what to prescribe. I do not believe the state really wants to help my brother although, interestingly my brother has cost the state over \$1 million and yet there is no final judgment. We get to do it next year again and again. This travesty has to stop. . . . **L.E.**

My beautiful 23 year old daughter was living in a storage facility with lice in her hair; the only food she had was a stale loaf of bread and a pot of chili with maggots in it. Her feet were swollen because she hadn't sat down in days and she was in a catatonic state. When the police arrived, they said she wasn't gravely disabled. She had shelter and food. The policeman hauled my daughter off finally, thank God, but in handcuffs. It traumatized her so much that she will not speak to us to this day and I'm now faced with the same situation. She's hold up in her apartment barricaded in a psychotic catatonic state and the police will not help me even though I am her conservator. I have requested they take her to the hospital but they won't do it because she has shelter. Something has to change. . . . **M.G.**

I do not have a family member, but I do have a friend with mental illness. We need to take the informed consent issues more seriously: my friend gave consent for a mastectomy and breast reconstruction but coming out of surgery she was manic. She is still manic and has had no cancer treatment since. She is refusing both cancer treatment and mental health treatment. Everyone I've talked to says that morally, religiously, personally, humanely, she should be treated. But everyone also says the law does not permit them. If the will of the people is being subverted by a thirty year old law, the law has to change. . . . **L.L.**

I'm a lawyer and a pro bono advocate for people who have been abused by the mental health system. You haven't heard much today about the bad things psychiatrists do. One woman was so badly over drugged by psychiatrist she ended up living on the streets. A woman had a messy condo and a man with stomach problems related to alcoholism were put on psychiatric holds. Other than attorneys who work on a percentage basis, I do not know of a greater group of white collar professionals with psychopathic tendencies than psychiatrists. There's tremendous monetary incentive. The state hospitals get over \$100,000 per patient per year and they're the ones making recommendations to the judge if someone should be continued. In other cases hospitals are just after the insurance money. Once the insurance has run out the patient is "cured" and can leave. A person can be held for seven days of incarceration before seeing a hearing officer. That should be cut. A lot of people in this room may not be

completely aware of the damage that can be done as a result of psychiatric medicine. There are all sorts of god awful things that can happen to people, even permanent damage as a result of psychiatric medicine. . . . **J.L.**

My son became schizophrenic at nineteen. In February he decided to go off all medication. I helplessly watched him regress to being unable to write a check, do marketing and laundry. Legally, I was told, he could not be hospitalized unless he was suicidal, homicidal or gravely disabled although the entire family, his friends and professionals were in agreement he needed hospitalization. In May, suddenly for no obvious reason, he began to scream "get out of my apartment." He picked me up and threw me out his door. 911 was called and in the interim he had thrown his TV set in a dumpster. Though I argued with the deputies to hospitalize him, they said he did not fit the criteria. After all he had food in the refrigerator. Later I learned he disposed of his ID, his radio, and his wardrobe. The apartment manager, to whom I am very indebted, called the police who did this time take him to an emergency. Today I realize that any improvement he makes will never reach the level he was at upon diagnosis. Presently in a locked IMD, it angers me that the financial cost to taxpayers will far exceed the cost had he been hospitalized when he first went off his medication and lost his reasoning and logic. . . . **J.S.**