The Institute for Civic Discourse & Democracy

in association with

the National Alliance on Mental Illness - NAMI Kansas

presents

ICDD

NAMI *Kansas*
Kansas' Voice on Mental Illness

ADDRESSING
MENTAL HEALTH CARE
a handbook for discussion & deliberation

treatment   *privacy*

consumers   *public*

society   *choice*

well-being   *responsibility*

Introduction

In the early morning of April 16, 2007, a Virginia Polytechnic and State University student killed 32 students and faculty and wounded 23 more before committing suicide. The massacre at Virginia Tech marked the deadliest of 100 university shootings in the history of the United States. The gunman was Seung-Hui Cho, a senior in English who was diagnosed and treated for severe anxiety disorder. In middle school and high school, Cho received therapy. In college, students and professors witnessed "delusional and disturbing behavior." One concerned professor, due to her observance of a trend in violent themes in his writing, insisted that he be removed from a class and tutored individually. In 2005, Cho was confronted by police as a result of several complaints from female students concerning Cho's inappropriate behavior towards them. As a result, Cho was detained for a day at a local behavioral health clinic where the staff recommended that he receive outpatient counseling and medication management. The next day, the court determined Cho to be an "imminent danger to self or others as result of mental illness" and was ordered by the judge to receive involuntary outpatient treatment. Although sources verify that Cho made an appointment at the counseling center at Virginia Tech, the university has not disclosed whether or not he received counseling. Even though the police, the health care community, the university and individuals surrounding Cho recognized serious problems, in the end, the tragedy still occurred. The aftermath of the shooting is igniting intense debate about the state of the mental health system in the United States and is presenting a number of challenges and important questions concerning what can and should be done to improve the system.

Tragedies naturally draw the attention of the public to an issue. The Virginia Tech case has pressed the public, agencies and government to identify important problems facing the mental health community. While drastic incidents like the Virginia Tech shooting do not fairly represent all of the issues facing mental health in the United States, the cases presented in this discussion guide have generated powerful debates on the subject.

The incident at Virginia Tech focused the public spotlight on a number of questions that mental health advocacy groups have been grappling with for years. For example:

-- Do individuals always have the right to make decisions concerning their own treatment?
-- What is the role of privacy law concerning mental health consumers?
-- What should be done when individuals are not capable of making personal health decisions? And does society have the right and/or responsibility to make those decisions for them?
-- How can we change misinformed perceptions about mental health in the public?
-- How might communities improve their mental health care systems?
-- How can society help individuals who need treatment without stigmatizing them?
-- How can the police best approach situations when individuals suffering from mental illness are involved?
-- How should the law treat individuals with mental illnesses who have committed crimes, both minor and severe?
-- Are there ways to improve the judicial system so that individuals receive better care?

Mental health issues are commonly misunderstood by the public. According to the National Alliance on Mental Illness (NAMI), "Mental illnesses are medical conditions that disrupt a person's thinking, feeling, mood, ability to relate to others, and daily functioning." There are many degrees to

> ❝About 6 percent, or 1 in 17 Americans suffer from a serious mental illness. Approximately 1 in 5 families in America are affected.❞
>
> -- National Alliance on Mental Illness (NAMI)

which individuals suffer from mental illness; however, severe mental illnesses include "major depression, schizophrenia, bipolar disorder, obsessive compulsive disorder (OCD), panic disorder, post traumatic stress disorder (PTSD), and borderline personality disorder." Mental illnesses affect approximately one in 17 individuals in the United States. Mental health is also a critical concern for health care providers, police departments, legal institutions and society in general. The questions listed to the left provide a starting point for addressing the complex issues surrounding mental health and the system that provides, or fails to provide, for mental health consumers and families. This discussion guide looks at the major issues surrounding approaches to mental health care in society by providing perspectives for discussing common concerns.

Framework for Discussion

This guide presents three perspectives, or approaches that the community and nation may pursue concerning the mental health care system. Each approach contains unique concerns and priorities. The nature of this format allows for the stimulation of dialogue and compromise so that some elements may be combined to produce variations on these three approaches.

Approach One -- Consumers Come First:

Supporters of this approach believe that privacy is paramount and that individuals should have the right to make choices about their health care. Mental health consumers should be able to decide what treatment is best and also have the option to refuse treatment altogether.

Approach Two -- Public Responsibility:

Advocates of this perspective contend that society has the responsibility to intervene in the treatment of individuals when they are unable or unwilling to do so themselves. Additionally, they believe information sharing is critical to a functional mental health care system.

Approach Three -- Treatment Over Criminalization:

Those who support this approach believe that incarceration should never be used as a substitute for needed treatment. Supporters of this perspective believe that treatment is not only more cost effective than the use of incarceration, but also is better for the welfare and security of individuals and society.

Veterans and Mental Health

-- Mental disorders are reported in more than 26 percent of soldiers returning from Iraq and Afghanistan.

-- One in six troops from Iraq met the screening criteria for major depression, generalized anxiety disorder or PTSD.

-- There is a sharp rise in divorce rates for military personnel: a 28 percent increase last year, and a 53 percent increase since 2000.

-- About one third of the adult homeless population has served their country in the Armed Services.

-- Approximately 43 percent of homeless veterans have a diagnosis of severe and persistent mental illness.

-- Almost 1,700 service members returning from the war this year said they harbored thoughts of hurting themselves or that they would be better off dead.

-- More than 250 said they had such thoughts "a lot." Nearly 20,000 reported nightmares or unwanted war recollections; more than 3,700 said they had concerns that they might "hurt or lose control" with someone else.

Sources: Government Accountability Office, Department of Defense, USA Today, Department of Veterans Affairs, Army Center of Health Promotion and Preventative Medicine, NAMI, Substance Abuse & Mental Health Services Administration

Timeline of Treatments
for Mental Illness

1840s Dorothea Dix begins career lobbying to create state hospitals for the mentally ill.

Late 1800s *New York World* reporter Nellie Bly poses as mentally ill person. Her reports result in more funding to improve conditions.

Early 1900s Primary treatments of neurotic mental disorders are developed by Sigmund Freud and others, such as Carl Jung.

1908 Clifford Beers publishes *A Mind That Found Itself*, detailing his experience in a Connecticut mental institution and calling for the reform of mental health care in the United States.

1930s Extreme therapies, such as electro-convulsive shock therapy and malaria infection, are used on people with persistent mental illnesses.

1946 Truman signs the National Mental Health Act to conduct research into mind, brain and behavior.

1955 Number of hospitalized mentally ill patients peaks at 560,000.

1960s Many seriously mentally ill patients are removed from institutions and directed toward local mental health homes and facilities. The deinstitutionalization is possibly due to anti-psychotic drugs, which allow more patients to live independently. However, many people suffering from mental illness become homeless because of inadequate housing and follow-up care.

1962 Ken Kesey's novel *One Flew Over the Cuckoo's Nest* opens audiences eyes to a new side of mental illness.

1963 The Mental Retardation Facilities and Community Mental Health Centers Construction Act is passed. It provides federal money for developing a communications network between mental health services.

1979 The National Alliance for the Mentally Ill is founded. It provides support, education, advocacy and research services.

1980s An estimated one-third of all homeless people are considered seriously mentally ill, the vast majority from schizophrenia.

1992 A survey of American jails reports that 7.2 percent of inmates are overtly and seriously mentally ill (100,000 incarcerated). Over one quarter are held without charges, often awaiting a bed in a psychiatric hospital.

2002 President George W. Bush establishes the New Freedom Commission on Mental Health to conduct a study of public and private mental health services and develop a long term strategy.

2007 *The Mental Health Parity Act of 2007* passes the U.S. Senate by unanimous vote. The act makes it illegal to impose annual limits on the number of visits or days to treat mental illnesses if the same limits were not imposed for other medical problems. The bill must be sent to the U.S. House of Representatives and then to the President for final passage.

Approach 1: Consumers Come First

People who approach mental health care issues from this perspective believe that it is always important to respect the rights and privacy of mental health consumers. Supporters of this approach believe that mental health consumers should have the same rights to privacy and self-determination as all other individuals concerning their medical care. Although the medical community is transitioning to cooperative treatment with consumers, it is not yet standard practice. Consumers should be able to decide on treatment that is right for them. Additionally, consumers have the right to live without the stigma that is often associated with mental illnesses.

> *"Nothing about me without me."*

Supporters of this approach feel that consumers should have the right to refuse any treatment they are not comfortable with, and treatment should not be forced upon anyone. In many states, "under certain conditions-such as when a person is considered a danger to self or others-he or she may be required to seek or receive treatment." However, no such laws are required for people facing non-mental-health conditions. In general, people have the right to refuse medical attention, even if they have serious or life threatening conditions. Proponents of Approach One feel that the same right should be extended to mental health consumers.

Mental Health Parity

It is true that limitations exist in all insurance plans on the types of treatments that are covered and which physicians can be used. However, supporters of Approach One feel that insurance companies should not be allowed to deny coverage or place unfair restrictions on a policy because of mental illness. They feel that mental health consumers should receive the same level of coverage that people with other types of long term or permanent illnesses, like asthma or diabetes, receive. Consumers should not be limited to a certain number of doctor visits, but instead be allowed care and medications for as long as their condition persists. According to NAMI, Congress is working to pass The Mental Health Parity Act of 2007 that will require "health plans to cover treatment for mental illness on the same terms and conditions as all other illnesses." While the U.S. Senate passed the plan in September 2007, it will need to pass in the House of Representatives and be approved by the President before it can take effect.

Existing Personal Rights Laws

There are federal and state laws that are intended to protect the rights of mental health consumers. For example, congress enacted the Health Insurance Portability and Accountability Act (HIPAA) in 1996. HIPAA prohibits group health plans from denying coverage or charging extra for coverage based on a family member's past or present poor health, including mental health conditions. Supporters of this approach value these types of laws and regulations. However, weaknesses in the laws and exemptions destroy the protections that laws such as HIPAA were intended to enforce.

> The Americans with Disabilities Act (ADA) also helps to protect the rights of people who have a mental illness.
>
> " The ADA ensures that people with disabilities, such as severe mental illness, have legal protection against discrimination in the workplace, housing and residential settings (including treatment facilites and hospitals), public programs and telecommunications."

> "Most people who suffer from a mental disorder are not violent — there is no need to fear them. Embrace them for who they are — normal human beings experiencing a difficult time, who need your open mind, caring attitude, and helpful support."
>
> -- John M. Grohol, Psy.D.

The privacy rule of HIPAA establishes regulations for the protection of the information contained in medical records like health status and payment history. It also regulates who can have access to that information. However, the privacy rule does not guarantee complete confidentiality of medical records. Medical records can be obtained through legal action against an individual's will. Information can also be released without first receiving consent from the individual if it is determined that the information can help improve treatment, payment or health care operations. This provision of the privacy rule may concern some individuals who are worried about the rights of mental health consumers. They are concerned that consumers could be convinced to grant access to their records to someone who does not have their best interests in mind. Additionally, the patient's records may be released to family members or others without the patient's consent.

Concerns About Stigma

Supporters of this approach are also concerned about the negative effects of stigma. Mental health consumers feel that misconceptions about mental illness lead to a reduction of their rights as citizens. Stigma is commonly defined as the use of stereotypes and labels when describing someone. Fear of stigma, and the resulting discrimination, discourages individuals from getting the help they need. Most of society's views of consumers stem from the media. The media, especially television, has created a distorted view of mental health issues. Mental health consumers are depicted as aggressive, dangerous and unpredictable. These representations bias the public's view and reinforce inaccuracies about mental health consumers.

People who support this approach point out that stigmatization prevents consumers from obtaining help and leads to discrimination. Stigma increases the likelihood that people diagnosed with mental illnesses feel isolated, lonely and fear rejection. For these reasons, society needs to be aware of how the media portrays consumers and be willing to critically evaluate those claims.

Proponents of this approach are also concerned about the potential misuse of criminal databases, like those maintained by police departments. These databases specifically flag individuals with a mental illness. Although tools like these could have some benefits for a community, supporters of individual rights fear that this kind of flagging will lead to unjust discrimination against consumers. People with access could form negative preconceptions about the people identified as mental health consumers. Police might view such identification as an indicator that the individual poses a high risk to himself or herself and/or others. This perception could result in unfair treatment or an imprudent response to an incident.

> "We (the professionals) frequently fail to understand their need to be in control of their lives and their bodies, just like any of us would want to. We are quick to prescribe solutions but not keen to listen to their voices. We frequently refuse to acknowledge their identity — I hate it when people say so and so is a schizophrenic — as if the illness is their identity."
>
> -- Soumitra Pathare

Critiques of Approach One

Opponents of this approach argue several disadvantages. Many mental health consumers rely heavily on a support structure of family members and close friends to provide them aid and reinforcement. Some people feel that tight restrictions on patient information may make it difficult for concerned family members to receive vital information to help their loved ones.

Additionally, people who suffer from anosognosia are unable to recognize that they are ill. They do not possess the ability to consciously acknowledge their condition and make treatment decisions. Strict laws about self-determination for patients may make it difficult to ensure that people with this and similar conditions are given the treatment that they need.

Finally, opponents of this approach believe that the safety of the general public is paramount, and not providing a safety net is a dangerous endeavor. Incidents like the shootings at Virginia Tech prompt some individuals to consider it in the public's best interest to have access to health care decisions regarding the mentally ill when necessary. Opponents of this approach may also support the use of involuntary treatment options to protect the well-being of the individual concerned as well as the public at large.

"The consumer movement strives for dignity, respect and opportunity for those with mental illnesses. Consumers — those who receive or have received mental health services — continue to reject the label of 'those who cannot help themselves.'"

-National Mental Health Consumers' Self-Help Clearinghouse

Approach 2: Public Responsibility

Two headline grabbing incidents in 1999 and 2001 turned the spotlight on mental health care problems in our communities. In 1999, Kendra Webdale was pushed in front of a New York City subway train by a man who had been diagnosed with schizophrenia, repeatedly failed to take medication and resisted long-term treatment options. In 2001, Laura Wilcox was working at a public mental health clinic during her winter break from college. She and two other people were shot to death by a diagnosed schizophrenic man who had resisted his family's attempts to seek treatment.

These two incidents resulted in the development of state laws titled "Kendra's Law" and "Laura's Law." Both laws created assisted outpatient treatment (AOT) requirements for consumers who, in light of their treatment history and present circumstances, are unlikely to thrive in the community without supervision. Justice Cutrona wrote in the *New York Law Journal* that "Kendra's Law provides the means by which society does not have to sit idly by and watch the cycle of decompensation, dangerousness and hospitalization continually repeat itself."

From this perspective, people believe that society has the responsibility to become involved in the health decisions of individuals. This perspective advances two ideas: first, involuntary treatment, as advocated in both Kendra's Law and Laura's Law should be an option for a community in which a consumer is not willing or is unable to get help. Second, there is a crucial need to improve information sharing among policymakers and agencies that provide mental health services.

Involuntary Outpatient Treatment

Those who call for an increase in public responsibility feel that there must be laws in place to intervene in health care decisions when required. According to the Treatment Advocacy Center, involuntary outpatient treatment involves a court-ordered plan for individuals who have a history of medication-non-compliance as a condition of remaining in the community. People from this perspective believe that a brief involuntary commitment is the best option in some cases. When individuals stop taking necessary medications, fail to realize that they need those medications, or are unaware that they suffer from an illness, intervention is necessary. Advocates say it is the only way to ensure that people suffering from mental illness return to their medications and cease to become a danger to themselves or others. This type of treatment program is shown to reduce hospitalization, homelessness, arrests, violence and victimization while improving treatment compliance. Results taken five years after Kendra's Law was enacted show that the system's ability to help consumers has improved.

Advocates for this perspective believe that for consumers like Anthony Goldstein, Kendra Webdale's attacker, who sought help but refused to continue any treatment plan, involuntary treatment is a good solution. In Goldstein's situation it was obvious to social workers and family that he needed structure, support and medication monitoring to stay well. The community and the mental health system failed Goldstein by not becoming involved in his treatment.

The majority of individuals participating in involuntary outpatient treatments reported that they were able to gain control over their lives, get well and stay well, and were more likely to keep appointments and take medication. Involuntary outpatient treatment

Involuntary Treatment Statistics

According to the New York State Office of Mental Health statewide involuntary treatment report as of June 1, 2001, the first 141 assisted outpatient treatment patients under Kendra's Law experienced:

- -- 129% increase in medication compliance
- -- 194% increase in case management use
- -- 107% increase in housing services use
- -- 67% increase in medication management services use
- -- 50% increase in therapy use
- -- 26% decrease in harmful behavior
- -- 100% decrease in homelessness

is also a way to ensure help for those who suffer from anosognosia.

Proponents of this perspective do recognize that some consumers intitally oppose involuntary outpatient treatment. However, when asked to rank their preferences, consumers responded that reducing symptoms, avoiding interpersonal conflict and avoiding re-hospitalization all outranked avoidance of outpatient commitment. A formal survey published in July 2004 found that a majority of consumers regard mandated treatment as effective and fair. While the interviews showed that the experience of being court-ordered into treatment made about half of recipients feel angry or embarrassed, after they received treatment, recipients overwhelmingly endorsed the effect of the program on their lives.
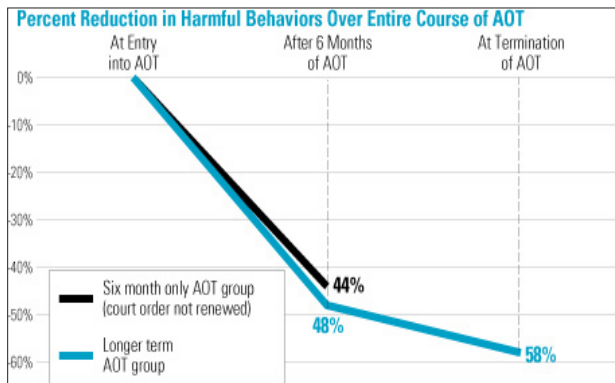
-- New York Office of Mental Health

Outpatient Respondent Report

In face-to-face interviews, outpatient treatment respondents reported the following results:

-- 62% felt that court-ordered into treatment has been a good thing
-- 81% felt that pressures or things people have done to get them to stay in treatment helped them to get and stay well
-- 75% felt that outpatient treatment helped them gain control over their lives
-- 90% felt that outpatient treatment made them more likely to keep appointments and take medication
-- 87% felt confident that their case manager can help them
-- 88% felt that they and their case managers agree on what is important for them to work on

-- New York State Office of Mental Health

Information Sharing and Confidentiality

In the cases of Cho, Goldstein and others the system failed to prevent tragedy. Proponents of this approach highlight systemic flaws regarding how confidential information should be shared between health care providers and other agencies. Although supporters recognize the delicate balancing act required when dealing with confidential information, they believe that there are too many legal obstacles preventing effective information sharing. This is critical to a functional mental health system. A smooth information sharing system is particularly important for youth who often receive services from more than one institution.

Advocates for this approach argue that confidentiality laws are complex, ambiguous and difficult to understand. To make matters more difficult, laws and regulations vary from state-to-state. Confusing laws and regulations, in combination with a public that prizes privacy, often results in over-cautious service providers who are reluctant to share necessary information with other providers and agencies. A well-designed communication system allows for service providers to determine what treatments are needed and make timely decisions concerning intervention. According to the Hogg Foundation for Mental Health, the "lack of sufficient information sharing can lead to inappropriate treatment, inaccurate assessments, and unmet needs." The end effect of a broken information system is less effective services for health care consumers and the genuine risk of consumers falling through the cracks and becoming a danger to self or society.

Critiques of Approach Two

People who oppose this perspective argue that the development of Kendra's Law and Laura's Law were reactionary policies based on misguided characterizations of mental health consumers. They believe it is only when society is confronted with extreme events that it takes notice of flaws in the system. Critics of this perspective argue that involuntary outpatient programs take control of treatments away from consumers. Forcing treatment on consumers without their voices being heard leaves consumers without an opinion in their own mental health care

program. In a 1972 U.S. Supreme Court decision, involuntary treatment was considered a "a massive curtailment of liberty." Opponents of this perspective view involuntary treatment as a form of coercion.

Another argument is that involuntary outpatient treatment does not work. According to the Judge David L. Bazelon Center for Mental Health Law, many of the studies on which Kendra's Law and Laura's Law are based are flawed. Data from outpatient treatment show that involuntary outpatient treatment achieves no better results than an enhanced community and family service approach. Critics argue that if the two options are equal in results then the better option is that which does not curtail a consumer's right to choose treatment.

Also, critics of this perspective point out that involuntary outpatient treatment may deter consumers away from seeking treatment intitally. The Bazelon Center argues that the potential for forced treatments with medications that possess harmful side effects will deter people from voluntarily seeking treatment. Critics of this perspective argue that it would be more beneficial to build an alliance between the consumer and his or her physician to encourage more discussion about treatments.

Finally, some critics also worry that this approach poses a risk of excessive information sharing. This may have serious unintended consequences such as loss of public housing, loss of employment and expulsion from school, to name a few.

"Recently, police arrested an individual with a long arrest record. During the arrest, he was injured and police took him to an area hospital for care. When the police came to check on him the next day, he had been released. The hospital spokesperson said that [HIPAA] made it impossible for the hospital to communicate with the police regarding the individual's release."
-- *John Petrila, JD, LLM*

Approach 3: Treatment Over Criminalization

> ❝We are literally drowning in patients, running around trying to put our fingers in the bursting dikes, while hundreds of men continue to deteriorate psychiatrically before our eyes into serious psychoses…❞
>
> -- California prison psychiatrist

Whether by choice, cost, convenience or stigma many consumers go without treatment each year. As a consequence, there is the possibility that crimes can be committed with serious ramifications. It is never easy to see friends or family go to prison after committing a crime. It is even more difficult when they may not understand the crime they committed, the punishment received, or both. The legal community is slowly evolving from seeing crime as simple guilt or innocence, to recognizing there is a gray area. Individuals suffering from mental illnesses might not realize that they have committed a crime or understand the punishment they are going to receive for their actions. Mental health consumers might not realize what they have done or why they are being punished, and for this reason, supporters of Approach Three value treatment over the criminalization of mental illnesses.

Incarceration v. Treatment

Proponents of this approach believe that individuals with mental health illnesses should not be criminalized by the legal system. They believe that persons with mental illnesses should be diverted from incarceration and instead given appropriate treatment. Since individuals with mental illnesses may not be able to control their behavior while untreated, incarceration is both inappropriate and morally deficient. Supporters of this approach argue that providing treatment instead of incarceration is best for the individuals and families involved since it promotes recovery. It is also a more effective means of reducing repeat offenses, therefore advantageous to improving public safety. Proponents also argue that treatment programs are more cost effective than incarceration in the long term.

The current system possesses significant procedural flaws which are preventing treatment-centered practices. First, police departments are ill-equipped and inadequately trained to respond to crises involving mental health consumers. Traditional police techniques are insensitive to the needs of consumers and may cause fear, resulting in a lack of cooperation and potential tragedy. Approach Three supporters advocate for programs such as the Crisis Intervention Team (CIT) model. Cities that have implemented the model provide volunteer officers with special training on how to respond to mental health crises. The training is conducted by mental health providers, consumer advocacy groups and consumers. Some cities have proven that such models can be implemented cost-free. The CIT model avoids the need for increased budgets by encouraging volunteerism and partnering with community organizations such as NAMI. Advocates believe that CIT programs are imperative to the treatment-centered approach. Police officers in these

> ❝Untreated and without access to long-term care, many mentally ill patients ended up with symptoms and behavior that led to their incarceration.❞
>
> -- Dr. Marcia Goin, American Psychiatric Association president

programs are able to effectively identify untreated consumers and direct them to the services they require instead of placing them in jail. This has been particularly effective in reducing the number of "victimless" crimes. Cities that have embraced CIT have also succeeded in reducing injuries to police officers and there has been a decrease in arrests made with the use of force and restraint systems.

The legal system is also a considerable concern. Proponents of this approach feel that this system is ineffective in meeting the needs of consumers and often leaves consumers in the dark. The lack of communication, training and resources to help consumers in the legal system frustrates proponents of this approach. Supporters want to see special advocates assigned to each consumer to help guide her or him through the legal process. These advocates would be trained in how to deal with various mental illnesses and specific needs within the legal system. They would also work to help consumers understand the crime they committed and the legal implications. Advocates would lead the evaluation process of whether or not a consumer was cognizant of his or her actions and make recommendations concerning legal defense.

Supporters of this approach also believe there is a need for more treatment facilities. Many people are forced to drive hours, especially in rural areas, in order to receive treatment. In California, for example, some counties use 10 percent of their mental health budget in transporting one person to state-run facilities. Consequently, routine treatment and follow-up treatment becomes inconsistent and infrequent. Supporters of this approach would like to see the expansion of laws such as California's Proposition 63, funded by taxpayers, to support county budgets in treating mental illnesses. Current space restrictions in treatment facilities and county budgets prevent consumers from receiving the treatment that they need. The development of more treatment facilities would reduce the strain and embrace the treatment-focused ideal.

Procedures and Insurance

Advocates of this approach feel that jail diversion should be the first priority. In last resort situations where incarceration is necessary, there are improvements that must be made to the system in order to better treat individuals.

Some state laws regarding the regulation of prisons can make it difficult for mental health consumers to receive needed medication and treatment while incarcerated. Supporters of this approach advocate the employment of trained professionals to administer medication in incarceration facilities. This reduces the risk of consumers harming themselves or those around them and improves the chances for recovery after release.

Supporters of this approach view restraints as a last resort in protecting an individual or others from harm. They argue they should only be used in emergency situations. If restraints become necessary, close supervision must occur. Restraints and seclusion should never be considered forms of treatment.

Medicare and Medicaid also cause substantial problems for treatment during incarceration. When an individual is incarcerated, he or she loses eligibility for medication benefits. Supporters of this approach argue that this tactic only perpetuates the problems consumers face and denying medication will only result in longer prison stays and repeat offenses. Imprisoned consumers require treatment and medication more than ever due to unfamiliar surroundings, hostile inmates or officials and the inherent stress of incarceration. Equally problematic is that "[w]hen inmates with mental illness are released from jail without …benefits, they are more

> "University of Tennessee studies have shown that the CIT program has resulted in a decrease in arrest rates for the mentally ill, an impressive rate of diversion into the health care system, and a resulting low rate of mental illness in our jails."
>
> -- Memphis PD CIT Model

likely to end up in the emergency room, prison, or back in jail," according to Chris Koyanagi, policy director at the Bazelon Center for Mental Health Law. Medication should not be viewed as a privilege, but rather a necessity beneficial to consumers, prison guards and society in the long-run.

Supporters of this approach argue that if society seeks to treat before locking up an individual and throwing away the key more can be done in trying to help individuals back into society and reducing recidivism.

Critiques of Approach Three

The first group of critics to this approach disagree that there is a "gray area" to the law. Those that commit crimes, particularly where a victim is involved, should be punished. These critics argue that potentially dangerous individuals, mentally ill or not, should be treated as criminals when they commit a crime. Police Departments should not have to rely on treatment programs and facilities to rehabilitate individuals who pose a threat to society. Opponents also argue that treatment is not always effective when a patient has violent tendencies. In fact, the FDA has issued warnings of the emergence of suicdality and the potential for violence in drugs that are commonly prescribed to treat mental illnesses such as severe depression. Eric Harris, one of the shooters of the Columbine High School tragedy, was taking antidepressants for the year prior to the event. Some argue that they may have had an adverse affect on his behavior. This group of opponents feels that treatment focused initiatives prevent the police from doing their jobs appropriately and are largely ineffective in preventing the worst tragedies.

Other critics target specific areas of the approach they feel are lacking. These opponents are concerned that programs like these will have high costs to establish an adequate infrastructure and would be an expensive burden, ultimately passed on to the taxpayer. Additionally, the trained advocate program would be difficult to initiate and manage. An advocate would need to be trained and skilled in psychology as well as the law. Opponents suggest that caseloads would be high, reducing the advocate's ability to spend adequate time with each client. This would defeat the purpose of having specially trained advocates and put consumers back at square one.

COMPARING APPROACHES

APPROACH 1

Approach One: Consumers Come First

Supporters of this approach believe that privacy is paramount and that individuals should have the right to make choices about their health care. Consumers should be able to decide what treatment is best and also have the option to refuse treatment altogether.

In Support

+ Ensuring the personal rights of mental health consumers by including them in the decision process at all levels of treatment.

+ Consumers have the right to refuse treatment, just like any other person who has a medical condition.

+ Consumers' privacy rights must be protected through strict restrictions of access to medical records and information.

In Opposition

- Tight restrictions to medical records could make it difficult for family members to get the information they need to be able to help a mental health consumer.

- Strict laws about self-determination could limit efforts to get patients who suffer from anosognosia the help that they need.

- Laws allowing consumers to always make their own decisions about treatment pose a potential risk to public safety.

APPROACH 2

Approach Two: Public Responsibility

Advocates of this perspective contend that society has the responsibility to intervene in the treatment of individuals when they are unable or unwilling to do so themselves. Additionally, they believe information sharing is critical to a functional mental health system.

In Support

+ Involuntary treatment ensures that consumers receive treatment when they need it, for their own protection as well as the public's.

+ Mental health consumers are most concerned about moving towards recovery, which can be achieved by involuntary treatment.

+ Removal of barriers to information sharing among providers allows for more effective and timely treatment assessments.

In Opposition

- Involuntary treatment unjustly strips the rights of individuals from making their own decisions concerning their health.

- An undue focus on the rights of the public often results in reactionary laws born from media frenzies and public fear.

- Involuntary outpatient treatment programs are not effective in comparison to other programs.

APPROACH 3

Approach Three: Treatment Over Criminalization

Those who support this approach believe that jail should never be used as a substitute for needed treatment. Supporters of this perspective believe that treatment is not only more cost effective than the use of jail, but also is better for the welfare and security of individuals and society.

In Support

+ Mental health consumers are treated in the stability of their support systems resulting in more effective care and recovery.

+ Treatment is more cost effective than incarceration.

+ Better trained police officers and legal support staff facilitate treatment over incarceration and provide dignity for consumers.

In Opposition

- The law does not contain a "gray area." Mental illness should not prevent police departments and legal institutions from punishing crimes committed.

- Treatment is not always effective where persons with violent tendencies are concerned.

- The cost of building new facilities and training legal advocates is too high for the inconsistent results they would produce.

ICDD Principles of Civic Discourse

-- Provide a framework for dialogue. (Establish ground rules; recognize any cultural differences.)

-- Provide all with voice. (Create safe rhetorical space.)

-- Focus on issues rather than personalities.

-- Invite/encourage a variety of perspectives.

-- Value evidence variety.

-- Seek common ground.

-- Avoid personal attacks.

-- Avoid ideological sloganeering.

-- The goal is to understand rather than persuade.

CONTRIBUTIONS

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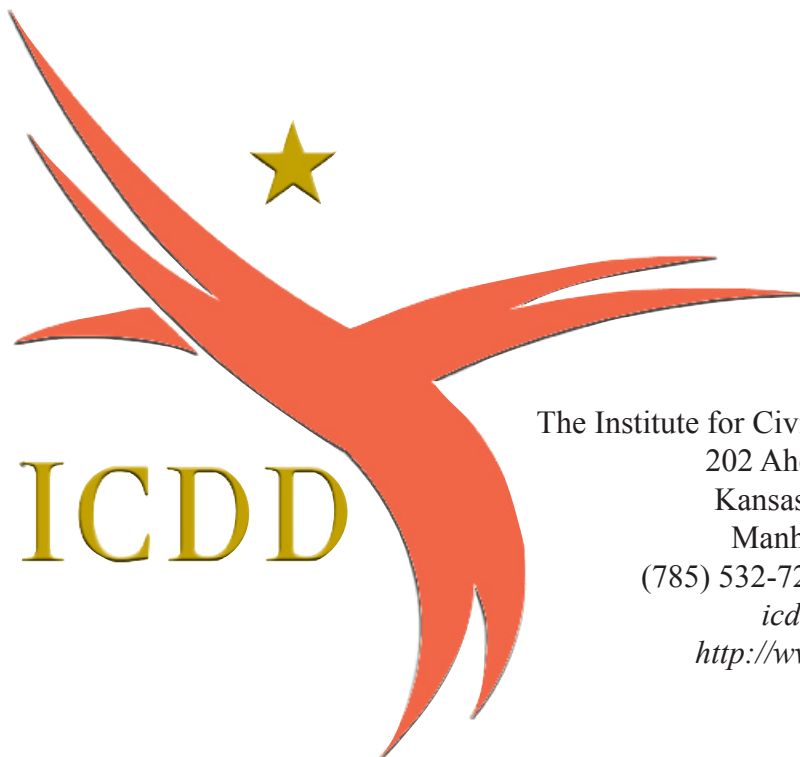## About the Institute for Civic Discourse and Democracy

The Institute for Civic Discourse and Democracy (ICDD) promotes citizen deliberation on tough political and social issues, resulting in increased citizen participation, reflection, communication and respect. ICDD works to enhance democratization locally, nationally and internationally through improved community deliberation, facilitation and evaluation practices, development of a certified facilitator training program and interdisciplinary research on models of civic discourse. ICDD is a non-partisan agency bringing together a diverse group of scholars and practitioners to address the relationship between democracy and civic discourse. ICDD's faculty includes communication specialists, engineers, geographers, political scientists, extension specialists, database managers, professional facilitators and evaluators, and authorities in conflict management. These individuals bring a variety of technical expertise, theoretical orientation, and process skills to promote civic engagement and deliberative democracy, to improve the quality of political communication and to increase our understanding of the relationship between communication and democratic decision-making. Through this breadth of scholarly and practical experience, ICDD has the capacity to assist citizen deliberation on a wide variety of public issues and in diverse public forums.

About the National Alliance on Mental Illness – NAMI Kansas

The National Alliance on Mental Illness (NAMI) is the nation's largest grassroots organization comprised of persons living with serious mental illness and their families. Founded in 1979, NAMI has become the nation's voice on mental illness. With organizations and affiliates in every state, Members of NAMI include mental health consumers, families and friends of people living with mental illnesses, mental health providers, students, educators, law enforcement, public officials, politicians, members of faith communities, and concerned citizens.

NAMI Kansas is a state-wide affiliate of NAMI. We are a self-help, membership organization of family members, mental health consumers and friends providing peer support, advocacy, and education and encouraging research dedicated to improving the lives of those affected by mental illnesses.

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