SUSPENSION TO HEALTH / MH

Mental Health Association of Erie County, Inc.

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COPY

Everybody's Column
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Dear Editorial Board:

This is in response to the recent News reports regarding the tragic death of Kendra Webdale in New York City. Andrew Goldstein, a person diagnosed with schizophrenia, is accused of pushing Ms. Webdale under a subway train. This follows the death of Judith Scanlon, Jeanette Garrisi, and Jesse Bester in the past two years by persons thought to have a serious mental illness. In fact, as the News article points out, all three were killed by those they loved or befriended. These four deaths call into question not only New York State's policy of de-institutionalization, but the relationship between mental illness and dangerous behavior. Since these events, family members, public employee unions, recipients of mental health services, mental health professionals, advocates and elected officials have all "weighed in" arguing alternatively for mandatory outpatient commitment, abandoning the preference for community based care and instead expanding the state-run psychiatric hospital system ("re-institutionalization"), and citing the need for more public resources to expand community based services.

The outcry over this series of events is somewhat predictable - eager politicians will submit bills for expansion of outpatient commitment ("Kendra's" Law ?), state public employee unions are advocating for "re-institutionalization," family groups are demanding easing up on the laws protecting patients rights and mental health consumers are rightfully wary of any attempt to coerce treatment. Finding a common ground between and among these competing forces is seemingly impossible.

First, let me respond to those who argue that "legal reform" - mandated outpatient commitment - is the answer. If only it were this simple. Andrew Goldstein, only 29, allegedly has suffered from schizophrenia for over 10 years. His life, as pieced together, shows an intelligent young man who graduated from a high school for the gifted and talented in New York City, but who gradually deteriorated as his illness took hold and became more severe resulting in several involuntary psychiatric hospitalizations at both State Psychiatric Centers and local hospitals. He lived in the community a lonely existence when not hospitalized, living on about $550 per month in federal disability benefits for the

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poor. Acquaintances said he did not seem dangerous, but lonely, lacking in motivation, and irresponsible in managing his financial and psychiatric care. It's reported that at the time of the incident, he was not taking his medication to control his symptoms related to schizophrenia. Despite two reported incidents of assault, he remained living outside the hospital since November 1994. He lived in a boarding house, an adult home and a small basement room. Despite his previous hospitalizations, his own request for help six month previously at a local hospital and some support from non-traditional mental health services, he was not visited on a regular basis, much less intensively, by any formal psychiatric program. He had reportedly stopped taking his medications due to the side effects he experienced.

I relate this history to illustrate two points. First, even with mandatory outpatient commitment, it is questionable whether Mr. Goldstein would have been re-hospitalized. The News article and previous editorials supporting outpatient commitment overlook both the experience with the current demonstration project at Bellevue Hospital and the extensive due process safeguards built into the law that make it extremely difficult to re-hospitalize. Simply not taking medications is insufficient cause to automatically order re-hospitalization. There must be associated behavior showing likelihood of a danger to self or to others. This is the same standard for emergency involuntary hospitalization under existing law- the main difference being that the individual can be ordered back into the hospital by a court with evidence of "decompensation," rather than outright harmful behavior. In actuality, current law can be used, in many instances more quickly, to obtain the same result through alternative admission procedures. And, already on the books is "conditional discharge" for patients who were committed by court order. The independent study of the Bellevue outpatient civil commitment program has recently concluded "there were no statistically significant differences between randomly assigned court ordered and control groups by any outcome measure, including rehospitalization." Not one patient in this program was court ordered to compel medication-compliance. In sum, we don't need a "Kendra's Law" on the books.

A wiser and more humane approach, not to mention cost effective, is to improve the system we have to make sure it works better, insist on coordination between State and local mental health officials and programs, and make a real and lasting financial pledge to bring community based mental health care into modern practice. The "law" is not the culprit, nor is well meaning but under funded community-based mental health practitioners. The major obstacle is "turfdom" - the State not coordinating well with local programs, the mental health disciplines (psychiatric, psychology, social work, nursing) competing with one another for professional stature rather than working as a team, managed care companies that focus only on "outcomes" without fully knowing what they are measuring, and family members and consumers blaming one another - or the "system"- for their plight. Private (commercial) insurance still refuses to give full "parity" for mental health coverage despite overwhelming evidence that early treatment and prevention saves money in the long run. The public sector pays for the majority of mental health and addictions treatment while private insurance accounted for only 26.3% of spending from 1986 to 1996.

Strong leadership is essential to bring about fundamental changes. We are at a genuine crossroads. One path is reactive - to look behind and ignore history - to "re-invent" the failed system of creating massive state-run psychiatric hospitals. Fear, community opposition and the prospect of more State jobs are the allies of "re-institutionalization." I am not advocating we "stay the course" either. Structural change is necessary, and all that this entails such as providing treatment with the best and most effective medications (this will be cheaper and safer in the long-run), expanding supported housing and intensive outpatient care, and creating a system of treatment that is inviting rather than foreboding to patients and family members. Unfortunately, New York has tried to straddle the fence, maintaining a large and very expensive public system of state-run hospitals while funding outpatient services and programs. While we spend as much per capita on mental health services as anywhere, as a result, both systems are de-moralized and lacking a clear focus. It's time to make a difficult but necessary choice. We must fully fund community services for mental health care even if we must de-emphasize the institutional model in our State. "Re-institutionalization" is not the answer.

Very truly yours,

Roger E. Stone

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