SANDY HOOK ADVISORY COMMISSION
APRIL 26, 2013
9:30 A.M.
LEGISLATIVE OFFICE BUILDING
HARTFORD, CT

SCOTT JACKSON, Committee Chair
KATHLEEN FLAHERTY
EZRA GRIFFITH
CHRISTOPHER LYDDY
DENIS McCARTHY
PATRICIA KEANEY-MARUCA
WAYNE SANFORD
DAVID SCHONFELD
HAROLD SCHWARTZ
BERNARD SULLIVAN

AGENDA

I. Call to Order
II. Violence and Mental Health Issues
John Monahan, Ph.D.; Professor of Law, University of Virginia School of Law
Richard J. Bonnie, LLC; Director, Institute of Law - Psychiatry and Public Policy, University of Virginia School of Law/Chair of Virginia Commission on Mental Health Law Reform/Consultant to Virginia Tech Review Panel

III. Addressing Trauma
Robert Pynoos, M.D. & M.P.H.; Co-Director, National Child Traumatic Stress Network
Julian Ford, Ph.D.; Professor of Psychiatry, University of Connecticut Health Center
Steve Marans, M.S.W. & Ph.D.; Harris Professor of Child Psychiatry/Professor Of Psychiatry/Director, National Center For Child Exposed to Violence/Childhood Violent Trauma Center - Yale University
Robert Franks, Ph.D.; Vice President/Director of Connecticut Center For Effective Practice, Child Health Development Institute

IV. Other Business
V. Discussion
VI. Adjournment

(The proceedings commenced at 9:46 a.m.)

MR. JACKSON: Good morning.

We're glad to have you with us and to see you again, Professor Bonnie.

We're glad that we got our technical difficulties settled.

Why don't we call to order this meeting of the Sandy Hook Advisory Commission at 9:46 a.m.

Let's start with the introductions. Let's start to my right. Ms. Flaherty.

MS. FLAHERTY: Kathleen Flaherty, staff attorney, Statewide Legal Services, and mental health advocate.

MS. KEANEY-MARUCA: Patricia Keaney-Maruca, retired special education teacher and member of the Connecticut State Board of Education.

MR. McCARTHY: Good morning. Denis McCarthy, Norwalk Fire Chief and Emergency Management Director.

MR. SCHONFELD: David Schonfeld, I'm a developmental behavioral pediatrician and direct the National Center for School Crisis and Bereavement, and I'm pediatrician and chief at St. Christopher's Hospital for Children.

MR. LYDDY: Good morning. My name is Christopher Lyddy. I'm the former state representative for the town of Newtown, and I'm also a licensed clinical social worker and program manager for Advanced Trauma Solutions here in Connecticut.

MR. SCHWARTZ: Good morning. I'm Hank Schwartz. I'm the psychiatrist and chief at the Institute of Living, vice president of Behavioral Health at Hartford Hospital, and professor of psychiatry at the University of Connecticut School of Medicine.

MR. JACKSON: Scott Jackson, mayor of the town of Hamden, Connecticut.

MR. GRIFFITH: I'm Ezra Griffith, faculty member of the department of psychiatry at the Yale School of Medicine.

MR. SANFORD: Wayne Sanford, University of New Haven, in Connecticut, obviously, and involved with emergency management and fire side training.

MR. SULLIVAN: Bernie Sullivan, former chief of police of the city of Hartford and former Commissioner of Public Safety for the State of Connecticut.

MR. JACKSON: Thank you.

And with us for our morning panel we have Dr. John Monahan, professor of law at the University of

Virginia, and Professor Richard Bonnie, who joined us at our initial meeting, from the Institute of Law, Psychiatry, and Public Policy at the University of Virginia School of Law.

Gentlemen, we thank you for joining us today. We have a couple of topics, including connections between violence and mental health, as well as some discussions regarding the role of leveraged coercion.

So, gentlemen, the floor is yours.

MR. MONAHAN: Hi. I'm John Monahan. I'm a professor of law at the University of Virginia, but my background is not in law but rather in psychology.

The way I had planned to organize my remarks today was in two parts. First, to look at issues and their relationship of mental illness and violence, and then to stop and have questions and comments. And then to do the second part of my presentation on mandated community treatment, after which my colleague, Professor Bonnie, will make some remarks. And then we'll open it up again for discussion, if that seems okay with you.

MR. JACKSON: Sounds perfect.

MR. MONAHAN: Okay. The slides should be coming up. Okay.

The first topic, about mental illness and violence. There are hundreds of studies relating mental

illness and violence, many more than we can review today. However, I've chosen two representative studies that are both very large scale and that use very different research designs.

The first study, which I think is the best epidemiological study of mental illness and violence ever done, the Epidemiological Catchment Area Study. In this study, 10,000 adults, household residents from three different cities were interviewed, the sample selection controlled for age, gender, socioeconomic status, and race. And people were interviewed with the Diagnostic Interview Schedule, which is a very structured detailed instrument to assess the presence or absence of certain kinds of mental disorder.

Embedded in the Epidemiological Catchment Area Study were five questions that had to do with violent behavior, which are parts of different diagnoses. Have you ever hit or thrown things at your partner; Have you ever spanked or hit a child hard enough so that he or she had bruises or had to stay in bed or see a doctor; Since age 18 have you been in more than one fight that came to swapping blows; Have you ever used a weapon like a stick, knife, or gun in fights since you were 18; Have you ever gotten into physical fights while drinking. I think there are all kinds of other questions we can

imagine, but those five were defined as violence.

The conclusions of the Epidemiological Catchment Area Study was that if the individual being interviewed had no diagnosis of a mental illness in the past year, 2 percent of those people committed one of the five violent acts that I just mentioned. People who were diagnosed with schizophrenia, 13 percent committed a violent act. People diagnosed with major depression, it was 12 percent. Mania or bipolar illness, it was 11 percent. People diagnosed with alcohol abuse, 26 percent of those people committed a violent act in the past year. And 35 percent of the people diagnosed with drug abuse committed a violent act.

So several things can be said. One, people with any form of major mental illness, schizophrenia, major depression, or mania, all had higher rates of violence than people with no disorder at all. Second point is that, in this study, anyway, the rates of violence were very similar across diagnoses of mental illness. And third, rates of substance abuse, alcohol or particularly other drugs, were by far the most highly related to violent behavior.

Indeed, violence, the probability of violent behavior in a given year was determined by many different risk factors, if you look down the left-hand

side of this column. You can look at younger age, male gender, lower socioeconomic status, whether people abused substances, whether they had a major mental disorder, if they had ever been arrested before, or ever been in a psychiatric hospital before. And you can see here that the lowest risk group, 1 percent likelihood of violent behavior, consisted of people who were older, who were female, who were not lower SES, who did not abuse substances, did not have a major mental illness, had not been arrested before, and had never been in a psychiatric hospital. Whereas the highest probability of a violent act in the next year, 65 percent likelihood was composed of people who were young, who were male, who were lower SES, who were abusing substances, who had a major mental illness, had been arrested before, and had been psychiatrically hospitalized before. So many different risk factors came into play in the relationship between mental illness and violence in the Epidemiological Catchment Area Study.

The second study was a very different design, was not an epidemiological study, that I and colleagues were involved in, funded by the MacArthur Foundation. This was a clinical study of people who were in short-term mental hospitals.

We followed, we downloaded over 1100

patients who were discharged from short-term psychiatric facility, average lengths of stay was 11 days, in Massachusetts and Pennsylvania or Missouri. We measured 134 possible risk factors for violence to other people, not violence to self here.

I should mention, say that one factor is if something is a risk factor for something else, it means two things and two things only. It means that the two variables statistically correlate; when one goes up the other tends to go up, when one goes down the other tends to go down. And it means that we measure the risk factor before you measure the outcome. There's no necessary implication that the risk factor caused the outcome.

We followed people up for five months after they were discharged from the hospital. We got their self report as to whether they were violent. We got this with the federal confidentiality certificates so nothing they told us, we need to report. We have the report of a collateral individual who knew the patient best in the community, often but not always a family member. We had their arrest records. And we had their mental hospitalization records in case they were hospitalized for violent behavior.

In this study we defined violence as

several things: The use of a weapon, threatening someone with a weapon in your hand when you made that threat, a physical battery that resulted in injury, or any form of sexual assault. So to say violence is to say one of those four things. The vast majority of violence in the study consisted of battery resulting in injury.

In Pittsburgh we had a comparison group of 500 people from the open community. They lived in the same neighborhood as the discharged patients did. They were matched for age and race. They were randomly assigned. They were not in mental hospital.

So that's the design of the study.

One of the main results is that if you look at violence in the first ten weeks after people were discharged from the hospital in Pittsburgh, 11.5 percent of the patients committed one of those violent acts that I just mentioned, again, mostly battery that resulted in a physical injury. The comparison group of the community, it was 4.6 percent of the people committed at least one of those acts of violence, so it was less than half of the discharged patients. So there clearly was an association between being discharged from a short-term mental hospital and violent behavior.

Equally importantly, however, if we look at violence in the first 10 weeks after discharge and

compare that between the patients after discharge and the community, was in the most recent 10 week period. We had given everyone instruments to measure symptoms of alcohol or drug abuse or people currently experiencing alcohol or drug abuse symptoms, looking at whether people had one or more symptoms of substance abuse when they were in the community.

You can see here for both the community comparison group as well as for the discharged patients, if they were not abusing alcohol or other drugs in the community, and I think this point is very important, there was no statistically significant difference between the discharged patients and their neighbors who did not have a mental illness, slight but not a statistically significant difference at all if the patients and the comparison group were not abusing alcohol or other drugs.

However, if there was at least one symptom of substance abuse in the community group, the rates of violence to others jumped from 3.3 percent to 11.1 percent if substance abuse was involved. But for the discharged patients the rate of violence jumped from 4.7 to 22 percent. So the patients were -- substance abuse drastically raised the rates of violence for both the community comparison group and for the group of discharged patients, but it raised the rates of violence

much more for the discharged patients than it did for the community comparison group, more than double, 22 versus -- more than double, 22 percent versus 11.

And very distressingly, if you look at the numbers on the bottom of the chart, 17 percent of the community comparison group, the people who were not hospitalized, had at least, had at least one symptom of substance abuse, whereas the patients, and this is after people were discharged from the hospital, 31 percent of the patients were still abusing alcohol or other drugs, even after they got out of the hospital.

So when patients and their fellow community members were not abusing substances, there was no difference in their rates of violence. When patients were abusing substances, violence was greatly increased and the patients were about twice as likely to be abusing substances as were the community comparison group.

If you look at who they were violent to, you can compare the groups. For about half of both groups it was a family member who was the target of the violent behavior. If you look at the bottom row, the discharged patients were actually less likely to be violent to strangers than were the community comparison group, perhaps because the discharged patients were less likely to socialize with others.

In terms of more specifically what risk factors were related to violence, we divided the risk factors into four groups, which we called: What the Person Is, What the Person Has, What the Person Has Done, and What Has Been Done to the Person.

So for example, What the Person Is. Age, each one year increase that the patients were in age, the rates of violence decreased by 20 percent. Older people were much less likely to be violent than were younger people. Anger control, a one standard deviation increase in a person's inability to control his or her anger resulted in rates of violence going up by 52 percent. Gender, men, male patients were 51 percent more likely to be violent than were female patients.

If you look at What the Person Has, whether the individual has a major mental disorder or a personality disorder -- sorry, the graph is somewhat complicated. If you look going from the left, 4.6 percent, the community comparison group in Pittsburgh, 4.6 percent of those people committed a violent act in a random 10 week period compared with patients with schizophrenia, 8 percent of those people were violent. Patients with bipolar illness, 15 percent of those patients were violent. Patients with depression, 19 percent of those patients were violent. So we did find

some diagnostic difference. However, the most, the group that had the highest rates of violence by far were those patients who had a primary diagnosis of a personality disorder.

All of the groups of people in the hospital were significantly more likely to be violent than were the community comparison group. But some of the groups of patients were much more likely to be violent than others.

If we look at substance abuse disorder, then we reflect on the slide that we just saw. Substance abuse drastically increased the risk of violence in people, in all groups of people.

What the Person Has Done. Prior crime and violence in almost every study ever done, and there have been many hundreds of studies done. Among the single best predictors of future violence is past violence. So for example, in the MacArthur study, 19 percent of the 1100 patients committed at least one violent act in approximately a five-month period. If a patient had never been arrested before, however, only 9 percent of the patients with no prior arrests were violent. If the patients had prior arrests for nonviolent crime, 20 percent of those patients were violent. If the patient had an arrest for a violent

crime, 36 percent of those patients were violent in the future.

Finally, what has been done to the person in the past, if the individual grew up in a pathological family environment, say the individual's father often used drugs when the individual was growing up, when the patient was growing up, that's double the rate, the likelihood that the patient would be violent himself as an adult. And victimization, if the patient self reported that he or she had been seriously abused as a child, which is to say had been abused in such a way that as a child he or she had to go to a hospital or missed school, that increased the rates of violence by 51 percent.

If you put all these risk factors together we could place patients in one of five groups that had, going from the left, at 1 percent, 8 percent, 26, 56, or 76 percent chance of committing a violent act in the next five months.

This green line describes the number of patients in each group. The great majority of the patients that we studied were in the first risk, had a 1 percent chance of being violent. The rates of violence, as fewer and fewer patients were in each succeeding group, only about 10 percent of the patients were in the

highest risk group, risk group 5. But those patients, as I say, had a 76 percent chance of being violent.

The bottom lines that I would take from the research on violence and mental disorder, particularly on the two studies that I just mentioned, are these. First, mental illness plays a very small role in American violence. According to the best research estimates, which is to say the Epidemiological Catchment Area Study, approximately 4 percent of violence towards others in American society is attributable to mental illness. That is, if we could somehow cure all mental illness overnight, we would be left in the morning with a rate of violence that is 96 percent of what it is now.

Second, mental illness does play some role in American violence. Mental illness modestly but clearly in my view increases the likelihood of violence to others. In the MacArthur Violence Risk Assessment Study, for example, for the first several months after discharge from short-term psychiatric facilities, about 11 percent of people with mental illness committed a violent act compared to about 5 percent of their nonhospitalized neighbors.

Two facts, however, need to be appreciated to understand this finding. First, violence committed by discharged patients, as I mentioned earlier,

was heavily mediated by substance abuse. If the former patients were not abusing alcohol or other drugs after they were discharged from the hospital, the rate of violence to others was no different than the rate in their surrounding community. In fact, however, the discharged patients abused alcohol or other drugs twice as frequently as their nondisordered neighbors, and those who did engage in substance abuse have substantially elevated rates of violence to others.

Second, 2b here, gun violence against strangers by people with mental illness is very uncommon. The most frequent type of violence that the discharged patients committed, as I mentioned, is hitting someone, most often a family member. In the MacArthur study only 3 percent of the violence committed by former patients was while using a gun or threatening to use a gun on a stranger.

Next point, homicide of strangers by people with mental illness is rare in the extreme. One international study by Neilson and colleagues found that one in every 140,000 people with schizophrenia will kill a stranger. The quote from that study: Measures that ensure earlier treatment of psychosis and continued treatment in the community would be likely to prevent homicides of both strangers and family members. However,

the extreme rarity of these events means that identification of individual patients who might kill a stranger is not possible.

Suicide is much more common than homicide among people with mental illness. Suicide among people with mental illness is much more common than violence to others. According to the Center for Disease Control, the age-adjusted suicide rate for the total population was approximately twice as high as the suicide rate. Over 38,000 suicides occur in the U.S. each year, compared with about 16,000 homicides. And the American Federation for Suicide Prevention estimates that 90 percent of all people who die by suicide have a diagnosable mental illness at the time of their death.

Victimization is often underappreciated. People with serious mental illness are far more likely to be the victims than the perpetrator of violence. For example, women with mental illness have five times greater risk of other women of being victims of domestic violence.

And finally, a quote from the current issue of the Journal of the American Medical Association, Psychiatry, from Paul Appelbaum, the former president of the American Psychiatric Association: Mental health professionals and other advocates for improved mental

health services must exercise caution in their endorsement of proposal for increased mental health funding. Such offers are often premised on the proposition that the problem of violence is largely a problem of untreated mental illness and its corollary that better treatment will preclude a repetition of the mass shootings such as Tucson or Newtown. However, tying the need for increased funding to public safety will lead to further demonization of people with mental disorders as well as an inevitable backlash when it becomes clear that more mental health clinics or inpatient beds have not had a major impact on the prevalence of violent behavior.

Thank you. That is all I have to say on the relationship between violence and mental illness. I'm happy for other people to make comments or for any questions before going on to the second part of the presentation.

MR. JACKSON: Thank you, Dr. Monahan.

Questions on this part of the presentation.

Ms. Flaherty.

MS. FLAHERTY: Thank you, Dr. Monahan. I appreciate your presentation this morning. I actually have something that's a comment and one question.

It seems, especially with comment number 5, I'm wondering if you think really the situation is that we need increased funding for mental health services in their own right and not because of a public safety issue.

And secondly, my question is, doesn't it seem like a priority would really be for funding for substance abuse treatment rather than mental health treatment in terms of the focus on public safety because it does seem like the rates of violence are up to 3 times higher for people with substance abuse disorders rather than mental health disorders. Thanks.

MR. MONAHAN: I agree completely with -- I agree completely with the first comment. I think the priority should be for funding for mental health services in its own right rather than as a way to reduce violence in society since, as I say, if the treatment was completely effective it would only reduce violence by 4 percent.

Secondly, I agree that treatment for substance abuse should be a tremendous priority. I do think that it's the combination of substance abuse and mental illness that have the highest rates of violence. But it seems to me -- I would hope that this is not an either/or situation. But certainly the data I just

presented would suggest that substance abuse funding be a priority.

MR. SCHONFELD: Thank you very much for the presentation. I agree with your findings and your recommendations, but I just wanted to bring up one or two points to consider.

The first is that because of the fact that individuals are often hospitalized into psychiatric facilities because of concern and patterns of risk to themselves and others, there is a certain confound in terms of that being a risk factor for subsequent violence.

In addition, you saw that personality disorders was the highest risk factor. I'm assuming that includes conduct disorder, and conduct disorder is defined and diagnosed based on a pattern of violent behavior and other behaviors that violate social norms.

So I'm not questioning your conclusions. I think it perhaps underscores that we may be even overestimating the actual risk attributable to mental illness. You already say that it is quite low. It may actually be even lower than some of what you have said in terms of a causal link.

And then the question that I have for you relates to the distinction between mental illness and

developmental disorders. Because I know there have been some questions posed to this group about whether autism spectrum disorder confers a risk of violent behavior, and I think your conclusions drawn on mental illness may actually even be far greater than it is for some of these developmental disorders. I would like you to comment on your thinking along that question.

MR. MONAHAN: Right. Three quick responses. Absolutely right that concern -- our study didn't confound violence to self versus violence to others. The purpose of our study was just to study violence to others. Risk of violence to self is an equally important topic, it just wasn't the topic we looked at. Many of the risk factors would be different in violence to self or others. And the most obvious one, it's young people who tend to be violent to others and older people who tend to be violent to themselves.

In terms of personality disorders being the highest risk diagnostic group, everyone we studied was between 18 and 60 years old, so I think very few people were there for conduct disorder. The reason that personality disorders had such a high rate of violence, I think, is that virtually all the people who were hospitalized for personality disorders are also substance abusers who were in the hospital primarily for their

acute substance abuse.

As to the developmental disability point, that again is an extraordinarily important thing to study, but it was not what we studied. We had an IQ cut-off, lower IQ cut-off, if I remember correctly, of 74 of this research. I don't believe that there were any of the subjects were hospitalized for autism spectrum disorder. I understand how it's very relevant in the current situation, but I know of no research that looks at the relationship between autism spectrum disorder and violent behavior. There may be such research, but I don't know of it.

MR. SCHWARTZ: Hi. Thank you for your excellent presentation.

The MacArthur study looks at individuals from the point of hospitalization forward, so presumably these are individuals who have started down the course of treatment. Could you address the issue of individuals with psychotic disorders who are untreated.

So for instance, an article in the British medical, in the Schizophrenia Bulletin, I'm not sure if it's the same one you cited, Neilson in 2009, I thought it was an article in 2008, does a meta analysis of studies looking at individuals with psychotic disorder during the period in which they are untreated leading to

first treatment, which was measured by hospitalization. And that article found those individuals to be at significantly higher risk than individuals who are identified and in treatment.

So can you address this special populations within the overall population of mentally ill.

MR. MONAHAN: I can, and I will address that in the next part of the presentation. What people who are untreated compared with people who receive some form of mandated treatment.

And I'm familiar with the article that you just gave and I think you accurately summarized the results, which is a separate article by the same individual that I quoted a little while ago.

MR. JACKSON: Okay. Thank you very much for fielding questions on that piece.

If you want to go into the part 2, mandated community treatment.

MR. MONAHAN: Okay. Thank you very much.

I thought I would first address the issue. The issue here is mandated treatment in the community. Not in hospitals, which was the topic of a recent research network that Professor Bonnie and I were on, also for the MacArthur Foundation.

One question one might ask to kind of join the two presentations is: Does voluntary community treatment reduce violence? And in the MacArthur Violence Risk Assessment Study that I just presented, we interviewed people often, as well as their collaterals, and in this slide we show -- after the first 10 weeks after they were discharged from the hospital we interviewed people and asked them how many outpatient treatment sessions they attended in the previous 10 weeks. And for almost everybody, for almost 90 percent of the patients an outpatient session meant both psychotherapy and some form of medication. So it is not possible to disaggregate medication from some form of therapy.

What we found is if in the first 10 weeks people had gone to no outpatient treatment, their rate of violence, defined as I defined it a few minutes ago, in the second 10 weeks was 14 percent. If they went to one treatment session per month, their rate of violence was 9.5 percent. And if they went to one treatment session per week, their rate of violence was 2.9 percent. Compared to 14 percent for people who had no treatment. So a very striking decrease.

I hasten to add these people were not randomly assigned to get no treatment, once a month, or

once a week. It's possible that other factors influenced whether people went to treatment. But when we statistically control, as it says on the bottom of the slide, for age, gender, race, education, marital status, substance abuse, diagnosis, and prior violence, we still get a statistically significant effect. And mind you, the community comparison group had a violence rate of 4.6 percent. So the people, the discharged patients who had one session per week of treatment, they were less likely to be violent than the average citizen, the average nondisordered citizen in their neighborhood.

I want to focus now on -- that was voluntary treatment -- on legally involuntary treatment. The example of that which is perhaps most controversial is outpatient commitment, which has been in existence for many years, but the issue has received new importance after Kendra's Law in 1999, named of course after Kendra Webdale, who was pushed by a person with untreated mental illness under a New York City subway car.

Outpatient commitment is very controversial for many points of view. One quote from the Bazelon Center for Mental Health Law, a leading legal advocacy group: Outpatient commitment penalizes the individual for what is essentially a systems problem. Lack of appropriate and acceptable community mental

health services is the issue, says the Bazelon Center. However, the Treatment Advocacy Center, headed by a well-known psychiatrist, E. Fuller Torrey, their view is: For a small subset of the most mentally ill, no amount of money spent on services will ever be enough to induce their competence -- their compliance with treatment.

What I want to do is very briefly put outpatient commitment in the context of what the MacArthur Foundation referred to as mandated community treatment. In an era where mental hospitalization was the primary form of treatment for mental illness, institutional treatment, you had various patients' needs, their need for housing, their need for disability benefits, their need for order, their need for treatment, all of that, when treatment is mandated in an institution, was provided by the hospital. But since the age of the institutionalization in the United States now, when people are being -- people with mental illness are in the community, if they need, if they have housing needs, those needs are handled by a housing agency. If they get disability benefits, those disabilities benefits are handled by a welfare agency. If they are in need of -- if they violate social norms, that's handled by the criminal justice system rather than by the hospital. And treatment is provided by an outpatient mental health

system.

So you can see that now, currently, mandated treatment in the community is provided by a wide variety of different agencies which oftentimes do not coordinate with one another and are often unaware of the activities being taken by the other.

I think what you see overall is a variety of different methods by which people with mental illness can get things that they often want and need, like housing or benefits, or they can avoid things that they don't want, like being in hospital or being in jail, if and only if they cooperate with mental health treatment in the community.

Let me give you several examples. First, using housing as leverage to get people with mental illness into treatment. This is a standard lease for subsidized apartment for people, for a person with mental illness: Refusing to continue with mental health treatment means that I do not believe I need mental health services. I understand that since I'm no longer a consumer of mental health services, it's expected that I will find alternative housing. I understand that if I do not I may face eviction from my subsidized apartment if I fail to go to mental health services. And it's worth noting that in 41 states the mean rent for a one-bedroom

apartment exceeds a hundred percent of federal disability benefits. So many people with serious mental illness in the community need subsidized apartments, and they can get them if and only if they participate in treatment.

The use of money as leverage. Oftentimes people with mental illness have someone who manages their money. People who receive disability benefits from Social Security Disability Insurance may have a representative payee appointed for them just as for a child beneficiary, for example, may have to have a representative payee assigned to him or her. This is from a brochure that was given to people on Social Security disability benefits who had a representative payee: You are receiving benefits based on the mental health problems that you have. The Social Security Administration requires that you be involved in mental health services so that you will feel better, otherwise you may lose your benefits. And over a million people in the United States receive benefits for psychiatric disability through a representative payee.

Jail as leverage. Treatment as a condition of probation. The United States Code explicitly says the court may provide as further conditions of a sentence of probation that the defendant undergo available medical, psychiatric, or psychological

treatment. So there is no question about the legality of offering a person with mental illness treatment as a condition of probation in general criminal courts. And indeed, now, as I'm sure people are aware, there are approximately 400 mental health courts in operation in the United States, where judges have a separate docket and they only dispose of cases where the defendant is mentally ill, and they may indeed suspend charges conditional on the person going to mental health treatment or make treatment a condition of probation.

Finally, you have hospitalization as leverage. Outpatient commitment, a civil court order requiring a person to accept mental health treatment in the community.

It's important to point out, as I'm sure people are aware, there are three different types of outpatient commitment. First, conditional discharge, where the patient meets inpatient commitment criteria. The patient is in the hospital, they could be kept in the hospital longer, but the patient is told, We're going to discharge you now but you must accept treatment in the community, and if you don't we're going to rehospitalize you based on the original commitment order.

An alternative to hospitalization, You meet the criteria for inpatient commitment, but we won't

send you to the hospital if and only if you promise to participate in outpatient treatment in the community.

And finally, and by far most controversially, the patient does not meet inpatient commitment criteria now, but it is the belief of mental health professionals that they are deteriorating and they will meet commitment criteria in the near future, so let's provide them with a period of treatment now.

The first question that the MacArthur project answered was, well, how often do these things happen, is this a problem really worth studying. And what we found is, we did a study of about a thousand, more than a thousand people in public sector outpatient treatment at five different sites across the United States. We asked people for their lifetime experiences of leverage, did this ever happen to you. And in fact, 32 percent of all people in outpatient public sector mental health treatment say that at some time in the past, since they became mentally ill, they have been told that if they didn't accept outpatient treatment they would have to get out of where they were living.

Half of all patients in public sector outpatient treatment have been arrested at least once in the past. And approximately half of them, which is 23 percent of the total percent, total population of people

in outpatient public sector treatment, have said that they have been told at some point in the past that if they wanted not to go to jail for the charge they had just been convicted of, or if they wanted to go to jail for a briefer period than they might otherwise go to jail for, they had to participate in outpatient mental health treatment. 15 percent of all patients said they were, in the past they were on some form of outpatient commitment. They were told that they could avoid being hospitalized or they could get out of the hospital sooner if and only if they accepted treatment in the community. And finally 12 percent of all patients said that money that they believed was legally theirs, they were not given until they agreed to participate in outpatient treatment.

If you look overall and not double counting any patients, 51 percent of all patients in public sector outpatient treatment in the five sites across the United States that we studied said that at least once in the past they had been -- a leverage had been applied to them in one of the four forms listed above. And about half of these patients said that two or more forms of leverage had been applied to them in the past; if one form of leverage didn't work people often added on other forms of leverage.

There is not the time to look at research

on all these different forms of leverage. Let me concentrate my remarks briefly on outpatient commitment, the one form of leverage that I think is most controversial. I think -- I think it's fair to say that the evidence on the effectiveness on outpatient commitment is mixed. So for example, the Cochrane Collaborative last year, which reviews different research studies, they reviewed outpatient commitment, and for severe, people with severe mental disorder, and said: The evidence found in this review suggests that compulsory community treatment may not be an effective alternative to standard care. And just last month in the Lancet, a study done in the United Kingdom, on what they call community treatment orders, concluded: In a well coordinated -- in well coordinated mental health services, the imposition of compulsory supervision does not reduce the rate of readmission of psychotic patients. We found no support in terms of any reduction in overall hospital admission to justify the significant curtailment of patients' personal liberties.

So I want to be clear that this review and this recent study from England both concluded that what we would call outpatient commitment did not have significant positive effects.

I say mixed because, on the other hand, a

major study funded by the MacArthur Foundation and the New York State Office of Mental Health that was published in a special issue of Psychiatric Services that a number of us were involved in, found different results. We found outpatient commitment to have some positive benefit.

Outpatient commitment in New York, which they call Assisted Outpatient Treatment, which strikes me as a flagrant euphemism, is applied on adults with mental illness who have a history of lack of compliance with treatment, who have been hospitalized 2 or more times within the past 3 years, or have committed one or more acts of serious violence towards self or others within the past 4 years, and the person must be found to be unlikely to voluntarily participate in the outpatient treatment that would enable him or her to live safely in the community.

We found that when we studied outpatient commitment in New York that in New York State, in the year we studied this, there were over 3,000 people on an outpatient commitment order. Approximately 2,000 of those 3,000 people were in New York City. About half the patients were in outpatient commitment for less than one year and about half the patients were in outpatient commitment for more than one year.

Outpatient commitment in New York is enforced by the police. You can hospitalize someone only for 72 hours, and at the end of that 72 hour period they have to be committed as an inpatient if they qualify. They have to sign into the hospital voluntarily or they have to be released. But if people don't show up, people on an outpatient commitment order do not show up for their therapy or their medication, the police are sent. And in the year that we studied New York State, 479 times the police went to people's houses and took them to the hospital. Most of that, 345 times, it was done from New York City.

The main findings of our study of outpatient commitment -- which was not a randomly assigned study, but we had a highly matched statistical control. There were increased medication possession rates in the study. So if you look at patients in the 6 months before they were on outpatient commitment and the first 6 months they were on outpatient commitment to the second 6 months, their rate of having, at least having medication in their possession at least 80 percent of the time increased from 35 percent to 44 percent to 50 percent. So about one of every 3 patients before being on outpatient commitment had medication in their possession, usually in their possession, whereas after

being on outpatient commitment 6 months that went from one out of 3 to one out of 2. You can see on the bottom we statistically controlled for the amount of time they'd been on outpatient commitment, region of New York State they were, their race, their age, and their sex, their diagnosis, and their co-insurance status.

Second, reduced inpatient admissions. We found that before -- this is inpatient admissions per month. Before outpatient commitment, 14 percent of patients were admitted to a hospital every month; for 6 months on outpatient commitment it decreased to 11 percent; the second 6 months it decreased to 9 percent, which was statistically significant. And you can see we control the same variables that are on the bottom. Reduced not just inpatient admissions but the total number of days that the person on outpatient commitment spent in the hospital during a 6 month period. Before people were on outpatient commitment they spent 18, an average 18 days in the 6 month period in a psychiatric facility; in the first 6 months on outpatient commitment, they spent 11 days; in the second 6 months, they spent 10 days on average in the hospital.

We also had reduced rates of arrest. This is the percent of people who are arrested per month. The arrest rate was low for any patients, but it reduced

by approximately half, from 3.7 percent of the amount of people arrested to 1.9 percent after an outpatient commitment, again controlling for age, sex, race, region, education, and diagnosis.

In addition, we found no significant differences between the patients on outpatient commitment and patients with similar diagnoses who were not on outpatient commitment in terms of the amount of coercion they perceived in their treatment, their working alliance with their primary care clinician, how satisfied they were with treatment, or how satisfied they were with their life in general. And if the person was on an outpatient commitment order for 12 months or more, the benefits that are listed above continued even after the outpatient commitment order was lifted.

A final controversial issue on outpatient commitment in New York is the question, is outpatient commitment racially discriminatory, a study done by Jeffrey Swanson and his colleagues. The charge was, by the New York Lawyers for the Public Interest and Advocacy Group, that blacks were nearly 5 times as likely as whites to be subject, the subject of court orders stemming from Kendra's Law, assisted outpatient treatment. It's important to know if our mental health policy is disproportionately taking away the freedom of

groups of people who have historically been oppressed.

The analysis that Swanson and his colleagues did was, if you look at the whole New York State population it's about 16 percent African American, whereas if you look at the people on outpatient commitment, 44 percent of the patients of New York, in outpatient commitment in New York State, were on outpatient commitment. So there seems to be a clear disparity.

The approach taken in the article by Swanson et al., however, said it depends on what you mean by the denominator. Racial disparity indexes in New York County, which is to say Manhattan, the ratio of outpatient commitment rates for African Americans compared with whites using different denominators. If you look at the whole county population of Manhattan, African Americans are 7 times more likely to be on outpatient commitment than whites. An extraordinary overrepresentation.

If you look, though, at the rates of outpatient commitment among people with diagnosed serious mental illness, then the disparity between African Americans and whites goes down from 7 to 1 to 4 to 1, still very substantial. If you look at people with serious mental illness in Manhattan who are receiving

mental health, public mental health services from the Office of Mental Health, it goes down further. African Americans are twice as likely to be represented. If you look at people in Manhattan with serious mental illness who receive public mental health services and who have been hospitalized in the past year, the rate there is also 2 to 1. However, if you look at people in Manhattan with serious mental illness who have been involuntarily hospitalized in the past year, you find almost no disparity. African Americans are 10 percent more likely to be on outpatient commitment than whites.

So the conclusion drawn in this article was as follows. The position taken here was that the question of racial disparity in outpatient commitment is unambiguous; is the disparity in access to treatment, treatment being a public good that outpatient -- that African Americans received much more treatment for serious mental illness than did whites. Or do we look at disparity and limitations on personal liberty, which is clearly a public ban, and conclude that African Americans are -- leverage is being applied more to African Americans than to white people.

It may be that one's interpretation of the previous question might depend on the assumed baseline situation. If the baseline was hospitalization,

that African Americans were being more likely to be involuntarily hospitalized in institutions, then one could look at outpatient commitment as a less restrictive alternative. It's coercive, but it's less coercive than is being hospitalized. On the other hand, if you look at the open community of the baseline situation, people being free to accept or to reject mental health services if they wish, then outpatient commitment is clearly initiating coercion.

The findings suggest that the source of overrepresentation of African Americans on outpatient commitment in New York State, may, the word used in the article was lie upstream from the decision to refer somebody to outpatient commitment. It may be nested within the organization and financing of care in the public mental health system such that African Americans are much more likely to receive mental health care if they receive it in a public than in a private mental health system, and they're much more likely to receive it in an institution than in the community. At least that's the point of view expressed in the article.

And that is what I have to say about mandated treatment. All the references for all the studies that I mentioned and many other studies that were conducted by the MacArthur Foundation were updated this

morning and were put on this Web site.
So thank you very much.
MR. JACKSON: Thank you.
Questions, comments?
Mr. Sullivan.
MR. SULLIVAN: In the studies it appeared you have rehospitalization. Was any consideration given as to the reasons for the rehospitalization between the two groups; i.e., was there more violence or threats of violence to themselves or others involved in one group than the other?
MR. MONAHAN: We just -- no is the answer. We just looked at whether people were hospitalized -- and New York State doesn't make that distinction between -- you can be hospitalized simply for need for hospitalization. It doesn't make the distinction between danger to self and danger to others as clearly as many other states do.
MR. SULLIVAN: The reason I ask is my experience in policing is normally when we run into people with mental health issues, when they're off their meds, it's usually because they're either threatening harm to themselves or some other person. That's why I was wondering about that comparison. But it wasn't done. Thank you.

MR. MONAHAN: Right. Correct, it wasn't done. It is the case that the vast majority of involuntary commitments of people with mental illness are for self rather than for danger to others.
MS. FLAHERTY: I have a couple of questions and a couple of comments.
One, I'm wondering, in the Duke study, one of the things that you called as a main finding was there were no significant differences between the AOT and non-AOT recipients in the perceived coercion, the working alliance --
MR. MONAHAN: Yes.
MS. FLAHERTY: -- the treatment satisfaction, the life satisfaction. Did you study whether people were actually recalled to hospital who were on the AOT orders and -- because one of the concerns that, as mental advocates, whether a recovery-oriented system that really engages people in voluntary care rather than imposing coercive care and this mandatory leverage is a real concern.
And supportive housing, this was an issue that came up last week, where housing isn't used as leverage because, as you point out, in Connecticut this is a real particular issue, people who are on benefits can't afford housing, especially in a high cost area as

Connecticut. And I just want to point out in terms of the rep payee, Social Security can certainly require somebody to have a rep payee when they believe they can't manage their benefits, and have put people through continuing disability reviews. If they feel they can't -- that their condition either has improved or if they're not cooperating with treatment, they won't have the medical evidence to show that they continue to be disabled.
That's it. Thanks.
MR. MONAHAN: Okay. In respect to the first question, we did indeed, on the scales that have been previously developed, the scale of perceived coercion, we found no difference overall in perceived coercion between people on outpatient commitment whether or not they had been recalled at some point to the hospital, and other people, the comparison group.
Now, part of that reason may that be a lot of people in, quote, voluntary, quote, treatment, leverage is applied, but not by the mental health system or by the legal system. Leverage is applied, for example, by their parents or by their spouse, who tells them, I can't take this anymore, you either get treatment or I'm leaving. So that may increase perceived coercion. The individual may not perceive the choice of

hospitalization to be entirely voluntary in those circumstances. But it is not legally coerced.
So many patients who wanted to get good services, they got good services on outpatient commitment and they were satisfied with the treatment they got. So I think that there's no question that if people are viewed as in need of treatment then they will voluntarily seek treatment, that that is for many, many points of view, preferable, the best of all possible worlds.
But at least in our study of the people on outpatient commitment, we did not find many differences along the lines that I indicated.
It is the case also in some areas like in New York State, for example, in terms of housing, people were frequently threatened with eviction if they didn't go to treatment. But as to whether people were actually ever put out on the street when not going to treatment, I think that that happened very, very infrequently. I was told by one person I interviewed, by one housing provider, that there would be ten years of litigation before they could put anybody out on the street. So how often or if it ever happened, I don't know. But it was frequently used as a threat.
MR. GRIFFITH: Professor Monahan, this is Ezra Griffith. I hope you don't mind if you and I go

over -- I'd like to go over with you the, at least the first two findings or three findings with respect to the violence --

MR. MONAHAN: Yeah, sure.

MR. GRIFFITH: -- because there are lots of people at home who I know are watching this and interested in these data and the conclusions drawn from them, and I'd like to go over it slowly, because it's so simple and so elegantly done I'd like to be sure that we really grasp in essence what you said.

So look at number 1.

MR. MONAHAN: Just one second. This is on violence, okay. Yup.

MR. GRIFFITH: This is the mental illness and violence.

MR. MONAHAN: Mental illness plays a very small role in American violence.

MR. GRIFFITH: You're saying in these findings that even if we treated all the violence within people with psychiatric disorders, that we would still be only dealing with 4 percent? The outcome --

MR. MONAHAN: Not that the amount of violence --

MR. GRIFFITH: Go ahead.

MR. MONAHAN: Yes, it is only 4 percent

of violence. The great majority of violence in American society is caused, is robbery, for example, and has nothing to do with mental illness. Substance abuse has a vastly higher correlation with violence than does mental illness. That's not to say that, I mean, a 4 percent reduction in violence would be extremely welcome. But it's not as if the key to preventing violence in American society is violence by people with mental illness.

MR. GRIFFITH: All right. So then, then in the next one, number 2 -- and I wasn't sure that you explained this clearly because the heading alone leads us to potential confusion. So for the people with mental illness there is still, there is still some potential for violence in the American scene. And you --

MR. MONAHAN: There is.

MR. GRIFFITH: Right. But I still -- so that's about 11 percent, you're saying, among the people with mental illness?

MR. MONAHAN: Among the people with mental illness discharged from those short-term hospitals, about 11 percent of those people committed a violent act within the next several months, which was twice as high as the comparison group. However, as I pointed out, it's the substance abuse which makes a huge difference.

MR. GRIFFITH: For that group.

But now what's the --

MR. MONAHAN: Substance abuse, abusing substances is clearly not good for anybody. But it has more of an effect on people with mental illness for whatever reason. Perhaps it's some form of medication or perhaps the substance abuse exacerbates their psychiatric symptoms. But it's higher for people with mental illness. And I think the really complicating factor is that even after people with mental illness are discharged from psychiatric facilities, a lot of them are still abusing substances in the community, and that is the single thing that I think where more clinical intervention is needed.

MR. GRIFFITH: How do you get the difference between the 4 percent in number 1 and the 11 percent in number 2? I want to be sure that that's clear so that people aren't going to be confused about it.

MR. MONAHAN: Right.

MR. GRIFFITH: Is the 4 percent, is it overall society, versus the 11 percent --

MR. MONAHAN: Right, right.

MR. GRIFFITH: -- discharged from the hospital?

MR. MONAHAN: Yes. Correct. The 4

percent is overall in American society, including all of the liquor store robberies, for example, which people with mental illness tend not to do. That's only 4 percent of the violence in American society overall is attributable to mental illness. But of the very small portion of the American population that is in hospitals, in psychiatric facilities, when they get out, for the first several months those people are more likely to be violent. And it strikes me that advocacy groups for people with mental illness are sometimes disingenuous to claim that there's no relationship whatsoever between mental illness and violence. I think the relationship, as I say here, is modest, and is easily overstated by the general public, but I think that denying any relationship is not productive.

MR. GRIFFITH: Right. And in the 4 percent, is it reasonable to conclude that a certain percentage of those would be involved also with the use of substances, so that 4 percent could be reduced even more? Am I being clear in my question?

MR. MONAHAN: I think, well, yeah, I think if you could somehow eliminate the substance abuse on the part of people with mental illness, would that 4 percent of violence go down, yeah, I certainly believe it would.

MR. GRIFFITH: All right. So I wanted to go over those with you. And then come back to the business of the mandated community treatment.

MR. MONAHAN: Yeah.

MR. GRIFFITH: So if the violence -- I'm just trying to understand now how we in the professional business, how we got into this linkage.

If the outpatients -- sorry. Let me start with a different predicate.

If the violence is in fact so low, the preoccupation with the use of outpatient, involuntary outpatient commitment, that really doesn't have much to do with violence, does it? I mean, the argument for it? Or should the argument really be a direction for treatment of these particular people that are difficult, their difficulties in staying in treatment. But it isn't necessarily linked to violence. Or do I get it wrong? I don't want to misinterpret.

MR. MONAHAN: No. No, I think the way you said it is exactly right. I think in the best of all possible worlds, the concern for some people with mental illness, who indeed can be difficult patients, that the argument about outpatient commitment should be focused on those people's mental illness and then treating those people's mental illness. The unfortunate fact of the

matter appears to be that the general public is frequently concerned about -- very concerned about violence, and I think that the concern is that people are likely to increase mental illness services, if part of their reasoning has to do with violence, than if it's just for the patients' benefits themselves.

I think that has always been the case. You can find references to the relationship of mental illness and violence in ancient Greek and Roman literature. The first mental hospital in the American colonies was founded by no lesser like than Benjamin Franklin, who first argued before the Pennsylvania colony that treatment should be provided to people with mental illness for humanitarian reasons because they were in pain. He was told that the resources weren't available. He came back in the next session and argued that people with mental illness were, quote, a terror to their neighbors, who are daily apprehensive of the violences they may commit, close quote. If you go to Philadelphia now, the treatment facility that was built at that time still stands.

So the issue is, I think, that violence is not irrelevant to outpatient commitment, but I think the main argument is and should be along the lines of does this help patients with serious mental illness.

MR. GRIFFITH: Thank you.

MR. SCHWARTZ: Hi. Thanks. I have a couple of questions.

Following up on Dr. Griffith's line of inquiry, so in the MacArthur study, in the MacArthur study, if 11 percent of individuals engaged in a violent act in the first few months following discharge, can we get back to the question that I've asked you previously, about the Neilson article in the Schizophrenia Bulletin which looked at individuals with psychotic disorder in the period of before treatment, leading up to the first hospitalization. These are significantly different populations, I think. And can you comment on the findings of that Neilson article?

MR. MONAHAN: As I recall that article, which was done on studies outside the United States, that in the period preceding first hospitalization, before many people were treated at all, there were significantly increased rates of violence to others.

MR. SCHWARTZ: Yes. In fact, and the particular violence that they were studying was the committing homicide. So in fact, the actual findings of the study, if they had looked at other forms of violence, undoubtedly would have been much higher, since homicide is a very extreme violence bar to pass. And if I read

that article correctly, individuals with untreated psychosis in that period of a year leading up to the first hospitalization actually had a rate of committing homicide that was 15 times greater than the rate of the normal population. Can you comment on that?

MR. MONAHAN: I believe that's true. Neilson and his colleagues actually studied many different forms of violence, and I think that they've done a tremendous job in doing that. 15 times higher is true, but the base rate, of course, of committing homicide is extremely low. Neilson also concluded that, as I mentioned before, only 1 out of every 140,000 people with schizophrenia commit homicide of a stranger, and clearly concluded that that is so rare that those kinds of violent acts can't be predicted on an individual case.

And I have no doubt that both those conclusions are true, that homicide by people with untreated mental illness are higher, much higher than the general population, but still as a percentage of people with schizophrenia, quite low.

MR. SCHWARTZ: And I have no doubt that both of those lines of reasoning are true also. I want to make it clear that I'm not trying to make an argument that the relationship -- that the violence problem in America that we're facing is related to mental illness.

I just want to support, however, a comment that you had made earlier, that it is somewhat disingenuous to continue to quote the 4 percent rate as evidence that there is no relationship between mental illness and violence because the percentage of overall violent acts that individuals with mental illness may commit is a very, very different perspective than the risk of violence that any particular individuals with mental illness may present. And I think that the Neilson article, for instance, that we were just discussing, approaches that issue in a somewhat more, you know, appropriate fashion.

I want to move on also to the outpatient commitment. The MacArthur study -- I'm sorry, not the MacArthur. The New York Assisted Outpatient Treatment Study compared individuals who were in assisted outpatient treatment with individuals who were in entirely voluntary situations. They were outside of the hospital and they could either accept treatment or not, as they chose. Is that an accurate description?

MR. MONAHAN: We had a number of different control groups in that study. We looked at each person as his or her own control, looking at them before they were in outpatient commitment at all, and then we looked at people who were getting mental health

services, enhanced mental health services on a voluntary basis in New York, and other comparisons. We looked at people with mental illness regardless of whether they got any treatment. And the main findings are the ones that I gave.

MR. SCHWARTZ: The Lancet article which you have quoted and have on the slide by Burns, however, compared a group that was essentially in what we would call assisted outpatient treatment or outpatient commitment program, they have a different term for it in Great Britain, with essentially a control group that was on what, in Great Britain, is known as conditional leave. This is a population of folks who are hospitalized, discharged to the community, but who can be rehospitalized if it is felt that they need to be brought back into the hospital. Is that correct?

MR. MONAHAN: I think that procedures in the United Kingdom for rehospitalization may not be the same as here. I have communicated with the author of that study. They estimate in that study -- they use some of our same instruments. And I believe it's fair to say that his view is that conditional discharge is not a comparable form of coercive hospitalization. I know other people who don't take that view.

MR. SCHWARTZ: I guess my point is it's

hard to distinguish, reading the article, as to whether it is a comparable form of coercive treatment. But it is a form of coercive treatment in that the hospitalizing authorities do have some capacity to involuntarily call the individual from the community back into hospital if the individual, under a set of circumstances that really aren't delineated in the article, whether it's noncompliance with treatment or clinical deterioration, we really can't tell, but the patient remains within a regulatory atmosphere that has a degree of coercion in it which would not compare, for instance, to a situation, say, here, in most of our outpatient treatment permitting states, in which the choice is between outpatient commitment and an entirely free or noncoercive situation, outpatient treatment situation for the patient. Am I characterizing that correctly?

MR. MONAHAN: I, I don't know. You're referring, I think, to Section 17 of the British Mental Health Code, which is, it's not -- you may actually be right, but I have nothing to add to that discussion. I hope that in the future that issue, the issue that you raised, which has been raised much in recent weeks about Dr. Burns' article, that becomes clarified in the literature.

MR. SCHWARTZ: That would be useful.

MR. JACKSON: Thank you. I'm going to jump in just for a moment for clarification along these same lines.

The Lancet article utilized certain data points. The Cochrane Collaboration is an international collaboration as well. So if you'll take a look at the way mental health services are delivered internationally versus the way that they are delivered in most parts of the United States, is there any, is there any more local comparison to your study in New York State that utilizes data points from here in America that we can wash away some of these potential conflicts?

MR. MONAHAN: The two other American studies that are cited very often are one that was done by Henry Sabin and his colleagues in New York City, at the Bellevue Hospital. That did not find a statistically significant effect for outpatient commitment.

The second was done by some of the same researchers I mentioned before at Duke. Morton Schwartz and Jeffrey Fortin, in North Carolina. They did have randomized control trial and they did find many significant developments, many significant benefits to outpatient commitment.

No study is perfect. And the Bellevue study, many of the psychiatrists participating in the

study did not understand that some of their patients were on outpatient commitment. It's not clear how many of the patients knew they were on outpatient commitment. And in terms of North Carolina, it's very difficult to maintain a random assignment throughout the process of a real world study. So I think that the North Carolina study found significantly positive effects. The New York study I just mentioned did. Other studies in the U.S. like the Bellevue study did not, and a number of international studies did not find positive effects. And that's just the state of the research.

MR. JACKSON: Thank you.

Ms. Flaherty?

MS. FLAHERTY: I just want to make sure, frankly, that I understand the numbers between -- if you go back to the two findings in the violence study, the 4 percent and the 11 percent, whether we're talking about folks after they've been hospitalized or the folks that Dr. Schwartz mentioned, before they're hospitalized, that all the violence committed by people with mental health issues accounts for 4 percent of the total violence in the United States. And the folks after discharge, 11 percent of them committed violent acts. Is that correct?

MR. MONAHAN: Both statements are correct.

MS. FLAHERTY: Thank you.

MR. MONAHAN: Both statements you made are correct.

MS. FLAHERTY: Thanks very much.

MR. JACKSON: Other comments, questions? Thank you very much.

MR. MONAHAN: Okay. My colleague, Richard Bonnie, has some --

MR. JACKSON: Yes, Professor Bonnie.

MR. MONAHAN: -- comments at whatever point you're ready.

MR. JACKSON: We are happy to see you again, sir, and look forward to your presentation. Thank you.

MR. BONNIE: Thank you.

Well, I want to thank you for inviting me to appear before you, so to speak, again today. I am really willing to discuss anything that I can make a contribution to in terms of the issues that you're thinking about. I have a couple of observations that I can make now that reflect on the statements that John Monahan made and your discussions with him. And I can make some broad comments about the role of coercion in a contemporary mental health system, which I understand obviously is a set of issues that you have to address.

I'm going to try to keep it short and try to then be as useful as I can in whatever areas you want to pursue.

So I want to give my own take, first of all, on the need, the challenge that all of us who are charged with thinking about mental health law and mental health -- and the role of law in mental health policy, to take into account the population perspective, on the one hand, and the individual level, so clinical perspective, on the other. And I think I can -- I think the threads, both of those threads have been woven in the presentation that John made, and in your questions.

And so my -- the observations I want to make about this are entirely unscientific. It's just based on, you know, hearing the challenge, I think, that you have before you of trying to take both of these things into account in making policy.

So first, with regard to the kind of a population level and the prevalence of violence in society and the attributed risk to mental illness. So I think that, obviously, that the observations that we heard in kind of the 4 percent figure are extremely important in counteracting the challenge that I mentioned even the first time that we, that I addressed you, on the concerns that any particular, you know, violent episode that might, you know, be related to mental illness, the

messages that that may send that completely exaggerate the relationship between mental illness and violence, and increase the risk of statementization, and have a lot of, you know, consequences if it's not corrected in terms of public understanding that actually can undermine sensible, you know, mental health policy. And I think all of us obviously are concerned about that, and it is important to sort of have that point, you know, in mind.

At the same time, even from a population point of view, I think that the observation that Paul Appelbaum made and that John properly invoked in his comments needs to have an addendum attached to it. So Paul's point, absolutely correctly is that, you know, we shouldn't be thinking about and selling, you know, investments in mental health services as a violence reduction strategy, because that obviously plays in, you know, to the exact kinds of public misunderstandings and fears that we have to be worried about. But on the other hand, violence in society is -- one thing we know is that there are many risk factors and there are many causal influences, many contributing influences.

And so when you're thinking about, you know, large public policy making a contribution, you know, whether it's gun control or whether it's investing in the treatment of people with mental illness, substance

abuse problems certainly become comorbid conditions. You know, one of the beneficial effects that maybe can't be measured, you know, precisely in public, in epidemiologic studies, but that one of the contributions that that can make is to reduce all of the social costs of untreated mental illness of which, you know, aggression and violence is one, even though it's only one of the many things that we would be trying to address.

So prevention, investments in prevention of all kinds, including the prevention that is attributable to providing treatment and early intervention for people with mental health problems, is designed to prevent many more social morbidities and social cost that are attributable to untreated mental illness.

So the point that Paul made and that John reinforced is that there are many other reasons that we need to invest in the treatment of untreated mental illness in society. But I think it's important to include in that, to whatever extent, that there's elevated risk of people under certain circumstances relating to deterioration of their condition related to mental illness. To whatever extent that is so, that is one of the reasons that, that we should make that investment.

Now, I don't think I've said anything controversial, but I think that it is worth, you know, putting that point in context.

The second point is to address the issue about elevated risk itself. So all the data, you know, do emphasize that when you look at this from the standpoint of, you know, the individual person, and the individual condition under particular circumstances, as every clinician does and every family member does when a loved one is, you know, their condition is deteriorating and they seem to be losing control, the immediate -- the concerns naturally that people have under those circumstances, among other things, do relate to the possibility that during loss of control, suicide, suicidal acts may occur, which of course, as John pointed out, from a statistical standpoint is much the larger concern.

But also, you know, having spent many, many years, you know, listening and thinking about the experiences that individual families have had with, you know, mental illness and issues relating to mental illness of a loved one, you know, there is elevated risk and people have reasons for being concerned. And so when we look at it from that point of view, that's the other set of challenges that we have in mental health law,

putting the epidemiologic story, you know, picture aside, that sensible public policy and sensible mental health policy obviously has to respond sensibly to periods and situations of elevated risk.

And that's what the law of civil commitment itself is about. That's what the issues relating to reducing risk factors that may be attributable of course to the access to a firearm when there are periods of elevated risk. Connecticut, you know, has a law that should be a model, you know, to the nation in terms of intervention during a period of elevated risk to reduce access to firearms. You know, putting aside all the challenges that we have about registries and, you know, sort of longer term, you know, concerns -- and I don't want to necessarily take the conversation in that direction. I think, though, that responding sensibly to periods of elevated risk is obviously one of the important social purposes of, you know, of the laws that we're talking about. And of course in that context, mandated community or mandated outpatient treatment or outpatient commitment, we call it mandatory outpatient treatment in Virginia, MOT, you know, is part, you know, of the conversation. So, and I'll offer some comments about outpatient commitment in terms of the way that we have been thinking about that in

Virginia.

So that's my, just some general thoughts about the people, the challenge we had in making policy here, to keep in mind the population perspective in order to correct public misunderstandings, correct impressions about, you know, the relationship between mental illness and violence. But at the same time respond in a sensible way to the challenges of appropriate societal interventions during periods of elevated risk.

Now, the other thing I thought I would say, just by way of, you know, general introduction to my comments, is the perspective that, as, that we took in the work of our commission to try to frame the role of coercion in a contemporary system of modern mental health services that is grounded in a recovery-oriented perspective. And I know that's precisely the kind of challenge that you are facing, and for whatever it's worth I thought I would, you know, share with you just some comments that I made immediately after the Virginia Tech shootings in trying, because we had the opportunity for public education, you know, that I described to you in the first time I spoke with you, and, you know, I do think, as all your comments and questions seem, you know, to certainly indicate, that we know that there are multiple audiences for the work that you are doing in

public education, and understanding is certainly critical. So trying to help people understand, you know, the role, the limited role, but important role, an essential role, that coercion plays, you know, in modern public health law is important.

So I spent a lot of time in doing the work that we did to try to get the talking point on this, you know, right. And I just am going to share with you the comments that I made, you know, at that time, trying to reach -- rather than trying to restate them. Here, this will take, you know, about 60 seconds, right, but let me just, you know, say this and then it will show the direction in which -- if you want to hear more about the specifics about what we have tried to do here and what my own views are, I can provide them for you.

So here's the excerpt: As we begin our deliberations at this time, it's important to remind ourselves of the commission's charge and its goals. To boil it down in a few words, the reforms that we propose should meet the following test. They should help people with mental health problems, mental health problems, get the help they need when they need it so that mental health crises can be prevented or ameliorated, and that suffering and injury can be avoided.

This overall goal can be achieved most

successfully by fostering a climate of caring and respect for people who need help, by reducing stigmatization, and by engaging people voluntarily in accessible recovery-oriented services over which they have a meaningful measure of control. Conversely, this goal can be fatally undermined if there are major gaps in services or if the system is perceived as unduly coercive and drives people away from treatment rather than drawing them into it.

The principles of voluntariness, respect, and self determination must always be kept at the very forefront of our thinking. At the same time, though, coercion is sometimes necessary. Our reforms must therefore assure that involuntary treatment, while being used only when necessary, occurs expeditiously and effectively when it is necessary. And the process of initiating, authorizing, and carrying out the involuntary treatment must always of course be fair and respectful to the people with mental illness.

That's the end of the particular quotation.

I think what that framing does is sketch out the two agendas, I think, for modern mental health reform. One is laying a good and strong legal foundation for the recovery-oriented patient-centered kind of

services that we ultimately want to create that draws people into the system rather than having to rely on pushing them into the system. And a second -- reforms, I think, flow from that, and they're not inconsistent, recognizing that there's a residual role for coercion, and perhaps leverage, as well, through the criminal justice system, although I have to say I'm not focusing on that here.

And so just to tick off a few things that we thought were absolutely critical -- I don't know what Connecticut law is on the issues I'm about to mention, but I'll just again note that in terms of the strategy that we adopted, they were absolutely critical.

So one was to put a system for facilitating advanced directives and empowerment for people in the mental health system in place, and not only adopting a law which would provide the authority for people to do that, but would also take it into the services system and try to make the execution and use, utilization of advanced directives a part of routine care. And we are in -- there are many obstacles to doing that successfully, but it was absolutely a core set of the strategy that all the stakeholder groups, you know, strongly supported, and we are, you know, continuing to try to make steps in that direction.

And again, I think the important thing here is that it's a legal foundation for the kind of services system that I think we all are ultimately aiming for and reinforce that. And of course there is evidence that the use of advanced directives and the execution of advanced directives promotes engagement and treatment and ultimately can reduce crises and reduce the need for coercion when there are crises. And building on that foundation, we are moving forward.

In addition, another important aspect of what we were trying to do is to assure that -- to try to minimize the use of the formal indicia of coercion, largely law enforcement, in the mental health system. And so providing alternative mechanisms of transportation, for example, is a critical part for people that are in crises. There ought to be alternative ways. Now, again, I don't know what the situation is in Connecticut. It was a serious problem here because there's so many financial incentives, essentially, that to use police transportation, that that tends to reinforce the connection between mental illness and the perception that there's a social threat, and kind of reinforces all the understandings that we're trying to erase, criminalization of mental illness and also indicia of violations of human dignity. So trying to minimize

the role of law enforcement in mental health crisis response is an important part of what we're trying to do, and there are a number of different angles to go at it. The major challenge, frankly, isn't the legal principle, but finding the resources in order to be able to do it successfully. So that was another part of what we were doing.

And then the third, I'll mention also, is that even when people are experiencing coercion, because it may be a case in which some form of coercion is necessary, the basic principle was that even when coercion is being used, it should be used in a way that is as respectful of the person's prerogative as possible and maximizes the range of choices and self determination that remain. So it shouldn't be basically obviously an all-in-one situation that you're using coercion or not.

So in looking at all the various practices relating to mandatory outpatient treatment, as well as inpatient admission, try to preserve, you know, the maximum room for respect and for allowing people to play a role in their own treatment and their own control.

And again, this was all reinforced by the work of the MacArthur network when it addressed coercion, which emphasized, at a very basic level, that treating people fairly is -- ultimately contributes to successful

outcomes.

So those were some of the issues that we emphasized in connection with the empowerment end of the challenge. The others of course related to the appropriate use of coercion, and we did obviously give a lot of thought to mandatory outpatient treatment. And let me just make a few comments about that and then I will see what direction you would like to take the discussion in.

So the first thing to be said, and this was emphasized in John's remarks and I know that you're aware of it, that obviously availability of services, adequate services, is a necessary condition for any successful use of mandatory outpatient treatment. Obviously there's a point of view that if you actually make the investment in services in the way that I've just said, that you will reduce the need for mandatory outpatient treatment, and I believe that to be true. You know, obviously, you know, in my view and certainly in our commission's view it will not eliminate it. There, again, what you would be trying to do is to reduce the number of cases for which such interventions are necessary.

Secondly, we decided, even though I think in principle everyone accepted the idea that there is a

subset of persons with mental illness, given their histories, that for whom mandatory outpatient treatment serves a useful role. But the -- there's so many challenges of course in terms of providing the available services, and also defining the criteria properly and then administering it properly, that we wanted to take a step by step approach to this. And so the first step that was taken was to think about increasing the use of mandatory outpatient treatment essentially as a less restrictive alternative to inpatient admission. Obviously that, there's, you know, it is a subset of cases for whom, for the patients for whom that would be appropriate. We didn't expect it to be a large number, but nonetheless if they all are able to become stabilized, somewhat stabilized in connection with the short-term emergency hospitalization, and are agreeable, you know, to, you know, a release, essentially, that's based on their willingness to comply with mandatory outpatient treatment orders, there may be some set of cases for whom that's appropriate. Again, it depends on really what the clinical course is and what the level of stabilization within the short-term hospitalization is.

I mention that because we have one jurisdiction in the state that is actually using this. I mean, you know, I'm sure many of you, the psychiatrists

in particular, but that's not going to apply to a whole lot of people if you're just really talking about alternative to inpatient commitment based only on the period of the emergency hospitalization. But we do have one jurisdiction that has actually been doing it this way, and they conduct an evaluation at the very moment before the hearing, essentially. That may be a slight exaggeration. But at the last -- you know, they try to do it as close to the hearing as they can, so a good clinical judgment can be made about the level of stabilization. And they find that there are some occasions for which the mandatory outpatient treatment order, you know, seems to serve a useful clinical purpose. And they were using it in that way.

The other step that we took was to begin a process of authorizing what we call step-down mandatory outpatient treatment, which is analogous to the conditional discharge. But to -- and I would remind you that in the New York study, most of the cases involving assisted outpatient treatment that had occurred in New York in the wake of Kendra's Law were step-down mandatory outpatient treatment or assisted outpatient treatment rather than up front, you know, for a person who was not already hospitalized.

So in a gradual way over time we have

introduced the use of the step-down commitment for people that meet the kind of criteria that are in Kendra's Law, at least to hospitalizations within the last three years. And that where the criteria aren't -- our normal commitment criteria, for example, are a substantial probability of violent -- or harm to self or others, conduct that presents a risk of to self or others within the near future, which is our basic commitment criteria. It doesn't require, obviously, proof of that. It is based on history and the prevention of relapse in the period immediately following hospitalization.

So we have put that in place, but the -- there are obviously many constraints on the use of that authority after the person is released. We don't have enough history at this point, you know, to, you know, present any data about, about what the effects of it have been.

But we chose to take a gradual approach to this issue where there was the greatest consensus. And the first was, of course, the up front commitment basically as a less restrictive alternative without adopting a wider array of criteria for a person who doesn't yet meet the inpatient commitment criteria. And the second was a wider array of criteria that, at the step-down phase, that takes into account what we all

know, which is that the periods of hospitalization themselves, you know, are often, you know, shorter than may be ideal in terms of promoting, you know, stabilization and so on, and that there may be a period of higher risk of relapse in the community thereafter. And of course for patients with a history of relapse, that providing, you know, the court order to try to promote compliance with treatment, you know, can serve a useful purpose.

Again, I'll just close by saying, you know, we tried to, you know, make sure everybody understood that this was for a small subset of patients, and that there was a common understanding of what we were trying to accomplish by these interventions. But numbers of them, since these have been put in place, are small. One of the reasons that it's small is that resources are so, you know, inadequate to do it on any, you know, more substantial scale than it's being done. But they were also meant to be small in order to be able to kind of, to study the effects of doing this on a step by step basis.

So those are some general thoughts about mandatory outpatient treatment and a little bit of an account of what we have done here.

MR. JACKSON: Thank you.

Questions for Professor Bonnie?

Dr. Schonfeld.

MR. SCHONFELD: This is a question not just to the two speakers but really to the overall commission.

I mean, the point was made that we need to think about the charge of the commission. And so I -- and I think we've talked about this before, but I think in this context it's useful to ask: What questions is this commission charged related to the question of involuntary treatment?

And so I think there was a presumption by some people that school crisis events similar to the one we're named after are somehow attributable to mental illness. I think that's a presumption that we need to first challenge. So there is the very important question, but perhaps outside of the purview of this group, about how we would design involuntary treatment for mental illness. But I think that's really predicated on the question whether involuntary treatment for mental illness has really anything to do with changing the attributable risk of school crisis events such as the one we were formed to address.

So part of that has to do with how broad do we want to make the charge of this group. But I think before we go into more specifics about the -- because

this sounds like -- it's a very critical and important and complicated topic, but I don't know how relevant the specifics are going to be to our group, because I think that -- I doubt our commission is going to come out with recommendations to remove necessary involuntary treatment for mental illness. I don't think that would be a conclusion we would reach. And I don't see that there is any evidence that furthering involuntary treatment for severe mental illness will prevent other significant numbers of school crisis events. So I'm questioning where we should be going with this.

MR. SCHWARTZ: As I read the charge, I don't think that the charge was written in such a way that we are -- we were being asked to limit our inquiry or discussion specifically to changes in the mental health system or improvements in the mental health system that could reduce the risk of what you're calling the school crisis events.

In fact, if we wanted to narrow school crisis event to mass shootings, I think if we interpreted our charge as what are the kinds of things that we might recommend in terms of changes to the mental health system that could reduce the risk of such mass shootings, we'd have a pretty quick inquiry into this, and rapidly conclude, assuming that Professors Bonnie and Monahan

would agree, that nothing in the recommendations or the discussion that we've had so far could actually be thought to address reduction of that specific risk.

But I think the charge reads in a broader way, and I think that we have an opportunity to think of it in a broader way. So I don't remember, recall if it was Professor Monahan or Bonnie, I think it was Professor Bonnie who suggested that to the degree to which, with regard to violence in general, we make enhancements by improving the mental health systems to the overall social morbidities that attach, you know, to mental illness, then we may make some minor or modest incremental enhancement with regard to the social morbidity of violence that individuals with mental illness, you know, might perpetrate, along with all others without mental illness. And if that were the case, you know, that would be good.

I think, as part of enhancements to the overall mental health system, looking to the social morbidities that might attach to mental illness, that examining the coercive elements of treatment along with examining other larger issues such as resources is a thing that we reasonably can do and we reasonably can make recommendations about.

MR. GRIFFITH: I just want to add, in

response to your important question, that I was charged with discussing with our two presenters this morning what they might talk about, and our, what we thought was important. And I brought up the issue of the mandated outpatient treatment because, not that I -- well, quite simply because going around the state these days, I think that is one of the most important topics of conversation I'm encountering. And this is among legislators, among psychiatrists, and so on. This is a topic at meetings of the Connecticut Psychiatric Society. This is just on everybody's mind. So I thought it made sense, with people who have both the experience as well as the conceptual practice and clarity in their heads, that we would benefit from hearing from them how they thought about it. That's all.

And I think they presented it, as I expected they would, very fairly, balanced, with attention to the research and so on. This is exactly what I wanted. It wasn't -- it was just to inform us because we have to be informed. There's no question in my mind that is one of the hottest topics right now in Connecticut.

And the relevance to the Sandy Hook agenda that got us here, this relevance may be different in different people's mind, but it has nothing to do with

the emphasis with which this particular topic is now coming up in all the conversations.

MR. SCHONFELD: And let me just clarify. I don't mean to in any way say that this isn't a relevant topic or that it isn't an important topic. But I do think in some people's minds there is a presumption that these two -- that the event and what we are now discussing is connected. I just did want to underscore that I am not sure there is as much of a -- there is a significant causal link, and it's important to underscore that.

Whether or not we want to spend -- how we want to devote the time and what issues we want to address, I think is something which the commission does need to explore. But I do want to make sure that we also address the issues that relate more specifically to the event which occurred, which has to do with promoting adjustment and recovery and assistance to those who are in Sandy Hook.

But I think there may be an opportunity to do both, but I think we just -- I just wanted to underscore that I don't think the causal link is there, and I don't want people to infer that, who may be listening to these proceedings.

MR. JACKSON: If I can make one comment

to that.

Based upon the evidence, or the data that's been presented over the last four weeks, the causal links have certainly been debunked. The relationship between mental illness and perpetrating acts of violence has been debunked. I think that one of our -- one of the things that we will need to do is emphasize that these things are in fact delinked. I think that's a critical component of what our deliverables are going to be. So I agree with you entirely. I think we have to be very up front in saying that data demonstrates that there is no link between these items.

Dr. Schwartz?

MR. SCHWARTZ: That being said, I think it's important to remember that we have not yet heard from the police or from the prosecutor in the state of Connecticut, and everything that we know about the perpetrator in Sandy Hook comes to us from the newspaper. And before we definitively conclude anything, I think we have to have that report.

That being said, again, I think that the issues that we have in terms of exploring violence and the fact that we were commissioned following Sandy Hook, we constantly tread a very fine line on the issue of

increasing stigmatization by assuming that because we're having this discussion that there were connections between Sandy Hook and mental illness. It could turn out that the perpetrator in Sandy Hook had a mental illness. We frankly don't know that as a matter of fact. If it turned out that he had the mental illness, we still would not know about the connection, nor could we infer that the mentally ill are a higher risk population for perpetrating such acts. But we still have to consider everything that we possibly can.

Let me ask the gentlemen from Virginia. In reading about the Virginia Tech incident, it appears as though the perpetrator of that incident was actually under an outpatient treatment mandate. Is that a correct interpretation of the facts? I think that there's been some lack of clarify about that.

MR. BONNIE: Yes. The situation there was -- the event occurred in April 2007. As the history began to be uncovered, you know, in the wake of the shootings, it became evident that Mr. Cho had been subject to a civil commitment proceeding in December of 2005 because of a suicidal statement, you know, that he had made, that his roommate was concerned about. And essentially they called the campus police and a temporary detention order was issued, and he was detained overnight

at an acute care hospital, you know, an hour away. And a hearing was actually held the next day. And the judge at the hearing basically, we would call it, committed him to outpatient treatment. The understanding that they had at that time was that he would get in touch with the Cook Counseling Center at Virginia Tech, and, you know, begin some kind of outpatient services.

You can tell just from the way that I said it, it was very informal in terms of the, you know, the agreement, and basically even on the form it said patient agrees, you know, to get in touch with, you know, participate in outpatient treatment. However, it was actually, in terms of the form, it was actually an outpatient commitment. He checked the box finding the commitment criteria, and, you know, this occurred.

Of course what happened was there was no follow-up whatsoever. And what it reveals, as far as we were concerned -- I mean, we had the situation, of course, in doing the kind of inquiry about that particular case, there was a direct connection between some of the -- many of the deficiencies that occurred over the course of the interactions with Cho, including this one and, you know, his condition.

Now, you know, no one can ever say, of course, without 20/20 hindsight that, you know, if this

had been done and something else had been done, or whatever, that the event could have been prevented. But the way I understand the situation, frankly, was there was a missed opportunity, you know, at that time. If there had been a more comprehensive evaluation when he was in the hospital, or had there been a more comprehensive evaluation in connection with the outpatient treatment, the guardedness that was so evident about him, you know, from that point until his death, you know, might have been broken through and then people would have found out about his history that nobody knew anything about, basically, at Virginia Tech. And, you know, obviously you would have had a situation where there may have been treated mental illness rather than untreated mental illness, you know, at that time.

So that was the situation. And as far as we were concerned, it just called attention to many of the problems that we were already studying, including the absence of any enforcement mechanisms in the outpatient commitment system, no monitoring, and so on. And we put all those into effect.

MR. SCHWARTZ: So it was an outpatient commitment that slipped through the cracks. Is that a fair characterization?

MR. BONNIE: That he, his case fell

through the cracks, no doubt. Not only with regard, of course, to this particular use of the civil commitment system, but in all the other ways that I think you're familiar with in terms of the absence of coordination and information sharing, you know, at Virginia Tech.

MR. SCHWARTZ: So I guess the point I would make for the commission is I think in terms of recent mass shootings, by recent I would mean over maybe the last 20 or 30 years, that this is actually the only case I think we know of in which somebody was under anything that would look like what we're talking about as an outpatient commitment. It didn't work. It slipped through the cracks. He slipped through the cracks. It was not effective.

But it raises the question, okay, so if an outpatient commitment could possibly be crafted in such a way that it was effective, might history have been different. Well, who knows. There are so many factors here.

And again, I don't want to be making the argument that we ought to be looking into outpatient commitment specifically as a way to address the kind of thing that happened in Sandy Hook. It is such a rare event that I don't believe any practice we could implement could necessarily predictably prevent it.

At the same time, we have an example before us in which there was an outpatient commitment activity, and I think it's at least worth discussion and consideration of the degree to which it addresses larger mental health needs and possibly in very, very, very rare instances could actually affect extreme situations such as Virginia Tech, Sandy Hook, or any of the other events that may come in the future.

Thank you.

MR. SULLIVAN: I go back periodically and play the governor's charge back so I remember in my mind what he said. I don't think he gave us any limitations on the mental health issues. He spoke about fixing the mental health system, having better access not just for people in need of mental health here, but also access for providers for resources. He gave us a very broad charge on mental health. He didn't necessarily link it all to the Sandy Hook shooting. So I don't think we're really limited to any aspect of discussion or viewpoints we come up with. I think we just have to be very careful at the end that we don't make the linkage because we're looking at something else. I think if we do that we're fulfilling the governor's charge.

MR. JACKSON: Professor Bonnie, you were -- and I'm going to give the full name. You were

chair of Virginia's Commission on Mental Health Law Reform. I think it's important to note that it is -- we're talking about law, we're not talking about the specific treatments that were issued as we look at these laws and these policies. The organization was formed prior to Virginia Tech with a very broad group of participants, including consumers of services and providers of services.

Can you talk a little bit about this very controversial issue and how, during your discussions, the consumers discussed this notion of coercion and whether or not that changed at all following the incident at Virginia Tech.

MR. BONNIE: Well, I can reflect on the question that you asked. Obviously I can't speak for, you know, individual consumers or consumer organizations. I can share my impressions about the consensus-building effort that we undertook. And if I'm repeating something that I said to you the last time, I apologize. I can't remember, you know, exactly what I may have said then.

But I've been involved in mental health law for my career, and, you know, which is decades, and particularly from the standpoint of a kind of an academic mental health lawyer. We are well aware of the kind of -- the finding issues, you know, in this field that

tend to focus on the use of coercion. And so I could have expected, you know, deep, you know, disagreements and arguments about some of these recurrent issues. One is the scope of the commitment criteria for inpatient treatment. Another is the use of mandatory outpatient treatment. That has been on the agenda for at least since the 1980s, because I remember actually working on a report in connection with the American Psychiatric Association, I think, the task force report on that very issue in 1987. The first report that we did in Virginia looking into the use of mandatory outpatient treatment was in 1988. And over time, and of course the commission, you know, we're talking about, you know, 2006, '7, '8, '9, '10, you know. So this I think has been on the agenda for 20 years at least. And of course, as you can tell, a matter that continues to be a controversial one in terms of when if ever is an appropriate intervention.

So I was prepared for this when we constituted our task forces. As I mentioned to you before, I mean, it was certainly the one on civil commitment, we purposely constituted in a way that would draw in all the variations and points of view and the intensity of points of view. In fact, in that particular task force, you know, I urged them, you know, not to

necessarily think that they had to have consensus about everything. I mean, many of the other issues about civil commitment that they had very strong consensus, and the differences in perspective among the stakeholders didn't matter. But I certainly knew on the issues of the commitment criteria and the use of mandatory outpatient treatment that there would be differences of opinion, as well there were.

And then when the, you know, the Tech shootings occurred, and all of a sudden our inquiry kind of exploded into public view, I thought actually it was very important. I mean, all of a sudden the press was there for every one of the task force meetings, much less the commission meetings. And I thought it was very helpful and useful that the differences in opinion about the commitment criteria and the use of mandatory outpatient treatment did, you know, come under public view because there was a process of public education, you know, that was really important there.

Eventually of course the commission did, you know, have to, you know, take a view about it. And, you know, the view paralleled what I suggested to you earlier, kind of a tentative step by step approach. But certainly not thinking of this as, you know, as a panacea for, you know, make your, you know, problems in the

mental health services system, you know -- of course we were about to go into recession. Everybody understood and was concerned that if you put mandatory outpatient treatment, a legal foundation for it, into effect, you know, and you didn't have the resources, you know, to implement it, that it could actually have a counterproductive effect. So, you know, we prevaricated and, you know, delayed things, you know, for a period of time. Overall I think, you know, it has worked well.

Now, on the issues -- in terms of, you know, the gradual approach that we've taken, I mean, I'm kind of pleased with the way things have unfolded in a gradual way.

On the issue of the stakeholder issues. So I think what basically did occur, even though there were, you know, some members of the commission, including, you know, certainly members of the task force, but even members of the commission, you know, who did come from kind of the consumer perspective, that, you know, voted against, you know, some aspects of the changes that we made, frankly, in most contexts they voted for them. Because basically recognizing the underlying sort of point that I made, that there are some persons maybe for whom appropriately tailored intervention of this kind could be useful. And, you

know, the general effort to kind of, you know, promote understanding among all the stakeholders and try to promote consensus, that we emerged not with a unanimous view from the point of the commission, but, generally speaking, much more substantial consensus than you might have predicted given the intensity of the debates about these issues, you know, over time.

In fact, just to make one point, one comment about this, one of the things that has impressed me more than anything about the work that we did in this highly fraught, you know, area is that despite the tendency to focus on these fighting issues and these areas of disagreement about coercion, there was substantial consensus about just about everything that we did.

And again, I -- you can hear it in what I said earlier, you know, that the overarching issue here is promoting the recovery-oriented system, promoting self determination, you know, encouraging empowerment, promoting voluntary interventions, and voluntary engagement. Everybody accepts, everybody accepts that that's ultimately, you know, the aspiration here, and that most of the reforms of the system should reflect that.

But I think also everybody, you know,

accepts that there are some cases for which a coercion is appropriate and for which inpatient admission, you know, forced inpatient admission, involuntary admission, is appropriate. We want to try to minimize it, we want to promote voluntary admissions, you know, et cetera. And there is a subset of patients for which mandatory outpatient treatment, by the same token, you know, is appropriate. And I think there was a general consensus, you know, about that particular idea. And I think that's what allowed us to move forward.

We never had -- you know, there were of course people, when the legislature began to address all these issues, occasionally of course people, you know, did not speak in favor of every proposal that we made. But every one of the things that we proposed passed unanimously when it got to the legislature. And I do think it was because of the consensus building, you know, that occurred within the forum, you know, of a widely inclusive group of stakeholders.

So again, that was my take-home message here. I was really quite pleased with the amount of consensus that there was, even though, of course, there are these issues that people tend to disagree about.

Thank you.

MR. JACKSON: Any other questions for

Professor Bonnie, Dr. Monahan?

Gentlemen, thank you very much for your time this morning and for your very thoughtful informative presentations. Thank you for joining us.

MR. MONAHAN: Thank you for inviting us.

CERTIFICATE

I hereby certify that the foregoing 92 pages are a complete and accurate transcription to the best of my ability of the electronic sound recording of the April 26, 2013, Sandy Hook Advisory Commission hearing.

Lynne Stein, LSR Date