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Op-Ed: Our mental health laws are failing

By JONATHAN SHERIN AND HENRY STERN

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Makeshift shelters crowd San Julian Street in the skid row area of downtown Los Angeles. Existing law makes it very difficult to help some chronically homeless people.(Los Angeles Times)

We see them every day.

They are people like C, a woman in her mid-50s who has for years lived mostly in the parking lot of a Hollywood mall. She suffers from untreated, severe psychotic illness as well as from diabetes and hypertension. She spends much of her time talking to herself angrily and screaming profanities at passersby. Unfortunately, trapped by her profound sickness, she has resisted repeated attempts by L.A. County's mental health workers to connect her with care and housing.

Or there's B, a man in his early 30s who lives next to the 110 Freeway, sleeping away much of his life wrapped in a soiled blanket on the ground. He is addicted to crystal meth, appears malnourished and has numerous skin lesions on his arms and face. He doesn't speak much, and although he has accepted food and water from mental health outreach workers, he refuses all efforts to connect him with other resources, including housing.

C and B suffer from different types of disease, but they both exemplify one of the chief challenges in trying to address chronic homelessness in California: Many people who live on the streets are unable or unwilling to accept services because of crippling mental illness, addiction or both.

C and B — and many others like them — aren't well served by existing policy.

It's complicated, of course. Legislators with the best of intentions have tried for decades to set the proper balance between self-determination and humane intervention.

Today, the law allows for people presenting acute emergencies to be involuntarily hospitalized for short-term holds. But brief hospital stays rarely lead to a future in which people suffering like C and B can recover and live safely in communities. In fact, repeated short-term hospitalizations can be traumatic. But the bar on longer term, mandatory treatment is set arbitrarily high.

If a person can articulate plans for providing for their food, clothing and shelter, even if that means getting donated food and clothes and sleeping in a tent on the street, that is enough to keep them from being considered "gravely disabled" in many courts under current state law.

Given this reality, we are constrained in our ability to design proper, proactive engagement strategies to serve and house people in desperate need. The current state of affairs is inhumane. The inflexibility of existing laws means we cannot deliver mental health care, addiction treatment and housing solutions to many who have, but do not recognize, severe, chronic and even life-threatening needs.

Meanwhile, neighborhoods are left to deal with the fallout from our policy failures. In many areas of Los Angeles, families are understandably afraid to take their children to supermarkets or playgrounds, or to walk under local freeways. Not surprisingly, these concerns are festering into outright animosity toward the unhoused and toward local governments.

The main tool we have to work with is the Lanterman-Petris-Short Act, which sets parameters for when a person can be compelled to accept treatment, including long-term care. But the act was passed more than half a century ago and was not designed to address mental illness, addiction and homelessness as they exist today. We need better and more nuanced tools of engagement to reach people who are in dire need yet refuse to accept care.

To start, we need laws and practices that enable mental health workers to help those who simply won't accept mental health care voluntarily. Laura's Law, passed in 2002, allows for court-ordered outpatient treatment in certain circumstances, but it hasn't been fully implemented and does not include the power to medicate at this time.

We need to look far and wide for ideas. One tool being used with promising results in other countries, for example, is "psychiatric advance directives." They allow an individual during a time of stability to legally commit to treatment during times of acute illness, with options to designate specific medications and providers of their choosing.

We also need to acknowledge that our current definition of "grave disability" as a standard to compel intervention is inadequate, in that it leaves many of the most ill in dire need. We need policies that lay out a simpler set of indicators to determine when someone is unable to live safely in the community, and those indicators should be formulated by a full range of stakeholders, including formerly homeless people with profound mental illness who are in recovery.

These policies shouldn't differentiate between those who become homeless because of addiction as opposed to mental illness. People with either or both afflictions languish on the streets, and we need policies robust enough to address all of the needs that, unmet, leave people suffering on sidewalks or cycling in and out of jail.

Though changing the laws is important, it won't be enough. Meaningful reform will require adequate resources to meet the need for guardianships, psychiatric treatment, social support and housing. Every time we even consider limiting a person's civil liberties, we must first exhaust all efforts to help that person find care voluntarily. And those efforts must be backed up with resources. We can't be in the position of offering help without being able to deliver it.

Shuttling people like C and B in and out of a broken system, with inadequate tools to ensure continued engagement, serves no one. It wastes time and money, and it erodes faith in the system. Though it is no simple feat to turn even one life around, thousands of Californians with serious mental illness, addictions or both are in recovery and living safely with proper care. Thousands more await our help.

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https://www.latimes.com/opinion/story/2020-12-18/need-for-new-laws-to-address-homelessness