LETTER OF CONCERN

Regarding The Helping Families In Mental Health Crisis Act (H.R. 2646)

We, the undersigned members of the scientific community, individuals with lived experience of “serious mental illness”, and affected family members join together to express our grave concern with The Helping Families in Mental Health Crisis Act, H.R. 2646, introduced on June 4, 2015 by Reps. Tim Murphy (R-PA), and Eddie Bernice Johnson (D-TX). While we applaud Representative Murphy’s commitment to bringing attention to the antiquated programs and ineffective policies in place throughout our country’s mental health system, his proposal in its current form will greatly increase the likelihood of, decreased engagement with services, increased rates of suicide and violence, higher rates of disability, and increased rates of mental illness across all segments of society. To quote Representative Murphy, “mental illness does not discriminate” and we are all in danger of being negatively affected by this bill’s proposed programs and alterations in law.

The word “evidence-based” appears in this legislation numerous times. We support valid science used to advance public interest and public health. For this reason, we are concerned that this legislation contradicts the current evidence-base, ignores a robust body of scientific literature, and will lead to an increase in the already inflated epidemic of mental illness and ineffective treatment of it. Further, it decreases civil liberties and violates the human rights of the very individuals it purports to help, while making it law that any individual or organization that promotes complementary and alternative approaches to mental health be defunded.

We are aware that numerous mental health and family organizations have written letters in support of this bill; these organizations all have substantial conflicts of interest and/or significant financial ties to pharmaceutical companies, as does Representative Murphy (see p. 14), which stand to benefit greatly from this piece of legislation. The signators below have no such conflicts of interest. We advocate for humane, empirically-based, effective treatment and preventative approaches for all human beings in distress.

We urge you to consider the perilous consequences, without scientific justification, this bill could have on public health, disability rights, and the value of freedom we, as Americans, hold dear. Given the stigma, discrimination, and shame already surrounding mental health problems and the serious human rights issues at stake, we would like to clarify the research, as it relates to specific assertions and suggestions throughout this bill.

Mental illness and violence

The basis of H.R. 2646 is the idea that “untreated mental illness” will linearly result in violence, and the proposal therein will prevent such violence from occurring. Although the authors of this bill state unequivocally that “the mentally ill are no more violent than anyone else, and in fact are more likely to be the victims of violence than the perpetrators…” they go on to negate this with “but individuals with untreated serious mental illness are at an increased risk of violent behavior”. Firstly, this is an oversimplification of the substantial research on this topic, particularly when variables such as substance use, including illegal and prescription drugs, age, gender, socioeconomic status, and other personality characteristics are not considered. More importantly, however, it erroneously insinuates that standard psychiatric “treatment” predictably decreases violent behavior when in fact it is shown to often do just the opposite (e.g., Breggin, 2008; Healy et al., 2006).

This bill originally was developed in response to the tragedy of Sandy Hook. The names of the children killed during this horrible event have been evoked in rhetorical fashion by Representative Murphy at numerous public events and private speaking engagements in an effort to instigate fear and support for his agenda. However, it must be pointed out, if such tragedies are going to continue to be used as example, that the offender in this case was alleged to have been on numerous psychotropic drugs. This is also the case for almost every single mass-shooter since Columbine, although the exact numbers are difficult to come by due to lack of access or investigation into this repeated probable variable. Additionally, these rare events of mass murder are NOT what is being examined when research studies are conducted; studies looking at violence and mental illness are concerned with personal acts of varying levels of violent behavior, which can include such innocuous behaviors as throwing a book or knocking down a chair. To compare any of these studies with these sensational events is comparing unrelated phenomena; it only serves to bias concerned readers in a manner not in line with evidence. Lastly, it is well-documented that assault rifles and other army-grade weaponry has a greater level of association with mass murder than any other variable ever tested. Nonetheless, Representative Murphy suggests throughout H.R. 2646 to further fund and even *increase* the very treatment approaches that these particular individuals were already subject to before committing their crimes.

Some studies do find that a first-episode of psychosis is associated with a higher risk of violence, including homicide, and that this rate drops after receiving increased treatment; however, this does not tell the whole story. It is unclear if “treatment” or simply the remittance of a psychotic episode is the causative factor in this decrease in violent behavior. Additionally, only about half of all studies find a significant difference of violence when individuals diagnosed with serious mental illness are compared with the general population. For example, there is not conclusive evidence of a positive relationship between delusions or hallucinations and violence (Bjorkly, 2002), and in some studies this association was found to be negative (Douglas et al., 2009). Douglas et al. (2009), in a meta-analysis of 204 studies, found that the relationship between symptoms of schizophrenia and violence is not always significant, has small odds ratios when a comorbid substance use disorder is not present, and tends to have a negative risk when compared to other disorders or in forensic populations. There are also findings that psychosis is negatively associated with recidivism, and that the best predictors of violent re-offending are non-clinical factors, such as criminal history and substance abuse (Bonta, Law, & Hanson, 1998). Overall, physical violence towards others is rare in persons with acute psychosis, and it appears that psychotic features have only a minor value in predicting violence risk, if at all (Foley et al., 2005; Steinert et al., 2000; Steinert, 2002). In other words, an initial breakdown may be associated with an increased possibility for violent behavior, but that person is unlikely to behave in such a manner repetitively.

Further, there is little evidence to support the assertion that psychiatric treatment decreases violence. For instance, Nielssen and Large (2010) found that the ratio of homicide in the first episode of psychosis was 15.5 times greater than the rate after receiving “treatment”, yet 46.8% of all homicide offenders diagnosed with schizophrenia were taking antipsychotic medication at the time of the offence. In fact, involuntary treatment has an odds ratio of 3.21 for a *greater* likelihood of violent and aggressive behaviors (Foley et al., 2005), Additionally, a recent study has shown how rates of suicide, aggression, and violent behavior have increased (and continues to increase) since treatment has become more medicalized, more coercive, and less focused on the psychological difficulties which these individuals face, and these negative effects appear to begin increasing from the moment one enters treatment and first gets diagnosed (Fazel et al., 2014).

The way in which one interprets such findings may be open for debate, but nobody can ignore the fact that our current way of practicing is making people worse, not better. And, although Representative Murphy clearly agrees that mental health services in the United States need an overhaul, his proposal suggests to do more of what the evidence base has shown does not work while it ignores the evidence for what does.

Although psychotropic drugs may be beneficial to many people, particularly in acute crises, many of these brain-altering chemicals have been known for at least 35 years to cause a substantial increase in violent and suicidal behavior for some (Dukes, 1980; Wise, 1989). Studies that are conducted evaluating unpublished data and/or are independent from pharmaceutical company funding consistently find inflated assertions regarding these drugs’ ability to decrease violence, and often find many instances where violence is increased (e.g., Healy, 2012; Morrison et al., 2012). Most trials fail to detect any decrease in symptoms, above placebo, that reaches a clinical threshold for minimal clinical improvement for both antipsychotics and antidepressants (Kirsch, et al., 2008; Lepping, et al., 2011; Leucht et al., 2006). Additionally, there is no evidence that shows any long-term benefit of, and especially not a necessity for, taking psychotropic medication for all people; rather, long-term studies actually show improved outcomes for those individuals who stopped taking their prescribed medications over time (Harrow, Jobe, & Faull, 2012; Wunderink et. al, 2013).

A meta-analysis by Fazel and colleagues (2009) concluded that the association between schizophrenia and violence, particularly homicide, appears to be mediated by substance abuse. In other words, violent actions are committed by individuals who are diagnosed with schizophrenia AND have substance abuse problems. More specifically, violence is related to substance use, and only minimally to mental illness. At the same time, when individuals’ psyches are not being altered by drugs, they are rarely shown to be more violent than the general population. When violence does occur, it is most often a result of having a history of child abuse, psychopathic traits, and/or substance abuse problems (Spidel et al., 2010).

In fact, these are risk factors for criminal behavior, generally, and not specific to the mentally ill population. Violence is not caused by mental illness, nor is mental illness sufficient to explain incidents of violence. Substance abuse, socio-demographic, and economic factors are the major determinants of violence (Stuart, 2003). In the general population, perceptions of unfair and unjust treatment by authorities has been found to relate to increased depression (Walker & Mann, 1987), anger (Montada & Schneider), extreme emotionality (Van den Bos, 2001), and decreased self-esteem (e.g., De Cremer & Tyler, 2005). Perceptions of social injustice have been found to be strongly linked to social movements and provide legitimizing arguments to support violent action (Tyler & Smith, 1995; Fischer & Skitka, 2006; Mikula & Wenzel, 200; Harb, Al Hafedh, & Fischer, 2006). Conversely, individuals report fair procedures when given the opportunity to express one's opinions and feelings (De Cremer & Van Hiel, 2008), feeling one has control over decision making by presenting opinions and arguments for their position (Tyler & Lind, 1992), and feeling respected and listened to by authorities (Stahl, Vermunt, & Ellemers, 2008).

Forced and involuntary treatment, an inability to defend oneself in a court of law and in front of a jury of peers, detainment without committing a crime, and not having control over decision making, according to robust evidence across many fields of study, will result in an increased likelihood of mental health difficulties and violence, independent of each other. To force people to take life-long drugs, that may actually increase violent tendencies for some, in an effort to decrease violence is illogical and not based on scientific evidence. The suggestions throughout H.R. 2646 are almost a guaranteed recipe for creating circumstances for more violence, more suicide, and more disability than our country has ever seen before.

Additionally, It is widely believed that professionals have the ability to predict who will become violent, and so not only have a duty to report, but also to force "treatments" that will prevent such violence from occurring. This is not true. Not only does treatment fail to predictably decrease aggression or violence long-term, but professionals' ability to predict violence is barely better than chance and is an inexact science (Dolan & Doyle, 2000; Szmukler & Rose, 2013). Most violent crime happens as a result of unanticipated factors, such as substance use, a fight, loss, or other random events that happen as part of life. It is a direct violation of the United States Constitution to detain and imprison individuals based on a suspicion that one day they *might* behave violently.

Gilead and Frank (2014) have stated, and we agree, that "Many proposed policy approaches, from expanded screening to more institutionalization, are unlikely to be effective. Most people with mental health problems do not commit violent acts, and most violent acts are not committed by people with diagnosed mental disorders."

Assisted Outpatient Treatment

H.R. 2646 focuses heavily on the need to provide accessible outpatient care, which is an issue that we agree needs to be addressed. At the same time, the bill proposes to increase funding for involuntary outpatient commitment, euphemistically called Assisted Outpatient Treatment (AOT), as an answer to this problem. These outpatient commitment programs are court-ordered mandates for “treatment” in the community for individuals who may otherwise choose not to participate in such procedures. Generally, it includes forced medications, which have extremely toxic side-effects and, as mentioned above, are not shown to be clinically effective for most people and may even increase the likelihood for violence in some, especially when force and coercion are used. The goal of AOT is to coerce compliance to psychiatric services in an effort to decrease relapse, hospitalization, suicide, violent behavior, and incarceration. The criteria for AOT eligibility include a history of involuntary hospitalization, incarceration, or violence, and is couched as an “alternative to incarceration.”

However, AOT is a costly and coercive intervention with a conflicting evidence base to support it (Rowe, 2013). The current evidence base does not support a proposal to increase services, particularly when non-coercive programs have a greater evidence base yet continue to suffer from poor funding. While it is true that there are some studies that find positive outcomes for AOT (e.g., Swanson & Swartz, 2014), the effective components in these studies are not delineated and often these studies are methodologically biased towards positive findings. For instance, when individuals are provided with intensive, in-home, community-based services, it is possible that this individualized help is sufficient without court-orders or forced medications.

Corroboration for this possibility is the rigorous and robust evidence base for supportive housing models, such as Housing First, yet these effective, voluntary programs suffer from a gross lack of funding for which H.R. 2646 does not propose to alter. Housing programs have been shown to reduce re-hospitalization rates and homelessness (Gulcer et al., 2003) and with greater satisfaction than non-housing model interventions (Leff et al., 2009). A study evaluating Pathways-to-Housing, specifically, found that shelter episodes were decreased by 88%, hospitalizations by 71%, and prison system involvement by 50% (Fairmount Ventures, Inc., 2011).

Additionally, peer-run respites, which are run by individuals who have recovered from a mental health condition, and mobile crisis teams have some evidence supporting their efficacy, and are much less intrusive and better tolerated than forced commitments. In a randomized-control trial of a peer-respite center found increased symptom improvement, increased service satisfaction, and 33% less cost than the hospital comparison group (Greenfield et al., 2008). Voluntary, community-based mobile crisis teams have been found to decrease hospitalization by 55% (Scott, 2000). Yet, many of these programs are in danger of losing funding with the passing of this bill when they already suffer from lack of funding for implementation or research.

On the other hand, many studies evaluating court-ordered outpatient commitment, or AOT, based on random assignment (i.e., bias was controlled for) have found no significant difference between those committed and those receiving voluntary care on any measure, including re-hospitalization, adherence to treatment, and violent crime (Steadman et al., 2001). In a major Cochrane systematic review on involuntary outpatient commitment (Kisely, Campbell, & Preston, 2011), as it is legislated in various different countries including the United States, little evidence was found to support the effectiveness of this legislation as measured by any outcome indice. Specifically, they found that it would take 27 commitment orders to prevent one instance of homelessness, 85 to prevent one possible re-hospitalization, and 238 to prevent one arrest. They concluded: “Compulsory community treatment results in no significant difference in service use, social functioning or quality of life compared with standard care.” We ask how odds such as these justify the repeal of the civil liberties of so many innocent people who have never committed any crime?

Not only is there a poor evidence base to support the effectiveness of many components of AOT, it also may repel individuals who voluntarily wish to seek services but are afraid of doing so due to the possibility of commitment (Smith & Allen, 2001). Over 30% of a sample of patients with a psychotic diagnosis met full-criteria for posttraumatic stress disorder as a direct result of their treatment experience (Mueser, Lu, Rosenberg, & Wolfe, 2010) and this was largely due to factors related to involuntary status and force. In fact, AOT is not an alternative to hospitalization or incarceration, precisely because of its coercive and involuntary nature; it is a potentially traumatizing commitment sentence like any other without the benefit of Habeus Corpus or due process of law, and without evidence supporting its effectiveness in reducing mental health symptoms or violent behaviors. Within the United Nations, it is considered inhumane and akin to torture to enforce involuntary commitment on those who have committed no crime (Human Rights Council, 2009). How does Representative Murphy justify *increasing* support for such inhumane practices?

Lastly, the entire premise upon which the idea of AOT stands is a hypothesis that currently lacks empirical evidence to support its use, particularly when it is used to justify repealing individuals’ rights. Many laws regarding forced outpatient commitment, as pointed out by Representative Murphy, are based on a concept of “anosognosia”; a term that lacks sound methodological or replicable evidence to support the certainty with which this term is used within psychiatry. This is a term that was originally developed by neurologists to described a type of physiological brain damage that results in the individual not being able to recognize parts of the body as his or her own, and so specifically delineated the term from the psychological process of “denial”. In recent years, a small group of controversial psychiatrists who have incredible conflicts of interest with pharmaceutical companies and other industry corporations have co-opted this term to refer to patients who “lack insight” into the existence of their “disease”. At this time, we do not fully understand the processes underlying these difficulties, nor have any biological mechanisms been identified as possibly causing a neurological symptom such as this.

This term is controversial for several reasons: 1) There is not a single biomarker ever found for any psychiatric disorder, as stated unequivocally by the chair of the Diagnostic and Statistical Manual (Kupfer, 2013); 2) There is a considerable community of mental health professionals who have written about the lack of validity or reliability of any diagnostic category delineated by psychiatry (e.g., Bentall, 2003; Deacon, 2013), a fact that even the head of the National Institute of Mental Health has explicitly stated (Insel, et al., 2010; Insel, 2012), and so it is plausible that an individual who denies he has a disease that lacks a scientific base to support its existence may actually be responding in a logical and insightful manner; 3) Most individuals who might be described with this term may otherwise readily admit to experiencing a great deal of distress for which they would like help, when this distress is framed within the context of stressful and traumatic life circumstances (e.g., Bassman, 2001; Bracken et al., 2012; Cohen, 2005; Dillon, 2012).

HIPPA and FERPA Caregivers

Citing families' concerns that health care providers deny them access to information about their adult loved ones' care and treatment, H.R. 2646 contains provisions that would alter the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and reduces the privacy rights of people with psychiatric disabilities. Proponents of the bill have suggested that the proposed changes will clarify HIPAA rules and provide access to family members, but the current rules are clear and reflect a careful balance between important patient privacy interests and the need to involve families in appropriate circumstances. It is imperative that this balance be maintained.

Provisions for disclosure of information to family members already exist under current law. Where a patient does not have the capacity to agree or object to the sharing of information, or in emergency circumstances, HIPAA allows a healthcare provider to share the patient's health information with family, friends, or others involved in the patient's care or payment for care, if doing so is in the best interests of the patient. Examples of when a patient may lack capacity to agree or object to disclosure include: when the patient is experiencing a temporary psychosis; is under the influence of drugs or alcohol; or when an individual otherwise cannot meaningfully agree or object to disclosure due to his or her current mental state.

HIPAA already allows disclosure of patient information to immediate family or caregivers when the doctor believes it will prevent or decrease a serious and imminent threat. HIPAA also already permits disclosure to a patient's family members, friends, or other persons involved in the patient's care or in payment for that care where the patient does not object. The HIPAA Privacy Rule takes a balanced approach because it provides needed protections for individuals' health care privacy while at the same time it allows disclosure in order to meet the patient's healthcare needs and to abide by public policy. If a person is not an imminent threat to self or others and is receiving appropriate healthcare, how does Representative Murphy justify taking away the person's rights when they expressly object to the release of their information?

Without confidence that privacy rights will be protected, people are less likely to seek treatment. People will engage in behaviors to protect their self and privacy as a way of ensuring that their health information is not used improperly. Such behaviors include failure to seek care and leaving pertinent sensitive information blank. If our goal is to encourage treatment, laws that would deter individuals from seeking treatment are the wrong solution.

The fact that persons with psychiatric diagnoses are so vulnerable to abuse in the event of loss of capacity underscores the necessity of state and national policy encouraging the development of psychiatric advance directives (PADs), which provide greater control and choice over health care decisions; improving the quality of communication between persons with psychiatric diagnoses, their loved ones, and their treatment providers; and reducing the need for involuntary treatment.

Medicare and Medicaid Reforms

While we understand the need for inpatient beds and long-term care for individuals who have more severe difficulties, and the need for Medicaid reimbursement for these services, the evidence-base does not support increased funding for institutionalization or involuntary psychiatric, hospital-based treatment. Rather, the evidence shows that increased involvement with psychiatric care is associated with an exponentially higher rate of completed suicide, in a dose-response fashion (Hjorthoj et al., 2014; Large et al., 2014). Further,as mentioned above, alternatives to hospitalization have at least equal benefit in terms of symptom stabilization without the associated rates of suicide and demoralization. These alternative programs additionally have been found to be more tolerable for patients, to increase community involvement and transition, to decrease stigma, and to operate at a significantly reduced cost than hospitalization (e.g., Bologna, & Pulice, 2011) . Yet, this bill specifically proposes to *withhold* funding for many of these emerging best practices operating across the country, and throughout the world. This not only stands in direct contrast of the scientific evidence, it defies logic.

We know that voluntary community services, when available, work well to support persons with even the most significant needs. In the state of Delaware, for instance, there have been systemic reforms that have taken place since 2011 under the *Olmstead* settlement to increase the availability of voluntary community-based services, including supportive housing, mobile crisis, crisis respite, and Assertive Community Treatment (ACT). As a result, there has been a rapid and significant decrease in the need for inpatient hospitalization and all forms of involuntary care (“Corrected Fourth Report”, 2013).

Behavioral Health Awareness

H.R. 2646 is said to decrease stigma and discrimination faced by persons diagnosed with serious mental illness. Yet it is entirely premised on biological explanations for “mental illness”; explanations which disregard the robust body of evidence for the traumatic origins of serious mental illness, especially psychosis (e.g., Janssen et al., 2004; Read et al., 2004). Interestingly, such biological explanations for mental disorders are found to decrease empathy in both clinicians (Lebowitz & Woo-kyoung, 2014) and the general public (Pescosolido, et al., 2010; Schomerus, Matschinger, & Angermeyer, 2014). Although Representative Murphy surely does not intend to contribute to stigma, the evidence suggests that his overall approach may do just that.

Certainly, erroneously linking mental illness with violence in the public mind is also going to increase stigma and negative evaluations of individuals labelled as mentally ill. In other words, the premise for Representative Murphy's bill and his suggestions for intervention, when looking at the actual evidence-base, is most likely to *increase* stigma and discrimination rather than decrease them.

The treatment interventions advocated for in H.R. 2646 are associated with increased violence, increased paternalistic attitudes of clinicians (Magliano, et al., 2013), and increased discriminatory attitudes (e.g., Henderson, et al., 2014; Read & Law, 1999). These discriminatory attitudes can lead to much worse outcomes (Jorm, 1999) and increased suicidality (Hemmings, 1999).

On the other hand, the larger international public actually prefers psychosocial and traumatogenic explanations for mental illness, and this is associated with decreased stigma and increased possibilities for hope and recovery (e.g., Read et al., 2006). Taking a trauma-informed, non-medicalized, empowering, and humanistic approach can lead to better outcomes, decreased disability and thereby a decreased strain on society, increased functioning, and increased sense of responsibility. It also is the approach most widely advocate for by individuals seeking services. Again, we have to question the logic and evidence behind H.R. 2646. Where is the unbiased evidence that any of the proposals within H.R. 2646 will actually result in a reduction of stigmatizing attitudes towards individuals in emotional distress?

Community Mental Health Services - Best available science and models of care

H.R. 2646 proposes to increase funding for very specific community mental health services, and this is something we applaud Representative Murphy for; however, we do so with reservation and concern. Psychological and psychotherapeutic community approaches have been found to be effective, and in some cases superior to standard psychiatric care in the long-term.For example, cognitive-behavioral therapy for psychosis, when it adheres to a trauma-informed, normalizing, non-medicalized perspective, is shown by robust evidence to be at least as effective as standard psychiatric care (Bentall, 2003; Morrison, 2009; Rathod, et al., 2010) even when individuals choose not to take antipsychotics (Morrison et al., 2012; Morrison et al., 2013). Further, trauma-based psychodynamic approaches that focus on relationship, meaning-making, and internal and family dynamics have been shown to be effective treatments for at least 100 years (e.g., Jung, 1909; Karon & van den Bos, 1981; Laing, 1960/2010; Searles, 1965/1986;

Sullivan, 1954) with resultant normalizing effects on the brain (Abbas, et al., 2014; Roffman, et al., 2012).

These approaches have been found to decrease overall symptomatology while increasing functionality in the long term. These approaches are focused on recovery, they are person-centered rather than disease focused, emphasis is on empowerment and respect, and many are trauma-informed (Farkas, 2007). These are the interventions consistently requested and tolerated by individuals diagnosed with serious mental illnesses.

Practitioners who practice many of these well-established therapeutic modalities are threatened with defunding under H.R. 2646 This bill vaguely alludes to "evidence-based" treatments throughout, which often are narrowly defined as manualized treatment protocols and/or psychotropic drugs that have been found "effective" through randomized control trials. Unfortunately, when working with individuals who have experienced chronic, developmental trauma, healing is a process that takes time and cannot be subjected to short-term, manualized protocols. The majority of individuals who are typical of those seen in the community are not eligible for randomized control trials. Additionally, these trials are heavily biased towards medicalized understanding and conceptualizations and always require adherence to pharmaceutical regimens, despite the substantial evidence for how effective therapy can be with minimal use of these interfering agents. It must be better explicated what exactly is meant by "evidence-based" treatments, it needs to justify how and why non-medicalized treatments, despite their empirical support for effectiveness and increased tolerance, may possibly be defunded due to vested interest biases, and what long-term studies are being relied upon to qualify a treatment protocol as actually being "evidence-based".

In addition to these clinical interventions, peer-run services that do not rely on coercion and focus instead on empathy, inclusion, voluntary treatment, and self-management of mental health difficulties are consistently found to result in increased hope, better awareness of triggering factors and an ability to seek help before crisis, better planning for symptom and crisis management, increased social support, greater rates of recovery, and an increased sense of responsibility (Cook et al., 2010; Corrigan, 2006). Peer support is also found to decrease rates of substance abuse (Davidson, et al., 2012), which is one of the major factors determining violent and/or criminal behavior. Importantly, these peer support systems operate outside of a medical framework and instead take a more context-based, empowering, and inclusive framework that honors individuals' subjectivity and autonomy without coercion. H.R. 2646 proposes to defund peer support systems that operate under these frameworks while increasing funding for peer support systems that rely on medicalized, coercive practices that undermine the value of non-clinician peers in the first place.

Redefinition of the peer support specialist discipline.

The concept of "peer support" emerged as a model of mutual support in the 1970s, though its origins have been traced back as far the 18th century (Davidson et al, 2012). Today the “certified peer specialist (CPS)” has become a thriving and evidence-based discipline within mental health care (and other areas of healthcare, including HIV/AIDS, cancer, and diabetes). Peer support services are currently Medicaid-reimbursable in several states.

While H.R. 2646 includes a provision on CPSs, representing a difference from the 2013 version, and calls for increased funding to develop the peer support workforce, it also seeks to re-define the discipline in clinical terms. For example, the bill would require states to submit a report on their CPS programs, and would require states to respond as to whether their CPS core competencies include training in areas such as “psychopharmacology” and the “identification of mental disorders--” competencies which are more characteristic of clinical practice and not the purview of “peer support”.

Peer specialists are not clinicians, and that is an important part of their unique role in health care. Peer support is based on the premise that “people who have like experiences can better relate and can consequently offer more authentic empathy and validation” (Mead and MacNeil, 2006). Peers for Progress defines peer support as reliant on “non-hierarchical, reciprocal relationships, which provide a flexible supplement to formal health system services...In addition, peer support fosters understanding and trust of healthcare staff among groups who otherwise may be alienated from or have poor access to health care” (American Academy of Family Physicians Foundation, 2015).

These various efforts to define peer support share a common denominator: recognition of the intrinsic value of peer support as a *non-clinical* role based on such values as “respect, shared responsibility, and mutual agreement of what is helpful” (Mead et al., 2001). Mead et al. (2001) note that “peer support is not based on psychiatric models and diagnostic criteria. It is about understanding another’s situation empathically through the shared experience of emotional and psychological pain”. The effort of this legislation to distort the peer specialist role into a clinical one represents a paternalistic, top-down attempt to control a discipline that has already been clearly defined by its practitioners and sanctioned by states.

Many states already have well-established peer specialist competencies, and the International Association of Peer Specialists (INAPS), in consultation with dozens of focus groups and over 1,000 CPSs, has already compiled a thoughtful set of national practice guidelines (INAPS, 2011), including core competencies and a detailed code of ethics. Other communities have defined their own codes of practice, such as Western Massachusetts Peer Network’s “Declaration of Peer Roles” (Western Mass Peer Network, 2014). The Pillars of Peer Support Summit, which has taken place annually since 2009, has defined a number of core competencies and best practices for the field (Daniels et al., 2013). The Centers for Medicaid and Medicare Services (CMS), in a 2007 letter to State Medicaid directors, clarified that “peer support providers must complete training and certification as defined by the State” (Smith, 2007).

This legislation, by seeking to re-define the peer specialist discipline through an act of Congress, would infringe on states' rights to to develop and implement their own certification and continuing education programs for peer specialists. No other mental health discipline has ever been subject to such Congressional scrutiny; another example of how H.R. 2646 serves to increase stigma and discrimination.

Advancing Critical Medical Research

Representative Murphy proposes to increase funding for brain-based initiatives in the study of mental illness. While this is an understandable and laudable effort, and may provide interesting academic exercises, it is not an endeavor that is based on the scientific evidence nor is it likely to yield extensive findings of clinical importance. This is a problem when funds are limited and are threatened to be reallocated from areas that are of critical import to clinical issues. Additionally, it completely ignores the robust literature showing the traumatic origins of most serious mental illness, the associations of brain functioning with all psychological functions, and the lack of any evidence produced thus far that there is a single biological brain abnormality associated with any mental disorder beyond those associated with childhood trauma (e.g., Gogtay, 2008; Gogtay & Rapoport, 2008; Read, Fosse, Moskowitz, & Perry, 2014; Read, Perry, Moskowitz, & Connolly, 2001; van der Kolk, 2003) or psychotropic drugs (Andreasen, Liu, Ziebell, Vora, & Ho, 2013; Szeszko, et al., 2014).

Research does show, however, that psychosocial interventions, such as family training (Neville, et al., 2013), meditation (Hölzel, et al., 2010), aerobic exercise (ten Brinke, et al., 2014), eating healthily (Deckersbach, et al., 2014) and psychotherapy (Abbass, et al., 2014; Roffman, et al., 2012) are all associated with positive changes in the brain. However, nowhere in Representative Murphy's bill is there room for increased funding in any of these areas; rather, it is quite the opposite.

SAMHSA Reauthorization and Reforms

***Protection and Advocacy for Individuals with Serious Mental Illness*.** This section of H.R. 2646 may represent one of the more consequential and frightening aspects of any legislation passed in the United States of America. The PAIMI program was created to investigate abuse and neglect against persons with mental illness, and allow for both individual and systems advocacy. While we appreciate the acknowledgement by Representative Murphy of the importance of the PAIMI program by dropping the provision that would have resulted in an 85% reduction in PAIMI funding, the program activity restrictions and other provisions discussed below would eliminate and overly restrict a lot of the critical work that the Protection and Advocacy (P & A) agencies are uniquely designed and empowered to conduct. None of these proposed changes are based on evidence of the failure of the PAIMI programs to follow the mandates of the PAIMI statute (National Disability Rights Network, 2015).

The first restriction, which would only allow the PAIMI program to provide advocacy in situations of “abuse and neglect,” would preclude many thousands of positive outcomes that have come from P & A advocacy on behalf of persons facing discrimination in the areas of employment, education, and housing.

Another proposed change bars PAIMI advocates from raising concerns with decisions made by doctors, families or guardians of people diagnosed with mental illness. This change would have made impossible the New York P & A’s advocacy to stop unnecessary prostate and cataract surgeries on people diagnosed with mental illnesses in a Medicaid fraud scheme. Further, P & A’s regularly encounter cases of guardians and family members who can be involved in financial exploitation, abuse, and neglect that would be unaddressed and leave individuals with no recourse under the provisions of H.R. 2646.

A further restriction would require the PAIMI program to ensure that caregivers have access to the protected health information of an individual diagnosed with a mental illness. This restriction alters the PAIMI program in such a way that is contrary to the original intent of the program; it changes the program form that is designed to provide advocacy for individuals with serious mental illness to one that provides legal advocacy for the caregiver of the individual diagnosed with a mental illness. It also creates a situation where this work would violate a lawyer’s code of ethics; The lawyer’s client is the individual diagnosed and H.R. 2646 would require attorneys to work to release information that an individual may have requested remain confidential, thus putting lawyers into a conflict of interest situation.

Additional changes would limit the use of unrestricted funds for lobbying activities that are currently allowed under federal guidelines. P & A’s follow the legal rules and do not use federal funds for lobbying, but like other organizations, may use unrestricted funds they have raised independently to perform this work. An essential part of legal advocacy roles is providing an opportunity for people who are marginalized to be heard in the public policy arena. Effectuating a positive change, e.g. in a Medicaid statute or regulation benefiting tens of thousands of people in a state, is a much more effective and efficient means to achieving a positive outcome than conducting individual Medicaid appeals. Limiting the ability of P & A’s to use their own unrestricted monies to pursue policy outcomes would close a critical avenue for improving the lives of people diagnosed with mental illnesses.

If enacted, these changes would deny people diagnosed with mental illnesses access to a legal advocacy system that individuals with other disabilities will have, relegating people them to a second class status. Once again, this another example of how H.R. 2646 serves to increase stigma and discrimination, rather than decrease it.

Advisory Councils and Peer Review. This bill proposes to set guidelines for advisory councils and peer review regarding ongoing and future Federal spending on mental health program grants. Interestingly, while appointed members of these advisory councils are not to have “a financial interest in any grant or program with respect to which they advise,” no other conflicts of interest are prohibited, including ties to the pharmaceutical industry. In order to ensure unbiased research and programmatic efforts that are geared towards improving mental health and quality of life for those in need, these councils and peer review groups would need to be independent of any involvement with pharmaceutical companies or other industry corporations. In this vein, the authors of this bill would be disqualified as would most members of the American Psychiatric Association and the American Psychological Association.

Conclusion

We call on legislators, family members, individuals with lived experience, professionals who are not beholden to the pharmaceutical companies or other corporate interests, and the lay public to be informed of the scientific evidence outlined here. Some may question how this vast evidence-base can so completely contradict the ideas presented by Representative Murphy; to those individuals we ask that you consider who stands to gain from the different perspectives put forth? Representative Murphy and many of his supporters stand to gain substantial financial benefits, as well as continued denial of the effects of poverty, discrimination and child abuse on the welfare of American citizens. At the same time, many of the below signators who support this letter stand to gain acknowledgment for the struggles they have been through, while individuals diagnosed with mental illness stand to gain the opportunity for effective treatment and care, if Congress would take notice of the concerns put forth herein and consider where funds are truly best allocated.

We must be wary of the detrimental consequences that are likely to arise should this bill pass, and the gross human rights violations that will suddenly become United States law. This bill will not serve to decrease distress, increase functioning, or decrease violence. There are many programs and services currently being funded by the Federal Government that have shown far greater effectiveness than standard, medicalized treatments, and will likely lose partial or full funding if this bill should pass. There is a limited amount of money available through grants and other Federally-funded programs. These funds should be directed towards programs that are based on scientific evidence and do not threaten to strip the civil liberties and privacy rights of vulnerable individuals who are supposed to be protected under law.

In closing, we offer the words of C.S. Lewis: “Of all tyrannies, a tyranny sincerely exercised for the good of its victims may be the most oppressive. It would be better to live under robber barons than under omnipotent moral busybodies. The robber baron's cruelty may sometimes sleep, his cupidity may at some point be satiated; but those who torment us for our own good will torment us without end for they do so with the approval of their own conscience.”

Some of Representative Murphy’s Campaign Fund Financial Contributors

- National Rifle Association
- National Association of Psychiatric Health Systems
- American Psychiatric Association

- Eli Lilly & Co (Pharmaceutical)
- Bayer Corp (Pharmaceutical)
- Sanofi (Pharmaceutical)
- Glaxosmithkline (Pharmaceutical)
- Amgen Inc (Pharmaceutical)
- Alkermes Inc (Pharmaceutical)
- Novartis Corp (Pharmaceutical)
- Astrazeneca Pharmaceuticals
- Lundbeck Inc (Pharmaceutical)
- Blue Cross/Blue Shield (Insurance)
- UPMC Health System (Insurance)
- Eckert, Seamans et al (Legal representation for pharmaceutical companies)

References

Abbass, A. A., Nowoweiski, S. J., Bernier, D., Tarzwell, & Beutel, M. E. (2014). Review of psychodynamic psychotherapy neuroimaging studies. Psychotherapy and Psychosomatics, 83, 142-147.

Allen, M., & Smith, V.F. (2001). Opening Pandora's box: The practical and legal dangers of involuntary outpatient commitment. Psychiatric Services, 52(3): 342-346.

American Academy of Family Physicians Foundation (2015). What is peer support? [webpage] Retrieved from: http://peersforprogress.org/learn-about-peer-support/what-is-peer-support/

Andreasen, N. C., Liu, D., Ziebell, S., Vora, A., & Ho, B. C. (2013). Relapse duration, treatment intensity, and brain tissue loss in schizophrenia: A prospective longitudinal MRI study. American Journal of Psychiatry, 170, 609-615.

Bassman, R. (2001). Whose reality is it anways? Consumers/ survivors/ ex-patients can speak for themselves. Journal of Humanistic Psychology, 41(4), 11-35.

Bentall, R. (2003). Madness explained: Psychosis and human nature. London, United Kingdom: Penguin.

Bjorkly, S. (2002b). Psychotic symptoms and violence toward others- a literature review of some preliminary findings Part 2. Hallucinations. Aggression and Violent Behavior, 7, 605-615.

Bologna, M. J., & Pulice, R.T. (2011). Evaluation of a peer-run hospital diversion program: A descriptive study. American Journal of Psychiatric Rehabilitation, 14(4): 272-286.

Bonta, J., Law, M., & Hanson, K. (1998). The prediction of criminal and violent recidivism among disordered offenders: A meta-analysis. Psychological Bulletin, 123(2), 123-142.

Bracken, P., Thomas, P., Timimi, S., Asen, E., Behr, G., Beuster, C., . . . Yeomans, D. (2012). Psychiatry beyond the current paradigm. The British Journal of Psychiatry, 201, 430-434.

Breggin, P. R. (2008). Medication madness: A psychiatrist exposes the dangers of mood-altering medications. New York, NY: St. Martin's Press.

Cohen, O. (2005). How do we recover? An analysis of psychiatric survivor oral histories. Journal of Humanistic Psychology, 45(3), 333-354.

Cook, J. A., Copeland, M. E., Corey, L., Buffington, E., Jonikas, J. A., Curtis, L. C., Grey, D. D., & Nichols, W. H. (2010). Developing the evidence base for peer-led services: Changes among participants following Wellness Recovery Action Planning (WRAP) education in two statewide initiatives. Psychiatric Rehabilitation Journal, 34(2): 113–120.

Corrected fourth report of the court monitor on progress toward compliance with the agreement: U.S. v. State of Delaware, U.S. District Court for the District of Delaware, Civil Action No: 11-591-LPS (September, 2013). Retrieved from: http://www.dhss.delaware.gov/dhss/dsamh/files/usdoj_courtmonitorreport4_2013_09_24.pdf

Corrigan, P. (2006). Impact of consumer-operated services on empowerment & recovery of people with psychiatric disabilities. Psychiatric Services, 57(10): 1493-1496.

Daniels, A. S., Tunner, T. P., Bergeson, S., Ashenden, P., Fricks, L., & Powell, I. (2013). Pillars of Peer Support Summit IV: Establishing Standards of Excellence, Retrieved from: www.pillarsofpeersupport.org.

Davidson L., Bellamy C., Guy, K., & Miller R. (2012). Peer support among persons with severe mental illnesses: A review of evidence and experience. World Psychiatry, 11(2), 123- 128.

Deacon, B. J. (2013). The biomedical model of mental disorder: A critical analysis of its validity, utility, and effects on psychotherapy research. Clinical Psychology Review, 33. doi: 10.1016/j.cpr.2012.09.007

Deckersbach, T., Das, S. K., Urban, L. E., Salinardi, T., Batra, P., Rodman, A. M., Arulpragasam, A. R., Dougherty, D. D., & Roberts, S. B. (2014). Pilot randomized trial demonstrating reversal of obesity-related abnormalities in reward system responsivity to food cues with a behavioral intervention. Nutrition & Diabetes, 4, e129; doi:10.1038/nutd.2014.26

De Cremer, D., & Tyler, T. R. (2005). Managing group behavior: The interplay between procedural fairness, sense of self, and cooperative behavior. In M. Zanna (Ed.), Advances in experimental social psychology (Vol. 37, pp. 151-218). New York: Elsevier.

De Cremer, D., & Van Hiel, A. (2008). Procedural justice effects on self-esteem under certainty versus uncertainty emotions. Motivation and Emotion, 32(4), 278-287.

Dillon, J. (2012). Recovery from 'psychosis'. In J. Geekie, P. Randal, D. Lampshire & J. Read (Eds.), Experiencing Psychosis (pp. 17-22). New York: Routledge.

Dolan, M., & Doyle, M. (2000). Violence risk prediction: Clinical and actuarial measures and the role of the Psychopathy Checklist. The British Journal of Psychiatry Oct 2000, 177(4), 303-311.

Douglas, K. S., Guy, L. S., & Hart, S. D. (2009). Psychosis as a risk factor for violence to others: A meta-analysis. Psychological Bulletin, 135(5), 679-706.

Dukes, M. (1980). The van der Kroef syndrome. Side Effects of Drugs Annual, 4, v–ix.

Farkas, M. (2007). The vision of recovery today: What it is and what it means for services. World Psychiatry, 6, 4-10.

Fazel S, Langstrom N, Hjern A, Grann M, and Lichtenstein P. (2009) Schizophrenia, substance abuse, and violent crime. JAMA 301: 2016–2023.

Fazel, S., Wolf, A., Palm, C., & Lichtenstein, P. (2014). Violent crime, suicide, and premature mortality in patients with schizophrenia and related disorders: a 38-year total population study in Sweden. The Lancet Psychiatry, 1(1), 44-54.

Fairmount Ventures, Inc., Evaluation of Pathways to Housing PA (Jan. 2011), available at http://pathwaystohousing.org/pa/wpcontent/themes/pathways/assets/uploads/PTHPA-ProgramEvaluation.pdf.

Fisher, R., & Skitka, L.J. (2006). Justice: Social psychological perspectives. In A.J.W. Taylor (Ed.), Justice as a Basic Human Need. Nova Science Publishers.

Foley, S., Kelly, B., Clarke, M., McTigue, O., Gervin, M., et al. (2005). Incidence and clinical correlates of aggression and violence at presentation in patients with first episode psychosis. Schizophrenia Research, 72(2-3), 161-168.

Gogtay, N. (2008). Cortical brain development in schizophrenia: Insights from neuroimaging studies in childhood-onset schizophrenia. Schizophrenia Bulletin, 34(1), 30-36.
Gogtay, N., & Rapoport, J. L. (2008). Childhood-onset schizophrenia: Insights from neuroimaging studies. Journal of the American Academy of Child and Adolescent Psychiatry, 47(10), 1120-1124.

Greenfield, T. K., Stoneking, B. C., Humphreys, K., Sundby, E., & Bond, J. (2008). A randomized trial of a mental health consumer-managed alternative to civil commitment for acute psychiatric crisis. American Journal of Community Psychology, 42(1), 135-144.

Gulcer, L., Stefancic, A., Shinn, M., Tsemberis, S., & Fischer, S. N. (2003). Housing, hospitalization, and cost outcomes for homeless individuals with psychiatric disabilities participating in continuum of care and housing first programmes. Journal of Community & Applied Social Psychology, 13(2), 171-186.

Harb, C., Al Hafedh, A., Fischer, R. (2006). Understanding support for resistance in Iraq: Social-psychological predictors in a nationally representative sample. Paper, 18th Congress, International Association of Cross-Cultural Psychology. Spetses, Greece.

Harrow, M., Jobe, T. H., & Faull, R. N. (2012). Do all schizophrenia patients need antipsychotic treatment continuously throughout their lifetime? A 20-year longitudinal study. Psychological Medicine, 42(10), 2145–2155.

Healy, D., Herxheimer, A., & Menkes, D. B. (2006). Antidepressants and violence: Problems at the interface of medicine and law. Public Library of Science Medicine, 3(9), e372.

Hemmings, A. (1999). Attitudes to deliberate self-harm among staff in an accident and emergency team. Mental Health Care, 2, 300-302.

Henderson, C., Noblett, J., Parke, H., Clement, S., Caffrey, A., Gale-Grant, O., . . . Thornicroft, G. (2014). Mental health-related stigma in health care and mental health-care settings. Lancet Psychiatry, 1, 467-482.

Hjorthoj, C., Madsen, T., Agerbo, E., & Nordentoft, M. (2014). Risk of suicide according to level of psychiatric treatment: a nationwide nested case–control study.Social Psychiatry and Psychiatric Epidemiology, 49(9), 1357-1365.

Hölzel, B. K., Carmody, J., Vangel, M., Congleton, C., Yerramsetti, S. M., Gard, T., & Lazar, S. W. (2010). Mindfulness practice leads to increases in regional brain gray matter density. Psychiatry Research: Neuroimaging, 191, 36-43.

Human Rights Council. (December, 2009). Thematic study by the Office of the United Nations High Commissioner for Human Rights on the structure and role of national mechanisms for the implementation and monitoring of the Convention on the Rights of Persons with Disabilities (A-HRC-13-29). Annual report of the United Nations High Commissioner for Human Rights and reports of the Office of the High Commssioner and the Secretary-General. Retrieved from: http://www.ohchr.org/EN/Issues/Disability/Pages/ThematicStudies.aspx.

Insel, T. (2012). Director's blog: The top ten research advances of 2012. National Institute of Mental Health. Retrieved from http://www.nimh.nih.gov/about/director/2012/the-top-tenresearch-advances-of-2012.shtml#3

Insel, T., Cuthbert, B. N., Garvey, M. A., Heinssen, R. K., Pine, D. S., Quinn, K. J., . . . Wang, P. S. (2010). Research doman criteria (RDoC): Toward a new classification framework for research on mental disorders. American Journal of Psychiatry, 167(748-751).

InterNational Association of Peer Supporters (2011). National Practice Guidelines for Peer Supporters. Retrieved from: https://na4ps.files.wordpress.com/2012/09/nationalguidelines1.pdf

Janssen, I., Krabbendam, L., Bak, M., Hanssen, M., Vollebergh, W., De Graaf, R., & van Os, J. (2004). Childhood abuse as a risk factor for psychotic experiences. Acta Psychiatrica Scandinavica,109(1), 38–45.

Jorm, A. F., Korten, A. E., Jacomb, P. A., Christensen, H., & Henderson, S. (1999). Attitudes towards people with a mental disorder: A survey of the Australian public and health professionals. Australian and New Zealand Journal of Psychiatry, 33, 77-83.

Jung, C. G. (1909). The psychology of dementia praecox. New York: Journal of Nervous and Mental Disease Publishing Company.

Karon, B. P., & van den Bos, G. R. (1981). Psychotherapy of schizophrenia: The treatment of choice. Maryland, US: Rowman & Littlefield Publishers, Inc.

Kirsch, I., Deacon, B. J., Huedo-Medina, T. B., Scoboria, A., Moore, T. J., & Johnson, B. T. (2008). Initial severity and antidepressant benefits: A meta-analysis of data submitted to the Food and Drug Administration. PLoS Medicine, 5(2), e45. http://dx.doi.org/10.1371/journal .pmed.0050045

Kisely, S. R., Campbell, L.A., and Preston, N. J. (2011). Compulsory community and involuntary outpatient treatment for people with severe mental disorders. Cochrane Database of Systematic Reviews. DOI: 10.1002/14651858.CD004408.pub3

Kupfer, D. (2013). News release: Chair of DSM-5 task force discusses future of mental health research. American Psychiatric Association. Retrieved from http://www.psychiatry.org

Laing, R. D. (1960/2010). The divided self: Existential study in sanity and madness: Penguin Books.

Large, M., Ryan, C. J. (2014). Disturbing findings about the risk of suicide and psychiatric hospitals. Journal of Social Psychiatry and Psychiatric Epidemiology, 49(9), 1353-1355.

Lebowitz, M. S., & Woo-kyoung, A. (2014). Effects of biological explanations for mental disorders on clinicians' empathy. Proceedings of the National Academy of Sciences of the United States of America, 111(50), 17786–17790.

Leff, H. S., Chow, C. M., Pepin, R., Conley, J., Allen, E., & Seaman, C. A. (2009). Does One Size Fit All? What We Can and Can't Learn From a Meta-analysis of Housing Models for Persons With Mental Illness. Psychiatric Services, 60(4), 473-482.

Lepping, P., Sambhi, R. S., Whittington, R., Lane, S., & Poole, R. (2011). Clinical relevance of findings in trials of antipsychotics: Systematic review. British Journal of Psychiatry, 198(5), 341–345.

Leucht, S., Kane, J. M., Etschel, E., Kissling, W., Hamann, J., & Engel, R. R. (2006). Linking the PANSS, BPRS, and CGI: Clinical implications. Neuropsychopharmacology, 31(10), 2318–2325.

Magliano, L., Read, J., Sagliocchi, A., Patalano, M., & Oliviero, N. (2013). Effect of diagnostic labeling and causal explanations on medical students' views about treatments for psychosis and the need to share information with service users. Psychiatry Research. Advance online publication. http://dx.doi.org/10.1016/j.psychres.2013.07.022

Mead, S., Hilton, D., & Curtis, L. (2001). Peer support: A theoretical perspective. Retrieved from: http://www.intentionalpeersupport.org/wp-content/uploads/2014/02/Peer-Support_A-Theoretical-Perspective.pdf

Mead S., & MacNeil C,. (2006). Peer Support: What Makes It Unique? International Journal of Psychosocial Rehabilitation. 10(2), 29-37.

Mikula, G., & Wenzel, M. (2000). Justice and social conflict. International Journal of Psychogology, 35, 126-135.

Montada, L., & Schneider, A. (1989). Justice and emotional reactions to the disadvantaged. Social Justice Research, 313-344.

Morrison, A. P. (2009). A cognitive behavioural perspective on the relationship between childhood trauma and psychosis. Epidemiologia e Psichiatria Sociale, 18(4), 294–298.

Morrison, A. P., Hutton, P., Shiers, D., & Turkington, D. (2012). Antipsychotics: Is it time to introduce patient choice? British Journal of Psychiatry, 201, 83–84.

Morrison, A. P., Hutton, P., Wardle, M., Spencer, H., Barratt, S., Brabban, A., . . . Turkington, D. (2012). Cognitive therapy for people with a schizophrenia spectrum diagnosis not taking antipsychotic medication: An exploratory trial. Psychological Medicine, 42(5), 1049–1056.

Morrison, A. P., Wardle, M., Hutton, P., Davies, L., Dunn, G., Brabban, A., . . . Turkington, D. (2013). Assessing cognitive therapy instead of neuroleptics: Rationale, study design and sample characteristics of the ACTION trial. Psychosis, 5(1), 82–92.

Mueser, K. T., Lu, W., Rosenberg, S. D., & Wolfe, R. (2010). The trauma of psychosis: Posttraumatic stress disorder and recent onset psychosis. Schizophrenia Research, 116, 217-227.

National Disability Rights Network (2015). Unpublished talking points, personal communication.

Neville, H. J., Stevens, C., Pakulak, E., Bell, T. A., Fanning, J., Klein, S., & Isbell, E (2013). Family-based training program improves brain function, cognition, and behavior in lower socioeconomic status preschoolers. Proceedings of the National Academy of Sciences of the United States of America, 110(29), 12138-12143.

Nielssen, O., & Large, M. (2010). Rates of homicide during the first episode psychosis and after treatment: A systematic review and meta-analysis. Schizophrenia Bulletin, 36, 702-712.

Pescosolido, B. A., Martin, J. K., Long, J. S., Medina, T. R., Phelan, J. C., & Link, B. G. (2010). "A disease like any other"? A decade of change in public reactions to schizophrenia, depression, and alcohol dependence. American Journal of Psychiatry, 167, 1321-1330.

Rathod, S., Phiri, P., & Kingdon, D. G. (2010). Cognitive behavioral therapy for schizophrenia. Psychiatric Clinics of North America, 33(3), 527–536.

Read, J., Fosse, R., Moskowitz, A., & Perry, B. (2014). The traumagenic neurodevelopmental model of psychosis revisited. Neuropsychiatry, 4(1), 65-79.

Read, J., Goodman, L., Morrison, A. P., Ross, C. A., & Aderhold, V. (2004). Childhood trauma, loss and stress. In J. Read, L. Mosher, & R. Bentall (Eds.), Models of madness: Psychological, social and biological approaches to schizophrenia (pp. 223–252). Hove, United Kingdom: Brunner-Routledge.

Read, J., Haslam, N., Sayce, L., & Davies, E. (2006). Prejudice and schizophrenia: A review of the 'mental illness is an illness like any other' approach. Acta Psychiatrica Scandinavica, 114(5), 303-318.

Read, J., & Law, A. (1999). The relationship of causal beliefs and contact with users of mental health services to attitudes to the 'mentally ill'. International Journal of Social Psychiatry, 45(3), 216-229.

Read, J., Perry, B. D., Moskowitz, A., & Connolly, J. (2001). The contribution of early traumatic events to schizophrenia in some patients: A traumagenic neurodevelopmental model. Psychiatry, 64, 319-345.

Roffman, J. L., Gerber, A. J., & Click, D. M. (2012). Neural models of psychodynamic concepts and treatments: Implications for psychodynamic psychotherapy. In R. A. Levy, J. S. Ablon, H. Kächele (Eds.) , Psychodynamic psychotherapy research: Evidence-based practice and practice-based evidence(pp. 193-218). Totowa, NJ, US: Humana Press. doi:10.1007/978-1-60761-792-1_11

Rowe, M., (2013). Alternatives to outpatient commitment. Journal of the American Acadamy Of Psychiatry and the Law,41(3): 332-336.

Schomerus, G., Matschinger, H., & Angermeyer, M. C. (2014). Causal beliefs of the public and social acceptance of persons with mental illness: a comparative analysis of schizophrenia, depression and alcohol dependence. Psychological Medicine, 44(2), 303-314.

Scott,R. (2000). Evaluation of a Mobile Crisis Program: Effectiveness, Efficiency, and Consumer Satisfaction. Psychiatric Services 9, 1153-1156.

Searles, H. F. (1965/ 1986). Collected papers on schizophrenia and related subjects (Reprint ed.). London: Karnac Books Ltd.

Seikkula, J., Alakare, B., & Aaltonen, J. (2011). The comprehensive open-dialogue approach in Western Lapland: II. Long-term stability of acute psychosis outcomes in advanced community care. Psychosis, 3(3), 192–204.

Spidel, A., Lecomte, T., Greaves, C., Sahlstrom, K., Yuille, J. C. (2010). Early psychosis and aggression: Predictors and prevalence of violent behaviour amongst individuals with early onset psychosis. International Journal of Law and Psychiatry, 33, 171-176.

Smith, D. G. (August, 2007). [Letter to state Medicaid director, on behalf of Department of Health and Human Services, MD]. Retrieved from: http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD081507A.pdf

Stahl, T., Vermunt, R., & Ellemers, N. (2008). For love or money? How activation of relational versus instrumental concerns affects reactions to decision-making procedures. Journal of Experimental Social Psychology, 44, 80-94.

Steadman, H., Gounis, K., Dennis, D., Hopper, K., Roche, B., Swartz, M., and Robbins, P. 2001. Assessing the New York City Involuntary Outpatient Commitment Pilot Program. Psychiatric Services. 52(3): 330-336.

Steinert, T. (2002). Prediction of inpatient violence. Acta Psychiatrica Scandinavica, 106, 133-141.

Steinert, T., Wolfle, M., & Gebhardt, R. P. (2000). Measurement of violence during in-patient treatment and association with psychopathology. Acta Psychiatrica Scandinavica, 102, 107-112.

Stuart, H. (2003). Violence and mental illness: An overview. in World Psychiatric Assoc., 2:121-124.

Sullivan, H. S. (1954). The interpersonal theory of psychiatry. New York: Norton.

Swanson, J. W., & Swartz, M. S. (2014). Why the evidence for outpatient commitment is good enough. Psychiatric Services, 65(6), 808-811.

Szeszko, P.. R., Robinson, D. G., Ikuta, T., Peters, B. D., Gallego, J. A., Kane, J., & Malhotra, A. K. (2014). White matter changes associated with antipsychotic treatment in first-episode psychosis. Neuropsychopharmacology, 39, 1324-1331.

Szmukler, G., & Rose, N. (2013). Risk Assessment in Mental Health Care: Values and Costs. Behavioral Sciences and the Law, 31(1), 125-140.

Ten Brinke, L. F., Bolandzadeh, N., Nagamatsu, L. S., Hsu, C. L., Davis, J. C., Miran-Khan, K., & Liu-Ambrose, T. (2014). Aerobic exercise increases hippocampal volume in older women with probable mild cognitive impairment: A 6-month randomised controlled trial. British Journal of Sports Medicine, doi:10.1136/bjsports-2013-093184

Tyler, T. R., & Lind, E. A. (1992). A relational model of authority in groups. In M. P. Zanna (Ed.), Advances in experimental social psychology (Vol. 25, pp. 115-191). San Diego, CA: Academic Press.

Tyler, T.R., & Smith, H.J. (1995). Social justice and social movements. In D. Gilbert, S.T. Fiske, & G. Lindzey (Eds.), Handbook of social psychology (4th ed., Vol. 2, p. 595-629),. New York: McGraw-Hill.

Van den Bos, K. (2001). Uncertainty management: the influence of human uncertainty on reactions to perceived fairness. Journal of Personality and Social Psychology, 80, 931-941.

Van der Kolk, B. A. (2003). The neurobiology of childhood trauma and abuse. Child and Adolescent Psychiatric Clinics of North America, 12, 293-317.

Walker, I., & Mann, L. (1987). Unemployment, relative deprivation and social protest. Personality and Social Psychology Bulletin, 13, 275-283.

Western Mass Peer Network (2014). Declaration of peer roles. Retrieved from: http://www.westernmassrlc.org/images/stories/Declaration_of_Peer_Roles_2014.pdf

Wise, B. (1989). Reports of hostility after exposure to triazolobenzodiazepines. Rockville, MD: Food and Drug Administration Division of Epidemiology and Surveillance.

Wunderink, L., Nieboer, R. M., Wiersma, D., Sytema, S., & Nienhuis, F. J. (2013). Recovery in remitted first-episode psychosis at 7 years of follow-up of an early dose reduction/discontinuation or maintenance treatment strategy: Long-term follow-up of a 2-year randomized clinical trial.JAMA Psychiatry, 70(9), 913–920. http://dx.doi.org/10.1001/jamapsychiatry.2013.19