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**TESTIMONY BEFORE CT MENTAL HEALTH PANEL:
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**END DISCRIMINATION – INTEGRATE MENTAL HEALTH CARE WITH PRIMARY
HEALTHCARE, PROVIDE VOLUNTARY HOUSING AND SUPPORTS IN THE
COMMUNITY**

**INTRODUCTION: MY BROTHER BILL’S STORY OF DISCRIMINATION AND
DEHUMANIZATION**

“Patsy, I don’t want to be a mental patient all my life” was my 55 year-old brother Bill’s plea to me. As an attorney, clinical psychologist and my brother’s chief family advocate for some forty years, I had watched his being moved from city to city in a shadow rendition system that the State of Connecticut operated as a way of “dealing” with persons with mental health challenges to their independence.

Bill sat on the edge of a metal hospital bed in 2004 in a “nursing home”, one among a string of private, for-profit institutions that advertised bogus “treatment” in exchange for taxpayer funded Medicaid coverage. This practice was formally inaugurated by the State of Connecticut in 2001 after decades of the state’s failure to provide housing and voluntary supportive services in the community. The claim that the state’s failure to provide appropriate housing and services in the community violates the Americans with Disabilities Act (1990) and the United States Supreme Court decision in *Olmstead v. L.C.* (1999) is the subject of a lawsuit pending in the United States Federal District Court in Hartford.

I found after Bill’s untimely death in that institution (see www.huffingtonpost.com/patriciadrone for Bill’s and my promise to address issues that led to it) a note about his hopes: “Unit 2B an open unit, 4C for me”. His words showed his lost hope of ever returning to the community after wrongful institutionalization.

Bill knew instinctively the discrimination that the words “mental patient” evoked, even among those supposedly “caring” for him including the public mental health system of the State of Connecticut and private, for-profit owners of institutions that continue to warehouse people.

**END DISCRIMINATION WITH PRIMARY HEALTHCARE, HOUSING AND
VOLUNTARY SERVICES IN THE COMMUNITY**

As all eyes turn to the question of WHY the tragedy in Newtown on 12/14/12, sweeping and overbroad proposals are being submitted for discussion in the field of mental health. We may never know the full details of this particular event and it should be stated that sweeping generalizations from one event, or even a number of “similar” events, while they may satisfy the public and officials, cannot be made.

Bill never lived to see the advances in healthcare and supportive community services that have proven effective over that last two or so decades in other states at the same time Connecticut was denying services to a population caught “in the system”. For a discussion of these services turn to www.ct.gov/opapd, www.bazelon.org, and www.pathwaystohousing.org. Also see: “Effect of Full-Service Partnerships on Homelessness, Use and Costs of Mental Health Services, and Quality of Life Among Adults with Serious Mental Illness” (T.P. Gilmer, et.al., Archives of General Psychiatry/Vol.67, No. 6, June 2010).

These research and practice developments would have made it possible for Bill to meet the challenges he faced in trying to live in the community. Within a year of Bill’s being dumped in an institution by the State of Connecticut in 1993, in the prime of his life at age 44, a book by the cognitive neuroscientist, Antonio Damasio of the University of Southern California (Professor of Neuroscience, Neurology and Psychology, Director of USC’s Brain and Creativity Center), *Descartes’s Error* (1994, updated 2005) piqued my interest. In it he discussed work that had never been covered in my graduate studies in clinical psychology, not in any of the practica or internships at which I worked.

FROM THEORY TO NEUROSCIENCE

Damasio’s work pointed out what he called Descartes’s error in 1596, i.e., the fallacy of assuming that the “mind” could be separated from the body. Damasio’s book was the story of “provocative concepts about intelligence, memory, creativity, and passion” stated one reviewer.

As recently as 2011 V.S. Ramachandran’s book: “*The Tell-Tale Brain: a Neuroscientist’s Search for What Makes Us Human*” explains that “... for most of the twentieth century all we had to offer in the way of explaining human behavior was two theoretical edifices—Freudianism and behaviorism—both of which would be dramatically eclipsed in the 1980s and 1990s, when neuroscience finally managed to advance beyond the Bronze Age (p. xiii).”

Ramachandran continues: “I feel as progress continues through the coming decades, the conceptual twists and technological turns we are in for are going to be at least as mind bending, at least as intuition shaking, and as simultaneously humbling and exalting to the human spirit as the conceptual revolutions that upended classical physics a century ago.” Dr. Ramachandran is the Director of the Center for Brain and Cognition and Distinguished Professor with the Psychology and Neuroscience Program at USC-San Diego.

And equally compelling is the work of Harvard psychiatrist Jordan Smollen in *The Other Side of Normal* (2012) concluding that “evidence from both psychological and genetic studies points to the notion that the most common psychiatric disorders are really the extremes of normal, quantitative traits that all of us share. And like other quantitative traits—blood pressure, body

weight, cholesterol levels, for example-where we draw the line between normal variations and dysfunction may be a pragmatic decision. Some experts have gone so far as to say that “what we call common disorders are, in fact, the quantitative extremes of continuous distributions of genetic risk ... there are not common disorders-just the extremes of quantitative traits (citing R. Plomin, et.al., “Common Disorders are Quantitative Traits” 2009).

**CONCLUSION: WE KNOW WHAT WORKS-INTEGRATION OF HEALTHCARE,
HOUSING AND CHOICE OF SERVICES**

As the general public and officials search for an answer to the question “WHY” the 12/14/12 tragedy we must keep in mind the danger , in the absence of answers,of scapegoating persons with health care challenges. As recent developments in research, practice and the law are proving, no longer should persons with disabilities be singled out for scapegoating for occurrences that had nothing to do with them.