Catalyst

Treatment Advocacy Center ❄ Spring 2002

Why TAC Exists: Watchguards of a Broken System

E. Fuller Torrey, M.D.

The stunning three-part series by Clifford Levy in *The New York Times* ("Broken Homes," April 28-30, 2002) is a poignant reminder of why we started the Treatment Advocacy Center (TAC). The series described in horrifying detail the victimization of individuals with severe psychiatric disorders, not only by outsiders, but also by insiders — people who run the group homes and who are being paid to provide protection and care. Even worse are the New York State officials who turned a blind eye toward the whole sordid mess. They did not want to even know who had died or why they had died. We have reached a new nadir in the delivery of services to individuals with severe mental illnesses.

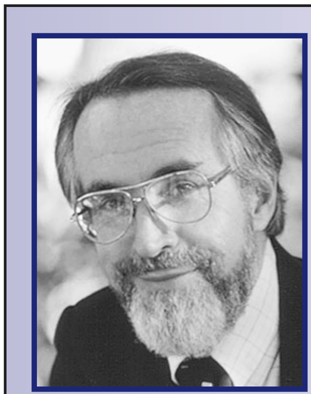
The *Times* series, however, failed to ask what may be the most important question: Where were the organizations that were supposed to oversee this vulnerable and disabled population? Where was the Protection and Advocacy (P&A) program, created in 1986 to prevent these kinds of abuses and funded with more than 30 million federal dollars? P&A now functions mostly to protect and advocate for its own budget. Where was the NYS Commission on Quality of Care, which, a decade ago, was making unannounced visits to group homes such as Mr. Levy describes? The Commission is now but a shadow of its former self, because Albany does not want to know what is going on.

The Treatment Advocacy Center is a small organization with a modest budget, but with the help of our financial supporters, we will continue to do everything we can to advocate for improved treatment for our most vulnerable citizens. We provided consultation to Mr. Levy for his series, as we regularly do to news reporters, and we will continue to speak out where other voices are silent.

Going to the NAMI 2002 Convention in June?

You don't want to miss the opening plenary session!
Thursday June 27 ♦ 3:30 pm - 5 pm
featuring:

Dr. E. Fuller Torrey
"A Perspective on the Community of Hope"



Published letter to the editor, New York Times, April 30, 2002

New York State's neglect of its most vulnerable citizens, as documented by your "Broken Homes" series (front page, April 28-30), is stunning. It is even more incomprehensible given that New York spends more per capita on mental health services than any other state, according to the National Association of State Mental Health Program Directors.

The key to fixing the system is to abolish the federal Institutions for Mental Disease exclusion, whereby states are reimbursed by federal Medicaid for patients placed in homes like those you describe but are not reimbursed for the same patients in state hospitals.

That federal regulation has been the main impetus for states to empty their hospitals and condone the placement of vulnerable people in homes unfit for human habitation.

E. FULLER TORREY, M.D.
President
Treatment Advocacy Center
Arlington, VA

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Catalyst

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The Center is a nonprofit organization dedicated to eliminating legal and clinical barriers to timely and humane treatment for the millions of Americans with severe brain diseases who are not receiving appropriate medical care.

Current federal and state policies hinder treatment for psychiatrically ill individuals who are most at risk for homelessness, arrest, or suicide. As a result an estimated 1.8 million individuals with schizophrenia and manic-depressive illness (bipolar disorder) are not being treated for their illness at any given time.

The Center serves as a catalyst to achieve proper balance in judicial, legislative and policy decisions that affect the lives of persons with serious mental illnesses.

> ***"Under current law, people cannot be committed in Maryland unless there is a 'clear and imminent danger of the individual's doing bodily harm' to himself or someone else …. Such rules were crafted in the name of the liberty of the mentally ill — to prevent confinement of people who could, in fact, function in communities. But in practice they have been a cruel joke for people who, without treatment, have seriously impaired thought and can't control their actions. In extreme cases, it means that people cannot be detained for treatment until they commit crimes — at which point they are detained as criminals. The right to live in a delusional state is a dubious victory for liberty."***
>
> **— From "Need for treatment in Maryland," March 3, 2002, editorial, *The Washington Post.***

> ***"Early intervention and continued treatment are less expensive and more effective than waiting for the problem to escalate; and, community-based treatment costs nearly 10 times less than inpatient hospitalization."***
>
> **— From two sheriffs, "Reform mental health law" April 4, 2002 *The Orlando Sentinel.***

State Updates

FLORIDA

The Florida Sheriffs' Association introduced legislation this past session to reform the state's 30-year-old treatment law. The reform bill (SB 2030/ HB 1389/HB 839) passed the Senate Children & Families Committee unanimously but did not make it to the Senate floor. For the bill to move that far this year was a positive sign as the Florida legislature was consumed with tax reform and redistricting. The Florida Sheriffs' Association plans to reintroduce the bill next year. Treatment Advocacy Center Executive Director, Mary Zdanowicz's testimony in support of the bill appears on page 10.

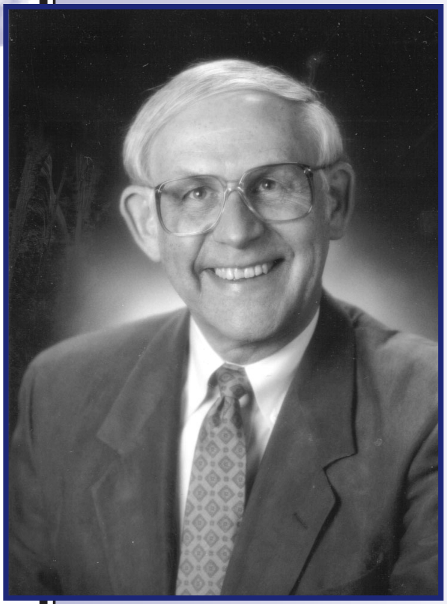
MARYLAND

This year NAMI Maryland put forward reform legislation (SB 645 / HB 923) that would revise the standard for treatment intervention. The current and outdated Maryland law is one of the strictest in the country and only allows treatment when a person becomes dangerous. The reform bill allowed for a judge to order inpatient treatment for a person with severe mental illness who lacks the capacity to make an informed decision about treatment and is "gravely disabled." Treatment Advocacy Center Attorney, Rosanna Esposito, testified in support of the bill; her testimony appears on page 10.

The bill was sponsored by 12 delegates and two senators and supported by the Maryland Psychiatric Association and the Maryland Sheriffs' Association as well as *The Washington Post*, but it died in a committee hearing. NAMI Maryland made great strides this year by putting the issue on the table and educating many about mental illnesses, barriers to treatment, and the tragedies caused by their current law. We salute a job well done this year and look forward to even further progress next year!

[Editor's note: In Catalyst's periodic effort to help us both remember where we have been and examine where we are going, we present to you another in our series of historical reprints that have as much power today as they did when they were first published. This article, by Dr. Darold A. Treffert, appeared in Prism magazine in 1974 — almost 30 years ago — and reads as if it were written yesterday. Dr. Treffert blazed the trail of documenting preventable tragedies to help keep the world focused on the results of lack of treatment; his vision inspired TAC's online database of preventable tragedies, which you can access and search for free on our web site at www.psychlaws.org.]

In our zeal to protect basic, human freedoms, this psychiatrist points out, we have created a legal climate in which mentally ill patients, and sometimes the people around them, are…



Darold A. Treffert, M.D.

Dying with Their Rights On

By Darold A. Treffert, M.D.

On November 10, 1971; in a Midwestern university community, a 26-year-old woman named Rene and her 20-year-old companion, Angela, stood for several hours on a busy street corner near the campus benignly and mutely staring at each other-"as if in a trance," police records said.

There is, of course, no law against people staring at each other, but because the girls' strange behavior continued for so long, a crowd gathered, creating considerable confusion on that busy corner. The police arrived to investigate and took Angela and Rene to a nearby station for questioning.

But the two women refused to speak. They simply sat and stared at each other. The police were quite naturally concerned about the bizarre behavior of the two and eventually decided that some kind of psychiatric observation was called for.

Police contacted the city and prosecuting attorneys' offices for advice. The opinion of both offices was the same: State law allows people to be held for observation only if they appear obviously dangerous to themselves or others. While the behavior of Angela and Rene was admittedly bizarre, they were, after all, merely staring at each other and not verbalizing any threats against themselves or others. Since neither homicidal nor suicidal tendencies were obviously apparent, the attorneys agreed that the girls did not legally "qualify" for psychiatric observation.

The police reluctantly, but necessarily, released the women that night. But they were to soon meet Angela and Rene again, and under tragic circumstances. Called to a campus apartment some 30 hours later, they found the two women on the kitchen floor, writhing and screaming in a self-made flaming pyre of butcher paper they had obligingly lit for each other in a suicide pact. Both were taken to the university hospital in critical condition.

Although more than 20 percent of her body was burned, including her chest, upper arms and upper legs, Angela lived.

Rene died. But she died with her rights on.

To me, this case is reminiscent of the old medical school saw about "dying in electrolytic balance." Each of us can remember the compulsive chemoclinician who solemnly occupied himself with the patient's sodium, calcium, magnesium, and potassium levels, along with a host of other electrolyte and trace metal levels, but scarcely noticed that the patient was slowly slipping away. Even though death came, the fact that it occurred with the patient's body in perfect electrolyte balance was somehow a morbid chemoclinical triumph.

Such extraordinarily limited vision is now affecting psychiatry, and in the zeal to impeccably protect a patient's civil liberties, an increasing number of troubled and psychotic patients are, as I choose to refer to the situation, "dying with their rights on" — as in the case of Rene — a morbid clinical-legal triumph.

In Wisconsin, where I practice, a federal court decision in the class action suit of Lessard v. Schmidt (349 F. Supp. 1078) has stiffened the state's commitment laws. In that decision, the new — and sole — definition of commutability became "*extreme* likelihood that if the person is not confined he will do immediate harm to himself or others." (My italics.) Other states, including Michigan, where Angela and Rene lived, have recently enacted or updated similar laws, and this was surely done by well-meaning lawmakers, judges, and doctors.

I submit, however, that in championing a cause they deeply believed in, their zeal may have exceeded their judgment. For there surely must be some reasonable middle ground between protecting the right of the psychiatric patient to remain free — a precious and important right — and protecting the right of both that patient and those around him or her from tragic and untoward effects of the patient's illness. The latter right has been overshadowed recently by our preoccupation with the former, but physicians and society must be equally concerned about both.

Since the Wisconsin law went into effect, a number of cases in which patients died with their rights on have been brought to my attention. I am in the process of collecting such cases from throughout the country so that they can be properly weighed by the psychiatric community in the always delicate task of balancing humane clinical and societal concerns against legal concerns in the commitment process.

My file is not complete yet, but consider these Wisconsin cases:

A 49-year-old woman with anorexia nervosa was admitted to a medical unit in a general hospital. Largely because of anxiety over a family struggle in which she was deeply enmeshed, she had steadfastly refused to eat and lost a great amount of weight. The woman, like many anorectic patients, presented a life-threatening — though not immediate— clinical picture. She was in good, general contact with reality and was not flagrantly psychotic. But she refused to voluntarily submit to any psychiatric help in spite of her family's concern and encouragement. In fact, she insisted on leaving the hospital although her condition was frail and deteriorating.

Her family and physician asked the court to permit psychiatric observation. But the judge felt that her condition was not dangerous in an immediate or imminent sense, and therefore, she failed to qualify for admission to a psychiatric hospital. She was allowed to go home, as she had wanted.

She died from starvation three weeks later — with her rights on.

A 19-year old coed, with a lingering schizo-affective depression of major proportions, attempted suicide by swallowing a massive overdose of prescribed and over-the-counter drugs. Only the unexpected arrival of friends, who found the girl unconscious and took her to a nearby emergency room, prevented successful suicide. After two days in intensive care, she regained consciousness and agreed to be transferred to the psychiatric ward in the same hospital.

"NO SUICIDAL INTENT"

Although only partially dissuaded from her wish to end her life, she voiced a feeling of well-being that was obviously superficial and insisted on being released in spite of her family's and her doctor's wishes that she remain for further treatment. The patient adamantly denied any suicidal intent and her family extracted a promise from her that she simply wouldn't try such a thing again. Her family considered commitment but was advised by lawyers that, in view of the girl's generally positive presentation of herself, she did not qualify for commitment under the new guidelines. Her situation lacked the element of "extreme likelihood of immediate harm to herself or others." The girl signed out of the hospital against medical advice.

The following day, she hanged herself. But like the others she died with her rights inviolably observed.

No doubt for every one of these cases there does exist somewhere a little old immigrant who, though perfectly sane, has been institutionalized for years because his broken, unintelligible English was mistaken for psychotic ramblings. Or somewhere an elderly woman, labeled retarded in 1920 and shuffled to a forgotten ward, may be found by an inquisitive psychology graduate student wandering the back wards to be, in fact, a genius. Or an eccentric who once delighted in storing pancakes will be turned up years later, after having been committed at a time when storing pancakes was unfashionable.

My intent is not to minimize the grievous harm done in such situations. In fact, the discovery of such cases has rightfully heightened our vigilance and concern that the commitment process should not be arbitrary, abused, or perfunctory. Yet we seem overly zealous with regard to the hazards of commitment. A public epidemic of "unicorn-in-the-garden" fear is sweeping society and the courts. I take the name for the epidemic from the late James Thurber's tongue-in-cheek tale of a woman who tries to have her husband committed after he speaks of feeding a lily to a unicorn in their garden.

But when she informs the authorities, they take her away instead.

Indeed, many fear that the sane rather than the sick will somehow be hospitalized without stricter laws, and that commitment to the psychiatric hospital (white coats, nets, and all) will be used as a subterfuge for unsavory, convenient motives, be they personal, societal, or political.

The attention and empathy of the public and press lately have focused on this problem - that of keeping the sane or eccentric from mistaken commitment. But how do we console the grief-shattered mother in California who, appearing before a state legislative committee looking into the commitment turmoil there, told of actually seeing her mentally ill son kill his wife, children, and himself after he was refused — by law — necessary continued hospitalization.

Those poor people died, it sees to me, with *his* rights on. But what about their rights to be spared the tragic outcome of his illness?

The California mother charitably acknowledged that those who changed the commitment law (unwittingly making the tragedy possible) were well intentioned and "humanely inspired." Yet she argued, as I do, that however necessary, important, and noble the effort to protect the civil rights of patients, we must guard the rights of those close to the mentally ill just as carefully. For suicide and homicide are not the only untoward consequences of the new laws; morbidity also occurs in the form of unnecessary suffering for the patient and his family.

Some patients become increasingly disturbed and develop a poorer prognosis as time passes until they finally accumulate the proper mix of symptoms to meet the law's dubious qualification of "dangerous."

And sometimes the family of a psychotic mother may literally disintegrate while vainly trying to construct some form of routine family life around mother's bizarre and often psychologically destructive symptoms. Or the wife of a mentally ill man may finally abandon her struggle to keep the family going, wearied by fruitless attempts to patch together the semblance of a normal marriage. Such morbidity is doubly tragic since early intervention could lessen or even prevent destructive consequences.

> ***"We are struggling now to come to some reasonable middle ground between the right to be ill and the right to be rescued, just as we struggle in criminal law to somehow balance the criminal's rights with the rights of the victim."***

Stifling Paternalism

There is another matter that should be considered in redefining qualifications for commitment. It is the abrupt reversal of social policymakers from an attitude of stifling paternalism toward the mentally ill to the outright abandonment of their needs. From Canada, England, and the United States come reports of a forced, mass exodus of dependent patients into a relatively unreceptive society with which they are ill equipped to cope.

This effort, also humanely inspired, has been carried to a grim extreme by politicians who are interested not in the mental health system, but in the economics of that system. The mass exodus has been chiefly an effort to solve fiscal problems, not the patients' human problems.

In New York, Suffolk County reports that 5,000 former mental patients are on the welfare rolls and have no family, no job, and no place in the community.

Balancing the complex equation of which of the mentally ill must be hospitalized is a difficult task at best and a treacherous one at worst. Somehow, however, all the elements of that equation need be given their proper weighting. These elements include not just the right to be free or the right to be sick, but also the right to be rescued; the right of the family and of society to be free from the serious untoward effects of such illness; the right of the patient to due process; and the right of the patient to dignity as a human being.

Man has never moved by plan. He has always moved by crisis. The pendulum has been the vehicle. A swing forward and a swing backward. Having reached the upward limit of too liberally defining illness and commitment, the pendulum now threatens to reach the other extreme. We are struggling now to come to some reasonable middle ground between the right to be ill and the right to be rescued, just as we struggle in criminal law to somehow balance the criminal's rights with the rights of the victim.

The Pendulum of History

But the pendulum of history is a peculiar instrument. Like all pendulums, it swings to and fro. But somehow, almost imperceptibly, its forward excursions have always slightly exceeded the backward ones, and thus we as a people have managed to awkwardly inch forward. But we've moved backward recently, toward once again criminalizing the mentally ill, taking a stance I thought we had abandoned a century ago. In Wisconsin, for example, in an obviously adversary proceeding one can be found "guilty" of being mentally ill, for mental illnesses is defined only in terms of dangerousness. Family members testify "against" each other, and what should be a private predicament becomes a public record.

Perhaps the next time the pendulum swings forward it will propel us, gently, further than we have ever been before, so that we will reach a more sophisticated point of balance. It will be too late for Angela, Rene, the California mother, and the several others I have briefly cited here. But I hope that their predicament will at least aid us in soon finding that humane balance point that will mean a more humane attitude toward the mentally ill.

The Author: Darold A. Treffert, M.D. is director of the Mental Health Institute — Winnebago, Winnebago, Wisconsin, and is in private practice as a psychiatrist in Fond du Lac, Wisconsin. His articles have appeared in the *American Journal of Psychiatry*, *Archives of General Psychiatry*, *Hospital and Community Psychiatry, Contemporary Drug Problems — A Law Quarterly*, and the *Wisconsin Medical Journal.*

Letters to the Editor — BE HEARD

The letter to the editor is one of the most commanding tools of advocacy. With one your passion can reach tens of thousands or even hundreds of thousands of readers.

What appears in newspapers is the chief grist of public opinion. As politicians keenly track the attitudes of voters, the media strongly influences legislative decisions and government administrators. This interplay is your opening to bring your goals before legislators and the public because the letters section is one of the most read. These letters are short policy statements and are respectfully treated as such, normally appearing on the page with or the one across from a paper's own editorials.

The threshold of success is not in being published — it comes when you drop your letter in the mailbox. Unpublished letters to the editor can affect which others are printed. Typically, an editor will want to present his or her readers with a selection of letters that fairly represents those that were received. The more letters that agree with your point, the more likely your point will make it to newsprint. And, conversely, those who do have letters published should realize the assistance that they most likely had from others of like heart and mind.

Newspapers, not surprisingly, like to sell newspapers. Editors will often use the number of letters received on an item to gauge the public's interest in it. And the more interest perceived, the more similar coverage in the future.

Plus, letter writers can impact even the position of the paper itself. *The Washington Post* recently, strongly, and insistently supported the reform of Maryland's treatment law, which is an old-line one that only permits psychiatric interventions for people who are an immediate danger to themselves or others. (See the article on page [PA.) How did the paper support this position? "Letters published on this page in recent weeks have testified to the cruelty the current law can inflict." The next seven sentences of the editorial were descriptions of and quotes from letters received by the Post. The accompanying [No] letters are some of the ones on which *The Washington Post* relied.

Whenever you see an item that touches on the treatment of those most severely ill because of mental illness — please write to the paper. Letters to the editor are short and to the point by nature, but with one you can bring your voice to the paper, to the public, to those who run the mental health system, and to those who can change it.

Tips on writing a letter to the editor

These are general guidelines. Your paper may have a specific policy, which you should follow.

- ✍ Newspapers usually only publish letters that respond to recent articles, op-eds, or editorials. Some papers do and others do not print responses to published letters to the editor. Always identify the article or opinion piece to which you are responding, including the date of publication.

- ✍ The sooner the better: the first letters received on a topic are read first and more likely to be selected.

- ✍ Write as if you're talking to the editor of newspaper - not to readers, not to elected officials, nor to the world at large.

- ✍ Stay on point. One topic per letter is best. And do not feel that you have to cover all aspects of your topic in a few short sentences. Rather, concentrate on a few powerful points that show the need for reform.

A DANGEROUS LAW IN MARYLAND
— printed in *The Washington Post,* March 20, 2002

Jeffrey Janofsky's March 10 letter concerning the current Maryland law for involuntary psychiatric hospitalization suggests that these standards are adequate. However, in the community, things are different, and the law is dangerously restrictive for the most seriously ill and vulnerable.

My son was examined in an emergency room for involuntary hospital admission. He was gravely disabled by paranoid schizophrenia and major depression. He refused treatment because of the distorted thinking the illness causes. He recently had purchased a gun. The hospital said my son did not meet the legal standard for involuntary admission because, at that moment, he did not "present a danger." Two weeks later he used the gun to commit suicide.

I find Kevin Dwyer's comment in his letter of the same day that "expanding involuntary commitment . . . will only exacerbate the problems of untreated mental illness" callous and uninformed. The surgeon general's report clearly indicates that timely treatment can prevent suicide.

Forty-four states already consider factors other than dangerousness as the basis for needed medical intervention. If the bill before the Maryland legislature, with its clear Gravely Disabled Standard, was law, my son and many others might be alive today.

Claire Weinberg
Chevy Chase

A DANGEROUS LAW IN MARYLAND
— printed in The Washington Post, March 20, 2002

If the present law is adequate, I challenge Jeffrey Janofsky to get my wife the treatment she needs. I have worked with several government agencies; none has been able to get her into treatment. My wife is not dangerous, and it is wrong to hope that she becomes dangerous for her to get the treatment she needs.

For the past two years our six young children have been living away from home because their mom would not communicate with anyone. Because she would not talk, it was not safe for the children to be at home with her. It has been lonely seeing her and not having a relationship. I would be happy if she would just hold my hand.

If she could get treatment, she would be living in a better environment. I love my wife, and it hurts so much to see her distance herself from the children she loved so much. To get help as the law stands now, I would have to abandon my wife and hope she gets help before it is too late.

Albert A. Arcand Jr.
Bethesda

PROTECT THEIR RIGHTS, BUT FIRST GIVE THEM CARE
— printed in *The Washington Post*, April 8, 2002

Virginia Holman's March 24 Outlook piece, "My Mother Wasn't Dangerous Enough," unfortunately mirrored my own frustrated efforts to help my ill spouse, who has suffered from schizo-affective disorder for 20 years.

As her illness deepened, my wife talked incoherently to herself, shouted at the television set, wandered the neighborhood looking for an illusionary person and drove her car erratically. Was this behavior "dangerous," and did it warrant hospitalization against her will? I thought so, especially when she started threatening me and others. But I was met with skepticism by the county official I approached to request an involuntary psychiatric hospitalization. The legal standard in Maryland, I was told, was "imminent danger" to self or others. Could I offer convincing evidence of that? I could not, and I decided not to pursue the matter. Instead I went home and put a lock on the door of a spare bedroom so I could sleep without fear.

As time passed my wife's illness worsened, and I did find a way to get her into the hospital. Since 1997 she has been hospitalized 10 times in six institutions. During these years, I have seen great emphasis placed on protecting her legal rights. I wish the same attention and concern had been given to her need for effective medical care.

Hospitals treated her acute symptoms, claimed she was "stabilized" and discharged her for follow-up care at community facilities that often were ineffective or nonexistent. And as soon as she left the hospital she again had the "right" to refuse to take the drugs her doctors prescribed to calm her delusions. Thus the cycle began again.

In Maryland we have a long way to go before we can claim that we provide effective and humane care to those who suffer from serious mental illness.

Roger Russell
Silver Spring

- Keep it short. There is a rough limit of 250 words for letters. Longer letters are less likely to be published and, if selected, will almost definitely be edited. Don't let the letters editor remove or dilute your most important points.

- No ad hominem attacks. Jumping on the ideas expressed by others can make for a lively letter; attacking the individuals themselves is uncivil behavior.

- You must use your real name. Newspapers do not accept anonymous letters. If your letter concerns your personal experiences, however, some papers will print it under a pseudonym.

- Be sure to include a home and work (if applicable) phone number as well as your address. This applies to e-mail, faxes, and regular mail alike. These will not be printed in the paper, but are used to contact you if the editors have a question.

- The best way to submit your letter is the fastest — by fax or e-mail. Least best, due to the delivery time, is regular mail. Tendering it in two, or even all, of those manners will maximize the chances of getting your letter published. But make sure to find out the preferred policy of the paper you are writing. Some have very specific rules.

- If you submit by email, paste your letter into the text of the email. Do not send attachments. Many papers will not even open an email with an attachment because of the potential for computer viruses.

Treatment Advocacy Center Honorary Advisory Committee

The Committee is composed of distinguished individuals who are devoted to improving the lives of individuals who suffer from severe mental illnesses. Each individual has made his or her own contributions to furthering that goal. We thank them for their work and for supporting our mission.

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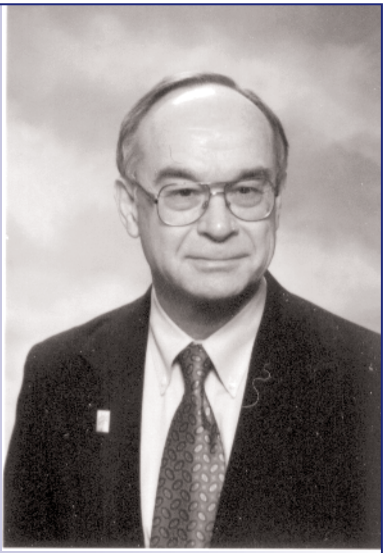
On Fred Frese: "Recovery: Myths, Mountains, and Miracles"

[TAC board member Fred Frese spoke at the Virginia Commonwealth University Alumni Honorarium on March 8, 2002. Betsy Brown heard him speak, and offers her opinion on this remarkable man. Reprinted with permission from the web site of Empowerment for Healthy Minds, at http://www.efhm.com/frese1.htm]


Dr. Fred Frese

I had been looking forward to seeing and hearing Dr. Fred Frese in a speech for the VCU Alumni Honorarium for weeks. I had a memory of him from a video I had seen years ago. I remembered laughing. So I described Dr. Frese to people as "a funny man" and "a stand up comedian." Maybe some wondered what would be funny about schizophrenia? "Guess you had to be there," and, "Better to laugh than cry," are some responses I can think of to that question. Laughter is healing and unites people. Not to mention that it just plain feels good. But I found out that Dr. Frese knows how to use humor in a powerful way, to teach truth, and to make a lasting impression. For those whose hearts were open, it was a good one.

He is a modest looking man with facial ticks because of tardive dyskinesia. Sometimes his speech is muffled and sometimes loud but always, there is emphasis on those things that need to stand out. I find myself working to hear all that he says.

He takes an appreciable amount of time with our large audience of rehabilitation professionals emphasizing his credibility. But he speaks only briefly about his many degrees in Business and Psychology. He says he has no need to prove he has these. He explains that he must work harder to define his credibility as a man who has schizophrenia. Naming himself "the psychotic psychologist" he then pokes fun at someone who may think, "how did we let this one get through?" Although he has the sheet of paper that says he has earned his degrees, he has nothing to show his audience that says that he really has schizophrenia.

But look at him. He has a funny way of speaking and his face twists and turns. Sometimes his voice gets very loud and sometimes it is barely audible. Sometimes he even bursts out and yells at the audience. He seems to delight in catching the audience off guard. At one point two men beside me get up and leave. Are they uncomfortable?

I wonder why he is trying to prove to the audience that he really has schizophrenia? Why does he feel the need to convince people of this? But by the end of his speech I know why. He brings us into his experience, into his thoughts. I am opening myself to hear "the meat" of what he is saying. The "schizophrenic mind" expands beyond the limits of the "chronically normal" he says. I understand the expansive mind he speaks of.

He uses an overhead projector that shows some editorial cartoons from the *Richmond Times Dispatch*. People are displayed with mental illness as monsters and "crazies." What happens next amazes me. The audience is caught up with this man, they love him already because he has made us laugh and now what does he do? He raises his voice and expresses anger. It moves over us in a very powerful way to make the point that there are still many myths perpetuated in the media about persons with mental illness. Is this when the men beside me decide to get up and leave? I can't say. I am truly caught up with this man.

Your Voice—Will Make a Difference

Dear Dr. Torrey, et al

I just wanted to thank you for all your efforts on behalf of the seriously mentally ill. Our only child, our son, was stricken with paranoid schizophrenia around his 21st birthday and he is now 35 — most of those years in treatment facilities. Keith has been in the Florida Treatment and Evaluation Center for the past 5 years, he tackled a LEO — very serious offense-in Florida. You are so right that too many mentally ill are incarcerated due to a lack of any other options. At any rate, wish we could give you more money — much of our hope for the future hangs on TAC.

M.P. Kernan,
Florida

Dear E. Fuller Torrey,

I am proud to be a supporter of TAC. The work you are doing can only be really appreciated by those of us who have a personal relationship with someone who has a mental illness.

My son, Stephen, first showed signs of his schizophrenia when he was in his early 20s. His story is typical of any, in and out of numerous hospitals and various respites. There were times of encouragement and times of despair. But we never gave up on him and always stood behind him with love and financial support.

Steve has come full circle in the past year and a half. He has held the same part-time job for the last year, and two months ago moved into his own apartment and even has a car. My wife and I feel we are truly blessed.

I just wanted to pass this story on to you because there are so any sad ones, it's always nice to hear something good for a change.

Friends from New Jersey

The following memorials and tributes were received by Treatment Advocacy Center since our last issue was published. Please accept our deep appreciation for choosing to support our mission in memory or in honor of someone very special to you.

—Treatment Advocacy Center Board and Staff.

Received From	City and State	In Memory Of	In Honor Of
Jocelyn D. Phillips	Seattle, WA	Virginia Davis Phillips	
Eileen Rorick	Orange Springs, FL		Michael Rorick
Warren and Irene Cook	Manasquan, NJ	Gloria Blumenthal (A Founder of NAMI Mercer)	
Madeleine Goodrich	Concord, MA		John Nash
Kelley Johnson	Bayville, NJ		Kim Johnson
Gerald T. Caprio	Verona, NJ	Deceased NAMINJ members	
NAMI Volusia/Flagler	Palm Coas, FL	Peter VonPein	
Christine Vaughan	Nashua, NH		Michael Dyer
Jeanne Walter	Sumner, WA	Jan Geary	Sue Geary
Isabel Ehrenreich	Flintridge, CA	Betty Miezner	
Anne Hudson	Grosse Pointe, MI	Ellen Rouse	
Gale Barshop	Alexandria, VA	Lynn Arden	
Walker and Sydney Pettyjohn	Chatham, VA	Stephen Kemp Pettyjohn	
Mary Ellen Gonzalez	Miami, FL		My son who doesn't know he is sick
Merrill David Blake Blake & Associates	Boston, MA	Jessie Bayldon Coakley Blake	
Jerome and Hazel Byers	Dallas, TX		Joel Feiner, MD
Carolyn Helt Colliver	Lexington, KY	Scott Lee Helt	
Darlene Haley	Riverside, CA		Brian and Darren Kotab
Jim and Jane Carlson	Westlake, OH	Christopher Carlson	
Anthony and Judith Gaess	Montvale, NJ	Kimberly Rose	
Peggy Dodson	Grove City, OH		Dana Patrick (Brother with Schizophrenia)
Eileen Rorick	Orange Springs, FL		Michael Rorick
Joan Hartley	Portland, OR		Mark Leonetti
Florence Keenan	Chevy Chase, MD		Ann Keenan
Carla Jacobs	Tustin, CA		Fred Frese
Mary Zdanowicz	Arlington, VA		Chip Correll and John Shanteau

Testimony of Mary T. Zdanowicz, JD, Executive Director of the Treatment Advocacy Center, before the Florida Senate Committee on Children and Families, February 20, 2002

The Sheriffs don't want to expand the Baker Act — they just want to make it work. The Baker Act is a runaway train speeding down the wrong track. Since 1997, there has been nearly a 40 percent increase in Baker Act cases. There was a 19 percent increase last year alone. The 15,000 new cases last year cost $43 million more for emergency evaluations alone (using Department of Children and Families cost figures).

The Sheriffs' proposal has two key provisions:

First, it is narrowly tailored to affect individuals with multiple prior Baker Act episodes and arrests (or one that resulted in physical violence) who are substantially likely to be Baker-Acted anyway. This allows early intervention for people who have established histories of dangerousness rather than waiting for the "real and present threat of substantial harm" required by the Baker Act.

Second, the Sheriffs' proposal keeps people from revolving through the Baker Act door by ensuring that when they leave the Baker Act facility after 8 days or less, the court can require that they participate in treatment, if it is available.

The bill that you have before you today is different from the one that was filed and used for the Senate staff analysis. The Sheriffs have consulted with various interest groups and have made major concessions that are reflected in the strike-everything amendment before you. The Sheriffs even incorporated amendments suggested by groups that said they would never support the bill, but the Sheriffs still tried to address their concerns. The list of concessions made for mental health providers, consumers, public defenders, the courts and the Department of Children and Families is almost as long as the bill.

There were more than 50,000 adults Baker-Acted in 2000, but approximately 7,500 of them were Baker Acted multiple times. These individuals accounted for a full one third of all Baker Act cases. The 7,500 adults could become eligible for the proposed new Baker Act criteria, but this is not an increase in cases because they are only eligible if it is substantially likely that they will deteriorate to current Baker Act criteria. Based on other states' experiences, there will be substantially fewer people affected by the bill. New York implemented a similar bill in 1997, which has survived constitutional challenge, by the way. The doom-sayers predicted that 7,000 people would be affected the first year. In reality, there were only 225 petitions. Now they have about 220 petitions each month. That is equivalent to less than 3 percent of total Baker Act cases.

If there were petitions for all 7,500 recidivist adults, and services were available so they could be required to participate in treatment, Baker Act cases could be reduced substantially. With a court order and at least three mental health contacts a month, the need for Baker Act can be reduced by 57 percent. For the 7,500 recidivist adults, there could be a cost savings of $34 million in emergency evaluations alone. It would also reduce arrests and violence — getting people with severe mental illnesses off the criminal justice track and back on the track to mental health.

For more on Baker Act reform, visit the Florida page in the "State Activity" section of the TAC website at www.psychlaws.org.

Testimony of Rosanna Esposito, JD, Treatment Advocacy Center, before the Maryland House Environmental Matters Committee, March 5, 2002

The Treatment Advocacy Center (Center) is a national non-profit organization, located in Arlington, Virginia. Our mission is to eliminate barriers to treatment for people with severe mental illnesses such as schizophrenia and bipolar disorder. The Center is particularly concerned about state laws that require a "clear and imminent danger" as the basis for medical interventions for people who do not recognize their own need for treatment. I have been asked today to speak about how Maryland's "dangerous" standard compares to other treatment laws and to share experiences from other states that have updated their treatment standards.

When was the last time Maryland revised its treatment criteria?

Maryland last revised its treatment criteria in 1982, at the tail end of a national trend where states changed their laws to require a court finding of dangerousness before treatment could be provided to those incapable of recognizing their need for it. While well intentioned, reform efforts meant to protect people with mental illnesses resulted in many of the most severely ill going without needed treatment. In too many cases waiting for "clear and imminent danger" has resulted in people becoming homeless, incarcerated, suicidal, victimized or prone to violent episodes.

How does Maryland's treatment law compare to other state treatment laws?

Here we are again, at the tail end of another trend where states have updated their treatment laws to allow earlier intervention. Maryland now has one of the strictest criterions for treatment in the nation. [Visit http://www.psychlaws.org/LegalResources/statechart.htm to see a chart summarizing the criteria for all 50 states.]

How does House Bill 923 compare to other state treatment laws?

Forty-four states have modernized their laws over the past twenty years to allow medical intervention before a person reaches the point of "imminent dangerousness." These reforms recognized that dangerousness-based criteria often resulted in tragedies that were preventable. The revisions were also meant to bring the treatment laws more in line with terrific advances in scientific understanding and ability to treat severe mental illnesses. The majority of states have criteria similar to the 'gravely disabled language' proposed in House Bill 923. Several states are even more progressive. [Visit http://www.psychlaws.org/StateActivity/Maryland/doc4.htm to see a selection of comparable criterions.]

Is the 'gravely disabled' criterion unconstitutional?

Since Washington State first passed its 'gravely disabled' standard in 1976, such narrowly tailored standards have been routinely upheld in constitutional challenges in state courts. The U.S. Supreme Court has never even decided to accept or hear a challenge to a 'gravely disabled' standard.

Does the U.S. Supreme Court require 'dangerousness' in order for the state to order a person into treatment?

The argument that O'Connor v. Donaldson requires dangerousness for civil commitment misreads the holding of that case. What the Court did rule was that a nondangerous person could not be confined if there was no treatment being given. According to Kenneth Kress, a prominent Mental Health Law professor from the University of Iowa who has published articles on the subject, "Scholarly opinion recognizes the parens patriae power to constitutionally commit and require coerced medication under three conditions: (1) mental illness; (2) incapacity to make informed treatment decisions; and (3) treatment is provided." House Bill 923 satisfies these requirements.

Should the law allow non-dangerous people to select their own course of medical treatment?

Absolutely. The Center supports the rights of non-dangerous people with severe mental illnesses who have the capacity to make an informed medical decision to make treatment decisions for themselves. The proposed 'gravely disabled' in House Bill 923 criteria upholds those rights because it is specifically tailored to apply only to those who are incapable of making an informed decision about treatment.

Why is the incapacity to make an informed decision a key element of the reform proposal?

It is commonly claimed that "if you make the psychiatric services attractive enough and culturally relevant, then individuals with serious mental illnesses will utilize them." This appears to not be true. There have been nearly 100 studies in recent years that address the question of "anasognosia" or lack of insight in people with severe mental illnesses. The research shows that nearly half of the people with schizophrenia or bipolar disorder do lack insight into their illness. In a recently published study the greatest reason for non-treatment, by far, was the person's lack of awareness of their illness. Very few of those polled in the study cited "not satisfied with available services," "could not get appointment," "language problem," etc., as a reason why they were not in treatment. Such individuals will not voluntarily utilize psychiatric services, no matter how attractive those services are, because they do not believe that they have an illness.

Rosanna answers questions at a NAMI convention.

Do people who are treated involuntarily refuse to be treated on a voluntary basis in the future?

The claim that involuntary treatment scares many away from even voluntary services appears to be unfounded. Studies demonstrate that the majority of individuals who refuse treatment accept it after being told that they must. Furthermore, the majority of patients who initially object to hospitalization or medication retrospectively agree with the decision to hospitalize or treat them. Research also suggests that, "attitudes toward treatment can improve over longer periods of time, and that previously committed patients tend to voluntarily seek treatment later."

Will updating the treatment standard result in more hospitalizations?

Opponents to reform measures in other states argued that changes would cast a "dragnet" and force a dramatic increase in hospitalizations of people with severe mental illness. Experience shows those fears have never been realized. In a study of eight states that reformed commitment laws between 1975 and 1990 to include need-for-treatment criteria broader than House Bill 923, it was reported that five states experienced decreased hospital admissions after the statutory reform. The remaining three states had moderate increases that were attributed to other factors because few of the new commitments were made using the need-for-treatment criteria.

In 1996, Wisconsin enacted a need-for-treatment standard for assisted treatment that is much broader than House Bill 923. Based on data from 4 years and 4 months after the standard was enacted, it accounted for less than 1% of psychiatric hospitalizations in that state.

[For more on reform efforts in Maryland, visit the Maryland page in the "State Activity" section of the TAC website at www.psychlaws.org.]

TREATMENT ADVOCACY CENTER

TREATMENT ADVOCACY CENTER CATALYST

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Please help the Treatment Advocacy Center achieve its mission to eliminate the legal and practical barriers to treatment for millions of Americans who suffer from, but are not being treated appropriately for, severe brain disorders, such as schizophrenia and manic-depressive illness, and to prevent the devastating consequences of non-treatment:

homelessness, suicide, victimization, worsening of symptoms, homicide, and incarceration.

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