Catalyst
TREATMENT ADVOCACY CENTER
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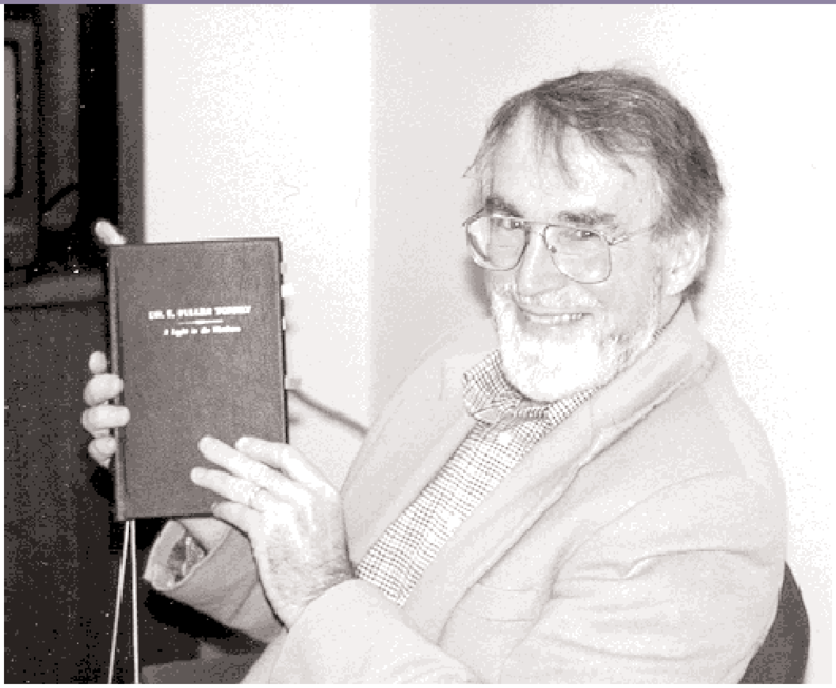
A note of thanks from Dr. Torrey

To all of you who contributed to the book which was presented to me by the Treatment Advocacy Center Board on November 8, I would like to thank you sincerely for your kind words. I will treasure the book always. To turn around the treatment system so that it serves all individuals with severe mental illnesses is, and will continue to be, a very difficult task, but if we all continue to work together, we will do so.

With gratitude,
Dr. E. Fuller Torrey



Dr. E. Fuller Torrey accepting a book which compiled personal messages from hundreds of individuals thanking him for a lifetime of contributions to research and advocacy related to severe mental illnesses.

State updates [see more updates inside]

Nine States identify outpatient civil commitment as one of Year 2000 priorities

According to the National Conference of State Legislature's (NCSL's) 2000 State Health Priorities Survey nine states have identified outpatient civil commitment among the legislative priorities next year. The states that answered yes to outpatient civil commitment on the 2000 priorities survey are: Indiana; Nebraska; New Hampshire; New Jersey; North Carolina; North Dakota; Texas; Maryland; and Kentucky. NCSL has also responded to information requests on the issue from legislative staff in Pennsylvania and Nevada.

Treatment Advocacy Center forms new Honorary Advisory Committee

The Treatment Advocacy Center is pleased to announce the formation of its Honorary Advisory Committee (see box on page 6). 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.

The new Honorary Advisory Committee members are:

S. Jan Brakel, J.D, Vice President, Isaac Ray Center, Inc., Chicago, Illinois

John Davis, M.D., University of Illinois at Chicago

Honorable Pete V. Domenici, United States Senate, New Mexico

Laurie Flynn, Executive Director, NAMI, Arlington, Virginia

Jeffrey Geller, M.D., University of Massachusetts

Honorable Marcy Kaptur, House of Representatives, Ohio

Richard Lamb, M.D., University of Southern California

Honorable Jim McDermott, House of Representatives, Washington

Honorable Lynn Rivers, House of Representatives, Michigan

Honorable Ted Strickland, House of Representatives, Ohio

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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 1.5 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 brain diseases.

Estimated 1,000 homicides per year in U.S. are committed by individuals with severe mental illnesses

Approximately 1,000 homicides per year in the United States are committed by individuals with severe mental illnesses. Where does this number come from?

The estimate came independently from two studies, both of which arrived at approximately the same conclusion.

Murder in families
by J.M. Dawson and P.A. Langan
U.S. Department of Justice, 1994.

This was a study of 2,655 homicides in 1988 drawn from a "representative sample" of 33 of the largest counties in the United States. The information was obtained from the files of prosecutors who examined the cases. They reported that 4.3 percent of the assailants had a "history of mental illness."

In 1988 there were reported to be 20,680 cases of "murder and non-negligent manslaughter" in the United States (Sourcebook of Criminal Justice Statistics online). Therefore, there were 889 homicides (20,680 x 0.43) caused by mentally ill individuals in the United States in 1988.

Since 1988 the murder rate has decreased in the United States (16,914 in 1998). Most of the decrease is thought to be caused by (1) increased incarceration rates of career criminals; (2) fewer drug-related homicides because of increased organization of the cocaine distribution; and (3) demographic factors, especially an aging population. None of these would be likely to affect the homicides committed by individuals with mental illnesses.

On the other hand, since 1988, public psychiatric services for individuals with mental illnesses have continued to deteriorate. There are now many more such individuals who have been released from state psychiatric hospitals and who are not being treated. In addition to this, the overall population of the United States has increased 12 percent (from 245 million in 1988 to 274 million in 1999). Given the increased number of untreated severely mentally ill individuals and the population in 1999 compared to that in 1988, it does not seem unreasonable to assume that the 889 homicides related to mental illness in 1988 grew to approximately 1,000 homicides in 1999.

Violent behavior by individuals with serious mental illness, *Hospital and Community Psychiatry* 45:653–662, 1994, by E.F. Torrey, M.D.

This reported a study of all homicides committed by severely mentally ill individuals reported by a single newspaper, *The Washington Post*, for the year 1992. There were 13 such homicides.

It was assumed that this newspaper was covering stories for the metropolitan Washington, D.C., area of approximately 3 million people. The total population of the United States in 1992 was 255 million, or 85 times that of the Washington area. Since homicides by severely mentally ill individuals were being anecdotally reported throughout the United States, in rural areas as well as in urban areas, it was assumed that the Washington metropolitan area was representative of the entire United States.

The total number of homicides committed by severely mentally ill individuals in the United States in 1992 would therefore have been 1,105 (13 x 85). This, of course, includes only those cases of which the newspaper became aware. In addition, between 1992 and 1999, the population of the United Sates increased 7 percent (from 255 to 274 million).

Summary: Given the similar findings of the two studies done independently in 1988 and 1992, the continuing deterioration of public mental illness services, and the increased population, an estimate of approximately 1,000 homicides committed by individuals with severe mental illnesses each year in the United States is probably conservative.

Tips for family members about the criminal justice system

by Taylor P. Andrews, Esq., Special Counsel, Treatment Advocacy Center

Dealing with the defense attorney.

The 1992 report, “Criminalizing the Seriously Mentally Ill”, by the National Alliance for the Mentally Ill and Public Citizen's Health Research Group, documented the criminalization process that had been apparent for years to those who work in the criminal justice system.

Mentally ill individuals have been caught up in the criminal justice system due to the closure of inpatient psychiatric hospitals and restrictive standards for involuntary treatment for mental illness. As total hospital beds for treatment have shrunk, jail and prison populations have exploded.

According to the United States Department of Justice, as of midyear 1998 an estimated 283,800 prison and jail inmates were mentally ill. This represented 16 percent of state inmates and 7 percent of federal inmates. Between 1.2 and 1.5 million acutely mentally ill individuals are admitted to our nation's jails each year. In comparison, there are less than 60,000 individuals in state psychiatric hospitals.

I am concerned about the anguish that I often see when a mentally ill individual is charged with a crime. As hard as it is for a mentally ill defendant to cope with a criminal charge, it is often harder for the family of the mentally ill defendant to experience the criminal prosecution. Family members who encounter behaviors and decisions that seem irrational and hostile commonly suffer frustration, disappointment, anger, and grief.

I hope to give some explanation about the criminal trial process that will reduce the anguish that derives from misunderstandings about the process. This article focuses on the defense function. Future articles may discuss the Court, the prosecutor, the jail/prison and the police.

Who is the defense attorney?

One of the first decisions that will confront a defendant, and therefore the family, is the selection of a defense attorney. A decision must be made. Will an attorney be hired? If so, which attorney, and who will contact and pay for the attorney?

An individual charged with a crime is entitled to a free lawyer if he or she cannot afford to hire a lawyer. Therefore, every court has a system for providing free legal counsel to those who are indigent. There may be a public defender office to provide counsel, or the court may appoint a lawyer to provide services with the cost paid by the government.

If the defendant is able to hire an attorney, the appointment of free counsel will not be an option. If the defendant is unable to hire an attorney, the defendant's family may want to hire an attorney, and a decision must be made whether to do so.

The family must understand that the attorney's ethical obligation flows to the defendant even if the family selects and pays for the attorney. A defendant cannot be forced to accept representation by an attorney hired by someone else. If the defendant does accept representation by an attorney hired by his family, the defendant enjoys the same relationship with the attorney as if he had hired the attorney himself. These principles frustrate many families who desire to have an active role in making decisions because they selected and paid the attorney.

It is essential that a criminal defense attorney be obtained, because special skill and knowledge is required to provide effective services in a criminal case. Do not routinely reject representation by the court appointed attorney. In many jurisdictions the public defender may provide high-quality services. Large caseloads may limit the amount of time that a public defender can spend with the defendant or the family, but the caseloads also provide a tremendous amount of experience in a short time.

Public defenders are specialists. Do not just rely on the family attorney that wrote your will or helped you settle on your house. Effective and experienced criminal defense attorneys can be very expensive. At the same time, there are defense attorneys that are expensive who are neither experienced nor effective. So how do you know if the public defender will do a quality job? How do you find a good attorney to hire?

If you have a family attorney, seek his or her opinion about appointed counsel and about possible referrals. If you know someone who works in the criminal court system, (e.g. policeman, probation officer, deputy sheriff) seek his or her opinion.

Though appointed counsel does not have to answer your questions, nevertheless ask about educational and professional experience. How long has the attorney been a defense attorney? Has he or she handled other similar cases? Does he or she understand the mental illness that is involved? If you encounter resistance or hostility you may want to consider other options if you have them.

When selecting an attorney to hire, look for prior experience in criminal court. Former district attorneys and public defenders or their assistants may be good possibilities. Membership in the National Association of Criminal Defense Lawyers reflects a particular interest and commitment to criminal defense work. The national office may be reached at 202-872-8600. Be sure the selected attorney has an understanding and sympathetic view of the mental illness that is involved.

Referrals from other families active with your local NAMI organization may be helpful. Ask about costs up front, and insist that the fee agreement be reduced to writing. It is common for criminal defense attorneys to require payment of most, if not the entire fee, in advance.

The attorney won't talk to me.

As noted above, the attorney's ethical obligations are owed to the defendant regardless of who is paying the fee. This means that the communications between the defendant and the attorney are privileged, and the attorney must keep them confidential. If the attorney allowed a family member to sit in during an interview with the defendant, even with the defendant's consent, the substance of the interview would no longer be privileged and the family member could be compelled to disclose what was said.

Attorneys develop standard operating procedures to avoid violations of their ethical obligations. These procedures often exclude family members from client conferences about decisions and strategies. This is a common source of frustration for family members,

If you have access to Internet, and have an e-mail address, please request to receive Treatment Advocacy News, an online publication.

This online newsletter is edited by Mary T. Zdanowicz, J.D., Executive Director of the Center.

There is no fee for the newsletter, but donations are welcome.

To subscribe send a message to maryz@psychlaws.org with your name, address, affiliations (if any), relationship (if any) to someone with a neurobiological disorder, and interest in laws surrounding the treatment of individuals with neurobiological disorders. This information will be kept confidential. Requests for subscriptions will also be processed without this information.

particularly if the family retained the attorney.

Even though communications from the defense attorney may be guarded and limited, there is no legal barrier to communications from the family to the attorney. If the attorney is receptive to contacts, by all means confer with the attorney. If the attorney is hard to contact, send information in writing that you want the attorney to have. The attorney's caseload may complicate the scheduling of conferences with the family. This is another reason to provide information in writing.

Sometimes the defendant sees the family as the opposition. The family may want a therapeutic result in the criminal case, and the defendant insists that he is not ill and opposes all treatment. In such a case, the defense attorney will not be an ally of the family. The family should nevertheless provide information to the defense attorney, including treatment histories and descriptions of symptomatic behavior of the defendant. Families will need to find other ways to be heard in the case. This may include communication with the prosecutor or the judge. Such communications will be addressed in a future article.

Does the attorney understand mental illness?

Unfortunately, instruction about mental illness is neither required in law school, nor a common topic for continuing legal education. A particular attorney's understanding of a particular mental illness will depend upon the attorney's prior experience in other cases, or other personal experiences. Attorneys can be as uninformed about mental illnesses as the general public.

If you are selecting an attorney, discuss with the attorney his or her knowledge about the particular mental illness that is involved. It is obviously best to find an attorney that understands the mental illness. If this is not possible, at least avoid an attorney who has a misunderstanding about mental illness, and is not receptive to new information.

You can also ask an appointed attorney about his or her understanding of the mental illness, though you cannot be assured of a response. If the attorney is not well informed, offer to provide information and do so in writing. Be diplomatic; no attorney likes to feel challenged and criticized, and you may be totally discounted and ignored by an alienated attorney.

I disagree with the decisions being made.

Disagreements about major decisions, such as whether to plead insanity as a defense, whether to have a jury trial, and whether the defendant will testify are frequently a source of family heartache. A mentally ill, though competent, defendant may opt to assert a defense that is doomed to fail. Or, he might forego a legitimate insanity defense.

It is the defense attorney's duty to counsel the defendant to make these decisions. However, it is the client, and not the attorney, who makes the decision. A defendant who was floridly psychotic at the time of a crime, but who will not accept that he is mentally ill, and who will therefore not assert an insanity defense, will not have the insanity defense in his case. The attorney cannot make this decision for the defendant.

It is wrong, therefore, to automatically conclude that a defendant is poorly counseled when he or she makes decisions that do not seem to be wise. This can be very frustrating to the attorney as well as to the family. The attorney may feel that he is prevented by confidentiality rules from sharing this problem with the family.

Let the defense attorney know if you think you can influence the defendant in his or her decision-making. Perhaps you can be enlisted to help the defendant make a particular decision. Do not attempt to influence the defendant without the knowledge of the defense attorney. This can lead to suspicion that you are fueling the unreasonableness of the defendant. If, on the other hand, you work cooperatively with the defense attorney, there can be a unified approach and suspicion can be avoided.

Unlike adoptions and real estate settlements, criminal prosecutions are typically unhappy occasions for all involved. This is particularly so if the charges are serious. The best defense attorney, the positive response of the defendant, and cooperative communications cannot remove the anquish that is inherent in the process of determining guilt and imposing punishment. Realistic family expectations about the criminal trial process will hopefully avoid some disappointment and frustration that would add to this emotional burden.

Taylor P. Andrews, Esq., has served as Chief Public Defender of Cumberland County, Pennsylvania, since 1976. Prior to that he was an assistant public defender in Philadelphia, Pennsylvania. A member of NAMI since 1992, he is currently the president of his local NAMI PA affiliate.

Major Media Interest—TV and radio stations, national newspapers, internet—taking an interest in issues of major importance to Treatment Advocacy Center mission [excerpts follow-editor]

October 25: Dateline NBC aired a story about the tragic subway pushing incidents that occurred this year in New York City. The incidents, which both involved individuals who were not being treated for their schizophrenia, resulted in the adoption of Kendra's Law. Kendra's Law, effective November 9, 1999, finally made assisted outpatient treatment available in New York. It was named after Kendra Webdale, a beautiful 32-year-old woman who lost her life when a schizophrenic man who was not being treated for his illness, pushed her into the path of a subway train. A second similar incident highlighted was the story of Edgar Rivera, a victim who lost both of his legs.

December 10: The Center co-sponsored the **First Annual Forum on Mental Illness and the Law** with the George Mason University's School of Law, Law and Psychiatry Center and the GMU's Center for Health Policy & Ethics. Proceedings were taped by Fed Net and were available for viewing on the Internet through the Center's Web site: www.psychlaws.org. Dr. Torrey was the featured speaker and discussed the science of severe mental illness and the devastating consequences of failing to treat these illnesses. Tape is available for purchase (703-739-3008).

December: U.S. Surgeon General's Report on Mental Illness released. (See editorials on this report at paragraphs beginning December 15, 20, and 30.)

December 15: Editorial criticizing the Surgeon General's Report appeared in the **New York Times** article, **Mentally Ill or Just Feeling Sad?** by Sally L. Satel, a psychiatrist, senior associate at the Ethics and Public Policy Center.

December 16: New York Times previewed **The Shattered Mind** (aired on December 17), written by Walter Goodman.

"The Shattered Mind offers hope in new generations of psychotropic drugs that cannot cure the ailment but can subdue its outbreaks while scientists strive for a better understanding of the workings or misworkings of the brain."

Personal case histories are featured including a first person account of schizophrenia from a man who is now on medication and "channels his emotions" by painting.

December 17: Bill Kurtis' **Investigative Reports on A&E** covered **The Shattered Mind** and featured Dr. E. Fuller Torrey.

This A&E documentary reported that some two million people have schizophrenia, and about 10 percent of them are potentially violent. Dr. Torrey was interviewed extensively about current brain research and the latest information about treatment for the mentally ill, which includes appropriate medication and inclusion of families in treatment decisions.

There was an interactive A&E Web site which posed the question, "Should individuals with schizophrenia be forced into mandatory treatment?"

December 18: NBC Nightly News had a story on the pending reform of the LPS Act. Ms. Elvira Gonzalez bravely spoke of how our inability to help those in need of treatment caused the death of her daughter and her daughter's two children. Doctors spoke eloquently of why we need to treat people who are deteriorating because of mental illness before they hit rock bottom.

December 20: New York Times article. **Mentally Ill are Squeezed by Parsimony**, by Joyce Purnick.

This article criticized the surgeon general's report for faulting private insurance companies for not providing parity while the federal government fails to provide parity for mental illness in Medicaid. Treatment Advocacy Center board member states that the Medicaid policy is, "federally sanctioned discrimination against the mentally ill." The unintended consequences of the policy include the cost-cutting discharge of patients from state mental hospitals. Many now live in the streets or move in and out of jail.

December 22: The Associated Press State & Local Wire—Headline: Study: Involuntary outpatient commitment [assisted outpatient treatment] pays long-term benefits reported findings in a study led by Duke University Medical Center researchers published in the December issue of the **American Journal of Psychiatry**. Associate Professor Marvin Swartz explained that, "This study suggests that there is a subgroup of patients, with severe psychotic disorders, who with six months or more in the involuntary outpatient commitment program, with a fair amount of treatment, do better at staying out of the hospital—the commitment, the court order, does exert an effect. This is a promising legal tool, but it doesn't substitute for high-intensity treatment." The group plans further research on violence and found that, "Preliminary results show that rates of violence and victimization decreased."

December 30: The Washington Post. Reprinted with permission, copyright 1999, all rights reserved.

Federal Neglect Of the Mentally Ill, by D.J. Jaffe and Mary T. Zdanowicz, J.D.

The recently released Surgeon General's Report on Mental Health is the equivalent of describing the maiden voyage of the Titanic without mentioning the iceberg. While the report criticizes private insurance companies for failing to provide "parity" in their coverage of mental illnesses, it is totally silent on the

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failure to provide parity in Medicaid, the federal government's insurance program.

For the most severely mentally ill, private insurance is essentially meaningless. Because of their illnesses, most are indigent, and private insurance is a luxury they cannot afford and are not in a position to obtain through employment.

Many of these individuals do have insurance through Medicaid, a federal insurance program that covers their care, except for a single exception—inpatient care in psychiatric hospitals. The federal government's Institution for Mental Diseases (IMD) exclusion prohibits Medicaid from reimbursing for most individuals who need care in a psychiatric hospital. If you have a disease in your heart, liver or any other organ and need treatment in a hospital, Medicaid contributes. But if you have a disease in your brain and need care in a psychiatric hospital, Medicaid does not.

As a result of this federally-sanctioned discrimination, state psychiatric hospitals are locking the front door and opening the back, making it increasingly difficult for the most severely ill to get inpatient treatment. They are discharging patients sicker and quicker in a headlong dash to make them Medicaid eligible by ending their inpatient residency.

There were about 470,000 individuals receiving inpatient psychiatric care in state hospitals when the Medicaid program started in 1965, compared with fewer than 60,000 today. Hospital closures have actually accelerated in recent years. Forty state hospitals shut their doors between 1990 and 1997—nearly three times as many as during the entire period from 1970 to 1990, and many more closings are planned.

Of the 3.5 million Americans with schizophrenia and manic-depression, 40 percent (1.4 million) are not being treated. Medicaid's denial of coverage results in homelessness, incarceration, victimization and even death for many people who are so ill they are unable to care for themselves. By the Justice Department's own statistics, there are currently about 283,800 mentally ill people locked up in the nation's jails and prisons.

The Los Angeles County Jail and New York's Riker's Island are currently the two largest "treatment facilities" for the mentally ill in the country. Another 150,000 to 200,000 mentally ill are homeless, and 28 percent get at least some of their meals from garbage cans. More than 10 percent will die from suicide. Others will commit acts of violence against family, friends and total strangers.

Not only does federal discrimination hurt the mentally ill, it affects the standard of living for everyone else, too. Many parks and public libraries, once enjoyed by all, are now rendered nearly unusable to the general community by the visions of lost, psychotic souls who need inpatient care but are locked out by the discrimination embedded in Medicaid law. Seemingly random acts of violence committed by individuals with a history of mental illness are frequently reported on the evening news. No amount of preaching by the Surgeon General against "stigma" will overcome the acts of a Russell Weston, a Ted Kaczynski or an Andrew Goldstein, all persons with untreated schizophrenia.

The federal government must accept its share of criticism for a policy that discriminates against individuals solely on a diagnosis of mental illness. We must steer clear of the iceberg that sank our state psychiatric hospital system and eliminate the Medicaid IMD exclusion.

D. J. Jaffe is a volunteer coordinator of the New York Treatment Advocacy Coalition. Mary Zdanowicz is executive director of the Treatment Advocacy Center in Arlington.

California's campaign to provide care

by Jonathan Stanley, J.D., Assistant Director, Treatment Advocacy Center

California's Lanterman-Petris-Short Act (LPS) was the model for almost all our nation's restrictive assisted treatment laws. LPS was enacted in 1967 and based in part on the recommendations of such anti-treatment figures as Thomas Szasz, who denies that mental illness even exists. The ways in which the LPS law effectively denies care to those who need it most is all too familiar: a standard that only allows for the assisted treatment of those who are dangerous rather than simply to those who are too sick to understand their need for care, no court-ordered outpatient treatment and ponderous, redundant procedures. Many states have since abandoned LPS prohibitions on treatment. This year we hope to see LPS reformed as well.

Californian Assemblywoman Helen Thomson and Senator Don Perata have introduced legislation to reform LPS. The Thomson/Perata proposal introduces the "need for treatment" criteria into LPS and allows for assisted outpatient treatment as well as streamlining California's absurdly cumbersome procedural laws pertaining to assisted treatment.

Among the bills many advances are that it would:

- allow consideration of the patient's medical history and condition beyond the immediate moment in order to consider the risk of further deterioration without treatment;
- combine certain court hearings to allow the need for involuntary commitment and treatment to be determined at the same hearing; and
- provide an outpatient treatment option to permit court-ordered treatment in a less restrictive setting.

In passing the bill, California would transform its law from one of the country's most prohibitive of treatment to one that most encourages the care of those overwhelmed by mental illness.

Our Center is supporting the efforts of the California Treatment Advocacy Center (CTAC) to secure the passage of the LPS reform bill. Ably led by Co-Coordinators Carla Jacobs and Randall Hagar, CTAC members are hard at work to reform LPS—writing letters to, speaking to and meeting with community organizations, legislators and newspaper editorial boards.

The efforts of CTAC's faithful have so far paid off. The Los Angeles Board of Supervisors unanimously resolved to support Assemblywoman Thomson and Senator Parata's measure. NAMI's national leadership is solidly behind the measure. NAMI Executive Director Laurie Flynn issued a press release that pronounced, "The reform initiative is consistent with NAMI policy, and I consider it a model of positive, exemplary leadership." Perhaps most importantly, editorials endorsing LPS reform have been published by most of California's leading newspapers, including the Los Angeles Times, San Diego Union-Tribune, Ventura Star, Sacramento Bee, Long Beach Press Telegram, and San Francisco Chronicle.

The future of the reform bill is by no means certain, but their appreciation of the vital need to change California's existing laws will no doubt spur CTAC's members to even greater efforts. As CTAC Co-Coordinator Carla Jacobs points out about LPS, "under the current law—for people too sick to realize their own need—there is no treatment available. Instead they eat out of dumpsters, shunning outreach attempts, hallucinating and delusional, too frequently ending in our jails and prisons."

A challenge to Vermont's assisted treatment reform

by Rosanna Esposito, J.D., Attorney, Treatment Advocacy Center

A recent case from a Vermont superior court illustrates an unusual example of how newly-enacted assisted treatment laws can get tangled up in legal challenges. In J.L. v. Miller, a judge denied the State of Vermont's motion to vacate an existing consent decree; a motion necessary for the full implementation of the State's new involuntary medication law. This decision applies only to Vermont and could still be overturned.

Since 1985, the J.L. Consent Decree has governed procedures for the involuntary medication of patients committed to the Vermont State Hospital. Under its provisions, the standard for making an involuntary medication decision is the "substituted judgment" standard. Under this standard, the administrative hearing officer must determine that the person, if competent, would consent to treatment.

In 1998 the Vermont legislature passed Act 114 with the intent to "render the use of the J.L. v. Miller Consent Decree no longer applicable." The law extended the application of the involuntary medication procedures to those who live in their communities under Orders of Nonhospitalization (assisted outpatient treatment) and inmates in correctional facilities. The new law also provides for a different set of procedures and a different standard for involuntary medication hearings. Family Court hearings replace administrative hearings. The "best medical interest" standard is to be applied rather than the "substituted judgment" standard.

In July 1998 the State of Vermont filed petitions for involuntary medication under the provisions of Act 114. The presiding Family Court judge dismissed the petitions for lack of jurisdiction; the J.L. Consent Decree needed to be vacated in order for the Family Court to hear such cases. Accordingly, the State filed a motion to set aside the J.L. Consent Decree. The Vermont Protection & Advocacy, Inc., opposed the motion in an effort to block implementation of the new law.

The Superior Court judge applied the established legal criteria to determine whether to grant the State's motion to set aside the J.L. Consent Decree. She found that the State did not meet its burden of proving that the Consent Decree should be overturned and therefore denied the motion. With this decision, the J.L. Consent Decree and the "substituted judgment" standard continue to govern the State's procedures for involuntary medication of individuals in the State's psychiatric hospital. However, the court did not make any findings concerning the constitutionality of Act 114, specifically stating that, "This court has not addressed whether the substituted judgment standard is constitutionally protected." Thus, the decision does not impact involuntary medication procedures under Act 114 for individuals in the community or inmates in correctional facilities who are not covered by the J.L. Consent Decree. The court left the door open for the State to further pursue a motion to have the J.L. Consent Decree overturned.

Congressional Record—Senate

Monday, July 12, 1999, 106th Congress, 1st Session, 145 Cong Rec S 8295, Vol. 145, No. 97. **Deinstitutionalization of the mentally ill.**

MR. MOYNIHAN: Mr. President, this past Friday (July 9, 1999), *The Washington Post* carried an excellent op-ed piece, "Deinstitutionalization Hasn't Worked," by E. Fuller Torrey and Mary T.

Zdanowicz. The authors are the president and executive director, respectively, of the Treatment Advocacy Center. They write about the continued stigma attached to mental illness. They write about barriers to treatment. Most important, they write about the aftermaths of deinstitutionalization and the seemingly horrific effects this policy has had.

In this morning's *New York Times* (July 12, 1999), Fox Butterfield writes about a Department of Justice report released yesterday which states that some 283,800 inmates in the nation's jails and prisons suffer from mental illness. (This is a conservative estimate.) As Butterfield puts it, ". . . jails and prisons have become the nation's new mental hospitals."

Over the past 45 years, we have emptied state mental hospitals, but we have not provided commensurate outpatient treatment. Increasingly, individuals with mental illnesses are left to fend for themselves on the streets, where they victimize others or, more frequently, are victimized themselves. Eventually, many wind up in prison, where the likelihood of treatment is nearly as remote.

This is a cautionary tale, instructive of what is possible and also what we ought to be aware of. I was in the Harriman administration in New York in the 1950s. Early in 1955, Harriman met with his new Commissioner of Mental Hygiene, Paul Hoch, who described the development of a tranquilizer derived from rauwolfia by Dr. Nathan S. Kline at what was then known as Rockland State Hospital (it is now the Rockland Psychiatric Center) in Orangeburg. The medication had been clinically tested and appeared to be an effective treatment of many patients. Dr. Hoch recommended that it be used system wide; Harriman found the money.

That same year Congress created a Joint Commission on Mental Health and Illness with a view to formulating ``comprehensive and realistic recommendations" in this area which was then a matter of considerable public concern. Year after year the population of mental institutions grew; year after year new facilities had to be built. Ballot measures to approve the issuance of general obligation bonds for building the facilities appeared just about every election. Or so it seemed.

The discovery of tranquilizers was adventitious. Physicians were seeking cures for disorders they were just beginning to understand. Even a limited success made it possible to believe that the incidence of this particular range of disorders, which had seemingly required persons to be confined against their will or even awareness, could be greatly reduced. The Congressional Commission submitted its report in 1961; it was seen to propose a nationwide program of deinstitutionalization.

Late in 1961 President Kennedy appointed an interagency committee to prepare legislative recommendations based on the report. I represented Secretary of Labor Arthur J. Goldberg on this committee and drafted its final submission. This included the recommendation of the National Institute of Mental Health that 2,000 "community mental health centers" (one for every 100,000 people) be built by 1980. A buoyant Presidential Message to Congress followed early in 1963. "If we apply our medical knowledge and social insights fully," President Kennedy stated, "all but a small portion of the mentally ill can eventually achieve a wholesome and a constructive social adjustment." A "concerted national attack on mental disorders [was] now possible and practical." The President signed the Community Mental Health Centers Construction Act on October 31, 1963—his last public bill signing ceremony. He gave me a pen.

The mental hospitals emptied out. The number of patients in state and county mental hospitals peaked in 1955 at 558,922 and has declined every year since then, to 61,722 in 1996. But we never came near to building the 2,000 community mental health centers. Only some 482 received Federal construction funds from 1963 to 1980. The next year, 1981, the program was folded into the Alcohol, Drug Abuse, and Mental Health block grant program, where it disappeared from view.

Even when centers were built, the results were hardly as hoped for. David Musto has noted that the planners had bet on improving national mental health "by improving the quality of general community life through **expert knowledge** [my emphasis], not merely by more effective treatment of the already ill." The problem was: there was no such knowledge. Nor is there. But the belief there was such knowledge took hold within sectors of the profession, which saw institutions as an unacceptable mode of social control. These activists subscribed to a redefining mode of their own, which they considered altruistic: mental patients were said to have been "labeled," and were not to be drugged. So as the Federal government turned to other matters, the mental institutions continued to release patients, essentially to fend for themselves. There was no connection made: we're quite capable of that in the public sphere. Professor Frederick F. Siegel of Cooper Union observed, ``In the great wave of moral deregulation that began in the mid-1960s, the poor and the insane were freed from the fetters of middle-class mores." Soon, the homeless appeared. Only to be defined as victims of an insufficient supply of affordable housing. No argument, no amount of evidence has yet affected that fixed ideological view.

I commend these two articles to my colleagues and ask that they be printed in the Record.

Your Voice -- Will Make a Difference

Has the second edition of the *Catalyst* been released yet? My sick son read the whole thing and asked me when the new one would be out. This is the first time in 25 years of illness that he has been interested enough to read about his illness.

[A] lack of commitment resulted in his losing control and almost killing me two years ago. I believe that he has learned that his medicines can prevent something like this happening again. It was too bad for all concerned.

I am trying to get out the word to as many people as I can.

Thanks for all the help you [Mary] and those working with you are doing. *Catalyst* is exceptionally well written.

Edna Cramer
Riverside, California

[I cannot tell you how much it means to hear that your son enjoyed reading Catalyst. We will make sure that you and your son get a copy of the second (and all future) issues. —Mary T. Zdanowicz, J.D.]

I want initially to welcome the *Catalyst* onto the stage as a player for better mental health. My personal 47-year experience—since 1953 at age 14—urges me to write to you both as consumer and as advocate here in Kitsap County, Western Washington State. Your request for "stories of personal experience" elicits the response which I enclose.

The appearance of Dr. Torrey on your masthead and as your president, must lend considerable clout to your pursuit of legal medical issues. His recent visit to Seattle gave our region a significant impetus. And now the rest of the story . . .

Confining my focus for the moment to the legal aspect of my manic-depressive decades, as a 14 year old I was a preppie in an upscale suburban school about 35 minutes north of Grand Central Station, New York City. Berserk, I ravaged the dormitory room, pulling drapes, dumping both desks and beds and scattering papers "manicly."

Father, summoned, rushed the 700 miles from Detroit (home) and in a headlong dash, transported me—by now down somewhat from my mania—back to an ominous unknown in Michigan. I was again confined—surging ultra-high by cycles—to a padded cell and a straight jacket in the psychiatric ward of the University of Michigan Hospital, Ann Arbor—there was nothing else.

The horrendous cost of this "elite" facility forced my father into a courtroom venue, which was to haunt him literally for decades. In order—in that unenlightened day—to bring about my transfer to the state hospital at Ypsilanti, Michigan, Dad had to make a statement, which he revealed to me only many years later. In that grim 1953 courtroom scene, my father lived out the worst day of his life! For he had to state publicly that his elder son was insane. Thank God this is now . . . how far, and yet again how far before us stretches the road that we must walk.

At that later sharing, behind me lay "another elsewhere"—a two-and-a-half year stay in Western State Hospital, Steilacoom, Washington, where in 1970 I was adjudged a likely permanent resident. But there was a glimmer, a ray, a beam, a beacon—his name was Dr. Sargent. His first-time diagnosis, and start of lithium medication, was my redemption from the bleakest of possible fates.

The memorial for Scott Hardman was very poignant. Highlighted were "if onlys" which the Center is addressing.

My graduate degree in Classical Studies (MA, UW, 1964) focuses on the Greek tragedians. The very word "tragedy" is linked to wild, berserk ragings in the Hellenic hillsides—very probably bipolarism. Also the plays themselves often portray humans sundered by forces outside themselves and beyond their control. Some commentators even see these "episodic experiences" as proto-attempts on the part of the playwrights to delve into the origins of madness.

I sincerely wish the *Catalyst* well. My personal advocacy is focused on my experience. I have opportunities here in Kitsap County which fill my free time and absorb my energies. I enclose some of my material, which my THRUST team (written and spoken advocates for the mental health community) has developed.

The following memorials and tributes were received by Treatment Advocacy Center in November/December 1999. Please accept our deep appreciation for choosing our mission to support in memory or in honor of someone very special to you. . . .Governing Board and Staff.

Received From	City and State	In Memory Of	In Honor Of
Laura S. Pears	Pittsburgh, Pennsylvania		Sibling Consumer-age 73 years
W.A. & Madeline Williams	Davis, California	David C. Williams	
Marion A. Smith	Crosslake, Minnesota	Scott Hardman's birthday (grandson)	
Joan Bezner	Spring Hill, Florida	Scott Hardman	
Norman D. Ohler	Endwell, New York		Jeff Pearlman
Sean & Anne O'Callaghan	Ardmore, Pennsylvania		Dr. Fuller Torrey
Nelson Goguen	Ashby, Massachusetts		Tex & Jane Moser's 50th Anniversary
Merry Kelley	Lisbon, Iowa	Bonnie Rae Picard	
The Smith Family	Agawam, Massachusetts	David Scott Smith, Ph.D.	
June W. Crouch	Scottsboro, Alabama	"A Suicide"	Dr. Fuller Torrey
Michael Long	Mechanicsville, Maryland-	Scott Hardman	
Lillian & Ray Hanscom	Machias, Maine		Our Son, Alan
Donna I. Dunn	Grapevine, Texas		Daniel P. Berry, Jr.
Wayne & Joyce Schut	Rochester, Minnesota		Katrina Schut
Bill & Alice Petree	Sanford, Florida	Deputy Gene Gregory & Alan Singletary	
Carol Whitley	Dingmans Ferry, Pennsylvania-	Scott Hardman	John O'Connell
Geraldine S. Hatfield	Henrico, North Carolina		Leonard Kreis
Elyse F. Jones	St. Clare Shores, Michigan		Elise Anne Jones
Jane Smith-Decker	Millersburg, Pennsylvania		Rahn Smith
David & Lorraine Gaulke	Crosslake, Minnesota	Vivian N. Kruse & Dwayne Roach	
Lynne Marchese	Crosslake, Minnesota	Dwayne Roach (husband)	

DON'T FORGET TO TAKE A LOOK AT

TREATMENT ADVOCACY CENTER

ON THE WORLDWIDE WEB!

OUR WEB SITE IS:

WWW. PSYCHLAWS.ORG

Saturday morning is almost over the horizon, and I close with every best wish. We can, we must, we will win.

Russell D. VanderKlomp
Olalla, Washington
NAMI Kitsap Board
KMHS Foundation Spokesman
Kitsap Regional Library

Your first issue of *Catalyst* was excellent. Please include me on your mailing list.

I served two terms as President of NAMI Michigan in the early 1990s. Because of our local needs, I have spent all my time in the last few years with local concerns. The battle never ends, but we won't give up.

Best wishes with the Treatment Advocacy Center and keep up the good work.

Louis P. Vescio
Saginaw, Michigan

Another great *Catalyst* and congratulations on passing Kendra's Law.

I am enclosing a list of board members which I hope you will add to the mailing list for the *Catalyst*. We are working towards the next legislature to amend the definition of mental illness which the attorneys say hampers use of intervention.

I'm sending a check to the Treatment Advocacy Center for your continued good work. If I win the lottery, I'll send lots more!! Thanks.

Mitzi Anderson
Montana

I recently received your November/December newsletter. It was heartening to read. I plan to post it and subsequent newsletters on the inpatient psychiatric unit where I am the Nurse Manager. I would also like to post your first issue but I did not receive a copy. Would you be good enough to send me one?

I wish to help advance the Treatment Advocacy Center. My check is enclosed.

Kate Relling, MS, RN, CS
New York, New York

The work that you do on behalf of the mentally ill in securing treatment for them is absolutely essential. It is a pleasure to send this check to help in the support of your fine work.

We in New Mexico are beginning the task of working to reform the laws that would allow for outpatient commitment. To assist in this effort, it would be very helpful if we could receive at least ten copies of the first edition of the *Catalyst* for distribution to specific lawmakers and governmental people to help educate them about the vital needs of the mentally ill for medication. Thanks.

Mary Tabor
Albuquerque, NM

I am glad you are undertaking this task. If I can help, let me know.

Mrs. Robert T. Hodges
Titusville, Florida

Great newsletters!

Rosalyn Kalmar
Los Angeles, California

I have often wondered what the Civil Liberties Union's position is on "commitment" to care centers for people who are suffering from Alzheimers disease, cerebrovascular strokes, dementia, or other debilitating illnesses that affect a person's ability to care for himself. If they use the same criteria as they do for persons with mental illness, shouldn't they all be released from care centers and nursing homes?

Hopefully, the pendulum is beginning to swing back to a more sensible approach to this problem.

I am speaking from a well-informed position on mental illness, as my 46-year-old daughter died two years ago with the dual diagnosis of schizophrenia and acute alcoholism. She struggled for 30 years with schizophrenia.

I am happy to enclose a donation to the Treatment Advocacy Center in memory of my daughter, Bonnie Rae Picard.

Merry Kelley

P.S. Please send me three copies of the inaugural issue of *Catalyst.* I plan on distributing them at our local "Abbe Center for Mental Health."

Good luck! We really need this as treatment needs to be improved by 90%.

Carmon and Lillie Williamson
Little Rock, Arkansas

I am very impressed with the TAC newsletter. Just reading it helps me to know that I am not alone and that there are others struggling with the same concerns for family members that I am. It lets me know that I am not dreaming when the mental health system treats my son the way they do—incompetently.

My son is 20 years old and was diagnosed with schizophrenia when he was 18. He is being shuttled from assisted living to “independent” living. When I see the apartment that they have found him, I want to cringe. And he is unable to see the inadequacies for himself, like broken smoke alarms, faulty outlets, outrageous rent (that he pays for some reason) for a little hole in the wall. Recently, he had to be rushed to the hospital because he was so constipated he was in pain. He called me at 4 a.m. not knowing what to do. When I returned to this apartment with him, I found no food in the refrigerator and the stove did not work. Where is his case manager and what do they get paid to do?

My frustration with the mental health system has caused me to file grievances only to find out that MHMR polices themselves and that the provider is a sole contract so there is nowhere else to go to get assistance for my son. It is up to my husband and I to keep an eye on him and structure his time in a productive way. And for this I pay taxes? My son is well enough to hold down a job, but is unable to take care of himself for a prolonged period of time. I can only hope for the best and keep firing off letters to my representatives and the MHMR system. Last year legal fees amounted to $1,000 with little to show for it. I would like to be named his guardian in the event I find him incapacitated but don’t know how to go about it on my own.

Your newsletter provides a valuable service to those of us who are fighting for our loved ones. You should include a monthly column that is devoted to letters from caregivers telling what steps they have taken in today’s circumstances to help their loved ones—like writing numerous times to state legislators. It feels futile and overwhelming to continue to fight on our own in our own small ways, but maybe as a group we can make a change and we can also use the column to educate others and give some encouragement during these bleak situations.

I am sending a donation (sorry, after legal bills, that’s all I can afford) in honor of my son Rahn Smith, who is making a valiant effort to lead a productive life while sturggling with this insidious illness. I would like to receive 200 issues of the most recent newsletter to send out to my state representatives, as I find the time. Maybe they will get the message. It’s all I can do to relieve the frustration left by the lack of competent care from the mental health system.

If my letter can be of any use, please feel free to include it in your newsletter.

Jane Smith-Decker
Millersburg, Pennsylvania

The *Catalyst*—on the mark!

Roger M. Halpern
Short Hills, New Jersey

PLEASE HELP THE TREATMENT ADVOCACY CENTER TO 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.

I WANT TO HELP ADVANCE TREATMENT ADVOCACY THROUGH A GIFT OF:

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☐ MY CHECK IS ENCLOSED MADE PAYABLE TO TREATMENT ADVOCACY CENTER

☐ PLEASE MAKE THIS GIFT IN MEMORY OF: ____________________________________

☐ PLEASE MAKE THIS GIFT IN HONOR OF: ____________________________________

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CITY: ____ STATE: _________ ZIP: _______________

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THANK YOU FOR YOUR SUPPORT!

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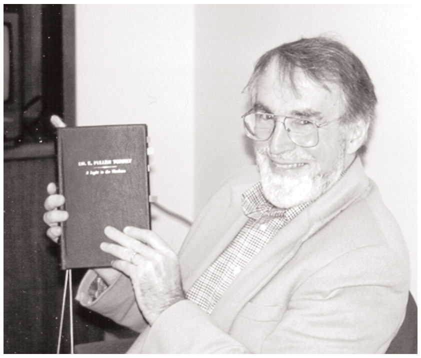
THE TREATMENT ADVOCACY CENTER (THE CENTER) IS A NONPROFIT ORGANIZATION DEDICATED TO ELIMINATING LEGAL AND CLINICAL BARRIERS TO TIMELY AND HUMANE TREATMENT FOR MILLIONS OF AMERICANS WITH SEVERE BRAIN DISEASES WHO ARE NOT RECEIVING APPROPRIATE MEDICAL CARE.

STANDARDS SHOULD BE BASED ON THE NEED FOR TREATMENT

Several states have abandoned dangerousness as the sole standard upon which inpatient treatment decisions are based. The states that have done so have incorporated the following factors into their standards in different combinations:

- **Probability of deteriorating symptoms that will result in dangerousness.**
- **Incapacity to make an informed treatment decision.**
- **Likely to benefit from treatment.**
- **History of a need for treatment.**
- **Exhibiting symptoms that previously resulted in the need for treatment.**
- **Needs treatment to prevent deterioration of symptoms.**

Standards based on the need for treatment allow for a medical intervention before an individual spirals to the depths of his illness.



Dr. Torrey receives a book full of thank you's for his many years of contributions to achieving better understanding and care of the mentally ill.