Catalyst

TREATMENT ADVOCACY CENTER

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Study Shows that Long-Term Assisted Treatment Reduces Violence and Hospital Utilization

By E. Fuller Torrey and Mary T. Zdanowicz

Long-term assisted outpatient treatment (lasting 180 days or more) significantly reduces violent episodes, hospital admissions and length of hospital stays for individuals suffering from severe mental illnesses according to the most recent and comprehensive study of court ordered outpatient treatment.

The individuals involved in the study are clearly representative of the individuals the Treatment Advocacy Center is concerned about. The participants generally did not view themselves as mentally ill or in need of treatment as measured by a commonly used insight assessment scale. In the four months prior to the violence study:

♦73% were medication noncompliant;

♦57% had alcohol and drug use;

♦51% had violent behavior; and

♦39% experienced two or more psychiatric hospital admissions.

The diagnoses for the study participants were 68% psychotic disorders (i.e. schizophrenia), 28% bipolar disorder and 4% recurrent major depression. A majority of the participants lived in a city, but a significant number were from rural areas and small towns.

In December, researchers published results that showed that long-term assisted outpatient treatment reduced the incidence and duration of inpatient hospitalization.[1] Long-term assisted outpatient treatment reduced hospital admissions by 57% and length of hospital stay by 20 days compared to individuals without court ordered treatment. The results were even more dramatic for individuals with schizophrenia and other psychotic disorders for whom long-term assisted outpatient treatment reduced hospital admissions by 72% and length of hospital stay by 28 days compared to individuals without court ordered treatment.

Decreased admissions derived from long-term assisted treatment combined with higher levels of services. Neither assisted outpatient commitment alone nor higher levels of services alone accounted for reduced hospital admissions. Short-term assisted outpatient treatment did not provide a significant benefit in reducing hospital admissions. Interestingly, longer periods of assisted outpatient treatment correlated with the provision of higher outpatient service levels, which the authors concluded "suggests that providers delivered more intensive services to people on sustained periods of outpatient commitment." However, individuals with a higher risk of relapse were more likely to be in the long-term court ordered group. Therefore, long-term outpatient commitment served to "prioritize more intensive treatment for individuals at high risk for relapse, particularly those with psychotic disorders."

Results published in April from the same study demonstrate that medication compliance and long-term assisted

Inside this issue...

From left to right - Deborah Farrell, Executive Director, NAMI-Memphis; Lt. Sam Cochran, Memphis Police Department, Crisis Intervention Team (CIT); Mary Zdanowicz, Executive Director, Treatment Advocacy Center, at the Annual CIT Awards Dinner in April. [See article on CIT in the March/April 2000 issue of Catalyst, page 8.]

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.

outpatient treatment significantly reduce the actual incidence and the predicted probability of violence among individuals with severe mental illness.[2] The study indicates that medication noncompliance and substance abuse are key predictors of violence. Individuals who were medication noncompliant were 63% more likely to be violent than individuals who complied with medication regimens. Individuals who were both medication noncompliant and abused substances had a three times greater risk of violence. Long-term assisted outpatient treatment improved medication compliance and reduced substance abuse, thereby reducing the risk of violence.

The actual incidence of violence among individuals in the study was reduced for individuals in long-term assisted outpatient treatment. Violent acts were committed by 41.6% of individuals who had either a short term (less than 180 days) or no court order as compared with 26.7% of individuals who were in long-term assisted outpatient treatment. That is, long-term court orders reduced the incidence of violence by 36%. The results were even more striking for individuals who were characterized as seriously violent because they committed a serious assault with a weapon or physically injured another person in the year prior to the study. While 63.3% of the seriously violent individuals who recieved only short-term assisted outpatient treatment repeated violent acts (i.e. serious assault with a weapon or injury to another person), significantly fewer (37.5%) of the individuals who had long-term court orders were violent, representing a 40% reduction in violence attributable to sustained court orders and regular outpatient services.

Long-term assisted treatment alone without services and services alone without court orders did not reduce violence. But, long-term assisted outpatient treatment combined with regular outpatient services (defined as three or more outpatient encounters per month including case management, medication, psychotherapy and other outpatient services) reduced the probability of violence in half from 48% to 24%. Individuals who were in long-term assisted outpatient treatment and regular outpatient services and were medication compliant and did not abuse substances were 75% less likely to be violent than those who did not receive long-term orders and services, who misused substances and stopped taking medication.

The results of the North Carolina study have important policy implications. Clearly there is a benefit to the individual in reducing hospital stays and in preventing the deteriorating symptoms of illness that precipitate the need for inpatient treatment. Reducing inpatient hospital utilization also has significant fiscal implications because inpatient care is so much more expensive than outpatient care. The study's conclusions regarding the effect of long-term assisted outpatient treatment in reducing violence are particularly significant. Needless to say, there are benefits to the individual and potential victims in reducing the risk of violence. But, reduced violence will benefit all individuals with severe mental illness. The Surgeon General recently acknowledged that the increase in stigma over the last 40 years is attributed to the public's perception and fear of violence in people with mental illness.[3] That fear and perception is fueled by highly publicized incidents of violence such as those involving Theodore Kaczynski, Russell Weston, Andrew Goldstein, and Joseph Palczynski. Preventing those incidents is our greatest hope of reducing stigma. The results of the North Carolina study support the Treatment Advocacy Center's conviction that long-term assisted treatment is a crucial tool in the campaign to fight stigma against individuals with severe mental illness.

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[1] Swartz, M.S., Swanson, J.W., Wagner, R.H., et al. *Can involuntary outpatient commitment reduce hospital recidivism? Findings from a randomized trial with severely mentally ill individuals. American Journal of Psychiatry,* 156:1968-1975 (1999).

[2] Swanson, J.W., Swartz, M.S., Borum, R. et al. *Involuntary outpatient commitment and reduction of violent behavior in persons with severe mental illness. British Journal of Psychiatry*, 176: 224-231 (2000).

[3] U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General*. Rockville, Maryland: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999.

For Whom the Whistle Blows

By Scott Jerome Mahoney

I would like to begin by saying that although I have paranoid schizophrenia, and am also a recovering alcoholic and drug addict, I do not blame anyone. It was not the case, but I could have come from the nicest, most normal family in the world, and given my genetic makeup, and then my experiences, I would have still needed psychiatric, and 12-Step help. I thank God that both are available today.

I was born on August 31, 1961. Until I was around five or six years of age, I was sexually abused by some sick individuals who also took it upon themselves to give me drugs, alcohol and cigarettes. I knew that I did not like the abuse, but that I did like the "buzz" of the intoxicants. Therefore, today I believe that even then, I was an alcoholic and addict. I have learned that a hallmark trait of the alcoholic is the idea that, "I want what I want, when I want it," and that was me.

When I was in my early teens, I began to abuse alcohol and drugs of my own volition. I also felt different, but do not know if this was the onset of my mental illness. I smoked a lot of marijuana, which can make one paranoid, and can "kick in" the symptoms, but I had slowed down the usage before my first episode.

In 1985, I had lost my license to drive and therefore my job; and in addition, my family had moved to Taylor, Michigan. I began to isolate, and got very paranoid. I felt that evil people were going to kill me so I decided to kill myself. After an unsuccessful attempt, I was admitted to a private hospital in Ann Arbor, Michigan. I was released after only about eight days and was told to go to outpatient treatment. I did this and was for the first time put on psychotropic medication.

After about six months, I returned to work at a service station, and shortly after that I was actively using drugs and alcohol. I changed jobs a couple of times, and on Christmas of 1986, I decided to quit taking my medication, and soon thereafter, quit seeing my therapists. I was to learn that I had a total lack of insight into my illness.

By March of 1987, I was for the first time experiencing hallucinations in the form of hearing a voice. My boss told me to go home in early April and get some help, as he was aware that I suffered from some type of mental illness. My parents came to take me to their home in Toledo, Ohio, after a hospital in Michigan gave me a prescription and sent me home.

As morning broke on April 29, 1987, the soothing sound of a train's whistle was intoxicating, only to be shattered by a voice screaming profane obscenities and commanding me to kill my parents. (Only I heard the voice because, as I was to learn, it was a command hallucination). I had no insight into this nor any other aspect of my mental illness. In fact, a classic symptom is that I had stopped taking my meds by choice, and felt no need to start taking them again. Today this is not an issue because I receive an injection of prolyxin.

I did kill my father and was first sent to jail and then to what was then called Dayton Forensic Hospital. Later, after being found not guilty by reason of insanity, I was sent to a civil mental hospital in Toledo.

There, I usually received more than adequate care by mostly outstanding staff. I worked at a job in the hospital's commissary as part of my therapy. The pastoral care staff went above and beyond the call of duty. Subsequently, I found 12-Step recovery to treat my drug and alcohol addiction, and as of this writing have over 11 years of continuous sobriety.

I was released briefly in 1989, but I had a setback and was re-hospitalized. However, I have been out of the hospital on a conditional release since 1991, without any altercations with the law.

My act of violence in 1987 could not go unanswered but the state of Ohio saw fit to place me in its mental health system as opposed to its criminal justice system. As a result of this decision, and although I am still under court supervision, I receive comprehensive treatment and live in the community. (In fact, I live in the home of one of the Chaplains by whom I was befriended).

Today, I drive, do volunteer work, go to 12-Step meetings, and plan to return to college. In addition, I am an amateur writer and I am going to take music lessons—all by the grace of God, good meds, some caring people and persistent footwork. Thank you for reading my story.

State Updates

CALIFORNIA

Treatment Law Reform Passes Its Second Test

Once again passionately championed by sponsor Assemblywoman Helen Thomson, California's proposed reform of its treatment prohibitive Lanterman-Petris-Short Act was approved by the Assembly Judiciary Committee by a 10-5 margin. California is one step closer to having laws that reflect that those too sick to make rational treatment decisions must be helped—not ignored.

AB1800's next stop (and hopefully the last before the Assembly floor) is the Appropriations Committee. There the fight will be not only to keep the bill alive, but also to secure as much funding for it as possible.

Although the bill faces several more tough hurdles, including general votes on the Assembly and Senate floors, we believe it can succeed. This faith comes foremost from the dedication of the members of the California Treatment Advocacy Coalition (CTAC). The Treatment Advocacy Center is providing informational, advisory, and logistical support to CTAC, but any contribution we have made barely compares to the momentous efforts of CTAC's members and especially its two coordinators: Carla Jacobs and Randall Hagar.

We also have hope because it seems that more than just those Californians typically interested in mental health issues are rising to the call for rational treatment laws. Among the dozens of individuals, organizations, and public officials already officially declaring support for AB1800 are: ACLU Members for LPS Reform; American Association of Retired Persons; American Nurses Association California; California Clients for LPS Reform; California Judges Association; California Medical Association; California Psychiatric Association; California State Sheriff's Association; Los Angeles County Board of Supervisors; Mayor of San Francisco, Willie L. Brown, Jr.; National Alliance for the Mentally Ill; National Alliance for the Mentally Ill - California; National Sheriff's Association; San Francisco County Board of Supervisors; State Parole Board; Union of American Physicians and Dentists.

IOWA

Setback for Proposed Outpatient Reform

In a tight vote, the Iowa House of Representatives voted down a measure that would have expanded that state's use of

Mark Your Calendars ! ! !

Treatment Advocacy Center Will Offer Two Workshops at the NAMI 2000 Convention in San Diego, California - June 14-18, 2000

The Center will conduct two thought-provoking workshops on Saturday, June 17th:

8:30 a.m. - 10:00 a.m. — "What Is It Like To Be Sick And Not Know It?"

Many suffering from mental illness refuse treatment because their brain disease prevents them from realizing they are sick. Learn why from leading expert Dr. Xavier Amador and hear first-hand from individuals including Dr. Fred Frese, who will take you inside the mind of someone who is desperately ill and doesn't know it.

12:15 p.m. - 1:15 p.m. — "Introducing TAC's Model Law for Assisted Treatment"

The Center will sponsor a special session to explain our Model Law, which is based on current knowledge of the nature and treatment of severe mental illnesses, and was critically reviewed by respected medical and legal professionals in the field. Learn how you can use the Model Law to educate legislators and reform treatment laws in your state.

We also invite you to visit the Treatment Advocacy Center at Booth 319 in the Exhibit Hall.

We look forward to seeing you there!

assisted outpatient treatment as well as established a need for treatment-based standard for its use. This is a particular disappointment because the proposed legislation was among the most comprehensive, thoughtful, and innovative we have encountered.

The bill, HF 2366, was virtually single-handedly created and promoted by Ken Kress, M.A., J.D., Ph.D., who is professor of law and director of the Civil Commitment Project at the University of Iowa College of Law. Lessons learned, Professor Kress vows to return to the Capitol next year. He comments, "Let us hope our legislators realize that people with mental illness who need help should be helped, just like everyone else."

CONNECTICUT

Tragedy Begets Legislation for Assisted Outpatient Treatment.

On June 24, 1999 near Hartford, Reverend Robert Lysz was bludgeoned to death in his church by Michael Oullette. Mr. Oullette, who has bipolar disorder, had a history of erratic behavior when not on medication for his condition. However, he had not taken any medications in the months before Father Lysz's death.

In the wake of this tragedy, Rev. Lysz's family, parishioners, and friends determined to take action. Representative Roger B. Michele of Bristol, whose district includes Rev. Lysz's parish, subsequently introduced a bill (SB 5699) that would establish, for the first time, assisted outpatient treatment in his state.

The bill is still being revised with the assistance of the Treatment Advocacy Center. The most recent version would allow for assisted outpatient treatment for people suffering from mental illness who have a history of medication noncompliance and associated violence and who are, without treatment, in light of their present condition, likely to again become violent.

We at the Center prefer laws that include not just a deterioration to violence criteria but also an eligibility standard based on a need for treatment combined with a lack of capacity to make informed medical decisions. Nonetheless, Representative Michele's measure would be an important victory if it establishes any type of assisted outpatient treatment program in Connecticut—one of only nine states that does not provide for some form of this proven treatment mechanism.

And still, the bill's focus on potential violence is easily understood. As Rev. Lysz's brother, Tom, explains, "My brother's death was the result of someone's violence. If someone were looking after the person who killed him, making sure he was still taking his medication, my brother might still be alive."

DELAWARE

HB 520 Introduced 04/06/00

Provides criteria for assisted outpatient treatment.

Relaxes the standard in existing law for assisted outpatient treatment. Allows treatment for someone who meets all the following criteria: probability of deteriorating symptoms in such person that will result in dangerousness; incapacity of such person to make an informed treatment decision; such person is likely to benefit from treatment; such person has a history of a need for treatment; such person exhibits symptoms that previously resulted in the need for treatment; and such person needs treatment to prevent deterioration of symptoms.

(State Updates page 10)

American Psychiatric Association (APA) Subcommittee Strongly Endorses Assisted Outpatient Treatment

By D.J. Jaffe,
Board of Directors,
Treatment Advocacy Center

The APA Subcommittee on Mandatory Outpatient Treatment has become the latest group to recognize the ability of assisted outpatient treatment to benefit individuals with serious mental illness and prevent some of them from needlessly deteriorating. A report approved by the APA Board of Trustees in December 1999 starts with the following words:

"Mandatory outpatient treatment refers to court-ordered outpatient treatment for patients who suffer from severe mental illness and who are unlikely to be compliant with such treatment without a court order. Mandatory outpatient treatment is a preventative treatment for those who do not presently meet the criteria for inpatient commitment. It should be used for patients who need treatment in order to prevent relapse or deterioration that would predictably lead to their meeting the inpatient commitment criteria in the foreseeable future." (American Psychiatric Association Resource Document on Mandatory Outpatient Treatment.)

The entire report was issued in January/February 2000 as an APA State Update and contains an excellent review of the important research to date. The report makes 11 specific recommendations (see sidebar), which are intended to guide state psychiatric associations in developing their own legislation.

The APA Subcommittee had previously endorsed limited use of assisted outpatient treatment in 1987, but this report relies on new research and is much more conclusive. In addition, it overturns the 1987 recommendation that assisted outpatient treatment only be reserved for those who lack the capacity to make medical decisions. The new recommendations suggest that assisted outpatient treatment could be beneficial to individuals who meet the following criteria:

1. The person is suffering from a severe mental disorder (an illness, disease, organic brain disorder, other condition that (a) substantially impairs the person's thoughts, perception of reality, emotional process, or judgement, or (b) substantially impairs behavior as manifested by recent disturbed behavior); and
2. In view of the person's treatment history, the person now needs treatment in order to prevent a relapse or severe deterioration that would predictably result in the person (becoming a danger to himself or others or becoming substantially unable to care for him or herself in the foreseeable future) (Meeting the state's inpatient commitment criteria in the foreseeable future); and
3. As a result of the person's mental disorder, he or she is unlikely to seek or comply with needed treatment unless the court enters an order for mandatory outpatient treatment; and
4. The person has been hospitalized for treatment of a severe mental disorder within the previous two years and has failed to comply on more than one occasion with the prescribed course of treatment outside the hospital; and
5. An acceptable treatment plan has been prepared which includes specific conditions with which the patient is expected to comply; together with a detailed plan for reviewing the patient's medical status and for monitoring his or her compliance with the required conditions of treatment; and
6. There is a reasonable prospect that the patient's disorder will respond to the treatment proposed in the treatment plan if the patient complies with the treatment requirements specified in the court's order; and
7. The physician or treatment facility which is to be responsible for the patient's treatment under the commitment order has agreed to accept the patient and has endorsed the treatment plan.

In developing these criteria, the APA Subcommittee incorporates approaches adopted in New York's Kendra's Law, which the Treatment Advocacy Center (TAC) was very involved in developing. We are delighted that the APA Task Force

Summary of Conclusions and Recommendations of the American Psychiatric Association Resource Document on Mandatory Outpatient Treatment

[Editor's note: The conclusions and recommendations are paraphrased. For the actual language, see the APA Resource Document]

1. Mandatory outpatient treatment, properly implemented, can be useful as part of a program of intensive outpatient services to improve compliance, reduce rehospitalization rates and decrease violent behavior among a subset of the severely and chronically mentally ill.

2. Mandatory outpatient treatment should be available to help prevent relapse or deterioration for patients who currently may not be dangerous to themselves or others but whose relapse would predictably lead to sever deterioration and/or dangerousness.

3. Predictions about the likelihood of relapse, deterioration, and/or future dangerousness to self or others should be based on the occurrence of such episodes in the recent past.

4. Mandatory outpatient treatment should be available to patients who as a result of their mental illness are unlikely to seek or comply with needed treatment, but not just those who lack insight.

5. Studies show mandatory outpatient treatment is most effective when it includes intensive services, such as the assertive community treatment or intensive case management models. States adopting mandatory outpatient treatment statutes must assure that adequate resources are available.

6. Studies show that long-term mandatory outpatient treatment (i.e. at least 180 days) is most successful. Mandatory outpatient treatment statutes should authorize initial commitment periods of 180 days and should permit extensions based on specified criteria demonstrated at regularly scheduled hearings.

7. Thorough medical examination should be a required component of mandatory outpatient treatment since many patients also suffer from medical illness and substance abuse disorders.

8. Clinicians must be involved in the decision-making process to assure that the proposed treatment plan is feasible and appropriate. The judge should ensure that the recommended treatment is available through the proposed provider before issuing an order.

9. Patients should be consulted about their treatment preferences and should be provided with a copy of the mandated outpatient treatment plan.

10. Mandatory outpatient treatment statutes should contain specific procedures for patient noncompliance (i.e. empowering law enforcement officers to bring non-compliant patients to a treatment facility for evaluation and specific provisions for a court hearing if patient's noncompliance is substantial and informal efforts will not likely motivate compliance).

11. Psychotropic medication is an essential part of treatment for virtually every mandatory outpatient treatment patient and the expectation that a patient take such medication should be clearly stated in the treatment plan. The APA resource document makes no recommendation about whether mandatory outpatient treatment statutes should either permit or preclude forced medication. If forced medication is permitted, it should be allowed only if a court specifically finds that the patient lacks the capacity to make an informed decision regarding his or her need for the medication.

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.

developed a scheme consistent with TAC's approach in such a substantive way. Our own approach was modeled on that endorsed by NAMI in 1995, and is incorporated in TAC's model law, which will be introduced at the NAMI Convention (see page 4).

With this report, the APA joins NAMI, TAC, and many other groups concerned about the seriously mentally ill, in recognizing that assisted outpatient treatment can be a useful tool to help some individuals with severe mental illness live safely and productively in the community.

For a copy of the entire report, which is highly recommended, contact your state APA or Katherine Becker, APA Office of Government Relations, at (202) 682-6321.

Wonderland — Two Sides

[Editor's note: In March, ABC launched a new television series called *Wonderland* that depicted life in a big-city psychiatric hospital. The show depicted severely ill patients in an inpatient facility, who were suicidal, homeless, violent, hallucinating, delusional and thought-disordered. The show's premier sparked a tremendously polarizing debate about the way the show depicted mental illness with some arguing that a realistic depiction of the most severe consequences of these illnesses might elicit public support for treatment while others argued that the show's depiction was stigmatizing. There were very strong feelings of both support and opposition, even within the Treatment Advocacy Center. After showing only two episodes, ABC placed the show on hiatus. We thank the authors who provided the following two articles that artfully express each viewpoint.]

Wonderland—We Hardly Knew You

By Brandon Fitch

A dim meteor flashed across the western sky. Its light was brilliant but fleeting as it quickly burned up in the Earth's atmosphere. It had a brief life, but many of those who watched it with consternation, were glad to witness its last rays die at the horizon. For them, this meteor was an object of fear and revulsion. They prayed fervently that it would not reach its target.

This meteor that plunked down on our television sets was the psychodrama, *Wonderland.* This program, which took place on a fictional psychiatric ward called Rivervue, was a jarring and rampant soap opera throwing patients and professionals together. Hence, they played off one another in a continuing dance of the sense and the senseless. There were moments of breakthrough, which was expected of everyone involved, and then there was Greek tragedy, which is also, in our age of television agony, absolutely essential, too.

However, *Wonderland* was a bold experiment. Nothing like this had been seen on the small screen. Scenes were short, the pace was frantic, there were wildly shifting point-of-view shots, and the rendering of psychotic symptoms was severe. But, there were some quiet and beautifully delineated moments where a connection was made between patient and professional, where both sides came to an understanding.

One must always keep in mind that *Wonderland* took place on a forensic unit in a triage area of a big-city hospital. *Wonderland* brought a certain integrity to the situation. It was realistic in its portrayal of some of the more debilitated patients. It may have seemed voyeuristic to watch them flail about the screen as if they were human screensavers, but it is a truth that they are out there, many in jail or on the streets. I should know, I saw them at even some of the more upscale psychiatric wards.

On *Wonderland*, many of these patients seemed to serve as disturbing window dressing. But, there were, in the two episodes aired, some very meaningful story lines, most of which were resolved, abandoned, or just winked at. Everything seemed to occur at fast forward and seemed to be coming apart at the seams. This was the scriptwriters way of jolting the viewer into the cognizance of how depressed and down-at-the-heels these forgotten members of society really are.

This show, for those who have worked and struggled with mental illness, may have seemed disturbing and may have seemed to set the campaign against stigma back. Yet, it is a discredit to those who are on the real forensic psychiatric wards, that they are not acknowledged for who they are and the Herculean battles they fight just to stay alive. Part of the campaign against stigma, a cause that claims me like all those who have suffered it, is a tendency to romanticize and moralize the painful symptoms. There is a yearning to gloss over the more unpleasant aspects of mental illness. These aims are noble, but this monstrous illness must be recognized in all its ferocity and must be treated first. Then we can work on patching up people’s lives. We must remember that as we sat in front of our television sets, we were watching only the first steps of those patients who had just about gone into the abyss. They are not pretty, they can be violent, they are often hard to talk to, and they are irritating.

I felt that with all that was on their plate, the professionals in this show, particularly Dr. Robert Banger, played with sublime understatement by Ted Levine, managed their distracting job with great aplomb and I credit them. But, I would not have recommended *Wonderland* as material for graduate students, at least not yet. It was a slice of life in a very hectic and agonizing location. The myriad caregivers at Rivervue would have loved to save every patient who came through the door, but they knew they had to be realistic. This was the sensibility of Wonderland.

[Brandon Fitch has struggled with schizophrenia since the age of eight. He is now the Program Annotator for the Cleveland Philharmonic Orchestra, the Editor of *The Remedy*, newsletter for the Psychobiology Clinic of Greater Cleveland, and a member of the Board of Trustees of Hill House Mental Health Agency in Cleveland, Ohio.]

Professor Kenneth Kress joins TAC's Honorary Advisory Committee

We are honored to welcome Ken Kress, Professor and Director of the Civil Commitment Project at the University of Iowa College of Law, to the Treatment Advocacy Center's Honorary Advisory Committee.

Professor Kress drafted and championed an assisted outpatient treatment bill in Iowa that was protective of patient rights while ensuring that those most in need of treatment could get it. While the bill did not pass in this year's legislative session, Professor Kress vowed to try again next year.

Professor Kress was awarded a J.D. and a Ph.D. in Jurisprudence and Social Policy from the University of California, Berkeley. His practice areas include: civil commitment, substance abuse, violent sexual predator commitment, torts, product liability, conflicts, criminal law, discrimination law and family law. He has an international reputation for his scholarship in legal philosophy. He has made many presentations and has numerous publications about the law and mental illness, including *An Argument for Assisted Outpatient Treatment for Persons with Serious Mental Illness Illustrated with Reference to a Proposed Statute For Iowa* (forthcoming, Iowa L. Rev., Vol. 85, May, 2000). Another recent article by Professor Kress, *Therapeutic Jurisprudence and the Resolution of Value Conflicts,* v.17, Behavioral Sciences and the Law, pp. 555-588 (1999) argues, contrary to the claims of many scholars, that it is possible to resolve value conflicts between consumers' civil rights and their interests in maximal mental health.

Wonderland—The End Does Not Justify the Means

By Claire Griffin-Francell

Jesuit education shapes one's thinking about the morality of behaviors designed to influence others and attain goals. A case in point is the recent uproar and demise of the television series *Wonderland*. For persons frustrated over public indifference to persons with psychotic disorders, it may have seemed like a bright and shining light. At last, millions of Americans got a shocking dose of true life inside an insane asylum. Like English Victorians who spent Sundays strolling outside the windows of Bedlam Psychiatric Hospital for a taste of the bizarre, now Americans—in the comfort of their homes—experienced a similar display thanks to the wonders of TV. But one must remember that television has an internal reality governing programming choices and recognize its decision-maker's motivations.

With the remote control allowing viewers to surf hundreds of channels, it is getting harder and harder to capture a committed audience. Enormous program costs have led to endless commercials sandwiched between shows. It is no surprise that more violence, profanity, and sex are needed to capture an increasingly desensitized audience. As Brenda Woods, news-anchor for an Atlanta TV station said, "We must give the public what it wants or they will change the channel. Dramatic content gives high ratings which sells advertising space which helps networks and local stations survive." This motivation is pragmatic—and good for the television industry—but is sharply divergent from the goal of trying to educate the public or change attitudes about persons with brain disorders.

Wonderland met the criteria for drama, crisis, and violence needed to capture a large TV market. What happened to eliminate this golden goose? We won't know unless a post-mortem autopsy is carefully done. Still, some of us can hazard a guess. My guess is that enough individuals and groups said, "The line has been crossed between balanced depiction and voyeuristic portrayal of vulnerable persons in crisis."

I am one of those who opposed the continuation of *Wonderland*. Others applauding the show may derisively call me a "member of the mental health establishment." The thousands of professionals, families, and consumers I have worked with since 1948 know that I have paid my dues as an advocate and psychiatric nurse on behalf of all persons with severe mental disorders. I have worked in state, county, federal VA, and private psychiatric hospitals, as well as in community mental health centers. I have taught in universities, prepared professionals, and designed continuing education for practicing clinicians. My peers and NAMI families know that basic human rights to housing, employment, medical care, and a social life are often denied due to public ignorance and fear. The entertainment industry strives for high ratings and financial profit—their programming rarely focuses on doing good for its own sake. The exceptions are a few producers of excellent balanced documentaries and the producers at National Public Radio who consistently broadcast intelligent commentaries.

Hundreds of thousands of persons are recovering from serious mental illness today. Some struggle to earn a living, some try to raise families, and many just try to live day to day. Almost all are forced to conceal their medical diagnosis from a careless, indifferent, and sometimes pernicious public. These are the persons who will be harmed by *Wonderland*'s reinforcement of devastating images. It is extremely naïve to think that *Wonderland*'s characters will create sympathy and votes on behalf of unfortunate persons who are sometimes psychotic and dangerous. More than likely, it will increase distancing from persons with brain disorders in the workplace and other life arenas.

The Hippocratic Oath warns health care providers, "Above all do no harm." Television producers do not take this oath. The tragedy of persons who deny their psychotic illnesses—or who are treated incompetently by an indifferent society—demands that policy makers and advocates change the system through legislation and the courts. It worked for African-Americans; it worked for women in many employment arenas; and it worked for disabled children in gaining a comprehensive public education. Yes, it is hard, arduous labor demanding persistence, commitment and energy—as TAC has well demonstrated. However, this justice will not come from a television series that harms many and benefits none of the very ill persons in our social environment.

[Claire Griffin-Francell, RN, MSN, APRN is a past vice president of NAMI and the President of Southeast Nurse Consultants, Inc. in Atlanta, Georgia and the mother of TAC board member Ed Francell.]

Your Voice— Will Make a Difference

I am with the Wyoming Alliance for the Mentally Ill. We are a support and advocacy group dealing with the mentally ill, their friends, and families within Wyoming. We saw two stories of interest in Catalyst, Volume 2, No. 2 March/April 2000. One was "Donnie's Story", and the other was "Testimony of Dick Taylor." We have a bi-monthly newsletter, and we ask for your permission to put both articles in. We are very interested and excited to use these articles! May we?? Thank you,

Shirley Green, Editor
Wyoming

[Thank you in return for helping us to educate every person possible about our mission as advocates for better treatment for the seriously mentally ill. We encourage all to use articles found in any issue of Catalyst. We ask that in return you credit the Catalyst issue, and please send us a copy of your publication ...Editor]

First I want to thank you for all your efforts on behalf of the individuals that we care so much about—our sons and daughters, neighbors, and friends with severe brain disorders. I am the Director of NAMI-Billings and our state is wanting more information to help it make appropriate decisions for funding and service provision. I would like to send some legislators a copy of TAC's Catalyst. Could you send me 10 copies of a recent issue. I will see that they get to decision-makers. Thank you!

Dee (and Paul) Holley
Billings, Montana

Thank you, thank you, thank you and to all those involved in forming the Catalyst and the Treatment Advocacy Center. I have a 20-year-old son at home in bed suffering from severe depression. He has been in the hospital ten times since October of 1998. I have been employed with Portsmouth Social Services for 27 1/2 years, and will retire in 2 1/2 years when I will be 52 years old. My vision is for exactly the work you have started: assisted outpatient treatment and changing the laws. I am the chairperson for the Alliance for the Mentally Ill Portsmouth and Chesapeake. I have dedicated my life to helping the mentally ill. Please keep me in mind if I can help, especially in the year 2002 when I retire.

Thank God that He is giving the same vision to more than one of us! It will take all of us together to fill this vision!

Mrs. Bobby Wahrenburg
Chesapeake, Virginia

What a breath of fresh air the Catalyst has proven to be. My son has been sick for 21 years. I have attended so many conferences, talked to way too many State legislators and tried all the other methods we NAMI members use to effect change in this so-called mental health system. As you know, so far we in Florida have taken one step forward and two steps back.

Governor Bush has appointed yet another committee to "study the mental health system in Florida and come up with recommendations for improvement." We very politely have told them that the last thing we need is another study; they should dust off all the others they have done and never followed through with. We have sadly come to the conclusion they think that doing a survey and formulating a new “five-year plan” is quite enough. That is all they seem capable of. NO ONE EVER DOES ANYTHING THAT IS RECOMMENDED IN THESE PLANS!

Anyway, thank you for the Treatment Advocacy Center and for the Catalyst. The lady who said that her son was willing to read it touched me. I am going to see if my treatment-resistant son will do the same. After trying everything else, it can't hurt!

Also, our members voted to send a small contribution, and we really would appreciate having the Catalyst go out to each one on our list. Some do not come to meetings, but we think they should know that someone is actually doing something for our folks and maybe it will give them a boost. Also, if you can, we would appreciate any old copies you might have of the first and second editions.

Again, thank you for all of your hard work. It keeps us inspired and hopeful!

Patti Hunt, President
NAMI St. Johns
St. Augustine, Florida

Bringing Some Sense to Civil Commitment Hearings

by Joanmarie I. Davoli, Director, George Mason University School of Law, Law and Mental Illness Clinic

Often frustrated by a confusing legal system that seems more intent on releasing the mentally ill to fend for themselves than on treating people who are sick and desperately in need of medical care, family members in Fairfax County, Virginia find relief when their request for psychiatric treatment for their loved ones is championed by a George Mason University law student. Student attorneys bring balance to civil commitment hearings and ensure that petitioners' concerns for, realistic fears of, and evidence about the mentally ill person are properly before the Court.

In Virginia, a mentally ill person who is resisting treatment receives a court-appointed defense attorney to assist him. However, the petitioner, who is almost always a private citizen with no legal training, usually must represent himself, attempting to introduce evidence, produce testimony, respond to objections, and argue points of law. As a result, family members, neighbors, and friends of the mentally ill patient struggle to obtain assistance for the patient. By having students with third-year practice certificates represent these petitioners under the supervision of an experienced trial attorney, the Clinic provides effective advocacy for the family members, and ensures that all the important information about the patient is presented to the Special Justice, who determines whether or not the patient is in need of psychiatric treatment.

The Law and Mental Illness Clinic at George Mason University School of Law provides free representation to petitioners in civil commitment hearings in Fairfax County. Having Clinic students present the cases benefits both the law students and family members of the mentally ill. While learning how to be effective trial attorneys, George Mason Clinic students are also exposed to a great variety of issues surrounding mental illness. Students enrolled in the Clinic are required to attend the classroom portion, in order to receive appropriate training. In the classroom, Clinic students learn about the areas of mental illness law pertaining to civil commitment hearings, as well as practice trial skills for participation in the hearings.

The students appear weekly at hearings held in a Fairfax County courtroom located in Mt. Vernon Hospital. Under supervision, students participate in each civil commitment hearing that occurs that morning. At least two Clinic students appear at each hearing session we attend. The Clinic has had a positive influence on civil commitment hearings in Fairfax. Previously under-utilized commitment criteria, such as inability of the patient to care for himself, are now effectively presented and argued. The judges are also more willing to listen to the patient's medical history, as Clinic students have successfully argued that when the person's mental illness follows a pattern, then that pattern is admissible to prove the seriousness of the patient's current behavior. This enables Clinic students to argue that the mentally ill person isn't just making a "lifestyle choice." Rather, he is unable to control himself or ask for help because he is sick and needs care.

Julia Gorey, a University of Maryland School of Law student who is attending George Mason this semester only because she wanted to participate in this unique program, finds the Clinic "an opportunity to get an insider's view of the problems inherent in the local commitment systems, as well as an appreciation for the families' struggles."

Indeed, while most people voice strong opinions about the commitment system, it seems that few people actually observe the proceedings or have a true sense of the experience. Graduating student Kourosh Sabet-Payman remarks that, "the Law and Mental Illness Clinic has afforded me the opportunity to gain first-hand experience with the consumers and courts of Virginia. The Clinic has provided me with great insight into the lives of the mentally ill patients and has dispelled any stereotypes that I may have had about mentally ill patients."

Clients represented by Clinic students encompass various races, ethnic groups, and socio-economic backgrounds. Regardless of the petitioners' backgrounds, most aren't prepared for the judicial proceeding awaiting them at 7:00 a.m. when they arrive at the hospital. Most only expect to relate background information, and are startled and confused by the formal hearing proceedings. This challenges Clinic students to communicate complex information across cultural and language barriers. Interpreters utilized by the Clinic include Arabic, Farsi, Japanese, Spanish, Vietnamese, and sign language.

In addition to helping family members of mentally ill individuals and learning about civil commitment laws, the chance to be "real lawyers," by calling witnesses and making legal argument, greatly enhances the students' education. Current student Anne Corbin feels that, "this Clinic has provided me a great and rare opportunity to participate in actual cases. Practicing advocacy skills is a rare event in law school, and I am grateful this law school has the Law and Mental Illness Clinic."

Petitioners express great satisfaction with Clinic representation. One mother, who had been unsuccessful on previous attempts to have her son with schizophrenia committed, wrote a letter in which she said that the student, Jillian Cass, "did an outstanding job of asking the right questions, bringing up the salient points of the case, and countering the questions and points the court's appointed lawyer was trying to make on my son's behalf. Ms. Davoli ensured the focus of Ms. Cass' questions and inquiry. She seemed very experienced in handing this type of case. Their support made ALL the difference in my fight to get my son help for his illness." [Reprinted with permission from the author.]

Clinic students daily witness the relief and gratitude felt by the family members when their cases are effectively presented to the court. Another Clinic student, Liz Homoki, adds that student representation "helps balance the scales of justice for the families and patients."

For more information about the Clinic, please contact the Director of the Law and Mental Illness Clinic, Joanmarie I. Davoli, at George Mason University School of Law, 3401 North Fairfax Drive, Arlington, Virginia, 22201. Office: (703) 993-8214. Fax: (703) 993-8202. E-mail: jdavoli@gmu.edu.

(State Updates from page 4)

MINNESOTA

Looking Forward to Next Year
HB 3107 Postponed indefinitely 03/22/00
SB 2634 Signed by Governor 04/03/00

State Representative Mindy Greiling introduced a bold, compassionate bill (HB 3107) to reform Minnesota's outdated treatment law after a long battle trying to get much needed treatment for her son. On March 22, 2000 SB 2634 was substituted for HB 3107. The substitute bill retained provisions requiring notice to certain relatives and modifying consent provisions for minors, however, it failed to incorporate provisions for early intervention mental health treatment and the related need for treatment standard. According to the Minneapolis Start Tribune, Representative Greiling acknowledged that the reform bill was not likely to pass this session, but "that she fully intends to bring it back during next year's legislative session, and thereafter if need be."

WISCONSIN

AB 746 Passed Assembly 03/28/00;
Failed to pass Senate 04/06/00

AB 746 was sponsored by Representative Rhoades and an additional 28 representatives and senators. Even with this strong show of support and passage by the Assembly, the Wisconsin Senate let time run out on the bill. The Senate failed to pass the reform measure pursuant to Senate Joint Resolution 1, which dictated the session calendar. The bill changed current law by disallowing emergency detention under the state's relaxed need for treatment standard, the so-called "fifth standard." However, AB 746 also ensured that the standard would be effective beyond 2002 for court-ordered treatment.

Changes In Mental Illness Law

[From the NAMI South Dakota Newsletter, Volume 1, Issue 70, March/April 2000. Reprinted with permission.
Editor: Donna Yocom, Exec. Director.]

House Bill 1063 was passed and signed by the Governor. It included several substantive changes to the statutes governing involuntary commitment, which family members and consumers need to understand.

Beginning on July 1, 2000, the definition of "danger to others" has been changed to say "a reasonable expectation that the person will inflict serious physical injury upon another person in the near future, due to a severe mental illness, as evidenced by the person's treatment history and the person's recent acts or omissions which constitute a danger of serious physical injury for another individual. Such acts may include a recently expressed threat if the threat is such that, if considered in the light of its context or in light of the person's recent previous acts or omissions, it is substantially supportive of an expectation that the threat will be carried out."

The definition of "danger to self" will be: "A reasonable expectation as evidenced by the person's treatment history and the person's recent acts or omissions which ... (continues much the same as in the "danger to others" definition; and continues in part (b) "...as evidenced by the person's treatment history and the person's recent acts or omissions which demonstrate an inability to provide for some basic human needs such as food, clothing, shelter, essential medical care, or personal safety, or by arrests for criminal behavior which occur as a result of the worsening of the person's severe mental illness."

"Essential medical care" is defined as "care, that in its absence, a person cannot improve or a person's condition may deteriorate, or the person may improve but only at a significantly slower rate."

The statute concerning the process for completing a petition for involuntary commitment, and the procedure which is described, include a change, which states that, "The state's attorney, or other person designated by the board of county commissioners, shall assist the petitioner in completing the petition." Since in the law, the word "shall" is determined to mean "must" there are two opinions (at least) about what that means. One interpretation is that it means they must if the help is needed. Another interpretation is that the designated person must be involved in the completion of the petition. We will have to wait and see what happens with that.

Another change was made in the "notification of next of kin upon discharge from the hospital" portion of the law where it now will read, "Upon obtaining consent to release information, reasonable attempts shall also be made to notify the person's next of kin. If the treating psychiatrist determines the person lacks the capacity to provide consent, the Human Services Center shall make reasonable attempts to notify the person's next of kin as to admission, or commitment to, or discharge from the Human Services Center, unless such notification is determined by the treating psychiatrist, with the input of the person's treatment team, to be detrimental to the person."

The following memorials and tributes were received by Treatment Advocacy Center in March/April 2000. 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. [Tearful and heartfelt thanks from editor Lorraine Gaulke for the generous gifts in memory of her son, Scott.]

Received From	City and State	In Memory Of	In Honor Of
NAMI Danville Area	Danville, Virginia	Kemp Pettyjohn (1971-1997)	
Donald & Audrey Albaugh	Port Orange, Florida	Scott Hardman (1966-1997)	
Katherine Reed	Mechanicsville, Maryland	Scott Hardman	
Mary Zdanowicz	Arlington, Virginia	Pat Geier	
Thomas E. Brett	Kew Gardens, New York		DJ Jaffe
Joan & Michael Long	Mechanicsville, Maryland	Scott Hardman	
Violette S. Kildahl	Crosslake, Minnesota	Scott Hardman	

New Book Release:

I Am Not Sick, I Don't Need Help, Helping the Seriously Mentally Ill Accept Treatment, A Practical Guide for Families and Therapists, **by Xavier Amador, Ph.D. with Anna-Lisa Johanson.**

This new book is a must read for families and caregivers trying to cope with a loved one with mental illness who refuses treatment because he/she does not believe that he/she is ill. You will learn that about 50% of all people with schizophrenia and manic-depression do not understand that they are ill and refuse treatment. Whether you are a family member or a therapist, in this book you will find hope in what the new research is revealing about the problem of poor insight into illness. Prepare to be surprised and to have new hope. There is much you can do to conquer denial.

Xavier Amador has a brother with schizophrenia. He is the Director of Psychology at the New York State Psychiatric Institute and a Professor of Psychology in the Department of Psychiatry at Columbia University College of Physicians & Surgeons. He is a world-renowned expert on the problem of poor insight into illness in individuals with schizophrenia and bipolar disorder. Anna-Lisa Johanson is the daughter of Margaret Mary Ray, the woman most people know as "David Letterman's stalker." Her mother, diagnosed with schizophrenia and schizoaffective disorder, took her own life in the fall of 1998. Ms. Johanson is finishing her law degree at Georgetown University Law School and works part time for the Treatment Advocacy Center in Arlington, Virginia.

Among the critical acclaim the book has already received:

Dr. E. Fuller Torrey - "This is the first book to address the elephantine question running roughshod over families of individuals with schizophrenia and bipolar disorder: Why won't the sick person take his/her medicine?"

Jonathan Stanley, Esq. - "What frightens me most is that my manic depression gave me an immovable certainty that it was the world around me that was convulsing but that my perception and judgment of it were unaltered. Thinking of this time leaves me frustrated and embarrassed as well as apprehensive that it might come again. I read Dr. Amador's book and felt better."

Fred Frese, Ph.D. - "The great value of *I'm Not Sick, I Don't Need Help*, is that it incorporates both the consumer's perspective and that of the clinician. It finds common ground, pointing out where the consumer and his/her clinician can work together in partnership. It is practical, easy to read, and hopeful."

Connie Lieber - "Reflecting Dr. Amador's own profound empathy and insight, the book is a guide to the shocked, bewildered and too often hopeless close relative. It is no mere compendium of generalizations. It is a practical, step-by-step program for achieving understanding and even expressing love in a situation where that love is difficult to convey."

To order a copy or to learn more, visit http://vidapress.com or call 800-431-1579. Orders can also be placed by sending a check or money order to VIDA PRESS Orders, 1150 Smith Road, Peconic, NY 11958, or credit card orders can be faxed to 631-734-7885.

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:** ____________________________________

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The Treatment Advocacy Center is a nonprofit 501(c)(3) organization; gifts may be tax-deductible.
Gifts should be made payable to Treatment Advocacy Center and mailed to:
3300 North Fairfax Drive, Suite 220 ❄ Arlington, VA 22201
Thank You for Your Support!

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CATALYST

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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.

Mark Your Calendars ! ! !
Treatment Advocacy Center Will Offer Two Workshops at the NAMI 2000 Convention in San Diego, California June 14-18, 2000

Annual CIT Awards Dinner.
(See page 1.)