



Reversing a Dangerous Precedent—Making the Case for a Model Law

By E. Fuller Torrey and Mary T. Zdanowicz

"We are literally drowning in patients, running around trying to put our fingers in the bursting dikes, while hundreds of men continue to deteriorate psychiatrically before our eyes into serious psychoses. The crisis stems from the recent changes in the mental health laws allowing more mentally sick patients to be shifted away from the mental health department into the department of corrections. Many more men are being sent to prison who have serious mental problems."

... Quote from a California prison psychiatrist in 1971, two years after California enacted the Lanterman-Petris-Short Act.¹

"How can so much degradation and death—so much inhumanity—be justified in the name of civil liberties? It cannot. The opposition to involuntary committal and treatment betrays a profound misunderstanding of the principal of civil liberties. Medication can free victims from their illness-free them from the Bastille of their psychoses—and restore their dignity, their free will and the meaningful exercise of their liberties."

... Herschel Hardin, former member of the board of directors of the British Columbia Civil Liberties Association and father of a child with schizophrenia.²

During the 1960s and 1970s, state laws governing treatment of severe mental illnesses, such as schizophrenia and manic-depression, for individuals who refused it underwent sweeping reform. Most notably, assisted treatment laws were changed to require a court finding of

dangerousness before treatment could be provided to those incapable of recognizing their need for it. While well-intentioned, reform efforts meant to protect people with mental illness resulted in many of the most severely ill going without needed treatment, and, in too many cases, becoming homeless, incarcerated, suicidal, victimized or prone to violent episodes.

It was foreseeable that changing the law to require dangerousness before a person with a severe psychiatric disorder could be treated would lead to people being incarcerated rather than treated when they became symptomatic.

❖ Philadelphia's police chief issued a directive that non-dangerous people who could no longer be taken into custody under the mental health act could be arrested for disorderly conduct.³



Dr. Xavier Amador during his presentation of the workshop, "What Is It Like To Be Sick and Not Know It?" at the NAMI 2000 Convention in San Diego. [See article on page 3.]

- ❖ A Pennsylvania prison experienced a sharp increase in the admission of inmates with severe mental illness a few months after the change in the law.⁴
- ❖ Two years after California adopted a dangerousness standard, the number of psychiatric hospital commitments of individuals found incompetent to stand trial doubled in one county.⁵
- ❖ Two years after a court changed Wisconsin's standard to imminent dangerousness, the number of criminal observation cases in three state psychiatric institutions nearly doubled.⁶

The criminalization of mental illness has reached crisis proportions. The Pacific Research Institute estimated that the cost to the criminal justice and correction systems of California alone was \$1.2 to \$1.8 billion in 1993-1994.⁷

In 1999, the Department of Justice reported that as much as 16 percent of the population of state jails and prisons, more than 260,000 individuals, suffer from severe mental illnesses.⁸ While the vast majority of these individuals are arrested for non-violent crimes, it is inevitable that

Inside this issue...

| | |
|---|----------------|
| <i>Case for a Model Law</i> | <i>Page 1</i> |
| <i>Interest in Workshop 3B?</i> | <i>Page 3</i> |
| <i>Your Voice</i> | <i>Page 3</i> |
| <i>TAC Releases Model Law</i> | <i>Page 4</i> |
| <i>Important Aspects of the Model Law</i> | <i>Page 4</i> |
| <i>A Supreme Decision</i> | <i>Page 6</i> |
| <i>TAC Booth at NAMI Convention</i> | <i>Page 8</i> |
| <i>And From Ontario</i> | <i>Page 8</i> |
| <i>Wade</i> | <i>Page 9</i> |
| <i>In Memory/In Honor</i> | <i>Page 10</i> |
| <i>Other State Updates</i> | <i>Page 11</i> |

Catalyst

**Catalyst is published six times a year by
the Treatment Advocacy Center
(the Center).**

**TREATMENT ADVOCACY CENTER
3300 NORTH FAIRFAX DRIVE
SUITE 220
ARLINGTON, VA 22201
PHONE: 703-294-6001
FAX: 703-294-6010
WEB SITE: WWW.PSYCHLAWS.ORG
E-MAIL: INFO@PSYCHLAWS.ORG**

BOARD OF DIRECTORS

**E. FULLER TORREY, M.D., PRESIDENT
JAMES COPPLE, SECRETARY
GERALD TARUTIS, ESQ., TREASURER
RAY COLEMAN
ED FRANCEL, JR., M.S.W.
FRED FRESE, PH.D.
CARLA JACOBS
D.J. JAFFE**

**EXECUTIVE DIRECTOR
MARY T. ZDANOWICZ, ESQ.**

**EDITOR
LORRAINE GAULKE**

**FUNDING SOURCES
STANLEY FOUNDATION
INDIVIDUAL DONORS**

**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.**

waiting for someone to become dangerous will culminate in violent episodes. The New York Times studied 100 "rampage killings," defined as "multiple-victim killings that were not primarily domestic or connected to a robbery or gang," committed during the preceding five decades.⁹ Of the 100 rampage killers, "more than half had histories of serious mental health problems" and 48 of them had "some kind of formal diagnosis, often schizophrenia."¹⁰ Based on their research, the Times staff concluded that, "the incidence of these rampage killings appears to have increased."¹¹

A natural outgrowth of a mental health system that withholds needed treatment until a person becomes dangerous is that police become the front line mental health workers. In 1976, the New York City Police Department took approximately 1,000 "emotionally disturbed persons" to hospitals for psychiatric evaluation.¹² By 1986, this number had increased to 18,500 and for 1998 it was 24,787.¹³ Most police are not trained to properly respond to "emotionally disturbed persons" and these encounters are often fatal. From 1994 to 1999, Los Angeles police shot 37 emotionally disturbed persons, killing 25 of them.¹⁴ In 1999 alone, police in New York City¹⁵, Houston¹⁶, and Tampa¹⁷, shot and killed three individuals with mental illness in each city.

While criminalization is the fastest growing dilemma facing the untreated mentally ill, years of neglect have created other tragic consequences of non-treatment. Sadly, we have grown accustomed to public places dominated by wasted human forms huddled over steam grates for warmth in the winter or wrapped in blankets in the summer. At least 150,000 people, or one-third of the nation's homeless population, suffer from severe mental illnesses.¹⁸ The majority of homeless individuals with untreated psychiatric illnesses regularly forage through garbage cans and dumpsters for their food.¹⁹ Studies reveal that at least one-third of mentally ill homeless women suffer sexual assault, many on multiple occasions.²⁰

The consequence of requiring treatment to be withheld until a person becomes a danger to himself or herself is predictable. By that time, he or she is likely to be either one of the 19 percent

who attempts suicide or one of the 10 to 15 percent who eventually succeeds.²¹ Suicide is the leading cause of death in jails and 95 percent of those who commit suicide in jails have psychiatric illnesses.²² Withholding treatment also puts people in jeopardy of victimization. Persons with severe mental illnesses are nearly three times more likely to be victims of violent crimes than the general population.²³

Clearly, a new wave of reform is needed. Enacting and utilizing standards based on the need for treatment will allow for intervention before it is too late. Abandoning dangerousness as the sole standard for assisted treatment will not require re-opening hospital wards. While counter-intuitive, it is logical that hospital usage will decrease by substituting a need for treatment standard for one based on dangerousness. The change will facilitate needed intervention sooner rather than later. For the most part, the same people who would be hospitalized when they become dangerous will simply be helped sooner. Because intervention occurs sooner, it will take less time to stabilize patients and they will spend less time in the hospital. At least five states that have adopted standards based on the need-for-treatment experienced decreased hospital admissions after the law changed (i.e., North Carolina, Alaska, Kansas, Texas and Colorado).²⁴

Perhaps the single most important reform needed to prevent the need for hospitalization and to prevent the consequences of non-treatment is to encourage the use of assisted outpatient treatment. When appropriate, assisted outpatient treatment fosters treatment compliance in the community through a court-ordered treatment plan. Moreover, not only does the court commit the patient to the treatment system, it also commits the treatment system to the patient. In the most comprehensive study to date, recently published from North Carolina, long-term assisted outpatient treatment was shown to reduce hospital admissions by 57 percent.²⁵ The results were even more dramatic for individuals with schizophrenia and other psychotic disorders whose hospital admissions were reduced by 72 percent.²⁶ Additionally, the same study showed that long-term assisted treatment combined with routine or

(Case for Model Law - page 7)



Members of the panel who presented information and answered questions at a workshop sponsored by the Treatment Advocacy Center at the recent NAMI 2000 Convention. Left to right: Jonathan Stanley, Kenneth Kress, Bernie Zuber, Donna Orrin, and Fred Frese. The workshop was about one of the devastating symptoms of severe mental illness, anosognosia.

Why all the interest in Workshop 3B?

By Jonathan Stanley, J.D.

People were interested in Workshop 3B at the annual convention. People filled every seat; people were sitting four across in the aisle; people were standing three deep at the back; and, we regret, many others were turned away. Audiocassettes of workshops were on sale at the convention, and, although it was held on the last day of presentations, the tape of 3B was the first to sell out. Yes, there was interest. But why all this attention?

Strangely, the focus of 3B, presented by the Treatment Advocacy Center, was an effect of mental illness that seems obvious. Entitled, *What Is It Like To Be Sick and Not Know It?*, the workshop detailed from both a clinical and personal perspective how a person can be overcome by mental illness, yet be completely unaware that what they are experiencing is caused by the illness. One of the most disturbing ramifications of this effect is that people in need of help because of their illness, will at times not seek treatment because they do not believe that they are sick.

Moderator Mary Zdanowicz introduced the workshop's featured speaker, Dr. Xavier Amador, Professor of Psychology in the Psychiatry Department of Columbia's College of Physicians and Surgeons. Dr. Amador is among the foremost experts on why people with mental illness often refuse treatment despite their obvious need for it.

He and others in his field have found and documented in numerous studies, as Dr. Amador lucidly described, that a prevalent effect of mental illness is that a person can lose, or have impaired, the

ability for self-assessment. This is a physiological symptom of mental illness known as anosognosia. It is akin to the results of physical trauma to certain parts of the brain. Dr. Amador convincingly showed that what are commonly termed "treatment denials" instead result from illness making a person unable to assess his or her own condition.

Following Dr. Amador were five people who have experienced anosognosia. Each spoke of how this confounding condition left him or her completely unaware of being very, very obviously sick.

Ken Kress enthralled the crowd with a wit and a speaking style worthy of a spot on the Letterman show. He told of his experiences with a long-time friend who was also bipolar. When his friend would become symptomatic, Ken would attempt to coax him into getting help, and the friend would try to do the same when Ken started to drift towards mania. But neither could ever convince the other that he was sick. Neither could break through the effects of anosognosia on the other.

Donna Orrin movingly told of her illness causing her to believe self-mutilation was her best course of action. She said, "I didn't think I was hurting myself, I just had to do it to keep them from coming in."

"I thought that my first suicide attempt [30 years before] had succeeded and that everything else in between was an illusion. I thought I was already dead," was the reason for Bernie Zuber's perilous and irrational actions at one time. Both Bernie and Donna had no idea that it was the symptoms of mental illness that were causing their worlds to convulse. Both were victims of anosognosia.

Jonathan Stanley described the worst

physical pain he had ever experienced. Searing radiation, nonexistent radiation that was a product of his psychosis, caused it. He was that sick. He was also so sick that he had no idea he was ill.

Last to speak was Fred Frese, and he was as only Fred Frese can be. The room shook with laughter. He intertwined multiple, seemingly

tangential points. And, when he was done, Fred had not only entertained the packed room, but had perfectly summed up and punched home the essence of the workshop's message.

Dr. Amador has just released a readable but comprehensive and helpful book on anosognosia and strategies to get treatment for those affected by it. Part of the proceeds from the book will go to NAMI. For information or to order *I Am Not Sick, I Don't Need Help*, visit www.vidapress.com or call 800-431-1579. [Mr. Stanley is Assistant Director of the Center.] ¶

Your Voice— Will Make a Difference

Thank you for your excellent *Catalyst*—very timely and much needed. It gets to the heart of the difficult situations that MI imposes on us. I was especially taken with the IMD Exclusion issue and will lobby locally to get this repealed.

NAMI Winston County is our local group and we would like five copies mailed at each publication—will see that these get passed around. I plan on being in San Diego and will look for your booth. Thank you in advance for coming.

The enclosed check is in honor of my brother Virgil Davis, who has suffered with schizophrenia since 1959 when he was 18.

Betty Hooper
Double Springs, AL

We lived in Maryland when K.S. Hardman [Scott] was born. His father is our nephew. We were so proud of his being in The Boy's Choir ... and so sad when he became a teenager and tragedy occurred.

(Your Voice - page 9)



Jonathan Stanley, Assistant Director, and Rosanna Esposito, Attorney, both on the staff of the Treatment Advocacy Center, sit on the panel at the Model Law workshop during the NAMI 2000 Convention held recently in San Diego.

Treatment Advocacy Center Releases Model Law At National Convention

By Rosanna Esposito, J.D.

The Treatment Advocacy Center conducted a workshop, "Introducing the Treatment Advocacy Center's Model Law for Assisted Treatment" at the NAMI Convention on Saturday, June 17th. The Center's Mary Zdanowicz, Jonathan Stanley and Rosanna Esposito presented the Model Law to the many conferees who attended this special session.

Mary Zdanowicz, Executive Director, opened the session with a look at why and how the Model Law was created. She explained that outdated state laws of the 1960s and 1970s have resulted in many of the most severely ill going without needed treatment and, in too many cases, becoming homeless, incarcerated, suicidal, victimized or prone to violent episodes. Ms. Zdanowicz stated that progressive assisted treatment laws must be crafted to reflect the significant advances that have been made in the last decade in our understanding and ability to treat severe mental illness. We now know that these conditions are treatable biological brain diseases and not lifestyle choices, as was the prevailing thought three decades ago. In drafting the Model Law, the Center solicited advice and assistance from individuals who are diagnosed with severe mental illnesses, their families, and medical and legal

professionals.

Jonathan Stanley, Assistant Director, highlighted some important aspects of the Model Law and noted that it is a compilation of the most effective provisions of existing state laws. The Model Law enables treatment for those overcome by severe mental illness, who are adjudicated to be dangerous, gravely disabled or chronically disabled. The last two criteria also require that a person is either unaware that he or she is ill or is otherwise incapable of making rational decisions concerning proposed treatment. The Model Law also adopts procedures from various states that promote clinical and judicial efficiency, such as having a combined commitment and treatment proceeding. The only "new" provisions, not in state laws currently, are for the additional protection of the rights and well-being of those placed in assisted treatment.

Rosanna Esposito, Attorney, detailed the Model Law provisions for assisted outpatient treatment. If an individual meets the criteria for assisted treatment, that individual may be placed in either inpatient or outpatient care. The Model Law requires that an assisted outpatient treatment order include provisions for case management and services. Ms. Esposito also reported findings from the most recent studies that demonstrate that assisted outpatient treatment is effective in reducing hospitalization and violence.

The Model Law is now available on the Center's Web site:

www.psychlaws.org. To receive a hard copy of the Model Law by mail, please contact us at 703-294-6001.

[Ms. Esposito is an attorney with the Center.]

Important Aspects of the Model Law

By Jonathan Stanley, J.D.

The Treatment Advocacy Center's Model Law for Assisted Treatment is a cautiously considered proposal to promote the provision of care for those who need it because of the effects of severe mental illness. At the same time, the Model Law includes numerous overlapping protections to safeguard those under court-ordered treatment and to ensure that only those for whom it is appropriate are placed or remain in assisted treatment.

The Model Law is more remarkable for what it is not than for what it is. It is not entirely revolutionary nor does it eradicate the basic constitutional protections provided by current treatment laws. There are familiar provisions for emergency treatment; a subsequent certification for a treatment hearing by an examining doctor; a more lengthy process to petition for the treatment of someone less sick; under different names, outpatient commitment and conditional discharge; periodic reviews and possible renewals of treatment orders; and a host of other mechanisms common to current laws for securing treatment for those overcome by mental illness.

A cursory examination may give the impression that the Model Law maintains the status quo, when it is actually a compilation of the most effective provisions of existing state laws. Variations of virtually all of this proposal's sections are the current law somewhere in the United States. In essence, we have combined each of the best available components into a statutory model better than any currently in effect.

Only in one area have we dared to be creative: the protection of the rights and well-being of those placed in assisted treatment. There we put forth procedures more extensive and vigilant than those now in place anywhere in the nation.

Following is a description of some of the key aspects of the Model Law.

STANDARDS

In developing a system to place individuals in psychiatric care, the most crucial question is, "When is such an intervention appropriate?" The answer is found in the legal standard that a person must meet in order for his or her placement in treatment to be allowed under the law. The Model Law sets out four alternative criteria that, if met, justify assisted treatment.

1. Chronically disabled: Only a few states have criteria designed to help people stuck in the "revolving door" of repeated hospitalizations, symptomatic behavior, and, for many, incarcerations. "Chronically disabled" allows consideration of possible harm to a person with symptomatic mental illness in light of past psychiatric history (which would include previous non-compliance with treatment), current likelihood of treatment compliance, and the risk of deterioration without treatment. This standard is thus tailored to assist those who are stuck in the revolving door.

2. Gravely disabled: A number of states have included "gravely disabled" as grounds for treatment placement. Most of these laws define this condition as when a person becomes so incapacitated by mental illness as to lose the ability to provide for his or her basic needs, with these normally delineated as food, clothing, shelter and, sometimes, medical care. The Model Law mimics the more progressive of the jurisdictions with gravely disabled criteria by explicitly including someone who is likely to suffer significant harm without treatment.

Incapable of making an informed medical decision: While not an independent ground for treatment placement, the "gravely disabled" and "chronically disabled" criteria each also require that the person is either unaware that he or she is ill or is otherwise incapable of making rational decisions concerning proposed treatment. Non-dangerous individuals who are capable of making informed medical decisions should not be placed in assisted treatment.

3. Danger to others: Every state allows for the court-ordered treatment of individuals who because of mental illness are a significant threat to the safety of other people. The Model Law incorporates a definition of "dangerous to

others" similar to that of most states, but makes clear that presenting a threat to a person in one's care, such as a child, or having caused intentional damage to the substantial property of another shall be evidence of dangerousness.

4. Danger to himself or herself: Similarly, every state allows for the assisted treatment of those who are demonstrated to be a danger to themselves, but the Model Law makes clear that a person's past related behavior shall be considered when making the determination as to whether someone meets this treatment standard.

PROVISIONS PROMOTING CLINICAL AND JUDICIAL EFFICIENCY

Many provisions of existing assisted treatment laws make little sense. They delay needed treatment, are inefficient from either a judicial or clinical perspective, or are concepts from other areas of law ill tailored to assisted treatment proceedings. The Model Law adopts procedures from various states that promote both clinical and judicial efficiency.

Combined Commitment and Treatment Proceedings: Although a common practice, the disadvantages of having separate hearings on whether a person should be committed and on his or her capacity to refuse treatment are patent. Having an interval between rulings on commitment and treatment produces the inherently cruel circumstance of medical professionals having to confine a psychotic or delusional patient without being able to provide treatment. Under the Model Law, the judicial determinations about treatment placement and the ability to refuse treatment are made in the same hearing. There is no reason, either logically or constitutionally, that both decisions should not be made concurrently. To be eligible for treatment placement under the Model Law, a person must be found either incapable of making an informed medical decision or to be a danger to himself, herself, or others. Each of those conditions is a constitutionally sufficient ground to suspend an individual's right to refuse treatment. Furthermore, the adverse ramifications of any such finding are mitigated by the Model Law's specific prohibition against an assisted treatment determination

**Seeing
Double
Double??**

***If you are receiving
more than one copy
of Catalyst and don't
want to, please let us
know and we will
correct it.***

Call:
703-294-6001

E-mail:
info@psychlaws.org

impacting a person's legal rights and privileges unrelated to the provision of treatment.

Single standard: The Model Law has the same standard for the placement of individuals in both inpatient or outpatient care. Some states have established distinct outpatient and inpatient treatment placement standards. Because of the different criteria, it is difficult in these states to transfer outpatients to inpatient status, and vice versa. A person who meets a more permissive outpatient standard may not meet the more stringent inpatient criteria. As a consequence, the Constitution's Due Process Clause requires there to be a hearing to determine whether an outpatient meets the more strict standard before being transferred to inpatient status. Because the Model Law has a single standard, judicial approval is not required to change a committee's treatment program. Nonetheless, the Model Law does provide safeguards that ensure that such transfers are appropriate and the least restrictive alternative that

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.

HONORARY ADVISORY COMMITTEE

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

**PROFESSOR KENNETH KRESS,
J.D., Ph.D**
UNIVERSITY OF IOWA
COLLEGE OF LAW

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

will meet the patient's clinical needs.

Psychiatric Treatment Board: Most times, the decisions of whether or not to place a person in treatment and, if so, what type of care is most appropriate are left to a judge who has little experience with or understanding of mental illness. The Model Law's decision-maker is a judicially-empowered panel made up of a lawyer, a physician and a person who has demonstrated experience, either personally or through a close relative, with mental illness. The advantage of having a tribunal with such a depth of knowledge and variety of experience is obvious.

Treatment plans: Extensive services may be included in an assisted treatment order providing for treatment on an outpatient basis. A treatment plan is mandatory for a person being discharged from assisted treatment.

PROVISIONS PROTECTING CONSUMER AND FAMILY RIGHTS

Where the Model Law does substantially depart from existing state laws is in enhancing the rights guaranteed to people with mental illness placed in assisted treatment and the rights of their families.

Family rights: Under the Model Law, relatives may, under certain circumstances, become actual parties to the assisted treatment proceeding, with the right to have counsel, present evidence, cross-examine witnesses, and appeal. When bringing a petition, family members are also eligible for the assistance of designated counsel.

Consumer rights: The Model Law has an extensive number of protections for those placed in assisted treatment. Subjects of assisted treatment petitions have the rights delineated in most state laws; i.e., to have designated counsel, to present witnesses, to appeal, to not have placement in treatment otherwise affect one's legal status, etc. Additionally, the Model Law introduces two novel procedures. Included is a formal grievance procedure whereby patients can bring complaints to the facility's medical director and, if necessary, to the Psychiatric Treatment Board. Perhaps even more significantly, the Model Law calls for the examination of a person placed on inpatient assisted treatment for

medication side effects every thirty days by a psychiatrist or physician other than the one treating him or her.

[Mr. Stanley is Assistant Director of the Center]. ¶

A Supreme Decision From South Dakota

By Edith Barry

On June 21st the Supreme Court of South Dakota upheld an appeals court decision ordering forced medication in the case of *Steinkruger v. Miller*, 2000 WL 815956 (S.D.), 2000 SD 83. The Supreme Court found that the South Dakota statute allowing involuntary treatment of incompetent, involuntarily committed patients (S.D. Codified Laws §27A-12-3) is constitutional, regardless of the fact that it contains no explicit least restrictive alternative requirement. Statutory language suggesting a least restrictive alternative requirement was deemed by the Court sufficient to maintain the statute's constitutionality.

DeWayne Miller is an involuntary patient at the South Dakota Human Services Center in Yankton, South Dakota. His diagnoses have ranged from schizophrenia to bipolar disorder. He holds delusions that "he can read minds, that he is pregnant, that all medications are poison" and he believes that smoking will cure his chronic obstructive pulmonary disease. The court recognized that Mr. Miller's disorder has impaired his judgment, that he lacks awareness of his illness and therefore refuses medication. His treating physician determined that psychotropic medication is the least restrictive treatment available for his condition, and that the benefits of such medication would "substantially outweigh" any side effects.

In South Dakota a court may order forced treatment if it finds by "clear and convincing evidence" that the patient is incapable of consenting because his or her "judgment is so affected by mental illness that the [patient] lacks the capacity to make a competent, voluntary, and knowing decision" regarding medication. S.D. Codified Laws §27A-12-3.15. Psychotropic medication must be "essential," "medically beneficial" and "necessary" because the patient:

(Supreme Court - page 10)

(Case for Model Law - from page 2)

outpatient services reduced the predicted probability of violence by 50 percent.²⁷

Progressive assisted treatment laws must be crafted to reflect the significant advances that have been made in the last decade in our understanding and ability to treat severe mental illnesses. We now know that these conditions are treatable biological brain diseases and not lifestyle choices, as was the prevailing thought three decades ago. Research shows that at least 40 percent of those diagnosed with schizophrenia and manic-depressive illness lack insight into their illness because of a biologically based symptom known as anosognosia.²⁸ A person suffering from this symptom does not believe he or she is ill and is likely to refuse treatment reasoning, "Why should I take medication if there is nothing wrong with me?" For those who previously refused treatment because of unpleasant or dangerous side-effects of medication, a much broader array of medications is now available so that possible adverse effects of treatment can be more effectively mitigated.

The Treatment Advocacy Center was established in 1998 to eliminate barriers to treatment caused by outdated treatment laws. In drafting a Model Law that would meet those goals, the Center solicited advice and assistance from individuals who are diagnosed with severe mental illnesses, their families, and medical and legal professionals. The Model Law was carefully drafted to withstand constitutional challenge. It is consistent with the seminal United States Supreme Court decision, *O'Connor v. Donaldson*, 422 U.S.563 (1974) which Judge David L. Bazelon explained held that, "persons institutionalized solely because they are in need of treatment are deprived of their constitutional right to liberty if they are denied treatment while confined."

The Treatment Advocacy Center's Model Law promotes the provision of assisted treatment of severe mental illness at every turn for those who need it, while zealously guarding the rights of those who receive it. [Dr. Torrey is President and Ms. Zdanowicz is Executive Director of the Center.]

Endnotes

¹Marc Abramson, *The Criminalization of Mentally Disordered Behavior: Possible Side-Effect of a New*



NAMI Sacramento and Treatment Advocacy Center joint fundraising event at the Blue Diamond Reception Center, Sacramento California. Pictured left to right: Dr. E. Fuller Torrey (Treatment Advocacy Center), Randall Hagar (NAMI Sacramento), Nancy Chavez (Legislative Consultant of Assemblywoman Helen Thomson), and Judy Hansen (NAMI Sacramento, event co-chair).

Mental Health Law, 4 Hospital & Community Psychiatry 101 (1972).

²Herschel Hardin, *Uncivil Liberties*, Vancouver Sun, July 22, 1993.

³Jennifer C. Bonovitz & Edward B. Guy, *Impact of Restrictive Civil Commitment Procedures on a Prison Psychiatric Service*, 136 Am. J. Psychiatry 1045 (1979).

⁴Id. ⁵Abramson, *Criminalization*, supra note 1.

⁶Donald A. Treffert, *The MacArthur Coercion Studies: A Wisconsin Perspective*, 82 Marquette Law Review 760 (1999).

⁷Lance T. Izumi, et al., *Pacific Research Institute, Corrections, Criminal Justice, and the Mentally Ill: Some Observations about Costs in California* (September 1996).

⁸Paula Ditton, U.S. Department of Justice, *Mental Health and Treatment of Inmates and Probationers, Bureau of Justice Statistics Special Report* (July 1999).

⁹Ford Fessenden, *They Threaten, Seethe and Unhinge, Then Kill in Quantity*, N.Y. Times, April 9, 2000.

¹⁰Id. ¹¹Id.

¹²E. Fuller Torrey, *Out of the Shadows: Confronting America's Mental Illness Crisis* 73-74 (John Wiley & Sons 1997).

¹³Id.; Elisabeth Bumiller, *In Wake of Attack, Giuliani Cracks Down on Homeless*, N.Y. Times, November 20, 1999.

¹⁴Steve Berry & Josh Meyer, *Mistakes Seen in LAPD Shootings of Mentally Ill*, L.A. Times, November 7, 1999.

¹⁵Anthony Baez Foundation, et al., *Stolen Lives, Killed by Law Enforcement* (1999).

¹⁶*Disturbed Peace, Calling Police Should Not be Death Sentence for Mentally Ill*, The Houston Chronicle, October 5, 1999.

¹⁷*Police Look at Policy on Mentally Ill*, St. Petersburg Times, November 22, 1998.

¹⁸R.C. Tessler and D.L. Dennis, *National Institute of*

Mental Health, *A Synthesis of NIMH-Funded Research Concerning Persons Who Are Homeless and Mentally Ill* (1989); Interagency Council on the Homeless, *Priority Home!: The Federal Plan to Break the Cycle of Homelessness*. (March 1994).

¹⁹Torrey, *Shadows*, supra note 12, at 19.

²⁰S. Friedman & G. Harrison, *Sexual Histories, Attitudes, and Behavior of Schizophrenic and "Normal" Women*, 13 Archives of Sexual Behavior 555 (1984), L.A. Goodman, et al., *Episodically Homeless Women with Serious Mental Illness: Prevalence of Physical and Sexual Assault*, 65 American Journal of Orthopsychiatry 468 (1995).

²¹C. Caldwell and I. Gottesman, *Schizophrenics Kill Themselves Too: A Review of Risk Factors for Suicide*, 16 Schizophrenia Bulletin 571 (1990), F.K. Goodwin & K.R. Jamison, *Manic-Depressive Illness* 230 (Oxford University Press 1990).

²²Center on Crime, communities and Culture, *Mental Illness in US Jails: Diverting the Non-violent, Low-level Offender* (1996).

²³Virginia Hiday, et al., *Criminal Victimization of Persons with Severe Mental Illness*, 50 Psychiatric Services 62 (1999).

²⁴Robert D. Miller, *Need-for-Treatment Criteria for Involuntary Civil Commitment: Impact in Practice*, 149 Am. J. Psychiatry 1380 (1992).

²⁵Marvin S. Swartz, et al., *Can Involuntary Outpatient Commitment Reduce Hospital Recidivism?*, 156 Am. J. Psychiatry, 1968 (1999).

²⁶Id.

²⁷Jeffrey W. Swanson, et al., *Involuntary Outpatient Commitment and Reduction of Violent Behaviour in Persons with Severe Mental Illness*, 176 British J. Psychiatry 224 (2000).

²⁸Xavier F. Amador, *Awareness of Illness in Schizophrenia*, 17 Schizophrenia Bulletin 113 (1991); S.N. Ghaemi, *Insight and Psychiatric Disorders: A Review of the Literature, with a Focus on its Clinical Relevance for Bipolar Disorder*, 27 Psychiatric Annals 782 (1997). □

TAC Booth A Huge Success

By Anna-Lisa Johanson

The Treatment Advocacy Center set up a booth at the annual NAMI Convention in San Diego, California, June 14-17. The booth saw a steady and thick stream of interested attendees throughout the convention, including Center supporters stopping by to see what was new, people who had been recommended to the Center by a friend or a forwarded copy of *Catalyst*, and newcomers interested in finding out what the organization does.

The booth provided a large selection of printed materials including copies of *Catalyst*, a sign-up sheet for the mailing list, copies of the Model Law and related press release, as well as articles by Dr. Torrey and Mary Zdanowicz. There were also copies of recent news media videos and the videotape of the conference at George Washington Law School. It was noted that more people seemed to pause at the booth when Dr. Torrey appeared on the screen. The video presentation led to an unexpected number of people requesting copies of other videos in the Center's collection to use in trainings and for their own information. Since the convention, additional orders for videos have continued at a constant pace.

Several NAMI members, including Consumer Counsel members, had heard of the Center and came to learn about the organization firsthand. The vast majority of consumers who came to the booth agreed with the mission of the Center and expressed interest in learning more about the Model Law. Additionally, some asked for multiple copies of the new Model Law to send to other interested people in their state. Many newcomers took sign-up sheets for *Catalyst* away with them, and approximately 60 people completed the forms and left them at the table.

A number of NAMI librarians or leaders of local NAMI chapters came to order additional materials for their libraries and members. A surprising number of the NAMI members who came to the table had either seen *Catalyst* or were already receiving a copy through someone in their organization. Jonathon Stanley noted that, "Knowledge of us and our issues has increased greatly over the



Ruth Posner, from New York, stops by the Treatment Advocacy Center's booth at the NAMI Convention to pick up materials and to speak with Jonathan Stanley and Anna-Lisa Johanson.

first two years we were at the convention."

Mary Zdanowicz noted that this provided one of the more comforting aspects of the convention, "I finally had an opportunity to meet so many wonderful people who I have developed a relationship with over the last two years." Jonathon Stanley and Rosanna Esposito had the same experience as supporters that they had worked with over the telephone or via e-mail came to the booth to introduce themselves.

The Center's team also educated many Californians about AB1800, the proposed LPS Reform law and its status in the state legislature. Jonathon Stanley had prepared packets with the latest update for people who had been following the progress of the bill.

During the time prior to the Center-sponsored panels, cards were passed out with the time and location of the sessions. Many people walked away with the cards and while there is no way to tell, the advance attention may have contributed to the overwhelming turnout.

The most interesting aspect of the booth was the opportunity to hear individual stories firsthand. While the personal struggles can not all be conveyed, the idea that there are many people who appreciate the work the Center is doing and need the movement to continue came across very clearly.

[Ms. Johanson is a legal intern with the Center.] ¶

And From Ontario

Great news from the North! Ontario has enacted Brian's Law, a progressive law for assisted treatment.

On June 21, the province adopted a package of reforms to its Mental Health Act. Among these, it has added need-for-treatment criteria and community treatment orders, the Canadian version of assisted outpatient treatment.

We are impressed by and even somewhat envious of our Canadian counterparts behind this victory for all those denied treatment by unthinking laws. The measure steamed through the Ontario Parliament by an astounding margin of 82-10.

The Treatment Advocacy Center supplied informational and advisory help to the proponents of Brian's Law, but can take little credit for its passage. That goes entirely to the determined Ontario advocates behind the measure. We thank and congratulate them. They have saved lives.

The news of this grand success evokes thought that while the laws of countries differ greatly, the problems caused by untreated mental illness are international. One of Brian's Law's architects stated, "What it does is it allows us to provide early intervention for people who are a danger to themselves or a danger to others."

Sound familiar? ¶

(Your Voice - from page 3)

We are 84 years of age now and have seen illnesses of all kinds, but mental illnesses are the worst! In many ways, the public still shuts the mentally ill up in an attic and pretends they don't exist.

... As soon as diagnosed the patient needs to be in a controlled environment. If it is God's will, and we pray so, there will come a day when a more permanent cure will be found. Meanwhile, please continue your work and if possible send your recent issue to the list of people below. We are sorry we can do no more with financial help, but living on a fixed income does not allow many give-a-ways! We add our prayers,

Blake and Lucy Bee
Arizona

Just a short note to convey my appreciation for the work you do. As you know, I have been trying to piece together a working understanding of the issues surrounding mental illness. During this ongoing process, I have come to rely on the *Catalyst* as one of the greatest sources of innovative ideas and compassionate commentary on the subject.

Please convey to all associated with the publication the respects of an interested third party, who like so many, is trying to understand why we can't do more for those who are mentally ill and living on the streets.

Robert L.E. Egger, Director
DC Central Kitchen, Washington, DC

Please let me know why the "Preventable Tragedies" link and database on your TAC Web site is not in operation. That database was my favorite link for information and references on your Web site.

Maxine Hayden

[Editor's note: The "Preventable Tragedies" database was apparently not operable, but it is now fixed. Please try it again.]

When my son was twice hospitalized (both times under the Baker Act), he was twice reminded of his option as an "adult" of the "right to refuse treatment." When I heard this I almost flipped out! How could any person, organization or government agency have the audacity to tell a mentally ill person under a Baker Act involuntary commitment to receive treatment that, "HE HAD THE RIGHT TO REFUSE TREATMENT"? Does this

make any sense?

This has got to change! Because of this "right," my son's recuperation from schizophrenia is going on three years and he still sometimes denies or wonders if he really has the mental illness. Imagine if public stigma is hard to fight, how hard it is to educate the mentally ill!

I was fortunate to attend the NAMI 2000 Conference in San Diego this past June 14-18 (thanks to Circles of Care who helped with the expenses), and one of the presentations that really interested me was the *"What Is It Like To Be Sick and Not Know It?"* symposium. The room was so full of people that there was no room to walk. I guess they expected a smaller crowd, but people just kept crowding in on the floor, against the walls, on top of tables, by the stage of panelists, etc. I was very glad to see this turnout; perhaps on the next Conference for 2001 (Washington DC), they will get the message and have a stronger voice (and bigger room) to educate family members and consumers alike. Vice President Fred Frese, a Doctor of Psychology, who had been hospitalized numerous times, gave a very strong presentation and viewpoint, and there were other speaker panelists.

If anybody is interested in some literature I brought back with me, including a copy of *"I am not Sick, I don't need help!"* reprint by Xavier Amador, please send me your mailing address and I will gladly forward it to you.

My appreciation goes to Rachel Diaz of NAMI-Miami for taking this subject very personally and for having so much interest. Rachel has been advocating about this subject for a while now. Don't give up, Rachel, your voice is getting stronger! You have our support!

Lou Iparraguirre, VP
NAMI-South Brevard County FL
961 Golden Beach Boulevard
Indian Harbor Beach, FL 32937

Wade

By JoLynn Woodland

I can still remember the day they came and took him away. I was five years old when the police came and arrested my brother. Wade was 20 years old and headed to prison. I remember my mom sending my brother, John, and I out to ride our bikes when the police came. I did not

understand at the time why my brother would not be living with us anymore. I did not believe the stories I was being told of all the bad things he had done. I just wanted my brother to be there when I got home from kindergarten like he had always been that year. He would take me for a motorcycle ride before we sat down to have lunch and watch TV.

I can remember our trips to the Idaho State Penitentiary. We would go up on Saturday or Sunday afternoon. We had to go through a metal detector and we had to be very quiet. John and I once got in trouble for running in the halls. We had to go through big metal doors with a big security guard. We met with Wade in a big open room with about eight or nine tables. We would sit and talk with him and play board games. I watched as we went to see him and his personality slowly changed. His hands began to shake and it was hard to have a conversation with him. Wade spent nine years in prison.

I wanted more than anything for Wade to get out of prison, and when I found out he was being paroled I was glad, but I was also scared. I had thought for so long that when he got out of prison he would be the same person that he had been when he left our home. Then when my parents told me that he was mentally ill and that he would never be the same again I was worried. I had heard a lot about mentally ill people, much of it was not true, and I was scared to be alone with him.

All the time Wade was in prison I didn't want anyone to know he was there. I didn't want them to judge me or make me feel like a bad person because of what my brother had done. I wanted to have a perfect family just like the rest of my primary class. So I put Wade and the circumstance of his life in the back of my mind and I didn't deal with them. I tried to forget him the best I could, because it was easier that way. The last few years that Wade was in prison I did not go and visit him very often. By this time I had made Wade something in the back of my mind that didn't really exist. And, whenever my family talked about him, I would always feel sorry for myself and wish that I had a better life. So I would just put the memory away again and not think about it, because it hurt.


Wade was paroled in 1996 and he went to live in a shelter home in Blackfoot. He

would come home on the holidays but he was so different. He was still the kind, loving person he had always been, but he was just different. He would have complete conversations with himself. He smoked cigarettes non-stop. He had no desire to do anything besides watch TV. It was hard to even have a conversation with him. He is mentally ill and the voices in his head tell him to do bad things. While at his shelter home the voices in Wade's head got so bad that they scared him, causing him to break parole, so now he is back where he started-in prison. He does not belong there, but there is nothing we can do to get him back to a shelter home where he belongs.

There is hardly a day now that goes by that I do not think about Wade. I pray for him, that he might be taken care of. I cry for him. There are times when things get bad that I still wonder why I could not be like everyone around me. Their families seem so perfect. I often wonder if the hurt I feel now would be easier to deal with if I had dealt with it all along instead of trying to hide from it. There are things in our lives that no matter how hard they are we must deal with them. My brother Wade is one of the things in my life that I cannot run away and hide from, hoping that if I don't deal with it that it will just go away. It is never going to go away and I must

deal with it. I can't hide from it any more. I am still scared to tell my friends and others that I have a brother in prison, but I tell myself that if they are my real friends they will not think of me any differently because my brother is in prison. I am not responsible for the things that my brother did, and I do not need to feel guilty or ashamed for the mistakes he made. But sometimes I still do. Some people may judge me and think that I am a bad person, but I think more than others thinking that about me I think that about myself. I am probably a lot harder on myself than anyone would ever be, and I always imagine the worst. I am just so scared of what people might think of me. I love Wade and I am not ashamed of him. He made some mistakes, but he is mentally ill and he was when he messed up, and that does not make him a bad person. I am going to do everything that I can to help him, even though probably the only thing I can do is pray for him. And as much as I want to be able to deal with this head on, I still find myself not thinking about it too much because the hurt is too hard to handle.

[Editor's note: This story was written by JoLynn Woodland for a senior year English class project. Marsha Parks, President, NAMI Magic Valley, Idaho, submitted it to us, believing that this poignant

remembrance of a young sister's suffering would touch the hearts of us all and perhaps move us to action.] 

(Supreme Court - from page 6)

(1) "presents a danger to himself or others;" (2) "cannot improve or his condition may deteriorate without the medication;" or (3) "may improve without the medication but only at significantly slower rate." S.D. Codified Laws §27A-12-3.13, 12-3.15.

Mr. Miller's attorneys argued that treatment refusal statute violates substantive due process because it does not specifically require that the treatment be the least restrictive alternative. However, because the statute requires that forced medication be "essential," the Court held that this language amounts to a least restrictive alternative requirement. The Court also found that there was no treatment available for Miller that would be any less intrusive. Miller had refused to participate in the local outpatient community program IMPACT (Individualized and Mobile Program of Assertive Community Treatment).

The Court also recognized that, "South Dakota has a strong parens patriae interest in caring for mentally ill persons and psychotropics retain a vital place in mental health treatment. It would be cruel

THE FOLLOWING MEMORIALS AND TRIBUTES WERE RECEIVED BY TREATMENT ADVOCACY CENTER IN MAY/JUNE 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.

| <u>RECEIVED FROM</u> | <u>CITY AND STATE</u> | <u>IN MEMORY OF</u> | <u>IN HONOR OF</u> |
|--|---|--------------------------------------|---|
| JANICE & JOHN DELOOF DJ & ROSE JAFFE | FULLERTON, CALIFORNIA NEW YORK, NEW YORK | BRADLEY JOHN DELOOF | ENGAGEMENT OF TALİ GROS & JON STANLEY VIRGIL DAVIS |
| BETTY HOOPER AL & JOAN BEZNER MARY M. MAY BOBBY B. WAHRENBURG | DOUBLE SPRINGS, ALABAMA SPRING HILL, FLORIDA NEW SMYRNA BEACH, FLORIDA CHESAPEAKE, VIRGINIA | SCOTT HARDMAN NANCY ELIZABETH MAY | ERNEST CRAWFORD & SAMUEL E. BEALE |
| BLAKE & LUCY BEE EILEEN RORICK MELVIN R. SILVERMAN DJ JAFFE DJ JAFFE | SUN CITY WEST, ARIZONA ORANGE SPRINGS, FLORIDA NEW CITY, NEW YORK NEW YORK, NEW YORK NEW YORK, NEW YORK | KENNETH SCOTT HARDMAN | MICHAEL RORICK DR. HOWARD TELSON OLIVIA NADINE, HENRY & CHARLES STEVENS |
| MARY ZDANOWICZ | ARLINGTON, VIRGINIA | MILDRED BOYD | |

forbearance to allow incompetents to reject senselessly the medicine necessary to restore their mental health."

The case is significant beyond the obvious implications of validating the constitutionality of South Dakota's law. It is evidence that courts are becoming much more sophisticated in applying the scientific advances in our understanding of severe mental illnesses to concepts in the law. The correlation between "lack of insight caused by illness" and the legal concept of "incapacity to make an informed medical decision" is drawn in this case. The court's recognition of the State's *parens patriae* interest and the "cruel forbearance" not to care for those in need are particularly significant and a source of hope that the law is beginning to acknowledge the need for treatment.

[Ms. Barry is a legal intern at the Center.] ¶

Other State Updates

CALIFORNIA

AB1800, Assemblywoman Helen Thomson's progressive legislation to reform the treatment restrictive Lanterman-Petris-Short Act, has been on a roller coaster. Riding with it have been the hopes for rational treatment laws, as well as the enormous efforts, of the members of the California Treatment Advocacy Coalition ("CTAC").

On May 24 there was victory. The Assembly Appropriations Committee unanimously voted AB1800 to that house's floor. But at the same time there was defeat, the committee cut the \$350 million funding request that Assemblywoman Thomson had made part of her bill.

However, this year's California budget negotiations made the loss of the allocation far less significant than it could have been. Those involved in the budget negotiations planned on coming to a total figure for increased mental health spending. Thus, unlike last year with Kendra's Law in New York, funding designated for AB1800 would not increase the total amount spent on mental health by the state.

On May 31, AB1800 blazed through the full Assembly. Despite the late hour and being inundated with bills stacked up

in the face of a legislative deadline, the entire Assembly devoted over half an hour to the bill-as much time as any legislation received all day. AB1800 passed 53-16, 77 percent of those voting favored rational treatment laws and two-thirds of the total Assembly supported the bill. This life-saving legislation seemed on the path to the Governor's desk.

But then came Senator John Burton, the Senate's President Pro Tem, majority leader, and most powerful legislator.

Perhaps it is the jerk of a civil libertarian knee in an inappropriate direction, but Senator Burton has imprisoned AB1800. The normal process is for a bill approved by the Assembly to go to a policy committee for a public hearing and the possibility of a vote on the Senate floor. Senator Burton has had his Rules Committee assign AB1800 directly to a study committee from which it cannot emerge without the Senator's permission. He is trying to stop the representatives of the people from considering this progressive measure—no consideration, no debate, no chance of a vote.

More mystifying than Senator Burton's opposition to AB1800, is why he would try to keep from the Senate a bill that has such wide and deep support. Numerous Californian newspapers and public officials as well as major civic and professional organizations throughout the state have endorsed the bill. Even San Francisco Mayor Willie Brown has enthusiastically backed this life-giving legislation. But this vital proposal is now threatened with a most undemocratic end.

But even if this year's campaign ends where it now stands, it will have been a success. The Assembly is now familiar with the need to reform LPS, almost all the newspapers have endorsed it, and CTAC has gone from nothing to hundreds united in the fight for treatment. The members of CTAC and NAMI California are attempting to educate Senator Burton, to convince him to loosen his grip on AB1800. Believing him sincere but misinformed, we hope he can be made to understand that to wait will harm thousands. But even should he remain unmoved, John Burton's procedural ploy will only prolong what we now know is inevitable. The flood of compassionate reform in California can be held back only so long.

CONNECTICUT

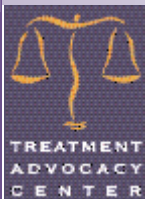
Tuck away this year's experience in Connecticut for future reference. Just over a year ago, a person overcome by, and who had a history of non-treatment for, mental illness killed Reverend Robert Lysz near Hartford. In response, Representative Roger B. Michele introduced legislation that would allow for assisted outpatient treatment (AOT) in Connecticut, one of only nine states without it. Rep. Michele fought valiantly for his bill, and ultimately a "Father Lysz's Law" became law. It was not, however, AOT that Rep. Michele gained for Connecticut.

The new law will establish a pilot program offering intensive community support and peer-engagement specialists to individuals who have threatened to be or been violent in the last five years. This sounds similar to a Kendra's Law type program. And it is, except participation in the Connecticut version will be completely voluntary—a compromise made during the legislative process.

Yet, it is those incapable of making rational treatment decisions, unaware that they are ill, or incapable of maintaining participation in outpatient treatment that AOT is designed to help. For people willing to voluntarily select an intensive outpatient program, AOT is, most likely, unnecessary.

We are heartened that the new program will enhance Connecticut's voluntary services in a portion of the state. Hopefully, it will become a model for the infrastructure of a future AOT program. We also hope that it is, if proven effective, expanded statewide. At the same time we see that Connecticut's provisions for the assisted treatment of those most in need of help are unchanged. And we note that the law named in honor of Robert Lysz, would not have, if in effect at the time, saved his life.

Rep. Michele is undeterred by having to weaken the content of his legislation to pass through potentially fatal procedural roadblocks thrown in its path. He has sworn to come back again next year, the next, and the next, as long as it takes to secure rational treatment laws for Connecticut. And when he returns, the Treatment Advocacy Center will stand with him. ¶



TREATMENT ADVOCACY CENTER CATALYST

Phone: 703-294-6001 ♦ Fax: 703-294-6010

Web Site: www.psychlaws.org

E-mail: info@psychlaws.org

3300 North Fairfax Drive Suite 220

Arlington, Virginia 22201

ADDRESS SERVICE REQUESTED

Nonprofit Organization

U.S. Postage

PAID

Permit No.

8287

Arlington, VA

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 THE TREATMENT ADVOCACY CENTER WITH A GIFT OF:

\$ _____

☐ MY CHECK IS ENCLOSED MADE PAYABLE TO TREATMENT ADVOCACY CENTER

☐ PLEASE MAKE THIS GIFT IN MEMORY OF: _____

☐ PLEASE MAKE THIS GIFT IN HONOR OF: _____

NAME: _____ PHONE: _____ E-MAIL: _____

ADDRESS (SUMMER/WINTER): _____

CITY: _____ STATE: _____ ZIP: _____

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!