Catalyst

TREATMENT ADVOCACY CENTER
Volume 3, No. 2 March/April 2001

In Honor of the Unsung Heroes

By Mary Zdanowicz, Executive Director, Treatment Advocacy Center

The Treatment Advocacy Center was created to prevent the consequences of untreated mental illness with the victims of the illness themselves foremost in our minds. Our ultimate purpose is to prevent people with schizophrenia and manic-depressive illness from suffering by ensuring they get timely treatment. But, we cannot forget the other victims of untreated mental illness. Ultimately, our work will benefit them as well.

This issue of *Catalyst* is dedicated to the victims of random violence that sometimes occurs when people with mental illness stop taking their medication. We want to recognize the brave and compassionate souls who have turned their grief to good by advocating more effective mental illness treatment. Most noble are the victims who express sympathy for the person with untreated mental illness. Edgar Rivera is a case in point. When Edgar Rivera awoke from coma after being pushed in front of a New York City subway train by a man with untreated schizophrenia, he expressed compassion for the man who was responsible. "I have no legs, but at least I have my mind," Mr. Rivera said. "This guy doesn't have that. I think I'm ahead."

We are honored to have articles by two wonderful women, Pat Webdale and Cindy Soto, who summoned considerable strength after the heartbreaking loss of their daughters to work to make life better for others who, like their daughters' assailants, have severe mental illnesses that are not being treated. Their stories provide a glimpse of their unbearable sorrow made all the worse because these tragedies could have been prevented. Pat and Cindy are exceptional. They offer hope. Despite their anguish, they appreciate that it is vital to ensure that those who need treatment the most get it. If they can see it, surely everyone else will see it too. If they can see that not all people with mental illness must be condemned because of senseless violent acts of a few, perhaps others will see that too.

Benedict's Haven
Judy Turnbaugh, Dolores Castaldo and Mary Zdanowicz (left-right) during a visit at Benedict's Haven, an outstanding family run group home in St. Petersburg, Florida for individuals with mental illness. For more information about starting a family run group home, you can contact Delores (727) 522-2478 or Judy (727) 942-8140. They are truly angels.

Both women are committed to building a lasting legacy to the children they lost. In Pat Webdale's case, her daughter's legacy is Kendra's Law. As Jon Stanley reports on page 11, all indications are that Kendra's Law has benefited the individuals who are in the program. For example, medication compliance increased 129% and harmful behavior decreased 26%. Furthermore, in both cases challenging this law, the judges ruled that it was constitutional. Most recently, New York Supreme Court Judge Charles LaTorella ruled Kendra's Law constitutional "in all respects" stating:

> Kendra's Law is a response by the Legislature to a tragic situation, which had its origins in a serious void in New York's system of caring for the mentally ill. That void arose from the fact that certain patients, who no longer posed a danger to themselves or others while in the hospital and accepting medication and treatment, stopped taking their medication upon release ... [and] would once again constitute a danger to themselves or others, sometimes with tragic results.

Contrary to dire predictions from the opposition that the law would be a "dragnet" stripping all individuals with mental illness of their rights, the law carefully guards civil liberties by providing strict standards and due process protections. Less than 1% of New York's mentally ill

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Catalyst

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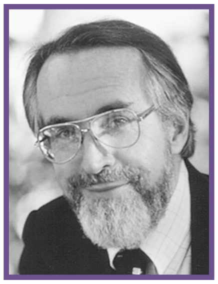
The Center is a nonprofit organization dedicated to eliminating legal and clinical barriers to timely and humane treatment for the millions of Americans with severe brain diseases who are not receiving appropriate medical care.

Current federal and state policies hinder treatment for psychiatrically ill individuals who are most at risk for homelessness, arrest, or suicide. As a result an estimated 1.5 million individuals with schizophrenia and manic-depressive illness (bipolar disorder) are not being treated for their illness at any given time.

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

Bazelon Center Is Wrong - Weston and Goldstein Refused Treatment and Services

By E. Fuller Torrey, M.D.



In a recent article in *Psychiatric Services,* Michael Allen, J.D., of the Bazelon Center for Mental Health Law, claimed that Andrew Goldstein and Russell Weston were "actively seeking treatment and services, and each was repeatedly turned away." (52 Psychiatric Services 342,343 (2001)) Mr. Allen is either seriously misinformed or consciously misrepresenting the facts.

Bazelon's assertion that Russell Weston, who shot and killed two Capitol Hill police officers, was actively seeking treatment is absurd. A videotape of Weston's competency evaluation for trial by a forensic psychiatrist reveals just how seriously delusional he is. He calmly explains that the primary significance of his trial is to provide a forum to expose the conspiracy of murder and cannibalism in this country. When asked if he is aware of the possibility that the death penalty could be imposed in his case, he answers affirmatively. As soon as the death penalty is carried out, Weston explains, he will end up in the Great Safe of the U.S. Senate where the ruby satellite control is hidden. That is what he was after the day he shot and killed Officers Chestnut and Gibson. Weston believes that the ruby satellite's time reversal system will "sweep him away" to a time when he is not deceased. But when asked if he has a mental illness, he adamantly denies it. For that reason, he rejects the possibility of asserting an insanity defense, even in the face of a possible death penalty.

Why would someone who goes to such lengths to deny that he has a mental illness seek treatment and services? The truth is, there is no evidence that he sought treatment for his mental illness, but rather that he consistently refused treatment. *The Washington Post* reported that Weston showed up at St. Peter's Community Hospital in Helena, complaining that a man in a field had pointed a gun at him and that a dentist had implanted a chip in his tooth that allowed communication with the Russian ambassador. He declined medication and follow-up treatment. On another occasion he went to an emergency room and threatened a lab worker he believed had injected him with a needle contaminated with feces and Rohypnol. That time he was involuntarily admitted to a state psychiatric hospital in Montana. Again he refused medication, but doctors administered medication over his objection. He responded to treatment and subsequently continued to take it voluntarily while in the hospital.

The Washington Post also reported that after Weston was discharged from the hospital, he appeared for a follow-up appointment at a clinic near his parents' home in Illinois. He was obviously delusional, and it appeared he was not taking his medication. He told clinic workers that a judge had ordered him to attend the clinic. When clinic staff told him that follow-up treatment had not been court ordered, he immediately left and never returned.

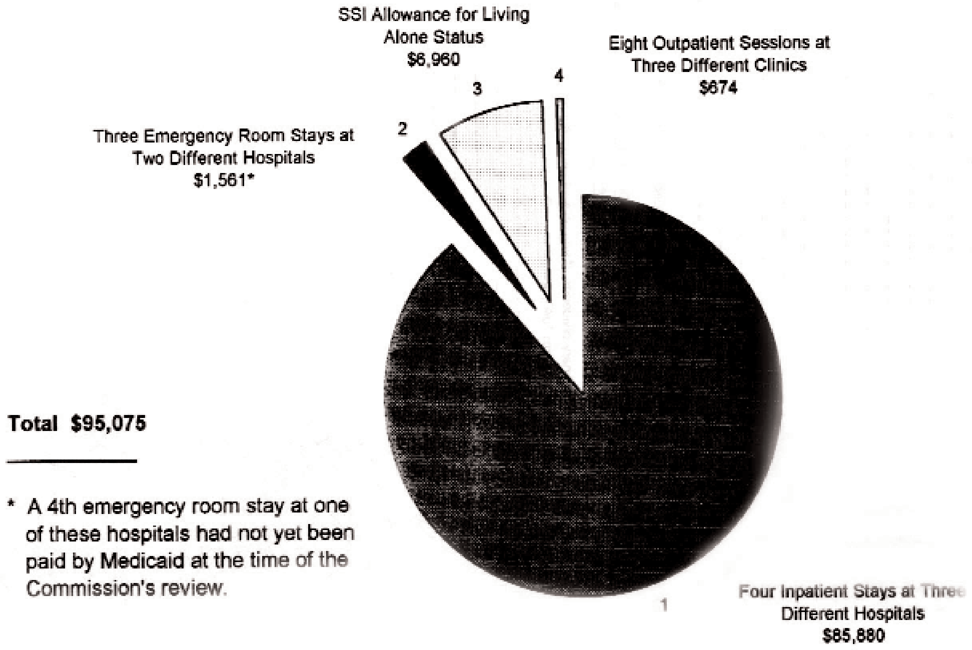
Contrary to Bazelon's fiction, Russell Weston's case is the paradigm for assisted treatment. He has no insight into his illness. Not only did he not seek treatment and services, he refused them unless he thought they were court ordered. But, when he was treated, he responded.

Portraying Andrew Goldstein as a person who begged for services and was refused is no closer to the truth. In 1998 alone, the State of New York and the federal government expended $95,075 for his mental health and residential care (see Figure 1). The New York State Commission on Quality of Care for the Mentally Disabled and the Mental Hygiene Review Board investigated and issued a report on the history of services and treatment for Andrew Goldstein (pseudonym David Dix). (A copy of the report can be found at www.cqc.state.ny.us/dix.htm).

The Commission reported that in the two years prior to pushing Kendra Webdale to her death in front of a New York City subway train, Goldstein received 199 days of inpatient and emergency room services, on 15 different occasions, in six different hospitals from

Figure 1 - Cost of Andrew Goldstein's Mental Health & Residential Care in 1998

Source: In the Matter of David Dix - A Report by the New York State Commission on Quality of Care for the Mentally Disabled and the Mental Hygiene Medical Review Board



Total $95,075

* A 4th emergency room stay at one of these hospitals had not yet been paid by Medicaid at the time of the Commission's review.

1997 to 1999. Four different clinics provided outpatient services in this time period (see Figure 2 on page 4).

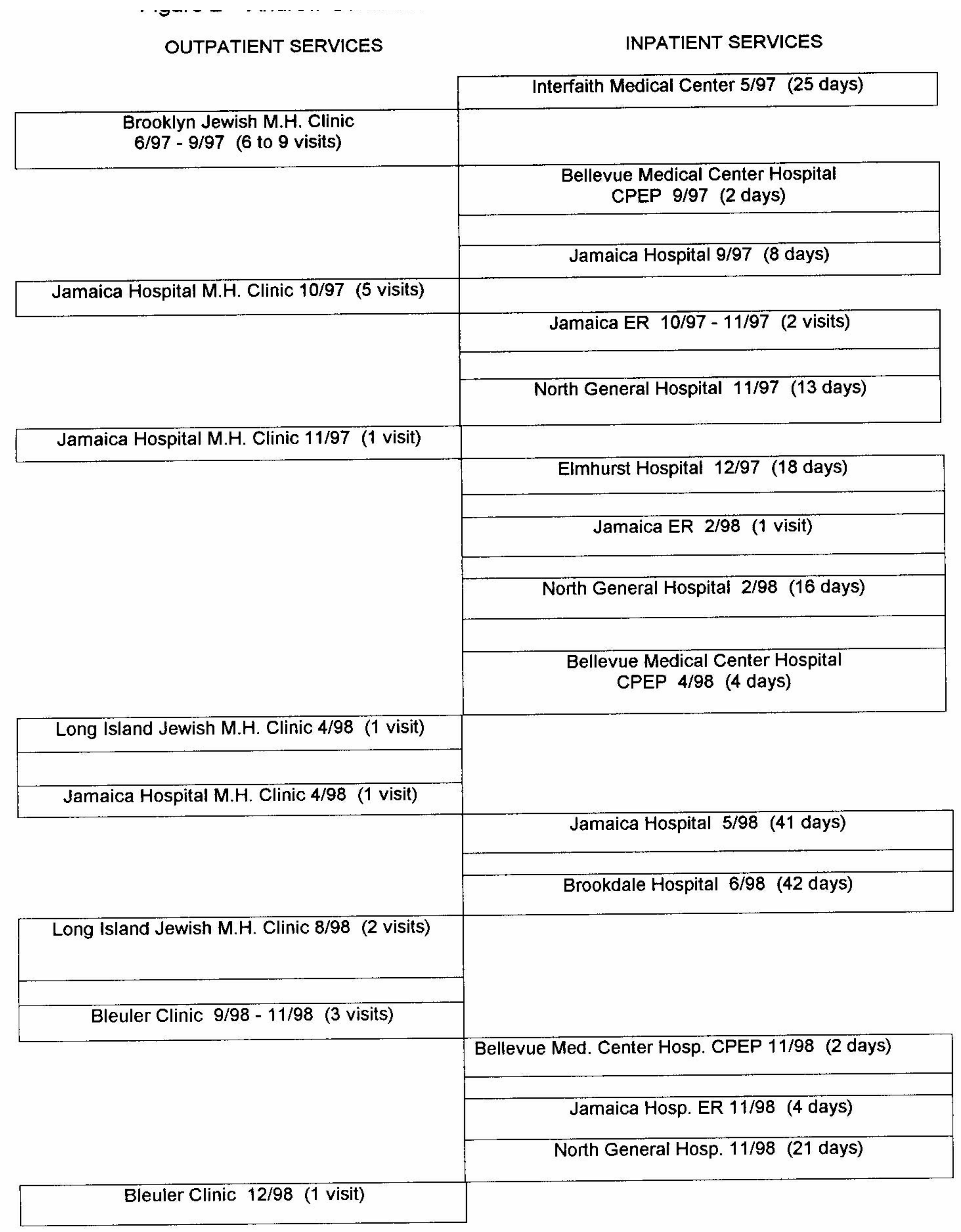
This is hardly the profile of a patient who was refused services. In fact, it was Goldstein who often refused services. He consistently stopped taking his medication after discharge from a hospital unless he was closely monitored. When he wasn't taking medication, he exhibited hallucinations, delusions, and unprovoked acts of aggression. On some occasions, when his untreated symptoms deteriorated to the point where he suffered anxiety, insomnia, or other unpleasant conditions, he went to an emergency room seeking relief. Other times, he was brought to the emergency room following a violent outburst.

For a period of approximately four years, while living in supervised residential programs, Goldstein remained medication-compliant and participated in treatment. He chose to leave the program to live on his own. Shortly after leaving, he was picked up by police after he acted aggressively in a supermarket. He returned to the supervised residence but, within months, chose to leave again. Subsequently, he refused placements offered to him in supervised residences, even though it was obvious to hospital social workers and Goldstein's mother that he needed structure, support, and medication monitoring to stay well.

Instead, the two years prior to Kendra Webdale's death were characterized by repeated emergency room visits, medication noncompliance after discharge, and at least eight incidents of unprovoked violence against others. Whenever he requested services, he either changed his mind before arrangements could be made or failed to follow through. On two occasions when he was willing to accept placement in a supervised residence, the system did not respond quickly enough before he changed his mind and opted to be discharged to his apartment instead. At no point during this time did he appear to take his medication regularly.

There is no question that the system failed Andrew Goldstein and consequently Kendra Webdale. Since New York State had no assisted treatment law at that time, there was little that could be done for someone like Mr. Goldstein who failed to stay in treatment, opted to live independently, refused services, and was medication noncomplaint. That is, until Kendra's Law was passed.

It is ironic that the Bazelon Center cites these two men as archetypes for their arguments against assisted treatment. In fact, these two men are excellent examples of why assisted treatment is necessary. Andrew Goldstein and Russell Weston had long histories of medication non-compliance, refused needed services, and had documented aggressive histories. When required to do so, both took medication and responded well. But, when they were left to their own devices, the course of their untreated illness led to violence that ravaged many lives, including their own. Goldstein and Weston strongly make the case for assisted treatment.



OUTPATIENT SERVICES	INPATIENT SERVICES
	Interfaith Medical Center 5/97 (25 days)
Brooklyn Jewish M.H. Clinic 6/97 - 9/97 (6 to 9 visits)	
	Bellevue Medical Center Hospital CPEP 9/97 (2 days)
	Jamaica Hospital 9/97 (8 days)
Jamaica Hospital M.H. Clinic 10/97 (5 visits)	
	Jamaica ER 10/97 - 11/97 (2 visits)
	North General Hospital 11/97 (13 days)
Jamaica Hospital M.H. Clinic 11/97 (1 visit)	
	Elmhurst Hospital 12/97 (18 days)
	Jamaica ER 2/98 (1 visit)
	North General Hospital 2/98 (16 days)
	Bellevue Medical Center Hospital CPEP 4/98 (4 days)
Long Island Jewish M.H. Clinic 4/98 (1 visit)	
Jamaica Hospital M.H. Clinic 4/98 (1 visit)	
	Jamaica Hospital 5/98 (41 days)
	Brookdale Hospital 6/98 (42 days)
Long Island Jewish M.H. Clinic 8/98 (2 visits)	
Bleuler Clinic 9/98 - 11/98 (3 visits)	
	Bellevue Med. Center Hosp. CPEP 11/98 (2 days)
	Jamaica Hosp. ER 11/98 (4 days)
	North General Hosp. 11/98 (21 days)
Bleuler Clinic 12/98 (1 visit)	

Source: In the Matter of David Dix - A Report by the New York State Commission on Quality of Care for the Mentally Disabled and the Mental Hygiene Medical Review Board

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—TREATMENT ADVOCACY CENTER BOARD AND STAFF.

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Mandate Treatment for Mentally Ill

By CINDY SOTO
(reprinted from Los Angeles Times, January 27, 2001 with permission of the author)

Cindy Soto

Last May, Steven Allen Abrams intentionally ran his 4,000-pound Cadillac into a Costa Mesa preschool, killing two children and injuring five others. Three-year-old Brandon Wiener was trapped underneath the vehicle. His mother, Pam, screamed as he was freed and rushed to the hospital. About an hour later, he died in his mother's arms.

Her small body broken and her skull crushed, four-year-old Sierra Beth had no need of a hospital. She was killed instantly.

Sierra was my daughter. As I drove onto the scene, disbelief surrounded me even before I was told my daughter was dead. After, I went into shock. My life was over. My beautiful, sweet, loving child was gone, forever.

Abrams was mentally ill. Although he exacerbated his illness by years of drug abuse, he was nonetheless sick and in need of treatment.

As the insanity phase of his trial unfolded, I was shocked and appalled to hear of the countless times Abrams had been in and out of treatment and in and out of a doctor's care, only to be released back into the community unmonitored. His refusal to comply with voluntary treatment and to take medication, except when he was made to, shows that he was not capable of making rational treatment decisions. He also had a history of violence and instability, which suggested that he was capable of future violence.

Abrams was a time bomb waiting to explode. He did.

In California, individuals are not eligible for involuntary treatment unless they present an imminent danger to themselves or others. Such treatment, when it occurs, is usually short-term and in an inpatient setting. This leaves a gaping hole in California's treatment of the mentally ill. There are voluntary community programs and much-needed steps being taken to strengthen those programs.

But, these voluntary programs fail to address individuals such as Abrams, who had access to care, but could not or would not comply with treatment. In order to help someone like Abrams, California needs a form of involuntary treatment that includes evaluating the history of an individual and, where appropriate, legally mandating that the noncompliant person stay in treatment once out of the hospital.

This care would allow the individual to continue to recover as well as to safely live and work in the community.

There are those, like the ACLU, who believe that mandated treatment infringes on the civil rights of the individual. While I understand their concern, I pose to them this question: "Should the rights of an individual who refuses to comply with treatment, who has a severely deteriorating condition, and who has a history of becoming violent when in such a condition, supersede the rights of my four-year-old daughter to live safely in her community?" I'd answer, "No."

Many times mentally ill individuals harm themselves when their illness renders them incapable of making sound decisions with regard to their own care. It is not in their best interest to end up repeatedly hospitalized or jailed. Civil rights become a hollow exercise under these conditions. If people overwhelmed by severe mental illness, like Abrams, were instead placed in mandated community treatment, they could get well enough to knowingly exercise and enjoy their civil rights. Meanwhile, our right to live in a safe and secure society would be protected.

Abrams was unable or unwilling to comply with treatment. For that, my daughter, Sierra, and Brandon paid the price. Mandatory treatment legislation is important because the right to life is the most important right of all.

[Cindy Soto Is the Founder of Sierra's Light Foundation, a Group Dedicated to Making Preschools Safer for Children.]

(continued from page 1)

citizens were referred to the program in its first 14 months. Half of those cases were dismissed, demonstrating that civil liberties are protected. Since the program started, 512 people who would not accept treatment voluntarily received services through court orders. Nearly twice as many previously non-compliant individuals accepted services voluntarily after being referred to the program. Most encouraging is that New York's experience shows that court-ordered outpatient treatment targets services to the most high-risk clients, protects civil liberties, and increases voluntary participation in treatment.

Nelson Kull, a consumer advocate from Florida informs us that contrary to the claims of leaders of the organized consumer movement, the majority of consumers actually support assisted treatment (see page 8). Dr. Torrey reminds us on page 2 that Andrew Goldstein was a perfect candidate for assisted outpatient treatment. An investigation by The New York State Commission on Quality of Care for the Mentally Disabled and the Mental Hygiene Review Board revealed that Goldstein failed to stay in treatment, opted to live independently, refused services, was medication non-complaint, and had frequent episodes of unprovoked violence.

Andrew Goldstein would have benefited from Kendra's Law. The tireless efforts of advocates born of senseless acts of violence, like Pat Webdale and her family, and Cindy Soto, bring hope that other families will not experience the excruciating pain they have endured. We are indebted to them because they are also helping to improve the quality of life for individuals with mental illness who would not otherwise get the treatment they need.

Pat Webdale with her daughter, Kendra.

Recollections of Kendra and a Look at Kendra's Law

By Pat Webdale

The new year is a sad time for our family. Winter winds and the bitter chill factor match the desolate feeling in our hearts as we ponder the holidays and the second anniversary of the death of our daughter, Kendra. We do a look back at all of the events that have occurred. The signing of Kendra's Law is most notable. Experiencing the sudden death of a loved one due to great trauma cries out for a response. As the details unfolded and I learned that the subway pusher who killed Kendra was a mentally ill man who was not taking medication I screamed out, "Why?—Why was this man not taking his medication?" At that moment I vowed to make a difference. My family has learned "why" and much more about mental illness. Strained family ties and frustrated therapists are the nuts and bolts of having a family member who suffers from a brain disease. Among the reasons a person with bi-polar disease, schizophrenia or major depression might refuse to take medication are: poor insight caused by the disease—a lack of understanding that they are sick, stigma attached to mental illness and the side effects of medication. Suicide and violence are often in the headlines when it comes to mental illness. There are upwards of one thousand murders a year committed by untreated mentally ill persons. They carry the label "preventable tragedies." Reforms are desperately needed. Kendra's law is one piece of the puzzle that has been put in place.

My thoughts trail back to the birthing of Kendra's Law. Kendra's youngest sister, Krista, wrote a letter to Attorney General Spitzer asking why his office would no longer monitor the release of mentally ill patients on to the streets. He explained that this task was now delegated to the Office of Mental Health. Eliot Spitzer was introducing the Assisted Outpatient Treatment Law to the New York State legislature. New York would be the 41st state to adopt this law. Naming it after Kendra would give impetus to pass the bill into law. We decided to go public with our personal tragedy. Kendra's law would allow individuals who fit the strict criteria to be ordered into treatment to prevent further deterioration. Seven months of lobbying in Albany followed our first press conference. Meetings with the Attorney General's team, letter writing and phone calls to the Senate, Assembly and Governor's office became part of our family routine. I recall the day we spent twelve hours round-trip on Amtrak only to miss the press conference we had rushed off to attend. The Treatment Advocacy Center located in Arlington, Virginia, is dedicated to the prevention of the devastating consequences of non-treatment. They were a limitless supply of support for assisted treatment. Kendra's Law celebrated it's first anniversary on November 8, 2000. Since it's inception there have been many questions asked. Is it effective? Has anyone been helped? Is it constitutional? One of our greatest concerns was putting Kendra's name on a law that would not work.

The December issue of the *OMH Quarterly* published by the NYS Office of Mental Health answers some of these questions. Program coordinator, Glenn Liebman, writes of some of the successes; which are more effective links between case managers and service providers and the individuals who oversee the AOT process. Statewide through October 18, 2000, 786 individuals received service enhancements, 393 court orders were processed and 25 Renewal Orders are in place. Kendra's Law also established a Medication Grant Program to ensure that individuals who are mentally ill and returning to the community from a hospital or correctional facility will receive medication while they wait for Medicaid eligibility. This has been in effect since September 2000.

Kendra's Law is sometimes challenged as being unconstitutional—as "taking away the right to refuse medication." In a recent ruling the decision of Judge Cutrona stated: "Kendra's Law provides the means by which society does not have to sit idly by and watch the cycle of decompensation, dangerousness and hospitalization continually repeat itself."

Kendra is always on our minds. It is with gratitude that we remember her smiling eyes, her funny sayings, and the way she took care of our family. It is with pain that our thoughts return to the moments on the subway platform. The memories of our last Christmas together are bittersweet; stinging, and at the same time cherished. Kendra was on the phone for that entire weekend with the U.S. Air baggage department. Her luggage was lost en route to Buffalo. It contained all of our Christmas presents as well as her wardrobe for the weekend. She remained calm and cheerful although I knew she was frustrated. It was just out of her hands. When it came time to exchange gifts she accepted hers graciously with her wonderful smile. This was a tough thing, for Kendra was a "giver." On December 27th, she and her sister Kim departed for LaGuardia. At eleven p.m. I received a call from U.S. Air. They were on the thruway with Kendra's suitcase. "Don't bring it here," I implored, "return it to LaGuardia." This was not to be as it was not policy. The next day I trudged though the snow and sent the suitcase "home" via U.S. mail. Kendra would never receive it, as the suitcase would not arrive until after January 3, 1999. I treasure the Christmas gift that was mine in that suitcase—a collage of our August visit to Boston, photographs she had taken and arranged in an old wooden frame. Ralph and I had gone to Boston for a short vacation and we were delighted that Kendra joined us for two days. It was a favorite city of hers to visit since her college days.

One consequence of this tragedy has been our family's involvement in mental health issues in a variety of ways. It is of some comfort to us to have Kendra's Law. Although we would rather have Kendra, this is not to be. I am mindful of organ donation. I have been an organ donor for a great many years. It was not an option to donate Kendra's organs to willing recipients due to the severe trauma sustained by her body. We were able instead to have a law that bears her name. The intention of Kendra's Law is to enhance humanity. It is a fitting tribute.

What Do Consumers Really Think About Assisted Outpatient Treatment?

By J. Nelson Kull, III

I would like to discuss two issues: political correctness and paternalism. These issues are on my mind as a result of the debate in Florida about outpatient commitment or as it is now called, assisted outpatient treatment.

I began responding to questions about this issue at least a year ago, maybe two. I spoke against it vehemently at a focus group of advocates and government officials, including state legislative staffers. I talked about all the usual reasons for opposing it. It was stated at that meeting that it would criminalize the mentally ill. It would interfere with trust between consumers and providers. It would clog up our system by giving priority to court-ordered patients so that they would displace people coming into the system from the traditional civil system. I went on to talk about constitutional rights. I may have even quoted one of the founding fathers:

> "Those who would trade freedom for security deserve neither freedom nor security."
>
> —Benjamin Franklin

People present at some of those discussions accused me of using high rhetoric. Looking back at it, I may have.

I have now read in excess of 300 pages on the topic. Here are some of my observations: Many, if not most, states have some type of outpatient commitment law. Yet the problems predicted above do not seem to be apparent. Most people in most states never have cause to get involved in outpatient commitment. They probably do not even know what their state law says. I find it hard to understand how, if the above problems were true, why do we hear so little about them?

Another observation: When I began talking about this issue with my fellow Pathways' members and other consumers, it became apparent that they either believed that the law already existed, in some seldom-used form, or that it should.

I was so surprised that I took some informal polls. Pathways serves 50 to 60 consumers a day. On one day when 22 people were present, I explained the topic to the best of my ability and asked them to vote. Twelve people supported outpatient commitment, seven opposed, with the remainder abstaining. One of the abstainers said he wanted to change to pro, but he is not included in that category.

The next day I polled 10 consumers at People, Inc., a peer support group. All 10 voted for the pro position.

A couple of days later, I polled 43 consumers at Lakeside Alternatives, our local community provider. Twelve polled in favor, one opposed, and the rest chose not to vote.

Some more observations. This is an issue that people are having much difficulty sorting out. A lot of anger is already being expressed. It is sad when people start questioning one another's motives and integrity. This often comes in the form of attacking how the other side got their results and their motives.

I will note that both sides have been guilty of this. However, the traditional consumer advocates spend more of their time arguing against the other side's methodology and less giving examples of actual current events that result from the proposed policies. On the other hand, the supporters of outpatient commitment stress events in the news instead of scientific studies.

What I find really interesting is something that at first seems counterintuitive (science talk for "not what one expects," or different from what common sense would have one expect). What I am talking about is the difference between what people I call the "consumer elites or the consumer leadership" and the people whom they are supposed to serve and represent. It has often surprised me that people like this who are always talking about tolerance, diversity, and individualism, are often the most heavily invested in political correctness.

Some of these people have actually said to me that they will not allow the use of language that is not "person first." They seem to believe that they have the right to control speech as a method of controlling thought, and I assume reality. To me the best definition of an ideologue is a person who is determined to see reality in light of his/her ideology, instead of his/her ideology in light of reality.

What is offensive is censorship in American society, especially by people who wax eloquently about human rights and freedom of expression. These people claim to be protectors of diversity and the right to be different. They would no doubt describe themselves differently, but like all who support censorship as serving a special purpose. The first principle of censorship is that the ends justify the means. Most wrongs begin with this predicate.

Political correctness in its true and extreme form is a type of paternalism. That is, one American telling another what they can do or say for their, and hopefully others, good. Those who have the right to censor are often self-appointed, or appointed by like-minded who trade legitimacy for support.

I have attended national conferences in which I was disappointed by the lack of real diversity. There were people of different races, religions, national origin, and first languages present. However, too many people talked like tape recorders. They all seemed to be saying the same mantra. The professionals, families, government, and drug companies were all wrong and the consumers are always right, provided they conform to political correctness. There were no dissident views. There was very little debate about really serious issues where people would have legitimate and serious disagreements such as outpatient commitment.

I personally like a good disagreement. Many of my best friends introduced themselves by screaming at me. Hopefully, some of you will do the same. I find it suspicious when everyone sounds like the same tape recorder. It is not healthy. It reminds me of those old films about communist party meetings where everyone always voted unanimously.

Obviously, I am using an extreme example, but you get the idea. The forces of political correctness can never understand what the founding fathers intended. The founding fathers never intended to protect the truth. They were far too clever for that. What they intended was to create a free market of ideas where conflicting ideas could compete with free access to the media and the public. The ultimate predicate of democracy is that the average citizen is not a fool, and that if allowed to hear both or all sides of an argument will be able to discern the truth or the most truthful.

If you believe in freedom, you must first believe in free thought and that means no censorship. If you can be trusted with the truth, then so can everyone else. The market place of ideas works better when left open and unregulated by the politically correct or government. Finally, if you believe in your cause, then censorship works against you. You do not need its protection and it gets in the way of projecting your own message with independent credibility.

[Mr. Kull is President, Pathways Drop-In Center, Inc., and a nationally-recognized consumer advocate. He encourages people to respond and comment on his article by e-mail at skull3@Earthlink.net.] ⚖

Your Voice— Will Make a Difference

Dear Mary,

Enclosed is my donation to TAC. Please consider it in honor of Carla Jacobs,who has worked SO long and hard for the "right to treatment." Recently, I was particularly moved by her short, direct article in the *LA TIMES* (12/20/00, "Tragic Cost of Mental Illness"), sent to us through e-mail.

I appreciate getting the TAC *E-News* the *CATALYST,* and the information about NIMH funding (I wrote our Congress people and urged our members to do so.), and the re-printing of *MADNESS IN THE STREETS*. I have an older copy and sent excerpts from it (and from *OUT OF THE SHADOWS*) to my elected officials some time ago. I should do it again.

This next year, I hope to do more for the cause of changing our state law regarding involuntary treatment. Good news for Pennsylvania is that Taylor Andrews is now our NAMI PA President. Perhaps he can help us get more organized around the assisted treatment issue. It certainly is of concern to more and more people, as hospitals close, and as doctors are forced by insurance companies and managed care to discharge people from private hospitals before they are stabilized. I get calls (sometime as many as four in one week) from local people needing information and support. By far the most frequent concern is trying to get an ill family member to accept treatment.

Many, many people deeply appreciate what TAC is doing to help people obtain treatment. We are so grateful to you, to the Board of Directors and to the Honorary Advisory Committee. You all are performing a very needed service that is benefiting many people.

Alice Fitzcharles
Media, Pennsylvania

Dear Mary,

Thanks for the outstanding work the Treatment Advocacy Center is doing. The TAC *E-News* helps to reinforce what we are trying to do to uphold Kendra's Law in New York State. While the law is controversial, it has already put in place discharge plans for people with mental illness leaving the county jails in New York State. And there's money in the governor's proposed state budget to see that Kendra's Law programs are expanded. For that we are thankful.

Roy Neville
Co-President, NAMI - Schenectady

I cannot tell you how delighted I am to receive a copy of the *Model Law for Assisted Treatment.* If in place years ago it would have saved my daughter from two years as a homeless mentally ill person in Dallas and five years homeless in Norman, Oklahoma, etc. She is now 54 years old; lives in an apartment in Norman with her cat; is able to care for herself without help, no meds, cannot work; fully delusional, refuses treatment; does not believe she is ill.

The direction TAC is going is appropriate to me. I did volunteer in

Out the Center's Window

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

We at the Treatment Advocacy Center work to improve treatment laws and programs throughout the nation, but it is hard for us to ignore our own backyard of Arlington, Virginia. Thankfully, as almost everywhere in America, our community is served by a local NAMI affiliate. An item from an issue of that chapter's admirable publication, *The Arlington Voice*, unintentionally—or perhaps with clever subtlety—evidenced the importance of our Center's mission.

The article was on a presentation given at an AMI meeting by two Arlington police officers and the local coordinator of emergency mental health services. The officers stressed that their foremost priority when dealing with a person overcome by mental illness is not an arrest, but to obtain needed treatment for the person. The speakers' compassionate approach was encouraging.

What really struck me, however, was the article's description of what the officers and mental health services coordinator's training had, by necessity, included.

The training emphasized that Mental Health Emergency Services:

♦ Cannot legally facilitate the removal of an individual from any location, under any circumstances, other than to facilitate an emergency psychiatric hospitalization.

♦ Cannot require individuals who do not meet the criteria for emergency psychiatric hospitalizations to receive mental health services. Emergency Services can only make recommendations and referrals.

♦ Cannot provide supervision, monitoring, or placement of an individual who has special needs if the individual does not require psychiatric hospitalization.

These are the handcuffs placed by Virginia's law on Arlington's government personnel—no matter how good their intentions—when trying to help people incapacitated by mental illness. Similar to those of many other states, Virginia's treatment standard is a strict one that requires a person be dangerous to self or others before being placed in treatment, although there is also an infrequently used and narrow gravely-disabled criterion. Should one of the officers in the article encounter someone obviously overcome by mental illness, but who does not appear to meet that restrictive standard, they have little option but to walk away.

We at the Treatment Advocacy Center realize that this frustrating scenario is not unique, that it is present across the country. Looking out our window reaffirms our resolve to help eliminate barriers to early intervention and treatment. It also reminds us that our work has just begun.

Oklahoma for NAMI-OAMI legislation for eight years, so I really appreciate what you are doing. As I am now 83, I can not do much, but I can pass the information along.

Mary Main
Dallas, TX

Dear Dr. Torrey,

We appreciate your continued support and work to alleviate the distress, stigma, and punishment by the general public against people who develop severe mental illnesses.

Jerome and Hazel Byers
Dallas, Texas

Dear Dr. Torrey,

Thank you for your life-long dedication to the understanding and treatment of severe mental illness.

Adele Kaschenbach
Dallas, PA

Dear Dr. Torrey and Mary,

Enclosed please find check from our family organization and also a check in memory of my son, Stephen Hurley. We admire your work in the mental health field. It is sorely needed.

Wishing you success in the coming year.

Dorothy Thaller
Chairwoman Concerned
Families of Greystone
East Hanover, NJ

My son has experienced homelessness, victimization, worsening of symptoms, and incarceration. I am grateful you are helping out. He is in a FACT team now and doing much better. It has a legal component to require treatment.

Jane McCabe
Forestville, CA

I much appreciate and admire the work you do.

Lou Matthews
Ventura, California

> ***We at the Treatment Advocacy Center realize that this frustrating scenario is not unique, that it is present across the country. Looking out our window reaffirms our resolve to help eliminate barriers to early intervention and treatment. It also reminds us that our work has just begun.***
>
> ***Jonathan Stanley***

Kendra's Law Working

By Jonathan Stanley, J.D.,
Assistant Director

Operational for nearly a year and a half, New York's assisted outpatient treatment program has provided that state with a middle ground for people partially incapacitated by severe mental illness.

Kendra's Law (the enactment that created the program) offers a modality of mandatory treatment between the absolute restriction of inpatient placement and unfettered release to the community-the disparate alternatives often faced by families, consumers, and mental health professionals in many other states. Due to legislation inspired by the tragic and horrific death of Kendra Webdale, New York now has court-ordered and supervised outpatient treatment for people in obvious need of care with a recent history of non-compliance with treatment that has led either to repeated hospitalizations or violence.

In the first months after it took effect, Kendra's Law was used sparingly. Since then, however, there has been increasing use of this vital treatment mechanism. Anecdotal reports had indicated that the program was effective. Recently we learned that it is not just working well-it is working spectacularly.

In February the New York State Office of Mental Health released a report entitled "Progress Report on New York State's Mental Health System." New York Governor George Pataki's brief opening message on the first page of the report holds out Kendra's Law as a paradigm for his future efforts:

> "Recent initiatives, such as the enactment and implementation of Kendra's Law, underscore my commitment to ensure that mentally ill individuals get the help they need."

He does not mention any other specific program.

But, as nice as it is for Kendra's Law to be placed on such a public pedestal by New York's leader, there is even better fare in the section of the report on assisted outpatient treatment (AOT).

As of January, "over 400 individuals assessed through AOT have been determined to need court-ordered treatment." Including those who, instead of being subject to a petition for AOT, entered formal treatment contracts and accepted enhanced services, "over 1300 individuals with serious needs are now receiving case management and other services for the first time as a result of AOT." And the report's data indicate that New York's mental health system is making ever-increasing use of AOT.

Kendra's Law has turned New York's attention to the most severely ill:

> "All localities have developed new mechanisms to ensure that individuals most in need receive highest priority access to services."
>
> "A wide variety of stakeholders, case management providers, county officials, family members, and individuals receiving services, acknowledge that AOT has improved access to case management and other services for those most in need."

Most startlingly are the outcome numbers. Based on preliminary findings for the first 141 people in AOT, those in the Kendra's Law program have experienced a:

- 129% increase in medication compliance;
- 194% increase in case management use;
- 107% increase in housing services use;
- 67% increase in medication management services use;
- 50% increase in therapy use;
- 26% decrease in harmful behavior; and
- 100% decrease in homelessness.

There is no need for us to embellish on numbers like those. The entire report is available (in pdf format) at:

www.omh.state.ny.us/omhweb/news/index.html.

States continue to gain interest in outpatient commitment.

By Rosanna Esposito, Attorney, Treatment Advocacy Center

The National Conference of State Legislatures (NCSL) and Health Policy Tracking Service (HPTS) recently released their 2001 Health Priorities Survey. The book compiles polling information from state legislators, legislative staff, governors' offices, executive agencies and other state health sources in order "to identify their legislative priorities."

The results show a dramatic increase in the number of states interested in outpatient commitment. Last year just nine states identified the issue as a legislative priority (*Catalyst,* Volume 2, No. 1, January/February 2000). In the 2001 survey, the following 30 states responded that outpatient commitment is a legislative priority:

Alaska, Arizona, California, Connecticut, Florida, Hawaii, Illinois, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, Tennessee, Texas, Virginia, West Virginia, Washington and Wisconsin.

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

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

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