Catalyst
TREATMENT ADVOCACY CENTER
Volume 3, No. 3 May/June 2001

Idealism Gone Awry

Exploring origins of dysfunction in mental health care

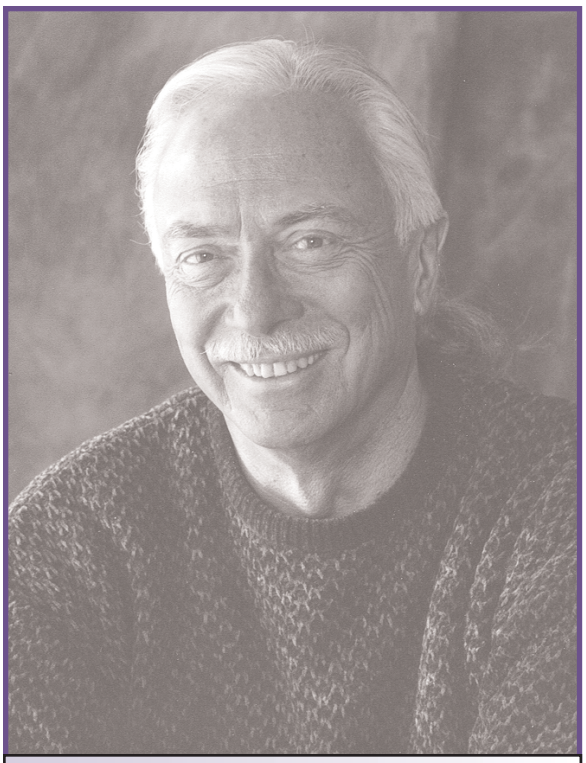
by John W. Milton, former State Senator
Co-chair, NAMI-MN Legislative Committee

Moved by Ken Kesey's book, *One Flew Over the Cuckoo's Nest,* a group of idealistic, energetic and naïve Minnesota state senators set out in the mid-1970s to reform the system of caring for the mentally ill. Visits to the old state hospitals confirmed our worst fears: Kesey's book, and the movie based on it, could just as easily have taken place here in Minnesota, presumed to be one of the nation's incubators of progress and reform.

As one of the prime movers in that group, I believed that we were creating a better alternative to those large, brick-and-stone warehouses where people with brain disorders were managed by psycho-surgery, electro-shock and numbing meds like thorazine. Where patients—out of sight, out of mind—would live out their lives, and present no danger to the families and communities which had sent them away.

After all, it was the mid-1970s. Surely, if we could stop the Vietnam War, desegregate the schools, win voting rights for African Americans, fight for equal rights for women, improve safety for workers, and protect the environment, we could reform the mental health system. And surely, if it could be done anywhere, why not here in Minnesota?

The plan was deceptively simple. Close down the big warehouses. Take the money saved from that to establish programs in local communities, where families and friends would be close at hand to support the mentally ill. Replace the more invasive treatments with family-based therapy and improved medication. In time, we would not only save lives, we'd be saving the taxpayers' money. It seemed too good to be true.



John W. Milton
former Minnesota State Senator, and
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It was. To begin with, the bureaucracy dragged its feet on shifting money and personnel to local programs. The stigma of mental illness produced a backlash in many communities, where the good citizens of Minnesota fought against having "those people" living down the street. Payment for services fell more and more under the control of three giant managed care plans, and these, rather than care providers, decided how much care was "medically necessary." Local governments were inclined to export their problems to the state, thus keeping a lid on local property taxes. And, state legislators of the 1980s and 1990s were mesmerized by the tangible benefits of cutting expenditures and returning money to the taxpayers. Whatever benefits might result from reform were too intangible and long-term, not relevant to incumbent legislators who ran on the short-term benefits they'd delivered to their constituents.

To make matters worse, when people with brain disorders were liberated from the old state hospital system, they were assumed to be competent to make choices about whether to continue treatment. The fact that nearly half of them suffered from anosognosia, a condition which rendered them incapable of recognizing their illness, was not as well understood as it is today, and the extreme civil libertarians were (and still are) unwilling to accept this as a factor in patients' choice of receiving or rejecting treatment. So in a caring place like Minnesota, where it is unthinkable to let a friend or relative with diabetes choose not to take insulin, where we prevent older people with Alzheimer's from wandering across freeways in the dead of winter, we continue to insist on letting people with serious brain disorders choose whether or not to be treated . . . until they deteriorate

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Catalyst

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

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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.

to the point where they become "imminently dangerous" to themselves or others. And then, in most cases, only if they are on the verge of, or in the act of, committing some heinous crime.

So, despite the fact that brain disorders strike roughly one in four Minnesota families, efforts to reform the commitment process are opposed by the Mental Health Association of Minnesota, (inexplicably) the state hospital association, and (predictably) the Scientologists, who don't seem to believe that mental illness even exists. To date, this coalition has succeeded in killing every legislative initiative for reform.

As a result, many of those who were formerly committed to the old state hospital system are now incarcerated in the state's maximum-security prisons. They have qualified to receive care by decompensating and committing violence to family, friends, or neighbors. Their stories are captured by the media, living in our consciousness for a day or two, then fading into the dark corners from which erupted the violence. Perhaps we've simply created a different kind of "cuckoo's nest."

There are rays of hope in this dark scene. NAMI-MN is backing a bill authored by Representative Mindy Greiling and Senator Don Betzold, which would permit earlier intervention, so that people with brain disorders could avoid decompensation without becoming "imminently dangerous." Another bill, authored by Senator Linda Berglin and Representative Fran Bradley, is aimed at funding community-based programs at a higher level, and making services more available throughout the state. If both of these pass during the 2001 legislative session, and if the managed care companies are required to pay mental health benefits on the same basis as those related to physiological health, Minnesota will take a significant step forward, and toward the vision which inspired those of us intending to reform the system a quarter century ago. Taking this step will require courage by legislators, and a better appreciation for the long-term return on this investment in our people.

It is not too much to hope for, but given political realities, it is perhaps too much to count on. Even in good old, progressive Minnesota.

West Virginia Has Improved Our Mental Hygiene Process

by Bill Byrne, Esq., Chair, Supreme Court Mental Hygiene Reform Commission and Tom Rodd, Senior Law Clerk, West Virginia Supreme Court

In 1999, the West Virginia Supreme Court of Appeals formed a Mental Hygiene Reform Commission. The Commission looked in depth at West Virginia's "mental hygiene" laws and procedures, that govern the involuntary hospitalization of people due to retardation, addiction, or mental illness.

A number of the Commission's recommended legislative improvements were contained in Senate Bill 193, which was passed by the Legislature on April 14, 2001, and signed into law by Governor Bob Wise on May 2, 2001. The new legislation goes into effect in mid-July of 2001.

As the result of this reform legislation, West Virginia can build on the strengths of our current mental hygiene system. Our medical and social service systems will have increased opportunities and flexibility to provide pro-active and preventive services for people and families in crisis. We can move toward a more medical model, while fully respecting liberty, autonomy, and due process.

Notably, this legislation was the result of a cooperative effort of the courts, the executive branch, the legislature, the private bar, prosecutors, health and social service professionals, and patient and family advocacy groups. We hope that other states may be interested in the results of our cooperate-and-compromise approach to reform in this area.

Why was mental hygiene reform needed in West Virginia?

The West Virginia Supreme Court has been spending over $1,000,000 a year (of its approximately 70 million dollar annual budget) on involuntary hospitalization proceedings, using court-appointed mental hygiene commissioners and adversarial hearings. This process was designed 25 years ago, when the average period of time for involuntary hospitalization in a state mental hospital was **15 years.** Today, the average

involuntary hospitalization is for **less than 15 days**—and in many cases, for a much shorter time period.

There are compelling constitutional, moral, and historical reasons why "court-type" procedures are (in some cases) a necessary part of society's response to serious mental illnesses like schizophrenia or bipolar disorder.

Sometimes a person as a result of their illness lacks understanding of the need for treatment, and involuntary or "assisted" treatment is necessary, to prevent grave harm to the person or to others. Moreover, until modern medicines were discovered, involuntary hospitalization and "locked up" living quarters were the only practical way to care for many people with severe mental illnesses.

Any treatment system that locks up and/or otherwise involuntarily treats people, even when it is "for their own good," has the potential for abuse. So bringing due process procedures and protections into play in the involuntary treatment and hospitalization area has been a great step forward, in preventing abuses of the power of the state.

However, West Virginia's mental hygiene process, while well fulfilling its due process, abuse-checking role, has in some cases been a source of needless contention and unnecessary and added misery for all concerned.

Simply put, sick people need help just as much as they need their rights protected.

A few of the problems identified by the Commission include: (1) lack of adequate community crisis and chronic relapse prevention services, to reduce involuntary commitments; (2) lack of less restrictive, court-approved alternatives to involuntary hospitalization, including release upon condition of medication or other treatment compliance; and (3) use of an outdated "dangerousness" commitment standard that stereotypes and stigmatizes people who have a mental illness.

To address these and other important issues, the Mental Hygiene Reform Commission—composed of political leaders, lawyers, patients, health care workers, and families—worked for a year to create a comprehensive consensus reform plan, to improve our current system.

The Commission believes that with comprehensive reform, involuntary hospitalization can ultimately be substantially reduced; and when involuntary hospitalization is unavoidable, the process can be made more medical and less criminal, and still respect and protect fundamental rights.

The important improvements in Senate Bill 193 include:

- **updated definitions** of "addiction" and "likely to cause serious harm," to comport with current medical practice. Stereotyped, vague, and stigmatizing "dangerousness" language is replaced with a medical/social definition that focuses on the need for treatment of acute and seriously harmful illness.

- **removal of mental retardation** as grounds for involuntary hospitalization, this issue being covered in other statutes.

- **evidentiary clarification,** to allow the decision-maker to consider reliable medical records and other evidence of past problems.

- **mandatory 3-day training** for all mental hygiene commissioners.

- **cooperative and flexible jurisdiction** for mental hygiene commissioners, prosecutors, sheriffs, and local police.

- **waiver of prosecuting attorney** at hearings set for non-judicial hours, where the applicant will suffer no detriment.

- **court-approved treatment agreements** as a less restrictive alternative to involuntary hospitalization, with the goal of reducing revolving-door hospitalizations and improving treatment compliance.

- **Conditional release on convalescent status** from hospitalization for persons needing to continue on medication.

These legislative reforms, along with a commitment by the Supreme Court of Appeals of West Virginia to exercise meaningful oversight of West Virginia's mental hygiene system, and to coordinate with other stakeholders, should bring greater efficiency and compassion to our society's response to the problems of severe mental illness.

The 2001 Legislature and its staff, Governor Wise and his staff, the groups and individuals that joined and supported the Supreme Court's Commission—and particularly Justice Larry V. Starcher, who got the ball rolling and helped keep it rolling—deserve a round of thanks.

We Should Know How Many People With Mental Illnesses Are Killed By Police

by Mary Zdanowicz, Executive Director

In April, tensions mounted after Cincinnati police fatally shot a young black man. The citizens of that city are not the only ones counting the number of black males who are shot in encounters with police. The U.S. Department of Justice, Bureau of Justice Statistics released a report in March that compiled statistics about justifiable homicides by police (in the report, all killings by police are called justifiable homicides). The report analyzes justifiable homicides based on race, gender and age of the person killed.

In 1998, the most recent year for which data is available, justifiable homicides occurred at a rate of 1.4 per million people in the general population in the U.S.[1] However, the justifiable homicide rate that year in the black population was 4.7 per million, 3.5 times higher than the general population. While the rate of justifiable homicides in the general population did not change from 1988 to 1998,[2] the encouraging note is that the rate for the black population declined 16% during that period (from 5.7 per million in 1988 to 4.8 per million in 1998).

In contrast, there is no official count of the number of persons with severe and persistent mental illness (SPMI) who are shot by police each year. And despite an unfortunate wealth of such tragic incidents, no organization of any type keeps track of them. The Treatment Advocacy Center records details on some in its *Preventable Tragedies Database*. The *Database* summarizes selected U.S.

newspaper accounts of the consequences of non-treatment for individuals with SPMI, including suicides, victimization, violence, and police shootings. But, the daily search from which the *Database* is compiled does not include all newspapers, police shootings are not always covered in the press, and it is not always reported that a person who is shot has a severe mental illness.

Therefore, we know that the *Database* cannot possibly contain all incidents of police shootings of persons with SPMI. Still, the *Database* shows that at least 37 people with SPMI were killed by police in 1998 [see chart beginning on this page]. Even this conservative estimate indicates that people with SPMI were killed at a rate of 5.3 per million,[3] 13% higher than the rate in the black population. The fact that this is a conservative estimate cannot be overemphasized.

Lacking any official statistics on the number of prior shootings, it is unknown whether the rate of SPMI shootings is declining, as in the black community, or--as we dread and fear--on the rise. We ask you to join us in requesting the Department of Justice to analyze this national crisis of people with mental illness being killed in altercations with police, just as it did the equally profound questions raised in Cincinnati last month.

DOJ contact information:
Lawrence A. Greenfeld, Acting Director
Bureau of Justice Statistics
810 Seventh Street NW
Washington, DC 20531
email: askbjs@ojp.usdoj.gov

TAC *Preventable Tragedies Database*:
< http://www.psychlaws.org/ep.asp>

Notes:

[1]There were 367 justifiable homicides in 1998 when the U.S. population was 270 million. Jodi M. Brown & Patrick A. Langan, POLICING AND HOMICIDE, 1976-98: JUSTIFIABLE HOMICIDE BY POLICE, POLICE OFFICERS MURDERED BY FELONS, BUREAU OF JUSTICE STATISTICS (2001); U.S. Census Bureau, Monthly Estimates of the United States Population, (visited May 4, 2001) <http://www.census.gov/population/estimates/nation/intfile1-1.txt>

[2]There were 339 justifiable homicides in 1988 when the U.S. population was 244 million. POLICING AND HOMICIDE, 1976-98; Monthly Estimates of the United States Population.

[3]There were 37 justifiable homicides of SPMI persons in 1998. The Surgeon General estimates that 2.6% of the population in the U.S. have SPMI. Therefore, there were 7 million SPMI people in the U.S. in 1998. MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES (1999).

The Treatment Advocacy Center
Preventable Tragedies Database (1998)

Date	State	Incident
Jan-98	IA	Perry John Sneller, 47, who had a history of mental problems, threatened family members, fired a shot in direction of sheriff's deputy, who returned fire killing Sneller.
Jan-98	MD	Blanche H. Baker, a mentally ill woman, was shot by police who were responding to a call about an armed woman roaming the area. She allegedly attacked them with a knife.
Jan-98	FL	Shirley June Ansley, 56, had a long history of mental illness. She was shot four times in the chest and killed by police, after she turned the wheels of her van toward a police officer and accelerated.
Feb-98	OH	Daniel Williams, 41, who had a history of mental problems, shot Cincinnati Police Officer Kathleen "Katy" Conway, who fired back killing Mr. Williams. His family members had complained that he threatened to shoot his mother.
Feb-98	NM	David Allen James, 37, who had a history of mental illness, was shot to death by four police officers when they apparently mistook a dark-colored ceramic cross that he had pulled out of his pocket for a weapon. James had previously threatened suicide and had asked police to shoot him in the past.
Feb-98	FL	Samuel Aaron Studley, a 20-year-old mentally ill man, was shot and killed after attacking a sheriff's deputy.
Mar-98	CA	Paul Rodrigues, a mentally ill homeless man, was killed by police after he allegedly lunged at an officer with a bicycle fork.
Mar-98	FL	Hung Xuan Cao, a mentally ill homeless man, was shot and killed by police after he hit an officer on the arm with a shovel.
Mar-98	FL	Jair Salazar, 27, suffered from paranoid schizophrenia and was fatally shot by police less than two hours after an escape from a Mental Health Center.
Mar-98	MD	Derrick Kenyatta Warner, 36, a resident of a group home for the mentally ill, was shot to death by a police officer who had come to serve an emergency evaluation petition. Warner attacked one of the crisis team members who was accompanying the police, then tried to take the handgun of one of the police officers.
Mar-98	NM	Bill Hadley, 20, had previously been hospitalized for mental health treatment. He was holding a loaded rifle to his head and when he dropped the gun from his head, he swung it around and pointed it at a police officer, who shot Hadley in the chest.
Mar-98	VA	Kenneth Allan Grant, a homeless man with schizophrenia, was shot to death by a Pentagon security guard.

The Treatment Advocacy Center
Preventable Tragedies Database (1998) (continued)

Date	State	Incident
Apr-98	CA	Kenneth Putt, 64, a retired Navy chaplain who suffered from mental illness, was killed by two officers who had been sent to his home to investigate a domestic violence report after he pointed a rifle at officers.
May-98	CA	Charles Vaughn, Sr., had mental illness and was shot and killed by police after they chased him to a roof.
May-98	CA	Michael James Ackle, 42, had an extensive history of mental problems. After a police chase in his car, he was shot by police when he moved abruptly with a shiny object; police only recovered a crescent wrench.
May-98	CA	Tom Neville, 36, after he left a psychiatric facility, was shot by police while struggling to get an officer's weapon.
May-98	FL	James Rowlett, who had a long history of mental illness, was shot after threatening police with two bottles of champagne.
Jun-98	NY	Ronald Kessler, who had schizophrenia, was shot to death by police, who said that they acted in self-defense when Kessler attacked them with a claw hammer.
Jun-98	OH	Andre Tony, a 27 year old psychiatric patient who shot at police from his motel room, was killed when police returned fire.
Jun-98	TN	Vernice Jordon, 38, had a long history of mental illness, and was shot and killed by police after he lunged at them with a knife.
Jul-98	CA	Marvin Noble, 45, had paranoid schizophrenia. He was shot and killed by police after he stabbed a police dog and threatened officers, who were trying to detain him for a psychiatric evaluation, which a county mental health worker had requested.
Jul-98	FL	Alan Singletary, 43, suffered from mental illness. He killed sheriff's deputy Gene Gregory and wounded two other law enforcement officers during a landlord-tenant dispute that evolved into a 13-hour standoff, and he was then killed by officers.
Jul-98	FL	Lateef Abdullah, 49, died during police use of a neck restraint while struggling to get him to a hospital psychiatric ward.
Jul-98	NY	Paul Maxwell, 28, who had mental illness, was shot to death by a police officer after he appeared in the street naked and used a baseball bat to attack officers.
Aug-98	CA	Brian Burgos, 16, with schizophrenia, held his mother hostage with a shotgun to her head and fired at a passing van. He was shot and killed by police after he pointed the gun at them.
Aug-98	WI	Walter Pagel, who was known for his psychotic behavior, was trapped sitting on the floor in a stairwell with a knife in hand. He died from injuries after police fired 135 rubber, plastic, and wooden bullets at him.
Sep-98	AR	Seth Parrish, 21, with paranoid schizophrenia, pointed a shotgun at an Exxon station clerk demanding an airplane ticket. He shot at police who returned fire and killed him.
Sep-98	CA	Han Huynh, 29, with schizophrenia and depression, was shot to death by deputies, who encountered him in the driveway of a home in a neighborhood where he was not a resident after he lunged at them with a knife.
Sep-98	CA	Nicholas Nelson, 43, drunk and mentally unstable, was shot by police, who responded to a disturbance call after Nelson fired shots from a .357 revolver while watching David Letterman, who he believed was making jokes about him and after Nelson pointed the gun at them.
Sep-98	CA	Martin Arias, 32, who was described as delusional and had previously been referred for an involuntary mental health commitment, was shot to death at his home by police who responded to a call that he was threatening neighbors after he threatened police with a pitchfork.
Sep-98	CT	Adrian Isom, a mentally ill man, was shot by police after he stabbed a woman to death and refused to drop his weapon.
Sep-98	SC	Clyde Harbey, 54, with paranoid schizophrenia, was shot to death by police after he allegedly lunged for an officer's gun while being questioned about a burglary.
Oct-98	CA	Joe Joshua, 76, suffered from psychological problems. He was killed by police when he refused to drop a knife.
Oct-98	NY	Kevin Cerbelli, 30, extensive history of psychiatric hospitalization, was shot and killed by police after he entered a police station and stabbed a sergeant in the back with a screwdriver.
Nov-98	FL	David Montgomery, 39, with paranoid schizophrenia, was shot to death when he attacked three police officers outside his apartment with a knife and a barbecue fork.
Dec-98	ME	Jerzy Sidor, 43, history of paranoid schizophrenia and psychiatric hospitalization, was killed by a state trooper after Sidor charged from his home and struck another trooper with a three-foot-long sword.
Dec-98	NJ	James Russell Stipek, 48, history of mental problems, died in a violent altercation with detectives, who were arresting him for allegedly stabbing his roommate.

It's Not Either Or … Obviously

by Darold A. Treffert, MD

If you build it they will come. Or will they?

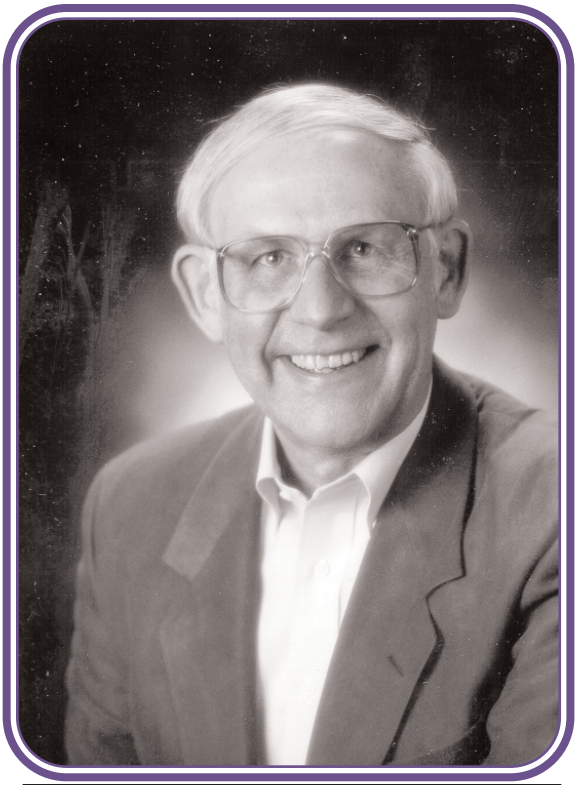
Community care activists argue that if you make mental health clinics accessible and responsive enough, with therapists who listen, along with caretakers who make house calls, everyone, even the severely mentally ill, will all voluntarily come for care to such a warm and inviting place. As to those who don't come, and the tragic episodes they sometimes trigger for themselves or others around them, those are unfortunate anecdotes, the price of the freedom to choose.

Clinical realists argue that the overwhelming number of psychiatric patients have always been, and always will be, served on a voluntary basis, just as elsewhere in medicine. However, mental illness being what it is in some few cases, by its very nature, it robs the patient of the capacity to choose. So no matter how comprehensive, accessible and pleasant the clinic might be, even with the retractable roof, plentiful bathrooms and pleasant staff, some persons with severe mental illness will still require "assisted" treatment because of some fixed, false belief, a delusion for example, that it is instead a dangerous or even poisoned place and not to be trusted.

So the question narrows to: if you make the system comprehensive enough, affordable enough, accessible enough and pleasant enough, do you need an involuntary outpatient treatment law at all? Or, contrariwise, does an outpatient treatment law by itself, absent a comprehensive system of care, do any good?

Those were essentially the two questions the Rand report on The Effectiveness of Involuntary Outpatient was asked to address. The report was prepared at the request of the California Senate Committee on Rules and released in March 2001.

I was one of two psychiatrists and three attorneys from Wisconsin who, along with 37 other professionals nationwide, were interviewed in depth for that study. Wisconsin was one of eight states studied in depth regarding its mental health laws and practices. The report is lengthy but I recommend it to you because it is a very comprehensive, evidence based review of the empirical literature on involuntary outpatient treatment and its alternatives. You can then draw your own conclusions, but let me share mine with you.



Darold A. Treffert, M.D.

First, some background: In its last session the California Assembly passed AB 1800, which would have overhauled the Lanterman-Petris-Short (LPS) Mental Health Act to expand the criteria for involuntary treatment and to create a separate statutory provision for involuntary outpatient treatment. It is that LPS Act, you may recall, about which Senator Lanterman himself said, in recent years, "I wanted the LPS Act to help the mentally ill. I never meant for it to prevent those who need care from receiving it. The law has to be changed." In so doing, California would have joined 38 other states, including Wisconsin, that have included provisions such as grave disability, our "fifth standard" or its equivalent, and outpatient commitment provisions for the severely mentally ill, adequately balanced of course with appropriate due process safeguards.

The California Senate balked at passage of such legislation, and instead commissioned this report to:

(a) review empirical evidence on the effectiveness of involuntary outpatient treatment and its alternatives; (b) analyze the experience of a select group of other states with such treatment; and (c) assess the potential impact on people with severe mental illness in California.

Now the bad news. A major flaw in the Rand study, in my view, is that it seeks to find if there is any empirical or scientific support for a premise that, to my knowledge, no one really holds; i.e., ***Do court orders, without treatment resources, have any useful effect on outcome?*** The obvious answer, even without study, is "of course not." Does anyone actually purport that they do? No one I know. The problem is that such a question is, in my view, a straw man erected to divert and distract so that it can be said, as the report does, that, "a court order, in and of itself, has no independent effect on outcomes." Extrapolating from that flawed premise, the argument continues, since such court orders are useless, there is no need to change the law to permit them.

The sensible question and crucial question, obviously, is whether a court order, even in a truly comprehensive system, is necessary to achieve compliance and good outcomes in some cases, recognizing that in the majority of cases it is not necessary to do so? Does a truly comprehensive mental health treatment system obviate the need for such orders in that everyone can be satisfactorily treated on a voluntary basis? On that more germane question there is some data.

The Duke Mental Health Study, as cited by the Rand Report, is a worthwhile and well done "second generation" report of a randomized, controlled study of outpatient commitment among 331 persons with severe mental illness in North Carolina. That study concluded that "extended outpatient commitment reduced

hospital readmissions only when combined with a higher intensity of outpatient services." The Rand Report appropriately concludes: "These findings show that outpatient commitment can work to reduce hospital readmissions and total hospital days when the court order is sustained and combined with intensive outpatient services … and that the court order is no substitute for intensive treatment." I wholeheartedly agree. Outpatient commitment, with treatment, can be effective when necessary in some cases, and a court order in and of itself, absent such treatment, is of no value in terms of outcome.

So what's the problem? Apparently some persons feel that the only way to empirically prove that court orders in and of themselves do no good, would be to carry out a controlled study in which some persons committed to outpatient treatment would receive no services, but carry only a court order, and compare them to a control group who would receive comprehensive services along with the court order. If the outcome of the group receiving services did better, then the uselessness of the court order alone would be demonstrated. To me such a study is unnecessary, and given what we do know about the effectiveness of treatment, depriving one group of such treatment services would pose serious ethical problems.

Next the good news. Even absent a "scientific study," the Rand study reports that, "Interview respondents expressed support for outpatient commitment laws in spite of the lack of empirical evidence and in spite of their acknowledgement of problems in implementing outpatient commitment in their own jurisdictions. This support may be explained by the fact that all respondents agreed that lack of compliance with outpatient treatment is a real problem, resulting in relapse and rehospitalization for at least some proportion of people with serious mental illness … among those who criticized the implementation of outpatient commitment laws in their own states, most criticized the programs because their states and communities were unable to deliver the promised treatment." In short, any of us who deal with the severely mentally ill intuitively and experientially know that it is not either court order or comprehensive treatment that is most effective with those few cases which require outpatient treatment commitment. It is a judicious, fairly applied, and due-process protected application of both that is effective.

On another encouraging note, there is mention in a number of places of the Wisconsin "settlement agreements" in a very positive light. These are permitted under Section 51.20 of Wisconsin's Mental Health Act and are in use in a number of counties. Under these provisions, if it is shown that there is probable cause that the person does meet civil commitment criteria, a patient can voluntarily stipulate to a finding of probable cause and waive the time limits (up to a maximum of 90 days) for holding the formal hearing. The court can then release the person pending a full hearing during which time the person has the right to receive treatment services on a voluntary basis in a community treatment program. Conditions the court might impose could include taking medication on a voluntary basis, keeping appointments, and generally cooperating with therapy, for example. The person's failure to comply with treatment can result in the court issuing an order for the patient's detention at an approved inpatient treatment facility, with a hearing on the matter within 72 hours, followed by proceeding to either a probably cause or final hearing. If the patient successfully complies with the "hold open" agreement, and there has been sufficient treatment progress during the 90-day period (which is often the case), the whole matter is dismissed and treatment continues, if necessary, on an entirely voluntary basis.

These settlement agreements represent an innovative, hybrid blending of "coerced" care with voluntary agreement that is often very successful in achieving mutual treatment goals for both the patient and courts without the long-term stigma of having been "adjudicated" mentally ill.

In its preface, the Rand Report states, "We have no doubt that those who advocate for and against involuntary outpatient treatment will use our report to support very different positions." That has already begun. In view of all of the above, I was disappointed to find in the Rand Law & Health Research Brief report of this research this sentence: "There is no evidence that a court order is necessary to achieve compliance and good outcomes, or that a court order, in and of itself, has any independent effect on outcome." While I agree with the last half of that sentence, I vigorously disagree with the first half. The Duke study does, in my view, support the usefulness of court ordered outpatient treatment when combined with appropriate treatment. Further, the support of involuntary outpatient treatment when combined with

(continued on page 9)

Frank Lanterman, one of the original authors of LPS, before his death said, "I wanted the LPS Act to help the mentally ill. I never meant for it to prevent those who need care from receiving it. The law must be changed."

Source: Dewees, Elaine, Letter to the Editor, *Los Angeles Times,* December 5, 1987. [Note: Elaine Dewees was Frank Lanterman's secretary.]

Your Voice— Will Make a Difference

Dear Mary,

I enjoyed reading the article written by Dr. Torrey and yourself in the March edition of *Psychiatric Services*. I was particularly interested in the analysis of the objections to OPC [outpatient commitment]. During the bruising debate in Ontario on the introduction of CTOs [court treatment orders], I came to the conclusion that these arguments were hollow in that they were usually put forward not as genuine concerns but as impediments or a smoke screen to thwart any progress on the issue. I could never decide whether to spend more or less time countering these objections as opposed to advancing the primary arguments about the need to change the legislation.

Here are a few additional counter-arguments that we found effective in Ontario:

1) "OPC is not necessary if we have 'perfect' services."

Utopian services do not, and will never, exist. So this is, of course, an obvious stalling tactic. We do, however, know that the argument is wrong.

Clinicians and family members who have had to confront a very paranoid individual know that service level is not the issue. On a systematic level, PACT teams provide as near as we can achieve to an ideal service in the community—highly staffed, fixed point of responsibility, and 24-hour service, 7 days a week. Yet, most PACT team members I know throughout Ontario, acknowledge that approximately 5% of their patients are persistently non-compliant with treatment and follow-up, no matter how kind, persuasive, and persistent the PACT staff. Only a tincture of coercion will work for these folks.

2) "We should not 'siphon off' resources to treat involuntary patients when there are not enough services for those who want to voluntarily access them."

While this argument may be seen as initially seductive, it is in effect a reincarnation of the logic which prevented many CMHCs from exercising their responsibilities to seriously mentally ill patients as they were discharged from the state hospitals in the 1960s and 1970s.

Moreover, in all areas of medicine we provide services to the most ill patients as a priority. To do otherwise with the mentally ill would be a gross abandonment of these individuals. The fact that this is what we have done historically only emphasizes that it is time to right the wrong.

3) "OPC will sweep the streets."

I think Dr. Torrey's 1995 paper surveying the use of OPC in the US showed that it is under-utilized, not over-utilized. I am not aware of any jurisdiction where there is extensive use of OPC. What I have heard from NY so far just confirms this trend. I surveyed psychiatrists in Saskatchewan a couple of years ago and estimated that about 20 individuals were on a CTO in that province at any one time. Saskatchewan conveniently has a population of 1 million which helps with extrapolation. Based on what I have seen to date, Ontario will not even reach that rate of utilization. Sweep the streets is clearly nonsense.

No doubt you have considered all of these arguements. It is clear however, that the nay-sayers are marshalling the same material in every jurisdiction, so I thought that I would fire off my two cents worth.

Keep up the good work. It is appreciated!

Dr. Richard O'Reilly
London, Ontario

Dear Dr. Torrey,

I have been and always will be one of your strongest supporters—mostly on the west coast where your message does not reach as far.

Ask Mary Z. and Jon S. I'm with you. But I must tell you that some things you stated in your response to Ms. Arnold's letter in the TAC email were not totally correct, from my own experience.

I recently had a relapse that caused me to spend a few days in crisis respite care. I was taking my meds and still relapsed. Yes, I was under an abnormal amount of personal stress, but I clung to the belief that my meds would see me through.

They did not. I cycled through the

meds and ended up in a psychotic manic episode with the "ability," yet not displayed, signs of aggression. I was not in control for those moments I cycled up.

The next day I voluntarily committed myself and am still under that for a few more months. No problems as long as I stick to my treatment plan/contract I made with my MD, family and therapist.

I was so embarrassed by this—and surprised. I thought as long as I was taking my meds this would not happen.

Please understand I didn't want to write this to you, but I felt I should.

Yours respectfully,

Jeff Houston, MA
Klamath County, OR

Jeff,

Wow, you had happen to you what I am really scared of. I am really sad about it, but from the clarity of your writing it looks like you are doing OK. Most of what I have learned since I dived into this field has made me feel better about having this thing—that decompensation scenario you went through is one of the few things that has made me feel worse. Hang in there.

I hope you don't mind me giving my two-cent thoughts on your comment to Dr. Torrey.

Your point is well taken. It is frustrating that those most faithful to their treatment regimens can—in the short term at least—end up no better than those who reject taking medications.

I must admit to being not clear as to whether you bring up your recent experience to clarify Dr. Torrey's assumption that, "homicidal acts by severely mentally ill individuals are related to not taking medication," or the statement that, "mentally ill individuals who are taking their medication are no more dangerous than the general population." It could logically apply to either, but I think both are still fair in light of your comments.

Clearly, although a specific medication can sometimes become ineffective, treatment far more often prevents the symptoms of mental illness that are the cause of increased violence.

Less innate is why, as the research reflects, people with mental illness are no more dangerous than the general population despite this possible destabilization while on medication. It may be because—the effects of symptoms aside—those who stay on their medications tend to be more responsible (which no doubt correlates to less prone to violence) than those who do not. Or, it may stem from ancillary effects of some medications.

It has been observed that communities with water supplies containing a high concentration of Lithium have lower rates of violence than surrounding areas. Whether due to one of those effects or some other, something appears to counteract the possibility of decompensation while taking medication that you so appropriately point out.

Whatever the reason it is still nice (both in terms of being someone with the thing and for advocacy purposes) to be able to in good faith say that medications leave people with MI no more of risk to others than anyone else.

You take care, Jeff. You are a really good man who has earned a lot of respect. And a heck of a good guy as well.

Jon Stanley, Assistant Director
Treatment Advocacy Center

I am so grateful for the important work you are doing.

Madeleine Goodrich
Concord, MA

Thank you all so much. Your information has been so valuable and it has helped open some people's eyes to our problems.

Cindi Tooley
Phoenix, AZ

State Update:

Washington State Governor Gary Locke signed SB 5048 into law on April 13, 2001. The bill requires that, in all commitment hearings, great weight be given to evidence of prior history of pattern of decompensation and discontinuation of treatment.

(continued from page 7)

available appropriate treatment. Further, the support of involuntary outpatient commitment for some persons in order to receive needed services by all the attorneys, behavioral health officials, from a variety of disparate vantage points and treatment philosophies, who were interviewed in depth for the Rand Report, was uniform and firm, calling such outpatient commitments "an effective legal tool" and "extremely useful and informative." The fact that some felt such services were inadequate in their particular communities is hardly a convincing argument against the usefulness of such approaches when adequate treatment does exist such as is the case in many communities in Wisconsin.

Once all of us can accept the basic ideas that outpatient commitment is necessary for some few patients who, because of the particular nature of their severe mental illness, require it, and that such outpatient commitment is effective only if combined with a comprehensive treatment system, then the polarization around this issue can end, and legitimate progress can continue to be made. I hope the Rand Report accelerates, rather than impedes, such efforts. That the Rand Report would help, and not hurt such efforts, was my hope in participating in the study.

To reiterate yet again: It's not either court order or adequate treatment that works. Obviously, it is both, judiciously and comprehensively applied.

[Reprinted with permission from *The Wisconsin Psychiatrist*, Spring 2001.]

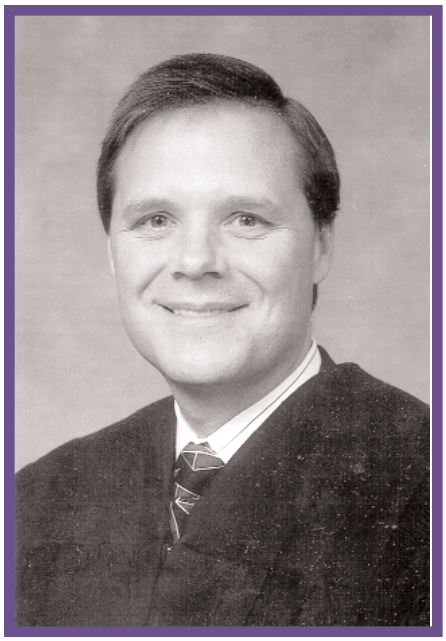
NEW BOARD MEMBER

We are proud to announce that James D. Cayce, Superior Court Judge, King County, Washington, has accepted a position on the Board of Directors of the Treatment Advocacy Center. Judge Cayce spent nine years in private practice prior to his appointment to the bench in 1989. His practice included business, real estate, domestic relations and criminal defense.

In 1998, as part of a larger initiative aimed at finding better ways to handle the mentally ill offender population, Judge Cayce chaired a community planning task force to explore the feasibility of creating a Mental Health Court in King County. King County's Mental Health Court, just the second of its kind in the United States, was implemented in February 1999. Judge Cayce presided over the daily Mental Health Court calendars until his appointment by Governor Gary Locke to the Superior Court, effective July 17, 2000.

On November 30, 1999, Judge Cayce finished his third consecutive term as Presiding Judge for the King County District Court. The District Court consists of 26 elected judges and approximately 300 staff located in 12 regional facilities. He was responsible for the overall operation of the court and worked regularly with the County Executive and Council on criminal justice policy and initiatives.

Judge Cayce created a Speakers' Bureau that provides a court outreach to immigrant and ethnic communities. This program was highlighted at the Bureau of Justice Assistance 1999 National Partnership Meeting at which Judge Cayce was a presenter on the topic of "Overcoming Cultural Barriers in the Criminal Justice System."



James D. Cayce
Superior Court Judge
King County, Washington

Judge Cayce's committee membership (past and present) is extensive, and includes, among others: Washington State Minority & Justice Commission; State Judges Association Diversity Committee; Courts Helping Courts; Regional Law, Safety & Justice Committee; Criminal Justice Council; Dangerous Mentally Ill Offenders Task Force; Drug Involved Offenders Task Force; Swift and Certain Justice Team; and Adult Justice Operational Master Plan.

Judge Cayce's unique experience with, and understanding of, the problems people with severe and persistent mental illness face in the criminal justice system, will be a great benefit to our mission. His thoughtful approach in helping individuals facing these crises from the bench is admirable.

We welcome Judge Cayce to the Treatment Advocacy Center.

ATTENDING THE NAMI 2001 ANNUAL CONVENTION IN WASHINGTON, DC??

MARK YOUR CALENDAR!!!
ON FRIDAY - JULY 13TH - 9:00 AM - 10:15 AM
THE TREATMENT ADVOCACY CENTER WILL PRESENT:

HELPING PEOPLE OVERWHELMED BY MENTAL ILLNESS: INNOVATIONS FROM ABOVE THE BORDER

How can we help those most affected by mental illness? Learn about methods used in Canada, including Ontario's new *Brian's Law*, and British Columbia's unique way of facilitating transitions from hospital to community. Then, compare these to the Center's *Model Law for Assisted Treatment* and current state efforts to establish rational treatment laws.

Featuring:

Stephen Connell, F.R.C.P., M.B.CH.B., Psychiatrist, Coalition of Ontario Psychiatrists

John Gray, Ph.D., Manager, Policy and Systems Development Branch, Adult Mental Health Policy and Mental Health Plan Implementation, British Columbia Ministry of Health

Carla Jacobs, Board Member, NAMI and Treatment Advocacy Center

WE ALSO INVITE YOU TO VISIT OUR BOOTH IN THE EXHIBIT HALL.
WE LOOK FORWARD TO SEEING YOU!

THE FOLLOWING MEMORIALS AND TRIBUTES WERE RECEIVED BY TREATMENT ADVOCACY CENTER SINCE OUR LAST ISSUE WAS PUBLISHED. PLEASE ACCEPT OUR DEEP APPRECIATION FOR CHOOSING TO SUPPORT OUR MISSION IN MEMORY OR IN HONOR OF SOMEONE VERY SPECIAL TO YOU.

—TREATMENT ADVOCACY CENTER BOARD AND STAFF.

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Katherine S. Petray	Sleepy Hollow, Illinois		Our Family
James W. Gladden	Alexandria, Virginia	My Father and Brother, David	
Anthony and Judith Gaess	Montvale, New Jersey	Kimberly Rose Gaess	
Loretta Ostmann	Silver Spring, Maryland		Mary Zdanowicz
Cynthia L. Tooley	Phoenix, Arizona	The ones we have lost.	All those who care.
Vic and Linda Taggart	Seattle, Washington		Alicia L. Taggart
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