Catalyst
TREATMENT ADVOCACY CENTER
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# The Case For Caring Coercion

*by Dr. Steven S. Sharfstein*

Recently, half the patients on the dual-diagnosis unit at Sheppard Pratt were homeless. Even if staff could begin meaningful treatment in the three to four days their managed care companies allowed, it was clear that discharge would lead to readmission in the near future. It is becoming alarmingly apparent that as inpatient care wanes, vigorous outpatient treatment must take its place. But how will this work for those patients who do not take their medications or defy therapeutic efforts? They, too, stay a shorter time in the hospital. The revolving door of hospitalization for mental illness has already become a huge turnstile, disgorging mental patients onto the street or into jails. What is to be done?

One solution is that of involuntary outpatient treatment. Thus, a paranoid schizophrenic with a history of multiple rehospitalizations for dangerousness will be informed by authorities that he must comply with outpatient treatment and take his medication or he will be detained against his will. A welfare recipient with substance abuse will be told that he must submit to urine testing and therapy or face the cut-off of his welfare benefits. And an attorney is warned that she must have treatment for alcoholism or suffer the loss of her license to practice law. These, and other constraints on the freedoms of patients, already comprise the elements of mandatory therapy in such states as Massachusetts and Washington. Yet society remains troubled by coercive treatment. Legislatures are loath to impose such regulations on constituencies. Ironically, it is the patient advocacy groups such as NAMI who press for coercive treatments even more than victims of crimes such as pedophilia.

**Inside this issue...**

Historically, most of the seriously mentally ill in Western society have been confined to institutions against their will. Fear of violence — to self or others — especially from delusional individuals, or those behaving erratically, has traditionally justified the concept of involuntary hospitalization. But in recent decades, the civil rights of those very mentally ill have triumphed. These victories have led to grave deficiencies in treatment as patients are released from the hospital prematurely. Paralleling this phenomenon is the very essence of hospitalization, an event which has changed dramatically with managed care. Patients are now admitted not simply because they are ill, but because they are dangerous. The criteria for retention within the hospital is continued risk, but nothing more. Thus after a few days of what is called "crisis stabilization," the patient's insurance is halted and he is put out, or in severe cases, transferred to a state hospital. There, too, stays are shortened. Fashioning itself like the private counterpart, the public sector has eliminated any semblance of refuge. Once functioning as a community haven for the ill, state hospitals are barren real estate with boarded up units, empty recreation halls, and vending machines instead of kitchens.

The psychopharmacologic treatment of severe mental illness has had a paradoxically contributing effect to abrupt hospital stays. Rather than augmenting care, drug treatment has counter-intuitively undercut it by effecting acute symptomatic relief at the price of long-term treatment. Patients are rapidly medicated, then released as if the core illness was abolished. The truth is otherwise. Core illness takes great time to effect and requires the full range of individual and social therapies. But few hospitals have full-time art or occupational therapists on their staffs any more. Psychosocial therapies are seen as luxuries, not necessities. Leaves of absence to test improvement are no longer allowed.

**Dr. Steven S. Sharfstein**
***President & Chief Executive Officer of Sheppard Pratt Health System***

Discharge without adequate treatment has created a vast new set of problems. In the last four decades, hundreds of thousands of patients have been deinstitutionalized. Some have managed well with supporting housing, rehabilitation, and community outpatient settings. But for others, the return to the community is a phantom concept. Many have gone from the hospital to the street, and from the street to jail. As long ago as 1939, Penrose demonstrated a negative correlation between the portion of people

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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.**

in a given nation placed in mental hospitals and the portion held in jail. In 1999 the Department of Justice reported that as much as 16 percent of the population of state jails and prisons suffer from several mental illnesses. This translates to more than 250,000 individuals. Housing 3,500 and 2,800 mentally ill inmates respectively, the Los Angeles County Jail and New York Riker's Island Jail are currently the two largest psychiatric inpatient treatment facilities in the country. This warehousing of the mentally ill in jails and prisons harkens back to the deplorable conditions in the nineteenth century, which prompted Dorothea Dix and the Quakers, who founded Sheppard Pratt in Baltimore, to develop asylum care.

We have, then, expanding populations of partially-treated, severely ill patients flowing into our communities. In 1995, Torrey and Kaplan estimated that 250,000 individuals were living in the community, who just a few decades before would have been patients in state psychiatric hospitals. Yet we know full well that an episode of mental illness may last many months, if not years. What, then, is the recourse for patients who need help to remain functional?

As of today, 40 states and the District of Columbia have outpatient commitment statutes, although most of these states implement this authority in a haphazard and inconsistent manner. Generally, some form of tragedy has spawned the creation of an outpatient law; for instance, the case of Andrew Goldstein who pushed Kendra Webdale onto the subway tracks in New York ultimately led to the passage of "Kendra's Law" establishing mandatory outpatient treatment in New York. But this is a drastic case. Are less extreme cases eligible for coercive treatment?

I believe we have little choice in the matter if we are to meaningfully treat the mental patients in our country. Doing something to someone else for "their own good" is fraught with ethical and moral dangers. To insure a democracy, there must be checks and balances, rights to hearings, advocates, and judges. I call for a "caring coercion." I believe rather than abandon our mentally ill, we can thoughtfully attempt to treat them outside the hospital.

Day and partial care facilities can be constructed. The hospital milieu — once a haven of healing — will need to be resurrected in spaces once bordered by locked doors and shatter-proof windows. And novelty and innovation will be requisite; simple legislation is not enough.

In November of last year, President Clinton signed a bill that authorized funding of up to 100 mental health courts for nonviolent offenders who are mentally ill. Building on models from Broward County, Florida, and King County, Washington, this initiative would have special judges hear cases involving persons with mental illness who committed nonviolent crimes. These judges would decide whether the offender should be placed in outpatient or inpatient treatment programs to be monitored closely.

Simultaneously, grants also will be awarded to local governments to set up the training of law enforcement officials and judiciary personnel to identify and address the unique needs of mentally ill offenders. These alternatives, though far superior to simple incarceration, still await meaningful implementation.

Most community mental health centers are not equipped to handle mentally ill offenders. There must exist all those techniques and modalities which would be available within a hospital. This is hardly a casual undertaking. The coercion must be a caring one insofar as there is present a panoply of services—a full hospital without walls. If we can erect such institutions, we can begin to erase the shame of our untreated mentally ill.

***[Steven S. Sharfstein, M.D. is President & Chief Executive Officer of Sheppard Pratt Health System. [Reprinted by permission from Sheppard Pratt Health System's New Psychiatric Review, March, 2001.]***

## Attorney education about mental illnesses

***by Angela D. Vickers, Esq., Mental Health Advocate & Educator***

Society has much misinformation and misunderstanding of those with mental illnesses, which has lead to prejudice and discrimination. Attorneys and judges rarely receive any training about mental illnesses in their legal studies. When a mental diagnosis is related to a legal

*Angela D. Vickers, Esq.*
*Mental Health Advocate & Educator*

matter, a person with a disorder, more often than not, cannot find an attorney who is familiar with his or her illness. Instead, the lawyer may have this same distrust and stereotypical attitudes as does much of the population. How can there be justice for the millions of Americans with mental illnesses, if their own lawyers doubt their credibility and may presume they are unfit for employment or parenting, and do not deserve to be treated normally, because of a mental diagnosis?

I understand this problem all too well. In 1988 I was diagnosed with a manic-depressive episode. I have been unjustly treated in employment, medical insurance, and in the family law courts. For the gory details, you will have to wait for the book, or until *Lifetime — Television for Women* discovers my incredible story.

Meanwhile, I have launched my personal campaign to see that all lawyers, all judges, and all school children in Kindergarten through Grade 12, learn basic facts about mental illnesses. When this happens, we will have a much safer and healthier world, and justice will be restored to millions of Americans.

I successfully persuaded the Florida Supreme Court to see that the mentally ill can find lawyers who have had some training in mental illness. On February 8, 2001, ***Mental Illness Awareness*** was added to the mandatory continuing legal education (CLE) program of the Florida Bar.

I have accomplished a major first step, but advocates like you will have to carry this work nationwide. Every bar association has some means of changing bar rules. This is often through the recommendation of a committee or group within the bar. Florida also allows a petition, signed by 50 members, to be presented to the Florida Bar and then be reviewed by the Florida Supreme Court for a final decision.

My petition stated that Florida's Rules labeled it "misconduct" for a lawyer to discriminate against someone because of a "disability," even if it were through "callous indifference." The argument was made that discrimination based upon a lack of education about the mentally ill amounted to misconduct. Before the June 1998 annual bar meeting, I wrote persuasive letters to each bar section, telling the leader how important this rule change was and giving them basic mental illness facts as to symptoms, frequency in the population, and examples of injustice. At the convention, I made brief presentations at several committee meetings and at the Council of Sections meetings, composed of all committee or section leaders. Many of the leaders I had written, and others, signed the petition, showing support from all areas of the bar.

Before the midyear bar meeting in January of 1999, an attorney, whose son has schizophrenia, and I addressed the Board of Legal Specialization and Education. While supporting the basic education, the BLSE proposed it as an elective course. They feared opening the floodgates and having many groups petition for inclusion. They also suggested removing "substance abuse" from the mandatory category and placing it back in the elective area.

By the May 1999 Florida Bar Board of Governors meeting, I had rallied the assistance of Florida's NAMI (National Alliance for the Mentally Ill), National Depressive & Manic-Depressive Association groups, and Mental Health Association leaders, asking them to contact specific Board of Governors members in their local areas and talk to them about the plight of the mentally ill. I had learned of key bar members who had family members with mental illnesses, and had enlisted their help in writing and calling the Board. I even wrote the Governor — whose attorney sent the Board a letter noting the Governor's support. I also wrote his mother, Barbara Bush — who had acknowledged personal encounters with the common illness of depression.

Hard work, personal contacts, political helpers, and prayers paid off. The Board of Governors voted unanimously (50 to 0) to support mandatory CLE in Mental Illness Awareness. Board member after board member spoke eloquently in support, telling stories of attorney suicides and career destruction that could have been prevented. I got goose bumps and fought back tears. They understood. They wanted to help. It was thrilling.

From May 1999 to February 2001 I waited. Patience is not the strong suit of a high energy bipolar. The wheels of justice turn ever so slowly — and then we had a presidential election and all those chads. But, finally, on a day that I happened to be in Tallahassee, our capitol, for a mental illness advocacy campaign, I dropped in again to the Florida Supreme Court and was directed to the clerk's office. "You mean these Rule changes," the assistant said holding up a phone book size summary of the 2000 Rule changes. I anxiously flipped through to the proper Rule number and then began saying, "Yes, Yes, Yes!" in my best *When Harry Met Sally* impression. Mental Illness Awareness is now an area of CLE and in the mandatory category.

On Sunday April 22, I shook the hand of the Chief Justice of the Florida Supreme Court as I was leaving the Methodist church where he was a lay speaker. I told him I was the lawyer who launched the effort for attorney education in mental illnesses. "Guess what," I said, "God wants the judges to learn this, too." I am counting on the faith community and Justice Wells to help in this civil rights movement.

I am a self-funded advocate, only because our society has not yet realized the great need for the work I do. My children's health is at stake. I cannot think of a better use for my law degree or my medical technology degree. I work for a boss who works miracles. Faith removes stress — and stress causes episodes of mental illness. It works for me.

Now, please, go start a civil rights movement for the mentally ill in your state. Ask your local and state bar associations and judges, state and federal, what they are learning about mental illnesses. Write letters to the editor. Ask your faith community to help. Let those one-in-five families and the many capable people with a mental illness in your community to help you restore "justice for all."

## First Person Account: Schizophrenia, Medication, and Outpatient Commitment

*by Valerie Fox*

*Valerie Fox*

Having suffered from schizophrenia for the past 30 years — including a period of homelessness — I know the complexity of the illness.

When I was a young woman in my twenties, working for an airline and traveling throughout the world, my life was wonderful, exciting. I was part of the theater scene in New York, liked the fabulous restaurants there, and was thoroughly enjoying my life.

One day, however, my life changed drastically. I was diagnosed with schizophrenia, hospitalized, and given medicine. When I was healthy enough to leave the hospital, I was overwhelmed. I could not believe the medicine was good for me, because I had never felt so depressed and lethargic as I did while taking the medicine. After a few months., I decided to stop taking the medicine, believing, as my psychiatrist did, that I would be fine, that I had been struggling with the transition from teenager to young womanhood, and that my "breakdown" would probably never recur. This was the thinking in the 1960s. There was no talk then of body chemistry being involved with schizophrenia.

I did go off my medicine about six months after my first episode. I felt great: I had my alertness, my good sense of who I was; I was not depressed; and I looked forward to working again. Instead, within weeks I was again hospitalized. This time I was sent to a long-term care facility, a state hospital. During this time I decided to take charge of my life. I realized that when I was taking the medicine I was able to stay in the community; without the medicine, I was institutionalized. Psychiatrists at that time believed that the patient's environment was the cause of schizophrenic episodes. I decided not to believe that. In my naïve way, it seemed to me that a pill kept me healthy; without that pill, I became mentally ill. I determined I would find a way to cope with taking the medicine, because I did not want my life to be a revolving door from society to the hospital and back again. I decided to try to work with my new psychiatrist, finding a way to take my medicine so it would not affect me during the day. I was able to take most of my medicine during the evening and work during the day.

While in remission I met a good man and discussed with my doctor the feasibility of my getting married and having children. In 1966, there was no evidence that body chemistry was responsible for schizophrenia; therefore, the possibility of passing the illness to children was not considered. I did marry and gave birth to two children.

During the course of the marriage, if we had an argument and I got angry, my husband would say, "Valerie, are you getting ill?" I wasn't getting ill, but my illness was a controlling factor for my husband to use over me. As this kept happening, I knew the marriage was over for me and that I would leave it as soon as my daughters were a little older. I did leave and retained custody of my two daughters. For 14 years, I remained healthy and was not rehospitalized. I took my medicine and went to psychotherapy. I had gained a relative peace, acceptance, and a good level of happiness.

Then came a dramatic schizophrenic episode. It started when someone began harassing me in the middle of the night. This harassment culminated with the person cutting my bedroom screen. I was terrified that because I slept so soundly as a result of the medicine, I would awaken one night with a stranger in my apartment. I decided to stop taking my medicine against the advice of my doctor. I had to do what I thought was responsible, and that was to be semi-awake in case an intruder entered my apartment. The police finally staked out my apartment and apprehended the person who was harassing me, but the damage was done. Because I was an adult and not acting out, I was free from forced hospitalization. I did not know I was ill. My ex-husband took our children, which I thought was kidnapping. No one would help me have the children returned. I must have been visibly ill, although I was not aware of it.

I went deeper and deeper into schizophrenia, ending in homelessness for a two-year period. During this period of homelessness and mental illness, I faced the dangers of street living, including being beaten and raped, almost freezing to death, and being malnourished, but I was free. In that state, freedom was what I wanted. My imaginary friends would explain all the tortures away, saying that I had to learn to be strong, or that the brutality occurred because I was mistaken for someone else. This odyssey ended one day when I decided to do whatever it took to have the good life I had known. I still did not know I was ill, but I did associate taking medicine and being hospitalized with living as I had previously, before homelessness.

One day, I summoned every bit of strength I had and did not back away from institutionalization. Fortunately, the psychiatrist I saw during the admittance process treated me with empathy, compassion, and respect. I trusted him, and, therefore, did not back away from my decision to seek treatment. I remained hospitalized for a six-month period, three months of which were spent waiting for a bed in a housing program in the community.

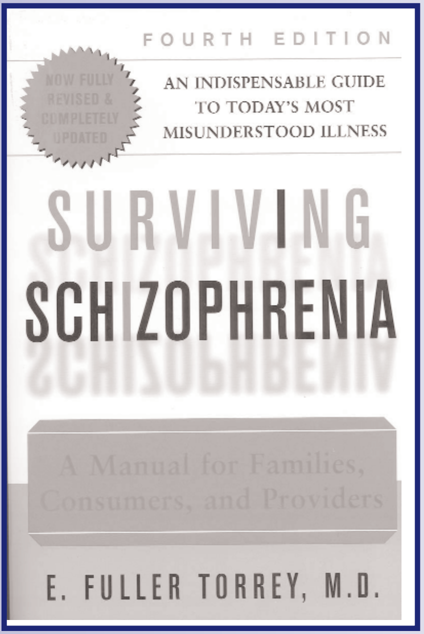
After I was out in the community again, I sought out the psychiatrist who had treated me during most of the time I suffered from schizophrenia. Because I did not have the stresses of being a single parent with two small children, I did not need the amount of medicine I had needed previously. Taking my medicine became easy for me. I took one dose at night before going to bed. This way, during the day I was not tired and could function well, holding a good job. I reunited with my children and built another life for myself.

I still see a therapist and can call between visits if I am very upset. I don't abuse this arrangement, and it has served me very well.

This brings me to outpatient commitment and being monitored in a program such as the Program of Assertive Community Treatment (PACT). Because I have been monitored for most of my adult life, and am grateful for it because it helps me not to slip into homelessness again, I am a proponent of outpatient monitoring with guidelines that allow a person to live in the least restrictive environment, as I have been able to do all of my adult life. I firmly believe that if a person is rational and wishes to live in a homeless state, that is his or her right.

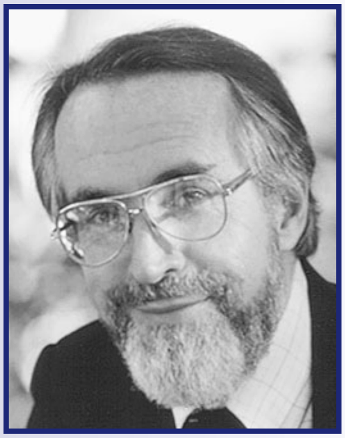
However, if a person is living in a state of fantasy and imagination (voices and hallucinations) and is lacking free will, I believe he or she should have to receive treatment through outpatient commitment until he or she is again living in reality. If ongoing linkage is indicated because the person has proven to be at risk for entering a schizophrenic state (usually from lack of medication compliance), I believe the person should be committed on an outpatient basis to be able to live in society. I don't think a person without free will should have the right to say, "I want to stay in this state and live in society." A state of schizophrenia is one without reason. I don't think it is fair to the person who may never again know reality if left in this state of schizophrenia, nor do I think it is humane or responsible to society.

[Reprinted from *Schizophrenia Bulletin* Vol. 27 No. 1 2001, by permission of the author.]



## Surviving Schizophrenia, 4th Edition

***E. Fuller Torrey, M.D.***
***New York: HarperCollins; 2001, $15***



The fourth edition of ***Surviving Schizophrenia: A Manual for Families, Consumers and Providers*** was published in May by HarperCollins. It is completely revised and updated. It includes information on all the new antipsychotics [except that the trade name of ziprasidone was changed from Zeldox to Geodon after the book went to press] as well as new information that has not been widely publicized; e.g., why pregnancies increase when women switch from first-generation (typical) to second-generation (atypical) anti-psychotics, and why drinking coffee increases and smoking decreases the blood levels, and thus the effectiveness, of clozapine and olanzapine.

The book also includes the latest research findings on the causes of schizophrenia and a comparison of schizophrenia with manic-depressive illness (bipolar disorder). Also included are summaries of nine commercial films portraying individuals with schizophrenia, evaluations of the nine best websites for information on schizophrenia, and summaries of 18 good videotapes and 50 useful books on this disease. Finally, Dr. Torrey summarizes his nominations for "the 15 worst books on schizophrenia." "It's getting harder to find worthy additions to this list," he told the *Catalyst,* "This is a sign that the field is moving forward."

***Surviving Schizophrenia*** is available through your local bookstore and can also be ordered over the Internet at Amazon.com, BarnesandNoble.com, and Borders.com.

## Minnesota's Victory

Governor Jesse Ventura signed SF179 [the combined bill for HF281 and SF179] into law on June 30. The Senate and House passed different versions of the bill and it was in Conference Committee for a few weeks at the end of the session. One of the last issues to be resolved was a concern that judges, out of habit, would commit people under the new standard to the hospital, rather than to assisted outpatient treatment, even if they did not need hospitalization. The Conferees finally agreed to insert a provision directing judges to commit people to community programs under the new standard rather than hospitalization. They passed the revised bill on June 28th and sent it to the Governor for signature.

The law will help provide access to treatment when it goes into effect in July 2002. It allows for earlier intervention, by removing the requirement that danger be "imminent" for emergency response, and by improving the standard for treatment so that a person's deteriorating psychiatric condition may be considered in the standard for care. The law also allows for lengthened hospital stays to stabilize a person's condition as well as timely intervention with medication.

Our profound admiration and grateful congratulations go to Minnesota Representative Mindy Greiling, the original sponsor of this legislation and the leader of the effort for treatment law reform in her state.

Mindy Greiling
Minnesota
House of Representatives

## Note from Mindy Greiling

Dear Mary, Rosanna, and the T.A.C.,

Thank you for the lovely surprise flowers of congratulations. I really appreciated them as well as your kind words in the e-news Friday.

As you know, there are few kudos and many barbs for doing important work to improve civil commitment laws.

We are just recovering from the shock of victory for now and know we'll have to protect the ground we have won next year.

I cannot emphasize enough. My deep thanks and gratitude to you both and the T.A.C. for all your wonderful help and information, without which we could not have succeeded. The model act was a godsend, Mary's expert testimony, all the calls & faxes with rescue information were exactly what we needed when we needed it.

Thanks & Love,
Mindy

## BOOK REVIEW

### A Street Is Not a Home — Solving America's Homeless Dilemma, by Judge Robert C. Coates

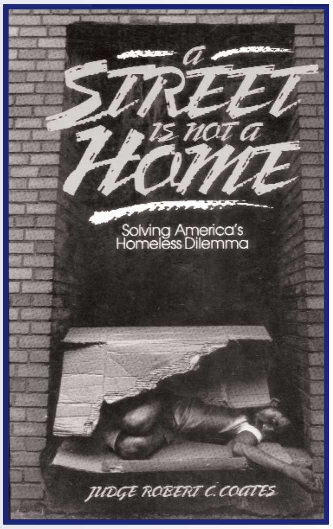
### Reviewed by Carla Jacobs

Superior Court Judge Robert Coates was newly appointed in 1983, when he found himself required to sentence and place "on probation" literally hundreds of San Diego's "new homeless."

Coates had represented hundreds of mentally ill persons as an attorney, and he knew his judicial duty was to "prevent the return to court" of the street's denizens. Like many politicians, reporters, social workers, and others concerned with the homeless, Judge Coates lived for a short time on the street to get the "feel" of homelessness. But rather than returning from his mission with yet another set of platitudes about the problem, the experience set him on the road to finding some answers. Those answers became the basis for his book: ***A Street is not a Home***.

While he discusses homelessness in general, considerable emphasis is given to solutions for people with mental illness in specific. One of those recommendations is reform of our current commitment laws. "Absent good community care systems and such legal changes," he writes, "large numbers of America's most alienated, utterly mentally ill individuals . . . will continue to exist in barbarous conditions, haunting our cities, shuffling and raving, or silent, sad, and terrified, horrifying us with their stark agony, peopling the dreams of our children and our judgments of ourselves. Our commitment laws need to be changed because they solve no problems, and today they command no respect."

This book is a tutorial for those who want to find solutions to the scourge of modern homelessness. In the words of Congressman Henry Waxman, " [it is] a veritable handbook for people who intend to do something about the homeless, and must reading for legislators, social workers, and others who deal professionally with the homeless. Coates' analysis is penetrating; his prescriptions are extremely credible."



***A Street is Not a Home*** is available through Amazon.com or by order via your local bookstore.

# LEGISLATIVE CONTACTS 101

### *by Jonathan Stanley*

Recently, one of our supporters asked me about the weight that legislators give to e-mail correspondence, and I thought the gist of my answer to her might be of interest to the *Catalyst's* readers.

I believe that legislators tend to ignore e-mails. Perhaps it is because they are old-fashioned. But, I think the real reason is that they recognize that it is too easy for an organization to accumulate bunches of e-mail addresses, group them together, and send them out to their people, saying, "Write one letter, insert this group of addresses in your address window, and send it." Walla — one message can go to 100, 500, or even thousands of people. And, — since they know this — legislators don't pay much attention to e-mails. Basically, one letter is many times more valuable than one e-mail. Exactly how many times? I don't know, but it is better to go with letters, even if that means having less total legislative contacts than if giving a group the option to use either form of communication.

With regard to phone calls — they are better than e-mails, but still not as good as letters. A phone call will tend to go to the lowest person on the totem pole in the office. You can talk to him or her as long as you want, but (unless you make a real impression) all that will be recorded is a tick in either the "pro" or "con" box on the bill's phone tick sheet. This will be considered in the big picture, but a letter is far more likely to be read by people higher up, and select ones will most likely be shown to the legislator. And letters should end up in a file that will be looked at (the file, at least) whenever the legislator has to make a decision concerning that legislation.

Occasionally phone calls are important, but that tends to be when a vote on a bill is fast approaching, and, for those who do not have access to a fax machine, a call is the only option. Also, going into the vote it is important that every legislator hears, "The phones are ringing off the hook about that bill." But, the timing is critical, as it doesn't help as much to have the calls spread out over, say, the two weeks before the vote. And by waiting till the last minute, there is a better chance of getting a double impact if people write and then call.

So the general valuation (from greatest to least) of legislative contacts from individuals is:

1. A personal contact by someone the legislator already knows.
2. A personal contact by a constituent.
3. A personal contact with the staff member responsible for an issue.
4. A personal contact with another staff member.
5. A letter (regular mail or faxed).
6. A phone call.
7. An e-mail.

At least among numbers 4, 5, 6, & 7, the differences from one level to the next are great.

So there you go: ***Legislative Contacts 101*** — according to me. But, I think that most grassroots lobbyists and legislative staffers would agree with most, if not all, of it.

## Treatment Advocacy Center Honorary Advisory Committee

**The Committee is composed of distinguished individuals who are devoted to improving the lives of individuals who suffer from severe mental illnesses. Each individual has made his or her own contributions to furthering that goal. We thank them for their work and for supporting our mission.**

### HONORARY ADVISORY COMMITTEE

## Your Voice—
## Will Make a Difference

In support and appreciation of the achievements being accomplished by Treatment Advocacy Center, please accept the enclosed contribution in memory of our beloved daughter, Kimberly Rose Gaess.

On April 19th 1998, Kim suffered a heart attack as a result of unintentionally taking a lethal combination of prescription and illegal drugs. She had battled a 12-year addiction to heroin/cocaine in a desperate attempt to find relief from mental illness by self-medicating.

Her tragic history of homelessness, hospitalizations, and incarcerations, is one more sad statistic and an all too familiar scenario for those who suffer with the diseases. It's a heartbreaking epidemic!

Having encountered the laws of "protection," I thank TAC for breaking down the legal barriers that stand in the way of helping those who cannot help themselves.

Judith C. Gaess
Montvale, NJ

Please accept this check from the NAMI of Milford Support Group. Hope that this will help your worthy cause for better treatment for our loved ones.

NAMI of Milford
Milford, CT

Please send me your hard copy of *Catalyst*. I am a 25-year advocate for the Mentally Ill and a member of Sarasota AMI and NAMI. I receive their newsletters but feel we need any information you can send.

I write a lot and send to newspapers; so far, they have printed all I send, but I need more, since I'm repeating the same stories.

Mrs. J. Stevenson
Englewood, FL

I was thrilled to get your newsletter. I am a person with bipolar disorder and an advocate. I am also a volunteer chaplain in our state mental hospital. I try to advocate for the poor and homeless mentally ill but my words have pretty much fallen on deaf ears. I am trying to look for some support in the legal system that doesn't cost an arm and leg. The legislative (political) system is so slow. I feel as if litigation on the state system is the way to go, but I don't approve of the Tennessee Advocacy and Protection Agency because of their sensational tactics; they come on like gangbusters.

I would like to be a member of your organization, but no dues amount was mentioned. I would also like about six copies of the recent newsletter to share with certain key people. I of course will pay for them.

Thank you
Carolyn Luetgens, BSMT(ASCP)
Chattanooga, TN

[Editor's Note: The Treatment Advocacy Center is a nonprofit organization and does not assess dues, nor does it charge for a subscription to *Catalyst*. Please just contact us to be placed on the mailing list as described on the cover application form. We do gratefully accept contributions to be used to support our mission, and we accept gifts in honor of or in memory of someone special to you.]

Thank you for sending me those extra copies [of *Catalyst*] to pass around to those who have not heard of you yet! Keep up the good work and I can always use 10 extra copies of future newsletters. Family members are so appreciative of all that you do.

Anne Handler
Pittsburgh, PA

This is to support your very welcome efforts on behalf of California's AB1421 and AB1422 (Thomson).Thank you.

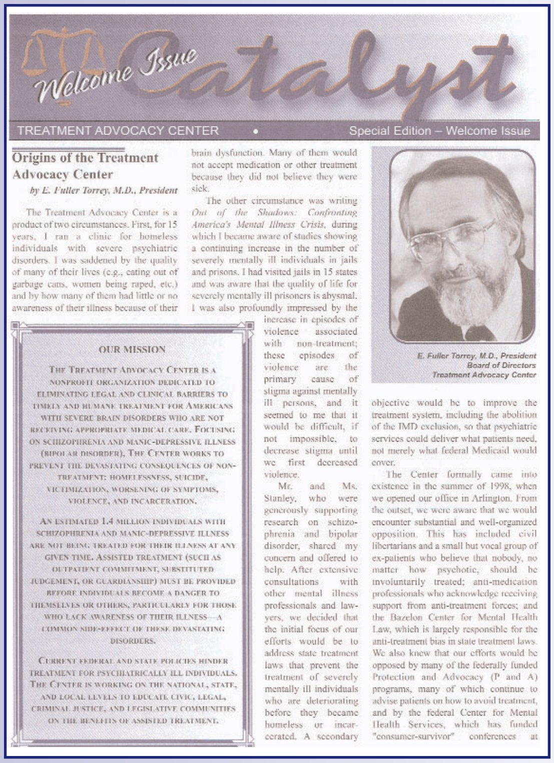
Elizabeth Galton, MD
Santa Monica, CA

Thank you for all the good work you do. I pass along some of the information from your newsletter through the NAMI of Washtenaw newsletter that I write. I was impressed with the artilce by Dr. Torey in the Washington Monthly. He has a way with words!

Carol Rees
Ann Arbor, MI

*Left to right: J. Nelson Kull III, Mary Zdanowicz, Joseph Rein at Pathways Drop-In Center, Inc., in Orlando, Florida. Mr. Kull is President of Pathways, which is an exceptional consumer operated drop-in center serving nearly 60 people, who have severe mental illness, each day.*

## Welcome Issue is available for distribution to individuals and groups



Welcome Issue Catalyst

TREATMENT ADVOCACY CENTER • Special Edition – Welcome Issue

### Origins of the Treatment Advocacy Center

*by E. Fuller Torrey, M.D., President*

The Treatment Advocacy Center is a product of two circumstances. First, for 15 years, I ran a clinic for homeless individuals with severe psychiatric disorders. I was saddened by the quality of many of their lives (e.g., eating out of garbage cans, women being raped, etc.) and by how many of them had little or no awareness of their illness because of their brain dysfunction. Many of them would not accept medication or other treatment because they did not believe they were sick.

The other circumstance was writing *Out of the Shadows: Confronting America's Mental Illness Crisis*, during which I became aware of studies showing a continuing increase in the number of severely mentally ill individuals in jails and prisons. I had visited jails in 15 states and was aware that the quality of life for severely mentally ill prisoners is abysmal. I was also profoundly impressed by the increase in episodes of violence associated with non-treatment; these episodes of violence are the primary cause of stigma against mentally ill persons, and it seemed to me that it would be difficult, if not impossible, to decrease stigma until we first decreased violence.

Mr. and Ms. Stanley, who were generously supporting research on schizophrenia and bipolar disorder, shared my concern and offered to help. After extensive consultations with other mental illness professionals and lawyers, we decided that the initial focus of our efforts would be to address state treatment laws that prevent the treatment of severely mentally ill individuals who are deteriorating before they became homeless or incarcerated. A secondary objective would be to improve the treatment system, including the abolition of the IMD exclusion, so that psychiatric services could deliver what patients need, not merely what federal Medicaid would cover.

The Center formally came into existence in the summer of 1998, when we opened our office in Arlington. From the outset, we were aware that we would encounter substantial and well-organized opposition. This has included civil libertarians and a small but vocal group of ex-patients who believe that nobody, no matter how psychotic, should be involuntarily treated; anti-medication professionals who acknowledge receiving support from anti-treatment forces; and the Bazelon Center for Mental Health Law, which is largely responsible for the anti-treatment bias in state treatment laws. We also knew that our efforts would be opposed by many of the federally funded Protection and Advocacy (P and A) programs, many of which continue to advise patients on how to avoid treatment, and by the federal Center for Mental Health Services, which has funded "consumer-survivor" conferences at

OUR MISSION

The Treatment Advocacy Center is a nonprofit organization dedicated to eliminating legal and clinical barriers to timely and humane treatment for Americans with severe brain disorders who are not receiving appropriate medical care. Focusing on schizophrenia and manic-depressive illness (bipolar disorder), The Center works to prevent the devastating consequences of non-treatment: homelessness, suicide, victimization, worsening of symptoms, violence, and incarceration.

An estimated 1.4 million individuals with schizophrenia and manic-depressive illness are not being treated for their illness at any given time. Assisted treatment (such as outpatient commitment, substituted judgement, or guardianship) must be provided before individuals become a danger to themselves or others, particularly for those who lack awareness of their illness—a common side-effect of these devastating disorders.

Current federal and state policies hinder treatment for psychiatrically ill individuals. The Center is working on the national, state, and local levels to educate civic, legal, criminal justice, and legislative communities on the benefits of assisted treatment.

E. Fuller Torrey, M.D., President
Board of Directors
Treatment Advocacy Center

***The Treatment Advocacy Center introduces a new Welcome Issue of Catalyst. This issue is a compilation of the highlights of past Catalyst issues and is intended to provide an introduction to the Treatment Advocacy Center and its newsletter. Copies of the Welcome Issue are available upon request at no charge for individuals and organizations who would like to distribute it to others.***

## Data Shows Adverse Impact of a Restrictive Mental Illness Treatment Law

The Florida Mental Health Act (The Baker Act) 2000 Annual Report (hereinafter "Report" www.fmhi.usf.edu/institute/pubs/pdf/mhlp/bakeract) summarizes and analyzes data for cases initiated under the Baker Act, Florida's mental illness treatment law. The Report illustrates clearly how the Baker Act has shifted the burden of caring for individuals with the most severe mental illnesses to the law enforcement community. The data in the Report also demonstrates that the Baker Act's dangerousness standard creates a risk of harm for people with severe mental illnesses and officers. The Baker Act's lack of an assisted outpatient treatment provision adversely impacts the quality of life for the most severely ill and fosters the high recidivism rates reflected in the Report.

Consider the following:

- ♦ More than 80,000 Baker act cases were initiated in Florida in 2000.
- ♦ Law enforcement initiated 36,000 — nearly as many as the 41,000 that were initiated by mental health professionals.
- ♦ In nearly half of Florida counties, mental health professionals did not initiate any Baker Act cases in 2000. (A Florida sheriff explained that the mental health professionals in his county refer all Baker act cases to the Sheriffs office because the Baker Act requires that people be dangerous).
- ♦ 82% of the Baker Act cases initiated by law enforcement agents (30,000 cases) specified that there was a "substantial likelihood that the subject would cause serious bodily harm to self or others in the future as evidenced by recent behavior" placing individuals with severe mental illness and officers at in significant risk of harm.
- ♦ 15,879 individuals had two or more Baker Act cases in a 21-month period.
- ♦ 32 individuals had more than fifteen Baker Act certificates in a 21-month period.
- ♦ 1,040 individuals were subject to the Baker Act six or more times in a 21-month period representing more than 8,000 Baker Act hospitalizations. That means, one-third of Baker Act cases were for 15% of the people subject to the Baker Act.

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.

| RECEIVED FROM | CITY AND STATE | IN MEMORY OF | IN HONOR OF |
|---|---|---|---|
| Rose Mary Boheler | Wallingford, Pennsylvania | | Victoria Ballard—Daughter who often suffers because she refuses treatment and does not believe she is ill. |
| Thomas E. Brett | Kew Gardens, New York | Kendra Webdale | |
| Ellen Rector | Denver, Coloroda | | Joe Rector |
| Mildred N. Fine | Lynbrook, NewYork | | Alice Cohen & Berna Case |
| John and Dorothy Rowley | Homewood, Illinois | | What TAC espouses. |
| Nancy Webster | Dallas, Texas | | Dr. E. Fuller Torrey Our Guru! |
| Joe D. Cobb | Florence, Alabama | | NAMI Shoals |
| Russell and Rose Vanderklomp | Olalla, Washington | | Dr. Robert T. Sargent, Ret. |
| Eleanore Feldman | Oak Park, Illinois | Ann Ruth White | |
| Sidney and Odelle Tobinick | Old Bridge, New Jersey | | Matthew Tobinick |
| Doris B. Goewey | Austin, Texas | | Your work. |
| Tex and Jane Moser | Springfield, Massachusetts | | David Lee Moser |
| Florence Keenan | | | Ann and Jack |
| Eugene and Sherry Grenz | Delmar, New York | | Carla Jacobs, DJ Jaffe and Jonathan Stanley |
| Denise Fazio | Longmont, Colorado | Peter G. Fazio | My Mother—to celebrate her 80th birthday |
| Timothy and Victoria Sayles | Warrington, Pennsylvania | | Trevor Sayles |
| Kyle and Elizabeth Glass | Mt. Tremper, New York | | Audrey Lou Banerjee |
| DJ Jaffe | New York, New York | | California State Assembly woman Helen Thomson |

## Where can you turn for legal advice?

***by Jonathan Olsen, Project Coordinator***

The Treatment Advocacy Center was organized as a nonprofit organization dedicated to eliminating the legal and clinical barriers preventing timely and humane treatment of those who suffer from severe mental illness and are not receiving appropriate medical care. Unfortunately, for those who are currently embroiled in the battle to get help for a loved-one, changing the laws may seem like a "too little, too late" proposition. But you should not have to be alone when you fight the battle to get treatment for someone with a mental illness. A qualified attorney can be insturmental in guiding you through the legal maze surrounding mental illness laws.

In an effort to bridge the gap between those who are suffering from mental illness and those who can provide assistance, TAC is compiling an ***Attorney Directory***. Our efforts to compile the directory come in response to the urgings of countless friends and family members who have called our office for help understanding state assisted treatment laws. Our hope is that the directory will be an invaluable resource in the battle to get help and understanding for those who suffer from mental illness.

Because of the great need for qualified and experienced civil commitment attorneys, we will provide attorneys a free listing in the directory. In addition, access to the directory, once completed, will be free of charge. We anticipate a publishing date in February 2002.

We would like to extend an invitation to qualified civil-commitment attorneys to be a part of our ***Attorney Directory***. Further, if you know of any attorneys who could be an asset to our directory, we encourage you to inform them of this opportunity to be a part of the catalyst for change. Attorneys may sign up for listing in the ***Attorney Directory*** by calling our office at (703) 294-6001, or by filling out the online registration form at www.psychlaws.org, or fill out the form on the next page and mail it to us.

# Treatment Advocacy Center

## *Attorney Directory Application Form*

Please complete the application and return to the **Treatment Advocacy Center** at **3300 North Fairfax Drive, Suite 220, Arlington, VA 22201.** For additional information or questions, you may call **(703) 294-6001**. This form may be forwarded via facsimile to **(703) 294-6010**. To contact TAC by email, send inquiries to **olsonj@psychlaws.org**. Upon receipt of the application, we will begin processing your request for inclusion in our database. Thank you for your willingness to be part of the catalyst for change.

---

**Title**: ________ **Name**: ______________________________ **Suffix**: __________
*(First, MI, Last)*

**Firm Name**: ______________________________

**Office Address**: ______________________________
*(PO Box)*
______________________________
*(Building)*
______________________________
*(Street & Suite No.)*
______________________________
*(City, State, Zip)*

**Office Phone**: (____) ______________ **Email**: ______________

**Office Fax**: (____) ______________ **Web Site**: ______________

**States and years licensed to practice law**: ______________________________

**State Bar Information**

| *State* | *Bar No.* |
|---|---|
| | |
| | |
| | |

**Number of years in civil commitment practice**: ______________

**Indicate your hourly rate and retainer fee requirements:**

**Hourly Rate**: ______________ **Retainer Fee Requirements**: __________

**Are you willing to provide legal services on a: Pro bono ____ Reduced fee ___ Contingency fee basis ___**

**I apply for registration in the TAC lawyer directory. I certify that the above stated information is true and correct.**

**Signature**: ______________________________ **Date**: ______________

**If you know of other Lawyers who may be interested in being listed in our directory, please include their name and contact information.**

**Name**: ______________ **Contact Info**: ______________

**Name**: ______________ **Contact Info**: ______________

**Name**: ______________ **Contact Info**: ______________

TREATMENT ADVOCACY

CENTER

## TREATMENT ADVOCACY CENTER CATALYST

Phone: 703-294-6001 ❖ Fax: 703-294-6010
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E-mail: info@psychlaws.org
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Arlington, Virginia 22201

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Brainerd, MN

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.

**I WANT TO HELP THE TREATMENT ADVOCACY CENTER WITH A GIFT OF: $ ____________**

❑ My check/money order is enclosed made payable to:
Treatment Advocacy Center

❑ Charge my credit card (circle one):

VISA MasterCard AMEX Discover

Account No. _________________________ Exp. Date ________

Signature (as on card) __________________________________

❑ Gift is in memory of: _________________________________
❑ Gift is in honor of: ___________________________________

(Please print all information except signature)

Name:
__________________________________________________________

Address :
__________________________________________________________

City: _________________________ State: _____ Zip: __________

Phone: ____________________ E-mail: ____________________

Gifts should be made payable to Treatment Advocacy Center and mailed to:
3300 North Fairfax Drive, Suite 220 ❄ Arlington, VA 22201
Thank You for Your Support!

Treatment Advocacy Center is a nonprofit 501(c)(3) organization; gifts are tax-deductible to the extent allowed by law. (3-4)