Catalyst
TREATMENT ADVOCACY CENTER Volume 3, No. 5 September/October 2001

The Florida Baker Act — Where are we now?

By Emerson Garner Farrell

The Florida Mental Health Act, a.k.a. the Baker Act, was enacted in 1971 with the aim of providing a comprehensive revision of Florida's mental health commitment laws. Twenty-five years later substantial reform was passed dealing with four issues: 1) greater protections for persons in the commitment system; 2) strengthened informed consent and guardian advocacy provisions; 3) expanded notice requirements; and 4) provisions for suspension and withdrawal of receiving and treatment facility designations.

But have these substantial reforms had the positive impact intended? What trends or impacts are actually evident over the past four years? Section 394.463 requires that the AHCA (Florida Agency for Health Care Association) submit an annual report describing the "certificates" received each year, analyzing the type (according to whether a judge, mental health professional or law enforcement officer issued the certificate) and the evidence (harm, neglect, both or neither). A collective analysis of the four annual reports (1997-2000) reveals the Baker Act may not be working as intended.

Figure 1 (see page 4) displays the growing number of counties which each year record zero certificates issued by a mental health professional. Counties with zero certifications by mental health professionals increased from 1 to 31 over four years (1, 3, 7, 31). The trend began with Dixie County in the first half of 1997, and the five additional counties which reported zero certifications in the second half of 1997 followed with zero frequency in 1998.

In addition, once a county has a year with zero mental health professional certificates, it remains without mental health certificates in the following years. In contrast over the four year period, when a county records zero certificates by either judges or law enforcement, the county always reported positive numbers the following year. There is not a single exception to either of these two trends over the four year history of the annual reports.

In 2000, the two cases where a county experienced a zero certificate count of a type other than mental health professional were in two counties that also had zero counts for mental health professionals. This fact would mean that for those two counties the responsibility for issuing/determining certificates was solely in the hands of the law enforcement officers because the two counties had both reported zero counts for judges as well as mental health professionals. The question arises: why are the mental health professionals increasingly absent from the process of issuing certificates?

Figure 2 illustrates the percentage division of certificate type on a

(continued on page 4)

Attorneys Rosanna Esposito and Jon Stanley answering questions at The Advocacy Center's booth at the 2001 NAMI Convention. (See story on page 3.)

Inside this issue...

Catalyst

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

TREATMENT ADVOCACY CENTER
3300 North Fairfax Drive
Suite 220
Arlington, VA 22201
Phone: 703-294-6001
Fax: 703-294-6010
Web Site: www.psychlaws.org
E-mail: info@psychlaws.org

FUNDING SOURCES
Stanley Foundation
Individual Donors

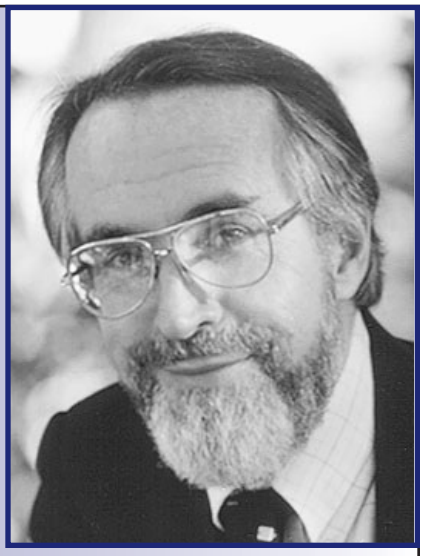
The Center is a nonprofit organization dedicated to eliminating legal and clinical barriers to timely and humane treatment for the millions of Americans with severe brain diseases who are not receiving appropriate medical care.

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

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

New Study Sheds Light on Medication Compliance and Violence

By Dr. E. Fuller Torrey



Dr. E. Fuller Torrey

The preliminary results of a new study on violence and schizophrenia demonstrate the importance of medication compliance in decreasing violent behavior. The results were reported at the International Congress on Schizophrenia Research, held in Whistler, British Columbia, in May 2001.

The study, which is still ongoing, is taking place in Cuyahoga County, Ohio, which includes Cleveland. It compares individuals with schizophrenia or schizoaffective disorder who are incarcerated in the county jail and who have a history of violent behavior with individuals with a similar diagnosis but no history of violent behavior at two community mental health centers. The preliminary report covered 100 individuals, 45 of whom had been violent and 55 of whom had not been violent.

The most striking differences between the two groups involved medication compliance and alcohol and drug use. Among those who had been violent, 80 percent had been noncompliant with medication prior to their violent act. An additional 9 percent had been partially compliant, and only 11 percent had been fully compliant. By contrast, among the individuals who had not been violent, none had been noncompliant with medication, 45 percent had been partially compliant, and 55 percent had been fully compliant.

Violent behavior in this study was defined as "direct physical aggression against person or property (not merely the threat of violence) for which legal charges were or would have been incurred." Three-fourths of the acts of violence were assault, 34 percent of which were against a law enforcement officer and 18 percent of which were against a family member. The other one-fourth of the acts of violence included attempted murder, arson, robbery, and vandalism.

The use of alcohol and/or street drugs was also more common among the individuals with schizophrenia who had been violent (69 percent) than among those who had not been violent (20 percent). These findings confirm previous studies, such as that funded by the MacArthur Foundation, that have shown that substance abuse is an important predisposing factor for violent behavior in individuals with severe psychiatric disorders, as it also is in individuals without severe psychiatric disorders.

Clinical evaluation of the individuals in the study also confirmed the findings from several previous studies showing that those who had been violent had significantly more symptoms of schizophrenia, as would be expected since most had been noncompliant with medication. Those who had been violent also had much lower scores on measures of insight and awareness of their illness. This, of course, is a major reason why they were also noncompliant with their medication - they were not aware that they were sick. Assisted treatment in such cases markedly decreases violent behavior, as was demonstrated in the recent study at Duke University by Schwartz et al.

The Cuyahoga County study is being carried out by Debra Hrouda, Phillip Resnick, Lee Friedman, and Stephen G. Noffsinger of the Case Western Reserve University Department of Psychiatry; M. Aronoff and M. Caso of the Cuyahoga County Court Psychiatric Clinic; and Peter Buckley of the Medical College of Georgia Department of Psychiatry.

Panelists for Treatment Advocacy Center at the 2001 NAMI Convention.
Left to right: Dr. John Gray, Dr. Stephen Connell, Carla Jacobs, and Jon Stanley.

Treatment Advocacy Center at the 2001 NAMI Convention

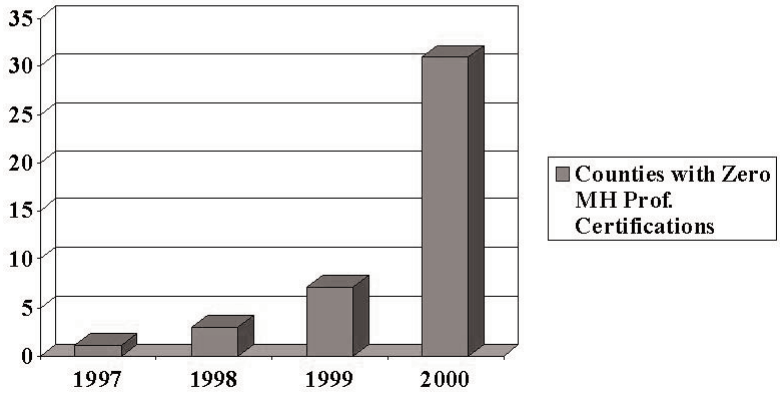
The Center's workshop on July 19th at the 2001 Annual NAMI Convention was a success despite a more technical orientation than in recent years and facing increased competition. Entitled, ***Helping People Overwhelmed by Mental Illness: Innovations from Above the Border***, the presentation featured two of Canada's leaders of treatment law reform — Drs. John Gray and Stephen Connell. Adopting a subject appropriate to the international theme of this year's convention, the workshop focused on Canadian assisted treatment laws and efforts to improve them.

Dr. Gray lucidly portrayed the status of treatment laws in Canada. Dr. Connell then spoke of the effort, to which he was integral, that lead to the recent adoption of Ontario's "Brian's Law." The legal reforms of that legislation are similar to that of New York's Kendra's Law; i.e., a widened placement standard that incorporates more than just dangerousness and the use of assisted outpatient treatment.

Although these capable Canadian doctors were given the bulk of the available time, we also incorporated the Center's mission and activities into the workshop. Jon Stanley briefly pointed out the similarities between the reforms above the border to those proposed by the Treatment Advocacy Center. The final presenter was Carla Jacobs, who described the ongoing campaign to improve California's restrictive Lanterman-Petris-Short Act.

Our workshop this year was competing against 18 others, as opposed to 9 or 10 in the past, due to NAMI's introduction of convention format with more featured presentations, leaving the same number of workshops but fewer sessions for them. Also, this workshop's content was more technical than in past years. Of the 2,500 people at the convention, undoubtedly many did not make the early morning workshop session. Yet, attendance was robust — about 270 people. Perhaps even more tellingly, no one left after the workshop started. People only came in.

Figure 1 - Number of Counties with Zero Certificates by Mental Health Professionals



(continued from page 1)

statewide basis; clearly the mental health professionals do still issue the majority of certificates on a statewide basis (51% compared to the 44% and 4% by law enforcement officers and judges, respectively). However, as can be deduced from Figure 2 and clearly illustrated from Figure 3, law enforcement has experienced almost 5% growth over the four years while both mental health professionals and judges experienced a decrease of over 2%.

Figure 2 - Percentage of Total by Certificate Types

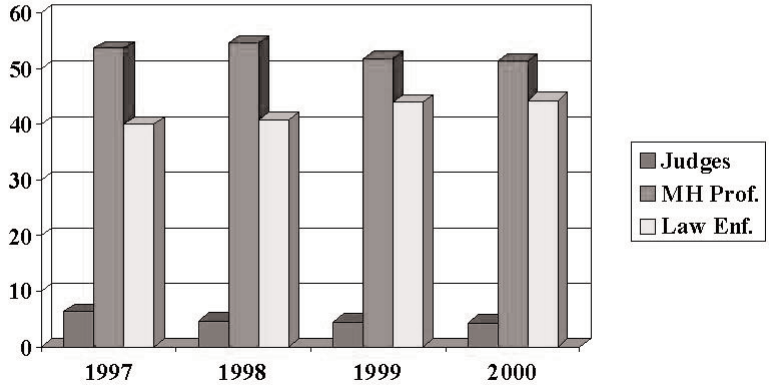
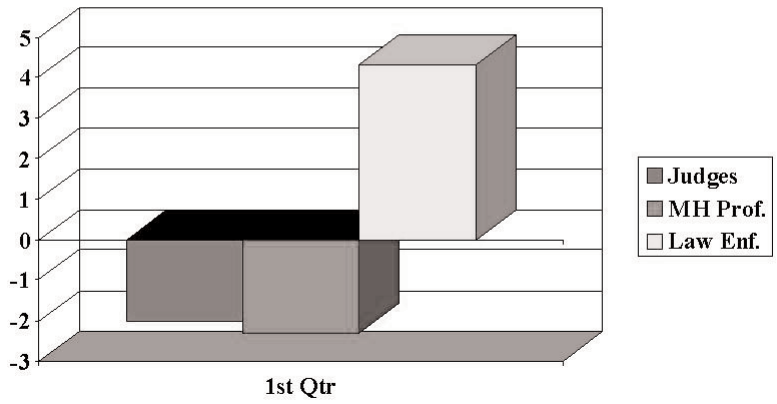


Figure 3 - Percentage Change In Certificate Type Over Four Years



These trends represent a growing trend of law enforcement officers acting as the primary source for committing mentally ill individuals. Are they adequately trained for this task? Is this even their proper role? Do they have the proper discretion to determine whether or not to commit? Why are the numbers of certificates by judges and mental health professionals declining?

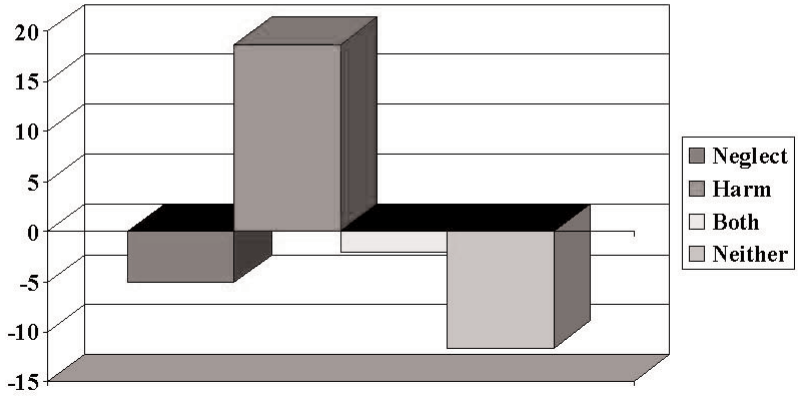
Additionally, is this resulting in more or less individuals getting treatment? Are the mentally ill receiving proper treatment if law enforcement is determining the needs of their illness? If law enforcement officers are spending more and more time evaluating the mentally ill, are there other emergencies that are going unanswered?

The last important trends to discuss are those illustrated in Figures 4 and 5 dealing with the evidence types of the certificates (harm, neglect, both or neither) which are indicated by the individual issuing the certificate. Only "harm" has experienced positive growth over the four years with close to 20%; the other three evidence classifications ("neglect," "both," "neither") experienced a decrease of 5%, 2% and 12%, respectively. Figure 5 further illustrates how the changes

have caused "harm" to reach nearly 70% of all certificate evidence types while the other three types have fallen to 18%, 5% and 8%, respectively.

This evidence seems to flow logically with the emergence of law enforcement as the primary issuer of certificates in many counties. Law enforcement is most likely to be called to a scene where there is a disturbance involved that would be classified as "harm" rather than a case of "neglect" which most likely is not causing a great disturbance and thus not reported to officials.

Figure 4 - Percentage Change In Evidence Type Over Four Years

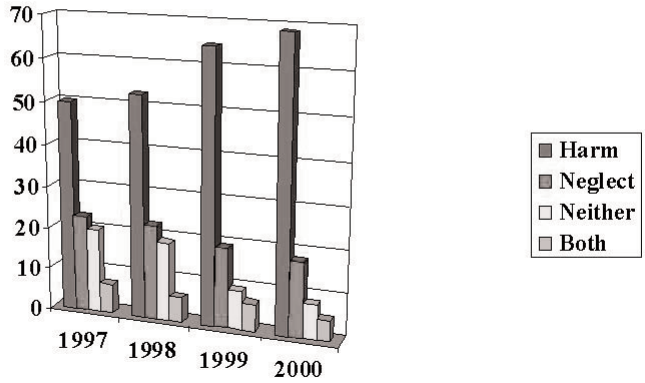


Why the changes in evidence type? Is there a specific change in the mentally ill population that would make them more prone to violence ("harm")? Or is there an aspect of the Baker Act which would cause there to be a tendency to only commit those individuals who are prone to being harmful?

Logically it would appear that the mental health professionals are limited to addressing the problem only after the individuals have reached a "dangerous" level at which point law enforcement officers become involved and are forced to evaluate the needs of the mentally ill. Clearly this is a disappointing and potentially disastrous trend which must be addressed.

What about those four earlier objectives of the substantial reforms in 1996: can they possibly be met under these circumstances? The growing role of law enforcement officers in evaluating the needs of the mentally ill seems to be exacerbating the problems of the mentally ill population while also preventing the law enforcement from addressing the issues for which they are trained and needed.

Figure 5 - Percentage of Certificates by Evidence Type



[Emerson Farrell is an undergraduate at Harvard University. Mr. Farrell interned at TAC in the summer 2001.]

Kevin's Law's Supports Intervention Before Violence

Legislators Release Details On Anniversary Of Kalamazoo Bus Station Murder

One year ago, Kevin Heisinger lost his life because another person's mental illness was not being treated. His attacker, Brian Williams, was off medication for his schizophrenia and later said that "voices" made him beat Kevin to death. Kevin's repeated screams of anguish and pain went unheeded by other travelers during the midday murder in the busy bus station in Kalamazoo, Michigan. To honor Kevin's memory on the one-year anniversary of his death, his family and state legislators demanded that Michigan lawmakers listen to Kevin's voice -— this time, by passing "Kevin's Law." Press conferences were held in three Michigan locations: Kalamazoo (at the bus station), Lansing and Southfield (near Detroit).

Representative Virg Bernero's (D-Lansing) and Tom George (R-Portage), the bill's bipartisan sponsors, spoke eloquently about the need for reform before a host of TV cameras. Charles Heisinger, Kevin's father; Kimberly McKenna, Kevin's mother; and Patricia Webdale, the mother of Kendra Webdale, for whom a similar law was named and passed in New York all spoke.

The Treatment Advocacy Center's Jon Stanley and Mary Zdanowicz were also present. "We cannot turn our backs while individuals with untreated mental illness commit suicide, die homeless on a park bench from malnutrition, or beat someone to death in broad daylight in a public building," said Zdanowicz. "The legal standard for intervention should be need for treatment, not dangerousness alone. If the law had helped Brian Williams, Kevin would still be alive today, working toward his graduate degree in social work and his goal of helping those who need it most. Kevin's Law is a fitting legacy." Jon Stanley told the Kalamazoo Gazette that "Kevin's law will help people simply because they are too sick to help themselves. It not only commits a person to the system — it also commits the system to the person."

> **"We cannot turn our backs while individuals with untreated mental illness commit suicide, die homeless on a park bench from malnutrition, or beat someone to death in broad daylight in a public building."**
>
> **— Mary Zdanowicz**

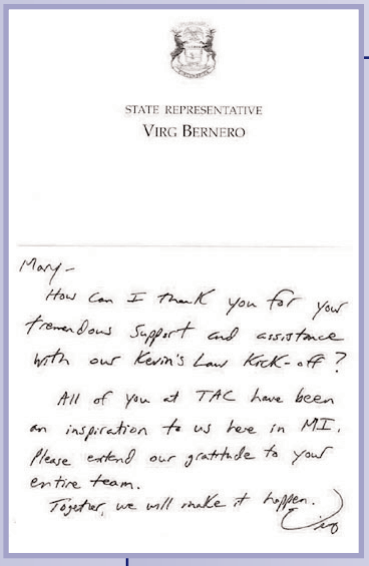
Rep. Bernero chose to sponsor Kevin's Law because securing mental health treatment for those in need is increasingly problematic. "After deinstitutionalization, too many people with mental illness are left adrift with nowhere to turn. They wind up on the streets, in jail, or dead. People with mental health issues and the communities in which they live all deserve better."

Rep. George, co-sponsor of the bill, believes that "by ensuring that those with severe mental illness get consistent and long-term treatment, Kevin's Law can help prevent tragedies like this one."

The *Lansing State Journal* published an editorial in favor of Kevin's Law stating that it is "a well-considered, prudent measure to get the ill the aid and supervision they need." Reps. Bernero and George plan to introduce Kevin's Law in the Michigan legislature by early November 2001.

(See picture and thank you note on next page.)

Kevin's Law press conference. Left to right: Michigan Representatives Tom George and Virg Bernero. Around them are members of Kevin's family, law enforcement, and a prosecutor.



STATE REPRESENTATIVE
VIRG BERNERO

Mary -
How can I thank you for your tremendous support and assistance with our Kevin's Law kick-off?
All of you at TAC have been an inspiration to us here in MI. Please extend our gratitude to your entire team.
Together, we will make it happen.
Virg

The note from Rep. Virg Bernero says:

"Mary, How can I thank you for your tremendous support and assistance with our Kevin's Law kickoff? All of you at TAC have been an inspiration to us here in MI.

Please extend our gratitude to your entire team.

Together, we will make it happen."

Virg

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.

Your Voice— Will Make a Difference

Thank you for the work you are doing. I am sending a donation via mail, but want to respond to the recent media attention of the young man who, in a psychotic mental state, went forward to the cockpit of a plane and was subsequently brought down by the other passengers. This could have been us. Perhaps this can be another cry for education, early intervention, and empathy for families who face this kind of crisis. One can only speculate what brought about the need to transport a son; did he have a break at college and need to come home? Had he been put untreated onto the streets with only his family to bring him home? The media will probably never fill us in on details. Hopefully this tragedy could be a time to educate, and establish the need for early intervention. I want to stand with others in reaching out to this family with hope and encouragement.

Dick & Sue (fellow parents)
Bellevue, WA

I cheered, jumped up and down, and couldn't stop shouting, "YES!" at the top of my lungs when I received the email from Jonathan saying, "It's Law."

Carla, thank you from the bottom of my heart for all your hard work, and that of all the others at CTAC.

I know the passage of AB1424 means a lot to many thousands of people.—.and to my family in particular.—.well, this may not only save my brother's life (Mark), but also my mother's.

Sans details, Mark has deteriorated almost beyond belief, is the "most acute" case the [mental health] professionals in Solano County have ever had (they claim).—.yet he continues to exercise his "right" to contest conservatorship. The next round in attempting to conserve him will soon begin, probably won't end up in court until AFTER January 1 — and the new requirement to consider his history almost guarantees that he will this time be conserved.

Mark has come within moments, within inches, of being hit by cars approximately 15-20 times in the past few months (he's in a special residential mental health program), but, they can't watch him every second. My 80-year-old mother's health, while exceptional for someone her age, is beginning to deteriorate due to worry and anxiety over Mark.

AB1424 will without question provide the legal means necessary to end this nightmare for our family.

Thank you, thank you, thank you.

Kay Silva

California Update

California — Hope for Those Who Are Most Ill

There has been a significant reform of the treatment laws in our most populous state. On September 4, the California Senate passed AB1424 (29-4). The bill previously passed the Assembly (79-0). Governor Gray Davis signed AB1424 into law on October 4.

AB1424 will require Californian judges to make treatment placement decisions not only based on a person's immediate condition — as they do now — but with reference to the person's psychiatric history. The bill will require that the historical course of the person's mental illness be considered when it has a direct bearing on the determination of whether the person is a danger to self/others or gravely disabled. When relevant to this consideration, courts will have to consider all evidence in available medical records or that is presented by either family members, treatment providers, or anyone designated by the patient. Furthermore, facilities will be obligated to make every reasonable effort to make available information provided by the family to the court.

We are indebted to Assemblywoman Helen Thomson for sponsoring this bill. We congratulate and thank the members of the California Treatment Advocacy Coalition for their successful support of AB 1424. Special recognition goes to the Coalition's co-coordinators, Carla Jacobs, Randall Hagar and Chuck Sosebee.

Anosognosia Keeps Patients From Realizing They're Ill

A growing body of evidence points to the fact that, for many people with serious mental illness, lack of insight is a medically based condition.

About half of the people with schizophrenia and bipolar disorder may not be getting the treatment they need because of a brain deficit that renders them unable to perceive that they are ill, according to one expert.

Anosognosia, meaning "unawareness of illness," is a syndrome commonly seen in people with serious mental illness and some neurological disorders, according to Xavier Amador, Ph.D., who spoke at the 2001 convention of the National Alliance for the Mentally Ill in Washington, D.C., in July.

"People with this syndrome do not believe they are ill despite evidence to the contrary," said Amador, who is director of psychology at the New York State Psychiatric Institute and professor of psychology in the department of psychiatry at Columbia University College of Physicians and Surgeons.

"People will come up with illogical and even bizarre explanations for symptoms and life circumstances stemming from their illness," he said, "along with a compulsion to prove to others that they are not ill, despite negative consequences associated with doing so."

Take Theodore Kaczynski, for example. Kaczynski, otherwise known as the unabomber, rejected claims that he was mentally ill even though it could have cost him his life.

At one point during his 1997 trial, Amador explained, Kaczynski, who stood accused of killing three people and injuring 23 with his homemade bombs, refused to be examined by state psychiatric experts. Although a mental illness defense was his only hope of escaping a first-degree murder conviction and a possible death sentence, he blocked his attorneys from using the insanity defense.

Amador, who served as an independent expert for the court, reviewed Kaczyinski's extensive psychiatric records, neuropsychological test results, and the infamous unabomber diaries. Amador then supplied the court with mounting evidence that Kaczynski's refusal to be evaluated related to anosognosia, a manifestation of Kaczynski's schizophrenia.

Amador's quest to understand the basis of this syndrome lies a little closer to home. It was his experience as a clinician and as a brother of someone with schizophrenia, Amador said, that led him to do research on anosognosia, "which is not to be confused with denial," he emphasized, although in the beginning, he did not make that distinction.

"That's what I called it when my brother refused to take his medications, and that is what I called it when after his third hospitalization, I found his Haldol in the trash can," said Amador.

"This is someone who taught me to throw a baseball and ride a bicycle. I really

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
Gale Barshop	Alexandria, VA	Lynn Arden	
H. Neal and Mildred Schaefer	Ormond Beach, FL	Dale Johnson	
Bill and Alice Petree	Sanford, FL	Alan Singletary and Deputy Gene Gregory	
Rebecca Mani	Arlington, VA	William Phillips	
Nelson and Theresa Goguen	Ashby, MA		Mark Alan Goguen
Walker and Sydney Pettyjohn	Chatham, VA	Stephen Kemp Pettyjohn	
Walter and Mary Born	Aberdeen, NJ	Hattie White	
Eileen Rorick	Orange Springs, FL		Michael Rorick
Bernadette Gilbert	Colorado Springs, CO		Ed and Willa Burleigh Wedding
Jack O'Brien	Wayne, PA		Richard J. O'Brien, Jr.
Maurice Burman	S. Palm Beach, FL	Jon Burman	
Judith Perlman & Marilyn Shonfeld	Glencoe, IL	Our Father, Joseph Perlman	
Mary Zdanowicz	Arlington, VA	Darrah Axelrod, Edith Reidy	Brian Jacobs

looked up to him and was appalled by what I thought was his immaturity, stubbornness, and defensiveness."

But research points to a much more complex problem.

Intrigued by a 1986 study by William H. Wilson, M.D., and colleagues, that found that 89 percent of patients with schizophrenia denied having an illness, Amador conducted his own investigation of the issue.

Amador and his colleagues found in a 1994 study that nearly 60 percent of a sample of 221 patients with schizophrenia did not believe they were ill.

A Frustrating Existence

Amador also described what it is like to work with someone who has anosognosia. One patient encountered by Amador had a lesion on the frontal lobe of his brain. He was unaware that he was paralyzed on his left side or that he had problems writing. "When asked to draw a clock, the patient thought he did fine," Amador recalled.

However, when Amador pointed out to the patient that the numbers were outside of the circle, the patient became upset. "The more I talked to him [about the drawing], the more flustered he got. Then he got angry and pushed the paper away, saying, 'It's not mine; it's not my drawing.'"

Amador finds the same reaction appears when he talks to people with severe mental illness, which sometimes involves similar frontal lobe deficits. "Instead of being an ally, I end up being an adversary," he said.

Building Trust

Amador urged family members and mental health professionals at the NAMI meeting to understand that collaboration with treatment by someone who has a severe mental illness and anosognosia is a goal, not a given.

"Don't expect them to comply with any treatment plan, because they don't believe they are ill," noted Amador.

It is important instead to develop a partnership with the patient around those things that can be agreed upon.

Amador said that family members and clinicians should first listen to the patient's fears, such as being placed in the hospital against his or her will.

"Empathy with the patient's frustrations and even delusional beliefs is also important," remarked Amador, who said that the phrase, "I understand how you feel," can make a world of difference.

"The most difficult thing for family members to do in building a trusting relationship," he said, "is to restrict discussion to the problems that the person with mental illness perceives as problems. You might see the hallucinations or delusions as the big problem. Your loved one, however, may be complaining about not getting to sleep at night. That is the problem you should be discussing."

"Perhaps a patient will only take his or her medications to get family members and clinicians to quit bothering them, and this is sometimes enough," Amador said. "You have to find out what motivates them to take their medications, then reflect that reason back and highlight the perceived benefits."

Amador wrote about getting people with serious mental illness to accept treatment in a book he co-authored with Anna-Lisa Johanson (see story below) titled, ***I am Not Sick, I Don't Need Help: A Practical Guide for Families and Therapists,*** published in 2000 by Vida Press. It can be purchased online at www.vidapress.com/INSIDNH-Main.htm

Committing A Loved One Can Be The Best Medicine

By Eve Kupersanin

When planned ahead of time, commitment can be an empowering process for people with mental illness, advocates maintain.

Hindsight is always 20/20, according to an old adage. Anna-Lisa Johanson now knows that committing a loved one with mental illness can be a lifesaving act inspired by love — but she learned this lesson the hard way.

Johanson's mother made headlines when she took her own life at the age of 46 by kneeling before a speeding train in October 1998. In her lifetime, Mary Margaret Ray gained notoriety in the media because of her bizarre delusional behavior and stalking of comedian David Letterman. Ray was diagnosed with schizophrenia and schizoaffective disorder.

"I lost my mother because I didn't know how to commit her," Johanson told a room of mental health professionals, family members, and people with mental illness at the 2001 convention of the National Alliance for the Mentally Ill (NAMI) in Washington D.C., in July. The only psychiatric treatment her mother received was through the criminal justice system during repeated incarcerations, she noted.

Now, however, Johanson is well on her way to becoming an expert in commitment law.

Johanson is finishing a joint program in law and public health at Georgetown University and Johns Hopkins University and is interested in pursuing a career in mental health advocacy.

She also has a new daughter and works part time at the Treatment Advocacy Center (TAC) in Arlington, Virginia., where she helps people with mental illness and their family members understand commitment laws.

TAC is a nonprofit advocacy organization dedicated to removing legal and clinical barriers to psychiatric treatment for people with severe mental illness.

Johanson also co-authored the book, ***I Am Not Sick, I Don't Need Help: Helping the Seriously Mentally Ill Accept Treatment*** with Xavier Amador, Ph.D., published by Vida Press in 2000.

"My father is an old Swedish socialist," said Johanson. "The reason he never committed my mother was that no matter what, he would never violate her independence or her rights."

Johanson said that she grew up believing that personal freedom and self-determination were sacred. But now she thinks differently.

"There is a certain point where a brain disorder takes over, and you no longer possess free will — it has been obliterated because of a chemical imbalance," said Johanson.

After taking an informal poll of NAMI members in the room, Johanson

Editor's Note: Above is a picture of Anna-Lisa with Jon Stanley at a TAC information booth. Beginning on page 10, Committing A Loved One, is a profile of Anna-Lisa Johanson from Psychiatric News. While it includes many of her activities and accomplishments, it does not note that Anna-Lisa authored an article in the October issue of Good Housekeeping, one of the most-read periodicals in the country.

We are proud that Anna-Lisa is part of the TAC family. After reading the article, you will understand why.

found that many felt dread at the thought of committing a loved one, and many feared being committed themselves.

Johanson empathized. "I suffer from bipolar disorder. It has never been far from my mind that a week or two beyond medication and I could be at a point where my loved ones would have to commit me."

Johanson advised family members and people with mental illness to research the commitment process and have all the necessary steps taken care of ahead of time, so that the commitment process is less traumatic if it ever needs to be used.

For instance, people with mental illness can shop around for a psychiatrist they trust and can talk with openly. People can also call the emergency room or psychiatric unit of their local hospital and ask if they have a partnership with the police department, Johanson suggested.

She also said that it is useful for people to find out if the police department has an officer who is specially trained to work with people with mental illness, and if so, keep the number of that officer handy.

Beyond this, there is one crucial measure that people with mental illness should take. "See if your state has something called an Advance Directive for Mental Health Care," said Johanson.

This is a legal document that allows people with mental illness to exert some control over the terms of their commitment prospectively through written instructions about psychiatric care. The advance directive also appoints an agent to ensure that the instructions are carried out (***Psychiatric News***, December 15, 2000).

"This legal document is useful," Johanson emphasized, "for people who may want to plan ahead for their own possible commitment."

In this scenario, someone might first choose a psychiatric hospital where he or she would prefer to be treated. Then, he or she can go with a loved one to an attorney and sign an advance directive, specifying that if two doctors decide that he or she needs help, this is the person's hospital of choice.

"It is empowering to set up this safety net for yourself," Johanson emphasized.

As of last count, 13 states recognize psychiatric advance directives, according to Bob Fleishner, J.D., who is an attorney at the Center for Public Representation in Northampton, Massachusetts. Fleishner said that all states do have general advance directive laws that allow for instructions for mental health care, however.

"It is a little late now, but had I been able to, I would have committed my mother," said Johanson. "It would have been the greatest service to her, and she would be here today to meet her granddaughter."

TREATMENT ADVOCACY CENTER
CATALYST
Phone: 703-294-6001 ❖ Fax: 703-294-6010
Web Site: www.psychlaws.org
E-mail: info@psychlaws.org
3300 North Fairfax Drive Suite 220
Arlington, Virginia 22201

ADDRESS SERVICE REQUESTED

Nonprofit Organization
U.S. Postage
PAID
Permit No.
570
Brainerd, MN

UNITED WAY 2001 CAMPAIGN

The Treatment Advocacy Center is participating in the United Way 2001 Campaign.
Designation Number 9201

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. (3-5)