



## Why TAC exists: To reduce victimization

by E. Fuller Torrey, M.D.

During the eight years I worked at a state psychiatric hospital (St. Elizabeth's Hospital in Washington, D.C.) and the 16 years I volunteered services at clinics for homeless mentally ill individuals, one of the most shocking things I became aware of was how often such individuals are victimized in the community. Having their SSI checks stolen and being assaulted were commonplace. For women, especially if they were young and/or attractive, being raped was very frequent. I was also impressed by the clear relationship between the severity of psychiatric symptoms, often caused by failure to take medication, and liability to victimization. Some of the most severely mentally ill individuals who were living in the community were, in the words of a Massachusetts judge, "like rabbits forced to live with dogs."

In the past decade, multiple studies have been published confirming the relationship between being severely mentally ill and being victimized. These studies are summarized on the TAC website ([www.psychlaws.org](http://www.psychlaws.org)) by the briefing paper "Victimization: One of the Consequences of Failure To Treat." In Los Angeles, one-third of individuals living in

group homes had been assaulted or robbed in the preceding year. In New York and Washington, D.C., one-third to one-half of severely psychiatrically ill women had been raped.

One reason for this high rate of victimization is that we frequently locate group homes and other living facilities for mentally ill individuals in high-crime neighborhoods. This is part of the NIMBY (not-in-my-backyard) syndrome. Another reason for the high rate of victimization is that many mentally ill individuals living in the community are unaware they are ill (anosognosia) and so do not take their medication. This failure to take medication increases their psychiatric symptoms and makes them much more vulnerable to victimization.

A recent study by Virginia Hiday and her colleagues in North Carolina is very important. It demonstrated that individuals with severe psychiatric disorders living in the community who were receiving assisted outpatient treatment (outpatient commitment) were victimized only approximately half as often as those who were not receiving assisted treatment. Those on assisted treatment took their medication more regularly. Clearly, compliance with medication reduces victimization.

TAC is working hard to spread that message.

## LANDMARK CALIFORNIA LEGISLATION

*At press time, California's AB 1421 was poised on the governor's desk for signature. Watch for a complete update in the next issue of Catalyst. Can't wait that long? Log onto the TAC web site at <http://www.psychlaws.org> for the latest.*

## A Giant Victory: Wisconsin Supreme Court unanimously upholds need-for-treatment standard

by Jon Stanley, J.D.

The Wisconsin Supreme Court has resoundingly rebuffed a constitutional challenge to that state's "Fifth Standard," which contains some of the nation's broadest eligibility criteria for the court-ordered treatment of people overcome by severe psychiatric disorders.

In *State of Wisconsin v. Dennis H.*, the unanimous court found that those who meet the Fifth Standard are in a condition that constitutes "dangerousness" under both the U.S. and Wisconsin Constitutions, but the court's definition of what is dangerous is what most would call "need for treatment."

The July 12 ruling was critical. An adverse ruling could not only have stricken the progressive treatment standard from Wisconsin law, but also have prompted a rash of similar challenges in other jurisdictions. The U.S. Supreme Court has never considered the constitutionality of need-for-treatment standards. And —

(continued on page 10)

### Inside this issue...

<i>Anosognosia causes treatment refusal</i>	Page 2
<i>Torrey speaks at NAMI 2002 Convention</i>	Page 3
<i>The Invisible Plague</i>	Page 4
<i>Suicide annually claims 5,000 untreated</i>	Page 6
<i>National Hopeline Network</i>	Page 8
<i>"Act of God" people</i>	Page 9
<i>Memorials/honorarium</i>	Page 11



## Catalyst

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The Treatment Advocacy 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 1.8 million individuals with schizophrenia and manic-depressive illness (bipolar disorder) are not being treated for their illness at any given time.

TAC serves as a catalyst to achieve proper balance in judicial, legislative and policy decisions that affect the lives of persons with serious mental illnesses.

## Majority refuse treatment because they do not believe they are sick

A recent study reported results of interviews with individuals with serious mental illnesses to ascertain why they were not receiving treatment. The majority — 55 percent — denied that they had any problem. Thus, they had limited awareness of their illness, also called anosognosia; this lack of awareness is known to be caused by changes in the frontal lobe and other areas of the brain due to the disease process. The 45 percent who acknowledged that they needed treatment (and thus had awareness of their illness) but still were not receiving treatment cited many reasons for this. These included (respondent could check several reasons):

### REASONS FOR NOT SEEKING TREATMENT:

- 32% "wanted to solve problem on own"
- 27% "thought the problem would get better by itself"
- 20% "too expensive"
- 18% "unsure about where to go for help"
- 17% "help probably would not do any good"
- 16% "health insurance would not cover treatment"

### OTHER REASONS WERE CITED MUCH LESS FREQUENTLY:

- 7% "scared about hospitalization against own will"
- 6% "concerned about what others might think"
- 5% "not satisfied with available services"
- 1% "could not get an appointment"
- 0% "language problem"

This study thus contradicts claims that many individuals with serious mental illnesses do not seek treatment because of fears of involuntary hospitalization, stigma, or dissatisfaction with available services. It is commonly claimed that "if you make the psychiatric services attractive enough and culturally relevant, then individuals with serious mental illnesses will utilize them." This appears to not be true. Very few individuals cited "not satisfied with available services," "could not get appointment," "language problem," etc., as a reason why they were not in treatment. *The greatest reason for non-treatment by far was the person's lack of awareness of their illness.* Such individuals will not voluntarily utilize psychiatric services, no matter how attractive those services are, because they do not believe that they have an illness. <sup>41</sup>

## FREE EMAIL NEWSLETTERS

Interested in regular updates on the consequences of lack of treatment? Subscribe to TAC's free weekly email "Preventable Tragedies" newsletter, which includes summaries of recent news articles in which an individual with a neurobiological brain disorder (usually untreated) is involved in a tragic episode, either as a victim or perpetrator. These incidents also appear in the Preventable Tragedies database at [www.psychlaws.org](http://www.psychlaws.org). This newsletter can be very disturbing to read, but it reinforces the need to improve treatment for individuals with serious brain disorders. TO SUBSCRIBE, send an email message to [info@psychlaws.org](mailto:info@psychlaws.org) with "Subscribe Preventable Tragedies" in the subject heading and your name and mailing address in the body of the message.

You may also be interested in our free weekly "E-News" newsletter, which offers weekly summaries of news stories, research developments, and state activity. TO SUBSCRIBE, fill out a TAC network form, located on our web site at <http://www.psychlaws.org/JoinUs/ContactForm.htm>.

## Hope Through Advocacy: The good news and the bad news about research and services

Treatment Advocacy President Dr. E. Fuller Torrey gave the keynote address at the June 27, 2002, plenary for the National NAMI Convention. His presentation, *"Hope through Advocacy,"* received a great deal of attention. A summary of his well-attended talk appears below. See the end of the article for information on getting a copy of his slides.

### RESEARCH: THE GOOD NEWS, THE BAD NEWS

In 1950, people widely believed that severe mental illnesses were caused by bad mothers. Moving through the 60s and beyond, the medical profession improved its tools, allowing scientists to see through neuroimaging (CT and PET scans and MRIs) that the cause was less about poor parenting and more about genetics and neurotransmitters. Now we are poised on the edge of a new frontier through the discovery of DNA microarrays that allow scientist to measure thousands of genes. The focus now is on molecular psychiatry: genomics and proteomics. Indeed, "proteins, not genes, are where the action is," as proteins are now targets for medications.

The bad news on the research front is that despite the hope offered by modern technologies, only 22 percent of NIMH grants have anything to do with severe mental illnesses, and that only 8 percent of the grants study clinical or treatment aspects of severe mental illnesses. The remaining 78 percent of research supported by NIMH covers projects such as "daytime sleepiness" (which was awarded \$318,818), "time pressures and well being" (\$60,959), and "adolescent romantic relationships" (\$26,998). In the wake of the Andrea Yates tragedy, Dr. Torrey noted that from 1972 to 2002,

NIMH funded exactly one study on postpartum psychosis — and 92 on pigeons.

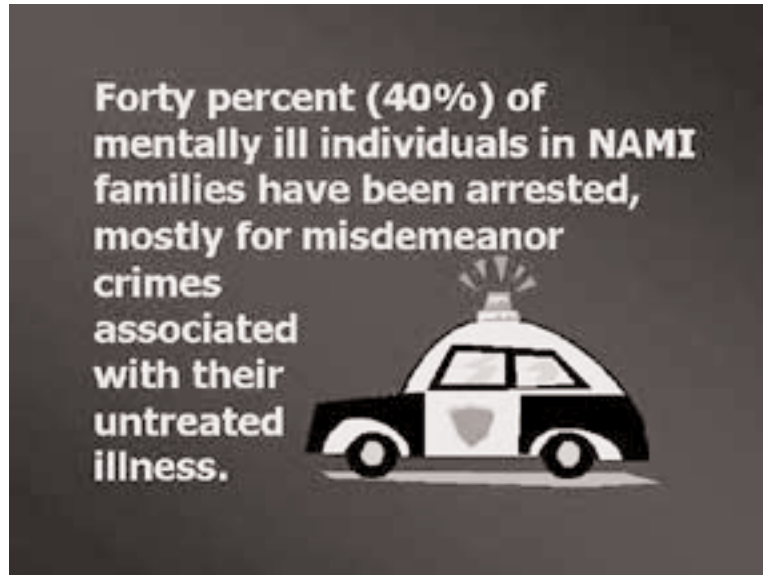
### SERVICES: THE GOOD NEWS, THE BAD NEWS

The good news on services is that we know how to deliver high-quality, cost-effective services to people with severe psychiatric disorders. We know that most such individuals require long-term

individuals did not think they were sick, a condition called anosognosia. This study contradicts the claim that people shun services because of stigma or dissatisfaction with services available. Failure to treat is the major reason why such individuals become homeless, are arrested, are victimized, or commit violent acts.

Assisted treatment is often necessary to help people who will not accept voluntary treatment because they do not believe anything is wrong with them. Assisted outpatient treatment is now legally available in 41 states, but it is still not widely used, despite the numerous studies that indicate that assisted outpatient treatment decreases hospital admissions, decreases arrests and jailings, and decreases episodes of violence.

To those who suggest that nobody should be subjected to assisted treatment until public services are "adequate," Dr. Torrey suggested they be asked to define adequate and explain what percentage of people must be eating from garbage cans or in jail before assisted treatment should be used.



medication, carefully monitored and in the lowest effective dose, and we know that a few people with severe mental illnesses require long-term hospitalization and asylum for their own protection.

We also know the importance of:

- ◆ continuity of care and caregivers, as demonstrated by the PACT model;
- ◆ rehabilitation and opportunities for employment, as demonstrated since 1948 by the clubhouse model; and
- ◆ decent and affordable housing with varying levels of supervision.

But, the bad news far outweighs the good. There are eight major problems.

**1. The failure to treat individuals with serious psychiatric disorders.** A recent study (see page 2 of this edition of Catalyst) indicated that the main reason for not seeking treatment was that those

**2. Jails have replaced psychiatric hospitals.** The three largest psychiatric institutions in the United States are the Los Angeles County Jail, Chicago's Cook County Jail, and Riker's Island in New York City. In virtually every county in the nation, the county jail holds more people with severe psychiatric illness than any psychiatric facility in that county. And 40 percent of mentally ill people in NAMI families have been arrested, mostly for misdemeanor crimes associated with their illness.

The problem continues to escalate — it is a major quality of life issue for inmates with severe mental illnesses, who are more likely to be beaten, victimized or commit suicide than those who are not sick. And it is a major expense for jail systems — last year, Ohio's Cuyahoga County Jail spent \$175,000 for olanzapine (Zyprexa) alone. The Los Angeles County Jail spends \$10 million per year on psychiatric medication.

## Severe mental illnesses are increasing: *The Invisible Plague*

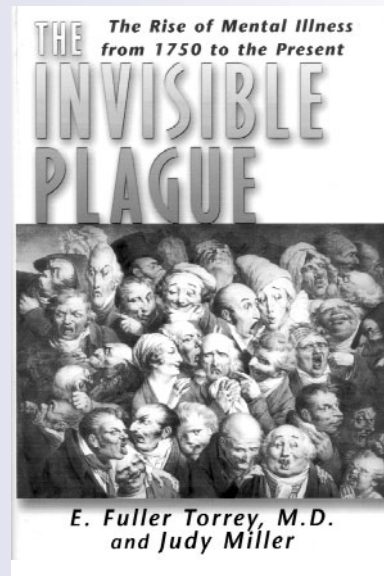
A newly published book offers evidence that schizophrenia and manic-depressive illness (bipolar disorder) have increased dramatically over the past 250 years and may be continuing to increase in incidence. This claim is directly contrary to the widespread assumption in psychiatry that severe mental illnesses have not increased in hundreds of years, if at all.

Coauthored by E. Fuller Torrey, M.D., and Judy Miller, *The Invisible Plague: The Rise of Mental Illness from 1750 to the Present* is the lead publication of the Rutgers University Press. Psychiatric historian Dr. Gerald Grob has called the book "important and provocative."

The authors examine data in the United States, Canada, England, and Ireland that suggest that the incidence of schizophrenia and manic-depressive illness has increased at least fivefold more than the population has increased since the early 19th century. The continuing increase in these disorders may account in part for the continuously increasing number of severely mentally ill individuals who are homeless, in jails, and who commit acts of violence. Historically, according to the authors, the increase also played a major role in historical developments such as the eugenics movement and immigration restrictions in the early 20th century in the United States.

What has caused this increase? The authors dispute the widespread assumption that stress has played a major role, since the increase was unaffected by the World Wars, the Great Depression, or the Irish Famine. Genetics also are unlikely to have been the cause, since most affected individuals were confined to hospitals, and thus were unable to reproduce, during this period. The authors speculate instead that other biological factors caused, and are continuing to cause, the increase. These factors appear to be related to increasing urbanization and industrialization and probably include such things as infections, toxins, and/or dietary changes.

*The Invisible Plague is now available through your local bookstore or online at [www.amazon.com](http://www.amazon.com).*



Failure to treat people before they enter the criminal justice system is the major reason for the increase in population. Jail diversion programs and mental health courts are laudable but don't address the fundamental problem: treating people before problems occur.

**3. Victimization and suicide.** In Washington, DC, 34 percent of homeless women with severe mental illnesses had been sexually assaulted. In California, 33 percent of "psychiatrically disabled" residents of board-and-care homes had been robbed and/or assaulted in the preceding year. Studies now indicate that adequate psychiatric treatment could prevent as many as 5,000 suicides each year. (For more on this, see page 6.)

Victimization and suicide are prevalent because we require many with severe psychiatric illnesses to live in run-down, crime-ridden neighborhoods, because we

fail to do unannounced inspections of group homes, and because we fail to ensure that sick individuals are receiving treatment.

**4. It is likely that schizophrenia and bipolar disorder are increasing in incidence and nobody is paying attention.** There is now evidence that these disorders increased at least sevenfold as a rate per population between 1800 and 1950. [For more on this, see Dr. Torrey's latest book, *The Invisible Plague*.]

Despite this, the Center for Mental Health Services (CMHS) is funding no studies to ascertain whether incidence rates are changing. Instead they gave \$1.3 million to the National Empowerment Center, whose directors believe that "mental illness is a coping mechanism, not a disease." And they fund conferences such as the one where a speaker described

schizophrenia as a "healthy, valid, desirable condition ... that should be facilitated instead of treated."

**5. Stigma and violence.** Stigma continues to be a major obstacle. Multiple studies have shown that violent acts committed by those with severe psychiatric disorders are the single largest cause of this stigma.

People with severe psychiatric disorders who ARE being treated are NOT more dangerous than the general population. But, those who are NOT being treated ARE more dangerous; a 2000 NIMH report estimated that they are responsible for 9 percent to 15 percent of all violent acts, including homicides. This would equal approximately 1,400 homicides each year.

The best way to address the problem of stigma is to address the problem of violent behavior.

6. The funding system for psychiatric services guarantees the failure of the services. Because of the Medicaid IMD exclusion, states save money by closing states hospital beds and dumping patients into the streets. There are no fiscal incentives to provide good services, but many incentives to deny services.

7. Pharmaceutical companies charge excessive prices and make excessive profits. Psychiatric drugs don't have to be this expensive. They are far less expensive

in other countries. In France, risperidone costs half as much as in the United States; you can get olanzapine in Canada for half of what it will cost you here; and you should go to Germany or Spain if you need clozapine — it is one third as much in Germany and one sixth as much in Spain.

Pharmaceutical companies' profits are higher than those in any other U.S. industry. And the CEOs of these companies get big paychecks. The CEO of Johnson & Johnson, maker of risperidone, took home \$3.2 million in 1997; the CEO of Eli Lilly, maker of olanzapine, brought home \$7.4 million that same year; the CEO of Pfizer, which produces ziprasadone, pocketed a cool \$14.5 million.

These rapidly rising drug costs have devastated the budgets of mental health centers.

8. For-profit managed care has almost nothing to do with care. Rather, it is managing costs. The average psychiatric hospital stay has decreased from 3½ weeks in 1990 to 1½ weeks in 2000. Yet it takes 30 percent of patients an average of 2 weeks to respond to medication.

Magellan Health Services provides psychiatric care for patients in seven states — including Maryland, Tennessee, and previously Montana, where that "care" is a disaster. But financially, Magellan is doing extremely well. Their CEO received compensation of \$4.9 million in 1999 and for the nine months ending June 2001, their revenues rose 9 percent to \$1.32 billion.

And the CEO of the United Health Care group received total compensation in 2000 of \$54.1 million, not including unexercised stock options. That is equal to or greater than the total mental health budget of nine states (Alaska, Delaware, Idaho, New Mexico, North Dakota, South Dakota, Vermont, West Virginia, and Wyoming.)

***"Though the physicians had predicted that their attendance [at the all-expense paid symposia] would not affect their prescribing practices, their prescriptions for one drug increased 87 percent and for the other, 272 percent."***

— from E. Fuller Torrey's article "The Going Rate on Shrinks: Big Pharma and the Buying of Psychiatry," *American Prospect*, July 15, 2002.

***"Families are so desperate to have a member, usually it's a son, hospitalized that I will advise them to have him arrested. But every time I do that, I know what the risks are. They may be beaten or assaulted in jail, and they may commit suicide or end up with a criminal record they don't deserve. But you have to get them in a place you hope is safer than the streets. It's not much of a choice, is it? But when you see the child you love disappearing into madness, what do you do?"***

— Lynne M. Shuster, local coordinator of the National Alliance for the Mentally Ill, Buffalo, New York. From "Jails struggle with a flood of mentally ill offenders," *Buffalo News*, July 22, 2002.

#### WHAT IS THE ANSWER?

Advocacy is the basis for hope in the future. Dr. Torrey ended his presentation by charging the audience to be wolves, not sheep; to be the people who make noise; to not let anyone get away with anything. As Benjamin Franklin said, "He that lives upon hope [alone] will die fasting."<sup>14</sup>

***TAC ON THE WEB:*** For a copy of Dr. Torrey's slides from the presentation, which include citations, visit TAC's web site at [http://www.psychlaws.org/general\\_resources/EFT\\_NAMI\\_Cincinnati\\_June2002.pdf](http://www.psychlaws.org/general_resources/EFT_NAMI_Cincinnati_June2002.pdf). [Please note that this file is in PDF format; you will need a free copy of Adobe Acrobat to open it. You can get a copy of this program at <http://www.adobe.com/products/acrobat/readstep.html>]

## Did You Know?

Suicide by inmates with schizophrenia or manic-depressive illness is relatively common. For example, data collected from New York State jails between 1977 and 1982 showed that half of all inmates who committed suicide had been previously hospitalized for treatment of a serious brain disorder. And in June 2002, the *Los Angeles Times* reported that suicides in California jails had reached an all-time high. They noted that "In 1983, when the previous peak was reached, inmate suicides accounted for nearly half the total of 85 deaths in California jails."

For each completed suicide in jails, there are many others that are uncompleted. According to a chief psychiatrist in the Los Angeles County Jail, the ratio of failed suicide attempts to deaths by people with untreated brain disorders is about 20 to 1.

### **Suicide in individuals with schizophrenia and bipolar disorder: How many lives could be saved if treatment were available?**

Suicide accounts for approximately 29,000 deaths each year in the United States. Two different methods of analysis both suggest that at least 5,000 of the individuals who commit suicide have schizophrenia or bipolar disorder at the time of their suicide. Other studies indicate that most of these individuals were not receiving adequate psychiatric treatment at the time of their death. It is concluded that adequate psychiatric treatment could save up to 5,000 lives per year.

Excerpts of TAC's recent briefing paper on this subject appear below.

#### **WHAT PERCENTAGE OF INDIVIDUALS WITH SCHIZOPHRENIA AND BIPOLAR DISORDER KILL THEMSELVES?**

- ◆ Estimates of the completed suicide rate for individuals with schizophrenia range from 10 to 13 percent.

- ◆ Estimates of the completed suicide rate for individuals with bipolar disorder are approximately 15 percent. Between 25 and 50 percent attempt suicide at least once.

- ◆ A recent reevaluation of studies of

suicide and mental disorders concluded that many of the previous studies were methodologically flawed. It estimated that approximately 5 percent of individuals with schizophrenia and bipolar disorder commit suicide, and that the suicide rate for individuals with severe psychiatric disorders is 7 to 10 times the rate in the general population.

**“THERE ARE HUNDREDS OF COMMUNITY-BASED CRISIS CENTERS AROUND THE UNITED STATES. EACH HAS AT LEAST ONE TELEPHONE NUMBER TO ESTABLISH AND PUBLICIZE IN THEIR AREA, AND THE RESULT CAN BE AN ACCESSIBILITY NIGHTMARE.”**

**— SEE STORY ON PAGE 8.**

- ◆ Incidence studies of schizophrenia and bipolar disorder suggest that there are approximately 110,000 new cases of these diseases (combined) each year in the United States. If the completed suicide rate for individuals with these diseases is approximately 5 percent, that would mean that approximately 5,000 individuals with schizophrenia and bipolar disorder commit suicide each year in the United States.

#### **WHAT PERCENTAGE OF INDIVIDUALS WHO COMMIT SUICIDE HAD SCHIZOPHRENIA OR BIPOLAR DISORDER AT THE TIME THEY COMMITTED SUICIDE?**

This asks the same question as #1 above, but asks it in a different way.

- ◆ The total number of suicide deaths in the United States in 1999 was 29,199. There were also 16,899 homicides in the United States, so suicides outnumbered homicides 5 to 3.

- ◆ The only major study of psychosis and suicide was done in St. Louis in 1956-1957. During one year, 134 individuals committed suicide, and 19 percent of them had symptoms of psychosis (mostly delusions) in the month preceding their suicide. This percentage should be considered to be conservative, since the study

was carried out prior to massive deinstitutionalization, when most of the most seriously mentally ill individuals were still hospitalized and thus less able to commit suicide.

- ◆ If that percentage, admittedly conservative, was true in 1999, then 19 percent of the 29,199 completed suicides, or 5,548 individuals who committed suicide in 1999, were psychotic at the time they committed suicide.

The conclusions reached by both sets of analysis are thus consistent: At least 5,000 individuals who commit suicide each year are psychotic at the time of their suicide.

**IS THERE A RELATIONSHIP BETWEEN SUICIDE IN INDIVIDUALS WITH SEVERE PSYCHIATRIC DISORDERS AND THEIR FAILURE TO RECEIVE TREATMENT?**

There are suggestions in several research studies that suicide is much more likely to occur in those individuals with schizophrenia and bipolar disorder who are not being adequately treated or not being treated at all:

◆ A study of 92 individuals with schizophrenia who committed suicide reported that 78 percent of them "were in the active phase" of their illness, with many symptoms at the time of the suicide.

◆ A study of individuals with schizophrenia who made serious suicide attempts reported that 81 percent of them had "positive psychotic symptoms at the time of attempting suicide."

◆ A study of 187 individuals with schizophrenia who attempted or committed suicide reported that "two positive symptoms (suspiciousness and delusions) were more severe among successful suicides."

◆ In a study of suicide among psychiatric patients, it was reported that "42 of the 59 patients (71.1%) who were depressed in their last episode [of hospitalization] were not receiving adequate antidepressant or lithium carbonate medication at the time of suicide."

◆ A case control study of 149 individuals (70 percent diagnosed with schizophrenia or major affective disorder) who committed suicide within five years of psychiatric hospitalization compared to 149 individuals who did not reported that "the main finding . . . is that suicides in people with mental illness were associated with reductions in care at the final service contact before death." The reductions included lowering the dose of medication,

less supervision, and reduced frequency of appointments.

◆ A case control study of 63 individuals with schizophrenia who committed suicide and 63 individuals with schizophrenia who did not reported that "there were seven times as many patients who did not comply with treatment in the suicide group as there were in the control group."

◆ Recent studies have suggested that some antipsychotic medications, and especially lithium, may decrease the incidence of suicide among individuals with severe psychiatric disorders. <sup>10</sup>

**TAC ON THE WEB:** Visit TAC's web site to see the full paper, with citations, at <http://www.psychlaws.org/BriefingPapers/BP6.htm>.

***"At least 5,000 individuals who commit suicide each year are psychotic at the time of their suicide."***

"A delusion by definition is a false belief. A person thinks he's part of the CIA or the Mafia's out to get him, whatever . . .

Now if you believe it, to you, it's not false, is it? And therefore, how can you see that you have a symptom? You can't. And therefore, somebody tells you you're mentally ill.

- ◆ Why am I mentally ill?
- ◆ Because you believe you're in the CIA.
- ◆ I am in the CIA.

So it virtually becomes impossible for the person with the disorder to understand that he has the disorder."

— TAC board member Fred Frese explains anosognosia on ABC's "UpClose with Ted Koppel," August 2, 2002.

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**Crisis Services and the  
National Hopeline Network**

*by H. Reese Butler and Karen M.  
Marshall, special to Catalyst*

Five years ago, a distraught Midwestern woman whose life was piled high with difficulties that seemed too much to bear recorded in her diary a last-ditch attempt to reach out for help. She dialed 1-800-SUICIDE, but the call went through to a telemarketing company that "hordes" telephone numbers.

Two days later, she ended her life.

Contrast that with a June 1999 call to 1-800-SUICIDE placed by a 16-year-old girl from Los Angeles. She had taken an overdose of pills and had sliced her wrists, and was losing consciousness. Also in a last-ditch attempt to reach out for help, she dialed 1-800-SUICIDE. Her call was answered by the crisis line staff of the Los Angeles-based Suicide Prevention Center, part of Didi Hirsch Community Mental Health Center. Her call was traced, an ambulance dispatched, and her life was saved.

Since the National Hopeline Network 1-800-SUICIDE (784-2433) was launched about three years ago, calls have increased dramatically, from an average of 100 a day to nearly 1,000 a day - all with very little publicity. As the number of calls has risen, so has the number of certified crisis centers that have joined the network - from eight in May 2000 to more than 70 today.

The National Hopeline Network is the first major project of The Kristin Brooks Hope Center, started by H. Reese Butler shortly after the April 7, 1998 suicide of his 28-year-old wife, Kristin Brooks Rossell. The Hopeline links those who call 1-800-SUICIDE to their nearest American Association of Suicidology (AAS) certified crisis center.

In just more than a year, the network has grown from eight crisis centers to more than 70, with dozens more in contracting phases.

Accessibility has been an impediment to some looking for crisis services, to family members worried about someone who seems despondent and perhaps suicidal, and to those seeking treatment for depression and other brain diseases. Crisis centers also maintain resource lists

that include grief groups, homeless shelters, and other services for people in search of them.

"There are hundreds of community-based crisis centers around the U.S.," notes Karen Marshall, president of the organization. "Each has at least one telephone number to establish and publicize in their area, and the result can be an accessibility nightmare."

Callers to the Hopeline Network reach a suicide crisis center staffed by volunteers and/or paid professionals who receive a minimum of 60 hours of training about de-escalating psychological crises and how to intervene if a suicide seems imminent. Callers are assessed with lethality scales, then referred on for mental health treatment or other services as appropriate.

Butler noted that only about 10 percent of the nation's active crisis centers are certified by independent agencies. "Under this grant and our partnership with AAS, up to 300 more crisis centers across the country will gain certification and join the network. This can only mean an increase in the quality of crisis center services across the board."<sup>10</sup>

*For more information about the Hopeline Network or the Hope Center, call 540-338-5756, email Reese@hopeline.com or Karen@hopeline.com, or write The Kristin Brooks Hope Center, 609 E. Main St., Unit 112, Purcellville, VA 20132. The Center's web site is www.hopeline.com.*

***A call to  
1-800-SUICIDE  
(1-800-784-2433)  
will automatically  
route your call to  
your nearest local  
certified crisis  
center.***

## "Act of God" people — Knitting a new life

by Gunther Stern, director of The Georgetown Ministry Center, special to Catalyst

A few years ago, a group of homeless outreach workers, including me, were sitting around talking about the homeless we have the most difficult time with. The ones that refuse our offers of help or who take us up only to come back to the street in short order. The most chronic. Someone coined the phrase "the act of God people," the ones who would die on the street but for an act of God. We have our "act of God people" here in Georgetown. Everyone knows them. They are colorful and ubiquitous. Some of them you can smell a block away, others you can hear three blocks away. I have always worried about each of them and wondered how we might effect change.

Our "act of God people" have been around for more years than I have. We have watched them, helpless to intervene, scrounging food from trash cans, insulting passersby, or risking illness or even death sitting outside on the coldest nights.

A few years ago, I was thinking about one of the homeless mentally ill people I have known for years. He was sick, and I worried he would die on the street. If only I could just get that guy off the street my work would have real meaning.

He had been on the street over 10 years. He wandered aimlessly throughout the city. He came into our shelter and tried one of the newer medicines despite past bad experience with older ones. He took it for a few days and then stopped. We asked him if he wanted more; he took it and lost it. We offered him more and he took it for a few days and then forgot about it. This went on for months. Each time he took it for a longer period. We referred him to a program, but the case worker didn't show up consistently. He left the program, but he continued to take the medicine and get better. We referred him to another program and things went better. This "act of God person" now lives in an

apartment with a roommate and is doing really well.

Over the past couple of years, the system has become more responsive to the involuntary hospitalization order that psychiatrists and certain trained public employees can write.

As a result, some of the most conspicuous Georgetown homeless have recently disappeared from the street. These are "act of God people." People we have all gotten to know and either care about or just wish they would go away. They made scenes, yelled obscenities, or just smelled bad and did things no one wanted to see. Three in particular have been fixtures in Georgetown for the entire 12 years I have worked here. They had friends in Georgetown who looked after them, seeing that they were warm and fed. People asked us: Why can't you help them?

Recently we came back from a visit to one of these "act of God people" at St. Elizabeth's Hospital. She is now taking medication and doing remarkably well compared to her condition just two weeks before. She has incredible insight into her

illness and recognizes, at least for now, that she will have to take the medicine for the rest of her life. She wants housing. She wants a sewing machine and a breadmaking machine. She has begun to knit. She can have knitting needles only during free time, known as "privileges." They worry others will take the needles to use as weapons; they don't worry about her.

I think of myself as a civil libertarian, but I can't understand how we can have laws that protect people's right to be psychotic on the street when we know that this kind of outcome is possible. <sup>61</sup>

*The Georgetown Ministry Center is a "community response to homelessness" in the Georgetown area of Washington, DC, offering or helping those in need secure intensive outreach, mental and physical healthcare, shelters and transitional housing, job training and placement programs, legal assistance, and disability benefits. More information about Mr. Stern's remarkable organization is on the internet at [www.georgetownministrycenter.org](http://www.georgetownministrycenter.org).*

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### Seen in *The Washington Post*

For much of his life, Robert Matthew Pomeroy struggled with bipolar disorder, depression and drug abuse. He was in and out of Northern Virginia mental health facilities, rehabilitation programs and jail. He seemed to deteriorate even more after his mother was struck and killed by a bus in late January. ...

The [shelter] ... where he was staying sent him to a hospital, which medically cleared him and sent him back. When he began mutilating himself with a razor, the shelter referred him to [a nearby mental health center]. But the center determined that Pomeroy did not meet the "imminent danger" standard and sent him back to the shelter, which then refused to readmit him because officials believed he was suicidal and might traumatize other residents, social workers said. He spent the next few days in the nearby woods before killing himself.

"This is just one of several examples of tragic deaths of mentally ill homeless people," said a social worker who did not want to be named because of the confidentiality rules. ... Another social worker who also did not want to be identified summed up the central contradiction in Pomeroy's case: "If he was dangerous enough to create a liability, then he was sick enough to need help."

—*The Washington Post*, "Mentally Ill Find More Doors Shut: Strict Treatment Rules Can Exacerbate Despair," June 24, 2002

(continued from page 1)

although more than a score of states have clinically-based criteria — only one state supreme court had ruled on such a challenge before *Dennis H.* Washington State's highest court upheld a standard similar to that of Wisconsin in 1986.

The Fifth Standard was secured by Wisconsin advocates in 1995. It allows a person rendered incapable of making informed medical decisions to be placed in treatment if a court finds a substantial probability that "if left untreated" he or she will "lack services necessary for his or her health or safety and suffer severe mental, emotional or physical harm that will result in the loss of the individual's ability to function independently in the community or the loss of cognitive or volitional control over his or her thoughts or actions."

The standard essentially permits the placement in psychiatric care of a person who is unable to make rational treatment decisions and likely to seriously suffer as a consequence. Although not identical, the criteria are similar to those in the Treatment Advocacy Center's Model Law.

While they attacked the Fifth Standard on a number of legal fronts, the central assertion of the opposing lawyers in *Dennis H.* was that the statute is unconstitutional because it lacks a requirement of imminent danger to self or others.

Those who seek to stymie treatment law reform consistently put forth the 1975 decision of the U.S. Supreme Court in *O'Connor v. Donaldson* as forbidding any commitments not based on the danger of immediate physical harm. Although the opinion in that case twice says that it does not apply to hospitalizing someone in order to "alleviate or cure his illness," the attorneys attacking the Fifth Standard predictably relied on that persistently asserted but long unproven interpretation of *O'Connor*.

The seven members of the Wisconsin Supreme Court did not buy it, ruling that "The Fifth Standard thus fits easily within the *O'Connor* formulation: even absent a requirement of obvious physical harm such as self-injury or suicide, a person may still be 'dangerous to himself' if 'he is helpless to avoid the hazards of freedom either through his own efforts or with the aid of willing family members or friends.'"

Rather than using *O'Connor* to strike down the Fifth Standard, the court used the case to justify it.

Moreover, the justices clearly looked not just at the law but also to the compelling need for timely treatment interventions. According to the Wisconsin Supreme Court's unanimous ruling:

"Mentally ill persons who meet the Fifth Standard's definition are clearly dangerous to themselves because their incapacity to make informed medication or treatment decisions makes them more vulnerable to severely harmful deterioration than those who are competent to make such decisions. The state has a strong interest in providing care and treatment before that incapacity results in a loss of ability to function."

"The Fifth Standard applies to mentally ill persons whose mental illness renders them incapable of making informed medication decisions and makes it substantially probable that, without treatment, disability or deterioration will result, bringing on a loss of ability to provide self-care or control thoughts or actions. It allows the state to intervene with care and treatment before the deterioration reaches an acute stage, thereby preventing the otherwise substantially probable and harmful loss of ability to function independently or loss of cognitive or volitional control. There is a rational basis for distinguishing between a mentally ill person who retains the capacity to make an informed decision about medication or treatment and one who lacks such capacity. The latter is helpless, by virtue of an inability to choose medication or treatment, to avoid the harm associated with the deteriorating condition."

The Treatment Advocacy Center and TAC board member Kenneth Kress each filed an *amicus curiae* brief in *Dennis H.*, and TAC Executive Director Mary Zdanowicz was given the exceptional privilege of presenting to the court during oral argument.

Apparently, the court was listening. <sup>910</sup>

**TAC ON THE WEB:** Links to the court's opinion in *State v. Dennis H.* as well as the *amicus* briefs filed by the Treatment Advocacy Center and by TAC board member Kenneth Kress are in the "Wisconsin State Activity" section of the web site at <http://www.psychlaws.org/StateActivity/Wisconsin/StatesvDennisH.htm>. For more on the Treatment Advocacy Center's model law, visit the "Legal Resources" area, specifically, <http://www.psychlaws.org/LegalResources/ModelLaw.htm>.

## What is an *amicus curiae* brief?

*Amicus curiae* is Latin for "friend of the court." Only the actual parties to an action normally file legal briefs. At times, however, a court will allow a person, group, or organization with expertise in the subject matter of a case or with a strong interest in its outcome to file an "amicus brief." Most commonly, these briefs are filed in appellate cases where the decision will impact the public interest. Unlike those of parties, *amicus* briefs need not address each and every legal point of a case. That, combined with the strict limits on the length of briefs, offers the ability to more thoroughly develop a given point than the named parties. It also means that a key decision is to determine what points to write on.

In this case, the legal issues were already strongly represented between the party brief of the Wisconsin Attorney General, representing the state, and the *amicus* one of TAC board member Kenneth Kress, who is a professor of law at the University of Iowa. So the Treatment Advocacy Center decided to focus on why the Fifth Standard is so needed.

We wrote of the ravages caused by untreated severe mental illness, how anosognosia can leave someone psychotic yet unaware that they are, the incredible progress in the effectiveness of medications, and how the Fifth Standard was necessary for Wisconsin to make use of less restrictive court-ordered treatment in the community. If it seems like we put forth policy arguments in a legal proceeding, you are right. Although they probably will never admit it, the members of any high court know that they make policy. They also tend to want to make the right policy.

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