



Catalyst

A Newsletter from the Treatment Advocacy Center

WINTER 2011

Confusion about Civil Commitment Standards – A Factor in Tucson, An Issue for Advocates

The rampage that left six dead and 13 injured in Tucson on January 8 has turned civil commitment standards – under which people with severe mental illness are court-ordered into treatment – into a subject of public discussion. While the Treatment Advocacy Center has long promoted greater awareness of these standards, the discourse surrounding alleged gunman Jared Lee Loughner has been riddled with misconceptions and misunderstanding that require correction.

The most serious of these misconceptions concerns the so-called “dangerousness” standard – the requirement that an individual with severe mental illness demonstrate an immediate, physical danger to self or

others before a court can intervene and order treatment. Many media outlets reported that since Loughner hadn’t previously shown outward signs of dangerousness (i.e., violent threats or acts), intervention in his apparently deteriorating mental health was not possible. In Arizona, as in most U.S. states, this is simply not true. Despite widespread misconceptions to the contrary, 42 states have laws that permit intervention based on other criteria that are broader than the familiar “dangerousness to self or others” standard. The specifics vary but generally include a second standard, referred to as “grave disability,” that focuses on the person’s inability to meet his or her basic survival needs.

From what has been published, it appears that Loughner was living safely in his parents’ home and would not have been committable as “gravely disabled.” However, in Arizona – as in about half the states – there is a third provision under which a court can intervene in a mental health crisis: the “need for treatment” standard. Need-for-treatment standards are typically based on a person’s inability to provide for needed psychiatric care, or an inability to make an informed medical decision, or the need to prevent further psychiatric or emotional deterioration. These provisions are particularly relevant for individu-

als who lack insight into their illness (the neurological syndrome known as “anosognosia”) because they focus a court’s attention on needless personal suffering from which the person is incapable of seeking relief. In Arizona, for example, the law permits intervention for a person who is “persistently or acutely disabled,” which is defined in detail in the state code. Under this progressive need-for-treat-

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ment standard, it may well have been possible for college officials, the local mental health department, a family member, or even an acquaintance to bring Loughner’s condition to the attention of the court.

In the wake of the tragedy, the Treatment Advocacy Center has been asked repeatedly, “What could have been done to prevent this event?” The question has at least three responses.

- It is essential that the public and public officials be better informed about the legal tools available in a mental health crisis prior to the point of dangerousness. At a practical level, misunderstanding and misinformation about the need for proof of dangerousness

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ARIZONA SHOOTING: Responding in Real Time

The email from board member Carla Jacobs to Treatment Advocacy Center staff was time-stamped 1:29 pm January 8, barely three hours after Jared Lee Loughner opened fire on U.S. Congresswoman Gabrielle Giffords and the crowd surrounding her in a Safeway parking lot in Tucson. “Is he one of our own?” Carla asked. With that, one of the more intense two weeks of the organization’s history began, a period that vividly illustrates one of the strategies we use in our quest to eliminate barriers to treatment for severe mental illness.

Carla’s question is the one we always ask ourselves whenever we hear news like the bulletins that were emanating from Arizona that Saturday: Was this a tragedy that could have been prevented with timely identification and treatment for a severe mental illness? And, if so, what needs to be changed to avoid a repeat?

We ask those questions because, tragic as events like the Tucson shooting are, they represent a “teachable moment” for the Treatment Advocacy Center, a time when news coverage of an awful event gives us an opportunity to get our message in front of millions of people, including lawmakers and mental health professionals.

In the world of 24/7 news cycles, the moment can be fleeting. By early Sunday morning, our staff was on the telephone, hammering out an action plan. I would contact our founder – scientist and author E. Fuller Torrey, M.D. – to find out whether he believed that Loughner was likely to be suffering from an untreated mental illness. Communications Director Doris Fuller (see related story, p. 8) would go straight to our Arlington, Virginia, offices to develop a public statement. Everyone would be on call to review the statement immediately.

The building that houses our offices isn’t heated on the weekends, and the day was frigid. When I reached the office to field any media calls that came in, Doris was already shivering at her computer as she emailed individual reporters with Dr. Torrey’s characterization of the tragedy as “psychiatric, not political” along with facts the Treatment Advocacy Center was uniquely equipped to provide about the mental health system in Arizona. It was long after dark before she left.

The next morning, our phones barely stopped ringing. Every major television network, public radio and every national newspaper turned to us for information about mental health laws, standards and treatment in Arizona, and research about the connection between violence and untreated mental illness. When *New York Times* columnist David Brooks prominently cited Dr. Torrey in his

Tuesday column, and the *Wall Street Journal* on Wednesday ran Dr. Torrey’s op-ed, the media torrent reached a high watermark. Dr. Torrey was scheduled onto CBS, CNN and an ABC affiliate. Policy Director Brian Stettin took PBS, MS-NBC and Fox. Every one of our legal advocates and I fielded radio, newspaper, magazine and wire service requests for information and comment. Not every story that ran quoted our experts or studies by name, but scores of stories contained data and other information the Treatment Advocacy Center researched, developed and supplied.

News events tend to develop a narrative. The first narrative to emerge from the Tucson shootings was that political vitriol had crystallized into violence. This one was quickly eclipsed by ours: that untreated severe mental illness has consequences. That the consequences can include violence. That treatment works to pre-empt consequences, including violence. That Arizona has a good treatment law, but any law is only as good as its implementation, and Arizona’s implementation was inadequate. That dismantling the treatment system for severe mental illness had left the state ill-prepared to intervene even if implementation were better.

We often remind ourselves that we can’t influence the conversation unless we are in it. By Thursday following the shootings, a USA Today/Gallup poll found that 53% of Americans blamed the shootings on the mental health system. We can’t take all the credit for that recognition, but we believe we can take some of it.

Our challenge now – and the challenge of every grassroots advocate who supports us – is turning the conversation into action for better treatment laws and their use. In this issue of *Catalyst*, you will find some of the facts and messages we use in the conversation. We hope you will embrace them as your own and use them to push for action that will help eliminate barriers to treatment wherever you live.

Do keep in touch,

Jim Pavle, Executive Director

Catalyst

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STATE BUDGET CUTS TO TREATMENT FOR SEVERE MENTAL ILLNESS: *Crisis and Opportunity*

In the rush to blame following the Arizona shootings, one popular target has been the state's mental health budget cuts. Whether state spending was a factor or not in this particular tragedy, the darkening fiscal picture for state governments nationwide is clearly raising new barriers to treatment for those with severe mental illness. Psychiatric beds – already at historic lows – are being reduced further. Entire hospitals are being closed or threatened with closure. Emergency-room holds for people with acute symptoms are ballooning into days and even weeks in the absence of open inpatient beds. Prescription-drug coverage for low-income patients is being eliminated – slashing the lifeline to sanity and functionality for thousands of people.

In such a fiscal environment, it is more imperative than ever for mental health systems to include assisted outpatient treatment (AOT) in their approach to community-based care. This need stems from two simple facts:

- Assisted outpatient treatment vastly improves treatment outcomes for its target population, which leads to savings in the avoidance of the costly consequences of non-treatment. E.g., a recent independent study of New York's AOT program found that, for the program's high-risk population, AOT cut both the likelihood of being arrested and the likelihood of hospital admission by about half.
- Without assisted outpatient treatment, a sizable portion of any amount spent on community-based services goes to waste because some of the intended recipients are not capable of accessing those services at all.

The darkening fiscal picture for state governments nationwide is clearly raising new barriers to treatment for those with severe mental illness.

Budget freefalls and budget cuts

Virtually all states are required by law to balance their operating budgets annually or biannually. As a result, unlike the federal government, states cannot maintain services during an economic downturn by running a deficit. State government revenues have been in a freefall because of falling tax revenues and pension fund investment losses, according to the Census Bureau. Revenues available for states to fund programs, including mental health care, plunged almost 31% between fiscal 2008 and 2009; dismal economic projections and the scheduled expiration of federal assistance to state Medicaid programs in June may lead to even deeper cuts in fiscal year 2012 budgets.

In this environment, every public program funded directly by states is subject to possible reduction. Already, budget cuts have impacted all major areas of state services in at least 46 states plus the District of Columbia since 2008, according to The Center on Budget and Policy Priorities. Health care – the category that includes mental health treatment – has been reduced in 31 states.

Even for policymakers untroubled by pangs of conscience, reducing public expenditures on mental health

is tricky business. Cuts made on the service side have a way of coming back to bite when the consequences of non-treatment are factored into the equation. Consider:

- Emergency room visits: A study of Medicaid beneficiaries in 10 states found that psychiatric patients who did not receive prescribed medications visited emergency rooms 74% more often than those who did. One example of what this looks like in practice comes from Austin, Texas, where nine people – seven of them with mental illness – generated 2,700 emergency room visits over six years at a cost of \$3 million to taxpayers and others.
- Hospitalization: A study of Medicaid beneficiaries with schizophrenia found that people not in treatment were 66% more likely to be hospitalized for psychiatric care and about twice as likely to be hospitalized for any medical care as those receiving treatment.
- Incarceration: An estimated 16% of the U.S. jail and prison population are people with severe mental illnesses. These individuals are incarcerated for more time than other inmates and are more likely to recidivate once released. States on average are spending 2.5% of their budgets to imprison persons with mental illness, most of whom would not be incarcerated if they were in treatment.
- Homelessness: *Psychiatric Services* recently reported that it costs \$22,372 per person to provide public services to 438 mentally ill homeless individuals in

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AROUND THE States



Minnesota

To escape the punishing fiscal impact of the federal government's "IMD exclusion," which prohibits Medicaid matching payments to "Institutions for Mental Disease ("IMDs")," Minnesota embarked on an experiment in 2008. Mindful that federal law defines an IMD as an inpatient facility with more than 16 beds and at least 51% of its patients under treatment for severe mental illness, Minnesota lawmakers established ten new 16-bed "Community Behavioral Health Hospitals" across the state, and the Department of Human Services proceeded to transfer severely mentally ill patients to them from the large state hospitals. In addition to unlocking Medicaid matching funds to subsidize costs, it was hoped that the transition would lead to friendlier, more individualized care.

Two years later, that brighter day has yet to arrive. *The (Minneapolis) Star Tribune* reports that "[t]he experiment hasn't quite worked out as planned. The 16-bed hospitals have been bedeviled by assaults, patient-on-patient confrontations and other safety problems that often required them to rely on local police rather than trained staff for security. Just last month, a patient at the Fergus Falls hospital hijacked a van while in transit, triggering a chase that ended only when police crashed into his vehicle."

The rate of assaults against facility staff has doubled, raising the ire of the staff members' union. The problems have also caught the attention of federal regulators, holding up millions of dollars of the very federal support that the policy change was intended to make available. Of the 10

facilities established, one has already closed and two others have been converted to other forms of care.

Debate is swirling within Minnesota's mental health system as to whether the notion of moving severely ill patients out of large secure hospitals was inherently flawed or if the problems are attributable to missteps in implementation that might still be corrected. DHS maintains that improvements have already resulted from its new efforts to block transfer of the most violence-prone patients and to train staff in avoiding physical confrontations.

Whatever the fate of Minnesota's change in hospitalization policy, the Treatment Advocacy Center looks forward to a time when such decisions are based strictly on what is deemed best for patient care and staff safety – uncorrupted by the dire need to plug holes in state budgets. That cannot happen until Congress sees fit to repeal the discriminatory and inhumane IMD exclusion.



Vermont

In Vermont, frustration is mounting over the length of time required to obtain a court order to administer medicine to a person who refuses treatment while hospitalized for mental illness. Vermont is hardly alone among states in requiring court approval before a committed person may receive medication over objection, but the legal process there takes far longer than it does elsewhere. In 2008 and 2009, the median length of time from court-ordered hospitalization to receipt of a treatment order was 84 days, according to a report in progress by Dr. Thomas A. Simpatico, professor of psychiatry and director of the University of Vermont Division of Public Psychiatry. The range was 44 to 746 days.

During these periods, patients with illnesses that cause them to refuse medication are essentially "warehoused" in the Vermont State Hospital. Not only are they denied an opportunity to get better and return home – they actually get sicker, and

To learn more about how you can help bring mental health treatment reform to your state, visit our website.

their odds of recovery diminish. (It is widely accepted that shortening the period of untreated psychosis is particularly important during the early stages of brain diseases like schizophrenia.) Hospital injury records establish that they also pose an increased danger to staff and fellow patients.

Encouragingly, there appears to be growing determination within Vermont's mental health community to identify and correct the causes of delay. Dr. Simpatico, NAMI-Vermont, and others are leading a charge to amend Act 114, the state law that dictates the medication-over-objection process. Among several proposals under consideration: allowing the court to weigh hospital commitment and medication over objection together, in a single hearing.

The advocates plan to have a reform bill introduced in the current session of the state legislature.



Colorado

A recent staff brief from the Joint Budget Committee of the Colorado General Assembly reported that of the 103,761 Colorado adults known to have both serious mental illness and incomes low enough to qualify for state-funded treatment (below 300% of the federal poverty line), *more than 71,000 – 69% – have not accessed any of the services to which they are entitled.*

The brief recommends that the committee "determine what measures the Department of Health Care Policy and Financing and the Department of Human Services are undertaking" to address this vast unmet need. Of course, before these agencies can

Around the States

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picked her up.... But they said that (they) couldn't hold her...."

According to a cousin who also spoke to the *Union Leader*, Ray is a registered nurse who put herself through college and a single mother who "took care of a chronically sick child his entire life." She reportedly had no history of violence before allegedly stabbing Doane to death.

Massachusetts is one of only eight states that do not permit hospital commitment without proof of a person's dangerousness to self or others. It is also one of only six states that do not authorize assisted outpatient treatment. To learn more about how you can help bring mental health treatment reform to your state, visit our website.



Hawaii

The good news:

Hawaii has a good assisted outpatient treatment law.

The law authorizes court-ordered intervention "to prevent a relapse or deterioration which would predictably result in the person becoming imminently dangerous."

The bad news: Hawaii's assisted outpatient treatment law is rarely used. Instead of receiving life-sustaining treatment in the community, people with severe mental illness who are too ill to seek care too often end up consigned to homelessness and despair. Families report to us that when they ask the mental health system for help, they are told that nothing can be done until their loved one actually becomes dangerous.

This is a perfect illustration of the misconceptions and misunderstanding decried in the front-page issue of this *Catalyst*. The language of the law makes clear that it should be invoked when a person is on the road to dangerousness, well before he or she reaches that dreaded destination.

According to Eileen Uchima, executive director of NAMI-Hawaii, Hawaii's assisted outpatient treatment law is poorly understood by the very people and agencies charged with its implementation. As a result, families are routinely given erroneous information, leading to lost lives and lost hope.

This travesty won't be corrected until state residents demand better from their mental health system. Implementation of effective assisted outpatient treatment has been repeat-

edly shown to save lives. We encourage advocates to visit the Treatment Advocacy Center website and use it to educate others on the untapped potential of AOT.



Missouri

When a government official takes a public stand that accurately reflects the realities of severe mental illness, it's worth noting.

Such is the case with Cathy Richards, public administrator of Boone County, Missouri. In an interview with the *Columbia Missourian*, Richards aptly described the impact of budget cuts for those living with severe mental illness in words we can heartily second.

"You see, mental illness just doesn't go away because there isn't money available," she said. "To provide little or no services to this group just means that the mentally ill will receive their services through some other venue, like jails or emergency rooms. These services are much more expensive than governmental funding and a completely ineffective way to manage the mentally ill."

Cutting mental health programs for those with the most severe mental illnesses causes great suffering for the sufferer and all who love and care for him or her. Furthermore, it costs the public more in the long run because the illness doesn't evaporate with the cash flow. Please turn to page 3 to read about the Treatment Advocacy Center's view on state budget cuts.



Indiana

A tragedy that found its way to the Indiana Supreme Court demonstrates just how broken the state's mental health system is. In *Galloway v. State of Indiana*, the undisputed evidence was that Galloway suffered from bipolar disorder, often with severe psychotic and manic symptoms. Committed to a hospital on a short-term basis more than 20 times, he was released back to his parents each time after two weeks

State Ratings: We Need Your Input

The Treatment Advocacy Center is undertaking a rating of the states regarding services for the most seriously mentally ill individuals. The ratings project is being done with support from the Torrey Action Fund and will be released this summer. One of the items on which each state will be rated is a composite leadership assessment for the state commissioner of mental health, the governor and the state legislature.

How are these officials doing in your state? Do they care about issues involving severe mental illness? Or do they just cut the budget and not seem to worry that more seriously mentally ill individuals will end up on the streets or in jail as a result?

Please email your thoughts – both positive and negative – to Policy Director Brian Stettin (stettinb@treatmentadvocacycenter.org) before March 31.

Tragedies like the one that befell the Galloway family will be avoided only when the system gets serious about providing treatment to those in greatest need before they become dangerous.

of care. The trial and appellate courts found that, when he was hospitalized and treated, his condition stabilized but that he lacked insight into the need for his prescribed medication and thus consistently terminated its use. Absent medication, he would become enraged, unpredictable and violent.

The family's efforts to engage the mental health system were consistently futile. Over and over, Galloway was released without court-ordered outpatient treatment that would have provided appropriate monitoring of his condition. The result: In an untreated state, Galloway stabbed to death his grandmother – a person he dearly loved – in front of his aunt and teenage son.

In spite of expert testimony and evidence to support a defense of insanity, the trial judge convicted Gallo-

way of murder and sentenced him to 50 years imprisonment. In court, the judge conceded “there is absolutely no evidence that this mental illness is feigned or malingered or not accurate.... I can pick apart about twenty mental health records that were submitted to this Court where I would have begged a mental health provider to keep Galloway long term in a civil commitment, but they have not.” The judge cited the failure of the mental health system to address Galloway's illness as the basis for the decision to incarcerate him, deeming that incarceration was necessary to prevent the mental health system from once again releasing Galloway was ordered into the community where he would be untreated and unsafe.

The Indiana Supreme Court overruled the sentence, finding it improper to incarcerate on the basis of a broken mental health system. Galloway was ordered back to a psychiatric hospital.

One can only hope the strange case serves as a wake-up call to Indiana mental health officials. Tragedies like the one that befell the Galloway family will be avoided only when the system gets serious about providing treatment to those in greatest need before they become dangerous.

Budget Cuts

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Philadelphia – \$9.8 million/year or about 60% of the city's entire expenditure for the homeless. And that doesn't count all the services this population receives. With an estimated one-third of the entire homeless population nationwide suffering from untreated mental illness, these numbers are doubtless replicated in cities nationwide.

These consequences can be mitigated by maximizing the use of existing mental health services by those in the most dire need, *and that is precisely why assisted outpatient treatment must be part of the current fiscal debates.* AOT remains unauthorized in six states and is grossly under-used in nearly all of the 44 states and the District of Columbia where it has been signed into law. With circumstances forcing mental health systems to do more with less, advocates *everywhere* must make the case that assisted outpatient treatment is a critical form of “smarter spending.” For briefing papers and other resources to assist in advocating, email us at info@TreatmentAdvocacyCenter.org.

Commitment Standards

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delays or prevents intervention before an individual actually threatens or hurts someone, including him- or herself.

- It is imperative that the District of Columbia, Arizona, and the other 26 states with need-for-treatment standards actively implement them.
- The 23 states that still lack need-for-treatment standards must enact them. These standards are

designed to get desperately ill people help before they prove by word or action that they are dangerous or to get treatment for those who are clearly suffering from illness but display no outward signs of physical harmfulness. Lawmakers looking for a course of action in the wake of the Tucson tragedy would do well to examine the civil commitment laws in their states to make sure that they have and are actually utilizing “need for treatment” standards.

Public opinion and public policy grounded in misconception and misunderstanding create an environ-

ment in which people like Jared Lee Loughner inevitably can – and will – continue to unravel to the detriment of all. We at the Treatment Advocacy Center battle misinformation routinely in our work to eliminate barriers to treatment. Grassroots supporters can amplify our efforts by educating their public officials and local mental health professionals. By referring reporters to our website, by submitting corrective letters to editors and online comments whenever errors are spotted, and by advocating with well-informed calls and letters to elected officials, we can together lay a foundation for the prevention of additional senseless tragedies.

Profiles

IN TREATMENT ADVOCACY

Doris A. Fuller is an author and former journalist who joined the Treatment Advocacy Center in June 2010 as communications director.

Q: HOW DID YOU COME TO BE SO INVOLVED IN THE SUBJECT OF SEVERE MENTAL ILLNESS THAT YOU WANTED TO COMMUNICATE ABOUT IT FULL TIME?

A: Like countless other family members, legislators and even members of the media, I “found” the issue of severe mental illness – and ultimately the Treatment Advocacy Center – after someone I loved fell victim to it.

Before my daughter Natalie’s psychotic break at the end of 2009, I had been on a long and colorful professional road paved with the written word. I’d enjoyed a journalism career in which I leap-frogged from a small weekly newspaper in Southern California to a “woman’s news” editorship at a semi-weekly, then from a city hall reporting gig at a small daily to an investigative reporting stint at a regional daily. Eventually I reached the financial section of the *Los Angeles Times* – then the most widely read newspaper in the U.S. Reporting some of the biggest business stories of the 1980s was exhilarating and all-consuming – as much a lifestyle as a job. When I decided the lifestyle was incompatible with the needs of my young family, I left the newsroom but continued to live by the written word. Eventually, I co-authored several books with experts, most recently *Sensational Kids: Hope and Help for Children with Sensory Processing Disorder*, which I wrote with sensory pioneer Lucy Jane Miller, Ph.D.

My favorite book project, however, was the “inside job” I wrote with my then-teenaged children. *Promise You Won’t Freak Out* was a candid and comic look at parent-teen communication. At 19, my son Greg had almost “aged out” of the story and made only cameo appearances in the book. But Natalie, at 16, was a full partner in the writing and – once the book was published days before she graduated from high school – in hitting the road to appear on national and regional TV and radio and to give countless newspaper and magazine interviews, readings and speeches. She was a proud parent’s dream – excelling in school, sports and even representing our state in a national beauty pageant, blossoming on schedule from a child into a happy, productive young adult.

Then, at 22 and just short of her college degree in studio art, everything changed. On a late December day, without warning just moments after a photographer friend had finished uneventfully shooting some new family pictures, she launched into a stream of incoherent ramblings and

frenzied activity. Baffled and terrified, my family’s first thought was that she’d taken an illicit drug or was having a reaction to the ADD medication she’d been on for years. Her stepfather disabled her car, my son and I searched her room for something to explain her bizarre behavior. We all hoped that, by morning, she’d be fine. But when that first night had passed and morning came, it was clear that whatever possessed her was not wearing off. With her manic laughter and ranting in my ears, I frantically googled “psychotic break,” “mental illness,” “ADD medication side effects.” What I most desperately wanted was a perfect match for the word HELP!

Q: WHERE DID YOU FIND HELP AND WAS IT EFFECTIVE?

A: I marvel today when I read news coverage and blogs and public statements from organizations and individuals suggesting that people like my daughter and Jared Lee Loughner, the accused gunman in the Arizona shootings, are byproducts of oblivious or indifferent parents. Or that family members just need to have good heart-to-heart talks with unraveling loved ones to right the course.

Individuals who are manic or psychotic – and Natalie was both – suffer from brain disease and can no more be loved or talked out of being sick than can people with colds or cancer. My daughter was incredibly fortunate to live in a state with enlightened civil commitment standards that the Treatment Advocacy Center had advocated. It was equally fortuitous that she resided in a progressive college-town setting where university officials, law enforcement, the courts and the mental health department were receptive to a parent’s pleas for intervention and where they all quickly and forcefully mobilized around the goal of getting her into treatment.



Natalie and Doris in 2003

Within weeks of her initial break, Natalie was committed involuntarily to the state mental hospital, where she received appropriate care for more than two months before being released on medication. Like many people with severe mental illness, she didn't accept her diagnosis initially. Seven months later, she stopped taking medications and relapsed immediately and profoundly. Again, she was involuntarily committed and hospitalized, this time for more than 10 months. She was released last December and is benefiting from the structure of a group home as she continues stabilizing. We all have high hopes she will return to school within the year.

Q: HOW DID THESE EXPERIENCES LEAD YOU TO THE TREATMENT ADVOCACY CENTER?

A. I learned about the Treatment Advocacy Center while reading Pete Earley's *Crazy: A Father's Search Through America's Mental Health Madness*, one of the many books friends showered me with after the onset of Natalie's illness. Upon closing the book, I thought, "My dream job would be as communications director of this group." How serendipitous that when I then went to the website the same day, I found an opening for the position I now occupy.

The sages say no experience is ever wasted, and so it has been for me since joining the Treatment Advocacy Center. The skills acquired as a reporter, the knowledge of brain science gained writing a book on a neurological disorder, the heartbreak of parenting a young adult with severe mental illness, the experience of successfully mobilizing the mental health system to intervene on her behalf – all these come to our offices with me every day. In the days following Loughner's alleged shooting of 19 people in a Tucson parking lot, it was these experiences that enabled me to recognize in the unspeakable tragedy the opportunity to raise the visibility and advance the cause of issues that I and you and we live and work with daily.

The Killer and Me

(Editor's Note: The following op-ed was originally published in 2003 in the New York Post following a preventable tragedy in New York. Its message is no less relevant following the January preventable tragedy in Arizona.)

By Jonathan Stanley, J.D.

Member of the Treatment Advocacy Center board

From just inside the church door, the rifleman fired at strangers. One shot killed Eileen Tosner, a mother of five. Another fatally struck Fr. Lawrence Penzes at the altar. More would have been hit but for an ex-Marine's tackle.

By adopting new laws and using the ones it has, New York could have stopped those tragedies. I know: It could have been me in the back of that church. Peter Troy, sentenced for those Long Island murders last week, and I each have a severe mental illness. My untreated symptoms are not as consistently debilitating as Troy's schizophrenia, but my bipolar illness is the type with "psychotic features."

At the worst, I perched on a milk crate in the middle of a Manhattan deli, naked. Secret agents had followed me for three sleepless days and nights. They sought to capture me and study my powers – mind reading, telepathic control of animals, a mind-generated electronic beam. These had kept me free, but now I was cornered.

Fighting fire with fire, the agents directed radiation into the deli from a satellite dish. The floor seethed deadly. Only the crate insulated me. Stepping down brought pain, real and agonizing pain. Imprisoned on a milk crate, my running was over. I hadn't hurt anyone, but – with a slight shift in my delusion-controlled world – I would have.

Troy, 34 at the time of the shootings, had been on and off medications since his illness struck at age 21; it is the difference between him and me. With proper care, the symptoms of severe mental illnesses can be tamed, at least rendered manageable. Without it, they can overwhelm – sometimes so intensely that the afflicted harm themselves or others.

I didn't believe I was sick. Neither did nor does Peter Troy. This is no doubt the result of anosognosia, a physiological effect of severe psychiatric disorders that renders people incapable of assessing their condition.

Laws, mechanisms and resources must be available to intervene when such symptoms run unchecked. What of these there are failed Peter Troy, and almost did me.

Laws, mechanisms and resources must be available to intervene when such symptoms run unchecked. What of these there are failed Peter Troy, and almost did me.

Eleven months before he entered that church, a doctor at Bellevue Hospital determined and reported that Troy needed court-ordered and -supervised outpatient treatment pursuant to Kendra's Law, which permits involuntary treatment if a relapse is likely to bring harm to the patient or another person. But Troy had already left Bellevue and wasn't found. The haphazard investigation was wait-listed, then closed.

Kendra's Law has worked spectacularly – the state Office of Mental Health reported this year on those placed under an initial six-month court-order under the law: 77 percent fewer were hospitalized in the half-year after the treatment mandate

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Memorials & Tributes

October 8 – December 31, 2010

The Treatment Advocacy Center expresses our deepest appreciation to all who have supported our mission with donations in memory of a loved one or a friend, including to the many who give anonymously.

Lauren Andrew, Orlando, FL
Gillian Austin, Rockville, MD
Mary Ann Bernard, Moraga, CA
Jeanette Castello, Newtown, PA

Susan Cleva, Bellevue, WA
Michael Cohen, New York, NY
Ronald Comer, Wallingford, PA
MaryJane & Tom Coursen,
Fort Wayne, IN
Carol Craig, Los Angeles, CA
June Crouch, Huntsville, AL
Linda Davis, Holmes Beach, FL
Janice DeLoof, Fullerton, CA
Ann Eldridge, Santa Barbara, CA
Mildred Fine, Lynbrook, NY
Eric & Melinda Fitzcharles, Lexington, KY

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Jim Gobeski, Plymouth, MI
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Randall Hagar, Sacramento, CA
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Vastie Hazel, Spartanburg, SC
Norb & Beth Hoffman, Green Bay, WI
Ron Honberg, Rockville, MD
Marshall Horsman, Auburn, CA

Sylvia Hughes, Albuquerque, NM
Ulysses & Nancy James, Alexandria, VA
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Torrey Action Fund

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The Killer and Me

CONTINUED FROM PAGE 9

than were in the six months before it. And 85 percent fewer experienced homelessness, 83 percent fewer were arrested and 85 percent fewer were incarcerated.

But an unused law can't prevent catastrophe.

Troy was hospitalized again because of erratic behavior. This time, New York's inpatient-commitment law kept him from care: A judge denied a physician's application for continued hospitalization, for a person can only be held in a hospital if found to be a danger to himself or others.

That same standard threatened me. After being brought in from that deli, I was almost released from a psychiatric facility after the 72-hour observation period: I was deemed psychotic, but my flight from imagined adversaries was taken as proof both of my desire for self-preservation and lack of animus to others - I was no danger. But my father somehow got me to sign a voluntary admission form, saving me from another frenzied sally on the city's streets.

In authorizing hospitalization, other states look at the need for treatment, probability of deterioration, inability to function independently and incapability of making informed decisions. But New York law still refuses aid to those rendered irrational by psychosis in apparently non-threatening ways. If New York won't treat people in such conditions until they become dangerous, it will get dangerous people.

I am exceedingly peaceful. Wednesday, Peter Troy was sentenced to prison for two consecutive life-terms for two murders. Yet when I look at him, I look at myself. I feel my fortune and his fate. And I wonder what will happen to the next ones like us.

When they lose their minds to these treatable illnesses, will their care be more than happenstance?

In 2011, we will be reviewing how we deliver *Catalyst*. If you would prefer to receive your *Catalyst* electronically rather than by mail, we will make that change for you beginning with our next issue. Please let us know at Info@TreatmentAdvocacyCenter.org or telephone us at 703-294-6001.



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Stanley Medical Research Institute Update

By E. Fuller Torrey, M.D.

The SMRI brain collection, under the direction of Maree Webster, Ph.D., is the most widely used collection in the world by researchers studying schizophrenia and bipolar disorder. The lab has sent out without charge more than 200,000 sections of the brains to 250 research groups in 21 countries. When the general collection was started in 1994, it was decided to make the tissue available in smaller collections of brains matched for age, sex, race and left or right side of the brain. Thus, the Consortium collection has 15 matched brains each with schizophrenia, bipolar disorder, major depression and normal controls. The Array collection has 35 matched brains each with schizophrenia, bipolar disorder and normal controls. The brain tissue is sent coded to each research group, and the researchers must send back the data from their experiments before receiving the code.

Over time, an enormous amount of data has been accumulated on the same sets of brains, including data on structural and neurochemical differences among them. The Consortium collection alone has 1,762 separate neuropathology datasets from 12 different brain regions. All of this has been put into an online database that can be accessed by any interested researcher. In recent years, genetic data has also been added to this, including 309,531 single nucleotide polymorphisms (SNPs) from cerebellum, along with 17 expression microarray data sets from five different brain regions. A researcher who finds a neurotransmitter abnormality can immediately go online and see what genes (SNPs) are associated with that abnormality. Or a researcher who finds a particular gene upregulated can see what structural or neurochemical abnormalities are associated with it. Such a database can be – and is being – used to identify neurochemical targets against which to develop new drugs to treat these diseases.

The database is open to everyone and is unique in the world. It is presently being used by almost 400 research groups, including many in pharmaceutical companies. It can be accessed through The Stanley Medical Research Institute website.