



Catalyst

A Newsletter from the Treatment Advocacy Center

FALL 2011

Publication of AOT Implementation Manual Provides Blueprint for Treatment Success

If you're a caregiver weaving a safety net for someone with untreated severe mental illness, the role of court-ordered outpatient treatment seems simple: it's a way to get intervention before your loved one becomes so ill he or she ends up on the streets, in a hospital or jail – or something worse.

If you're a mental health professional running or working in an agency with multiple competing responsibilities, the role of assisted outpatient treatment – AOT for short – in your overall strategy is more complicated. Before you can establish a program, you need to establish protocols and procedures for how it will operate, who will administer it, how to evaluate results and other administrative and clinical issues.

Beginning next month, a new Treatment Advocacy Center publication – "A Guide for Implementing Assisted Outpatient Treatment" –

will be available to provide a helping hand to local mental health officials who want to tap the vast potential of AOT but aren't sure how to get started. Unique and practical, the handbook is based on in-depth examinations of successful, functioning AOT sites across the country. Contents include an "Implementation Checklist" that details how successful agencies have handled tasks such as designating an AOT coordinator, developing a multidisciplinary team, developing assessment forms and outcome tracking tools and evaluating patient outcomes. (See page 6 for the complete checklist.) Case studies, research summaries and cost information also are provided. Appendices supply sample forms, documentation and other implementation tools.

"Until now, technical guidance materials on AOT were virtually nonexistent, despite the mounting empirical evidence of the need for and the benefits of this vital intervention," said Executive Director James Pavle. "Our hope is that by publishing the collective experience from these models, their success can be replicated across the country."

The Role of AOT

Involuntary treatment for severe mental illness of those in acute psychiatric condition was once largely limited to hospitals. Today, 44 states and Washington, D.C., provide for the use of assisted outpatient treatment, also known as outpatient commitment, court-ordered outpatient treatment, mandated outpatient treatment and by other terms, depending on

the location. AOT authorizes court-ordered treatment outside a hospital for individuals with symptoms of severe mental illness who meet strict legal criteria, e.g., they have a history of medication noncompliance. Every state law is different, and counties within those states typically apply the law differently. (The six states without statutes authorizing assisted outpa-

Nevada County, California, won recognition from the National Association of Counties for its innovative and cost-effective AOT program under Laura's Law – its second award of the year. See "Around the States" (p. 7) for details.

tient treatment are Connecticut, Maryland, Massachusetts, New Mexico, Nevada and Tennessee.)

Most AOT laws were passed as states were faced with the consequences of deinstitutionalization, a trend that began in the 1960s and shifted patients from hospitals to communities irrespective of whether sufficient support existed. Homelessness, increased demands on law enforcement and hospital emergency rooms and violent incidents by people who would have been hospitalized in an earlier era followed. Court-ordered outpatient treatment emerged as a legal and clinical strategy for treating the fraction of individuals with men-

CONTINUED ON PAGE 11

What's Inside

- 2.....Executive Director's Corner
- 3.....Profiles in Treatment Advocacy
- 5....'Stopping the Revolving Door' to Save and Rebuild Lives
- 6.....Around the States
- 9.....Memorials & Tributes
- 11.....Torrey Action Fund
- 12.....SMRI Update

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Recipes for Implementation Success

Whether you're the type of person who likes to start with a recipe and then adjust it to suit your taste or add local ingredients, or you're the type who prefers following tried-and-true steps to good results, our new "A Guide for Implementing Assisted Outpatient Treatment (AOT)" is a resource you'll find indispensable. We developed the manual because AOT is a flexible approach to severe untreated mental illness whose success requires adapting to local conditions such as community services, practices and leadership. When we let you know the manual is available, please take a look to see for yourself what others have accomplished and how their experiences can be applied in your own community.

The new guide isn't the only way to see how assisted outpatient treatment is being implemented. In "Stopping the Revolving Door: A Civil Approach to Treating Severe Mental Illness," our 30-minute documentary video, we show AOT at work in the courtroom and in people's lives. Hundreds of you have already watched this video online, and hundreds more have requested DVD copies. In the feature starting on page 4, we give you the backstory of why and how we produced the video and provide several "recipes" for sharing it with audiences in your community.

With the AOT implementation manual and the "Revolving Door" video, we've created a robust menu that advocates everywhere can confidently present to legislators, judges, mental health professionals and fellow advocates. The importance of doing so is clear from the words of a 27-year-old AOT participant in Georgia who reported, "The OPC order ... motivates me to change, and that's recovery for me."

The Treatment Advocacy Center monitors and opposes barriers to treatment, which take many forms. One of the barriers we see rising coast to coast is on the housing front. A dozen state hospitals have been slated for closure since the economic crisis began in the late 2000s, and a recent Department of Justice action in North Carolina represents a potential threat to the kinds of group

homes where many of our loved ones currently live. We've decried the "community-based hysteria" that erupted when Sheppard Pratt Medical Systems set out to create private community-based transitional housing for psychiatric patients in Baltimore, and we applaud the entrepreneurial residential treatment options developed by organizations like ClearView Communities in Frederick, Maryland, and Browning Communities in Seattle, Washington. These, too, are "recipes" for treatment.

The one approach to "housing" individuals with mental illness we continue to expose and denounce is incarceration. As you'll read in Around the States, the primary mental health facility in the biggest county in Texas - Harris County, home to Houston - is the county jail. Meanwhile, California is about to discharge 30,000 inmates from its prisons to county jails. The U.S. Supreme Court found the overcrowded prison conditions and dearth of treatment for inmates with mental illness and other medical needs so "incompatible with the concept of human dignity" that the state is in violation of the Constitution's protection against cruel and unusual punishment. So many people with mental illness are incarcerated in the U.S. today that the term "justice-involved" has become a common euphemism for criminalizing mental illness. In the face of such trends, we applaud models like those of Bexar County, Texas - featured in our "Stopping the Revolving Door" documentary - and award-winning Nevada County, California.

By creating tools like our AOT implementation manual, our "Revolving Door" video and the Psychiatric Crisis Resources Kit that we showcased in our spring/summer issue of Catalyst, by maintaining the worldwide web's only central source of state-by-state information about civil commitment laws and standards and in a host of other ways, we hope we are equipping you for success in your personal quests for treatment and better treatment laws.

Keep in touch,

Jim Pavle, Executive Director

Catalyst

Catalyst is a publication of the Treatment Advocacy Center to update friends and supporters about our programs, activities and other news and developments affecting the treatment of severe mental illness.

Treatment Advocacy Center is a private, nonprofit, 501(c)(3) organization and does not accept funding from pharmaceutical companies or entities involved in the sale, marketing or distribution of such products. For additional information, visit our website at www.TreatmentAdvocacyCenter.org, or send an email to info@TreatmentAdvocacyCenter.org.

AOT is improving community-based treatment for individuals with severe mental illness across the country. If you know a county that deserves to be recognized, please let us know by emailing info@TreatmentAdvocacyCenter.org.

Profiles IN TREATMENT ADVOCACY

Dr. Jeffrey Geller is director of Public Sector Psychiatry and professor of psychiatry at the University of Massachusetts Medical School, where he teaches, conducts research and works directly with patients. An author of hundreds of academic and non-academic papers and the book Women of the Asylum, he is the winner of multiple national awards for his work, including our own Torrey Advocacy Commendation (2006). Somehow Dr. Geller juggles his responsibilities at UMass with consulting to the U.S. Department of Justice and to public institutions in more than half the U.S. states and abroad; editing the book review section of a monthly publication of the American Psychiatric Association; and co-authoring "A Guide for Implementing Assisted Outpatient Treatment" for the Treatment Advocacy Center, where he also serves on the board of directors.

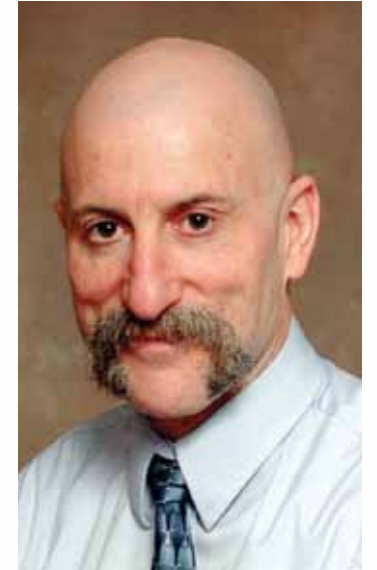
WHY DO YOU FOCUS YOUR TIME AND ATTENTION ON TREATING PEOPLE WITH SEVERE MENTAL ILLNESSES?

The rallying cry of the last quarter of the 20th century - to close hospitals and move everyone to the "community" - was predicated on the factoid assumption that community-based care would be less expensive than hospital-based treatment. But community-based mental health services for persons with serious mental illness became and will continue to be an uncoordinated, fractured potpourri of purposeless activities, confounding the beneficent efforts of those who work daily with this population. While the states and the feds engage in cost-shifting exercises and budgetary sleights of hand, persons who are disabled by the brain injuries we call psychiatric disorders will continue needlessly suffering and dying.

Advocating for these individuals - some of whom are patients and many more of whom should be but aren't because of stigma and its consequences - is a natural extension of treating them.

YOU SERVE AS A BOARD MEMBER FOR THE TREATMENT ADVOCACY CENTER, WHOSE MISSION IS ELIMINATING BARRIERS TO THE TREATMENT OF SEVERE MENTAL ILLNESS. WHAT ROLE DO YOU THINK PUBLIC FINANCING OF MENTAL HEALTH TREATMENT - OR NON-TREATMENT - PLAYS IN THE CREATION OF BARRIERS?

The bottom line in providing care and treatment for persons with chronic mental illness is the bottom line.



Dr. Jeffrey Geller

We can talk about transformation, normalization, deinstitutionalization, medicalization and destigmatization. We can bandy about whether to call persons who receive treatment for psychiatric disorders patients, clients, consumers, recipients or survivors. We can debate the degree of restrictiveness or integration of supported housing, supportive housing, adult homes, state hospitals, general hospital psychiatric units, nursing homes, crisis/respite beds, jails, prisons and street corners. And we can ponder the extent of coercion in outpatient commitment, jail diversion, assertive community treatment, mental health courts, representative payeeships, treatment-contingent housing, probation, case management, managed Medicaid, and Medicare Part D. At the end of the day, major reforms in the structure and organization of services for persons with mental illnesses, whose services would be funded by public dollars, have always been fueled with the promise of saving money. This has become only more true in the current fiscal environment. If this obstacle is to be overcome, advocates are going to have to rewrite the bottom line by proving that it's not only humane and practical to treat mental illness before it destroys lives and futures but that doing so saves money, too.

WHEN YOU WERE NOMINATED FOR THE TORREY ADVOCACY COMMENDATION, A COLLEAGUE RECALLED THAT NPR ONCE INVITED YOU TO DISCUSS YOUR ADVOCACY FOR PEOPLE WITH SERIOUS MENTAL ILLNESSES AT A TAPING THAT CONFLICTED WITH YOUR PATIENT CLINIC DAY. YOU PURPORTEDLY DECLINED THE NATIONAL EXPOSURE, SAYING, "HOW CAN I GO ON A RADIO SHOW TO SPEAK OF ADVOCACY AFTER CANCELING ALL MY PATIENTS?" IS THIS TRUE OR APOCRYPHAL?

It's true. With the exception of two short breaks, I have followed some patients in the public sector for 32 years - 27 of them while these individuals lived outside hospitals. Their lives and mine are changed all the time by our relationships, which I prize as among the most significant accomplishments of my professional life. What could a radio show offer to compare with that?

Some of the foregoing answers include adaptations of previously published statements by Dr. Geller.

“Stopping the Revolving Door” to Save and Rebuild Lives

If a picture is worth a thousand words, the value of 30 minutes of moving pictures is immeasurable.

With that in mind, the Treatment Advocacy Center in 2011 produced “Stopping the Revolving Door: A Civil Approach to Treatment Severe Mental Illness,” a documentary video that shows court-ordered treatment – both inpatient and outpatient – at work.

“It’s one thing to read about how civil commitment saves the lives of people with crippling mental illness,” says Treatment Advocacy Center Communications Director Doris Fuller, project manager for the production. “It’s another to see the process in action in a courtroom and to watch beneficiaries and families tell their own stories.”

Taped on location in Pennsylvania, Texas and Maryland, the video opens in San Antonio, where Bexar County estimates its involuntary outpatient commitment (IOPC) program – what we call assisted outpatient treatment or AOT – has provided crucial support to hundreds of individuals with severe mental illness and saved millions of dollars since its inception in 2003. County officials and AOT participants allowed our crew into the courtroom for a rare look at AOT in process. Consumer Eric Smith, a graduate of the Bexar County program, and his parents, Brad and Nancy, relate in detail the events that led up to Eric’s civil commitment and how AOT supported his return to college and the music he loves. The documentary closes in Pennsylvania, where Curt Bauer describes the personal cost of his own untreated mental illness and how two years of involuntary hospitalization saved his life. Now a NAMI-Pennsylvania volunteer, Bauer also talks about the need for court-ordered treatment in



Why Assisted Outpatient Treatment Is a “Civil” Approach

Unlike drug courts and mental health courts, getting into AOT doesn’t require the recipient of treatment to first commit a crime. To the contrary, when used in a timely way, court-ordered treatment goes to the source of illness-driven criminal acts by treating the illness before the acts occur.

the community so individuals with severe mental illness get treatment before they become so ill they require hospitalization.

Throughout the film, research psychiatrist and author Dr. E. Fuller Torrey, founder of the Treatment Advocacy Center, provides commentary on the nature of severe mental illness, the role of anosognosia (lack of insight) and why involuntary treat-

ment is a life-saving intervention for some patients.

“With ‘Stopping the Revolving Door,’ we’ve given advocates and professionals a tool for educating and encouraging people about where court-ordered treatment fits into the spectrum of interventions for severe mental illness,” says James Pavle, executive director. “Along with the AOT implementation manual (featured

Putting “Stopping the Revolving Door” to Work

Professionally produced by the award-winning, Atlanta-based media professionals of SplendidVid, “Stopping the Revolving Door” is a unique tool for public and professional education and for caregiver encouragement. Here are six ways to put the video to work:

- **Advocates for AOT** – Send a link or the DVD along with a description of your own experience or support for assisted outpatient treatment to lawmakers and other officials in a position to enact or implement AOT legislation.
- **NAMI affiliates and other community groups** – Show the documentary as the centerpiece of a regular meeting or special event. Follow the showing with commentary from a local judge, mental health provider or consumer with experience in assisted treatment and/or with a discussion.
- **Law enforcement** – Incorporate the video in training and/or morning roll call to acquaint officers with the civil alternative of court-ordered outpatient treatment and how it can reduce demands on law enforcement.
- **Judges** – View the documentary to see and hear how one court successfully uses assisted outpatient treatment to stop the revolving door of illness, arrest and incarceration.
- **Elected officials and mental health professionals** – Watch the video to see first-hand accounts of the impact of AOT on consumers, families and communities.
- **Families** – Familiarize yourself with the option of court-ordered treatment in the community (authorized in 44 states) so you can seek it for a loved one or take hope from its possibilities.

“Stopping the Revolving Door” is available at no cost online through the Media Library on the Treatment Advocacy Center website, on DVD by request to info@TreatmentAdvocacyCenter.org or at 703-294-6003.

on page 1), the documentary provides a critical bridge between the concept and the reality of assisted treatment.”

Within weeks of its summer launch, hundreds of people had watched “Stopping the Revolving Door” online, advocates were mailing it to lawmakers in a position to act on AOT laws, and NAMI chapters were planning local meetings around it. (See “Putting ‘Stopping the Revolving Door’ to Work” for ideas about how to use the documentary wherever you live or work.)

Production of “Stopping the Revolving Door” and its distribution were underwritten entirely by the Torrey Action Fund, which honors Dr. Torrey’s lifetime of advocacy to those too disabled by severe mental illness to seek or accept treatment.

Get Help Online

No matter where you are or what time of day or night, you will find links, tools and tips for responding to psychiatric crises on the Treatment Advocacy Center website. Every element of our new Psychiatric Crisis Resource Kit can be found under the **Get Help** tab, along with other information to help you —

- Know the laws in your state
- Be prepared for an emergency
- Find out about the options
- Respond in a crisis

Staying Up to Date – As Easy as 1-2-3

1. **By email** – Receive periodic emails about major news and updates. Click on **Sign Up** on our website to provide your email address, or telephone us at 703-294-6001
2. **On Facebook** – Join the Treatment Advocacy Center community, share views and news with other supporters, read our daily commentaries on trends and issues. Find us on **Facebook.com**.
3. **On Twitter** – Read headline news as it’s breaking, learn about advocacy opportunities as they arise, get links to research, reports and other useful materials. Find us at twitter.com/treatmentadvctr.

AROUND THE States



California

Nevada County's assisted outpatient treatment (AOT) program received national recognition in July when the National Association of Counties presented the county with an Achievement Award in Health for innovation that "modernizes county government and increase(s) its services." The program earlier in the year had been recognized with a Challenge Award for innovation from the California State Association of Counties.

Nevada County was the first – and is still the only – California county to fully implement the state's AOT statute, known as Laura's Law. The law is named for Laura Wilcox, one of three persons killed in a 2001 Nevada County shooting by a man suffering from untreated severe mental illness.

County Behavioral Health Director Michael Heggarty, a key player in the program's success, acknowledges that even he had concerns prior to implementing the law. Now he is one of its greatest champions. The county estimates it has saved \$1.81 for every \$1 invested by providing AOT. Costs have been offset by savings from decreased hospitalization and incarceration for a total net savings of \$503,621, according to Heggarty.

Nevada County Superior Court Judge Tom Anderson – who oversees the judicial side of the program – says AOT is making his county safer at the same time it helps individuals get help before they or their communities experience consequences of non-

treatment that include hospitalization, incarceration, violence and others.

According to Judge Anderson, "The impact of Laura's Law and similar programs in other communities definitively demonstrate that these programs are more successful than any other programs currently in use. The law provides a means to intervene to prevent serious brain injury, to prevent extreme crisis and to encourage cooperation. In doing so, it also saves money for the taxpayers. Further, Laura's Law is one of the few programs that include a means (however minimal) to hold service providers accountable as well as patients."

Nevada County's AOT was not fully operational in time to be included in a site visit during research for the AOT implementation guide but has reported data that is included in the manual. A video about the program that features interviews with Heggarty and Judge Anderson can be found through the Media Library on our website.



Florida

Seminole Behavioral Healthcare is the Florida state leader in utilizing assisted outpatient treatment, known as "involuntary outpatient placement (IOP)" under Florida law. The provider at any given time serves 18-25 individuals with severe mental illness who are on IOP orders. Seminole Behavioral Healthcare started using the IOP law in 2005, the year it became effective, by creating a model program and tracking patient outcomes.

According to Valerie Westhead, M.D., medical director for outpatient services, "The clients involved in the model program were given the opportunity to recover at home with the support of their families and, by doing so, avoided being sent to the state hospital. Most clients truly appreciated the changes in their lives and continued to comply with treatment recommendations, which resulted in additional improvement even after their court orders were completed."

"Most clients truly appreciated the changes in their lives and continued to comply with treatment recommendations, which resulted in additional improvement even after their court orders were completed."

The successes achieved by these individuals are inspiring; watching these people move forward in their lives was one of the most rewarding experiences of my career."

Between June 1, 2005, and November 30, 2006, 36 people participated in the model IOP program. Prior to their placement, the majority of the patients had been offered community health services but had not actively engaged in them. Nor were they adhering to prescribed medications. In the year prior to receiving IOP, participants averaged 117 days hospitalized and 23 days incarcerated. After placement in the program, the participant group experienced significant reductions in hospitalization days (43%), hospitalization costs (\$303,728 cumulative), incarceration days (72%) and incarceration costs (\$14,455 cumulative).

AOT was implemented with existing services and funding except for a grant that made it possible to hire a short-term coordinator to help initiate the program and to collect outcome data. After the grant was completed, Seminole continued to utilize outpatient orders using existing staff and programming to meet the needs of its clients without any additional funding. Seminole Behavioral Healthcare is now a vital resource to other counties seeking to help patients using involuntary outpatient placement in Florida and elsewhere.



Utah

Utah enacted the "Susan Gall Involuntary Commitment Act" in 2003, a year after the death of the law's namesake. Susan Gall was killed by her son, Leonard, who suffered from untreated severe mental illness. The legislation modified the process by which adults are involuntarily committed to mental health programs on an inpatient or outpatient basis. The changes to the law eliminated the "immediate danger" standard in Utah and implemented a standard based on "substantial danger." Additionally, the new law shortened the time that a person detained for evaluation may be required to wait for a commitment.

In 2008, roughly half of all of the applications for commitment under the state law were filed in Salt Lake County's Third District Court. Most assisted outpatient treatment orders, called "outpatient commitment" in Utah, are used to facilitate continuity in the transition from the hospital to the community. The University of Utah Hospital and Valley Mental Health provide structure and support to allow individuals who would otherwise cycle in and out of the hospital to receive court-ordered treatment on an outpatient basis. According to a professional involved with the program, outpatient commitment "gives patients a sense that they are under legal obligation to follow through [with their treatment plans] as ordered."

The Salt Lake City AOT program is one of five locations that were visited during the collection of data for "A Guide for Implementing Assisted Outpatient Treatment," the new publication featured on page 1.



Texas

Harris County – which includes the city of Houston and is the third most populous county in the United States – has become the second county in Texas to establish a dedicated program that provides assisted outpatient treatment, known in Texas

as "court-ordered outpatient mental health services."

Texas's AOT law is woefully underused. Until now, Bexar County (San Antonio) has been the only county in the state to make full use of the law. It operates a program in which high-risk, AOT-eligible outpatients are systematically identified, placed under court order and connected with appropriate services and monitoring.

Among those who have taken notice of the results achieved in Bexar County is Dr. Stephen Schnee, executive director of the MHMRA of Harris County, the Houston-area public mental health agency. Last October, Dr. Schnee and Lt. Mike Lee of the Houston Police Department CIT unit attended a presentation on AOT by Treatment Advocacy Center Policy Director Brian Stettin. Later, at Brian's suggestion, they and several other Harris County mental health and criminal justice officials visited San Antonio and gained nuts-and-bolts knowledge of how and why AOT works. This led to several months of careful planning to make AOT an integral part of Harris County's approach to securing treatment for those too ill to recognize their own need for care.

Recently these plans turned into a functioning pilot program. For the time being, eligibility has been limited to individuals arrested for non-violent offenses, the intent being to keep them out of the Harris County Jail. (The jail has become the largest mental health facility in Texas; about 2,400 of the inmates, a quarter of the total population, are diagnosed with the psychiatric illness.) The program began with five mentally ill people placed under AOT this summer, supervised by Probate Judge Christine Riddle Butts and a dedicated staff based in MHMRA's Northwest Clinic.

Like most public mental health agencies today, the MHMRA is operating under severe fiscal distress. Dr. Schnee's goal for the small-scale AOT pilot is to prove that the combination of intensive services, court orders to comply with treatment and continuing judicial oversight will save Harris County far more money – in avoided ER visits, hospital days, arrests and

jail-based treatment – than it costs. When armed with this data, he hopes to ask the Harris County Commissioners Court to fund an expansion, making AOT available even to those in need who have managed to avoid arrest.



Virginia

Four years have passed since the Virginia Tech massacre in which 33 people died – 32 while going about their business at school and one so ill he had been deemed "imminently dangerous" by a Virginia court and ordered into outpatient treatment, which he never received.

As often is the case with high-profile tragedies, state legislators were inspired to revisit the state's civil commitment laws and court-ordered

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outpatient standards with the stated goal of preventing future tragedies. The result was two versions of involuntary court-ordered treatment, both called "mandatory outpatient treatment (MOT)." Neither version has significantly improved the quality of care for people with the greatest needs.

A major problem with both versions of MOT is their requirement that – before a court can order treatment – the local community service board (CSB) must "actually agree to deliver the services." However, if the CSB does not "actually agree," a court order for treatment does not issue, regardless of the individual's need. Many family members have told us

CONTINUED ON PAGE 8

The county estimates it has saved \$1.81 for every \$1 invested by providing AOT.

Around the States

CONTINUED FROM PAGE 7

their CSBs misinform people, saying “there is no court-ordered outpatient treatment option in Virginia.” In addition, both versions require that an MOT recipient must “agree to abide by [it].” In the absence of this agreement, a court order cannot issue.

In this treatment void, many individuals struggling with mental illness continue deteriorating. Some will be arrested, and some of those will be incarcerated. Some will be hospitalized, and many more will become homeless. A number will commit suicide, and a few – like Seung-Hui Cho, the Virginia Tech shooter – will commit acts of deadly violence.



Nevada

[Excerpts from testimony submitted to the Assembly Health and Human Services Committee on April 11, 2011, by Kristina Ragosta, Treatment Advocacy Center legislative and policy counsel.]

“The state of Nevada cannot afford to wait to pass AB 94. Based on 2009 U.S. Census data, Nevada is home to 64,748 individuals with schizophrenia and severe bipolar disorder, of whom 34,647 are not treated in any twelve-month period. Given that people with untreated severe mental illness commit 10% of the homicides in this nation, represent 30% of the homeless population and comprise at least 16% of all the jail and prison inmates, this population represents a risk to public safety and a resource-intensive segment of the state’s residents.

“Nevada currently has one of the most restrictive civil commitment laws in the country. The state forces

individuals to deteriorate to the point of dangerousness before help can be provided. In Nevada there are almost 10 seriously mentally ill persons in jails and prisons for every one person in a hospital.

“If Nevada were to pass a law allowing for assisted outpatient treatment and use it effectively, the state could begin to address some of the problems created by untreated mental illness.

“Facilitating outpatient treatment before individuals with severe mental illness require more costly services or interventions (e.g., hospitalization, incarceration, homeless services) would be both humane and fiscally responsible.

“... AOT is a legal mechanism that makes more efficient use of existing services for those who meet the law’s eligibility standard. Many individuals are currently receiving ‘services’ in the form of taxpayer-funded visits to hospital emergency rooms, law enforcement interaction, court hearings, incarceration and others.... Assisted outpatient treatment has produced measurable results in multiple states. The majority of those studies are overwhelmingly positive.

“... Nevada is one of only six states that do not have an outpatient commitment law. The state’s only option for mandated treatment is involuntary hospitalization – the most expensive form of mental health treatment. A common argument you will hear is that Nevada simply needs more community mental health services. Of course, we would all like to see more services and resources dedicated to mental health. The fact is that the individuals who will benefit from this law will not voluntarily uti-

lize psychiatric services – no matter how abundant and attractive those services are – because they do not believe that they have an illness (which is the case in about 50 percent of individuals with schizophrenia and 40 percent of individuals with bipolar disorder).

“The longer someone has to wait for treatment, more intensive and costly services will be required. Assisted outpatient treatment allows people to get services before they are in crisis.”



Oklahoma

In May, Oklahoma Gov. Mary Fallin signed legislation that makes several welcome amendments to the state’s inpatient civil commitment standard. These changes should make it a bit less onerous for Oklahomans to obtain desperately needed psychiatric care.

Even before the changes, Oklahoma law reflected some recognition that commitment should not be limited (as it still remains in some states) to those at imminent risk of violence or suicide. The state commitment statute was amended previously to authorize the involuntary hospitalization of a person “unable to provide for [his or her] basic physical needs.”

But this sensible and compassionate reform came with strings attached that severely limited its usefulness. Before a court could order commitment on grounds of inability to meet “basic physical needs,” it was required to find, first, “a substantial risk of immediate serious physical injury to self, or immediate death” (forcing families and caregivers to wait for a crisis to reach the point of utter desperation); and second, “that appropriate provision for those needs cannot be made immediately available in the community” (regardless of whether the person was willing to utilize such resources).

Another more general shortcoming of the Oklahoma law was its lack

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Memorials & Tributes

April 30 – September 15, 2011

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

Carol Ager, Cardiff, CA	In honor of Camryn Ager	Faye Morton, Lexington, KY	In honor of my son, Timothy Morton
Richard & Arlene Allen, Boynton Beach, FL	In honor of Craig Lawrence Allen	Arunachala Nagarajan, Austin, TX	In honor of Barath
Sonia Aubrey, St. Thomas, VI	In honor of Sonia Aubrey	NAMI Evansville, Evansville, IN	In memory of Steve Barnhart
James & Ruth Barnwell, Atlanta, GA	In memory of Brooks Dorn	Dave O’Neill, New York, NY	In honor of Dr. Fred Goodwin
Camille Callahan, Newport Beach, CA	In memory of Ed Callahan	Emily Paulhamus, Barbours, PA	In honor of Emily Paulhamus and in memory of Mark
Connie Cereola, Greenlawn, NY	In memory of Gail Richards	Bill & Alice Petree, Sanford, FL	In memory of Alan Singletary
Susan Cleva, Bellevue, WA	In honor of Gerald Tarutis	Charles Pisano, Enola, PA	In memory of Jean Pisano
Melinda Cohen, Trabuco Canyon, CA	In honor of Jordan Molina	Janice Reeves, Bloomington, IN	In honor of Adam Drake
Jeanie Coltart, Monmouth, ME	In honor of Peter Angus Coltart	Karen Reilly, Shelton, CT	In honor of Vinny
Thomas DePetro, Denver, CO	In memory of Anette	Louise Schnur, Auburn, CA	In memory of Teddy Jack Jones
Gladys Dyer, Lowell, MA	In honor of my son, Michael Dyer	Hattie Segal, Maplewood, NJ	In honor of Dr. Torrey and Stephen Segal
Bernidette Dyer, Harleysville, PA	In memory of Maggie Renteria	Fred & Bernice Seifter, Matawan, NJ	In memory of Mark Seifter
Eastern High Class of 2001, Voorhees, NJ	In memory of Jevon Lampkin	Rosemary Seneviratne, Queensland, Australia	In memory of Daniel Goldstein
Megan Erhardt, Washington, DC	In memory of Jevon Lampkin	Jacqueline Shannon, San Angelo, TX	In memory of Charley H. Shannon
Gannett Foundation, McLean, VA	In memory of Gail Richards	Hilary Silver, Stockton, CA	In honor of Aram Silver
Ruth Grant, Vergennes, VT	In honor of Ruth Kennedy Grant with thanks to Kristina Ragosta and Dr. Geller	Terri Smoot, Elkin, NC	In honor of Caleb D. Smoot
Marguerite Hodges, Petersburg, IL	In honor of Amanda Arnold	Alan Stone, Cambridge, MA	In honor of Dr. E Fuller Torrey
Pat Hubbard, Cortez, CO	In memory of James William Hubbard	Alan Strasser & Patricia Hartge, Chevy Chase, MD	In memory of Peter Hartge
Charles Hudson, Cooperstown, NY	In memory of James Miller	Joanna Taylor, Buffalo, WY	In memory of Thor and Tyrone Taylor
George & Kristine Klinger, West Richland, WA	In honor of Denise Fazio	Bobbin Teegarden, Bellevue, WA	In honor of Donald Teegarden
Gail Kroll, Northbrook, IL	In honor of an unnamed honoree	Diane Thomas-Young, Rancho Murieta, CA	In honor of Peyton
Anne Lange, Norfolk, NE	In honor of The Taylor family and in memory of Thor Olney Taylor	Bonney Wasson, Oakland, CA	In honor of Aileen Kroll
Brian Marcum, Tulsa, OK	In honor of Mary Kay Marcum	Curt Whitcomb, Novelty, OH	In memory of Bob
Frances Moon, Tampa, FL	In honor of My Hero, My Son	Hinda Wolf, Stratford, CT	In honor of Liz Pavle & Brian Mixer
Margaret Moore, Bradenton, FL	In honor of Gregory Moore		

of guidance on how the need for commitment is to be proven. This caused some judges and patients’ attorneys to conclude that evidence of a person’s mental health history (i.e., a pattern of incidents showing that non-treatment has frequently led the person to dangerous conduct in the past) was not admissible in assessing the person’s current condition.

These flaws were addressed in this year’s legislation, introduced by Rep. Ann Coody (R-Lawton) and

Sen. Don Barrington (R-Lawton). The new law:

- includes a provision to clarify that evidence of mental health history is relevant in determining a person’s current need for treatment;
- omits the requirement that a court find community resources unavailable before ordering commitment on grounds of inability to meet basic physical needs;

- allows commitment on grounds of inability to meet basic physical needs to proceed on evidence of “substantial risk of death,” even if such risk is not “immediate.” (Regrettably, commitments based on substantial risk of injury will continue to require immediacy of risk. As originally introduced, the bill would have modified this to a substantial risk of injury “in the near future.”)

AOT Manual

CONTINUED FROM PAGE 1

tal illness who are untreated and too ill to seek or accept needed psychiatric care outside a hospital.

The effectiveness of assisted outpatient treatment in reducing the consequences of non-treatment has been studied and independently verified by multiple researchers in a number of states. Their studies consistently have found a reduction in consequences among participants who receive AOT. Despite such proven success, in the absence of instructional models for implementation, jurisdictions have been slow to implement programs. This has limited the impact and benefits of AOT to individuals with untreated illness and their communities.

Putting Together the Guide

To fill that void, the Treatment Advocacy Center chose five sites to visit in urban and rural locations from different geographic regions: Akron, Ohio; Columbus, Georgia; Iowa City, Iowa; Salt Lake City, Utah; and Queens, New York. Reports from Seminole County, Florida, and Nevada County, California, were added to the guide after the site visits were complete.

“We were interested in learning more about what jurisdictions in different locations were doing and

then sharing their lessons with others,” said Rosanna Esposito, deputy executive director of the Treatment Advocacy Center and director of the AOT manual project. “Our hope is that every jurisdiction in the country will be able to find some practices that can work in their own local community.”

Psychiatrist Jeffrey Geller, a member of the Treatment Advocacy Center board of directors, participated in interviews and data collection at all five sites. (See p. 3 for Dr. Geller’s “Profile in Advocacy.”) Rosanna and Kristina Ragosta, Treatment Advocacy Center legislative and policy counsel, each participated in at least two site visits.

Before the visits, Treatment Advocacy Center staff researched AOT implementation by conducting interviews nationwide. At the same time, an extensive set of questions and requests for information from representatives at each location was developed. The goal was to gather as much information as possible from the various supervising agencies, AOT participants and other stakeholders where AOT was at work. A specific agenda was developed in cooperation with local representatives prior to each site visit to assure that meetings took place with all key representatives and stakeholders.

Each site visit was conducted over a two-day period and involved

meeting with psychiatrists, patients, case managers, law enforcement officials, judges, attorneys and others involved. “What we wanted to know in visiting each site were the factors contributing to the successful implementation of their AOT laws,” says Kristina, who visited Iowa City, Salt Lake City and Queens. “Interestingly, we found some common characteristics that transcended location and demographics.”

Rosanna, who visited Akron and Columbus, says, “We also found that the ease of administering AOT effectively was directly correlated to the level of cooperation and philosophical buy-in from participating stakeholders, including service providers, law enforcement agencies, courts and attorneys representing the participants. The most encouraging commonality our visits uncovered was the way stakeholders in these communities were committed to improving the lives of people with severe mental illness – and working with the resources that are available to them.”

In addition to implementation guidelines, the manual provides a summary of the extensive research into AOT effectiveness that has been conducted and examines the issue of implementation costs and savings. “Legislatures passing measures for AOT have rarely included specific funding allocations with the authorizing legislation,” the guide reports. Additionally, the cost of AOT in states that have allocated funds for implementation has been subject to “gross exaggerations” that “have become fodder for fantastical estimates of how much other states must invest in order to establish AOT.” Anecdotal reports from California, Florida and Texas indicate significant savings in hospitalization and criminal justice costs.

“A Guide for Implementing Assisted Outpatient Treatment” will be available at no cost online in the “Solutions” section of the Treatment Advocacy Center website or on CD. Email info@TreatmentAdvocacyCenter.org or telephone us at 703-294-6001 for more information.

STEPS FOR EFFECTIVELY IMPLEMENTING AOT

Details Provided in “A Guide for Implementing Assisted Outpatient Treatment”

- Know the law
- Educate and inform stakeholders
- Collect information and contact resources
- Select first AOT candidate wisely
- Ensure leadership support
- Seek ongoing input from within agency and beyond
- Identify stakeholders and establish community partnerships
- Resolve common issues
- Designate an AOT coordinator
- Create informational resources
- Develop a team to work on the project
- Evaluate patient outcomes
- Create the process
- Make modifications
- Develop assessment forms
- Educate policymakers and the public about successes
- Develop outcome tracking tools
- Evaluate program
- Educate agency staff

Torrey Action Fund

CONTRIBUTORS

2011 Contributors (through September 15)

The Treatment Advocacy Center thanks all those who made donations to the Torrey Action Fund, which honors our founder E. Fuller Torrey, M.D., and enables us to continue pursuing his vision of eliminating barriers to the treatment of severe mental illness.

Nora Jill Adelman & Joan Cummings, Glen Ellyn, IL
Carol Ager, Cardiff, CA
Gerry & Ann Akland, Knightdale, NC
Carl Alaimo, Melrose Park, IL
Mitzi Anderson, Whitefish, MT
Sonia Aubrey, St. Thomas, VI
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Thomas & Janice Baldwin, East Lansing, MI
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June Beeby, Kingston, ON
Robert Beilman, Madison, WI
Judy Bennett, Orange Park, FL
Mary Ann Bernard, Moraga, CA
Mahala Bishop, Brooksville, ME
Jeffery Bonacci, Charlottesville, VA
Marilyn Booth, Inverness, FL
A.J. & Jane Carlson, Westlake, OH
Mary Chapman, Harrisburg, PA
Susan Cleva, Bellevue, WA
Richard Cleva, Washington, DC
Melinda Cohen, Trabuco Canyon, CA
Jeanie Coltart, Monmouth, ME
Orabelle Connally, Seattle, WA
James Curtis, Albion, MI
Clay & Ellie Dawson, Placerville, CA
John Denkowski, New York, NY
Gladys Dyer, Lowell, MA
Alice Fitzcharles, Media, PA
Earl & Sheran Flippo, Palm Beach Gardens, FL
Glenn & Evelyn Flittner, Rockville, MD
Mark & Theresa Gale, West Hills, CA
Nelson & Theresa Goguen, Ashby, MA
Maureen Goldstein, Overlad Park, KS
Helen Gomes, San Diego, CA
Weston & Jane Goodnow, Moorestown, NJ
Madeleine Goodrich, Concord, MA
Marsha Grant, San Rafael, CA
Stephanie Green, Madera, CA
Walter & Wheyting Hampe, Napa, CA

Anne Handler, Pittsburgh, PA
Nancy Hayes, Mount Vernon, IA
Lisa Hendrickson, Schaumburg, IL
John & Angelina Henry, East Brunswick, NJ
John & Jackie Herum, Ellensburg, WA
Barbara Hesnauer, Midland, MI
Norma Hill, Mishawaka, IN
Howard Family Trust, Los Angeles, CA
Charles Hudson, Cooperstown, NY
Hubert & Helen Huebl, Dearborn, MI
June & John Husted/Travis, Lincoln, CA
Rael Jean Isaac, Irvington, NY
Lillian Jerman, Bradenton, FL
Karen Jones, Hartford, CT
Kathleen Kaspar-Paty, Falls Church, VA
David & Jean Kelly, East Providence, RI
Buck & Marianne Kernan, Pinehurst, NC
Marilyn Kinman, West Monroe, LA
George & Kristine Klinger, West Richland, WA
Irina & Yori Koltoniuc, Brighton, MA
Kenneth Kress, Iowa City, IA
Gail Kroll, Northbrook, IL
Garneth Kuiper, Sioux Falls, SD
Roy & Leane Lemcke, Havre, MT
Ann Lentz, South San Francisco, CA
Howard & Jacqueline Leventhal, Bronx, NY
Marguerite & Stacy Li, Santa Rosa, CA
Carolyn Mackenzie, St. Petersburg, FL
Mary Main, Dallas, TX
William & Jill-Allyn McCluskey, Madison, MS
Julie Meeker, Pueblo, CO
Phyllis Melvin, Warren, OH
Ann Menges, Steamboat Springs, CO
Nancy Merola, Austin, TX
Mary Ellen Moran, Bowie, MD
Ed Morrison, Alexandria, VA
Faye Morton, Lexington, KY
Arunachala Nagarajan, Austin, TX
Sally Norris, Springfield, VA
Martin & Martha Onishuk, Missoula, MT
Eleanor Owen, Seattle, WA

Dottie & George Pacharis, West River, MD
Michael & Ruth Parsons, Watkinsville, GA
Emily Paulhamus, Barbours, PA
Deborah Paulmann, Sherman Oaks, CA
Vera Pfifferling, Durham, NC
John Plesko, Pontiac, IL
Sue Potoczak, Louisville, KY
Karen Reilly, Shelton, CT
Gene & Catherine Robillard, Stoneham, MA
David & Anne Robinson, Columbus, OH
John Robinson, Sacramento, CA
Diane Russakoff, Richmond, VA
John & Helen Sampsel, Miles City, MT
Hattie Segal, Maplewood, NJ
Stephen Segal, Philadelphia, PA
Jacqueline Shannon, San Angelo, TX
Marikay Shellman, Bayfield, CO
Ingrid Silvian, Columbus, OH
Arthur Singer, Westport, CT
Eleanor Slater, Pittsburgh, PA
Gerald Smith, Seattle, WA
Rose Patricia Smith, Havertown, PA
Terri Smoot, Elkin, NC
Cassie Stallings, Towson, MD
Bentley Paul Stansbury, Torrance, CA
Harold & Ruth Stein, Longmeadow, MA
David & Kathleen Stetter, Rosedale, WI
Anne Stiles, Blackstone, VA
Alan Stone, Cambridge, MA
Jim Strange & Val Elliot, Indianapolis, IN
Leah Sullivan, Pasadena, CA
Joanna Taylor, Buffalo, WY
Bobbin Teegarden, Bellevue, WA
Dorothy Thorman, Altadena, CA
Clyde Topping, Annapolis, MD
Helen Tucker, Ontario, Canada
Ketty Wadia, Austin, TX
Teresa Walker, San Mateo, CA
Sara Walker, Indianapolis, IN
Jeanne Walter, Sumner, WA
Robert & Mary Watt, Reston, VA
Curt Whitcomb, Novelty, OH
Donald & Elisabeth Wilcox, Tempe, AZ
Lavera Winter, New Palestine, IN
Austin & Ellen Wolf, Fairfield, CT
Judith Woodin, St. Louis, MO
Nathan & Lois Yuhl, Tracyton, WA
Tiffany Zachmeier, Santa Cruz, CA



Treatment Advocacy Center
200 N. Glebe Road, Suite 730
Arlington, VA 22203

www.TreatmentAdvocacyCenter.org

Stanley Medical Research Institute Update

By E. Fuller Torrey, M.D.

During the early years of the SMRI research grants program, we supported a large number of researchers doing work on a wide variety of aspects of schizophrenia and bipolar disorder. In recent years, we have focused more on specific research areas, funding a smaller number of researchers we think do especially good work.

One such researcher is Dr. Sabine Bahn at Cambridge University. Sabine is originally from Germany and had a father with bipolar disorder, so she is highly motivated. SMRI has supported her research for more than ten years, during which time she has developed the first commercially available diagnostic test for schizophrenia.

The test is based on the protein pattern in the person's blood. She uses 51 protein markers that she identified by looking at over 200 proteins in 800 individuals with schizophrenia and controls. The diagnostic test became commercially available in 2010 as VeriPsych and costs \$2,500. It is not perfect, but it is the best diagnostic test developed to date. Further modifications and improvements are in process, as is a similar test for bipolar disorder.

Sabine works closely with six other laboratories funded by SMRI and organized by Dr. Robert Yolken as the SPECTS program (Stanley Program for the Evaluation and Clinical Treatment of Schizophrenia and Bipolar Disorders). They include laboratories at the University of Aarhus in Denmark; the Karolinska Institute in Stockholm; the University of Pittsburgh; the University of Michigan; the Walter Reed Army Institute of Research in Washington; and Sheppard-Pratt Hospital in Baltimore. Dr. Yolken coordinates this research.

Dr. Torrey serves as executive director of SMRI, where he oversees groundbreaking research on the causes of and treatment for schizophrenia and bipolar disorder.