



# Catalyst

A Newsletter from the Treatment Advocacy Center

SUMMER 2010

## NEW STUDY:

# More Mentally Ill People in Jails Than Hospitals

In the mid-1800s, Americans were shocked to learn most mentally ill people were inhumanely housed in jails and prisons. A reform movement sparked by Dorothea Dix inspired state legislatures to build psychiatric hospitals and provide mentally ill people with treatment, not punishment.

Today our nation has regressed to the 19th century in criminalizing severe mental illness. Americans with brain diseases such as schizophrenia and bipolar disorder are three times more likely to be imprisoned than hospitalized, according to *More Mentally Ill Persons are in Jails and Prisons than Hospitals: A Survey of the States*, a new report by the Treatment Advocacy Center.

"If Dorothea Dix came back today, she would feel right at home," said Dr. E. Fuller Torrey, founder of the Treatment Advocacy Center and co-author of the report, which analyzes previously unpublished state data. "The present situation, whereby individuals with serious mental illnesses are being put into jails and prisons rather than into hospi-

tals, is a disgrace to American medicine and to common decency and fairness."

The Treatment Advocacy Center partnered with the National Sheriffs' Association in releasing the report to call attention to the high incarceration rates of severely mentally ill people in each of the 50 states.

While ratios of imprisonment to hospitalization vary from state to state, all states' ratios are dire. On the low end, North Dakota has an equal number of mentally ill individuals in hospitals as in jails or prisons. By contrast, Arizona and Nevada have 10 times more mentally ill individuals in prisons and jails than in hospitals. (See 50-state table on page 5.)

"In the best state, an individual suffering from a psychotic episode would have a 50-50 chance of imprisonment over hospitalization," said Treatment Advocacy Center Executive Director James Pavle. "The report

unveils an alarming trend of exiling the severely mentally ill out of hospitals and into the oblivion of the criminal justice system."

Recent studies suggest that at least 16 percent of inmates in jails and prisons have serious mental illnesses. As noted by study co-author and National Sheriffs' Association Executive Director

**"The present situation, whereby individuals with serious mental illnesses are being put into jails and prisons rather than into hospitals, is a disgrace to American medicine and to common decency and fairness."**

Aaron Kennard, "Jails and prisons are not designed for treating patients, and law enforcement officials are not trained to be mental health professionals."

The report is available at [www.TreatmentAdvocacyCenter.org](http://www.TreatmentAdvocacyCenter.org).

## Maine is 44th State to Adopt AOT

On April 14, 2010, Maine Governor John Baldacci signed into law LD 1360, making Maine the 44th state to adopt assisted outpatient treatment. The law improves Maine's ability to provide treatment to people with severe mental illnesses by allowing for court-ordered outpatient treatment as an alternative to inpatient hospitalization.

Championed by state senators John Nutting (D-Leeds) and Peter Mills

(R-Corvine), LD 1360 was supported by the courts, psychiatrists and families. "We adopted a law that will be immensely helpful to victims of mental illness and to their families. Today's achievement was in no small measure the product of thoughtful analysis and powerful advocacy of the Treatment Advocacy Center. Their timely assistance was crucial to our success," said Senator Mills.

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[www.TreatmentAdvocacyCenter.org](http://www.TreatmentAdvocacyCenter.org)



## Making History

“Those who do not learn from history are doomed to repeat it.” That quote applies equally to social problems and major events like wars and economic collapses. The report jointly released by the Treatment Advocacy Center and the National Sheriffs’ Association that you see described in this Catalyst triggers that “uh oh” feeling of history repeating itself.

We did not hear objections or rebuttals to this report from the usual corners. On the contrary, most of the media inquiries (the study has been covered by papers around the country), comments from supporters and, yes, inmates with serious mental illnesses, were along the lines of “this is abysmal, this is obvious...what are you doing about it?” We don’t have a magic wand, but we do work in our own way to actively advocate for improved treatment laws and to

shine a light on the problem. In that regard, I look forward to moderating a top-notch workshop panel on anosognosia, July 3, at the NAMI convention in Washington, D.C.

I recall a history professor who insisted in a voice that cracked with the emotion of living through the mid-20th century’s great challenges that “nothing is inevitable.” What he meant was that people, not invisible, inevitable or unstoppable forces, make history. We at the Treatment Advocacy Center may not make history every day, but we do influence it where we can — with your help.

In this issue you will read about great breakthroughs, as when Maine became the 44th state to adopt an AOT law; and you will read about the collaboration of our staff advocates working with family advocates and individuals with severe mental illnesses in Pennsylvania, Tennessee and elsewhere to fight the odds on behalf of better treatment laws.

So, help us to continue to make history. Because, as we know, nothing is inevitable.

Keep in Touch,

Jim Pavle, Executive Director

## ANOSOGNOSIA: Why Some Cannot Volunteer for Treatment

Impaired awareness of one’s own illness, medically known as anosognosia, is a strange condition. Caused by damage to specific parts of the brain, anosognosia is especially dangerous for those with severe mental illnesses.

Among neurologists, unawareness of illness is well known since it

also occurs in some individuals with strokes, brain tumors, Alzheimer’s disease and Huntington’s disease. However, in psychiatry impaired awareness of illness has only been widely discussed since the late 1980s.

Anosognosia affects approximately 50 percent of individuals with schizophrenia and 40 percent of individuals with bipolar disorder. It is the single largest reason why individuals with schizophrenia and bipolar disorder do not take their medications. Without insight into their disorder, these individuals believe their delusions and hallucinations are real and not a manifestation of illness.

To an observer, anosognosia is difficult to understand and easy to mislabel as denial. While denial is an unconscious defense mechanism used to refuse painful or unpleasant reality, impaired awareness of illness is the result of brain damage, particularly in the right hemisphere.

The presence and severity of anosognosia can vary in those with severe mental illnesses. Some individuals may fluctuate over time in their awareness, being more aware when they are in remission but losing the awareness when they relapse. When

taking medications, awareness of illness may improve in certain patients.

Without medication symptoms worsen, making the individual more vulnerable to victimization, suicide, and violent acts against others. It also often leads to repeated hospitalization, homelessness, or incarceration.

The prevalence of anosognosia in those with brain diseases such as schizophrenia and bipolar disorder necessitates assisted treatment, in both inpatient and outpatient settings, which helps those who are incapable of seeking treatment voluntarily, and those whose conditions have deteriorated as a result of rejecting treatment.

### 2010 NAMI Convention

Treatment Advocacy Center staff will be hosting a booth and a workshop on **Anosognosia**. Join us on Saturday, July 3, 2010 in Washington, DC. Panelists include: author Dr. Xavier Amador, attorney Jonathan Stanley, and film-maker Dr. Delaney Ruston.

## 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.

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# Profiles

## IN TREATMENT ADVOCACY

*Aileen Kroll, Legislative and Policy Counsel,  
Treatment Advocacy Center*

**Q. AILEEN, WHAT WOULD POSSESS YOU TO MOVE FROM SUNNY SOUTHERN CALIFORNIA TO ARLINGTON, VIRGINIA?**

A. I can't begin to tell you how many times I've been asked this question!

I was raised in Brooklyn, lived in northern California as a young adult, moved to Colorado and spent 17 years raising my kids (Genny and Jason) in the Ventura/Santa Barbara area. At this time I was working as the Legal Consultant for Patients' Rights for Santa Barbara County Alcohol, Drug and Mental Health Services. In this capacity, I represented people with severe mental illness who were involuntarily committed to a psychiatric hospital. It became clear that the more successful my representation, the more likely that someone would be prematurely discharged from the hospital, resulting in predictable recidivism (the hospital staff would actually take bets on how soon someone would be back), incarceration, or worse. It seemed to me that there had to be a better way. During this time I

learned about the Treatment Advocacy Center. Being a diehard civil libertarian, I had to think long and hard about whether I thought court-ordered outpatient treatment made sense. What I came to realize was that NOT having outpatient treatment made no sense and that legislative and systemic change was the answer I was looking for.

**Q. WHAT'S BEHIND YOUR DRIVE AND A PASSION FOR THE WORK?**

A. I was raised in the whirl and chaos of untreated severe mental illness. As a kid, I could not understand how it was that my mother could be so loving one minute and violent the next. This was at a time when the term 'mental illness' was a dirty word and even the suggestion of it brought admonitions from my father. Untreated and undiagnosed, she (and the whole family) suffered the unnecessary indignities of madness run amuck.

My baby brother, Scott, was also caught in the tentacles of mental illness. Diagnosed with paranoid schizophrenia, he went through the hell that is familiar to so many: repeated incarcerations, hospitalizations, medication regimens...and his death, at the tender age of 29. This is very hard to talk about, even 18 years later.

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*Aileen Kroll*

## Stanley Medical Research Institute Update

By Dr. E. Fuller Torrey

At any given time, SMRI is supporting about 60 treatment trials (see [www.stanleyresearch.org](http://www.stanleyresearch.org); click on Treatment Trials, then List of Awarded Treatment Trials). Almost all of these are on drugs that are no longer on patent or drugs that are available over-the-counter; thus, big pharmaceutical companies are not interested, because they cannot make big profits on them. Sometimes, SMRI supports trials of drugs that are still on patent but are being tested for a disease, such as schizophrenia or bipolar disorder, other than what the drug was approved for (called "off-label use").

Valnoctamide is a drug in the same family as valproate, one of the most commonly used mood stabilizers for bipolar disorder. It was briefly sold in the U.S. in the 1960s as a mild sedative and anti-anxiety drug and was sold in four European countries over-the-counter until a few years ago. With SMRI support, Dr. Robert Belmaker and his colleagues in Israel recently completed a double-blind trial using valnoctamide as a mood stabilizer on patients with bipolar disorder and schizoaffective disorder, and it was found to be effective. This is of special interest because previous studies in mice have shown that valnoctamide does not harm the fetus. All commonly used mood stabilizers, including valproate and lithium, are known to affect the fetus. This puts women with bipolar disorder who wish to become, or are, pregnant in a very difficult position. They can either stop their mood stabilizer and hope they do not become manic or severely depressed, or they can continue their medicine and hope it does not affect the fetus.

SMRI met with the FDA and has begun extensive tests of fetal toxicity to meet FDA standards. If it passes, we will move on to other tests and a larger clinical trial. The ultimate goal is to make available a mood stabilizer that has no effects on the fetus and would thus become a first choice drug for women with bipolar disorder who are in their childbearing years.

*Dr. Torrey continues to serve as Executive Director of SMRI where he oversees groundbreaking research on the causes of, and treatment for, schizophrenia and bipolar disorder.*

# AROUND THE States

## Maine

Maine is now the 44th state to adopt assisted outpatient treatment into law. “LD 1360 is a breakthrough. Not only will it protect rights, it will also provide safety and quality of life for the individuals, their families and the community,” said Joe Bruce, a local advocate who worked with state senators to get the law passed. Bruce became a champion of mental health reform after his family was afflicted by a tragedy caused by untreated mental illness. He worked closely with state lawmakers to change the law, which was not easy. Opponents tried to stop the bill at every turn. It took nearly ten years, strong bill sponsors, diligent family advocates, and coordination among numerous organizations that supported the legislation to bring about change.

However, the journey is just beginning. Implementing the new law could prove just as challenging. In many states, assisted outpatient treatment laws are not effectively used. We are hopeful that Maine will embrace its new law and use it to save lives. Here are some steps Maine and other states should take to ensure success:

- **Education** — The new law is a tool that can only be effective if those who need it know it exists. Educating stakeholders and families is one of the keys to success. Those interested in spreading the word can take summaries of the law (available at [www.TreatmentAdvocacyCenter.org/Maine](http://www.TreatmentAdvocacyCenter.org/Maine)) to local support groups, NAMI meetings, service providers, police stations, libraries and emergency rooms. Take a minute to talk about how the new law can help those whose lives are affected by severe mental illnesses.

- **Coordination** — Successful implementation requires coordination among families, law enforcement, judges, receiving facility administrators, and mental health providers. This may include working with those who object to the new law. Encourage stakeholder groups to meet and talk through the process for using the new law and the role each group can play.
- **Accountability** — In many states where assisted outpatient treatment laws are not implemented, no one is held accountable. Those who stand in the way of implementation bear some responsibility for tragedies caused by untreated mental illness; they should be held accountable through letters to local papers, elected and public officials.

While the new law is not an answer to all the issues with the mental health system, LD 1360 is a good step in the right direction. It has the potential to help get treatment to people with severe mental illnesses before a tragedy occurs.

## Pennsylvania

Pennsylvania lawmakers heard powerful and brave testimony during the April 8 House Public Health and Welfare Committee hearing on pending assisted outpatient treatment legislation. The testimony of Curt Bauer, a Pennsylvanian with severe mental illness, exposed the absurdity of the current law’s requirements for intervention:

*“I vehemently argued that I was not depressed...I’d know if I was... According to the therapist I was not in any ‘clear and present danger’. [My wife was told] to ‘sell the idea’ of how sick I was.*

*“Luckily she didn’t have to wait long [as] I tried to commit suicide.*

*Everything was dark. I had no feelings...I just existed, naked*

*spiritually, emotionally and physically. I did not die, and for this I am grateful. It also gave my wife the evidence that I now fulfilled the State’s requirement of being a clear and present danger to myself and others, and I found my way into recovery...*

*“The time has come for the passage of House Bill 2186 as a means of providing compassionate early intervention for individuals with mental illness or those with anosognosia.”*

The bill would help those incapable of seeking treatment voluntarily get the treatment they need to prevent harm to themselves or others.

## Indiana

*What to Do in a Psychiatric Crisis*, a booklet created by NAMI-Indiana, is now available to help Indiana residents find the mental health resources they need. “When a person is in a psychiatric crisis, it is imperative to be able to get him or her into treatment as quickly as possible,” said NAMI Indiana Executive Director Pamela McConey. The booklet and accompanying website with county specific resources are available online. NAMI Indiana distributed copies to community mental health centers, libraries throughout the state, local social security offices, and people seeking assistance. The booklet was dedicated to the memory of Abby Flynn, a spirited advocate for people with severe mental illnesses who inspired the project.

## North Carolina

Severely mentally ill North Carolinians are 3.5 times more likely to end up in jail than a hospital, which is more than the national average (See cover story). North Carolina, like all states, has returned to the conditions of the mid-1800s by putting large numbers of mentally ill persons back into jails and prisons. Outraged by the inhumane treatment of mentally ill inmates, 19th century mental health

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# Around the States

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reform activist Dorothea Dix petitioned state legislatures for better treatment, sparking a national reform to move severely mentally ill people out of jails and into more humane living conditions. Were Dix to speak before the North Carolina General Assembly today as she did in 1848, she could reuse her testimony:

*"I appear as the advocate of those who cannot plead their own cause; I come as the friend of those who are deserted, oppressed, and desolate. ...I am the voice of the maniac whose piercing cries from the dreary dungeons of your jails penetrate not your Halls of Legislation. ...Could the sighs and moans, and shrieks of the insane throughout your wide-extending land reach you here and now... how eager would you be to devise*

*schemes for their relief — plans for their restoration to the blessing of a right exercise of the reasoning faculties."*

## Tennessee

Tennessee is one of six states without an assisted outpatient treatment law. In recent years, a few enlightened members of the state legislature have introduced bills to establish such a law in Tennessee, only to be stymied by opposition from the state's department of mental health. But when the Legislature re-convenes in 2011, public uproar over recent shootings in public places involving mentally ill individuals just might prove stronger than any bureaucratic resistance to change.

The most recent tragedy occurred in Knoxville. As reported in the news, on April 19, Abdo Ibssa entered Parkwest Hospital with a gun and shot three employees, one fatally, before taking his own life. Ibssa was

well known to local authorities for his severe mental illness. He allegedly suffered from a delusional belief that a Parkwest doctor had implanted a tracking chip in his body. Earlier in 2010, Ibssa's family had successfully committed him to a state hospital. But when Ibssa's condition stabilized, he was released with a prescription and nothing more. Police investigators do not believe he was taking his medicine at the time of the shooting.

Much of the local news coverage has focused on how assisted outpatient treatment might have led to help for Ibssa before his condition deteriorated. Advocate Karen Easter wrote in the Knoxville News Sentinel, "The time has come for Tennessee to leave the Dark Ages of mental health care and enact an AOT law...But if the Parkwest tragedy doesn't wake up our legislators and mental health officials to this urgent need, I can't imagine what will."

Will Tennessee lawmakers take heed? Stay tuned.

## RATIOS OF INCARCERATION TO HOSPITALIZATION

State odds of a seriously mentally ill person being in jail or prison compared to in hospital:

Alabama	4.0 to 1	Montana	3.1 to 1
Alaska	3.6 to 1	Nebraska	1.7 to 1
Arizona	9.3 to 1	Nevada	9.8 to 1
Arkansas	3.3 to 1	New Hampshire	2.0 to 1
California	3.8 to 1	New Jersey	1.6 to 1
Colorado	4.1 to 1	New Mexico	3.3 to 1
Connecticut	1.9 to 1	New York	1.2 to 1
Delaware	3.0 to 1	North Carolina	3.5 to 1
Florida	4.9 to 1	North Dakota	1.0 to 1
Georgia	5.1 to 1	Ohio	4.0 to 1
Hawaii	2.9 to 1	Oklahoma	3.6 to 1
Idaho	4.6 to 1	Oregon	3.0 to 1
Illinois	2.7 to 1	Pennsylvania	2.0 to 1
Indiana	2.6 to 1	Rhode Island	1.5 to 1
Iowa	2.6 to 1	South Carolina	5.1 to 1
Kansas	3.5 to 1	South Dakota	2.4 to 1
Kentucky	2.9 to 1	Tennessee	3.1 to 1
Louisiana	4.6 to 1	Texas	7.8 to 1
Maine	1.2 to 1	Utah	4.0 to 1
Maryland	2.6 to 1	Vermont	1.8 to 1
Massachusetts	1.2 to 1	Virginia	3.6 to 1
Michigan	4.3 to 1	Washington	3.1 to 1
Minnesota	1.2 to 1	West Virginia	2.1 to 1
Mississippi	1.8 to 1	Wisconsin	3.9 to 1
Missouri	2.7 to 1	Wyoming	2.8 to 1
		<b>TOTAL</b>	<b>3.2 to 1</b>

## NOMINATE YOUR HERO!

Nominations are now being accepted for the Torrey Advocacy Commendation. Visit our website for full details. Entries must be postmarked by September 1, 2010 and sent by regular mail, email, or fax (703 294 6010) to The Treatment Advocacy Center, c/o TAC Award Nominee.

## Profiles in Advocacy

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My childhood experiences have informed my professional choices. Early on I sought "answers" which led me to my undergraduate degrees in Psychology and Anthropology, graduate work in Holistic Psychology and Social Work and serving as an outreach social worker. My decision to go to law school was largely based on my desire to learn more about the overall system to effect greater change.

### Q. THIS IS VERY HEAVY STUFF. WHAT DO YOU DO FOR FUN?

A. I love being outdoors: running, hiking, backpacking, canoeing, biking, climbing. I recently came back from a wondrous hiking and rock climbing trip in Utah. I am awed and inspired by the beauty of the natural world.

# Memorials & Tributes

(October 16, 2009 – May 31, 2010)

*The Treatment Advocacy Center expresses our deepest appreciation to all who have supported our mission with a donation in memory of a loved one or a friend.*

*We are also grateful to those who choose not to make their donation public. Thank you.*

Carol Ager, Cardiff, CA	In honor of my daughter	Dr. Irving Gottesman, Edina, MN	In memory of Norman Garmezy, Ph.D
Andrew Allerman, Tijeras, NM	In memory of Scott Ritterling	Linda Gregory, Jacksonville, FL	In memory of Deputy Eugene Gregory
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Sondra Beach, Montoursville, PA	In honor of Jennifer Dunn	Carl & Buzz Hays, Batavia, IL	In memory of Eric Hays, suicide of schizophrenia
Ruth Bean, New Paltz, NY	In memory of our wonderful son, Jason R. Bean	Mary Hershberger, Greenwood, IN	In honor of my son, Mark Hershberger
Linda Berglund, Minneapolis, MN	In honor of Kris Berglund	Jacquelyn & John Herum, Ellensburg, WA	In memory of Beth Skahill
Richard & Carol Boos, Portland, OR	In memory of Mary L. Boos	Barbara Hessenaure, Midland, MI	In honor of my children
Marilyn Booth, Inverness, FL	In honor of Michael Moore	Norma J. Hill, Mishawaka, IN	In honor of Dr. Fuller Torrey
Rhonda J. Bourne, Waltham, MA	In honor of staff of the Massachusetts Dept. of Mental Health	Dorothy Holmes, Red Wing, MN	In memory of Tom Holmes
Lucy L. Butcher, Sprague River, OR	In honor of Mary A. Bahl	Dr. & Mrs. Merle Hoops, Columbus, OH	In memory of Scott William Ritterling
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Jim & Jane Carlson, Westlake, OH	In memory of Christopher Carlson	June Husted & John Travis, Lincoln, CA	In memory of Todd Husted
Renee Casey, Fishers, IN	In honor of Andrea Woods	Nancy & UI James, Alexandria, VA	In honor of Beth James
Helen Caskey, Council Bluff, IA	In memory of Scott William Ritterling	Laura Hawley Jarvis, Silver Spring, MD	In memory of Susan Marie Dovel
Jeanette M. Castello, Newtown, PA	In honor of Aileen Kroll, TAC	Mr. & Mrs. Omar Jensen, Lincoln, NB	In memory of Joseph W. Bohn
Connie Cereola, Greenlawn, NY	In honor of Jean & Doug Richards	Elyse Jones, St. Clair Shores, MI	In honor of Anne Hudson
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Ken & Marilyn Fischer, Delaware, OH	In honor of Catherine M. Fischer	Mary Lou & Alan Lowry, Glen Ellyn, IL	In memory of Joanna Lowry
David & Alice Fitzcharles, Media, PA	In honor of Aileen Kroll	Marilyn Martin, Poolesville, MD	In honor of my beloved son in treatment by a warm psychiatrist
Eric & Melinda Fitzcharles, Lexington, KY	In honor of Alice & David Fitzcharles	Marcia & Michael Mathes, Orlando, FL	In memory of Eugene Gregory & Alan Singletary
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Hattie Segal, Maplewood, NJ  
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In honor of TAC  
In honor of Linda Hardy  
In memory of Scott C. Baker  
In honor of Matthew A. Parks  
In honor of the TAC Staff  
In memory of Iris A. Pistner  
In honor of Vera Kim McGraw  
In honor of Omar Pogue  
In honor of Joseph Esposito's  
75th birthday  
In honor of Ryan Riedel  
In memory of Scott William Ritterling  
In memory of Scott William Ritterling  
In memory of our son,  
Scott William Ritterling  
In memory of Scott William Ritterling  
In memory of Adam W. Roach,  
1979-2006  
In memory of Alice Dalton  
In loving memory of our cousin,  
Charmis Schalander  
In memory of William A. Hunt, III  
In memory of William A. Hunt, III  
In memory of Sharra Taylor Hurd  
In memory of Joyce Peterson  
In honor of Stephen Segal  
In memory of Mark Seifter  
In memory of my son, William A. Hunt, III

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In memory of John Schoepf  
In honor of Jennifer A. Scott  
In honor of D.J. Jaffe  
In honor of Aram Silver  
In honor of Deborah Gleeson  
In honor of my brother, my friend  
In honor of Karsten B. Soleng  
In honor of our son Paul  
In memory of Charles E. Stevens  
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In memory of Laura L. Wilcox  
In honor of Dr. E. Fuller Torrey  
In honor of Elyse  
In honor of Dr. Torrey  
In honor of Dr. E. Fuller Torrey

# Torrey Action Fund

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(July 1, 2009– May 31, 2010)

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