Across the nation, headlines decry our broken mental health system. Those with the most severe mental illness too frequently go without care, leading to dire consequences for them, their families and society at large. Untold human suffering—criminalization, homelessness, suicide, violence—has become commonplace as our system fails those most in need.

Efforts to effect reform are complicated by the fact that the U.S. mental health system is actually not one single broken system. Responsibility lies at the feet of 50 states and thousands of local governments, each with a unique set of laws, regulations, policies and budget decisions. As a result, whether or not an individual receives timely, appropriate treatment for an acute psychiatric crisis or chronic psychiatric disease is largely dependent on what community he or she is in when the crisis arises.

Grading the States: An Analysis of Involuntary Psychiatric Treatment Laws examines the laws that provide for involuntary treatment of psychiatric illness in each state, assessing each state’s treatment laws in comparison with those of the rest of the country. The question to be answered is simple: If an individual in a particular state needs involuntary evaluation or treatment, does the law allow this to occur in a timely fashion, for sufficient duration, and in a manner that promotes long-term stabilization?

Grading the States does not attempt to analyze every aspect of the involuntary treatment system. It focuses on its foundation—the legal underpinnings of how treatment can be provided for individuals most in need of care, and identifies specific statutory changes each state can make to improve access to care for this population.

Only seven states received A grades, while 10 failed our test completely. Maryland, a state fraught with barriers to treatment, fared the worst. Fewer than a third of states received a B grade or better. Wisconsin edged out Michigan and North Dakota for the highest score.

CONTINUED ON PAGE 12
hope you enjoyed our 20th anniversary edition of Catalyst. This edition returns to form, shining the spotlight on the work of the Treatment Advocacy Center and supporters like you to reform our mental health system and eliminate barriers to treatment for people with severe mental illness.

On the cover, our new Grading the States report details just how far the country has come in our 20 years of work to modernize treatment laws. Without laws that make mental illness treatment accessible, those most ill suffer needlessly.

As Dr. Torrey explains, this sort of analysis “represents the very core of the Treatment Advocacy Center.” We are proud of the impact our small shop has had on making treatment accessible nationwide and excited about making an even greater impact in the coming years.

Even as we continue this important work, we have ambitious goals to expand our impact even further.

On page 9, you will learn more about our work to help communities implement assisted outpatient treatment (AOT) programs. We recognize that passing a strong law is just the first step; that law must be accompanied by education and trainings to stand up AOT programs on the ground. And so we have expanded our staff to make education and training a priority. I am pleased to note it is already paying dividends – our team is now leading statewide AOT symposia and our AOT webinars have been attended by more than one thousand people.

Research on severe mental illness continues to be a priority of ours and this edition of Catalyst is no exception. From board member Bob Yolken’s research on the role of nitrated meat in mania hospitalizations to our damning analysis of NIMH’s failure to prioritize schizophrenia treatment trials (page 4), the Treatment Advocacy Center is conducting research on vital issues that are too often ignored by the mental health community. That work will continue this fall, as we release our first-of-its-kind analysis of the transportation costs associated with criminalizing mental illness (page 7). Stay tuned for more information on that!

Without laws that make mental illness treatment accessible, those most in need of care suffer needlessly.

As Dr. Torrey explains, this sort of analysis “represents the very core of the Treatment Advocacy Center.”

But we know that truly lasting mental health reform cannot happen without the engagement of families and dedicated supporters like you. That is why we are expanding our efforts to empower our grassroots supporters through new technology (page 6) and to be an even greater presence at events and conferences.

There is much to do, but we remain dedicated to the task of eliminating barriers to treatment for the severely ill. I cannot thank you enough for your continued support. I am proud of the Treatment Advocacy Center’s accomplishments and excited for our future. I hope you are too.

John Snook

SAVE THE DATE:
National AOT Symposium –
October 10-11, 2019 in Columbus, Ohio

The Treatment Advocacy Center will be hosting the first ever National Assisted Outpatient Treatment (AOT) Symposium on October 10-11, 2019, in Columbus, Ohio. The event will be open to teams from communities throughout the country interested in developing a new program or improving one already in existence.

The symposium will showcase model AOT programs; highlight the core elements of effective programs; emphasize the importance of treatment engagement using the “black robe effect” and “white coat effect”; and provide an opportunity for judges, mental health professionals, advocates, families and AOT participants to hear from and discuss concerns, challenges and successes with their counterparts.

We will be sharing a registration link with our email subscribers and on our social media platforms early next year. The symposium is being generously funded by Peg’s Foundation.
Remembering Dr. Fred Frese III

By Dr. E. Fuller Torrey

We are all a bit poorer because of the death of Fred Frese. Among all the people I know, I admired him the most and counted him as a close and valued friend. He was one of the founders of the Treatment Advocacy Center in 1998 and continued as a board member until his death.

Having been homeless and involuntarily hospitalized himself, he realized that assisted outpatient treatment was absolutely essential for some individuals with schizophrenia. He stuck to his position and supported the Treatment Advocacy Center despite great pressure on him from some of his friends who were bitterly opposed to any form of involuntary treatment.

Fred gave approximately 2,000 presentations between 1988 and 2018 on his experience of having schizophrenia, covering virtually every state and Canadian province as well as several foreign countries. Thus, he single-handedly educated a whole generation.

I had the pleasure of introducing him for the past 15 years for his annual two-hour lecture on schizophrenia to the medical students at the Uniformed Services University of the Health Sciences. The students would invariably arrive for the 7:30 am lecture looking half asleep and bored. Within 20 minutes they were on the edge of their seats as Fred, crouching in one corner of the stage, described what it was like to be crouching in a corner of the seclusion room to avoid the bullets of those sent to kill him. He would intersperse these experiences with very funny one-liners. On at least three occasions the students voted Fred as the best lecturer of the year.

I will remember Fred most for his warmth, invariable politeness and thoughtfulness of others. He was a great man who was afflicted with a terrible disease that he used to help educate others. He was a rare human being and we are all poorer for his death.

By John Snook

Dr. Frese’s involvement in the growth of our organization was extensive, and his humor and optimism were infectious.

As Dr. E. Fuller Torrey said, “Fred is an extraordinary person who has helped educate a whole generation about schizophrenia as a brain disease and has demonstrated that it is possible to live a full and productive life despite having it.”

Fred was also instrumental in the growth and direction of the Treatment Advocacy Center, serving as a founding board member and on our board for nearly twenty years. From testifying before Congress to appearing on Nightline, he remained a dedicated and hopeful champion for our cause, frequently saying that there is more hope for recovery today than ever before.

When I first met Fred at a talk at George Mason Law School, I was awed by his ability to engage an audience. Full of passion, energy and humor, Fred took a classroom full of wide-eyed students through the realities of what it was like to have psychosis, to be hospitalized, and what that experience was like for someone potentially with access to nuclear weapons. It was an amazing discussion; he took his illness from the abstract and made it real, illuminating the concerns that severe mental illnesses pose better than any other lecturer could have hoped.

To those who were unfamiliar with Dr. Frederick J. Frese, we encourage you to review some of his writings and videos.

For example, appearing before the Hogg Foundation for Mental Health last year, Fred spoke with characteristic pith and poignancy, telling a story of his last hospitalization, concluding proudly, “I am an escaped lunatic.” That video is available on YouTube.

In a blog post, Fred took on a specific moral concern, urging states to “Take the Death Penalty Off the Table.” No civilized county should allow the execution of people with severe mental illness, he argued with eloquence and conviction. We continue to make this case today, as we press for a death penalty exemption for people who commit crimes while psychotic.

On behalf of the Treatment Advocacy Center and our supporters across the country, I extend our heartfelt condolences to Fred’s many friends and his family. We will dearly miss Fred, but we know his legacy of advocacy will live on.
New research funded in part by the Stanley Medical Research Institute indicates that nitrates—chemicals used to cure beef jerky, hot dogs and other processed meats—may contribute to mania, an abnormal mood state common in patients with bipolar disorder. The Stanley Medical Research Institute is a supporting organization of the Treatment Advocacy Center.

Treatment Advocacy Center Board Member Robert Yolken, MD, and colleagues from Johns Hopkins University and Sheppard Pratt Hospital found that individuals hospitalized for mania had three and a half times higher odds of previously eating nitrated meats than individuals with no history of psychiatric disorders.

The authors analyzed ten years of patient records from more than 1,100 patients at Sheppard Pratt Health System in Baltimore, Maryland. A history of eating cured meats was significantly more likely to result in hospitalization for those with psychiatric disorders and manic episodes.

Mania is a state of elevated mood and energy that can last anywhere from a week to many months and is generally seen in people with bipolar disorder. Manic states can include delusional thinking and may lead to dangerous risk-taking behaviors. While eating nitrate-cured meats does not necessarily cause mania, the results indicate that certain diets and bacteria in the gut may contribute to disorders that affect the brain. The authors investigated the effect of feeding nitrated meats to rats and found similar results — rats who had been fed nitrate-rich foods exhibited extreme hyperactivity compared to rats fed a normal diet.

“We looked at a number of different dietary exposures and cured meat really stood out,” says Dr. Yolken. “It wasn’t just that people with mania have an abnormal diet.”

Dr. Yolken expresses caution in interpreting these results, indicating more research is needed before making any sort of final conclusions about dietary changes for individuals with bipolar disorder. However, the paper concluded that “While further investigations are warranted, individuals at risk for mania may consider limiting ingestion of added dietary nitrates.”
Saying NO to Big PHARMA

No nonprofit can survive, much less thrive, without reliable and generous donors. However, individuals and private foundations are unusually vital to the Treatment Advocacy Center because from the beginning — and alone among major mental health organizations — we have not accepted funding from the corporations most closely associated with mental illness treatment: pharmaceutical companies.

This is our position because we advocate for reforms that can result in individuals with severe mental illness being ordered to adhere to treatment plans that may include medication. And we believe that taking money from the companies that make those drugs and therefore stand to profit from the policies for which we advocate would create an unacceptable conflict of interest.

Further, we continue to be critical of corporate practices that result in the over-prescription of certain psychiatric medications.

The national failure to treat the disease adequately generates enormous economic and social costs. The mounting expense to taxpayers includes tens of billions of dollars in excess direct health care costs, and the cost of warehousing those with severe mental illness behind bars, as well as lost wages and caregiver costs.

An estimated 1.1% of the U.S. population has schizophrenia—roughly 2.8 million people—approximately 40 percent of whom are untreated. We strongly recommend that the NIMH reverse its policy on schizophrenia drug trials immediately since better medications are essential to helping people with this devastating disease.

To receive a copy of our report, please email your request, including your mailing address, to info@treatmentadvocacycenter.org.

Our Mission

The Treatment Advocacy Center is the only national nonprofit organization exclusively dedicated to eliminating barriers to the timely and effective treatment of severe mental illness.

We promote laws, policies and practices for the delivery of psychiatric care and support the development of innovative treatments for and research into the causes of severe and persistent psychiatric illnesses, such as schizophrenia and bipolar disorder.
Empowering Family Members and Engaging Grassroots Support

There are an estimated 8.3 million people in the United States with a severe mental illness, and many have one or more family member burdened by fear and anxiety and frustration whenever the system interferes with their loved one’s access to treatment.

After 20 years of advocacy, we know that those people—people like you—are the most powerful and persuasive voices for encouraging elected officials to take action. That is why we have been working to empower grassroots supporters to eliminate barriers to treatment from the ground up. Each day, more and more advocates across the country are stepping forward.

- In California, we rallied supporters behind proposals that would expand the definition of “gravely disabled” to those whose other mental illness endangers their lives through other medical conditions. Ultimately, hostile amendments could not be removed and the bill was withdrawn by its sponsor. Yet it garnered strong support from our California advocates and will be reintroduced next session.

- In New Hampshire, we created a letter calling attention to the state’s shameful practice of sending people with severe mental illness straight to prison, where members of this vulnerable population are effectively incarcerated. It is the only state in the country that does this. Despite being penalized by the court for not providing adequate treatment, the legislature’s solution was to pretend the Department of Corrections is an appropriate medical authority and that the State Prison for Men is a hospital. With our help, New Hampshire residents are saying “no—that is not okay; end this shameful practice!”

- In New Jersey, we supported a resolution by State Senators Richard Codey and Joseph Vital that urges Governor Phil Murphy to address dangerous overcrowding in state psychiatric hospitals by reopening Hagedorn Gero-Psychiatric Hospital. Scores of advocates in the Garden State sent messages to their legislators, telling them to support the Codey-Vitale resolution so Governor Murphy can reopen the hospital and create additional treatment beds. The bill received unanimous support in the Senate and was referred to the Assembly Health and Senior Services Committee.

- When we heard that New York-Presbyterian Hospital was considering closing the Allen Hospital Psych Unit in upper Manhattan, even though those beds are regularly at capacity, we rallied to action. The hospital’s plan continues a worrisome trend across New York, as other hospitals have already eliminated vital psychiatric beds, including Mount Sinai, Staten Island University Hospital, and H+H Woodhull Medical and Mental Health Center. In collaboration with the New York State Nurses Union and other advocates, we pressed New Yorkers and their representatives in Albany to end the shortsighted elimination of inpatient psychiatric beds at Allen Hospital and all across New York. We succeeded for the time being, as that closure is currently on hold.

- In Pennsylvania, we engaged family members to write their legislators in support of advancing an AOT bill. The bill creates a path to care in the community for people too sick to volunteer for services—a path currently unavailable under the Commonwealth’s “clear and present danger” standard for treatment. These letters were referenced by legislators in negotiations and ultimately helped advance the bill with unanimous support from the Senate Health and Human Services Committee to the full Senate where it awaits floor action.

- In Virginia, a young man with schizophrenia named Christopher Sharikas has been imprisoned for the entire 20 years of the Treatment Advocacy Center’s existence. He received a harsher sentence than someone not suffering from a severe mental illness, and he does not belong in jail; he belongs in a treatment bed instead. In collaboration with Christopher’s family and hundreds of supporting voices, we have been urging residents of the Commonwealth to tell Governor Northam to rectify this injustice and pardon Chris.

- At the federal level, our campaign to repeal the Institutions for Mental Diseases (IMD) exclusion, continues. To date, more than a thousand Americans have signed our petition, written letters, and tweeted to the President, Vice President, and their members of Congress, calling on them to repeal this outdated and discriminatory Medicaid law, now. Congress has still not repealed the IMD exclusion, our desire to remove this restriction on insurance reimbursements remains.

- We also worked to hold the National Institute of Mental Health accountable, as we noted earlier in this publication, calling attention to the decision of NIMH’s director, Dr. Joshua Gordon, to halt new drug trials for schizophrenia. Given that the current drug treatments for this disease are ages old, we found this inexcusable. We took our concerns to the media, and urged supporters to write to their members of Congress and say that the stakes are too high for NIMH to just give up on the search for better medications.

Click on the “What You Can Do” tab of our homepage www.treatmentadvocacycenter.org and scroll down to the “Advocate” link for ways that you too can effect positive change in your state.
Law enforcement officers are often called ‘frontline mental health workers,’ ‘street corner psychiatrists,’ or ‘gatekeepers to the mental health system’ due to their increased involvement in crisis response for individuals with severe mental illness.

It should not be that way, but deficiencies in the mental health system force law enforcement to intervene, and dedicate significant time and resources responding to such crises. Often, they must transport individuals in mental health crisis to emergency rooms, crisis centers, or inpatient facilities, and wait with the individual until service is received. Because mental health treatment facilities are in short supply and may be miles away from the original pick-up location, officers often transport would-be patients over great distances.

That is why the Treatment Advocacy Center, in partnership with the National Sheriffs’ Association and New York State Association of Chiefs of Police, conducted a survey of law enforcement officers throughout the United States -- to understand the role of law enforcement in psychiatric crisis response and the transport of individuals with severe mental illness, as well as the impacts these responsibilities have on public resources.

Together, we collected data from police departments and sheriffs’ offices across the country. One of the things we learned is that for many officers, there are clear incentives for officers to transport an individual in mental health crisis to jail instead of a medical facility due to how long they have to drive and how long they have to wait until transfer of custody occurs.

We will be publishing the complete survey results and recommendations for policymakers soon. A preview of our findings can be found in the infographic below, which our director of research Elizabeth Sinclair showcased at a recent Crisis Intervention Team International conference in Kansas City, Missouri. Elizabeth will also be presenting the preliminary findings to an international audience in late October at the Law Enforcement Public Health meeting in Toronto, Canada.

Everyone suffers when law enforcement is forced unnecessarily onto the front lines of mental health care. Our upcoming report, funded by the Bodman Foundation, will provide, for the first time ever, a national view into how just how broken the system has become and what must be done to address it.
By Keith Kutz

I remember my son Travis developing a temper. He was not necessarily physically violent, but he was unruly enough that I had to throw him out of my house. When I did, he went to his mother’s house. Later, he returned to mine.

I would try to talk to him, but our discussion would devolve into arguments. Travis would then leave in a huff—a vicious and volatile cycle: okay one day; pissed off the next.

At his mother’s place, Travis started having conversations with the television. He thought he was talking to me, but I was not there.

One winter morning, I looked out my window into the woods. Something was off. There was an unfamiliar shape in the landscape.

I put on my shoes and approached. It was Travis in a sleeping bag, completely covered in snow. I feared the worst and yelled his name. No response.

Travis was still alive, but he continued to sleep outside and in sheds behind his friends’ houses. He needed help.

Twice I called the police and had Travis involuntarily committed. However, limitations in Pennsylvania’s Mental Health Procedures Act allowed Travis to sign himself out of the hospital the next day.

I could not get my son to seek help voluntarily, and the hospitals would not keep him. My hands were tied...

Until one day when my neighbor called. He said he called the cops after seeing someone sneaking through the front window of my house.

Minutes later, I received another call. A policeman told me Travis had been caught crawling out my window with food. He had been hungry. “Do you want to press charges?” the officer asked.

That was when I made one of the hardest decisions of my life—I had my son arrested. It’s something no parent should have to do.

I reasoned that people in the correctional system would see that he needed medical attention and care for him in a way I could not. I was wrong.

Travis was put in a cell. There, his condition deteriorated. I asked about visiting. Someone at the prison told me Travis would probably know me. Probably... That broke my heart.

When our court date came, my son threw a tantrum. He yelled at me in the courtroom. He was declared incompetent to stand trial.

Prison had not helped, and it ate at me that I put him there.

Riley Yates, a reporter from the daily newspaper in Allentown, the Morning Call, took interest and interviewed me for a video. His piece exposed Pennsylvania’s broken mental health treatment system and the poor conditions for inmates with severe mental illness.

I learned that the American Civil Liberties Union had sued the Commonwealth of Pennsylvania over the lengthy backlogs for mentally ill defendants needing treatment at one of two state mental hospitals. The official term for this process is “competency restoration,” and the line for one of the state’s few remaining psychiatric beds had bottlenecked. The cases of drug dealers and murderers go right to trial, but people like Travis were waiting months to be stabilized enough to make it through a court proceeding.

The delay killed some prisoners. In Philadelphia, one person took his own life before his competency could be restored. Another was murdered in jail.

And let’s be frank, the treatment these so-called “forensic patients” receive is the bare minimum needed to face their charges in court; it’s not the type of comprehensive medical care that dangerously delusional people need.

The state conceded that point, settling the lawsuit. It promised to reduce bed waits and to invest in other improvements to the treatment system. However, the number of inmates awaiting beds only grew. I grew frustrated. I just wanted my kid back.

A month after the Morning Call story ran, a bed miraculously opened up at the State Hospital in Norristown, Pennsylvania. But for that article, Travis would still be waiting.

I was relieved. But Norristown is an old, run-down building more than an hour drive from my house. It was little better than Northampton County Prison. The state should be embarrassed at the condition of its hospitals.

Fortunately, Travis is currently at a different facility, where he is being cared for by good doctors and therapists. He is doing okay.

As for me, I am hopeful for a day when we can all get on with our daily routines without the anxiety and uncertainty of the last few years, but I am still mad that Pennsylvania puts the families of people with severe mental illness through ordeals like mine.

Keith Kutz lives in Bangor, Pennsylvania, where he drives a truck and serves as president of a local VFW. He has two children, including Travis.
Implementation Trainings and Webinars

As communities across the nation embrace assisted outpatient treatment (AOT), the Treatment Advocacy Center is stepping up to ensure that decision makers, providers, families and consumers have the tools they need to make AOT a success. Our partnership with the Ohio-based Peg’s Foundation is a central component of our efforts.

Peg’s Foundation works to improve the lives of people with severe mental illness by investing in innovative, transformational, and impactful projects. Together, we are supporting the implementation of AOT in counties across Ohio and working to make the state a national model.

As part of our partnership, communities interested in implementing AOT are visiting Ohio to witness first-hand how these programs operate. From Seattle to Baton Rouge, the lessons of Ohio are helping communities stand up AOT programs and help those most in need.

The Treatment Advocacy Center has also been bringing teams of practitioners together for statewide AOT symposia. In May, in collaboration with the Kansas affiliate of the National Alliance on Mental Illness, the Kansas Association of Chiefs of Police, the Kansas Sheriffs’ Association, and the Association of Community Mental Health Centers, we assembled teams from across the state for a daylong AOT symposium that encouraged networking and idea sharing.

Members of our staff have also been educating people through series of webinars, covering a range of issues from integrating AOT programs with Crisis Intervention Teams to engaging families, to best practices for an effective AOT judge.

Our webinars have addressed many of the most pressing issues communities face when starting up AOT programs, and the response we have received has been phenomenal. One webinar we conducted in May along with the Substance Abuse and Mental Health Services Administration’s Center for Mental Health Services and Duke University researcher Dr. Marvin Swartz had more than 1,000 participants!

Meeting of the Interdepartmental Severe mental illness Coordinating Committee

On June 8, the federal Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC), which focuses on ensuring coordination and focus on severe mental illness among federal agencies, held its latest daylong meeting. Our executive director John Snook serves as one of the committee’s fourteen national experts.

Treatment Advocacy Center’s influence was apparent from the start of the meeting. As Health and Human Services Secretary Azar called the meeting to order he cited our finding that there are ten times more Americans with severe mental illness in jail and prisons than in psychiatric hospitals.

As the committee moved on to discuss other major issues, the conversation highlighted just how the federal government has honed its focus on severe mental illness. The meeting considered how to create supports for states interested in modernizing their civil commitment standards, psychiatric bed registries, a host of initiatives around decriminalizing mental illness and addressing competency restoration issues, and efforts to bolster the full continuum of crisis response services.

Treatment Advocacy Center has been involved in each of these areas and will continue to fight to make sure any federal initiatives reflect the lessons we have learned from families and communities across the nation.

In the afternoon, our work was again referenced in presentations by the National Institute of Mental Health National Mental Health and Substance Use Policy Laboratory, which highlighted the inefficacy and inadequacy of the federal government research on severe mental illness, in particular as it pertains to prevalence data. The initiative was spurred by a paper our research director Elizabeth Sinclair and our founder Dr. Torrey authored, and which was featured on the cover of Psychiatric Times, and summarized in our previous edition of Catalyst.

The good news is that both the ISMICC and the Department of Health and Human Services Assistant Secretary for Mental Health and Substance Use, Dr. Elinore McCance-Katz, recognize that the federal government’s prevalence estimates are woefully outdated and pledge a strong federal focus to address the problem—a great victory for the Treatment Advocacy Center!
On July 11th, our former executive director and chief researcher, Doris Fuller, travelled to Washington, D.C. to share her perspective at a session of the Federal Commission on School Safety. Her panel focused on the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and confidentiality. She was invited to speak as both a mental health advocate and a family member who has observed HIPAA’s role in mental health care delivery in a number of settings, including on college campuses.

Doris explained to the commission that “medical providers, schools and a host of others routinely claim they withhold information or bar family members from treatment deliberations to avoid liability for violating HIPAA,” despite the fact that the HIPAA Privacy Rule allows communications between health care providers and patient family and friends, and that there is no statutory provision in HIPAA for such legal action.

She continued by explaining how heart-broken she was, and remains, over her daughter’s death, but adds that she could not imagine the grief of parents she has met whose first knowledge that their child had mental health issues came in the call notifying them their child had died.

Doris’ testimony concludes: “We should be beyond debating the principle of whether it is in the best interest of young people or their communities to exclude family members from the mental health care team. We don’t leave family members out of decisions about the care of aging parents with compromised thinking. We don’t shut family out of the ER when their loved ones have a medical crisis or are injured in car accidents. Federal law and clinical practice recognize the family’s vital role in mental health care. Anything less than universal embrace should be unacceptable.

“Our school children are our future. For their sake and ours, the HIPAA training mandates of the 21st Century Cures Act need to be funded and fulfilled so that inclusion, not exclusion, of families is the default.”

We applaud Doris’ continued advocacy and the strength and conviction with which she shares her personal story.
Making the Case for More Psychiatric Beds, Better Access to Treatment

The Treatment Advocacy Center has long encouraged policymakers to address the severe shortage of psychiatric treatment beds in America. Among other opinion pieces published this year, our executive director made this case while arguing for striking a proper balance between guarding one’s civil liberties and ensuring the public welfare. Below are excerpts from two columns, one in the National Review and another in Health Affairs.

**AMERICA BADLY NEEDS MORE PSYCHIATRIC-TREATMENT BEDS**
By John Snook & E. Fuller Torrey

In a time of competing narratives and virtually unprecedented levels of polarization, there is one sad truth that Americans can readily agree on: our mental-health system is broken.

Specifically, the U.S. has long faced a critical shortage of inpatient psychiatric-treatment beds, with devastating societal consequences. From its historic peak in 1955 to 2016, the number of state psychiatric-hospital beds in the United States plummeted almost 97 percent, in a trend known as “deinstitutionalization.” There are now fewer beds per capita in the United States than there were in 1850. An analysis of the broader system of both inpatient and other 24-hour residential-treatment beds similarly found a 77.4 percent decrease from 1970 to 2014.

While inpatient treatment beds represent only one aspect of a functioning mental-health system, they are a vital one. Without access to a bed, acutely ill individuals are left to wait for the proper treatment, forcing mental-health professionals to triage the most severely ill in hopes of short-circuiting the next awful, unnecessary massacre. At the same time, families are caught in their own nightmare, watching helplessly as their loved ones deteriorate in the absence of the right care. With nowhere else to turn, those in need end up in the only remaining systems that cannot say no: emergency rooms, homeless shelters and, too often, jails and prisons.

**THE REAL CIVIL COMMITMENT CRISIS AND HOW TO SOLVE IT**
By John Snook

Civil commitment is by tradition a state purview, with little role for the president or federal government. In state legislatures, the debate over dangerousness standards has largely ended.

Over the past 20 years, my organization, the Treatment Advocacy Center, has worked with more than 30 states to modernize their civil commitment standards to include factors beyond overt dangerousness. This reform effort gained vital advocacy support from families who had faced the nightmare of seeing an obviously ill loved one denied care simply because they had not yet become violent. As evidenced by these families’ experiences, demanding immediate evidence of danger delays the provision of care, often leading to unjustifiable deterioration and unnecessary criminalization.

Communities across the country are facing a mental health crisis of unimaginable proportions. Our safety nets—jails, emergency departments, and homeless shelters—are stretched beyond their breaking point. In the face of such urgency, our task should be clear: We must come together to establish a mental health system that includes robust services at all levels and that provides a full continuum of care for those with the most severe mental illness. That this position could be seen as controversial is a testament to the severity of the problems we face. We can and must do better.

*These articles can be found online in full in the Features and News section of the Treatment Advocacy Center website.*
While this report is limited to evaluating the letter of the states’ laws, we caution that even our highest scorers have much room for improving the treatment available to people with severe mental illness. Pitfalls remain related to funding and the practical implementation of those laws—pitfalls that lead to significant and unnecessary barriers to treatment for people in desperate need of care. The sad reality is that across the country, patients and their families continue to face a crisis-level shortage of treatment beds, supportive housing and community-based services, and policymakers appear unwilling to prioritize the needs of the severely ill.

Whether you are an advocate in the legislative trenches fighting for reform or someone eager to get help for a loved one, please review *Grading the States* for an in-depth analysis of what your state laws do—and do not—make possible. Find it on our website at TACreports.org.

At the National Alliance on Mental Illness convention in New Orleans in June we hosted a meet and greet for conference participants, area advocates, and anyone else who was interested in getting to know more about our work. At a local cafe, we networked with a room full of like-minded people and discussed our efforts to eliminate barriers to treatment for people with severe mental illness.

Many of the attendees were unfamiliar with our unique status in the advocacy community as the only national nonprofit dedicated to reforming the mental health system that does not accept funding from companies or entities involved in the sale, marketing or distribution of pharmaceutical products. We appreciate the time and interest of everyone that attended.