Helping Families in Mental Health Crisis
A CHANCE FOR CONGRESS TO IMPROVE TREATMENT

The most comprehensive mental health legislation in half a century is now pending in Congress. Over a hundred pages long and addressing more than a score of treatment policies and practices that create barriers to treatment, the Helping Families in Mental Health Crisis Act (H.R. 3717) is a potential game-changer for individuals and families living with severe mental illness and their communities.

The last piece of comprehensive mental health legislation Congress passed was the Community Mental Health Centers Act (CMHA) of 1963. While well-intentioned, the CMHA set off the destruction of America’s treatment system for people with the most severe psychiatric diseases, precipitating the many negative consequences that followed. Rep. Tim Murphy’s Helping Families in Mental Health Crisis Act is designed to reverse those trends.

“Those who need help the most are getting it the least because the nation’s mental health system is broken,” Murphy told a press conference after introducing the legislation. “Too many individuals with mental illness are ending up on the street or in jail because of mental illness. We must no longer be silent on the need to help the mentally ill because millions of families are struggling with a son, daughter, or loved one who is sick and needs help.”

Murphy’s bill emerged from a series of hearings on mental illness treatment issues held last year before the House Energy and Commerce Subcommittee on Oversight and Investigations, which the Pennsylvania Congressman chairs. The hearings “revealed that the approach by the federal government to mental health is a chaotic patchwork of antiquated programs and ineffective policies across numerous agencies,” in the lawmaker’s words.

Many of the policies and practices identified as barriers to treatment during the hearings are problems the Treatment Advocacy Center has long worked to resolve. These include laws that limit involuntary treatment options for individuals in psychiatric crisis until they become dangerous, the failure of five states to authorize assisted outpatient treatment (AOT) and the failure of the other states to use AOT as widely as they could.

To see just how high the barriers to treatment are in your state, look no further than our latest study, “Mental Health Commitment Laws: A Survey of the States.” Released in February, this study found most U.S. states in need of significant improvements to their mental illness treatment laws to protect and provide for individuals in psychiatric crisis.

(See page 4 to learn more.)

CONTINUED ON PAGE 3
When Location, Location, Location is Wrong

A MESSAGE FROM THE Executive Director

sometimes half-joke that I live my work because, besides being the Treatment Advocacy Center’s executive director, I’m guardian to an adult daughter with a serious mental illness. This at times gives my personal life the texture of a proving ground for the public policies we advocate – days when I get behind the wheel and see for myself how well policies and practices work or don’t.

These test drives give a whole extra layer of meaning to two of the topics we cover in this issue of Catalyst: Rep. Tim Murphy’s Helping Families in Mental Health Crisis Act (pages 1 and 3) and our own latest study, “Mental Health Commitment Laws: A Survey of the States” (pages 4 and 5).

When my daughter experienced her first psychiatric crisis, she was a college senior living in Idaho. Idaho is best known as the land of famous potatoes, but our survey of the states found it’s also home to some of the best mental illness treatment laws in America. That explains why, when my daughter was on the early-diagnosis roller coaster of soaring recoveries punctuated by terrifying plunges, she repeatedly was able to get the inpatient or outpatient treatment she needed when her symptoms indicated she needed it – not after she deteriorated to dangerousness. The quality of the state’s laws also accounts for why she was discharged from care only after clear evidence she no longer needed treatment.

At the time, I assumed that’s how things worked everywhere.

How very wrong I was.

Last September, having completed the senior year of college she began so many roller coaster rides ago, she moved to Virginia to live near me and other family members. Almost as soon as she’d turned in her Idaho driver’s license, her latest flight of recovery came to an end with a sudden episode of dangerousness requiring a brief emergency hospitalization.

In the three weeks that followed, she admitted herself to hospitals three more times, after she became unsafe. But because she wasn’t entitled to treatment just because she needed it, pressure from Virginia’s Medicaid program to discharge her began about a nanosecond after she

What I’ve learned by living my work is this:

Location is everything. Find out from our state survey what your state has decided about the treatment you or your loved one can receive in a crisis and use the information to demand better laws and wider use of them where you live.

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resembled wearing mascara (which was oddly viewed as a sign of wellness), regardless of how symptomatic or psychiatrically unstable she actually was.

She’d been sucked into the revolving door the Treatment Advocacy Center works to stop: ER/hospital/discharge/ER . . . ER/hospital/discharge/ER, each time being admitted in worse condition than she’d been at her last discharge. Bountiful county outpatient services were available to support her at home, but she wasn’t well enough to access them herself. She needed intensive inpatient care, and she could only get it a few days at a time.

In a press release announcing our new survey of the states, we declared that “where a person lives should not determine whether or not he or she receives treatment.”

What I’ve learned by living my work is this: Location is everything. Find out from our state survey what your state has decided about the treatment you or your loved one can receive in a crisis and use the information to demand better laws and wider use of them where you live. Meanwhile, learn how Rep. Murphy’s landmark bill would address some of the geographic differences and let your Congressman know you support its passage.

To get the treatment you or a loved one needs when it’s needed, you shouldn’t have to move to Idaho.
How the Mental Health Crisis Act Helps

The Helping Families in Mental Health Crisis Act (H.R. 3717) has the potential to reshape America’s mental health system and make lifesaving treatment available to more individuals with the most severe psychiatric diseases.

Proposed by Republican Congressman Tim Murphy and co-sponsored by Democrats and Republicans alike, the problems the bill addresses are everybody’s problems. Specific provisions of the bill include:

• Requiring states to have commitment criteria broader than “dangerousness” in order to receive Community Mental Health Services Block Grant funds
• Requiring states to have assisted outpatient treatment (AOT) laws in order to receive Community Mental Health Services Block Grant funds
• Allocating $15 million for a federal AOT block grant program funding up to 50 grants per year for new, local, court-ordered outpatient treatment programs
• Clarifying HIPAA to assure caregivers are able to receive protected health information when necessary to protect the health, safety or welfare of a patient or the safety of another. (The definition of “caregiver” includes immediate family members.)
• Progress in ending longstanding discrimination against people with mental illness by permitting federal Medicaid reimbursement of acute, inpatient psychiatric treatment
• Encouraging the diversion of individuals with mental illness from the criminal justice system by promoting mental health courts and crisis intervention team (CIT) policing
• Requiring the U.S. comptroller general to submit a report to Congress detailing the costs to the federal and state government of imprisoning people with severe mental illness
• Preventing federally funded “Protection and Advocacy” organizations from engaging in lobbying activities and counseling individuals on “refusing medical treatment or acting against wishes of a caregiver”
• Increasing Congressional oversight of SAMHSA (Substance Abuse and Mental Health Services Administration) programs and seeking improvements to the programs it supports
• Establishing a new National Mental Health Policy Laboratory in the Department of Health and Human Services

A clinical psychologist with three decades of professional experience, Murphy identified 13 goals of the Helping Families in Mental Health Crisis Act:

• Empowering parents and caregivers
• Addressing the shortage of psychiatric beds
• Stabilizing patients beyond the emergency room
• Promoting alternatives to institutionalization
• Encouraging greater use of criminal diversion programs
• Reaching underserved and rural populations
• Fostering evidence-based care
• Advancing critical medical research
• Improving the quality of community behavioral health services
• Reducing mental illness stigma in schools
• Integrating primary and behavioral care
• Increasing physician volunteerism in community mental health facilities
• Reforming the Substance Abuse and Mental Health Services Administration (SAMHSA)

Rep. Murphy continues to recruit cosponsors for the bill, which will ultimately be heard by the committees that oversee each of the issues addressed in the legislation. The committees must vote them out before they can be considered by the House of Representatives and sent to the Senate. A number of well-organized and well-financed constituencies have mobilized in active opposition to the Murphy bill, especially those that stand to lose government funding if the legislation passes.

If enacted, the Helping Families in Mental Health Crisis Act has the potential to improve lives as dramatically as the Community Mental Health Centers Act destroyed them.

Now is the time to tell your members of Congress you support H.R. 3717.
Treatment Advocacy Center Reports on State Treatment Laws and Their Use

DISMAL RESULTS IN MOST STATES

The majority of U.S. states need to significantly improve their laws to protect and provide for individuals in psychiatric crisis, according to a study released in February by the Treatment Advocacy Center. Compounding the problem, the study also found most states grossly underuse the laws they have.

The analysis led to some troubling findings:

- No state earned a grade of “A” on the use of its civil commitment laws.
- Only 14 states earned a cumulative grade of “B” or better for the quality of their civil commitment laws.
- 17 states earned a cumulative grade of “D” or “F” for the quality of their laws.
- Only 18 states were found to recognize the need for treatment as a basis for civil commitment to a hospital, and several of those were found to have less than ideal standards.
- Only 45 states have laws authorizing the use of court-ordered treatment in the community, only 20 of those were found to have optimal eligibility criteria.
- 27 states provide court-ordered hospital treatment only to people at risk of violence or suicide even though most of these states have laws allowing treatment under additional circumstances.
- While 45 states have laws authorizing the use of court-ordered outpatient treatment (often called “assisted outpatient treatment” or “AOT”), including eight states with laws on their books authorizing such treatment.
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- 17 states earned a cumulative grade of “D” or “F” for the quality of their laws.
- Only 18 states were found to recognize the need for treatment as a basis for civil commitment to a hospital, and several of those were found to have less than ideal standards.
- While 45 states have laws authorizing the use of court-ordered treatment in the community, only 20 of those were found to have optimal eligibility criteria.
- 27 states provide court-ordered hospital treatment only to people at risk of violence or suicide even though most of these states have laws allowing treatment under additional circumstances.
- 12 states make no use whatsoever of court-ordered outpatient treatment (often called “assisted outpatient treatment” or “AOT”), including eight states with laws on their books authorizing such treatment.
- 20 states received scoring penalties for the prevalence of bed waits. In two of the most populous states – Florida and Texas – bed waits were reported to typically exceed two weeks.
- Significant delays in delivering medication over objection were found in only five states, four of them in New England. In Vermont and New Hampshire, the typical delay in providing medication over objection to individuals in psychiatric crisis who were unable to recognize their need for treatment was reported to be more than two months.

While these collective results underscore the scope of the national problem, the report’s greatest value may lie in the roadmap it provides to grassroots advocates and policymakers who wish to improve treatment laws and practices in their own states. On our TACReports.org website, the scoring behind each state’s grade is reported on detailed, state-specific pages that identify the particular areas in need of improvement.

See page 5 for our report card on the states. The full report is published online at TACReports.org/state-survey. For a printed copy, please email us at info@treatmentadvocacycenter.org.
# Quality of Laws from A Survey of the States

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OREGON
A new assisted outpatient treatment (AOT) program is beginning to take shape in Josephine County, with guidance from the Treatment Advocacy Center. To more effectively implement the program in his state, Oregon Judge Pat Wolk visited California to meet with Nevada County Superior Court Judge Tom Anderson and learn more about how the county’s award-winning AOT program works. Our state survey gave Oregon a C- for its use of civil commitment laws, which reflected among other practices its spotty and variable use of AOT around the state.

WASHINGTON
Doug and Nancy Reuter’s son, Joel, 28, was killed by police in Seattle in July 2013. Since the tragedy, the Reuters have been working to make changes to the law to prevent future tragedies in Washington state, where Joel lived at the time of his death. The changes they are seeking would make it easier for family members to petition the courts for an emergency evaluation of someone too ill to seek treatment. The Reuters believe that if the law had allowed them to petition, their son would still be alive.

The Washington State House of Representatives unanimously passed a bill promoted by the Reuters to establish a process allowing an immediate family member to be involved in the petition process. Washington’s Senate Ways and Means Committee voted March 3 to send the bill to the Rules Committee, where it remains. Visit page 9 to read Nancy and Doug Reuter describe how they became advocates for “Joel’s Law.”

FIND AN UPDATE ON THESE PAGES
OTHER STATES WHERE LEGISLATION HAS BEEN INTRODUCED SINCE THE BEGINNING OF THE YEAR
MARYLAND

Our survey of state mental health commitment laws found that Maryland has some of the nation's worst laws for addressing the needs of individuals with severe mental illness who cannot recognize their own need for care. Three bills drafted by the Treatment Advocacy Center to resolve these problems were introduced this year in the Maryland legislature.

Maryland remains one of only five states without assisted outpatient treatment (AOT). One bill would finally move the state into the AOT column. A second would make it clear that inability of a person with mental illness to meet his or her own basic survival needs is grounds for hospital commitment, even if the person is not violent or suicidal. The third bill would undo a disastrous court decision that prevents medication over objection of involuntary hospital patients unless they are found to be dangerous to self or others while in the hospital, regardless of the danger they would pose in the world outside.

Families across the state who struggle with the current laws have rallied in support.

OHIO

A bill to clarify Ohio's AOT law (S.B. 43/H.B. 104) would eliminate any question about whether a probate court judge in the state has the authority to order qualifying individuals with serious and persistent mental illness into outpatient treatment.

Once enacted, judges would have clear authority to step in before individuals with serious mental illness who meet the state's criteria become so ill that hospitalization or other consequences of non-treatment, such as incarceration, result. The new law creates an opportunity for Ohio to vastly expand its use of assisted outpatient treatment to benefit some of Ohio's most vulnerable citizens.

PENNSYLVANIA

Pennsylvania received Fs in our state survey for the quality of its inpatient and outpatient laws. The state's civil commitment laws currently are among the most restrictive in the country, requiring "clear and present danger" before a person unable to seek help can be provided with involuntary treatment. S.B. 796, sponsored by Pennsylvania State Senator Patricia Vance, stands to change that. The bill, which would change the commitment standard from "clear and present danger" to one of "a totality of the circumstances," eliminates the requirement that a patient "commit an act in furtherance of a threat" to meet criteria for dangerousness, such as writing a suicide note or purchasing the means to carry through on a threat. While these potential changes fall far short of what is necessary to fully repair the law in Pennsylvania, they are a step in the right direction.

VIRGINIA

In late 2013, Virginia Senator Creigh Deeds' 24-year-old son, Gus Deeds, stabbed the senator multiple times and then took his own life. Just hours earlier, Bath County authorities had released Gus from an emergency custody order because the six-hour time limit expired before mental health officials could find an available psychiatric bed to hold him for an additional period. Responding to the tragedy that resulted, Senator Deeds filed multiple bills addressing treatment for mental illness.

One of the senator's proposals, backed by the Senate, extended the time a person may be held under an emergency custody order from 6 to 24 hours. In a compromise with the House, the legislature voted to extend the emergency custody order for up to 12 hours. The legislature also voted to extend the time a person can be held involuntarily under a temporary detention order from 48 to 72 hours and passed a bill that requires the creation of an acute psychiatric bed registry to allow emergency workers to search for public or private hospital beds in "real time" to speed the process. Another of Deeds' bills established a new joint subcommittee to study the delivery of mental health services in Virginia.
PROFILES IN ADVOCACY

The Torrey Advocacy Commendation is given in recognition of the courage and tenacity of individuals who selflessly advocate for the right to treatment for people too severely disabled by mental illness to recognize their own need for care. In 2013, the commendation was awarded to DJ Jaffe of New York.

DJ JAFFE

DJ Jaffe, New York resident and longtime advocate for people with severe mental illness, was awarded the Treatment Advocacy Center’s 2013 Torrey Advocacy Commendation for his commitment to helping vulnerable people get access to better treatment.

“DJ Jaffe is a powerful advocate for people with severe mental illness,” said Doris A. Fuller, executive director of the Treatment Advocacy Center. “He was instrumental in the passage of Kendra’s Law in New York, which has been shown to improve outcomes and significantly reduce the costs associated with treatment of people with severe mental illness, and he has toiled without pause for treatment law reforms in other states and at the federal level.”

Jaffe witnessed firsthand the impact of the broken mental illness treatment system after living with his sister-in-law, who is diagnosed with schizophrenia.

“The system was horrific,” he said. “Yet, my efforts to move people with severe mental illness to the front of the line for treatment ever since have been fought tooth and nail by much of the mental health community.”

As the founder and executive director of Mental Illness Policy Org., an independent nonpartisan think tank that advocates for better treatment options for people with severe mental illness, Jaffe says he routinely receives calls from families who are desperate to get a loved one into treatment.

“We need to ensure treatment for people who need it the most, instead of the prisons and jails they are ending up in,” Jaffe said.

Jaffe also has served multiple terms on the boards of directors of the Metro-New York City Alliance on Mental Illness, New York State Alliance for the Mentally Ill, National Alliance on Mental Illness (NAMI), the Treatment Advocacy Center and as a member of the leadership council at the Brain and Behavior Research Foundation.

JENNAY GHOWRWAL, Research and Communications Associate

Raised in the Washington, D.C. suburbs, Jennay earned a Master of Health Science in Mental Health from the Johns Hopkins Bloomberg School of Public Health before joining the Treatment Advocacy Center in early 2014.

Q: WHAT ATTRACTION TO THE WORK OF THE TREATMENT ADVOCACY CENTER?

In 2011, as a caregiver of a mother diagnosed with paranoid schizophrenia, I was fed up with the obstacles I kept hitting while trying to get treatment for her. To be honest, before my personal experiences with untreated severe mental illness, I was ignorant of how complicated and challenging an issue it really is. I decided I wanted to dedicate my career to improving the options and outcomes for individuals and families affected by severe mental illness and started researching organizations that worked toward that goal.

Of course, the Treatment Advocacy Center’s mission really spoke to me, so I reached out. I’ve worked with the organization ever since, in various capacities as a volunteer and consultant, but I’m really excited about my new role among the full-time staff. The Treatment Advocacy Center is the only organization that is solely dedicated to removing barriers to treatment for people with severe mental illness, and that means a lot to me.

Q: WHAT WERE SOME OF YOUR PROFESSIONAL ACTIVITIES BEFORE JOINING THE TREATMENT ADVOCACY CENTER?

Earlier in my career, I worked for several organizations that focus on international health and poverty-related issues, some engaged in service delivery, and others in advocacy or in research and training towards informed policy making. Through those experiences, I developed an appreciation of how much public health programs and policies impact individuals, families, communities and societies. Without access to proper health services, lives may not only be lost but can be forever shattered by disability. Severe mental illnesses are some of the most disabling medical conditions but, with proper treatment, they don’t have to be.

Q: WHAT ARE YOUR PERSONAL ASPIRATIONS AS YOU JOIN THE TEAM?

I hope we can continue to inform the public – including policy makers, media and private citizens – about the massive social, ethical and financial costs of failing to treat severe mental illness. My background in policy communication, mental health services research and epidemiology will put me right in the thick of those efforts. I am excited to help use compelling information to enlighten key audiences of the need to ensure access to treatment for severe mental illness – even for those too ill to seek help themselves.
How Tragedy Can Beget Change

By Nancy and Doug Reuter

Like so many heartbroken parents, investing our lives in mental illness treatment reform was not in our life plan, but the death of our beloved son changed that plan.

Joel was our brilliant, kind and gentle 28-year-old son. He was diagnosed with bipolar disorder in 2004, at the age of 19, but recovered successfully after receiving court-ordered treatment twice in Arizona. He graduated from the University of Arizona and moved to Seattle to take a job in the software industry. He did well there, made lots of friends and was quickly promoted.

But, due to medical complications, Joel went off his meds and rapidly fell into a manic episode in February of last year.

After he withdrew all his money from the bank and booked a flight to London to seek asylum from people he thought were out to get him, we called King County’s office of Designated Mental Health Professionals (DMHP) to request an emergency evaluation, but they said Joel didn’t meet the criteria for evaluation. His friends staged an intervention to get him to a doctor, but that didn’t work either because he suffered from anosognosia (lack of insight into ones’ own illness) and didn’t realize he was sick.

A crisis team was sent to find him at Seattle’s airport when he was returned from London. They called us later to say that, while they couldn’t tell us Joel was perfectly fine, he “didn’t meet the criteria” to be held for evaluation. Over the next four months, he was hospitalized three times. Recently, I found his discharge pills from one of his hospital stays; he hadn’t taken any of them.

Eventually, Joel became someone who bore no resemblance to our son. On July 4, he purchased a gun and became involved in an eight-hour standoff with the Seattle police that ended when he was shot and killed by the SWAT team after he fired his gun.

Joel’s death was so preventable, and we became determined that his death would not be in vain.

In February, Joel’s Law passed 96-0 in the Washington House and is now in the hands of the Senate. We are cautiously optimistic it will pass there, too, and become law, equipping families of people suffering from severe mental illness with a way of helping untreated loved ones in situations like the one that led to Joel’s death.

Whatever the outcome in Washington, advocating for reform has been a very rewarding experience. We have raised awareness of the need for better mental health laws with lawmakers and, through our interviews, with the media. We have also put a lot of people in touch with each other who will keep the pressure on next year and beyond to protect and save the most vulnerable among us.

We won’t give up! (See page 6 for an update on “Joel’s Law.”)
The Treatment Advocacy Center expresses our deepest appreciation to all who have supported our mission with donations in memory or in honor of others.

Alicia Aebersold, Washington, DC
Christine & William Albinson, St. Louis, MO
Mary Alexander, Millis, MA
Sheila Andonaegui, Boise, ID
Kathleen Barry & Robert Burnett, Berkeley, CA
Marcy & Daniel Bacine, Philadelphia, PA
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In memory of Janet
In honor of Alex
In honor of Nancy Allen and in memory of Jack Atkinson
In honor of Stephen Segal
In memory of Svetlana Kleyn
In memory of Lynn Arden
In honor of Treatment Advocacy Center
In honor of Drew Wagenfeld
In memory of Jordan Binion
In honor of Dr. E. Fuller Torrey
In honor of the Honorable Jan R. Jurden
In honor of Richie Wade
In honor of Diana
In honor of Congressman Tim Murphy
In honor of Brian Stettin and in memory of Robert W. Burton
In honor of Mary Bahl
In honor of Joseph Smeeding
In memory of Christopher Carlson
In memory of Andrea Woods
In honor of NAMI Dauphin County
In honor of Dr. E. Fuller Torrey
In honor of Alan & Shirley Wright and in memory of Marzena Holly
In honor of Matthew Hanna and in memory of Esther Mullin
In honor of Kathy Day
In memory of George Michaud
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In honor of Tod Shakespeare
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In honor of Jeremy Nelson
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In honor of Stephen Segal
In honor of Evelyn Burton
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In honor of Dr. E. Fuller Torrey
In memory of Keith Frederick Leffey
In memory of Joel Reuter
In honor of Max
In honor of Michael Lewis
In honor of Matt
In memory of Jessica Cole Henderson
In memory of Eugene Gregory
In memory of Helen Matlick
In honor of Dr. E. Fuller Torrey
In memory of Toby & Chris and in memory of Christopher Lee Roberts
In honor of NAMI Bucks County, PA
In honor of Lottie Merola
In honor of Dr. E. Fuller Torrey
In honor of Laura’s Law
In memory of Penelope Seaver and Matthew Bean
In memory of Chris North
In memory of Stanley & Marjorie Truman, James Truman & Deborah Case
In memory of Agnes Hatfield
In memory of Kathleen R. Pelletier
In honor of Treatment Advocacy Center Staff
In memory of Paul Pfiffnerling
In memory of Mary Laura Pikenton
In honor of Ryan
In memory of Jean Pisano
In memory of Adam Roach
In memory of Brian Robinson
In honor of Susan Shacklock
The Treatment Advocacy Center extends its gratitude to all who donated to the 2014 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.

Nancy & Robert Aebersold, Greensboro, NC
Marcy & Daniel Baciné, Philadelphia, PA
Harriet & George Baldwin, Hanover, NH
Ruth & Victor Balestra, Coral Gables, FL
Carolyn & Douglas Berry, Camarillo, CA
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Jane Ryan, NAMI Alger/Marquette County, Marquette, MI
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Blanche & Carl Hays, Batavia, IL
Gilbert Hudson, Grosse Pointe, MI
Peter Mills, Skowhegan, ME

Memorials & Tributes

CONTINUED FROM PAGE 10

Marsha Ryle, Emeryville, CA
Alison Sandler, Castle Rock, CO
Louise Schnur, Auburn, CA
Amy Leah Schussheim, Washington, DC
Hattie Segal, Maplewood, NJ
Patty & Stephen Segal, Philadelphia, PA
Rosemary Shadek, La Jolla, CA
Jacqueline Shannon, San Angelo, TX
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Harold Wachs, San Diego, CA
Jeanne Walitzer, Sumner, WA

Susan Warren, Albuquerque, NM
Diana Weddle, Plano, TX
Jim & Marilyn White, Champaign, IL
Joel & Diane Wier, Columbia, SC
Nick & Amanda Wilcox, Penn Valley, CA
Joe Zwack, St. Paul, MN

In memory of Jared Bonnet
In honor of Justin
In memory of Teddy & Jack Jones
In memory of Morton Schussheim
In honor of Stephen Segal & Dr. E. Fuller Torrey
In honor of Richard Lamb and in memory of Doris Lamb
In honor of Natalie Fuller
In memory of Dr. Charley H. Shannon
In honor of Marc
In memory of Harold W. Sinclair, Jr.
In honor of Eric W.T. Smith
In honor of Sean Taber
In memory of Carol Thorman
In honor of Everett A. Drake
In memory of Michael Wachs
In honor of Sue & Pat Geary and in memory of Jan Geary
In honor of Eric Livingston
In memory of Gregory Daniel Weddle
In memory of Svetlana Klyey
In honor of Dr. Mefra Naharishman
In memory of Laura Wilcox
In memory of Paul Zwack

THE POWER OF LEGACY GIVING: Easy Steps to Make a Difference!

The Treatment Advocacy Center depends upon your generosity and compassionate support to fight for the mental health and well-being of 7.7 million adults living with schizophrenia or bipolar disorder. There are many different ways you can support our mission to eliminate legal and other barriers to the timely and effective treatment of severe mental illness – including leaving a lasting legacy gift through your will or other estate plans.

Will you consider giving a gift to the Treatment Advocacy Center in your will or living trust? Please take the time to contact your professional advisor to let them know of your desire to make a difference. It’s simple and flexible. Just a few sentences are all that is needed, and you can change your mind at any time.

To find out exactly how you can leave a lasting gift that will help change the lives of millions of vulnerable individuals, visit our website atTreatmentAdvocacyCenter.org or contact Doris Fuller, Executive Director at DorisFuller@treatmentadvocacycenter.org or (703) 294-6001 today. A few hours of your time will yield a lifetime of impact.

Thank you!
ASPRIN MAY REDUCE SYMPTOMS OF SCHIZOPHRENIA

In December, the Stanley Medical Research Institute approved funding for 17 new treatment trials, bringing the total to 59 currently funded trials; the 17 were funded from 51 applications. Especially prominent this year were many applications proposing the use of anti-inflammatory drugs, of which five were funded. As always, we funded trials evaluating drugs currently used to treat other diseases, such as exenatide used for diabetes, spironolactone used in heart disease and dimethyl fumarate, recently approved for the treatment of multiple sclerosis. Also of interest were three proposals we funded to use monoclonal antibody drugs, a new class of medications that must be given intravenously every few weeks and which target specific aspects of the immune system. These drugs are being used to treat rheumatoid arthritis and other diseases.

Two funded studies are of special interest. The first is a follow-up study of aspirin. Past studies of aspirin in schizophrenia have suggested it might have at best a weak effect. In a large study SMRI recently funded in Romania, the overall study showed no effect. However, we collected blood on all the patients at the beginning and end of the study and analyzed it when the study was done. What we found was that a subgroup of patients did have significant improvement of their symptoms on aspirin, and these patients also had an elevated blood level of C-reactive protein (CRP), a non-specific marker for inflammation. In order to verify this finding, we funded a new study of 160 patients, all of whom will be included because they have a high CRP blood level. They will be randomized to aspirin or placebo, along with their regular antipsychotic, and blindly rated on their symptoms. This should show conclusively whether aspirin is useful or not for this subgroup.

The other study of special interest is an attempt to replicate a report published in May 2013. Sodium nitroprusside is a drug that has been used for almost a century to treat severe hypertension. It must be given intravenously. Because of its effect on glutamate receptors, a group in Brazil gave an intravenous injection or placebo injection to 20 patients with recent-onset schizophrenia. The patients who received the sodium nitroprusside had a remarkable improvement in their symptoms, and the improvement lasted four weeks. To see whether we could replicate these findings, we funded a study of 20 patients to be done exactly as it had been carried out in Brazil.

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