TREATMENT ADVOCACY CENTER

RESTORING REASON TO TREATING MENTAL ILLNESS

Catalyst

A Newsletter from the Treatment Advocacy Center

FALL 2012

Psychiatric Bed Numbers Plummet to 1850 Levels, Putting Patients, the Public at Risk

NEW STUDY CALLS FOR MORATORIUM ON HOSPITAL CLOSURES

The Treatment Advocacy Center this summer called for a moratorium on state hospital bed closures until a sufficient number of public psychiatric beds are available for individuals living with acute or chronic severe mental illness.

In our 2008 report on state hospital bed trends, we found individuals in psychiatric crisis being crowded into emergency rooms because public psychiatric beds were in such short supply, law enforcement answering more and more service calls in which untreated severe mental illness was a factor, and individuals with untreated illness increasingly ending up behind bars.

Given the severity of the situation then and anecdotal evidence that public bed populations had declined even further with a corresponding increase in consequences of untreated severe mental illness, we undertook the current study using 2010 data that became available in May 2012.

Our conclusion: things have only gotten worse.

In "No Room at the Inn: Trends and Consequences of Closing Public Psychiatric Hospitals," the Treatment Advocacy Center reported in July the number of public hospital beds available nationwide for people with acute or chronic psychiatric illness plunged between 2005 and 2010 to levels not seen since 1850.

Nationwide, state hospital bed numbers dropped 14% during the five-year period, falling to 43,318 beds in the 50 states. (This compares with 49,907 beds in 2005 and 558,922 in 1955, the peak year of psychiatric hospitalization before the trend known as "deinstitutionalization" began.) By the beginning of 2010, there were 14.1 beds per 100,000 people nationwide, a fraction more than the 14 beds per 100,000 that existed in 1850, before Dorothea Dix and other advocates began their drive for humane treatment options for people with severe mental illness.

"The loss of hospital beds for people who are psychotic or otherwise acutely or chronically affected by severe mental illness endangers them and society at large," said Doris A. Fuller, executive director and one of the study's co-authors. "Closures are creating enormous strains on law enforcement, jails, prisons and hospital ERs – where seriously ill people are 're-institutionalized' – or left to live on the streets."

Data for the report came from the National Association of State Mental Health Program Directors Research Institute (NASMHPD) and reports on beds provided by state governments. Private psychiatric beds and the limited number of public beds provided outside a state hospital system (e.g., county beds in California) are not reported to NASMHPD or included in the study.

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LEARN MORE ABOUT THE STATE HOSPITAL BED CRISIS

"No Room at the Inn: Trends and Consequences of Closing Public Psychiatric Hospitals" is available online or in print.

Read or download the full report online at **TACReports.org/bedstudy.** Request a printed copy by emailing: **BedStudy@TreatmentAdvocacyCenter.org.**

To see where your state ranks, see page 9 or visit **TACReports.org/bedstudy/tables.**

What's Inside

TreatmentAdvocacyCenter.org

PUBLIC PSYCHIATRIC HOSPITALS:

Going, Going, Gone, Even Though the Need Remains

I can't remember a time when "mental hospitals" were not in my life.

Growing up in California during the peak era of psychiatric hospitalization, my family drove past the state hospital in Orange County on our way to the beach. Another state hospital operated in a neighboring county where I worked at one of my first newspaper jobs. A third was located in yet another nearby county where my precious newborn daughter was born. Everyone knew that "Fairview," "Norwalk" or "Camarillo" were shorthand for a state hospital.

I knew people who were patients, too. In those days, people who acted on their untreated schizophrenia were taken to the nearest state hospital. So it was routine that the mother of my best college friend was hospitalized whenever she got arrested for acting on the instructions of voices she heard. I had a cousin who was a patient at various times in each of the local hospitals, not because he was mentally ill but because he was developmentally disabled and had epilepsy, and his parents could check him into the hospital whenever his care overwhelmed them.

None of this casual exposure prepared me for the day when my daughter grew into a beautiful young woman who, at 22, experienced a psychotic break that resulted in her court-ordered hospitalization. As a stunned and terrified parent, I had no idea at the time how lucky both of us were she was living in a state where public hospital beds are still reserved for non-forensic patients and where enlightened public policy supports hospitalizing people in crisis long enough to stabilize them.

Today, my cousin couldn't be dropped off at a state hospital – one of the praiseworthy outcomes of the trends described in "No Room at the Inn," the Treatment Advocacy Center's new study of public hospital bed trends and their consequences. On the other hand, my girlfriend's mother would have spent her life desperately ill, untreated and on the streets or in a jail cell. Had my daughter's crisis occurred in my home state – where all but a fraction of the public hospital beds are now occupied by people who had to commit a crime before receiving court-ordered inpatient treatment – she might not be alive.

None of us at the Treatment Advocacy Center doubt that civil commitment procedures and state hospital systems across the United States were in desperate need of reform by the mid-20th century. At the same time, we know it is inconceivable that a nation whose population has increased almost 50% since the peak of psychiatric hospitalization now needs less than 5% of the public hospital beds that existed then. We have sent "No Room at the Inn" to every state governor and every state health committee chair in America and called for a moratorium on the further closure of public psychiatric beds until a sufficient number of beds to meet public need is available in state hospitals or community facilities.

We hope when you finish reading this issue and visiting our dedicated hospital bed study website, you will join us in the fight to preserve and expand public psychiatric hospital beds. Many of the people who were patients in those landmark hospitals of my youth can – and do – live successfully in the community today. For those so ill they need more intensive care, public psychiatric hospitals can be the essential bridge back to the community.

With warmest personal regards,

Doris A. Fuller
Executive Director

We have sent "No Room at the Inn" to every state governor and every state health committee chair in America and called for a moratorium on the further closure of public psychiatric beds until a sufficient number of beds to meet public need is available in state hospitals or community facilities.

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 OF SUPPORT

Sylvan Herman: Building Better Mental Health

More than half a century ago, Baltimore native Sylvan C. Herman began developing commercial office space that helped modernize the face of Washington, D.C. Before that, he was a sailor in the U.S. Navy, went through college on the G.I. bill and sold pots and pans for $50 a week to get by. By saving money and buying downtown land one small piece at a time, he was able to build his first office building in 1960. Since then, S.C. Herman & Associates has built as much as two million square feet of commercial space in D.C., success that has made it possible for the namesake Sylvan Herman Foundation to become a significant supporter of the Treatment Advocacy Center. One of Mr. Herman's most recent projects is a private residential facility in suburban Maryland where residents with severe mental illnesses or with co-occurring mental illness and substance abuse receive intensive, integrated treatment. Both through his generous gifts to the Treatment Advocacy Center and his ClearView Communities, Sylvan Herman has emerged as a "builder" of better mental health.

WHAT PROMPTED YOUR INTEREST IN MENTAL ILLNESS TREATMENT ISSUES?

When my son was 19 and a freshman at Syracuse University, he wasn't doing well at all. Eventually, he became psychotic. Like so many parents, we thought he was using drugs and didn't recognize his problems were signs of a mental illness. When we took him to a doctor who diagnosed schizophrenia, we couldn't believe it. But that's what was going on. I'm a father and a successful businessman. I thought we were going to lick this thing. I didn't understand you don't just "lick" schizophrenia. I slowly came to see the reality. Slowly but surely, I became educated. A lot of people believe that if they've got the right pull or they get the right doctor, they'll beat mental illness. That's not how it works.

WHAT DID BECOMING EDUCATED CHANGE FOR YOU?

I said, "What can I do to help my son and other people?" That began opening doors. I started a foundation about five years ago without knowing what exactly I could do but knowing that I wanted to find a cure for this terrible disease. Because a cure would be a long time coming, I also began looking for things I could do immediately, right now, for people. That's when I began to support the Treatment Advocacy Center, because of what you do to change state laws so treatment is available for people too sick to seek it. My son is an example. He's been on the street, smoking pot, coming in contact with police, filled with paranoia – and they've taken him to jail, sometimes thrown the key away. That's where you come in. You're the ones doing something to stop this cycle.

I also began looking at rehabilitation, which led to building ClearView Communities in Frederick, Maryland, in affiliation with the Sheppard Pratt Health System. It's private, fee-based treatment where a maximum of 16 people live, most of them with psychotic disorders. Usually when they arrive, they are uncooperative, won't take meds, can't get a job. Our premise is that every patient can set goals they can meet so they can do better, however "better" is defined. Some of the beds are reserved for new arrivals who are acutely ill. After a few months, they move into semi-independent accommodations where they can eventually be ready to move into the community. Because the program is intensive and privately paid, it is not for everyone. But, just like every patient is an individual with a different set of problems and challenges, every family is different and has different options for intervention. For some families, this is a solution.

HOW IS YOUR SON TODAY?

He is 36 now. He's been involuntarily committed several times, and it's saved his life. He was the catalyst for me to get involved with the issue of mental illness and its treatment, and what I've done since then gives me a tremendous satisfaction. I'm the kind of guy who wants to see something happen. I was put here for a purpose. Maybe before I die, something good will come out of my efforts to help people. That would be a nice thing.

AROUND THE States

California

The California legislature in August voted overwhelmingly to extend the state's assisted outpatient treatment (AOT) law, known as "Laura's Law," until 2017. Assemblymember Mike Allen's AB 1569 was signed by Governor Jerry Brown on September 22.

In a separate development, two California state legislators asked the Joint Legislative Audit Committee to order an audit of the mental health funds generated after California voters approved Proposition 63 in 2004. The ballot initiative established the Mental Health Services Act (MHSA) to generate money for mental illness treatment through a tax on personal income in excess of $1 million.

Since passage of the proposition, billions of dollars have been distributed to counties for mental health services. There is serious question as to how much of the "Prevention & Early Intervention" portion of the proposition is being directed towards people with severe mental illness, such as the act intended.

According to an Associated Press report published in July, millions of MHSA dollars have been spent on "wellness" offerings such as yoga, gardening, acupuncture, sweat lodges, horseback riding and other activities for individuals with no diagnosis or symptoms of mental illness. The report set off a public outcry, with several newspapers, legislators and advocates calling for a state audit. The legislative audit committee instructed the state auditor to conduct a review, but questions remain regarding whether that evaluation will be sufficient to root out problems of compliance with the original intent of the proposition: expanding services for people with severe mental illness.

California has cut mental health spending by $764.8 million since 2009, and its state hospital bed population was reduced 16% from 2005-2010, according to "No Room at the Inn," our latest study of public hospital bed trends and their consequences. The vast majority of those beds are reserved for forensic patients – people accused or convicted of crimes – leaving few beds for long-term care of people who would benefit from civil commitment. At the same time, individuals with severe mental illness are nearly four times more likely to be jailed than hospitalized in the state.

In such an environment, voter-approved money for treatment being frittered away is especially concerning. While the audit did not reveal a misuse of funds, the state should be looking at ways to ensure these precious dollars are spent more appropriately and effectively, including implementing programs like Laura's Law.

Tennessee

Tennessee is one of only six states without an assisted outpatient treatment (AOT) law. But in April, years of dogged efforts by treatment advocates bore fruit in the passage of a bill to establish a modest, state-funded AOT pilot program at Knoxville's Helen Ross McNabb Center. The program will serve up to 10 patients at a time over two years.

At a press conference at the McNabb Center in July, Knoxville Mayor Tim Burchett (a longtime AOT champion), Tennessee Mental Health Commissioner Doug Varney, McNabb CEO Andy Black, and four state lawmakers who spearheaded this year's successful bill heralded AOT's potential to reach people with severe mental illness whose lack of insight undermines their ability to access voluntary services.

The lawmakers emphasized that the pilot was created as a first step towards a statewide AOT law. And, in an encouraging departure from his agency's long-held opposition to AOT, Commissioner Varney said, "You don't have to wait until a person gets so seriously ill that it's much more difficult (to get help). It's really to prevent people from getting committed to a hospital."

In August, Treatment Advocacy Center Policy Director Brian Stettin and Knoxville advocate Karen Easter, visited the McNabb Center. Brian shared copies of the Treatment Advocacy Center's "Guide for Implementing Assisted Outpatient Treatment" and his own insights on how to structure the program to ensure success.

The McNabb Center hopes to launch its program this fall. We will continue to monitor and assist their progress.

West Virginia

West Virginia's procedure for hospital commitment is unusual. Whereas nearly all other states call for an initial, short-term evaluative detention (known in many states as a "72-hour hold") that leads directly into an extended period of commitment if found to be warranted, West Virginia law adds a step.

If the initial hold for evaluation yields evidence that the person meets commitment criteria, a judge may order the person held for no more than 15 days of continued "custody for examination and treatment." Only at the end of these 15 days may a petition for a more lengthy commitment be considered. Not surprisingly, this has the effect of discouraging longer-term commitments and the benefits that can result from hospitalization for acute psychiatric crisis.

In the instructions accompanying the commitment application form provided to families, the state court system currently advises that commitment "is usually very short[.] Few respondents are hospitalized more than a few days."

This system was created with good intentions in 1965. In recognition that "West Virginia's mental health system … has not kept up with the times," four members of the state's House of Delegates recently sponsored

a resolution requesting that a joint legislative committee hold hearings on the state's involuntary commitment process.

A subcommittee hearing pursuant to the request was held in August at the state capitol in Charleston. Treatment Advocacy Center Policy Director Brian Stettin was asked to testify on how West Virginia's commitment process compares to that of other states.

In his presentation, Brian urged that the commitment process be streamlined and offered the technical assistance of the Treatment Advocacy Center in drafting specific language. He also seized the opportunity to draw the lawmakers' attention to additional defects in West Virginia's commitment law that had not been noted in the delegates' resolution, such as the lack of a "need-for-treatment" standard and the inconspicuousness of the current law's "grave disability" standard.

Connecticut

Connecticut is one of six states without an assisted outpatient treatment (AOT) law on the books. The legislature considered revisions to the state's treatment laws earlier this year. The following guest commentary by our Senior Legislative and Policy Counsel Kristina Ragosta eloquently outlines why improvement to Connecticut's laws is crucial.

Illusions, Delusions and Possible Solutions

By Kristina Ragosta, Esq.

On March 29, the Joint Committee on the Judiciary held a hearing on raised bill, SB 452, which is now dead. Unfortunately, the committee was largely presented with a highly distorted and misinformed picture of Connecticut's existing civil commitment law and what the bill would have done. The discussion centered on patient rights and the ineffectiveness of "forced medication;" it ignored many of the realities of untreated mental illness and the need for such laws.

Among the critical information largely absent from the discussion:

Every state in the country has some form of court-ordered treatment laws, sometimes called mandated treatment or involuntary treatment. Connecticut is no exception.

Every state in the country allows for individuals who are a danger to themselves or others (defined differently in virtually every state) to be held against their will, in a hospital setting. Connecticut is no exception.

Every state has laws for guardianship provisions or conservatorship provisions (often used for elderly individuals suffering from diseases like Alzheimer's). Connecticut is no exception.

Every state has laws, procedures or regulations to medicate a person overcome by severe mental illness in a hospital setting when certain standards are met ("forced medication"). Connecticut is no exception.

Where Connecticut deviates from the majority of the country is in its absence of an option for court-ordered community treatment (assisted outpatient treatment, or involuntary outpatient commitment) as a less restrictive alternative to hospitalization or jail. Connecticut is one of only six states without an option for court-ordered community treatment.

SB 452 would not have changed this.

The reason assisted treatment laws are necessary is because a small, but significant, number of individuals with severe mental illness are so ill that they are unable to seek mental health treatment voluntarily.

This lack of capacity to understand they are sick – a neurological syndrome called anosognosia – is believed to be the single largest reason why individuals with schizophrenia and bipolar disorder do not take their medications (or seek treatment). The condition is caused by damage to specific parts of the brain … and affects approximately 50% of individuals with schizophrenia and 40% of individuals with bipolar disorder.

In their well-intentioned efforts to advocate for the larger population affected by mental health problems who are capable of seeing medical care voluntarily, many mental health advocates discount or ignore those who are so ill they can only choose treatment after they have received involuntary treatment to stabilize them. This is the population that ends up trapped in the revolving door of criminal justice, homelessness and emergency rooms.

The next time that Connecticut has the opportunity to make improvements to its civil commitment law, a better strategy for addressing the issue of untreated mental illness would be to provide an option of assisted outpatient treatment to those patients too ill to seek treatment voluntarily.

Assisted outpatient treatment laws typically utilize a court order to provide for a comprehensive treatment and services plan, which may include medication and, when implemented, require the individual patient to follow his or her treatment plan. These laws do not typically authorize the actual administration of medication. Rather, the purpose of the court order is to help individuals (often with a history of non-compliance) to comply with treatment and to ensure more oversight from community mental health agencies in order to prevent costly and more intrusive consequences such as arrest, incarceration, hospitalization.

Results from multiple studies demonstrate that when implemented, assisted outpatient treatment laws work at reducing rates and incidents of hospitalization, arrests, emergency room visits, victimization, and violence. For example, one study of results under New York's law found that:

- 77% fewer experienced hospitalizations compared to before participation.
- 74% fewer experienced homelessness compared to before participation.

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Around the States

SPECIAL REPORT

"NO ROOM AT THE INN" – A VIEW FROM THE STATES

To see where your state ranks, see "Loss of Public Psychiatric Beds between 2005 and 2010" on page 9. To learn more about your own state's hospital bed picture, select your state's page from the dropdown menu at **TACReports.org/bedstudy.**

Alabama

I first visited Alabama in the spring of 1847. I was fortunate to spend a productive day with Chief Justice Henry Collier. Little did I know that he would one day become governor. Two years later, in his inaugural address to the Legislature, Governor Collier recommended the establishment of a state hospital for the insane. In 1861, nearly 12 years later, the hospital was completed. I've never had a prouder day in my life.

– Dorothea Dix

In early 2012, just over 150 years after activist Dorothea Dix had the proudest day of her life, Alabama mental health officials announced plans to lay off 948 mental health employees and close all but two of the state's psychiatric hospitals. Only one forensic and one geriatric hospital were to be spared.

The department has since delayed some of these closures, but the newly appointed state mental health commissioner did confirm the governor's intentions to close institutional facilities and move people to the community.

The ostensible reason for the move is to give patients "better care in smaller, less isolating facilities." In reality, this is regressive folderol masquerading as progressive reform. Hospitals still provide care, treatment and services that cannot be replicated in community settings. We don't have policies to treat other medical emergencies in "smaller, less-isolated settings." Why mental illness?

"No Room at the Inn: Trends and Consequences of Closing Public Psychiatric Hospitals" further illustrates why this is a foolhardy plan. By 2010, Alabama provided 23.4 beds for every 100,000 people. That ranked the state 5th nationally in beds per capita – which sounds good until you find out the estimated number of beds needed for minimally adequate psychiatric inpatient care is 50 beds per 100,000 population. Continued reductions will only mean the state falls further behind in meeting the needs of people with the most severe psychiatric disorders.

Ms. Dix's work to improve care for the mentally ill has been undone by this country's 95% reduction in public hospital beds since deinstitutionalization and all its consequences began.

What would Dorothea Dix say to Alabama today? Perhaps, once again, that we are building "melancholy monuments of the imperfections with which society discharges its social and moral obligations."

Kansas

In 2005, Kansas had 594 state hospital beds. By 2010, the number had grown to 705, a 19% increase. This is a good start, but the state still has a way to go.

Even after this increase, only 24.7 beds were available per 100,000 Kansans. That's just about half the number of beds experts say is required for minimally adequate psychiatric care. Further darkening the picture: One-third of those beds were occupied by patients accused or convicted of crimes and thus were not available to the general public. Both state hospitals – Osawatomie and Larned – have been consistently overcrowded.

Angela Hardee, whose son suffers from schizoaffective disorder, shared how the lack of hospital beds affects the community in "Living with schizophrenia: Haunted by voices" (*Kansas City Star*, August 13):

"There's just so many people with psychiatric problems, and they keep cutting the budgets. I feel like no longer is there a safety net for these people.... When somebody (with schizophrenia) goes on a shooting spree, everybody says these are evil people," she said. "They're not evil people. They're sick people, and they need help."

At the time of the *Kansas City Star* article, Ms. Hardee's son was behind bars. Individuals with severe mental illness in Kansas are 3.5 times more likely to be incarcerated than hospitalized ("More Mentally Ill Persons Are in Jails and Prisons than Hospitals: A Survey of the States," Treatment Advocacy Center, 2010).

Alaska

As one of the five wealthiest states in per-capita income, Alaska has traditionally been one of the leading states in per-capita funding of state mental health programs. But, mental health budgets can be deceiving because they typically include a great deal of spending on services for people whose mental illnesses or coping problems are not severe enough to prevent them from seeking help.

Alaska appears to be a case in point. In 2010, the state had 52 public psychiatric hospital beds, a 30% decrease from 2005. This computes to only 7.2 beds per 100,000 residents of the state or 16% of the per-capita state hospital beds considered necessary for minimally adequate inpatient psychiatric care. For all its spending on "mental health" generally, Alaska ranks 45th in psychiatric bed availability.

Maybe that's why a January 2009 count found more than 500 people with severe mental illness among

Alaska's homeless population and why our 2010 study, "More Mentally Ill Persons are in Jails and Prisons than Hospitals" estimated another 750 severely mentally ill people were residing in the state's jails and prisons.

Oregon

In 2007, the state legislature authorized funds to replace the aging Oregon State Hospital facility with two modern psychiatric hospitals that will produce a net increase of nine beds. A new facility was completed in Salem last year, and a site in Junction City is expected to open in the next two years. It will be co-located on a campus with two state prisons.

While any increase in public psychiatric bed populations makes it possible to meet the treatment needs of more individuals, a bump of nine beds is unlikely to change the fact that people with severe mental illness are in Oregon are three times more likely to be behind bars than hospitalized. ("More Mentally Ill Persons Are in Jails and Prisons than Hospitals: A Survey of the States," 2010).

What's more, the state continues to provide less than half the state hospital beds estimated to be necessary for adequate psychiatric care. Fifty beds per 100,000 people are considered minimal. (By way of comparison, the number in England in 2008 was 63.2 beds per 100,000.) With 18.3 beds per 100,000 residents, Oregon by 2010 was providing only 18% of that minimum.

Sadly, Oregon's bed population was "good enough" to tie the state with Massachusetts as 15th in the nation in per-capita beds. Even more sadly, if Oregon's public psychiatric beds occupied by people accused or convicted of crimes are excluded, the actual number of beds available to the general public is less than 10 per 100,000.

Rhode Island

In 2010, Rhode Island had 108 public psychiatric beds, compared to 134 in 2005, a 19% decrease.

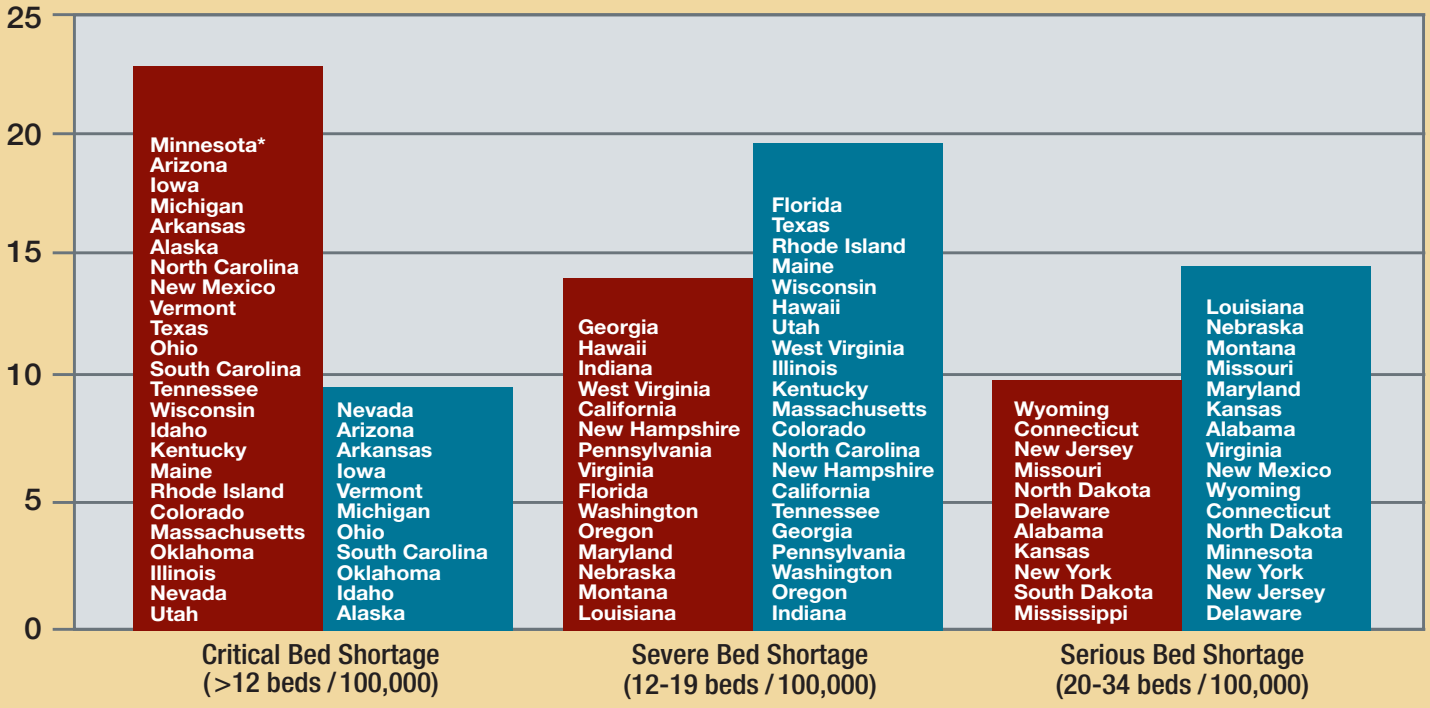
After this decrease, Rhode Island had 10.3 beds per 100,000 people, only 20% of the minimum beds needed for adequate psychiatric care. The Ocean State was ranked one of four states tied for 32nd in the nation.

According to an Associated Press article from April 2011, "mentally ill patients often languish in hospital emergency rooms for several days, sometimes longer, before they can be moved to a psychiatric unit or hospital" in Rhode Island.

The bed shortage has become so critical that it's not only the Treatment Advocacy Center and hospital advocates drawing attention to it. Earlier this year, the state senate established a task force on Emergency Department Diversion to investigate the problem.

A GROWING CRISIS: Worsening Bed Shortage Severity

In 2005, the shortage of state hospital beds was rated "critical" in 11 states, "severe" in 21 states, and "serious" in 16 states. From 2005-2010, the number of states with a "critical" shortage more than doubled while the number of states whose shortage was "only" "severe" or "serious" declined.



*Partially reflects change in treatment model to multiple 16-bed community facilities

***NOTE:** In 2005, South Dakota was termed "marginal"; Mississippi was deemed "meets minimal standards." Both now have "serious" bed shortages. NO states are now "marginal" or "minimal".*

Bed Numbers

CONTINUED FROM PAGE1

Here's how the numbers look at the state level:

- Five states reduced beds by at least 40%: New Mexico (60%), Minnesota (56%), North Carolina (48%), Michigan (47%) and Tennessee (42%). Minnesota's reductions were partially offset by the creation of a network of 16-bed community facilities for psychiatric patients. This was not the case elsewhere.
- Eight additional states eliminated at least 25% of their public hospital beds: Iowa (38%), Colorado (33%), New Jersey (32%), Alaska (30%), Kentucky and Massachusetts (both 31%), Georgia (27%) and Delaware (26%).
- Two states increased beds by at least 50%: Nevada and Florida. Nevada more than doubled its population of state hospital beds (from 119 beds to 302) but still provided only 11.2 beds per 100,000 people, leaving it in the lower half of the nation in beds per capita. Florida increased its bed population 58% – from 2,101 beds to 3,321 – raising its per-capita population to 17.7 beds per 100,000, still well below the recommended number for minimally adequate inpatient psychiatric care.

The Treatment Advocacy Center's 2008 bed study, "The Shortage of Public Hospital Beds for Mentally Ill Persons," surveyed 15 experts on psychiatric care (hospital directors, county mental health officials, medical personnel and others) and found a consensus that approximately 50 psychiatric beds are needed per 100,000 people to provide minimally adequate inpatient psychiatric services. By way of comparison, England in 2008 was providing 63.2 beds per 100,000 people.

Not surprisingly, the decreased number in public hospital beds for the most acutely ill psychiatric patients was accompanied by increased consequences of untreated severe mental illness. Among those noted in "No Room at the Inn":

- Hospital emergency departments are so overcrowded that acutely ill patients may wait days – or even weeks – for a psychiatric bed to open; some ultimately are released to the streets without ever receiving treatment.
- Service calls, transportation and hospital security involving people in acute psychiatric crisis are creating significant and growing demands on law enforcement and straining public safety resources.
- Jails and prisons are increasingly populated by individuals with untreated mental illness; some facilities reporting that one-third or more of their inmates are severely mentally ill.
- The number of persons with mental illness who are homeless has increased. In some communities, officials report as many as two-thirds of their homeless population is mentally ill.

"No Room at the Inn" also uncovered a relationship between state hospital bed populations and violence. States that decreased funding for public hospitals, which is typically reflected in decreased hospital beds, experienced an increase in arrest-related deaths. States that closed more public psychiatric beds between 2005 and 2010 also reported higher rates of violent crime generally and of aggravated assault in particular.

"Although they constitute a small subset of all persons diagnosed with mental illness, the most severely ill patients are in dire need of the specialized, intensive treatment that has been delivered since the early 1830s through state hospital systems," the report said. "The elimination of these systems is producing significant public and personal consequences in communities nationwide."

WHAT'S NEEDED

The shortage of psychiatric beds for acute or chronic mental illness has profound and devastating impacts for individuals too sick to seek help, their loved ones and communities. To reduce these impacts, the Treatment Advocacy Center recommends:

- **Stopping public hospital bed closures until a sufficient number of psychiatric beds for acutely and/or chronically ill individuals is available either in state hospitals or community facilities.**
- **Holding state governors and mental health officials responsible for the shortage and demanding they create a number of beds to meet the minimum levels of adequate treatment (50 beds per 100,000 people).**
- **Implementing and using assertive community treatment (ACT) programs and assisted outpatient treatment (AOT) in every community.**
- **Lifting the federal prohibition on the use of Medicaid in state hospitals ("Institution for Mental Diseases [IMD] Exclusion") so treatment decisions are based on clinical needs rather than to shift public costs.**

THE LOSS OF PUBLIC PSYCHIATRIC BEDS: 2005-2010

State	Number of beds 2010	Number of beds 2005	Number of beds lost or gained	Percent of beds lost or gained	2010 beds/ 100,000 total population	Percent of target beds per capita	State ranking per capita (highest to lowest)
Alabama	1,119	1,001	118	+12%	23.4	49%	5
Alaska	52	74	-22	-30%	7.3	16%	45
Arizona	260	338	-78	-23%	4.1	8%	49
Arkansas	203	184	19	+10%	7.0	14%	46
California	5,283	6,285	-1,002	-16%	14.2	29%	22
Colorado	520	776	-256	-33%	10.3	23%	32-35
Connecticut	741	889	-148	-17%	20.7	43%	10
Delaware	209	281	-72	-26%	23.3	51%	6
Florida	3,321	2,101	1,220	+58%	17.7	38%	18
Georgia	1,187	1,635	-448	-27%	12.3	27%	26
Hawaii	182	171	11	+6%	13.4	29%	25
Idaho	155	157	-2	-1%	9.9	23%	36
Illinois	1,429	1,821	-392	-22%	11.1	23%	29
Indiana	908	1,201	-293	-24%	14.0	29%	23-24
Iowa	149	239	-90	-38%	4.9	10%	48
Kansas	705	594	111	+19%	24.7	51%	4
Kentucky	446	646	-200	-31%	10.3	21%	32-35
Louisiana	903	914	-11	-1%	19.9	40%	12
Maine	137	166	-29	-17%	10.3	21%	32-35
Maryland	1,058	1,203	-145	-12%	18.3	38%	15-16
Massachusetts	696	1,015	-319	-31%	10.6	22%	31
Michigan	530	1,006	-476	-47%	5.4	11%	47
Minnesota	206	464	-258	-56%	3.9	8%	50
Mississippi	1,156	1,442	-286	-20%	39.0	79%	1
Missouri	1,332	1,238	94	+8%	22.2	46%	8
Montana	194	194	0	0%	19.6	42%	13
Nebraska	337	361	-24	-7%	18.5	38%	14
Nevada	302	119	183	+153%	11.2	25%	27-28
New Hampshire	189	224	-35	-16%	14.4	29%	21
New Jersey	1,922	2,820	-898	-32%	21.9	44%	9
New Mexico	171	425	-254	-60%	8.3	18%	42-43
New York	4,958	5,269	-311	-6%	25.6	52%	3
North Carolina	761	1,461	-700	-48%	8.0	18%	44
North Dakota	150	164	-14	-9%	22.3	48%	7
Ohio	1,058	1,210	-152	-13%	9.2	18%	39-40
Oklahoma	401	386	15	+4%	10.7	23%	30
Oregon	700	691	9	+1%	18.3	39%	15-16
Pennsylvania	1,850	2,349	-499	-21%	14.6	30%	20
Rhode Island	108	134	-26	-19%	10.3	20%	32-35
South Carolina	426	443	-17	-4%	9.2	20%	39-40
South Dakota	238	311	-73	-23%	29.2	62%	2
Tennessee	616	1,068	-452	-42%	9.7	21%	38
Texas	2,129	2,128	1	0%	8.5	19%	41
Utah	310	329	-19	-6%	11.2	26%	27-28
Vermont	52	55	-3	-5%	8.3	17%	42-43
Virginia	1,407	1,659	-252	-15%	17.6	37%	19
Washington	1,220	1,170	50	+4%	18.1	34%	17
West Virginia	259	258	1	0%	14.0	29%	23-24
Wisconsin	558	716	-158	-22%	9.8	20%	37
Wyoming	115	122	-7	-6%	20.4	45%	11
TOTALS	**43,318**	**49,907**	**-7,797**		**14.1**		

Memorials & Tributes

February 1 – August 31, 2012

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

Jill Adelman & Joan Cummings, Glen Ellyn, IL	In honor of my son, Michael
Mary Barksdale, Athens, AL	In memory of Farron Barksdale
Ed & Marilyn Battiste, Farmington Hills, MI	In honor of Dr. E. Fuller Torrey
Tab Battle, Petersburg, VA	In memory of my mother, Mary Battle
Charlene Blumenthal, Silver Spring, MD	In honor of Dr. E. Fuller Torrey
Sean & Tamara Brabenec, Lake Isabella, CA	In honor of Sean & Tamara
James Cayce, Black Diamond, WA	In honor of Dr. E. Fuller Torrey
Susan Cleva, Bellevue, WA	In memory of Henry Cleva
Ann Eldridge, Santa Barbara, CA	In memory of Nancy Olderman
Vicki Ferrara, Athens, AL	In memory of Farron Barksdale
Doris Fuller, Arlington, VA	In honor of my daughter
Madeleine Goodrich, Concord, MA	In honor of Mame Lyttle
Camille Gordon, Reynoldsburg, OH	In honor of Carter
Jeanette Griffith, West Newbury, MA	In memory of Ed Griffith
Jesse Hauser, Bronx, NY	In honor of Dr. Rose F. Kavo
Martha Hellander, Wilmette, IL	In memory of Betty Lou Hellander
Jackie Herum, Ellensburg, WA	In memory of Beth Skahill
Mary Hopfinger, Lee's Summit, MO	In honor of Andrew
Sylvia Hughes, Albuquerque, NM	In honor of Kevin Hughes
DJ Jaffe, New York, NY	In honor of Doris Fuller
Carol MacLean, Dover, NJ	In memory of David C. MacLean
Brian Marcum, Tulsa, OK	In honor of Mary Kay Marcum
Jane Nangle, Savannah, GA	In honor of Dr. E. Fuller Torrey
Dottie & George Pacharis, Ft. Meyers Beach, FL	In memory of Scott Baker
Judy Perlman, Highland Park, IL	In honor of Dr. E. Fuller Torrey
Madeleine Rahamim, Phoenix, AZ	In memory of Ronit
Barbara Redfield, San Francisco, CA	In memory of Buzzy
Alice & Hugh Roberts, Wilkes-Barre, PA	In memory of Michael Daniel
Patricia Rudloff, Edwardsville, IL	In honor of Rob & Jane Roennigke
Louise Schnur, Auburn, CA	In memory of Teddy Jack Jones
Hattie Segal, Maplewood, NJ	In honor of Stephen's birthday & Doris' appointment
Rosemary Seneviratne, Perth, AU	In memory of nephew, Daniel Goldstein
Linda & Michael Shepard, Sacramento, CA	In honor of our son, Paul Shepard
Hilary Silver, Stockton, CA	In honor of Aram Silver
Shannon Snead, Brooklyn, NY	In honor of my husband Daniel Jones' birthday
Mary Tabor, Albuquerque, NM	In honor of Dr. E. Fuller Torrey
Victor & Linda Taggart, Seattle, WA	In honor of Alicia Grigori
Jeanne Walter, Sumner, WA	In memory of Jan Geary
Carolyn White, Cambridge, MA	In memory of Frances S. White
Mary Zdanowicz, Arlington, VA	In honor of Doris Fuller – a passionate advocate
Katherine Zuckerman, Boise, ID	In memory of Nathan Alexander South

Connecticut

CONTINUED FROM PAGE 5

- 83% fewer experienced arrests compared to before participation.
- 88% fewer experienced incarceration compared to before participation.

Assisted outpatient treatment is a bridge to the "recovery" that advocates speak so passionately about. By providing structured, early intervention outside of psychiatric hospitals, these laws encourage patients to be engaged in their own recovery through active participation in their treatment plans.

The overwhelming majority of individuals testifying on March 29 focused on their perceived negative consequences of "involuntary outpatient commitment" and equated outpatient commitment to forcible medication (e.g., physically forcing an individual to take medication). Both perceptions are without basis. The first disproven by a large body of independent research and the second because it is without factual accuracy.

A more constructive use of such advocacy energies would be to focus on ways to help this neglected population while making the most effective and efficient use of scarce resources.

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Have You Seen Us "Making a Difference?"

At the Treatment Advocacy Center, we are working to save lives and families.

Now you can see what we mean.

In "Making a Difference: How the Treatment Advocacy Center Helps Individuals, Families and Communities," seven women and men whose lives we have touched tell their own stories of how we have made a difference.

The video is a great way to introduce our work to other advocates for mental illness treatment reform, your NAMI affiliate or another community group, legislators and other policy makers, mental health professionals and potential contributors.

The video is online through our Media Library. You may also request a DVD version by emailing: Video@TreatmentAdvocacyCenter.org.

Torrey Action Fund
CONTRIBUTORS

September 16, 2011 – August 31, 2012

The Treatment Advocacy Center extends its gratitude to all who donated to the 2011-2012 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.

Gerry & Ann Akland, Knightdale, NC
Anthony & Marie Aurigemma, Smithtown, NY
Erma Barber, Clio, MI
Marybeth Barraclough, Haddonfield, NJ
June Beeby, Kingston, ON
Wayne Bert & Kerstin Jagerbo, Arlington, VA
John & Maude Boerger, Fort Myers, FL
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John & Jackie Herum, Ellensburg, WA
Barbara Hessenaur, Midland, MI
Roderick & Betty Hooper, Double Springs, AL
Gilbert Hudson, Grosse Pointe, MI
June & John Husted/Travis, Lincoln, CA
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Lillian Jerman, Bradenton, FL
Paula John, Shorewood, WI
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Stanley Medical Research Institute Update

By E. Fuller Torrey, M.D.

PREVENTION OF SCHIZOPHRENIA AND BIPOLAR DISORDER

"Prevention" has recently become a buzzword for schizophrenia and bipolar disorder. SAMHSA widely advertises the fact that "prevention works" and several states, especially California, divert funds badly-needed for treatment to programs they claim to be preventing mental illness. For schizophrenia and bipolar disorder this is all unscientific nonsense.

In order to prevent a disease, you have to first have some theory about how it is being caused and then plan how to interfere with the theoretical causal chain of events. SMRI has recently supported several such trials. One was a trial of folate, a naturally occurring B vitamin which reduces the level of homocysteine, an amino acid thought to exacerbate some psychiatric symptoms. Folate has been used in treatment trials for schizophrenia, depression and cardiovascular disease. Given this theory, SMRI funded Dr. Philip Cowan and colleagues at Oxford to treat 112 young adults (age 14-24) whose father and/or mother had bipolar disorder or recurrent depression, with folate or placebo for 3 years to see whether the folate would prevent the onset of mood disorders in the young adults. The results, recently available, showed no differences in onset of mood disorders in the folate (14%) or placebo (18%) groups.

On the other hand, an initial study of fish oil to prevent the onset of schizophrenia was more promising. Fish oil is an essential nutrient for the brain. In 2003, SMRI funded Dr. Paul Amminger and colleagues in Austria to give fish oil for one year to 80 individuals thought to be at high risk for schizophrenia, e.g., very early symptoms, family history plus decreased functioning, etc. The conversion to psychosis was 20% in the placebo group but only 2.4% in the fish oil group. SMRI is currently following this up by re-examining those 80 individuals, five years later, to ascertain whether the fish oil made any difference in the long run. We have also funded a much larger multi-site study of 320 high-risk individuals in Europe and Australia, currently in process, and an additional study of 200 such individuals in Ireland, not yet underway.

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