

August 16, 2013

We are writing to respond to an article in the National Review online (August 15, 2013) by E. Fuller Torrey and D.J. Jaffe. Dr. Torrey heads the Treatment Advocacy Center, whose mission is to expand the use of involuntary outpatient commitment (also called Assisted Outpatient Treatment, or AOT) throughout the country.

Dr. Torrey does not believe that individuals with mental health diagnoses – such as schizophrenia, bipolar disorder, and major depression – can recover. **He is wrong.** We – members of the National Coalition for Mental Health Recovery (a coalition of 32 statewide organizations representing individuals with mental health conditions) – are among the millions of individuals who have recovered despite the fact that we have been diagnosed with such disorders.

Long-term studies such as the [Vermont](#) Longitudinal Study of Persons with Severe Mental Illness, by Courtenay M. Harding, Ph.D., et al., show that 68% of persons labeled with schizophrenia significantly or completely recovered. In Finland, a new, home-based approach called [Open Dialogue](#), which shares many of the principles of recovery, has been very successful. When it was used with persons with psychosis, after five years 76% were working or in school; only 14% were on disability. In comparison, a traditional, hospital-based approach in Stockholm resulted in 62% of the participants being on disability benefits at the end of five years (1). Open Dialogue's extremely high recovery rate, with only 11% being on an antipsychotic medication at the end of the study, indicates that these are not permanent biological brain disorders.

A decades-long study by the World Health Organization found that individuals diagnosed with schizophrenia usually do better in countries in the developing world – such as India, Nigeria and Colombia – than they do in such Western nations as Denmark, England and the United States.<sup>i</sup> According to an analysis of results, “Patients in developing countries experienced significantly longer periods of unimpaired functioning in the community, although only 16% of them were on continuous antipsychotic medication (compared with 61% in the developed countries). . . . The sobering experience of high rates of chronic disability and dependency associated with schizophrenia in high-income countries, despite access to costly biomedical treatment, suggests that something essential to recovery is missing in the social fabric.”<sup>ii</sup>

One such essential factor is peer support, which the federal Substance Abuse and Mental Health Services Administration (SAMHSA) has identified as a vital component in recovery.<sup>iii</sup> Since the mid-20<sup>th</sup> century, individuals who have psychiatric diagnoses have been creating effective and cost-efficient services that provide that missing factor.<sup>iv</sup> Peer-run services are based on the principle that individuals who have shared similar experiences can help themselves and each other.

In his National Review article, Dr. Torrey references the May 22, 2013, hearing held by a Congressional subcommittee on the effectiveness of federal grant programs for mental health services. During his testimony at this hearing, Dr. Torrey showed the brain scans of identical twins. One of the twins has schizophrenia and shows some damage. Dr. Torrey states that studies such as this prove that schizophrenia is a biological brain disorder and that Daniel Fisher, M.D., Ph.D. – a psychiatrist whom Dr. Torrey criticizes in the National Review article – was incorrect in saying that it was due to severe emotional distress. (It should be noted that Dr. Fisher at times prescribes medication, is co-founder and director of the National Empowerment Center – which receives SAMHSA funding – and himself is in recovery from schizophrenia. He served on President George W. Bush's New Freedom Commission on

Mental Health, which made recovery the recommended vision for the country's system of mental health care.) However, the fact that the identical twins do not have identical brain scans shows that there is no genetic/biological cause of schizophrenia. If there were, the same abnormality would show in both brains.

A more likely explanation for the difference in brain scans is that the twin with schizophrenia has been treated with a major tranquilizer. Dr. Nancy Andreasen has demonstrated that antipsychotic drugs cause brain damage in persons with schizophrenia. According to an article about this study that was published in the Archives of General Psychiatry: "Longer follow-up correlated with smaller brain tissue volumes and larger cerebrospinal fluid volumes. Greater intensity of antipsychotic treatment was associated with indicators of generalized and specific brain tissue reduction after controlling for effects of the other 3 predictors. More antipsychotic treatment was associated with smaller gray matter volumes. Progressive decrement in white matter volume was most evident among patients who received more antipsychotic treatment." Her team found the same results in monkeys treated with antipsychotic medication (2).

Dr. Thomas Insel, director of NIMH, recently stated that NIMH would no longer use the Diagnostic and Statistical Manual 5 (DSM 5) in its research, because even after over 50 years of concerted research scientists have failed to find any biological cause of any of the mental illnesses: "The weakness is its [DSM's] lack of validity. Unlike our definitions of ischaemic heart disease, lymphoma, or AIDS, the DSM diagnoses are based on a consensus about clusters of clinical symptoms, not any objective laboratory measure"(3).

Soon after, the APA Chair of the DSM 5 Committee, Dr. David Kupfer, defended the DSM 5, by saying there are not any reliable biological markers for psychiatric conditions, so they need to continue to use consensus to define these conditions. In other words the APA is saying there is no basis for saying these conditions are primarily due to biological defects. Therefore, the APA and the NIMH agree that they have not yet found a biological cause of schizophrenia. **On the other hand, a very high percentage of persons with a diagnosis of schizophrenia have significant histories of trauma.**

The concept of recovery from mental illness grew from the lived experience of persons who have been themselves recovering. The "recovery movement" was developed independently of the 12-step substance abuse recovery movement, but has a similar history. People labeled with mental illnesses, in a fashion similar to those with substance abuse disorders, started meeting in church basements and homes, providing mutual support. This is a genuine movement, and we are the evidence of its reality.

In his National Review article, Dr. Torrey specifically calls into question the value of the Alternatives conferences, national conferences held annually since 1985 and funded in part by SAMHSA, at which many hundreds – and at times more than a thousand – individuals with psychiatric disabilities from around the U.S. gather to share information and hope. Many who have attended these conferences say that their lives have been changed forever by what they learned there and by the people they met.

This conference is complementary to psychiatric treatment. Most of the participants have a major mental illness, are on medication and have case managers. These conferences give people hope, provide wellness and recovery skills, and help people network with others to give and receive peer support.

Last year, when there were questions about whether an Alternatives conference would be held in 2013, a petition urging SAMHSA to hold the conference was signed by over 500 persons with mental health challenges. There were a variety of testimonies extolling the conference. Below are some of the

comments the National Empowerment Center received when asking individuals with mental health conditions if Alternatives was worthwhile:

- *Alternatives is the largest consumer conference in the nation. It is a chance for us to explore and present new ideas for ways to deliver services, work with each other, and celebrate recovery. It also shows that we are still important, and mental health needs to be addressed on all levels.  
\* I have been to a few Alternatives conferences, and always came away informed and invigorated.*
- *This is the conference where I come to hear what my peers have to say about their recovery processes, their experience of care, and their hope and for some, their despair. This is the place we come to know that we are not alone.*
- *As President of a county Depression and Bipolar Support Alliance, I realize the importance of investigating and utilizing alternatives in addition to traditional treatment options for mental illness. Peer support helped me to get through and progress farther along the path of recovery.*
- *Alternatives saved my life and gave me one worth living!*
- *The Alternatives Conference is very important to me. I meet national people with ideas and goals. Recovery is something that grows from education and self-efficacy. I am currently finishing my masters in psychology, and am using people I have met at Alternatives as resources.*
- *The networking and the valuable tools and learning opportunities have helped me grow in my recovery! I also have gleaned much insight into peer support practices and holistic methods of healing from both mental health AND substance abuse challenges!!*
- *Every time I attend these conferences, my self-image improves, my confidence is bolstered, and I receive the energy needed to PASS ON THE GOOD NEWS OF RECOVERY!*
- *This conference educates people living with mental health issues and people working in this field and it gives a POSITIVE approach to recovery.*
- *Please understand the importance of these conferences to many people. Perhaps most important, these conferences give people hope that instead of living the life of illness and dependency that may have been predicted for them, they can instead live lives of meaning and purpose. For example, when asked "one thing I learned that I will incorporate into my life and/or my work," one Alternatives attendee responded, "We can influence the direction of the future."*
- *I have attended this conference four times and have had a great experience every time. Alternatives is a great opportunity to empower people in recovery to be agents of change.*
- *I attended my 1st Alternatives conference in Portland last fall, and it was the most inspiring, empowering event.*
- *A lot of valuable resources about getting and staying well and especially about helping others in their own recovery. Alternatives is invaluable and necessary.*
- *This is the very best mental health gathering for mental health peers. I gained so much knowledge and support from this conference last year. It's all about the gathering of peers and learning from my peers' shared experiences. Thank you.*
- *Alternatives is THE networking event of each year. For newcomers and many others, it is a life-changing event.*
- *Alternatives is the single most powerful event annually which awakens Americans to mental health recovery and advances best practices to the most affordable component of the mental health system – peer support. Alternatives is a very valuable educational conference. It gives a great number of folks from around the country and other parts of the world time to network and share ideas with one another. It also provides an opportunity for those just starting out in this very important work we do to receive peer mentoring, support, and learning tools.*

- *I went to this conference not as a peer, but as someone who works with peers. I can't speak more highly of a conference. I learned so much and met so many great people. This conference helped me be able to work better with peers and helped develop my career.*
- *Alternatives is the premier conference of people challenged by mental illness to advocate for our own solutions. This conference is essential to recovery and to people's lives.*

Dr. Torrey argues that making it easier to commit people would promote public safety. In fact, there is considerable evidence that persons with mental illness are no more violent than the general population. People with serious mental illnesses are far more likely to be victims of violent crime than perpetrators of it (4). Reporting their records will not meaningfully increase public safety. Studies show that “severe mental illness alone [is] not statistically related to future violence” (5).

The seminal study on risk of violence and mental illness, the MacArthur Violence Risk Assessment Study, compared the prevalence for violence among individuals with mental illnesses to the prevalence for violence among other residents of the same neighborhoods (6). The study showed that the two groups’ prevalence for violence was “statistically indistinguishable” (7). Indeed, “if a person has severe mental illness without substance abuse and history of violence, he or she has the same chances of being violent as any other person in the general population”(8).

According to Richard A. Friedman, M.D., writing in *The New York Times*: “[T]here is overwhelming epidemiological evidence that the vast majority of people with psychiatric disorders do not commit violent acts. Only about 4 percent of violence in the United States can be attributed to people with mental illness.”<sup>v</sup> And the 4 percent statistic is about violence of *any* kind – which, according to the study he cites,<sup>vi</sup> would include something as relatively innocuous as threatening behavior – as opposed to just homicides. Also, since the fears of the general public largely focus on strangers with mental health conditions, it is significant to report another study, which estimated that there is only one stranger homicide per 14.3 million people per year.<sup>vii</sup>

In addition, “studies have shown that psychiatrists’ accuracy in identifying patients who would become violent was [only] slightly better than chance.”<sup>viii</sup>

Dr. Torrey has an axe to grind: he and his organization push to pass outpatient commitment laws in every state, despite the fact that studies<sup>x</sup> have shown that outpatient commitment is not an effective treatment modality. He is aided in this misguided effort by D.J. Jaffe: “Seventeen years ago, D.J. Jaffe, an advertising executive, advised mental health advocates that ‘from a marketing perspective it may be necessary to capitalize on violence’ to pass laws compelling psychiatric outpatients to take psychotropic medication. Soon Jaffe joined forces with Dr. E. Fuller Torrey, a psychiatrist who shared Jaffe’s compulsory medication agenda. Thus was launched an intensive public relations campaign linking mental illness with violence.”<sup>x</sup>

Again, experts have little ability to predict violence. To the extent that research has identified risk factors, demographic variables such as age, gender and socioeconomic status are more reliable predictors of violence than mental illness (9). “The main risk factors for violence still remain being young, male, single, or of lower socioeconomic status” (10).

The most relevant factors to predicting serious violence include “having less than a high school education, history of violence, juvenile detention, perception of hidden threats from others, and being divorced or separated in the past year” (11).

In regard to Assisted Outpatient Treatment, Robert Bernstein, Ph.D., who heads the Bazelon Center for Mental Health Law, made an important point in a recent article about Kendra's Law in *The New York Times* ("Program Compelling Outpatient Treatment...", 7/30/13): "If outpatient commitment was so beneficial either clinically or financially, states would have flocked to use it" – which is not the case. As Dr. Bernstein notes, what works is an array of services, as studies have shown.

Assisted outpatient commitment frightens individuals with mental health conditions. The individual is told that although they have been discharged from a psychiatric hospital, they can be rehospitalized if they do not follow their treatment plan. The re-hospitalization can occur even if they do not meet the criteria for commitment to a hospital. Here are three studies showing that the fear of involuntary/forced treatment keeps people from seeking mental health treatment.

- The first statewide study of what factors promote or deter the well-being of people diagnosed with serious mental illnesses and published by the State of California under the George Deukmejian Administration found that 47% of the sample of mental health clients responding said that the fear of involuntary treatment had kept them from seeking treatment (12).
- Swartz, Swanson and Hannon (2003) found that more than a third of patients (36%) with schizophrenia and related disorders reported fear of coerced treatment (e.g., fearing involuntary commitment, contact with law enforcement officials or forced medications) as a barrier to seeking treatment (13).
- Across 5 sites – Chicago, IL; Durham, NC; San Francisco, CA; Tampa, FL; and Worcester, MA – 32.4% to 46.3% of mental health client respondents reported barriers attributed to fear of forced treatment. Conclusion of the study: "Perceived barriers to care associated with mandated treatment experience have the potential to adversely affect both treatment adherence and therapeutic alliance" (14).
- "This is the third, and largest, randomised trial of CTOs, and, similar to its predecessors, did not find any evidence that CTOs achieve their intended purpose of reducing readmission in so-called revolving door patients with a diagnosis of psychosis."(15)
- 

A far better way to engage people who otherwise would not seek psychiatric treatment is through peer-delivered services. An excellent example of such a service is peer-run crisis respite alternatives to psychiatric hospitals (16).

Dr. Joe Parks, Commissioner for DMH for Missouri, in his testimony of May 22, 2013, also criticized assisted outpatient commitment: "Regarding research outcomes for outpatient commitment, the most recent systematic review of outpatient commitment published up until November 2009 by the Cochrane Collaboration suggests that compulsory community treatment may not be an effective alternative to standard care. This research is on the effectiveness of compulsory community treatment for people with severe mental illness through a systematic review of all relevant randomized controlled clinical trials. Only two relevant trials were found and these provided little evidence of efficacy on any outcomes such as health service use, social functioning, mental state, quality of life or satisfaction with care. No data were available for cost and unclear presentation of data made it impossible to assess the effect on mental health state, and most aspects of satisfaction with care. In terms of numbers needed to treat, it would take 85 outpatient commitment orders to prevent one readmission, 27 to prevent one episode of homelessness, and 238 to prevent one arrest. **The reviewers concluded that compulsory community**

**treatment results in no significant difference in service use, social functioning or quality of life compared with standard care.”**

Although Dr. Torrey believes that individuals diagnosed with mental health conditions should be force-medicated if they refuse to take medication voluntarily, award-winning journalist Robert Whitaker believes that medication contributes to chronicity. In the era that followed the introduction of Thorazine in 1955, there has been an exponential rise in the numbers of individuals disabled by mental health disorders, he reports in his book “Anatomy of an Epidemic.”<sup>xi</sup> Whitaker told *Behavioral Healthcare*, “. . . [U]nfortunately I’m afraid psychiatry no longer knows how to get back on track with honest reporting of what it does and does not know, and honest investigations of psychiatric medications. . . . Ultimately, I think we need a new paradigm built on the framework of psychosocial and recovery practices.”<sup>xii</sup>

Dr. Torrey is adept at bending the facts and twisting the truth for his purposes. For example, he writes, “if you query the SAMSHA website for publications on schizophrenia or bipolar disorder, you will be told that these are covered by a single generic product: *Core Elements for Responding to Mental Health Crises*. But it is out of stock.” However, he fails to mention that the “Core Elements” document is easily available for free download on the SAMHSA website. <http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427>. Typical.

The best way to reach people who are frightened is through compassion, respect, hope, and believing in the whole person. These are the cornerstones of recovery. They apply as much or more to helping people who are severely distressed and in psychosis as to less distressed persons.

Sincerely,

**SIGNATURES**

**References:**

1. Seikkula, J., et al. (2006). Five-year experience of first-episode nonaffective psychosis in open-dialogue approach: Treatment principles, follow-up outcomes, and two case studies. *Psychotherapy Research*. 16(2): 214-228.
2. Beng-Choon Ho, Andreasen, N.; Steven Ziebell, S., Ronald Pierson, R., Magnotta, V. (2011). Long-term Antipsychotic Treatment and Brain Volumes, A Longitudinal Study of First-Episode Schizophrenia. *Archives of General Psychiatry*. 68(2):128-137.
3. Insel, T. <http://www.nimh.nih.gov/about/director/2013/transforming-diagnosis.shtml>
4. Teplin, L.A. et al., (2005). Crime Victimization in Adults with Severe Mental Illness, *Arch. Gen. Psychiatry* 62:911-914 (“Over one quarter of the SMI sample had been victims of a violent crime (attempted or completed) in the past year, 11.8 times higher than the [general population] rates”); Stuart, H. (2003). Violence and Mental Illness: An Overview. *Journal of World Psychiatry* 2:121-123. (“It is far more likely that people with a serious mental illness will be the victim of violence,” rather than its perpetrator.)
5. Elbogen, E.B. and Johnson, S. (2009). The Intricate Link Between Violence and Mental Disorder: Results from the National Epidemiologic Survey on Alcohol and Related Conditions. *Arch. Gen. Psychiatry* 66: 152-157; Vinkers, D.J., et al., (2012) Proportion of Crimes Attributable to Mental Disorders in the Netherlands Population, *World Psychiatry* 11:134 (discussing a study indicating that the

proportion of violent crime directly attributable to mental illness is 0.16 percent, which is below the incidence of mental illness). Some other studies have shown a “other factors contribute more strongly to violent events for persons with mental disorder than does one’s ‘mental illness’ alone.” See R. Van Dorn, et al. (2012) *Mental Disorder and Violence: Is There a Relationship Beyond Substance Use?*, *Social Psychiatry and Psychiatric Epidemiology*. 47:487-499.

6. Steadman, H.J. et al., (1998). *Violence by People Discharged from Acute Psychiatric Inpatient Facilities and by Others in the Same Neighborhoods*, *Arch Gen Psychiatry* 55: 393-400. The authors chose control subjects from the same neighborhoods as discharged patients in an effort to isolate mental illness from other socioeconomic and environmental factors that correlate with mental illness. Id. at 401; Stuart, H. (2003). *Violence and Mental Illness: An Overview*. *Journal of World Psychiatry* 2:121-122 (“The MacArthur Violence Risk Assessment stands out as the most sophisticated attempt to date to disentangle [the] complex relationships” of mental illness, prior history of violence, co-morbid substance abuse, and “broad environmental influences such as socio-demographic or economic factors that may have exaggerated differences in past research.”)

7. Id.

8. Elbogen & Johnson, *supra* note 2, at 157.

9. Elbogen & Johnson, *supra* note 2.

10. Stuart, H. (2003). *Violence and Mental Illness: An Overview*. *Journal of World Psychiatry*. 2:121-122.

11. Elbogen & Johnson, *supra* note 2, at 155

12. Campbell, J., Schraiber, R., (1989), *The Well-Being Project: Mental Health Clients Speak for Themselves*, Sacramento, CA, California Department of Mental Health)

13. Swartz, M., Swanson J., Hannon, M., *Does the fear of coercion keep people away from mental health treatment? Evidence from a survey of persons with schizophrenia and mental health professionals*, *Behavioral Science and the Law*, 21(4), 459-472.

14. Van Dorn, R., Elbogen, E., Relich, A., Swanson, J., Swartz, M., Mustillo, S. (2006). *The relationship between mandated community treatment and perceive barriers to care in persons with severe mental illness*, *International Journal of Law and Psychiatry* 29: 495-506.

15. Burns, T., Rugkåsa, J., Molodynski, A., Dawson, J., Yeeles, K., Vazquez-Montes, M., Voysey, M., Sinclair, J., and Priebe, S. (2013). [Community treatment orders for patients with psychosis \(OCTET\): a randomised controlled trial](http://dx.doi.org/10.1016/S0140-6736(13)60107-5). *The Lancet*, Vol 381. online: [http://dx.doi.org/10.1016/S0140-6736\(13\)60107-5](http://dx.doi.org/10.1016/S0140-6736(13)60107-5)

16. Greenfield, TK, Stoneking, BC, Humphreys, K, Sundby, E, and Bond, JA (2008). *Randomized Trial of a Mental Health Consumer-Managed Alternative to Civil Commitment for Acute Psychiatric Crisis*. *American Journal of Community Psychology* 42 (1/2):135-144.

---

<sup>1</sup> “Social Network’s Healing Power Is Borne Out in Poorer Nations”  
<http://vedantam.com/culture2-06-2005.html>

---

ii "What Did the WHO Studies Really Find?"

<http://schizophreniabulletin.oxfordjournals.org/content/34/2/253.full>

iii "SAMHSA Issues Consensus Statement on Mental Health Recovery"

[http://www.samhsa.gov/news/newsreleases/060215\\_consumer.htm](http://www.samhsa.gov/news/newsreleases/060215_consumer.htm)

iv "Emerging New Practices in Organized Peer Support"

<http://www.consumerstar.org/pubs/Emerging%20New%20Practices%20in%20Organized%20Peer%20Support.pdf>

v "In Gun Debate, A Misguided Focus on Mental Illness"

<http://www.nytimes.com/2012/12/18/health/a-misguided-focus-on-mental-illness-in-gun-control-debate.html>

vi "The Population Impact of Severe Mental Illness on Violent Crime"

<http://ajp.psychiatryonline.org/article.aspx?articleid=96905>

vii "Homicide of Strangers by People with a Psychotic Illness"

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3080680/>

viii "Predicting violence is a work in progress"

[http://articles.washingtonpost.com/2013-01-03/national/36209329\\_1\\_mental-illness-mental-health-violence-risk](http://articles.washingtonpost.com/2013-01-03/national/36209329_1_mental-illness-mental-health-violence-risk)

ix "Does Involuntary Outpatient Treatment Work?"

[http://www.rand.org/pubs/research\\_briefs/RB4537/index1.html](http://www.rand.org/pubs/research_briefs/RB4537/index1.html)

x "Stigmatizing Fear Tactics"

<http://stigmanet.net/FEAR%20TACTICS%20IN%20ADVOCACY%20EXAMPLES>

xi "Anatomy of an Epidemic: Summary of Findings," by Robert Whitaker

<http://www.ncmhr.org/downloads/Anatomy-Of-An-Epidemic-Summary-Of-Findings-Whitaker.pdf>

xii "Transforming our thinking about psychiatric medications (Part II)"

<http://www.behavioral.net/ME2/dirmod.asp?type=Publishing&mod=Publications%3A%3AArticle&mid=64D490AC6A7D4FE1AEB453627F1A4A32&tier=4&id=A5BC331586DC4D8B89B194044A0D83F1>

<http://www.behavioral.net/ME2/dirmod.asp?sid=9B6FFC446FF7486981EA3C0C3CCE4943&nm=Archives&type=Publishing&mod=Publications%3A%3AArticle&mid=64D490AC6A7D4FE1AEB453627F1A4A32&tier=4&id=43C2D89CC0364CFA94916B05462A9556#sidebar>