



## MENTAL HEALTH POLICIES ARE CAUSE FOR ALARM

### Why law enforcement and corrections communities should care

by Mary T. Zdanowicz, Esq.

Why should law enforcement and corrections executives care about mental health policy? Because America's law enforcement personnel are by default the first responders for people in psychiatric crises, and jails and prisons have become the nation's *de facto* psychiatric hospitals.

How times have changed. In the 19th century, Dorothea Dix discovered with horror that many in the country's jails and prisons had mental illnesses. She began a crusade that eventually led to the creation of the state psychiatric hospi-

tal system. It was successful. By 1880, less than 1 percent of the population in jails and prisons were mentally ill.

If we had the same conditions today, there would be fewer than 22,000 incarcerated severely mentally ill. Instead today's estimates range from 175,000 (8 percent) to 350,000 (16 percent) of the jail and prison populations.

#### Present-day crusaders are ignoring needed reforms of the mental health system

Unlike Dorothea Dix, modern mental health advocates overwhelmingly refuse to own this crisis. In fact, they do exactly the opposite – focus little on what the mental health system should do to abate this tragedy, instead shifting the burden to law enforcement and corrections officials.

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### THE SHERIFF AS ADVOCATE

by TAC board member Donald F. Eslinger, Sheriff, Seminole County, Florida



Sheriffs are not medical professionals.

And yet, my deputies are increasingly called on to handle dangerous situations involving people with untreated severe mental illnesses.

This situation has become a public safety concern for our officers and the citizens we are charged to protect.

This issue became more personal for me nine years ago when, in the course of a 13-hour standoff, Seminole County Sheriff's Deputy Gene Gregory and Alan Singletary, a man with untreated schizophrenia, were both killed and other deputies injured.

Reeling from this incredible loss, we were stunned by the primary reason: State law prohibited Alan's family from getting him the treatment he needed.

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### Fond farewell to Mary Z.

The Treatment Advocacy Center is conducting a nationwide search for an executive director following the resignation of Mary Zdanowicz after nine years as TAC's executive director. Zdanowicz will remain involved as a member of TAC's Honorary Advisory Board.

Zdanowicz is returning to work in the environmental field, where she spent most of her career before joining TAC. "The change will enable me to more effectively care for my two siblings who suffer from schizophrenia," said Zdanowicz, who remains passionate about the issues TAC addresses. "I am sad to leave the Treatment Advocacy Center but proud of what we have accomplished so far, from improving laws to changing minds. We have succeeded in bringing real hope to families who suffer the most extreme consequences of untreated mental illnesses," said Zdanowicz. "I am certain TAC will continue

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# Mary Zdanowicz laid groundwork for TAC's successes

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making a profound difference in the lives of a group of people many mental health organizations find it easier to ignore.”

TAC's assistant director Jonathan Stanley is acting executive director during the nationwide search for a successor.

“TAC has been very fortunate to have Mary Zdanowicz's strong leadership for the past nine years,” said board president Dr. E. Fuller Torrey. “Mary guided TAC through its infancy and laid the groundwork for TAC's many victories. Today TAC is a well-respected advocacy organization that has played a major role in influencing positive changes in mental illness treatment laws, policies and attitudes.”

Over the past nine years, TAC has been involved in reforming treatment laws in 18 states, including Kendra's Law in New York, now hailed as a national model for assisted outpatient treatment. And TAC is now a force to be reckoned with in the

national media, its messages reaching an estimated 79 million people through the press in 2006 alone.

During Zdanowicz' tenure, the American Psychiatric Association awarded TAC its Presidential Commendation, noting in part that TAC's “unique advocacy is restoring the important balance between individual freedom and caring coercion.” TAC also earned a prestigious 4-star rating from Charity Navigator, a testament to strong fiscal responsibility.

“The staff and board are grateful to Mary for her years of service and wish her the best of luck in her future endeavors,” said Dr. Torrey. “The

general reluctance of other mental illness organizations to address issues surrounding the need for assisted outpatient treatment means the Treatment Advocacy Center is the only organization focused on this critical issue.”

“I am supremely confident in our staff and board and look forward to continuing the fight for treatment.” ❖

**TAC will continue making a profound difference in the lives of a group of people many other mental health advocacy organizations find it easier to ignore.**

**- Mary Zdanowicz, TAC's former executive director**



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## About TAC

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The Treatment Advocacy Center is a national nonprofit organization dedicated to eliminating barriers to the timely and effective treatment of severe mental illnesses. TAC promotes laws, policies, and practices for the delivery of psychiatric care and supports the development of innovative treatments for and research into the causes of severe and persistent psychiatric illnesses, such as schizophrenia and bipolar disorder.

The American Psychiatric Association awarded TAC its 2006 presidential commendation for “sustained extraordinary advocacy on behalf of the most vulnerable mentally ill patients.”

Since TAC was launched in 1998, treatment laws in 18 states have improved. Today, we continue the fight for sustained and effective treatment for individuals touched by severe mental illnesses.

Catalyst is a free periodic newsletter. TAC also produces a free weekly news roundup, sent via email to subscribers. To subscribe, send an email to info@treatmentadvocacycenter.org with “Enews subscription” as the subject.

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# The sheriff as advocate

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But what could we do to prevent future tragedies?

Quickly it became clear. Law enforcement officers may not be medical professionals, but we are in a prime position to be formidable advocates on this issue.

An ad hoc group was formed to assess what actions we could take to ensure people who needed treatment would get it. With support from an amazing alliance between Deputy Gregory's widow and Alan Singletary's sister, we pulled together a group to work for reform. The very first issue on which a consensus emerged from our group was that more resources should be dedicated to helping people with severe mental illnesses.

It was also readily apparent that resources alone were not enough. More money could not help the population that needed it the most, those refusing treatment not because of a dearth of services, but because they didn't believe that they were sick. This lack of insight into illness is a common symptom of severe brain diseases and keeps many from treatment. We realized we needed a strong law to allow the sickest people to be court-ordered into outpatient treatment, a practice referred to as assisted outpatient treatment (AOT).

The Florida Sheriff's Association knew that if we wanted this change, we would have to take the lead.

Some activists have succeeded in turning AOT into a controversial topic, although data on its successes are clear. This perception of controversy keeps obvious advocates—including some in the mental health community who understand the benefits of AOT—from standing up for change.

But as sheriffs, we can.

**“A serious consequence of failing to treat severe mental illnesses is that, on any given day, there are at least five times more people with mental illnesses detained in Florida jails and prisons than are treated in Florida's state psychiatric hospitals each year.”**

**- Florida Sheriffs' Association resolution in support of reforming the Baker Act to help people with severe mental illnesses**

Even with extensive crisis-intervention training and other diversion tools, officers do not want to confront someone who is delusional and psychotic. The job of caring for our most ill, and most vulnerable, citizens is better left to those with training and expertise to handle such healthcare crises. And the job of promoting public safety by lobbying for stronger treatment laws is perhaps best placed in the hands of those who are facing people in crisis every day.

The Florida Sheriff's Association made AOT a legislative priority and thanks to our partners, including the Treatment Advocacy Center, an improved law went into effect January 1, 2005. It has been successfully implemented by the caring professionals at the Seminole Community Mental Health Center.

Seeing our improved law bring life-saving treatment to some of our most severely mentally ill citizens is one of the most rewarding experiences of my career.

Can sheriffs be mental health advocates?

The real question is, can we afford NOT to be? ❖

## Get your own data. Survey your officers!

You know there is a problem in your community - the need for a law enforcement response for people in psychiatric crises seems to be growing. It is a significant burden for police officers, deputies, and families.

You don't have any hard data for your community? Don't wait around for someone else to get it. Do it yourself.

Survey your police officers and sheriffs deputies. On pages 11 and 12 of this issue of *Catalyst*, you'll find a sample survey that can be photocopied, distributed, and completed during roll call. The results can help you quantify the magnitude of the problem and some of the causes. Additional copies can be printed from our website. Just write your information in the RETURN IT TO section before copying.

Results can be very enlightening. For example, officers and deputies are asked what the local mental health agencies can do to be more responsive to officers in responding to calls involving emotionally disturbed people in crises. In one study that used a version of this survey, it was revealed that **92 percent of officers reported encountering mentally ill individuals in crises in the month prior to the survey**. On average, officers had been involved in six encounters that month.

Share your results by sending them to [info@treatmentadvocacycenter.org](mailto:info@treatmentadvocacycenter.org). We're interested in what you learn. ❖

# Voices of experience: Crisis encounters

## Advice from those who have been there

*Catalyst* asked some real-world experts to share their perspectives on encounters between law enforcement and people in mental health crises ... and how better laws would make a difference

### An officer: Making the best of a hard situation

by Melissa Beasley, Special to *Catalyst*  
*Beasley is a captain in the Florence, Alabama, Police Department, Criminal Investigations Division/Internal Affairs, and is Lauderdale County's Community Mental Health Officer.*

I have been a law enforcement officer for 14 years and a community mental health officer for 10. My position as a mental health officer was created based on a law that allows the Probate Judge and the respective County Commissions to appoint someone to the position of county Community Mental Health Officer.

This position allows me to get an immediate psychiatric evaluation for people who are seriously mentally ill and a danger to themselves or others. This has been a very successful program in that it allows law enforcement to immediately remove the threat of harm and gives them another option of treatment for that person instead of jailing them on criminal charges.

We have approximately 89,000 people in Lauderdale County, Alabama. In 2005, I received more than 1,000 calls for service just involving persons with mental illness.

Mental health professionals and I also provide crisis intervention training (CIT) for law enforcement, which I believe is imperative for every officer due to the increasing calls for service involving mental illness. I respond to most of these calls involving seriously mentally ill persons and know firsthand that crisis intervention techniques can reduce the chances of injury to both the officers and the mentally ill person.

Some problems I have encountered here in our area are probably similar to other parts of the nation.

There have been cuts in the number of state hospital beds to provide for long-term psychiatric treatment of a seriously mentally ill person.

This eventually trickles down to law enforcement when they have someone who is very much in need of psychiatric treatment, but there is nowhere to send them. A lot of times this

results in our only other option in order to keep them and the community safe ... jail.

Another problem is that most of the time, the person in question is typically noncompliant with medication and/or treatment.

When someone is released from the state facility, our outpatient treatment requirement just doesn't have the "teeth" to force them to be compliant with treatment. This in turn runs the recidivism rate fairly high because once the state stabilizes people and they are back in the community, there's really nothing to hold their feet to the fire to comply with treatment.

Our community has a pretty good mental health system. We have an inpatient unit for those instances of immediate danger involving a mentally ill person and we have facilities for outpatient treatment.

But it's only a short-term fix for an immediate problem. There just aren't adequate resources for support of that mentally ill person once they are released back into the community.

**In 2005, I received more than 1,000 calls for service just involving persons with mental illness.**

There have been excellent programs implemented involving the PACT

(Programs for Assertive Community Treatment) models of community based treatment, but even when seriously mentally ill people are being kept up with, there still isn't a way that requires them to be compliant with treatment.

I see too many people with serious mental illnesses being caught up in this system of a revolving door – law enforcement officers have to deal with the same people time and again.

I believe that more law enforcement officials need to be involved with mental health agencies and state officials in order to work together to help reduce the state hospital admissions and successfully treat people in the communities where they live. I believe this can be done by shifting resources instead of "building buildings."

If the resources that are available are used properly and there are some changes in outpatient treatment requirements, together we can successfully reduce the admissions to the state hospitals and keep everyone safer. ❖

## Tips for law enforcement officers facing someone in crisis

Police officers *will* encounter persons with mental illness while in a crisis situation. So it is best to be prepared, even as you join the effort to advocate for better laws that will reduce the number of these encounters. Communication allows the officer and the individual to understand each other and reduce the tension that accompanies these encounters.

### DO

- Introduce yourself
- Remain calm
- Take your time
- Be patient
- Look over the situation
- Continually assess the situation
- Ask others to leave the area that are causing agitation
- Maintain safe and comfortable distance
- One person communicate with the individual
- Give clear specific directions
- Be respectful
- Offer assistance
- Be reassuring
- Respond to “emotional” or “feeling” content
- Know that you are dealing with someone with an illness

### DON'T

- Lose your composure
- Get excited
- Shout or give rapid orders
- Startle the individual
- Move suddenly
- Act in anger
- Threaten
- Abuse
- Deceive
- Agree/disagree with delusions
- Touch
- Ridicule
- Tease or joke
- Whisper to others
- Confuse the individual

*Excerpted from the “Law Enforcement Street Guide to Mental Illness,” a pocket manual written by Captain Melissa Beasley and Henry Stough, retired Mental Health Authority Director, Montgomery, Alabama. Find the full manual at [www.treatmentadvocacycenter.org](http://www.treatmentadvocacycenter.org).*

## A consumer: Facing an officer of the law

by Diana Kern, Special to *Catalyst*  
*Kern is a consumer advocate from Austin, Texas.*

In 1981, I was diagnosed with postpartum depression and hospitalized for a year and a half. During this first hospitalization, I was given other diagnoses as well, with schizoaffective disorder being the “final answer.” This was the first of more than 30 hospitalizations from 1981 to the mid-1990s.

I was treated with the old line antipsychotics, antidepressants, and mood stabilizers and nothing helped.

Why didn't any of the medications help?

- I did not like the way they made me feel (side effects) so I continually stopped taking them and “cheeked” them to flush them down the toilet.
- I believed the pills were tainted by the bureaucrats in the Texas government.
- I also believed I was not sick and I did not need help...from anyone.

**Obviously he was a natural at de-escalating persons in crisis. However, the difference lay in how he saw me and acted toward me.**

Imagine what my family went through for more than a decade. Imagine the deterioration in my broken brain. As I cycled through hospitals and halfway houses and friends' apartments, I depended on social security disability income and Medicare to pay for my life.

In the 1980s and early 1990s, I came in contact with mental health deputies more than once. The following incident is the one that I can remember.

A plain-clothed officer appeared at my apartment door at the request of my doctor. I was in a mixed state, both manic and suicidal. I was very suspicious of everyone and because this officer quietly let me rant and rave and showed understanding for me (as if I was like anyone else), I was able to gradually calm down.

I can remember that he did not disagree with me when I suggested bizarre things, nor did he get too close and invade my space. Rather, he spoke to me calmly while he brought me down to reality.

Obviously he was a natural at de-escalating persons in crisis. However, the difference was in how he saw me and acted toward me. He was not speaking to me as if I were an illness. He spoke to the part of me that was encouraged to take control of myself.

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## A consumer: Facing an officer of the law

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I voluntarily agreed to admit myself to a hospital.

My memory of this encounter with law enforcement is clear. I imagine that I can remember it because it was a positive experience with a good ending. My memories of other involvement with the mental health deputies (now known as CIT officers) are unclear and I only know what I was told about them more than 12 years ago.

This is a complicated issue. I am not saying that it is easy, but I am blessed with a wonderful life that I want for others.

**This is a complicated issue. I am not saying that it is easy, but I am blessed with a wonderful life that I want for others.**

It is unfortunate that we must rely on law enforcement to intervene when mental illness turns to danger or crisis. Until we can engage a mental health system to offer comprehensive treatment, and until we can educate the public about the serious effects of untreated mental illness, we will need our law enforcement officers to step in and help.

It is necessary that outpatient commitment laws must change in order to help those who lack insight into their mental illness and consequently, their behavior. I

should know, for I could not comprehend my illness until I was treated with new generation medications and I learned to take my medications ... every day. ❖

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## An officer: All we can do is wait for danger

by Detective Liz Thomson, Special to *Catalyst*  
*Thomson is a Crisis Outreach Officer for the Albuquerque, New Mexico, Police Department and a member of the APD's Crisis Intervention Team.*

*Editor's note: New Mexico is one of only eight states that still doesn't allow the option of assisted outpatient treatment, a way for a court to compel someone with a severe mental illness to receive treatment in the community. Despite efforts from many activists, the legislation stalled two years in a row in the Senate.*

I am the Crisis Outreach Officer for the Albuquerque Police Department and a member of the APD's Crisis Intervention Team (CIT). CIT consists of approximately 125 specially trained officers, detectives and the civilian Crisis Outreach & Support Team (COAST). CIT responds to people in crisis, many have mental illness.

Police must respond and intervene to keep citizens safe regardless of budget cuts and lack of services. We must utilize the tools available; there is no time for wishing and hoping for more money, more services, and better help.

The reality CIT officers know is that some people have mental illnesses that cause disturbing, horrifying delusions and/or hallucinations. For some, their mental illness makes it impossible for them to understand that what they experience is due to their illness.

We encounter people who beg, plead, and demand the police 'arrest' their persecutors or use 'police technology' to stop the 'rays' from injuring them. Some ask us to shoot them to end their pain. They do not tell doctors about their suffering because they believe it is not a mental illness, it is a crime being committed against them.

Some people take matters into their own hands to stop their own suffering. This can be the most dangerous.

The police in Albuquerque currently take people who meet the criteria of "danger to self or others" to hospitals for involuntary inpatient commitment in the hospital. Some become stabilized, get released, and then refuse to comply with their prescribed outpatient treatment. The cycle starts over again. Family members, social workers, case managers, and law enforcement are painfully aware of their patterns and histories of behavior.

Currently in New Mexico, all the police can do is wait until the person's behavior becomes dangerous again, then pick him or her up for another "forced" trip for inpatient care.

It is a vicious and cruel cycle.

**"The most significant barrier to treatment for the most severely mentally ill are laws that prevent the treatment of individuals who refuse treatment until they are a danger to themselves or others and laws that prevent a court from ordering individuals to take medications while living in the community."**

- National Sheriffs' Association resolution

## AOT can't help if it isn't available

Could AOT have saved these lives or averted these situations? We will never know. But one thing is for sure – we know these tragedies occurred without AOT as an option to intervene.

April 2006. Brian Patterson, a resident of Albuquerque and well known to our CIT detectives, jumped the fence at the White House in Washington, DC, for the fourth time. He was yelling and screaming, "I am the victim of terrorism, I am from New Mexico, my family is being poisoned!" Patterson's sister told reporters he needs help. "He doesn't trust anybody. He thinks President Bush is the only one that can help him." Family members have stated Patterson refuses to take medications for his mental illness.

July 2005. Carlos Preciado of Las Cruces, who is diagnosed with mental illness, had previously attacked his mother, calling her the anti Christ, knocking out her front teeth, and leaving her bruised and scratched. Ordered by a judge to be evaluated, he was soon released and then knocked down a woman in a store parking lot and stole her car. He led police on a chase during which he struck and killed 68-year-old Alvin Moore. Preciado's mother told her son he needed to take his medications but he refused. Since the murder, he has been committed to the state hospital.

February 2005. Mitchell Rockwood pulled a knife on a citizen and an Albuquerque Police Officer. Rockwood was well known to police and the courts with a history of violence and being found incompetent to stand trial. Diagnosed with mental illness, Rockwood was committed to the state psychiatric hospital's forensic unit but was eventually released back to the community.

July 2003. Duc Minh Pham, diagnosed with schizophrenia, took Albuquerque Sgt. Carol Oleksek's gun and shot her. Pham had a long history of arrests, chronic homelessness, and threatening police. Pham himself was killed by police in the encounter. Oleksek survived and is now an advocate for the mentally ill, including bringing AOT to New Mexico. ❖

*Case summaries compiled by Detective Liz Thomson.*

Assisted outpatient treatment (AOT) would be an additional tool for law enforcement to use to try to break this cycle. These people are already consumers of 'forced' mental health services; AOT would simply change the services from inpatient to outpatient. Outpatient services are more effective and less expensive than parallel inpatient services.

In CIT, we see the result of mentally ill people who get regular outpatient services. There is a reduction in their need for involuntary inpatient care, calls for police services, and dangerous behavior.

Most people have no way to see inside this issue because it will never truly touch their lives.

Most doctors will never have to commit a patient to a hospital for involuntary treatment, inpatient or outpatient.

Most families will never have to call 911 to get assistance with a dangerous mentally ill loved one.

Most lawmakers will never have to make a decision about what to do with the mentally ill constituent who refuses treatment and continues to act out in a dangerous way.

Most lawyers will never represent a mentally ill person in civil commitment proceedings.

Most mentally ill people themselves will never experience their illness to the extent that would make them a candidate for AOT.

Most people reading this will never know someone who is mentally ill and would meet the stringent criteria for AOT.

**As a society we should be very careful we do not further stigmatize the mentally ill by continuing to insist that all mentally ill people can simply make decisions about their own care.**

As a society we should be very careful we do not further stigmatize the mentally ill by continuing to insist that all mentally ill people can simply make decisions about their own care.

For some it is not a matter of choice, or a matter of courage, or even a matter of which service to choose.

To continue to insist all mentally ill people can simply choose their own treatment is to leave behind those who cannot make informed decisions because their illness interferes with their ability to understand their illness and make these decisions. ❖

### GET A DAILY NEWS FIX FROM TAC

Do you miss TAC's take on research and news between issues of *Catalyst*? If you have internet access, read something new every day! **Visit our BLOG** online at <http://psychlaws.blogspot.com/>.

# A father: Thank you, Detective

by Pete Earley, father and author of *Crazy: A Father's Search Through America's Mental Health Madness*

Excerpted from an op-ed piece originally printed in the Washington Post May 12, 2006. Reprinted with permission of the author.

*Editor's note: In May 2006, Michael Kennedy walked up to the Fairfax County police station and fired more than 70 times before being shot and killed himself by officers. At the end of his psychotic rampage, Detective Vicky Armel and Officer Michael Garbarino, veterans of the police department in Fairfax County, Virginia, were dead.*

*Police in Fairfax County and elsewhere are just as frustrated as families of the mentally ill by the inadequate response of the mental health system to people like Kennedy, who needed but was not getting treatment. By all accounts, Detective Armel was the officer others sought when they encountered people with untreated mental illness. Pete Earley knows this firsthand.*

Four years ago, I rushed my college-age son to a Fairfax Hospital emergency room only to be turned away. Although Mike was delusional and had been hospitalized twice before for treatment of bipolar disorder, a doctor said he was not sick enough - yet. Mike thought pills were poison, and Virginia's restrictive commitment statutes prohibit doctors from treating a person with a mental illness against his will unless he poses an "imminent danger" to himself or others. I was told to bring my son back after he hurt himself or me.

Forty-eight hours later, Mike broke into a stranger's house to take a bubble bath. The homeowners, away for the weekend, pressed charges, and Detective Armel was assigned to the case. Because I had been rebuffed at the hospital, I was outraged my son was now being punished for a crime that easily could have been prevented. Detective Armel sympathized. She personally took my son through booking and arranged for Mike to be released without being held in jail. This enabled me to whisk him back into a treatment program that, by this time, he had entered voluntarily.

Later, when his case came before a judge, the owners of the house that he had vandalized objected to a plea bargain that our attorney had negotiated with prosecutors. The state had been willing to let Mike plead guilty to two misdemeanors as long as he remained in treatment. But the victims wanted him to plead

guilty to at least one felony, which would have marked him for life. Once again, Detective Armel came to our aid. She persuaded the homeowners to give us time to come up with an alternative sentence. In the end, Mike was not branded a felon, the homeowners were placated and my son spent twice as long in a community treatment program as prosecutors had originally sought. The community was better served and my son got the help he needed, largely because Detective Armel had cared enough to intercede.

I spent the past 3 years investigating our national mental health system as a reporter. What I found is police officers such as Detective Armel - not doctors and therapists - are now on the front lines dealing with those who have mental disorders. Our mental health system is so deeply flawed that it is extremely difficult for people who are ill to get help. Instead they are being arrested for crimes they commit while psychotic. This is why jails and prisons have become our new asylums.

The federal Bureau of Justice Statistics found that 300,000 inmates in jails and prisons take medications for severe mental illnesses such as bipolar disorder and schizophrenia. An additional

500,000 are on probation. Some 700,000 pass through the criminal court system each year. The largest mental facility in America is not a hospital; it is the Los Angeles County jail.

Data from the nonprofit Treatment Advocacy Center [show that] people with mental illnesses kill law enforcement officers at a rate 5.5

times greater than the rest of the population. People with severe [mental illnesses] are killed by police in justifiable homicides at a rate nearly four times higher than others.

When I heard a female detective had been murdered, I thought about my friend .... A good police officer, loving wife, and mother of two children is dead.

Her murder was preventable. Her killer [who also died] should have gotten treatment. Their deaths should serve as a wake-up call. How many more police officers will be murdered; how many young men and women with untreated mental disorders must die, before we reform a disgraceful mental health system that fails to treat the sick and protect the innocent? ❖

*Earley and TAC's John Snook sit on a task force of the Virginia Commission on Mental Health Law Reform. The Commission, convened by the Chief Justice of the Supreme Court of Virginia, is working to improve the state's commitment law.*

**A good police officer, loving wife and mother of two children is dead. Her murder was preventable. Her killer [who also died] should have gotten treatment. Their deaths should serve as a wake-up call.**

# Just the facts

## The reality of violence

To those in the law enforcement community, proving that violence is a reality for those with untreated mental illnesses likely seems a ridiculous exercise.

That is because law enforcement and corrections officers know too well from personal experience that when people with brain diseases like schizophrenia or bipolar disorder go untreated, aggression and violent incidents oftentimes follow.

Because the mental health community has abdicated its responsibility to help the sickest of the sick, police officers and sheriff's deputies are often called in to intervene with homeless people who are delusional, to transport people with severe mental illnesses who need emergency evaluations, and manage domestic disturbances, incidents of violence, and threats of suicide.

The lack of action by the mental health community to intervene earlier to help people who are decompensating is compounded by the fact that about half of states require someone who is psychotic to deteriorate to a state of dangerousness before they can be involuntarily committed.

That means when they eventually meet that “dangerous” threshold, it is the police who respond to the call – and the police who end up having to confront and hopefully safely transport a psychotic delusional person to a treatment facility.

The results are not surprising.

- In Phoenix, incidents in which police used force with mentally ill people tripled between 1998 and 2003, continuing to rise despite a training program introduced in 2001 to teach officers about mental illness and how to appropriately respond to a mentally ill individual in crisis. In 2002, 30 chronically mentally ill people had confrontations with Phoenix police that ended with force, from physical restraint to shooting.
- A 2000 review of 30 cases of people shot and killed by police in Seattle disclosed that one-third of the people showed signs of being emotionally disturbed or mentally ill at the time of the incident.
- In 1998, law enforcement officers were more likely to be killed by a person with a mental illness (13 percent) than by assailants who had a prior arrest for assaulting police or resisting arrest (11 percent).

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## Virginia Tech

On April 16, 2007 in Blacksburg, Virginia, Seung-hui Cho carried out the deadliest school shooting in U.S. history. In the end, 33 people were dead, including Cho.

What happened to keep Seung Hui Cho from getting needed treatment and at what point could the Virginia Tech massacre have been prevented? A state-appointed panel charged with answering those questions assessed Cho's history, noting the many times he might have been stopped from falling through the gaping cracks of Virginia's mental health system. He had been ordered to outpatient treatment, but no one followed through on the order. When a professor noticed Cho's troubling behavior, she was told there was nothing she could do because Cho wasn't yet an “immediate danger.”

Governor Tim Kaine's panel concluded that “The Virginia standard for involuntary commitment is one of the most restrictive in the nation and is not uniformly applied.”

They also made some key recommendations about Virginia's law.

- The panel recommended that the involuntary treatment criteria be improved to “allow involuntary treatment in a broader range of cases involving severe mental illness.” The current standard for involuntary commitment in Virginia for someone with a severe mental illness requires a person to be an “imminent danger to self or others” before he or she can be court-ordered to treatment. This makes it difficult, if not impossible, to treat someone before they have harmed themselves or someone else, or threatened to do so. About half of states have more humane standards that focus on the person's deteriorating condition and “need for treatment,” rather than requiring them to deteriorate to “dangerousness.”
- The panel recommended that “reports of prior psychiatric history” be presented at the commitment hearing. Current Virginia law instructs magistrates to rely solely on what is happening currently with a person with untreated severe mental illness, ignoring what happened in the past. That means past episodes of violence, psychiatric history, and past treatment are not considered. As is clear from the extensive report on Cho, past history is not only relevant, but oftentimes critical.

It now falls on the legislature to act to improve state law. There is no question people who are clearly psychotic should get treatment. But Virginia needs to do better than that, as the Governor's panel recommends, and help people before they become a danger. ❖

# The reality of violence

Continued from page 9

Yet the mental health community persists in claiming the connection between violence and untreated mental illness is at best overplayed by the media or at worst completely fabricated. The Surgeon General's report in 1999 claimed "the overall contribution of mental disorders to the total level of violence in society is exceptionally small."

As recently as April 2007, in the wake of the Virginia Tech tragedy, the National Alliance on Mental Illness said "acts of violence are exceptional."

That is simply untrue.

The anecdotal evidence is overwhelming. But look at the science.

Eight major U.S. studies have addressed the issue of violence and mental illness. Dr. E. Fuller Torrey M.D., discusses them in his forthcoming book *The Insanity Offense*.

The MacArthur Violence Risk Assessment study followed 961 individuals discharged from psychiatric hospitals. Despite high refusal and drop-out rates, which potentially removed many of the most violent individuals, the 961 individuals committed a total of 608 acts of serious violence (physical injury; threat or assault with a weapon; sexual assault) in a one-year period.

The violence included six homicides and occurred despite the fact that mental health authorities contacted these individuals every ten weeks during the study period. Overall, 18 percent of the mentally ill individuals who were not also substance abusers, and 31 percent who were also substance abusers, committed an act of serious violence.

European studies also support the connection between violence and untreated mental illnesses.

Although there are fewer European studies that focus on acts of violence other than homicides, those that exist are consistent with the American studies. An English study of 168 individuals with recent-onset psychosis found that 10 percent were seriously violent (used weapon, caused injury, or sexual assault) in a three-year period. In another study of 112 individuals being discharged from an English psychiatric hospital, 19 percent had committed a violent act (physical injury, use of weapon, or sexual assault) within six months.

A third English study of 271 individuals with schizophrenia reported that 25 percent of them "physically assaulted another person" in a two-year period, a finding the authors called "alarming."

Studies now are uncovering the link between violence and lack of insight. In 2006, researchers conducted a five-city study of 1,011 outpatients in mental health clinics, all of whom were being treated, but one-third of whom were not taking medication regularly. They found over six-months that the prevalence of

serious violence was 6 percent (defined as assault with injury; threat/assault with lethal weapon; sexual assault) and the prevalence of other aggressive acts was 14 percent (defined as simple assault). They concluded that the violence rate was inversely related to treatment adherence and perceived treatment need – and that patients who

did not believe they needed treatment were 2.5 times more likely to commit acts of serious violence. (More on page 14.)

Most in the mental health community still not only ignore the issue of violence, but claim it is a fallacy. So NIMH Director Thomas Insel's recent comment is a watershed moment.

"My own sense of the community is that there's been an avoidance of talking about violence in schizophrenia because of a concern that it would increase the stigma. In fact, the data support the proposition that people with schizophrenia are more likely to be involved in violence either toward others or toward themselves unless they're treated .... Our failure to talk about the risk has led to loss of credibility in some of our attempts to reduce stigma. People with this illness, or with bipolar illness during the manic phase, are more likely to be violent than the general population by several-fold. Some people estimate that 50 percent of manic episodes involve violence, sometimes self-directed but other times not." [Schizophrenia Research Forum, August 9, 2007]

Is this the beginning of acceptance by the mental health community of what law enforcement has always known? Or is Insel's voice alone in the politically correct wilderness of mental health providers?

What IS certain is that for anything to improve, the mental health community must accept what the law enforcement community has known for too long – violence among those with untreated mental illness is a reality. ❖

**The mental health community persists in claiming the connection between violence and untreated mental illness is at best overplayed by the media or at worst completely fabricated.**

# Police response to people with mental illness in crisis

## PATROL OFFICER SURVEY

Dear Officer: There is no question law enforcement officers are increasingly the ones responding to people with mental illnesses in crisis. We are gathering data for our community on the prevalence and extent of the problem from the law enforcement perspective. Thank you for your time.

We appreciate your completing this survey and returning it to: \_\_\_\_\_

Date \_\_\_/\_\_\_/\_\_\_ Roll Call Shift Time: \_\_\_\_\_

1. **How well prepared do you feel when handling people with mental illness in crisis? (circle one)**

1	2	3	4
Not at all prepared	Somewhat prepared	Moderately well prepared	Very well prepared

2. **Overall, how well prepared do you think the other patrol officers in the police department are to handle people with mental illness in crisis? (circle one)**

1	2	3	4
Not at all prepared	Somewhat prepared	Moderately well prepared	Very well prepared

3. **Overall, how effective do you believe your department's response to handling people with mental illness in crisis is in accomplishing the following objectives: (circle one for each answer)**

a. Meeting the needs of people with mental illness in crisis?			
1	2	3	4
Not at all effective	Somewhat effective	Moderately effective	Very effective
b. Using non-jail alternatives when appropriate?			
1	2	3	4
Not at all effective	Somewhat effective	Moderately effective	Very effective
c. Minimizing the amount of time officers spend on these types of calls?			
1	2	3	4
Not at all effective	Somewhat effective	Moderately effective	Very effective
d. Maintaining community safety?			
1	2	3	4
Not at all effective	Somewhat effective	Moderately effective	Very effective

4. **Relative to other problems the department faces, how big of a problem are people with mental illness in crisis for the Police Department? (circle one)**

1	2	3	4
Not at all a problem	Somewhat of a problem	Moderate problem	A big problem

5. **About how many encounters with mentally ill people in crisis have you had in the past month:**

(Write in a number): \_\_\_\_\_

6. **How helpful is the mental health system in providing assistance to you when you are handling people with mental illness in crisis? (circle one)**

1	2	3	4
Not at all helpful	Somewhat helpful	Moderately helpful	Very helpful

7. **How effective is the emergency room in providing assistance to you when you are handling people with mental illness in crisis? (circle one)**

1	2	3	4
Not at all helpful	Somewhat helpful	Moderately helpful	Very helpful

- Survey continues on the next page -



# Treatment Advocacy Center fact sheet

## Anosognosia as a cause of violent behavior in individuals with severe psychiatric disorders

**SUMMARY:** Anosognosia, unawareness of illness, is the most important reason individuals with severe psychiatric disorders do not take medication for their illness. Multiple studies have demonstrated that the presence of anosognosia increases the incidence of violent behavior, both because it is associated with medication nonadherence and because it appears to directly increase violent behavior. Anosognosia is a major contributor to aggressive and violent behavior among individuals with severe psychiatric disorders. Because anosognosia is the major cause of medication nonadherence, the association can be assessed either by studying violent behavior and nonadherence or by studying violent behavior and measures of insight.

### 1. Violent behavior and nonadherence

Many published studies have linked aggressive and violent behavior to medication nonadherence. Three examples follow.

- In the United States (Massachusetts), 133 outpatients with schizophrenia were assessed for violent behavior over six months. During that period, “13 percent of the study group were characteristically violent,” and this was associated with medication nonadherence. “Seventy-one percent of the violent patients had problems with medication compliance, compared with only 17 percent of those without hostile behaviors.” Bartels SJ, Drake RE, Wallach MA, et al. Characteristic hostility in schizophrenic patients. *Schizophrenia Bulletin* 17:163–171, 1991.
- In the United States (multisite study), 1,906 individuals with schizophrenia and related disorders were prospectively followed and assessed for three years. Medication nonadherence was significantly associated with being violent, arrested, and victimized (all significant at a level of  $p < 0.001$ ). Ascher-Svanum H, Faries DE, Zhu B, et al. Medication adherence and long-term functional outcomes in the treatment of schizophrenia in usual care. *Journal of Clinical Psychiatry* 67:453–460, 2006
- In the United States (five sites), 1,011 outpatients with severe psychiatric disorders were assessed for medication adherence and physically assaultive behavior over six months. Those who became physically assaultive were significantly more likely to have treatment nonadherence ( $p < 0.001$ ), to be sicker, to be a substance abuser, and to have a personality disorder. Elbogen EB, Van Dorn RA, Swanson JW, et al. Treatment engagement and violence risk in mental disorders. *British Journal of Psychiatry* 189:354–360, 2006.
- In Sweden, 40 “mentally disordered” individuals with a history of “violent criminality” were discharged from two forensic hospitals and followed for between 3 and 12 years. Twenty-two of them committed additional violent crimes, and 18 did not. Among the strongest predictors of those who committed additional violent crimes were lack of insight and “noncompliance with remediation attempts.” Strand S, Belfrage H, Fransson G, et al. Clinical and risk management factors in risk prediction of mentally disordered offenders—more important than historical data? *Legal and Criminological Psychology* 4:67–76, 1999.
- In England, 503 patients in two forensic psychiatric hospitals were assessed for aggressive and violent behavior. Lack of insight strongly correlated with higher levels of such behavior. Woods P, Reed V, Collins M. The relationship between risk and insight in a high-security forensic setting. *Journal of Psychiatric and Mental Health Nursing* 10:510–517, 2003.
- In the United States (Ohio), 115 individuals with schizophrenia who had committed violent acts for which legal charges were incurred were compared to 111 individuals with schizophrenia who had no history of violent acts. The violent individuals had “marked deficits in insight” and were much more symptomatic. Compared to the nonviolent individuals, those who had been violent scored significantly lower ( $p < 0.001$ ) on awareness of mental disorder, awareness of achieved effect of medications, and awareness of social consequences of mental disorders. Buckley PF, Hrouda DR, Friedman L, et al. Insight and its relationship to violent behavior in patients with schizophrenia. *American Journal of Psychiatry* 161:1712–1714, 2004.
- In England, 44 male inpatients in a forensic psychiatric hospital were assessed for violent behavior. It was found that “a previous diagnosis of mental illness, lack of insight, and active signs of mental illness were the most predictive of inpatient violence.” Grevatt M, Thomas-Peter B, Hughes G. Violence, mental disorder and risk assessment: can structured clinical assessments predict the short-term risk of inpatient violence? *Journal of Forensic Psychiatry and Psychology* 15:278–292, 2004.
- In Ireland, 157 individuals with first-episode psychosis were assessed for violent behavior. The strongest predictors of violent behavior in the week following admission was poor insight (odds ratio 2.97) and a past history of violence (odds ratio 3.82). Foley SR, Kelly BD, Clarke M, et al. Incidence and clinical correlates of aggression and violence at presentation in patients with first episode psychosis. *Schizophrenia Research* 72:161–168, 2005.
- In the United States (New York), 60 male patients with psychosis who had been charged with a violent crime were assessed. Severity of community violence was strongly associated with poor insight, medication nonadherence, and substance abuse. Alia-Klein N, O'Rourke TM, Goldstein RZ et al. Insight into illness and adherence to psychotropic medications are separately associated with violence severity in a forensic sample. *Aggressive Behavior* 33:86–96, 2007. ❖

### 2. Violent behavior and poor insight

- In the United States (North Carolina), 331 “severely mentally ill” individuals who had been involuntarily admitted to a psychiatric disorder were assessed for their history of assaultive and violent behavior. The findings indicated “that substance abuse problems, medication noncompliance, and low insight into illness operate together to increase violence risk.” Swartz MS, Swanson JW, Hiday VA, et al. Violence and severe mental illness: the effects of substance abuse and nonadherence to medication. *American Journal of Psychiatry* 155:226–231, 1998.
- In Spain, 63 individuals with a diagnosis of schizophrenia or schizoaffective disorder were assessed for violent behavior during their brief hospitalizations. The strongest predictors of violent behavior were insight into symptoms (especially delusions), being sicker, and past history of violence. Arango C, Calcedo Barba A, González-Salvador T, et al. Violence in inpatients with schizophrenia: a prospective study. *Schizophrenia Bulletin* 25:493–503, 1999.

# Keeping the pressure on: TAC's message in the media

## Wall Street Journal

Mentally ill individuals have a civil right to receive treatment, even when their brain disease precludes awareness of their illness. And the public has a civil right to be protected from potentially dangerous individuals. We are failing both the patients and the public. - **op-ed by TAC president E. Fuller Torrey, M.D.**

## Washington Post

But the pendulum has swung so far in the opposite direction, protecting the mentally ill at the expense of the broader community, that caring people find themselves stymied at every turn. - **Columnist Marc Fisher**

## National Review and New York Post

There is, of course, a balance to be struck between civil liberties and treating the mentally ill. But that balance is now badly off-kilter. - **Columnist Rich Lowry**

## San Diego Union Tribune

Cho became by any person's reckoning a danger not only to himself but to others, although his future behavior was hard to predict. Because of that unpredictability, the law in California and elsewhere should allow involuntary detention based on current actions and past history of mental illness. - **Editorial**

## Star Ledger

New Jersey already closed one hospital and "reinvested" the money in the community. Yet the psychiatric hospitals are overcrowded because community mental health providers can't - or won't - do what is necessary to keep patients out of the hospital. Thus, tragedies among this very vulnerable population are inevitable both in and out of hospitals.

Blaming the hospitals is the easy way out, and allows the mental health community to again dodge blame for the crisis we are now facing. The community isn't doing its part, and it is far past time to hold them accountable. - **Op-ed by (former) TAC executive director Mary Zdanowicz**

## Pittsburgh Post Gazette

Many states have improved their treatment laws to take these scientific advancements into account. Not Pennsylvania. Its law is one of the strictest in the country. As a result, those who cannot access treatment voluntarily must hit rock bottom before they can be helped. Treatment is dependent on them first posing a "clear and present danger." This invites tragedy. - **letter to the editor by TAC legislative and policy counsel John Snook**

## Dallas Morning News

This situation is an understandable overreaction to abuses of the past, when the mentally ill were confined too often and too long. But it's time for the pendulum to swing back to a more sensible middle. That's slowly happening. The Treatment Advocacy Center in Arlington, Va., is leading the way. - **Columnist Steve Blow**

## Minneapolis Star-Tribune

It's folly to wait until someone suffering from mental illness is teetering on a window ledge - or stockpiling Uzis - before intervening... [Minnesota's] statute permits outpatient commitment plans - an ingenious option too rarely used to good effect. - **Editorial**

## San Francisco Chronicle

Being completely and absolutely overcome with illness - walking around and thinking you're on Mars and that everyone is a Venusian - is not enough to get someone into treatment. They have to be in physical danger at the time. - **news story with TAC assistant director Jon Stanley**

## Miami Herald

"[AOT has] been hugely successful in Seminole County," said Sheriff Don Eslinger, who pushed for the law after one of his deputies was killed by a mentally ill man who wasn't taking his medication. "It's dramatically decreased homelessness, hospitalizations and violence in this population." - **news story**

## Los Angeles Times

Today, some hospital staffers say they feel as if they must gird themselves for battle at the beginning of their shifts. Doctors also say patients have suffered lasting, and avoidable, damage from psychotic breaks that might have been avoided with medication. - **news story**

## Roanoke Times

The families of people with mental illnesses know how hard it is to get them care. Those failures, too, sometimes end in violence, in suicides or murders that don't stun the world but are no less tragic to those touched by them. - **Editorial**

## Washington Post

On the books, in part due to the lobbying efforts of the Arlington, Va.-based Treatment Advocacy Center, most states have departed from the "imminent danger" standard. In recent years, 23 states have lowered the bar to include a "need for treatment" standard to determine whether someone should get court-ordered treatment, either outpatient or inpatient. - **feature by Asra Nomani** ❖

## Research update

### The link between state psychiatric hospital closures and criminalization: Report on the Markowitz study

In an article published this year, Fred Markowitz at Northern Illinois University reported the results of a very sophisticated study to determine how psychiatric hospital capacity impacts crime and arrest rates. He studied data from 81 cities around the country and, not surprisingly, found that public psychiatric hospital capacity is inversely related to crime and arrest rates. That is, communities with greater access to public psychiatric beds have lower rates of arrests and crime. The same relationship exists when violent crimes are analyzed separately.

Markowitz found the same can't be said for psychiatric beds in general hospitals. With the closure over the years of large public psychiatric hospitals (which do not qualify for Medicaid reimbursement under the federal "IMD exclusion"), state and local governments have come to rely on small psychiatric wards in general hospitals (which are eligible for Medicaid) to address the needs of patients who need inpatient hospitalization.

While these community beds can be just as expensive on a per diem basis, they lack the clinical capacity for treating the most severely ill patients. This is evidenced by recent data from Virginia in which the average length of stay for patients in the state hospital (55.3 days) was nine times that of the contracted community beds (6.1 days).

Perhaps the more rapid discharge of patients from the local hos-

pitals explains in part why access to psychiatric beds in general hospitals did not have the same effect as access to beds in public hospitals in reducing crime and arrests.

What this research demonstrates is the corrections community will lose out if it sits idly by and lets the mental health community determine hospital capacity issues. Under pressure from mental health advocates to move the money from hospitals to community treatment, public psychiatric hospitals closed in the 1990s at a rate three times greater than in the years 1970–90. In 2004, when asked if they were experiencing a shortage of psychiatric beds, more than half of responding states said yes.

Between 1981 and 2001, the great proportion of funding flipped from state psychiatric hospitals (63 percent to 32 percent) to community mental health (33 percent to 66 percent).

Yet, things don't seem much better.

In fact, Dr. Markowitz evaluated whether the total amount of city mental health expenditures made a difference in reducing crime and arrests – it did not. He acknowledges that the amount of expenditures is not necessarily an indication of effectiveness. An important factor may also be whether assisted outpatient treatment, which has been shown to reduce arrests, incarceration, and homelessness is used. ❖

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### The science of treatment: Research update from SMRI

TAC works closely with the Stanley Medical Research Institute (SMRI), which carries out research to ascertain the causes of and develop better treatments for schizophrenia and bipolar disorder. Following is a brief update on some current SMRI research; similar updates will be carried in future issues of *Catalyst*.

**Metabolic abnormalities in schizophrenia.** One of the most successful SMRI grants has been to the Institute of Biotechnology at the University of Cambridge in England. The program, directed by Dr. Sabine Bahn, has continued to publish studies describing metabolic abnormalities in individuals with schizophrenia. Many of these abnormalities involve glucose metabolism, which is especially important since it is now known that antipsychotic medication can also disturb glucose metabolism. Dr. Bahn's group is utilizing their findings to try to develop new medications for treating schizophrenia.

**A parasite as a possible cause of schizophrenia.** SMRI continues to support promising research on infectious agents as possible causes of schizophrenia and bipolar disorder. Much of this research is taking place in the Stanley Laboratory of Developmental Neurovirology at Johns Hopkins Medical Center under the direction of Dr. Robert Yolken, who is a member of the TAC Board of Directors. In a spring 2007 issue of *Schizophrenia Bulletin*, Drs. Yolken and Torrey coedited six papers on *Toxoplasma gondii* as a possible cause of schizophrenia. *T. gondii* is a protozoan parasite that occurs normally in cats but is transmitted to humans in a variety of ways. More than 40 studies have found that individuals with schizophrenia have increased antibodies to *T. gondii* compared to unaffected controls. A paper describing these findings is featured on [www.schizophreniaforum.org](http://www.schizophreniaforum.org), a useful website for keeping up with schizophrenia research. ❖

## Legislative update

### Illinois' new law: TAC works with NAMI Illinois, family members to remove "dangerousness" requirement

Governor Rod Blagojevich signed Senate Bill 234 into law Sept. 10, 2007, to the elation of many in Illinois who have been fighting for five years to improve that state's strict mental illness treatment law. Illinois currently requires someone to be an actual physical danger to themselves or someone else before they can be court-ordered into mental illness treatment. The new law, which will go into effect June 2008, loosens that strict standard to allow earlier intervention for people with incapacitating symptoms of illnesses like schizophrenia and bipolar disorder.

"This measure opens far wider the door to needed treatment for a small group of people who are extremely ill," said Jonathan Stanley, acting executive director of the Treatment Advocacy Center. "With the stroke of the governor's pen, Illinois' law went from one that virtually mandated non-treatment of those lost to severe mental illnesses to one that can and will save lives. Illinois has now joined the national trend toward making mental illness treatment laws more rational and humane"

This standard will make it easier to use assisted outpatient treatment (AOT) in Illinois. AOT has been shown to reduce rates of hospitalization, homelessness, arrests, and incarceration, saving both lives and money.

"The passage of SB 234 is a monumental victory for the mental health system in the State of Illinois," said Senator Dale Righter, the bill's chief sponsor, who along with Representative David Leitch guided the bill through the legislature. "The current criteria make it very difficult and sometimes impossible for individuals suffering from mental illness to get the help they need. In many instances, the individuals stop taking necessary medications, and as a result, fail to realize they need those medications, or even that they suffer from an illness. In these situations, a

brief involuntary commitment is the only way to ensure someone with a mental illness returns to their medications and ceases to become a danger to themselves or others."

"The new law has one goal," agreed Lora Thomas, the executive director of NAMI Illinois. "It offers the hope of getting a loved one with mental illness into treatment. Illinois can no longer retain the right for people to remain dangerously ill."

Sen. Righter credited family member Karen Gherardini for first bringing the legislation to his attention. "Karen has struggled for years to help a loved one receive appropriate help and treatment. Karen's perseverance, persistence and dedication to this issue, in addition to the support of many other families who have loved ones that suffer from a mental illness, have finally paid off."

Ms. Gherardini, whose frustrated efforts for treatment for her loved one sparked her five-year quest for the reforms embodied in SB 234, said "I am thankful to the many legislators who stood strong and believed a real change was necessary to save lives. I am elated for the many people that will now be given the opportunity to receive the treatment that will prevent the progression of a cruel disease. At the same time a part of my heart is very sad...because it comes too late for my loved one."

"This means so much to so many families," said Linda Virgil, Chair of NAMI Illinois' Public Policy Committee.

"The old law protected the right to be sick, even to the point of dangerousness. This reasonable law allows everyone the chance of a good outcome." ❖

*For more, visit the Treatment Advocacy Center online at [www.treatmentadvocacycenter.org](http://www.treatmentadvocacycenter.org).*

### CALLING ALL OFFICERS ... Do you know your state law?

Law enforcement officers are often told the only time they can intervene to bring someone with severe mental illness in for treatment is if the person poses an "immediate danger to self or others." However, the standards in many states actually permit interventions for other reasons. To be sure you know when you can intervene, learn the following about your state mental health treatment law:

- What is the standard for a law enforcement officer to take someone with severe mental illness in for emergency treatment?
- What is the standard for a law enforcement officer to take someone with severe mental illness in for an involuntary psychiatric evaluation?
- Can law enforcement officers initiate a petition for court ordered inpatient treatment? If so, what is the standard?
- Can law enforcement officers initiate a petition for court ordered outpatient treatment (now available in 42 states)? If so, what is the standard? ❖

# Why should officers care about mental health policies?

Continued from page 1

The criminal justice system is called upon to divert the mentally ill through specialized police programs and mental health courts. Mental health advocates push law enforcement to improve jail-based treatment and crisis intervention training, ignoring the fact that it is their role to stop crises before they get to that point. Advocates laud the establishment of mental health courts, seemingly forgetting those useful tools still require someone with a severe mental illness to be arrested before that “diversion” tool can be implemented.

## Mental health policies directly impact jail and prison operations

The magnitude of the crisis, and the lack of leadership by the mental health community for reversing it, means members of the law enforcement and corrections communities have no choice but to understand – and get involved in reforming – mental health policy. Criminal justice officials must recognize that federal, state, and local mental health laws and policies have a direct impact on the size of their mentally ill inmate populations.

**The impact of the policy of exclusively self-directed mental health care.** The current trend is driven more by what “feels good” than practices that are “proven good.” The federal government is funding the “transformation” of state mental health systems to care only for psychiatric patients who are on the road to recovery and able to direct their own care. Self-directed care is the cornerstone of this new system – refusing medication and all of the consequences of non-treatment are viewed as a “choice” patients make.

**“Three times already [this year] law enforcement officers have responded to mentally ill individuals falsely claiming to have bombs. In two of the cases, police SWAT teams were held at bay for several hours, and in the third, Route 80 was closed for nearly two hours, all tremendous burdens on personnel and budgetary resources.”**

- New Jersey State Association of Chiefs of Police resolution supporting legislation creating assisted outpatient treatment for people with severe mental illnesses

**There is nearly a 1:1 relationship between the decline in state psychiatric hospital census and the increase in incarceration in the U.S. over the last 30 years.**

That means when the mentally ill are diverted from jails and prisons, they are still free to refuse treatment. Treatment non-adherence leads to relapse in a system that encourages choice until someone becomes dangerous. Then police are called and the cycle continues.

**The impact of the policy of reducing hospital beds.** While mental health experts wax dreamily about a perfect mental health system where trusting relationships rather than medication are the road to recovery, law enforcement executives lament the reality.

Gabe Morgan, Sheriff of Newport News, Virginia, describes how changes in mental health care impacted criminal justice:

“Acute care for the mentally ill was once provided by the staff of psychiatric hospitals – but now many who are severely ill are instead living in our communities, where the burden of managing symptomatic and psychotic behaviors often falls on law enforcement. Because the mentally ill can refuse treatment until they are dangerous, officers often have no alternative but to take them to jail. Jails were never intended to be treatment facilities, but now it seems they are replacing psychiatric hospitals.”

The criminal justice system is dependent on psychiatric hospitals, not only as a means of preventing criminalization, but also for evaluating and restoring defendants’ competency to stand trial and caring for the growing number of those found not guilty by reason of insanity. This is clearly evident in the proportion of state psychiatric hospital beds committed to forensic use.

In 2006, Florida judges threatened to jail a mental health official for failing to transfer more than 300 jail inmates to state psychiatric hospitals for treatment. The back-up in the jails really should not have surprised anyone considering that the state closed a 382-bed state psychiatric hospital in 2002.

The state psychiatric hospital system that Dorothea Dix championed is nearly defunct. Since 1970, 90 percent of public psychiatric hospital beds have closed.

To most people it is obvious there is a connection between state hospital closures and increased criminal justice involvement with the mentally ill. Recent research dispels any doubts. There is nearly a 1:1 relationship between the decline in state psychiatric hospital census and the increase in incarceration in the United States over the last 30 years.

Continued on page 18

# Why should officers care about mental health policies?

Continued from page 17

Those in the system don't need data to see the trend. Stan G. Barry, Sheriff of Fairfax County, Virginia, voiced what many in his position have also observed:

"When I first started it was very, very rare that someone who was clearly mentally ill ended up in jail. Over the years, I've watched that change drastically."

Research demonstrates that public psychiatric hospitals play a very important role in reducing crime and arrests and thus, the burden on the criminal justice system.

**The flawed policy of choice.** The most common reason for hospitalization is medication non-adherence. The most common reason for non-treatment is the belief that treatment is not needed – usually because these patients don't even realize they are ill. For example, they think the CIA is causing the voices in their head. They take medication in the hospital because they know that's the only way to get released. Once in the community, "choice" is the mantra, and many choose not to take medication, often because they think they don't need it. Without medication, symptoms return. For these patients, it doesn't matter how much money is invested in the mental health system – if services are voluntary, they can choose not to participate.

If there is ever to be any real hope of breaking the cycle of criminalizing the mentally ill, the community mental health system must take responsibility for the most severely ill patients.

## Leveraged treatment common and effective

Researchers found that the use of formal and informal means of leveraged treatment is already quite common. The MacArthur Network on Mandated Community Treatment identified several forms of leverage used to facilitate people's acceptance of outpatient mental health treatment.

- **Money as leverage.** Government disability benefits for people with a serious mental disorder are in some cases received and distributed by a family member or other appointed payee. Payees frequently use these payments as leverage to coerce treatment.
- **Housing as leverage.** People who depend on disability benefits often can't afford market-rate housing, so government-subsidized housing is used, formally and informally, as leverage to ensure adherence to treatment.

**If there is ever to be any real hope of breaking the cycle of criminalizing the mentally ill, the community mental health system must take responsibility for the most severely ill patients.**

- **Avoidance of jail as leverage.** For people who commit a criminal offense, adherence to treatment may be made a condition of probation. This long-accepted judicial practice has become more explicit with the recent development of specialized mental health courts.
- **Avoidance of hospital as leverage.** Consumers are made aware that if their condition deteriorates sufficiently, they will be hospitalized. Awareness of this consequence of non-treatment leverages medication adherence.
- **Advance directives.** In some states, a patient can attempt to gain some control over treatment in the event of later deterioration by specifying treatment preferences or a proxy decision maker.

Interviews with outpatients from five sites in five states around the county revealed that 44 percent to 59 percent of patients had experienced at least one form of leverage.

Leveraged treatment is necessary because some patients, particularly those with schizophrenia, can lack the capacity to make informed decisions about treatment. Mental health systems that wholesale adopt the federal government's "transformation" initiative based on patient self-direction and choice will only be serving those patients capable of directing their own choice – those who are not just willing to consent, but able to do so.

That means an entire segment of the mentally ill population – the ones who are sickest and most likely to land in jail – are not included in this flawed policy.

In fact, according to the "transformation" initiative, neither informal nor formal means of leveraged treatment can be condoned in a system built on choice. This should cause great alarm in the criminal justice community.

## Assisted outpatient treatment: A proven option

When someone refuses treatment despite all efforts to cajole them, where do we turn? Civil commitment laws – laws that govern when and how to treat people over objection.

Data show a clear connection between civil commitment laws and criminalization. In the 1970s, civil commitment laws were weakened dramatically to require immediate danger before a person could be hospitalized. Jails and prisons were affected almost immediately.

In 1976, a few months after Pennsylvania weakened its laws, one prison documented a sharp increase in the number of

severely mentally ill inmates. In 1971, a California prison psychiatrist lamented:

“We are literally drowning in patients, running around trying to put our fingers in the bursting dikes, while hundreds ... continue to deteriorate psychiatrically before our eyes into serious psychoses ... The crisis stems from the recent changes in the mental health laws allowing more mentally sick patients to be shifted away from the mental health department into the department of corrections ... Many more men are being sent to prison who have serious mental problems.”

Since the 1970s, many states have improved their laws to allow for more timely treatment intervention.

There has been a recent trend to reform laws to allow for court-ordered community treatment, known as assisted outpatient treatment, for individuals who have a history of repeated hospitalization or arrests or who may become violent without treatment.

Assisted outpatient treatment (AOT) allows people overcome by a severe mental illness to be court-ordered into a treatment plan while still in the community – BEFORE they are arrested, and before they significantly deteriorate.

Of patients in New York’s AOT program, known as Kendra’s Law, 83 percent fewer experienced arrest and 87 percent fewer experienced incarceration. Kendra’s Law also dramatically reduced homelessness and the need for inpatient psychiatric hospitalization.

AOT laws require the mental health system to take responsibility for the sickest patients before they enter the criminal justice system.

### **Corrections and law enforcement: Vital role as mental health advocates**

There is no incentive for mental health directors to keep the mentally ill out of the criminal justice system. In fact, fiscal pressure on state and local mental health budgets is alleviated when clients are treated in jail and on probation rather than in community mental health systems.

So it falls in large degree to the law enforcement and corrections communities to take the reins to ensure that mental health laws and policies work to divert people away from prisons and jails, help people before they deteriorate to crisis, and keep the responsibility for people with severe psychiatric diseases where it belongs – with the mental health system.

How can law enforcement and corrections officers begin this critical work as advocates?

**Ask questions.** The mental health community has no trou-

**“This bill would be an invaluable aid to the CIT officers who are the first-responders during a mental health crisis.”**

**- Portland, Maine, police department letter in support of legislation creating assisted outpatient treatment for people with severe mental illnesses**

ble querying sheriffs and jail administrators about their policies and practices in regard to mentally ill inmates. Law enforcement officials can turn the tables and ask whether the mental health system is prepared to keep its clients engaged in treatment once they have been diverted. And what is the mental health system doing to prevent its most vulnerable clients from having encounters with law enforcement?

**Go to the source.** Make sure everyone knows what the state civil commitment laws allow. Forty-two states allow for assisted outpatient treatment. At least half of states allow for inpatient treatment for reasons other than “dangerousness” such as “grave disability.”

This means that the mental health system can intervene before a person is dangerous and law enforcement officers don’t have to be the first responders.

**Become an advocate.** If not actually advocating for new hospitals, corrections officials must be engaged in the dialogue about the feasibility of closing more hospital beds. And officers can be a formidable force in convincing legislators the state’s treatment laws need to be improved and implemented.

In Florida, the Florida Sheriffs Association led the legislative charge to reform their state’s mental illness treatment law. In states like Maine, New Jersey, and California, corrections and/or law enforcement personnel have testified in front of legislative committees about the burden of caring for people with mental illnesses in prisons and the costs – both fiscal and in personnel – to do so. Officer advocates have written letters to the editor, talked to reporters, spoken to advocates, attended task force meetings – all with the goal of turning the responsibility of care back to the mental health community.

In the 21st century, corrections and law enforcement community must play the role of Dorothea Dix to advocate reform of the mental illness treatment system.

As states and communities begin “transforming” their mental health systems, corrections officials need a seat at the table to remind everyone what will happen to the patients who do not choose treatment – and that law enforcement and corrections officers, no matter how well trained, are not mental health professionals. ❖

# Memorials and Tributes

Our deepest appreciation to the people and organizations who sent in memorials and tributes since our last issue of *Catalyst*. We are grateful that you chose to support the Treatment Advocacy Center's mission in memory or in honor of someone very special to you. Your generous contributions allow us to continue our mission.

We are also grateful to all those who support our efforts but who choose not to make that donation public. Your names do not appear below, but the result of your contribution appears in everything we do.

– *The grateful board and staff of the Treatment Advocacy Center*

Nora Jill Adelman and Joan Cummings, Glen Ellyn, IL	In honor of Michael Adelman
Mary Alexander, Millis, MA	In memory of Barbara Flory
Allen and Jean Anneberg, Carroll, IA	In honor of Skip Anneberg
Jerry and Aedene Arthur, Palmer, AK	In honor of Beth Arthur & in memory of Aaron Arthur
Lori, Jeff, Jordan, and Alana Asch, Kendall Park, NJ	In memory of Daniel Stone
Larry and Mary Bacon, Grand Lake, CO	In honor of Sheriff Don Eslinger
Dennie and Carol Baker, Warrington, PA	In memory of Grace Hood
Victor and Ruth Balestra, Coral Gables, FL	In memory of John F. Schmelzer
Thomas and Marcia Barnes, Buffalo, NY	In honor of Gregory F. Barnes
Gale Barshop, Alexandria, VA	In memory of Lynn Arden
Jason Beierle, Shakopee, MN	In honor of Mike Mullecha & in memory of Uncle Mike
Norman and Patricia Bishop, Corvallis, OR	In memory of James C. Bishop
Michael Bit-Alkhas, Belleville, NJ	In honor of Susan
Barbara Bocci-Givens, Kyle, TX	In memory of Sean Paul Bocci
James and Nancy Bollini, Oakton, VA	In honor of the work of TAC
Leo and Ruth Ann Booms, Warren, MI	In honor of Amanda Booms
Hollis and Marilyn Booth, Inverness, FL	In honor of Gene McGee & Dr. Torrey
Rhonda Bourne, Waltham, MA	In honor of Dr. Harry Ford & in memory of Dr. Thomas Maier
Helen Brown, Columbus, OH	In honor of Dr. Torrey
Mary Buffington, Keystone Heights, FL	In memory of Willie Mae George
Beth Ann Burgess, Tehachapi, CA	In honor of Sean Burgess Pedersen
Gerald Caprio, Verona, NJ	In honor of Mary Zdanowicz
Joseph and Carol Carey, Spring Hill, FL	In honor of Michael Joseph Carey
A.J. and Jane Carlson, Westlake, OH	In memory of Christopher Carlson
Martha Chacin, Anderson, SC	In honor of Henry Salazar
James and Iva Chambers, Roanoke, VA	In honor of Dr. Torrey & Jon Stanley
Ron and Sunny Chandonais, Kila, MT	In memory of Patrick Coffey
Josephine Chappell, Wedowee, AL	In memory of Stanley Chappell
Satyajit and Heather Chatterjee, Cranberry Township, PA	In memory of Renee Cathryn Humel
Dave and Terry Clark, Tuscon, AZ	In honor of Eric M. Clark (AZ DOC #180165) and Juanita W. Clark
Richard Cleva, Washington, DC	In memory of Henry Cleva
Susan Cleva, Bellevue, WA	In memory of Henry V. Cleva
Carolyn Colliver, Lexington, KY	In memory of Scott L. Helt
Warren and Irene Cook, Manasquan, NJ	In memory of Gloria Blumenthal - NAMI Mercer
Josephine Cooper, Portland, OR	In honor of Angel Marie Crowe
Daniel and Christi Cronin, Inwood, WV	In honor of children with pediatric Bipolar Disorder
June Crouch, Huntsville, AL	In memory of Rick Webb and Gordie Little
Don Culwell, San Antonio, TX	In honor of Fred Frese
Linda Davis, Holmes Beach, FL	In honor of Nathaniel
Kerry DeMarco, Fairfax, VA	In memory of Robert Forrest Pratt
Jean DeRosa, Andover, MA	In memory of Barbara Flory
Gloria Dialectic, Tulsa, OK	In honor of Mark Dussinger, son
Joseph Diaz (location not provided)	In memory of Daniel Stone
Rachel Diaz, Miami, FL	In honor of the families of the mentally ill
Paul Dorn, College Park, GA	In memory of Mattie Dorn
Dream Machines of Carroll County, Finksburg, MD	In memory of Carol Johnson
Gerald and Harriet Dubow, Glen Oaks, NY	In honor of NAMI Queens/Nassau
John and Susan Duff, Belleville, MI	In memory of Jeffrey Bugg
Gladys Dyer, Lowell, MA	In honor of our son Michael Dyer
Karen Dyskstra, Mendham, NJ	In memory of Daniel Stone

Isabel Ehrenreich, Flintridge, CA	In memory of Mark and Edward Ehrenreich
Louis Ellman, Boynton, FL	In memory of Jonathan Michael
Judy Eron, Alpine, TX	In memory of Jim Siebold
Elizabeth Farr, Henrietta, NY	In memory of Michael Mox
Denise Fazio, Longmont, CO	In memory of Cho Seung-Hui, and the 32 others who died on Monday, April 16, 2007
Mildred Fine, Lynbrook, NY	In honor of Alice Cohen
Debra Fisch, Downey, CA	In honor of the Virginia Tech victims and their families
Ken and Marilyn Fischer, Delaware, OH	In honor of Catherine M. Fischer
David and Alice Fitzcharles, Media, PA	In honor of John Snook who is helping in PA
Eric and Melinda Fitzcharles, Lexington, KY	In honor of Alice, David and Michael Fitzcharles
Nancy Rita Flanner, Wauwatosa, WI	In honor of Patricia Spoerl
Nan Fogell, Boulder, CO	In memory of Susan Thorne
Forks Area Chamber of Commerce, West Forks, ME	In memory of Amy Bruce of Caratunk, Maine
Karen and William Frank, Seguin, TX	In honor of WD Frank, Jr.
Harold and Joyce Friedman, Lake Worth, FL	In honor of Joyce H. Friedman
Abraham and Lucy Fuchs, Ambler, PA	In honor of Dr. Torrey
Anthony and Judith Gaess, Montvale, NJ	In memory of Kimberly Rose Gaess
Susan Garrett, Princeton, NJ	In honor of Lee Stover
Phyllis Garvey, Indianapolis, IN	In memory of Kevin Garvey
Gordon and Lucy Gay, Shenandoah Junction, WV	In memory of Benjamin Kevin Gay
Jeffrey Geller and Merle Brandzel, Worcester, MA	In memory of Wayne Fenton
James Gladden, Alexandria, VA	In memory of my wife Mary
James Gladden, Alexandria, VA	In memory of my father James W. Gladden III and my brother David B. Gladden
Robert and Christa Glowacki, Cudahy, WI	In honor of John Crawford
Edward and Rita Goebel, Erie, PA	In honor of Dan Kimberlin
Nelson and Theresa Goguen, Ashby, MA	In memory of Mary B. Kalogher, Barbara Flory and Cecilia Higgins & in honor of Isabelle McSherry, on her 104th Birthday & in honor of Mary Zdanowicz
Madeleine Goodrich, Concord, MA	In honor of Laurie Flynn
Beverly Greene and Joe Gerst, Parkville, MD	In memory of Carolyn Lu Johnson
Linda Gregory, Jacksonville, FL	In memory of Deputy Eugene Gregory
Richard and Darlene Gross, Johnstown, PA	In honor of Cambria County NAMI, PA
Dorothy Gunderson, Nashville, TN	In honor of Ernestine Gunderson
Daniel Hadl, Sherman Oaks, CA	In memory of Dr. Joyce Hadl
Claire Hafner, Sacramento, CA	In memory of Joseph E. Hafner, Jr.
Catherine Hair, Monroe, CT	In honor of your work
J. Christopher Hardman, Callaway, MD	In memory of Scott Hardman
Katherine Harkey, Doswell, VA	In memory of Joshua Steven Collins
Joseph Harris, Houston, TX	In memory of Ira Harris
Laura Hawley Jarvis, Silver Spring, MD	In memory of Susan M. Dovel (1970-1999)
Gladys Herreid, Seattle, WA	In honor of Rosanna Esposito
Eric Hochreiter, Langhorne, PA	In memory of Carol Harvey
Ron Honberg, Rockville, MD	In honor of Fred Frese
Roderick and Betty Hooper, Double Springs, AL	In memory of Virgil Davis
Anne Hudson, Grosse Pointe, MI	In memory of Ellen Rouse
William and Sylvia Hughes, Albuquerque, NM	In honor of Kevin Hughes
Freze Jacobson, Monroe Township, NJ	In memory of Daniel Stone
Susan Jacobson, Fairfax, VA	In memory of Betty Jacobson
Ulysses and Nancy James, Alexandria, VA	In honor of our daughter, Beth
Paula John, Shorewood, WI	In memory of Elise K. John
James Johnson, Juneau, AK	In honor of Jimmy Johnson
Ted Kakavas, Baltimore, MD	In memory of Seung-Hui Cho and others whose lives were lost due to untreated mental illness
Geraldine Keipe, Henrico, NC	In memory of Carolyn Palmer
Merry Kelley, Hiawatha, IA	In memory of Bonnie Rae Picard

## Who is your hero?

Each year, the Board of Directors of TAC formally recognizes the role of selfless advocates by giving the Torrey Advocacy Commendation (TAC) Award. The TAC Award rewards the courage and tenacity of those who selflessly advocate, despite criticism and opposition, for the right to treatment for those so severely disabled by severe mental illnesses that they do not recognize they need treatment.

Nominations due October 22. Get details on our website.

# Memorials and tributes

Buck and Marianne Kernan, Pinehurst, NC	In honor of all those suffering with a mental illness
Amber Kesterson, Colusa, CA	In honor of my children living with FASD
Michael Knable, Bethesda, MD	In memory of Wayne Fenton, MD
Kramer/Goldstein, New York, NY	In memory of Daniel Stone
Lois Koneczny, Chantilly, VA	In honor of my sister with schizophrenia
Rudolf and Slava Kosurkin, West Bloomfield, MI	In honor of Lev
Barbara Kunowsky, Midlothian, VA	In honor of FACES
Roy and Leanore Lembke, Havre, MT	In honor of Paul Campanella, Jr.
Raymond and Florence Lemke, Milwaukee, WI	In memory of Mary P. Epperson
Dori Linn, Lakewood, OH	In honor of Linn Twins
Karen Lohmeyer, Lafayette, IN	In honor of Eunice I. Lohmeyer
Mary Lou and Alan Lowry, Glen Ellyn, IL	In memory of Joanna Lowry
Karen Mapleson-Torres, Miller Place, NY	In memory of Robert Pratt
Michael and Marcia Mathes, Orlando, FL	In memory of Alan Singletary and Gene Gregory
Martha Mayes, Swainsboro, GA	In honor of Hil Mayes & in memory of Betty Mayes
Laura McCandlish, Baltimore, MD	In memory of Jennifer Baubli
James and Agnes McFarlane, Jamison, PA	In memory of Tom Gorman
Dotti McKee, Fairfax, VA	In honor of Mike Maraney
Theodore and Anne McWilliams, Pittsburgh, PA	In honor of Patrick Mc Williams
Susanne Meredith, Grosse Pointe, MI	In memory of Heather Drewior
Paul and Nancy Merola, Austin, TX	In memory of my father, Lewis J. White & in memory of Joseph A. Merola
Arnaud and Joan Michaud, Largo, FL	In memory of Nancy E. Michaud
Shari Miller-Johnson, Chapel Hill, NC	In honor of Mark Miller
Erin Moriarty, Long Beach, CA	In honor of Jean and Diane Lancaster
Norman, Syd, Seth, Jen, and Lisa Morris, Long Beach, NY	In memory of Sam Greenberg
Phyliss Morris, Corpus Christi, TX	In honor of Robert Russell
Tex and Jane Moser, Springfield, MA	In honor of David Moser
Larry and Daria Moskowitz, Fort Collins, CO	In memory of Daniel Stone
Keith Mundt, Riverside, CA	In honor of Kerilyn Mundt & in memory of Winifred Mundt
Wesley and Rita Murray, Whittier, CA	In honor of Carla Jacobs, Randall Hagar, and Chuck Sosobee
Emil and Adrienne Nagy, Athens, OH	In memory of Peter Nagy
NAMI Lake/Sumter Alliance, Leesburg, FL	In memory of John Zeller
Nancy Neathery, Applegate, CA	In honor of all who have [severe mental illness] or are suffering this way
Stanley and Anna Nissen, Reliance, SD	In memory of Timothy Nissen
Kathryn Obermeyer, Seattle, WA	In honor of Michael & in memory of Charles Timmerman
Jack O'Brien, Devon, PA	In honor of Richard J. O'Brien
Kathy O'Connor, Charlestown, MA	In honor of staff at Dudley Inn - Roxbury, MA
Fred and Carol Olson, Langley, WA	In memory of Thomas A. Olson
Dottie Pacharis, West River, MD	In memory of my son, Scott C. Baker
Cheryl Pachinger, San Ramon, CA	In honor of Jeffrey Pachinger
Robert Palazzo, Clifton, NJ	In honor of Deborah Ammerata
Lois Palmer, Roshester, NY	In memory of Stephen T. Mox
Doreen Parks, Oro Valley, AZ	In honor of Matthew A. Parks
Kathleen Pearce, Silver Spring, MD	In honor of Kristy Borge
Judy Perlman, Highland Park, IL	In honor of E. Fuller Torrey and staff
Bill and Alice Petree, Sanford, MA	In memory of Alan Singletary
Jocelyn Phillips, Seattle, WA	In memory of Virginia Davis
Alan and Linda Van Broeke Pierce, Austin, TX	In honor of Everett Drake
Deborah Pipas, Crosby, TX	In honor of Cynthia Darlene Pugh
Charles Pisano, Enola, PA	In memory of Jean Pisano
Laura Powell, Fountain Valley, CA	In honor of Gary J. Powell
Betty Robertson, Florence, AL	In honor of David Robertson
William Romine Jr., Canton, GA	In memory of my mother Dorothy June Zude Romine and my ex-wife Joy
Alex and Muriel Rosenthal, Rochester, NY	In memory of Moses Levine
Julius and Sharon Rousseau, New York, NY	In memory of Daniel Stone
Barbara Rushmore, Provincetown, MA	In memory of Emily Sara Rossmoore
James and Linda Salmons, Morrow, OH	In memory of Daniel Stone
Glory Sandberg, Wilmington, DE	In memory of Sharra Taylor Hurd
Barbara Sanders, Nashville, TN	In honor of Jack and Adele Waide
Elise Sanford, Athens, OH	In memory of Dr. Edward R. Sanford
Stefanie Sanford, Marysville, OH	In memory of Robert Forrest Pratt

Pat Schmieding, Yukon, OK	In honor of E. Fuller Torrey
Louise Schnur, Auburn, CA	In memory of Jack Jones (brother)
Linda Schoepf, Eatontown, NJ	In memory of John Schoepf
Ted and Carol Schultz, Clallam Bay, WA	In honor of all the encounters and time in mental institutions
Hannah Schussheim, Washington, DC	In honor of E. Fuller Torrey & in memory of Hanna Schussheim
Hattie Segal, Maplewood, NJ	In honor of Stephen's election as vice president of the TAC Board of Directors
Fred and Bernice Seifter, Matawan, NJ	In memory of Mark Seifter
Hilary Silver, Stockton, CA	In honor of Aram Silver
Ingrid Silvian, Groveport, OH	In honor of Debbie Gleeson
Kristina Simms, Perry, GA	In honor of Claudia A. Simms
Eleanor Slater, Pittsburgh, PA	In honor of Laura Nowakowski
Sonja Soleng, Kensington, MD	In honor of Karsten B. Soleng
John and Georgia Strozyk, West Long Branch, NJ	In honor of Mary Zdanowicz
Al and Dorothy Supino, Ramsey, NJ	In honor of A.J. Supino
Joseph Swope and Carol Walz, Penndel, PA	In memory of Joseph E. Hafner, Jr., of Havertown, PA
Lois, Barry, Josh, Danielle, and Adam Tadack, Wethersfield, CT	In beloved memory of Daniel Stone
Vic and Linda Taggart, Seattle, WA	In honor of Alicia Taggart
John and Marianne Tampanello, King of Prussia, PA	In memory of Mark Forry
Mary Thompson, Sebastopol, CA	In honor of Christian Baum
Dorothy Thorman, Altadena, CA	In memory of Carol and Carl Thorman
Alma Tovar, Arlington, VA	In honor of Alfonso Tovar
Natalie Trem, Virginia Beach, VA	In honor of William Scott Trem
Kristen Tucker, San Francisco, CA	In memory of Daniel Stone
Donald and Judith Turnbaugh, Palm Harbor, FL	In honor of Daniel Moschelli
Katie Vath, Atlantis, FL	In honor of Tim Pedon
Connie Walker, Leonardtown, MD	In honor of Michael T. Segich
Judith Walsh, Sound Beach, NY	In memory of Robert F. Pratt
Jeanne Walter, Sumner, WA	In memory of Jan and Sue Geary
Susan Warren, Albuquerque, NM	In honor of Eric Livingston
Steven and Candace Watt, Richmond, VA	In memory of Justin Myers
Jane Weaver-Sobel, Charlotte, NC	In memory of Adam Weaver Roach, who died at age 26 in February 2006
Joel and Diane Wier, Columbia, SC	In honor of Warren Garrison, M.D.
Larry Wiesenauer, Anderson, IN	In memory of Carl Wiesenaur
Nick and Amanda Wilcox, Penn Valley, CA	In memory of Laura L. Wilcox
Mitchell and Alise Wilkinson, Holiday Island, AR	In honor of Ted Wilkinson - inmate at Denton County Jail - Denton, Texas
Kevin Wilkinson and Francine Levine, Montpelier, VT	In honor of Max
Kitty Yelenosky, Austin, TX	In honor of Michael Yelenosky
Anne Zerrien-Lee, Los Angeles, CA	In memory of Bernie Zuber

## THE MAGNITUDE OF THE PROBLEM

In one study that used a version of the survey on pages 11 and 12, it was revealed that **92 percent of officers reported encountering mentally ill individuals in crises in the month prior to the survey.**

On average, officers had been involved in six encounters that month. In other studies using different methods:

- A survey of sheriffs in Virginia disclosed that virtually all survey participants had encountered arrestees with psychiatric illnesses.
- Sheriffs in California reported that 9 percent of emergency calls were related to a mental illness crisis.
- The number of police responses to complaints about “emotionally disturbed persons” in New York City rose from 20,843 in 1980; to 46,845 in 1985; to 64,424 in 1998.
- In Florida, law enforcement officers respond to people with mental illnesses who are in crisis by having them assessed under the state’s mental health treatment law, the Baker Act. In 2000, there were 34 percent more Baker Act cases (80,869) than DUI arrests (60,337) and Florida law enforcement officers alone initiated nearly 100 Baker Act cases each day. That is comparable to the number of aggravated assault arrests for the state in 2000 (111 per day) and 40 percent more than the arrests for burglary (71 per day).

**Use the survey on pages 11-12 to gather data for your community.  
Find out more at [www.treatmentadvocacycenter.org](http://www.treatmentadvocacycenter.org).**

# Catalyst



## Treatment Advocacy Center

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703 294 6010 (fax)

info@treatmentadvocacycenter.org (email)  
www.treatmentadvocacycenter.org (web site)  
http://psychlaws.blogspot.com (blog)

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### NEW LAW IN ILLINOIS!

"This means so much to so many families ..."

See page 16 for details.

**"Law enforcement officers may not be medical professionals. But we are in a prime position to be formidable advocates on this issue."**

- Sheriff Donald Eslinger, Seminole County, Florida

Why support the Treatment Advocacy Center? We use your donations wisely. Recently, TAC's fiscal responsibility was honored with a coveted four-star rating from Charity Navigator, the largest independent evaluator of U.S. charities.

You can feel confident when you donate to TAC, your money is being used to help eliminate barriers to treatment and advocate for timely and effective treatment of severe mental illnesses.

TAC is very proud we have achieved so much without accepting money from pharmaceutical companies. Our continued success hinges on generous donors like you. Thank you for helping TAC help the millions of people suffering from the symptoms of untreated severe mental illness.

**I want to help the Treatment Advocacy Center with a gift of \$ \_\_\_\_\_**

(Please print all information except signature)

My check/money order is enclosed, made payable to the "Treatment Advocacy Center"

Charge my credit card (check one):  VISA  Mastercard  AMEX

Account number: \_\_\_\_\_

Expiration date: \_\_\_\_\_

Signature (as on card): \_\_\_\_\_

Name: \_\_\_\_\_

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City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

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Gift is in memory of:

Gift is in honor of:

Thank you for your generous support.

Treatment Advocacy Center  
200 North Glebe Road, Suite 730  
Arlington, VA 22203

The Treatment Advocacy Center is a nonprofit 501(c)(3) organization. Gifts are tax-deductible to the extent allowed by law. TAC does not accept funding from pharmaceutical companies.

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