TREATMENT ADVOCACY CENTER

RESTORING REASON TO TREATING MENTAL ILLNESS

Catalyst

A Newsletter from the Treatment Advocacy Center

SPRING 2012

NEW REPORT:

Law Enforcement Resources Are Increasingly Diverted by Calls Involving Mental Illness

The impact of mental illness on jails and prisons is now well-established. Nationwide, three times more people with mental illness are incarcerated than are hospitalized for psychiatric treatment. Solitary confinement cells have been called "America's new asylums" and house more than 10,000 inmates with serious psychiatric conditions. Altogether, an estimated 800,000 people suffering from severe mental illness end up behind bars during any given year – consigned to a "mental health gulag," as one state correctional official describes the default institutional setting for many people who, 50 years ago, would likely have received hospital care instead.

Staggering though they are, these numbers represent only the most visible impact of untreated psychiatric diseases on the criminal justice system. Less visible to the public are the demands the failing mental health system places on law enforcement officers and the danger this shift poses to officers and public safety. So pressing are these demands that a nationwide survey of 2,400 senior law enforcement officials found that calls to law enforcement involving serious mental illness are "increasingly diverting officers from the streets and exposing them to risk of injury or death because of illnesses that can be treated."

"[L]ocal law enforcement is dealing with the unintended consequences of a policy change that in effect removed the daily care of our nation's severely mentally ill population from the medical community and placed it with the criminal justice system," according to New Windsor, New York, Chief of Police Michael Biasotti, who authored the online survey of police and sheriff's department officials. "This policy change has caused a spike in the frequency of arrests of severely mentally ill persons, of the prison and jail population and of the homeless population. [The survey] indicates that the deinstitutionalization of the severely mentally ill population has become a major consumer of law enforcement resources nationwide."

Biasotti conducted "The Impact of Mental Illness on Law Enforcement Resources" in conjunction with his thesis project for the Naval Postgraduate School's Center for Homeland Defense and Security. The Treatment Advocacy Center adapted and published the survey in December 2011. Although there is no shortage of anecdotal reporting about law enforcement agencies overwhelmed by the demands of dealing with untreated severe mental illness, official tracking of those impacts has been scarce or non-existent. Biasotti's survey addresses this void by providing the first quantifiable information about how senior law enforcement officials perceive their operations being affected by individuals in psychiatric crisis.

> "Under more widespread AOT legislation, law enforcement would require fewer resources to address recurring issues with the mentally ill."
>
> – Chief of Police Mike Biasotti

Key findings include:

- State laws that make it possible for people in psychiatric crisis to be involuntarily hospitalized in an emergency are poorly understood or are perceived by law enforcement officials as too complicated to use. Even in states where laws permit involuntary treatment on broader grounds, respondents believe

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What's Inside

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GUEST COMMENTARY

Reversing Criminalization

By H. Richard Lamb, M.D.

Member of the Treatment Advocacy Center Board of Directors

This Catalyst focuses on issues that arise when individuals with serious mental illness become involved with the criminal justice system.

Persons with serious mental illness (schizophrenic disorder, schizoaffective disorder, bipolar disorder and major depressive disorder with psychotic features) are a heterogeneous group. On the one hand, a large percentage recognize they are mentally ill and participate willingly in treatment. In most cases, these individuals are able to live in the community, are often productive in terms of work, do not have a serious problem with substance abuse, are not violent, and show potential for recovery. Because of their very visible success, much of the discussion in treating persons with serious mental illness has focused on such individuals.

On the other hand, there is a sizable minority of persons with serious mental illness who do not believe they are mentally ill and, as a result, are generally resistant to psychiatric treatment (including medications). Evidence suggests this may indicate the presence of anosognosia, a biologically determined inability to recognize that one is mentally ill. This minority is also characterized by overt psychotic symptoms, problems with substance abuse, great difficulty interacting appropriately with others, and a tendency to become violent when stressed. For this group, recovery from the illness becomes difficult.

Currently, attention to the two groups varies significantly. The mental health system and the mental health literature tend to focus on the first group. There is less discussion of the second group and fewer mental health services available for them. These are not the individuals who are usually thought of when developing options for the community treatment of persons with serious mental illness. Moreover, it is possible to overlook this group because so many of them – perhaps more than 300,000 of them – reside in our jails and prisons, where many mental health professionals do not go.

This minority is at most risk for criminalization. High degrees of structure may help reduce this risk. These individuals need a range of outpatient and inpatient treatment, including assertive community treatment, intensive case management, assisted outpatient treatment, structured housing, co-occurring substance abuse treatment, pre- and post-booking diversion, and available hospital beds.

Unfortunately, too little of these services are provided to these persons, and they are left for the criminal justice system to deal with. Chief Michael Biasotti's survey of senior law enforcement explores the impacts on law enforcement when this happens. The interview with Terry Clark, whose mentally ill son has been incarcerated for nearly 12 years, illustrates the personal costs. The mental health system can reduce criminalization by taking greater responsibility for these challenging persons. The "Public Policy Implications" of Chief Biasotti's survey on page 8 and the excerpt from our new backgrounder on assisted outpatient treatment on page 9 suggest a few of the places where this process could begin.

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Catalyst

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Profiles IN TREATMENT ADVOCACY

The Treatment Advocacy Center congratulates four New Jersey advocates who have been named winners of the 2011 Torrey Advocacy Commendation. The Board of Directors selected Cathy and Mark Katsnelson, Sen. Richard J. Codey and Speaker Sheila Y. Oliver in recognition of their courage and tenacity in fighting – despite criticism and opposition – for the right to treatment of those too disabled by severe mental illness to seek or accept care.

The Torrey Advocacy Commendation is named for E. Fuller Torrey, M.D., Treatment Advocacy Center founder and board member, whose unflagging resolve to remove barriers to treatment for people with severe mental illness sparked a national reform movement. The four 2011 winners all played pivotal roles in the initial passage of New Jersey's assisted outpatient treatment law – and, after the law was suspended a year later – its resurrection. Their effectiveness is matched by their selflessness, and we are delighted to salute them.

Since the the naming of our 2011 awardees, the New Jersey Division of Mental Health and Addiction Services has invited county mental health agencies to apply for funding to implement AOT. Annualized funding of up to $2 million is available for up to seven counties to participate. The law provides a new option in New Jersey for people with severe and persistent mental illness who are unable to seek treatment voluntarily, at risk of becoming dangerous if not treated, but not so imminently dangerous that they require inpatient hospitalization.

CATHY AND MARK KATSNELSON

Cathy and Mark Katsnelson are parents of Gregory Katsnelson, who was 11 years old when he was brutally killed by a man with untreated paranoid schizophrenia. Despite their profound personal loss, the Katsnelsons became determined advocates for the statute unofficially known as "Gregory's Law," which took more than six years of advocacy to achieve passage. When Gov. Chris Christie suspended the law on the eve of its implementation, the Katsnelsons again spoke out about the need for the law to save other lives and families. "In the name of Gregory and on behalf of all the families like ours in New Jersey, we challenge Gov. Christie to have the decency to make way for a law that will save money and save lives," they wrote in an op-ed for the *Philadelphia Inquirer*.

Cathy and Mark Katsnelson

SEN. RICHARD J. CODEY

Sen. Richard J. Codey

Sen. Richard J. Codey has been a champion for mental illness issues since the 1981 day he first stepped onto the New Jersey Senate floor and challenged state officials to do a better job for those with mental illness. Early in his career, he exposed major problems in the state psychiatric hospitals by going "undercover" to expose abuse. Nearly two decades later, while governor, he established the Governor's Task Force on Mental Health to report to him on the direction New Jersey should take in delivering improved services to its mentally ill, especially for those too ill to voluntarily seek care. A champion for Gregory's Law, his career-long advocacy led Mental Health America of Monmouth County to describe Sen. Codey as the state capital's "strongest advocate for the mentally ill."

SPEAKER SHEILA Y. OLIVER

Speaker Sheila Y. Oliver

Speaker Sheila Y. Oliver emerged as a staunch supporter of mental health treatment issues as chairwoman of the Assembly Human Services Committee. She was the primary sponsor of legislation providing social services and medical treatment for inmates with mental illness and of the bill that became Gregory's Law. Her personal efforts helped at last to win the bill's passage and were renewed after the Christie administration delayed implementation. "This law is designed to make certain that people who represent a danger to themselves are compliant with treatment plans and regiments of medication," Speaker Oliver has said. "It will be tremendous help to families and those trying to overcome mental illness. It will save lives. It is the right thing to do."

AROUND THE States

Arizona

On the night of June 21, 2000, a young man with untreated schizophrenia named Eric Clark circled a residential block in Flagstaff, Arizona, in his pickup truck, believing he was saving the city from aliens. Responding to complaints, Police Officer Jeffrey Moritz stopped the vehicle. Less than a minute later, Eric Smith shot Officer Moritz dead in a delusional panic.

At Eric's trial for first-degree murder, he invoked an insanity defense. Members of his family testified to their repeated yet futile efforts to get Eric committed to treatment. But under Arizona's exceedingly narrow insanity defense law, Eric's psychotic state on that tragic night did not matter. He was convicted notwithstanding the prosecution's acknowledgement of his illness. In 2006, Eric's challenge to the constitutionality of the Arizona insanity law reached the U.S. Supreme Court. The Treatment Advocacy Center submitted an amicus brief, urging the court to consider recent medical research on anosognosia and noting that "the insanity defense is becoming a scapegoat for problems actually created by unworkable state civil commitment laws." The Supreme Court upheld the Arizona insanity defense law.

Eric's mother Terry Clark has never rested in her quest to get Eric out of prison and into the hospital care he desperately needs. (See "Mentally Ill Behind Bars – One Mother's Story" on p. 6 for her account.) Last November, her tenacity was rewarded. A federal judge in Arizona ruled that Eric's trial attorneys were deficient in failing to present "observation evidence" that might have resulted in Eric's acquittal. The observations described Eric's paranoid delusions that Phoenix was under assault by space aliens on the night of the tragedy. The state of Arizona was ordered to immediately release Eric from prison or retry him.

Eric Clark's non-treatment led to his complete loss of freedom as a prisoner and to the loss of Officer Moritz's life. The situation certainly provides a real-life counter to the arguments that court-ordered treatment deprives patients of their freedom and deprives the system of precious resources better spent on "voluntary services." On the fiscal side, we can add up what Arizona has spent to date on Eric's trial, appeals and incarceration. We suspect it would have been enough to provide a few folks with effective community services.

Oregon

In a bid to improve mental health crisis intervention and reduce demands on law enforcement, 911 dispatchers in Oregon's most populous county soon will begin routing emergency calls for "non-dangerous" psychiatric symptoms to a crisis line staffed by 13 mental health professionals. The Multnomah County program was scheduled to begin in March.

"We're definitely breaking some new ground here," Heeseung Kang, the call center's supervisor, told *Portland News* reporter Maxine Bernstein for a Dec. 1, 2011, story ("Next year, a 911 call from a mental health emergency call won't automatically bring a Portland cop").

"Portland's group, called SaferPdx, studied why people in mental health crisis often end up in police custody," the article said. "They learned that crucial information wasn't being shared between law enforcement, mental health and emergency dispatch systems…." The new approach has been designed to address this issue. Said call center supervisor Kang, "Our mission is to try to catch these people."

We have no doubt they will. As long as psychiatric emergencies are treated as a police issue – or, worse, as no issue at all – people with severe mental illness who are in crisis will not get the treatment they need. Handling calls for psychiatric help as a medical issue instead of a criminal justice issue is a step in the right direction.

Texas

Texas is fortunate to have a carefully conceived set of laws on assisted outpatient treatment (AOT, known under the Texas code as "court-ordered outpatient mental health services"). But one unfortunate phrase in the Texas code is not up to these high standards, and it has led to a great deal of misunderstanding and underuse of AOT in the state. In a section providing detail on the AOT court order, the law provides that the court "may advise, but not compel, the … patient to receive treatment with psychoactive medication …, participate in counseling, and refrain from the use of alcohol or illicit drugs."

Advise, but not compel? More than one Texas mental health official has encountered that language and squinted at the page. At first blush, it seems to say the court cannot order an outpatient to take medicine or follow other critical elements of treatment. This leads people to wonder what exactly the court can order, and if that really leaves any reason to bother with AOT. One of the consequences of this wondering is that the

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great majority of Texas counties make no use of the AOT law.

The law says "may not compel," but it doesn't say the court "may not order" medication or other intervention. A court "compels" medication either by having it administered through physical force or by punishing the person with jail or a fine for refusing to submit. By providing that judges "may not compel," Texas law forbids these steps. That said, there's nothing in the law to prohibit judges from issuing an unambiguous "order," and it is the "order" that studies show is critical to AOT's success. Indeed, all patients in San Antonio's highly successful AOT program are ordered to take medicine, and patients' attorneys do not allege that this violates the law.

Because the perception problem remains elsewhere in Texas, the law needs to be amended. The Treatment Advocacy Center has drafted a proposal to replace "advise but not compel" with language that more accurately reflects the original intent. The proposal is currently under review by a statewide committee of mental health experts and stakeholders that has been convened to recommend changes to the state Mental Health Code for the 2013 legislative session.

Wisconsin

The *Milwaukee Journal Sentinel* has produced a stunning multi-media online report on "Imminent Danger." The special series explores the topic of mental illness, danger and treatment through a number of articles, short videos and a full documentary. Treatment Advocacy Center founder E. Fuller Torrey, M.D., praised the series as, "[O]ne of the finest I have seen anywhere in my many years of following problems associated with untreated mental illness."

The series marks the anniversary of the landmark mental health law decision in *Lessard v. Schmidt*, which ushered in greater due process protections for individuals in civil commitment hearings but also contributed to America's shift towards danger-based treatment criteria. According to the *Journal Sentinel*, "Forty years ago, a new legal standard for mental health commitment emerged from a Milwaukee lawsuit to become the law of the land. It has proved to be tragically inadequate."

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In reaching that conclusion, reporter Meg Kissinger – a Pulitzer Prize finalist for investigative journalism in 2009 – spent months researching and interviewing people for the series, including Alberta Lessard, Dr. Torrey, survivors of the Virginia Tech massacre, members of Rep. Gabby Gifford's staff, consumers and family members, opponents of treatment law reforms and numerous others who live and work with severe mental illness and the consequences of non-treatment.

The *Journal Sentinel* encouraged a community discussion on how to best care for individuals with mental illness by offering an online chat room, its documentary on DVD, public speakers, radio appearances and a forum co-sponsored in January at Marquette Law School. The forum included Virginia Tech professor Lucinda Roy, who told a crowd of 240 that while people with mental illness are not dangerous as a group, individuals under certain conditions are dangerous and "not admitting this is shortsighted."

Tennessee

With the arrival of a new governor and mental health commissioner in 2011, Tennessee mental health advocates had reason to hope for a fresh start at enacting an assisted outpatient treatment law. We helped Sen. Doug Overbey (R-Maryville) craft a bill that would be impervious to any charge of budget busting. Where prior Tennessee bills had ambitiously provided for counties to establish formal AOT programs, the new proposal was simply to empower courts to order AOT in individual cases – and only if a family member or caregiver could establish that treatment providers had already agreed to participate. In other words, the bill would do nothing more than allow court orders to be integrated with existing services, to boost the likelihood of patient adherence.

Last spring, when Sen. Overbey made an agreement with the Tennessee Department of Mental Health (DMH) to table the bill in exchange for their promise to study it carefully and issue a report to the Legislature, we fretted over whether the report would be fair. But, at the very least, we expected the report to concern itself with the scaled-back approach to AOT that had been proposed.

No such luck. In November, DMH released its report, estimating an implementation cost of $40 million over three years and rehashing old claims about the challenges of establishing AOT programs, hiring new staff, providing additional psychiatric evaluations, monitoring patients and compelling local providers to participate. That the bill at issue would mandate none of these things went unmentioned.

Even beyond this obvious misrepresentation, the findings mystify. For example, DMH assumes (absurdly) that the number of AOT recipients in Tennessee would be proportional to the numbers that have been served in New York. By that logic, Tennessee would have no reason to expect more than 270 AOT orders per year. And yet the report somehow estimates 600 patients in the first year and 800 in the second.

Mentally Ill and Behind Bars
ONE FAMILY'S STORY

Eric Clark in 8th grade

Terry Clark

Eric Clark was 17 years old in June 2000 when he shot and killed Flagstaff, Arizona, police officer Jeffrey Moritz. Suffering from untreated paranoid schizophrenia, Clark was delusional and thought he was defending Arizona from invading space aliens. After a period of sustained medication treatment, he was found competent to stand trial, convicted of murder and sentenced to life in prison with possibility of parole. Clark entered the Arizona correctional system in October 2003 and has been there ever since, largely in solitary confinement. A federal judge recently ruled he should be re-tried or released because evidence of his mental illness was not properly presented at his 2003 trial. The state has appealed the ruling. (See the Arizona report in Around the States on p. 4 for more information.)

Terry Clark, Eric's mother, has been an unrelenting advocate for treatment of her son's severe mental illness since long before the 2000 shooting. Today, she is equally unrelenting in her advocacy for reform of a mental health system that imprisons victims of disabling brain disease instead of treating them. Here, Terry Clark describes her experience and what she has learned from it.

DESPERATE FAMILIES SOMETIMES THINK THAT, IF THEIR LOVED ONE GETS ARRESTED AND GOES TO JAIL, AT LEAST HE OR SHE WILL GET TREATMENT. YOU TRIED FOR YEARS WITHOUT SUCCESS TO GET HELP FOR ERIC. DID YOU EVER THINK THAT INCARCERATION WOULD LEAD TO TREATMENT AND, IF SO, WHAT HAS HIS ACTUAL EXPERIENCE LED YOU TO CONCLUDE?

As a parent, you try to do whatever you can to get your child help. There was a time I did believe that getting arrested would get Eric the help he needed. It was when he was arrested prior to the shooting and placed in juvenile detention. When the county released him and said they would wait until he was 18 to press charges, I went to his attorney and begged him to ask the district attorney to press charges immediately. I thought this was his chance for treatment.

As soon as Eric was arrested for the shooting, I found out how mistaken I had been. Yes, if someone is arrested, and the arrest results in a psychiatric evaluation and referral to treatment, that could help. But if they just go to jail – as Eric did and so many others do – it just compounds the issues.

We all know that jails and prisons have become de facto mental health institutions. What we don't all realize is that the money is not there for treatment. Employees don't have the training to deal with mentally ill individuals, and their training may be so antiquated that what they're taught is actually inhumane. If someone has no medical background at all and no loved one with severe mental illness, it's very hard for him or her to understand what's needed.

Eric was so psychotic, but his act provoked such an emotional response that it was easy for the criminal justice system to look at him not as a mentally ill person but as a "cop-killer." I honestly believe people thought he was faking it, that I was lying about things he had been doing just to get him off. This was a young man who was very, very ill. Finally, they put him on Zyprexa and, after about two weeks, I thought I was getting my Eric back. That was the last time I ever saw him like that. The state hospital took him off the drug because they said it didn't make any difference. I showed them letters he sent while on the medication. They didn't listen. They said he was malingering and was competent to stand trial, where he was convicted and sentenced to prison.

Yes, prisons have social workers and counselors. But you might have one doctor trying to manage medication and therapy for 1,500 to 2,000 inmates. You have a social worker or counselor whose "visit" might consist of walking up to an inmate's cell and saying "How are you doing today?" As soon as he says, "Fine," that's the end of the visit. There's just not enough time to offer therapies that should

be given in conjunction with the medication. They don't have the personnel – there are just too few people.

Unless we end up with a loved one behind bars, most of us also don't realize that people in any system who are not court-ordered to take medication can refuse medication. They offered Eric medication before he finally received it, but he didn't believe he was sick so why should the state believe he was sick? It was very frustrating that I knew he needed treatment, but he was the one who was asked if he wanted it. And, when he was finally on medication, there was not adequate communication between different parts of the system. As a result, when he was transferred between agencies, his medication regimen wouldn't be sustained. There was a marked delay in getting him onto medication in the first place, and then he was on and off it so many times. This has been extremely damaging.

YOU HAVE UNFAILINGLY ADVOCATED FOR ERIC'S TREATMENT IN THE CRIMINAL JUSTICE SYSTEM. HOW SUCCESSFUL HAVE YOU BEEN AND WHAT WOULD YOU TELL OTHER FAMILIES WHO FIND THEMSELVES IN THIS SITUATION?

The most effective thing people with a loved one in jail or prison can do is, first, never abandon that loved one and, then, be persistent in reaching out to those who can make a difference. If you're not getting the answers you want at one level, you go to the next level. Keep calling. Write letters, if you have to. Send emails, if you have to. Do your research on mental illness. Have a basic understanding of what your loved one is suffering from and of what treatments are available. It's a state of continual advocacy. Keep a journal and make notes after every visit: what you saw, what your loved one said. I kept every letter Eric ever wrote me so that if I needed to prove changes had occurred after a change of medication, I had proof. Having things in writing has been huge.

I knew that I had to be Eric's advocate because he didn't have a voice, and the voice he did have was psychotic. Wherever he was, I needed to identify the person who was in charge, to find the people who could see that – even though Eric was in a prison – he was very ill. Sometimes those people are hard to find, but they are there. By never giving up, I found them. Over the years, I found doctors and deputy wardens and wardens who went to bat for Eric. I found officers with compassion who watched out for him.

You get told "No" so many times by so many people that you can feel overwhelmed by a sense of futility. You feel like giving up. But you have to be stronger than what it is you are fighting.

HOW IS ERIC TODAY AND WHAT DO YOU SEE IN HIS FUTURE IF THE STATE LOSES ITS APPEAL OF THE FEDERAL COURT RULING AND HE IS RELEASED OR RETRIED, WHICH THE JUDGE SAID WOULD LIKELY RESULT IN HIS ACQUITTAL?

I think Eric right now is in the best position he's been in for a long time. He's on a mental health unit where, even though he is still in solitary, he's able to function in terms of being around the officers and having visitation. He's finally on multiple meds for his schizophrenia, which I'd been pushing and pushing and pushing for years for them to try.

I don't know that he fully understands about the court ruling. He thinks he's going to be getting out. I've tried to explain that our goal has always been to get him to the state hospital where he can get more than just medication.

IT'S BEEN ALMOST 12 YEARS SINCE ERIC SHOT AND KILLED OFFICER MORITZ. WHAT HAS HELPED YOU NOT TO GIVE UP?

I have a very strong faith, and that keeps me going. I have wonderful friends and a strong family. And I hold onto hope. I hope I actually will be able to touch him again someday. He was only once in the entire 12 years in a setting where I could touch him. That's selfish to say because I never forget the officer and his family, who can never have the hope of touching their loved one again. But if I said "no" to hope, I'd be saying "no" to the possibility that maybe, someday, Eric will be a contributing member of society, and I can't do that.

The things that happen to you in life are going to make you bitter or better, and I have chosen to be better. My son's experience opened my eyes so fully to the needs of people with severe mental illness – especially those who are incarcerated. I've told people I firmly believe anything I do that benefits Eric will benefit others with mental illness, too. That's what keeps me going.

One More Way to Follow Treatment News!

Nearly every weekday, the Treatment Advocacy Center publishes news and commentary about mental illness – breaking news, research breakthroughs, personal stories and more.

To receive these reports by email the minute we post them, just click the orange button in the upper right corner of every page on our website or go to feeds.feedburner.com/treatmentadvocacycenter/ourblog and sign up.

You can also follow our news and updates about developments in mental illness and its treatment by —

- **Joining our Facebook community at Facebook.com.**
- **Following us on Twitter at twitter.com@TreatmentAdvCtr.**
- **Signing up to receive our weekly news roundup by clicking on Sign Up at the top of every page on our website.**

New Report

CONTINUED FROM PAGE1

the greatest obstacle to referring individuals for evaluation or treatment is the "requirement" of dangerousness to self or others.

- Mental illness is seen as a significant factor in the injury or death of on-duty law enforcement officers. More than 60% of the respondents believe that officer casualties are resulting from incidents that involve someone with a severe mental illness.
- Transportation and hospital security demands associated with incidents involving severe mental illness are perceived as "a major consumer of law enforcement resources nationally," requiring an increasing amount of time and manpower. Routine larceny, traffic accident reports and domestic disputes all are perceived to consume less officer time than calls involving mental illness.
- Respondents – most of whom had 20 years of experience or more in law enforcement – have seen growing numbers of mentally ill persons in the general population, in jails and prisons, and among the homeless over their careers. They also report increased numbers of calls resulting from suicide and suicide attempts.

Biasotti concluded that "highly cost-effective policy recommendations exist that would assist in correcting the current situation, which is needlessly draining law enforcement resources nationwide." These include wider use of assisted outpatient treatment (AOT), more progressive commitment standards and multi-disciplinary training to familiarize emergency services workers with existing mental health treatment laws. (See Public Policy Implications on this page.)

Among the most troubling survey findings was that 77% of the respondents said law enforcement cannot refer "obviously psychotic persons" for psychiatric evaluation because the individuals don't meet the "dangerous to self or others" standard.

"The mere fact that an individual is psychotic (i.e., experiencing auditory or visual hallucinations, imagining threats to self or others, otherwise unable to distinguish reality from illusion, unable to meet basic human requirements for food or shelter, etc.) is typically seen as failing to meet the 'dangerousness' or 'imminently dangerous' standard," Biasotti said. "As a result, the vast majority of individuals in the early stages of psychiatric crisis or in a nonviolent psychiatric crisis are required to deteriorate to a point at which they are notably dangerous or until they enter the criminal justice system…." Because immediate family members are most likely to report a psychiatric emergency "and are typically rebuffed pending the development of danger, family members are often at risk of becoming victims of

PUBLIC POLICY IMPLICATIONS

(from "The Impact of Mental Illness on Law Enforcement Resources")

"Senior law enforcement respondents to 'The Impact of Mental Illness on Law Enforcement Resources' overwhelmingly believe that issues arising from untreated severe mental illness are substantial and have grown over the course of their careers. The demands specific to service calls involving the severely mentally ill population – especially transportation and hospital security, which can drastically reduce manpower for other police calls in small jurisdictions – are widely perceived to be a major consumer of law enforcement resources nationwide.

"Among the most critical policy changes suggested by the survey data is the dire need for better training of law enforcement agencies about criteria for intervention when individuals are in acute psychiatric crisis. The prevalent misconception that – without dangerousness – emergency hospitalization and other interventions are unavailable directly contributes to the deterioration of mental health in affected individuals. Such deterioration leaves those individuals, their family members and the public at risk for violent acts that treatment could prevent.

"It is imperative that first responders are knowledgeable about the statutory options available to them in dealing with this vulnerable population and the means of exercising them. This need is dually critical in those states where existing law would allow commitment of individuals with untreated mental illness to an assisted outpatient treatment (AOT) program without the necessity of meeting 'dangerous' or 'imminently dangerous' standards.

"Additionally, federal agencies such as the Department of Justice that track crime, police shootings and other law enforcement activities need to add mental illness to their statistical monitoring. Better identification of the role that mental illness is playing in law enforcement operations would make the need to reduce its impacts on public and police safety more inescapable."

violence, and the individual in crisis is left at risk of self-harm," he added.

Also alarming: Respondents perceive that people with mental illness are responsible for many police injuries and deaths. Slightly more than 60% of those taking the survey said that mental illness is involved in at least 20% of officer casualties.

An overwhelming 80% of the respondents said the amount of time their departments spend on calls involving mentally ill individuals has increased over their careers. More than 80% believe the number of people with mental illness in the community has grown. More than 75% said that mentally ill detainees and prisoners require more supervision than they once did, possibly indicating that they are encountering more people who are severely ill. More than 60% perceive that the number of suicides and suicide attempts has increased.

In a foreword to the report, E. Fuller Torrey, M.D., founder of the Treatment Advocacy Center, wrote, "Police officers, sheriff's deputies and corrections personnel have become our nation's frontline mental health workers. It isn't supposed to be this way.... We need to restore sanity to the system so that mentally ill individuals will once again be treated by mental health professionals, thereby freeing up law enforcement officials to do the jobs they were trained to do."

"The Impact of Mental Illness on Law Enforcement Resources" solicited the participation of senior law enforcement officials nationwide through their respective police and sheriff's professional associations. Participants completed an online survey that consisted of 22 questions, including five demographic questions. Several questions provided an area for comments.

"The Impact of Mental Illness on Law Enforcement Resources" and Chief Biasotti's thesis are linked from the "Reports, Studies, Backgrounders" page located in About Us at TreatmentAdvocacyCenter.org.

Assisted Outpatient Treatment Reduces Criminalization of Severe Mental Illness

Assisted outpatient treatment (AOT) is court-ordered treatment (including medication) in the community for individuals with severe mental illness who meet strict legal criteria, e.g., they have a history of medication noncompliance. Typically, violation of the court-ordered conditions can result in the individual being hospitalized for further treatment.

Forty-four states and the District of Columbia permit the use of AOT, also known as outpatient commitment. The six states that do not have AOT statutes are Connecticut, Maryland, Massachusetts, New Mexico, Nevada and Tennessee.

A substantial body of research conducted in diverse jurisdictions over more than two decades establishes the effectiveness of assisted outpatient treatment in improving treatment outcomes for its target population. Specifically, the research demonstrates that AOT reduces the risks of hospitalization, arrest, incarceration, crime, victimization and violence. AOT also increases treatment adherence and eases the strain placed on family members or other primary caregivers.

The following excerpt from the newly updated "Assisted Outpatient Treatment" backgrounder on our website illustrates why law enforcement organizations are strong supporters of AOT laws and implementation.

Assisted outpatient treatment reduces arrests and incarceration.

A study of the New York State Kendra's Law program published in 2010 concluded that the "odds of arrest in any given month for participants who were currently receiving AOT were nearly two-thirds lower" than those not receiving AOT (Gilbert et al. 2010).

According to a New York State Office of Mental Health 2005 report on Kendra's Law, arrests for AOT participants were reduced by 83 percent, plummeting from 30 percent prior to the onset of a court order to only 5 percent after participating in the program (New York State Office of Mental Health 2005, 18).

In a Florida report, AOT reduced days spent in jail among participants from 16.1 to 4.5 days, a 72 percent reduction (Esposito et al. 2008).

Similarly, a report from studies at Duke University in North Carolina found that, for individuals who had a history of multiple hospital admissions combined with arrests and/or violence in the prior year, long-term AOT reduced the risk of arrest by 74 percent. The arrest rate for participants in long-term AOT was 12 percent, compared with 47 percent for those who had services without a court order (Swanson et al. 2001).

Assisted outpatient treatment reduces violence, crime and victimization.

The 2005 New York State Office of Mental Health report also found that Kendra's Law resulted in dramatic reductions in harmful behaviors by patients on AOT. Among AOT recipients at six months of assisted outpatient treatment compared to a similar period of time prior to the court order: 55 percent fewer recipients engaged in suicide attempts or physical harm to self; 47 percent fewer physically harmed others; 46 percent fewer damaged or destroyed property;

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Memorials & Tributes

September 15, 2011 – January 31, 2012

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

William & Christine Albinson, St. Louis, MO	In honor of Charlotte Albinson
Barbara Alexander, San Rafael, CA	In honor of Carla Jacobs
Fay Anderson, Park Ridge, IL	In honor of Patricia Rodbro
Belinda Arroyo, Franklin, MA	In honor of Michael Arroyo
Barbara Ballinger, Menlo Park, CA	In honor of Phil and Denise Ballinger
Marybeth Barraclough, Haddonfield, NJ	In memory of Dorothy and Terry Barraclough
Kathleen C. Barry, Berkeley, CA	In honor of Nancy Allen & in memory of Jack Atkins
Gale Barshop, Alexandria, VA	In memory of Lynn Arden
June Beeby, Kingston, ON	In memory of Matthew Beeby
Marilyn Booth, Inverness, FL	In honor of Debbie Lattin
Peter & Mary Talley Bowden, Houston, TX	In memory of Brooks Cameron Dorn
Richard & Kathleen Breen, Powder Springs, GA	In honor of Mike my son and Mike my brother
Mary Brenneman, Princeton, WV	In honor of Richie Wade
Robert Bruce, Caratunk, ME	In honor of Robert D. Bruce, Jr.
Stephen Burke, Bloomfield Village, MI	In honor of Jim Pavle
George & GG Burns, Lexington, KY	In honor of the need to change mental health laws
Evelyn Burton, Potomac, MD	In memory of Robert Burton
Lucy Butcher, Sprague River, OR	In honor of Mary Butcher Bahl
Jerome & Hazel Byers, Dallas, TX	In honor of Hazel Byers
Alice Byrne, Franklin Park, IL	In honor of Cook County N.W. Housing Group (NAMI)
A.J. & Jane Carlson, Westlake, OH	In memory of Christopher Carlson
Renee Casey, Fishers, IN	In memory of Andrea Woods
Jeanette Castello, Newtown, PA	In memory of Ed Griffith
Susan Cleva, Bellevue, WA	In memory of Henry Cleva
Richard Cleva, Washington, DC	In memory of Henry Cleva
Myra Clodius, Bremerton, WA	In honor of Myra Clodius
Cheryl Cole, Yosemite National Park, CA	In honor of Rebecca
Carolyn Colliver, Lexington, KY	In memory of Scott Lee Helth
Warren & Irene Cook, Manasquan, NJ	In memory of Gloria Blumenthal
Laurie Corson, Camden, NJ	In honor of Laurie A. Corson
Lynda Cutrell, Marblehead, MA	In honor of Lynda Cutrell
Gail Dembin, Egg Harbor Township, NJ	In honor of Marlene Dembin
Marna Dickson, Dana Point, CA	In honor of my daughter, Kelly
Patricia Dowell, Whitefish, MT	In honor of Luke R. Dowell
James Drake, Papillion, NE	In honor of James Drake
Bernadette Dyer, Harleysville, PA	In honor of Bobbie Koenig and in memory of Janeanne Koenig
Jo H. Evans, Hendersonville, TN	In memory of my son C. Michael Evans
Edith Fairhall, Seattle, WA	In memory of Jeff Fairhall
Denise Fazio, Longmont, CO	In memory of brother, Peter George Fazio
Eric Fitzcharles, Lexington, KY	In honor of David & Alice Fitzcharles
Earl & Sheran Flippo, Palm Beach Gardens, FL	In honor of Sandra Clark and Joanne Clark
Valerie Flores, Oxnard, CA	In honor of Gabriel Flores
Laurie Flynn, New York, NY	In honor of E. Fuller Torrey
Rachel Forman, Milwaukee, WI	In honor of The Members of Grand Avenue Club & Rachel Forman
Jerry Fulenwider, San Antonio, TX	In memory of my wife, Betty
Gary Gallo, Nutley, NJ	In memory of Tony
Phyllis Garvey, Indianapolis, IN	In memory of Robert E. Garvey
Gordon & Lucy Gay, Shenandoah Junction, WV	In memory of our son, Benjamin Kevin Gay
Jim Gobeski, Plymouth, MI	In memory of Erin Gobeski
Mary Ellen Gonzalez, Miami, FL	In honor of our son
Stephanie Green, Madera, CA	In honor of Stephanie Green
Judy Gunther, McLean, VA	In honor of Glory Sandberg
Bonnie Hammerschlag, Bethesda, MD	In honor of Bonnie Hammerschlag
Katherine Harkey, Doswell, VA	In memory of my son, Joshua Steven Collins
Peggy Harnisch, Santa Fe, NM	In honor of Joyce Burland
Judith Harris, Washington, DC	In memory of Renee Harris
Trudy Harsh, Centreville, VA	In memory of Laura Harsh
Carl & Blanche Hays, Batavia, IL	In memory of Eric Hays
Vastie Hazel, Spartanburg, SC	In honor of Johann Hazel
Gladys Herreid, Seattle, WA	In honor of Natalie Johnson
David & Mary Hershberger, Greenwood, IN	In honor of my son, Mark
John & Jackie Herum, Ellensburg, WA	In memory of Beth Skahill
Marguerite Hodges, Petersburg, IL	In honor of my daughter, Amanda
Charlotte Huffaker, Signal Mountain, TN	In memory of Patricia S. Smith on behalf of Barbara
Sylvia Hughes, Albuquerque, NM	In honor of Kevin Hughes
Susan Inman, Vancouver, BC	In honor of Dr. Fuller Torrey
Ulysses & Nancy James, Alexandria, VA	In honor of Elizabeth James
Nancy Jones, Shorewood, IL	In honor of Edward Jones
Thomas & Grace Kaelin, Hemet, CA	In honor of Kevin T. Kaelin and in memory of Thomas C. Kaelin
Carl & Adele Kaschenbach, Dallas, PA	In memory of Adele & Bill Jancik
Samuel & Constance Katz, Philadephia, PA	In honor of Stephen Segal
Geraldine Keipe, Henrico, NC	In memory of Bill Keipe
Amanda LaPera, Laguna Hills, CA	In honor of Dad
Mary Ann Laubacher, Syracuse, NY	In honor of Mary Ann Laubacher
Steven & Charla Lerman, Potomac, MD	In honor of Jim Pavle
Fran Levine, Berlin, VT	In honor of Max
Robert Loesche, Kensington, MD	In honor of Jim Pavle
Neal & Nomi Lonky, Yorba Linda, CA	In honor of Jeffrey Hoblin
Brian Marcum, Tulsa, OK	In honor of Mary Kay Marcum
Fred Martin, Jr., San Francisco, CA	Fred & Shirlee Martin
Michael & Marcia Mathes, Maitland, FL	In honor of Linda Gregory
Sue Matthews, Finksbury, MD	In honor of my friend, Deb Spicer and her son, Keith
William & Jill-Allyn McCluskey, Madison, MS	In honor of our son

Frederick McDonald, Toledo, OH	In honor of Fred McDonald
Peggy McGuirk, Johnstown, PA	In honor of Margaret L McGuirk
Janet McSweeney, Seabrook, NH	In honor of Dr. Torrey
Stephen Messner, Washington, DC	In honor of Jim Pavle
Jeff Mickey, Cedar Falls, IA	In honor of Scotti Klepfer
Rebecca Moryl, Jamaica Plain, MA	In honor of Matthew Bean and Penny Seaver
Leroy & Jane Moser, Springfield, MA	In honor of David Moser
Emil & Adrienne Nagy, Chesterhill, OH	In memory of Peter Nagy
Roy Neville, Schenectady, NY	In honor of Roy E. Neville
Rubye Noble, Metairie, LA	In honor of my brother
John O'Brien, Devon, PA	In honor of Richard J. O'Brien Jr.
Anne O'Toole, George School, PA	In memory of Mary Kay Gradel Ciccone
Norman & Betty Ohler, Endwell, NY	In honor of Phillip Ohler
Debra Orozco, Plentywood, MT	In honor of Daniel Chervenka, Jr.
Teresa Pasquini, El Sobrante, CA	In honor of Teresa Pasquini
Jeff Pelletier, Lafayette Hill, PA	In honor of Jeff Pelletier and in memory of Kate Pelletier
Robert Pistner, Arlington, VA	In memory of Iris M. Pistner
Laura Powell, Fountain Valley, CA	In honor of Gary J. Powell
Cameron Quanbeck, San Mateo, CA	In honor of Carla Jacobs
Saul Raw, Brooklyn, NY	In honor of Saul Raw
Karen Redmond, Old Bridge, NJ	In honor of Lawrence Redmond III
Mary Ann Renz, Brandon, MS	In memory of Charles Winston Renz
John Robinson, Sacramento, CA	In memory of my son, Brian Robinson
Glory Sandberg, Wilmington, DE	In memory of Sharra Hurd Taylor
Marlene Schaffer, Phoenix, AZ	In honor of Dan Kirshenbaum
Louise Schnur, Auburn, CA	In memory of Teddy Jack Jones
Hattie Segal, Maplewood, NJ	In honor of Stephen Segal
Stephen & Patty Segal, Philadelphia, PA	In honor of Jon Stanley
Susan Shea, Deerfield Beach, FL	In honor of Christopher
Ingrid Silvian, Columbus, OH	In honor of Debbie Gleeson
Marge Simeone, Natick, MA	In honor of Paul Simeone
Norma Slattery, Berryville, VA	In honor of Norma Slattery and in memory of Aric
Elizabeth Smith, Sharon, CT	In honor of Adair
Dee Smith, Nazareth, PA	In honor of my brother, my friend
Sonja Soleng, Kensington, MD	In honor of Karsten B. Soleng
Nancy Stanton, Waltham, MA	In honor of Adrian Fink
Krista Sweigart, Arlington, VA	In honor of Rosanna Esposito
Joan Tanchek, Pasadena, CA	In memory of Lacy
Joanna Taylor, Buffalo, WY	In memory of Thor & Tyrone Taylor
Vanguard Charitable Endowment Program, MA	In honor of Stephen Segal
Jassie Vilela, Miami, FL	In honor of A.N.V.
Linda Vonbroeke-Pierce, Austin, TX	In honor of my cousin, Everett A. Drake
Harold Wachs, San Diego, CA	In memory of Michael Wachs
Jeanne Walter, Sumner, WA	In memory of Jan Geary
Pat & Ralph Webdale, Fredonia, NY	In memory of Kendra A. Webdale
Diana Weddle, Plano, TX	In memory of Greg
Joel & Diane Wier, Columbia, SC	In honor of SC State Senator Richard W. Hayes, Jr.
Nick & Amanda Wilcox, Penn Valley, CA	In memory of Laura L. Wilcox
Amy Wu, Temple City, CA	In honor of Grace Wu
Robert Yolken, Baltimore, MD	In honor of Dr. Torrey
Diane York, Richmond, VA	In memory of Alan Potz

Assisted Outpatient Treatment

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and 43 percent fewer threatened physical harm to others. Overall, the average decrease in harmful behaviors was 44 percent (New York State Office of Mental Health 2005, 16).

A 2010 study by Columbia University's Mailman School of Public Health reached equally striking findings about the impact of Kendra's Law on the incidence of violent criminal behavior. When AOT recipients in New York City and a control group of other mentally ill outpatients were tracked and compared, the AOT patients – despite having more violent histories – were found four times less likely to perpetrate serious violence after undergoing treatment (Phelan et al. 2010).

The "Duke Study" in North Carolina found that long-term AOT combined with intensive routine outpatient services was significantly more effective in reducing violence and improving outcomes for severely mentally ill individuals than the same level of outpatient care without a court order. Results from that study showed a 36 percent reduction in violence among severely mentally ill individuals in long-term AOT (180 days or more) compared to individuals receiving AOT for shorter terms (0 to 179 days). Among a group of individuals characterized as "seriously violent," 63.3 percent of those not in long-term AOT repeated violent acts, while only 37.5 percent of those in long-term AOT did so. Long-term AOT combined with routine outpatient services reduced the predicted probability of violence by 50 percent (Swanson et al. 2001).

The North Carolina study further demonstrated that individuals with severe psychiatric illnesses who were not on AOT "were almost twice as likely to be victimized as were outpatient commitment subjects." Twenty-four percent of those on AOT were victimized, compared with 42 percent of those not on AOT. The authors noted "risk of victimization decreased with increased duration of outpatient commitment" and suggested that "outpatient commitment reduces criminal victimization through improving treatment adherence, decreasing substance abuse, and diminishing violent incidents" that may evoke retaliation (Hiday et al. 2002).

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Stanley Medical Research Institute Update

By E. Fuller Torrey, M.D.

For many years, SMRI supported research grants aimed at clarifying risk factors for developing schizophrenia. Such risk factors provide clues to the causes of this disorder and thus suggest possible avenues that might be pursued for treatment and prevention.

We recently summarized what is known about risk factors and have submitted it for publication. A comparison of the known risk factors is as follows. The risk is expressed as an odds ratio (OR) or relative risk (RR); for example, an OR of 2.3 means that this factor increases the chance of a person being diagnosed with schizophrenia by 2.3 times.

I. Highest risk factors
- Having a parent or sibling with schizophrenia (RR 6.99–9.31)
- Being the child of an immigrant from selected countries (RR 4.5)

II. Intermediate risk factors
- Being infected with *Toxoplasma gondii* (OR 2.73)
- Being an immigrant from selected countries (RR 2.70)
- Being raised in an urban area (RR 2.75)
- Being born in an urban area (RR 2.24)
- Cannabis use (OR 2.10–2.93)
- Having minor physical anomalies (OR 2.23)
- Having a father 55 or older when conceived (OR 2.21)

III. Low risk factors
- Having a history of a traumatic brain injury (OR 1.65)
- Having been sexually abused in childhood (OR 1.46)
- Obstetrical complications at birth (OR 1.29–1.38)
- Having a father 45 or older when conceived (OR 1.38–1.66)
- Specific genetic abnormalities (OR 1.09–1.24)
- Being born in the winter or spring (OR 1.07)
- Maternal exposure to influenza (RR 1.05)
- Prenatal stress (RR 1.00)

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