Results from National Survey Reveal Immense Costs Borne by Law Enforcement in Responding to and Transporting People with Mental Illness

For years, headlines have highlighted the problem. Now, the results of our national survey of law enforcement detail the costs of handling people in psychiatric crisis differently than we do those with other health emergencies.

Road Runners: The Role and Impact of Law Enforcement in Transporting Individuals with Severe Mental Illness, the first-of-its-kind survey, details the outsized role law enforcement plays in psychiatric crisis response and transportation across the nation.

Faced with limited community treatment options and a dire shortage of psychiatric inpatient beds, those in need of mental health treatment may not receive it until a crisis occurs and law enforcement intervenes. Approximately one-third of individuals with severe mental illness have their first contact with mental health treatment through a law enforcement encounter.

Law enforcement officers are thus often on the front lines of psychiatric care, charged with responding to, handling and even preventing mental illness crisis situations.

Although members of law enforcement do not serve as treatment providers for any other illness, they have become “road runners,” responding to mental health emergencies and traveling long distances to shuttle people with mental illness from one facility to another.

Road Runners provides a unique glimpse into the burdens they must shoulder, as well as the fiscal and societal implications for our mental health and criminal justice systems. Continuing to put law enforcement on the front lines of a public health crisis is costly and dangerous.

Our survey, which was released in partnership with the National Sheriffs’ Association and the New York State Association of Chiefs of Police, and funded by the Achelis and Bodman Foundation, should serve as a wake-up call for policymakers at all levels.

The responses we received represent 355 sheriffs’ offices and police departments in the United States in 2017 and

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In June, I was honored to participate in a special meeting convened by the National Sheriffs’ Association and the Department of Justice focusing on the mental health crisis in our nation’s jails. There, one of the participants asked me why the Treatment Advocacy Center has been so involved in prioritizing the decriminalization of mental illness.

To me, the answer is simple. We exist to eliminate barriers to the treatment of severe mental illnesses, and nowhere are those barriers more apparent than in our criminal justice system. We recognize that reality throughout this edition of Catalyst. Even as we celebrate reforms all across the country, far too many people with severe mental illness are being failed by our mental health system and becoming caught up in a cycle of unnecessary arrest and incarceration.

Our cover story heralds our latest report, Road Runners, which provides the first national view of the extent to which mental illness response has become a law enforcement concern. Road Runners surveyed law enforcement across the country and found a common problem — officers forced to become de facto mental health professionals, responding to mental health emergencies and traveling long distances to shuttle people with mental illness from one facility to another.

Even as we celebrate reforms all across the country, far too many people with severe mental illness are being failed by our mental health system and becoming caught up in a cycle of unnecessary arrest and incarceration.

Our message from the Executive Director

John Snook

Would we subject someone having a heart attack to arrest and transfer them in the back of a police cruiser? Of course not. But that is regularly our response to severe mental illness. As Road Runners highlights, this reality poses serious problems and very real costs on our communities.

We also mourn the passage of Dr. H. Richard Lamb, a cherished member of our board of directors and an exceptional psychiatrist. It is difficult to overstate the impact that Dr. Lamb’s work had on our national understanding of the criminalization of mental illness. His ideas shaped much of the work here at the Treatment Advocacy Center and indeed much of the world. He will be greatly missed.

The crisis of criminalization also informs our work at the state level. In the Colorado Springs Gazette, we detail the consequences it is having on families and consumers in the Centennial State, and celebrate the passage of two significant pieces of legislation the state passed in response.

We also hear a powerful message from Dr. Susan Parvoti, the medical director of Homeless Health Care Los Angeles, who explains why jail is no place for people with mental illness.

Finally, we are inspired by the reflections of our founder, Dr. E. Fuller Torrey, which he shared in Psychiatric Services. Looking back on the seminal events that shaped his career, Dr. Torrey highlights four: his younger sister’s psychotic break, his service abroad as a Peace Corps physician, his employment at the National Institute of Mental Health, and his work at St. Elizabeth’s Hospital.

As always, thank you for your dedication to this cause, your support of the Treatment Advocacy Center and your advocacy in support of those most in need. To echo the words of Dr. Torrey, there is much work to be done.

John Snook

Saying NO to Big PHARMA

No nonprofit can survive, much less thrive, without reliable and generous donors. However, individuals and private foundations are unusually vital to the Treatment Advocacy Center because from the beginning — and alone among major mental health organizations — we accept no funding from the corporations most closely allied with mental illness treatment: pharmaceutical manufacturers.

This is our position because we advocate for reforms that can result in individuals with severe mental illness being ordered to adhere to treatment plans that may include medication orders. And we believe that taking money from the companies that make those drugs and therefore stand to profit from the policies for which we advocate would create an unacceptable conflict of interest.

Further, we continue to be critical of pharmaceutical practices that result in the over-prescription of certain psychiatric medications, especially to children and individuals with dementia.
Dr. H. Richard Lamb, a cherished member of the Treatment Advocacy Center Board of Directors and unparalleled psychiatrist, passed away in late July following an illness. It is difficult to overstate the impact of Dr. Lamb’s work on America’s mental illness policy. He was one of the most influential psychiatrists addressing the nexus of mental illness and criminal justice in the world; his work on deinstitutionalization and the criminalization of mental illness shaped public policy conversations for decades and continues to influence policy decisions throughout the nation.

Dr. Lamb received his medical degree and psychiatric residency training from Yale University. He was director of psychiatric rehabilitation services for California’s San Mateo County Mental Health Services from 1964 to 1976. Dr. Lamb became Professor of Psychiatry at the University of Southern California School of Medicine in 1976, a post he held until 2006 when he became Professor Emeritus. His numerous publications include: six books, more than 50 book chapters and over 150 peer-reviewed articles.

In the 1970s, Dr. Lamb was the first to document the sub-standard living conditions of those who had spent years in state hospitals and were trying to re-integrate themselves into society. In the 1980s, he published numerous prominent studies and articles on the imprisonment of the mentally ill and served as the chair of the American Psychiatric Association’s Task Force on the Homeless Mentally Ill. In 1998, the American Psychiatric Association awarded Dr. Lamb with the Arnold L. van Ameringen Award in Psychiatric Rehabilitation to honor his efforts advocating for people with severe mental illness and his extensive contributions to research on the subject. He was also the recipient of the 2003 Don and Peggy Richardson Memorial Award for Distinguished Service to Persons Afflicted with Serious Mental Illness from the National Alliance on Mental Illness, an organization he helped found.

Dr. Lamb also generously lent his intellectual might to the Treatment Advocacy Center and its research, joining our board in 2009. During that time, he co-authored numerous reports, including some of the organization’s most widely known work addressing the loss of psychiatric treatment beds and the overrepresentation of people with mental illness in jails and prisons. His most recent contribution, in January of this year, questioned the National Institute of Mental Health’s reduction in clinical trials for schizophrenia.

Dr. Lamb’s 2011 commentary in the Journal American Academy of Psychiatry and the Law with frequent partner Dr. Linda Weinberger aptly sums up the philosophies that underpinned his work, “the mental health system should stem the tide of criminalization by taking back the responsibility of caring for persons with serious mental illness who are the most disabled and difficult to treat and by not relinquishing their time-honored obligation to treat this population.”

Dr. Lamb and his contributions to our research and advocacy will be dearly missed.

In Memoriam: Board Member, H. Richard Lamb
A Case Study of Mr. T: Suicidal, Violent, and Treatment Resistant Schizophrenia

A n August Current Psychiatry article co-authored by Treatment Advocacy Center director of research Elizabeth Sinclair and board member Cameron Quanbeck, MD showcases the work of our founder Dr. E. Fuller Torrey and board member Dr. Robert Yolken on the role of infections in schizophrenia.

The article profiles the difficult clinical case of “Mr. T,” and illustrates how innovative therapies are being utilized to reduce inflammation in the brain and transform the lives of those struggling with treatment-resistant serious mental illness.

Below is a version of the article as it appeared in one of our Research Weekly emails:

MR. T

Mr. T is a middle-aged man with schizoaffective disorder, the serious brain illness that combines the delusions and hallucinations of a psychotic disorder with the manic and depressive symptoms of a mood disorder.

Over the course of his illness, Mr. T made several suicide attempts. He consistently struggled with treatment adherence, both due to impaired insight into his condition as well as a lack of response to standard antipsychotic approaches. At times, he drank alcohol heavily. During a psychotic episode, he attacked his mother with a knife when she came to take him to a psychiatric appointment because he believed she and the CIA were conspiring against him. Mr. T was arrested and taken to jail.

TREATMENT RESISTANCE

While in jail, Mr. T was found incompetent to stand trial due to his psychiatric illness and sent to the state hospital in California to receive competency restoration. After three years, it was determined that Mr. T was unable to be restored due to repeated decompensations of his illness and was sent back to jail. In jail he decompensated further and began showing signs of catatonia, refusing food and medications and becoming mute. After a particularly severe episode, Mr. T was sent to a local hospital.

Mr. T was started on clozapine, the most effective antipsychotic medication for treatment-resistant schizophrenia. His catatonic symptoms improved, and he was transferred to a mental health rehabilitation center.

PHARMACOGENETICS AND BRAIN INFLAMMATION

Mr. T agreed to pharmacogenetic testing that allows his treatment team to adjust his dose of clozapine to achieve the best response. Further testing for infections of the brain showed that Mr. T tested positive for Toxoplasma Gondii, a parasite spread by feral cats. Research has shown that persons with schizophrenia who have latent Toxoplasma Gondii infection have a more severe form of the illness compared to persons with schizophrenia who do not have the infection.

In addition to clozapine and a medication for depression, Mr. T was prescribed minocycline, a potent anti-inflammatory drug. Afterwards, Mr. T begins a slow but steady improvement in symptoms, with inflammation markers in his blood decreasing.

One month after the initiation of this new treatment regimen, Mr. T’s test results reflected his immune system was better controlling the toxoplasmosis infection. He continued to show significant symptom improvement and stopped cycling into periods of perseverative thought and intense anxiety. Mr. T later expresses interest in also trying a natural agent and is given ginger root extract in addition to valproic acid, both known to target toxoplasmosis infection.

Eventually, Mr. T’s criminal charges were dismissed and he was discharged to a less restrictive level of care. Currently, he is volunteering in a peer support program, will soon begin working there part-time, and plans to move into his own apartment. He spends weekends with his family members and friends.

Our Mission

The Treatment Advocacy Center is the only national nonprofit organization exclusively dedicated to eliminating barriers to the timely and effective treatment of severe mental illness.

We promote laws, policies and practices for the delivery of psychiatric care and support the development of innovative treatments for and research into the causes of severe and persistent psychiatric illnesses, such as schizophrenia and bipolar disorder.
People with Mental Illness Belong in Treatment not Cells

By John Snook
JUNE 11, 2019

A recent Colorado Springs Gazette headline betrays the grim reality: "Colorado's jails and prisons house many of the state’s mentally ill."

Over the last half-century, America’s psychiatric treatment system for the most severely ill has been dismantled. The basic infrastructure needed to address the scourge of mental illness — a public health epidemic — has been stripped bare. Jails and prisons have been left to take up the slack. Colorado’s problems typify this national crisis.

A functional mental health system requires a combination of community services and at least 50 psychiatric treatment beds per 100,000 people to provide individuals with severe mental illness with a minimal level of care. However, Colorado provides just 10 such beds per 100,000 people. In 2016, that meant just 543 psychiatric beds for the estimated 144,000 Coloradans with schizophrenia and bipolar disorder.

Without inpatient treatment beds for this population, those most in need become trapped in an endless cycle of deterioration and crisis. Many wind up on the streets, vulnerable to abuse and exposed to medieval diseases like typhus and tuberculosis. They also overcrowd hospital emergency rooms, where they sit amidst the chaos, sometimes for weeks at a time.

And, as The Gazette reported, many inevitably land behind bars. The Colorado Department of Corrections estimates that one out of every three men and four out of every five women imprisoned in Colorado have some type of moderate to critical mental health need. At the El Paso County jail alone, nearly a third of the inmates — more than 6,000 people — had a mental health diagnosis or history, or had been flagged as suicide risks.

Science now shows us that mental illnesses are medical conditions requiring a medical response. The provision of health care behind bars is a constitutional responsibility, but it is not a viable solution to this problem. The correctional system is neither designed nor equipped to provide appropriate psychiatric treatment.

Without inpatient treatment beds for this population, those most in need become trapped in an endless cycle of deterioration and crisis.

Moreover, jails and prisons are arguably the worst possible place for people in serious psychiatric distress. And the consequence of warehousing people in medical crisis in cells is too often deadly.

A national effort to track the deaths of those with mental illness in jails identified more than four hundred since 2010. The actual number of deaths was likely significantly higher. And when people with severe mental illnesses die in custody, taxpayers foot the bill for the massive settlements that the correctional and criminal justice systems reach.

The means for repairing the mental health system and averting future tragedies is to ensure that people with severe mental illnesses receive a full continuum of medical care when they need it and before they are incarcerated, as we would for those with other diseases.

Colorado recognized this when it passed bipartisan legislation to begin to address the crisis. But the Centennial State has more to do.

In Grading the States: An Analysis of Involuntary Psychiatric Treatment Laws, my organization examined whether state law allows an individual in need of involuntary treatment to receive it in a timely fashion, for sufficient duration, and in a manner, that promotes long-term recovery. Colorado's laws received a D+.

To improve that grade, state lawmakers can and should revise their treatment statutes to reflect the latest science on mental illness. They must ensure treatment does not demand police intervention and avoid unnecessary over-reliance on outdated and stigmatizing notions of dangerousness before someone can get help.

Colorado must also address its critical bed shortage. Late last year, Secretary Alex Azar of the U.S. Department of Health & Human Services announced important regulatory changes that will finally allow states to overcome The Medicaid Institutions for Mental Diseases (IMD) exclusion — an outdated federal barrier that disincentivizes states from building needed treatment beds. Colorado should take advantage of those changes to add needed beds immediately using federal Medicaid matching funds.

Colorado has finally recognized having a mental illness is not a crime. That is a vitally important realization. But Gov. Jared Polis and the Colorado Legislature must not stop now. They must modernize their treatment laws and add needed treatment beds by making Colorado’s waiver application a top priority.
PERSONALLY SPEAKING:

**Behind the Muddied Glass:**
*A Doctor’s Look at Untreated Mental Illness*

By Dr. Susan Partovi

I met “Carrie” while making rounds at the Los Angeles County women’s jail with a group of mental health professionals.

A woman in her mid-50s, she had no clue what day it was.

Naked and thin, Carrie ambled over, peering through the muddied glass of her jail cell. But it was not mud on the glass. She had streaked feces on it, and all over her body.

“Ms. Carrie? Hi. I’m Doctor Partovi,” I said. She bent over, fixated on an imaginary circuit board.

“A, B, C. That goes in A, then you go in B,” she muttered.

“Ms. Carrie, do you take any medications?” I asked.

She replied, “Yes, the vitamins go in A, but what about B...!??”

Whenever I encounter people with severe mental illnesses they break my heart. Carrie was no different. I fought back tears.

One of the group’s psychologists asked, “That bad?” I nodded.

“She’s our number one, then,” the psychologist announced, indicating that Carrie would be sent to the jail’s psychiatric hospital as soon as a treatment bed became available.

There are now fewer psychiatric hospital beds in the United States per capita than at any time since the 1850s, but by a stroke of luck, Carrie was placed later that day. She would receive the care she needed and deserved.

Some people with severe mental illnesses like schizophrenia and bipolar disorder need to be involuntarily hospitalized and medicated. Most become remarkably more lucid after a few days and voluntarily accept prescribed medication. Their responsiveness to treatment underscores my belief that they do not belong in the correctional system.

The mental health clinicians I know strive to provide compassionate care for people like Carrie behind bars, but there is only so much one can do. Jails create a perfect storm for someone with a severe mental illness. Being locked in a cold cell with one’s hallucinations only invites further psychiatric deterioration.

However, we have created a system in which the severely ill — people like Carrie — are incarcerated, in part, because they have nowhere else to go.

At least one-third of chronically homeless adults in California now have a severe mental illness, along with more than 20 percent of inmates at the Los Angeles County Jail. Many are there for petty offenses, like stealing a bag of chips.

Society also seems to operate under the false assumption that Carrie wants to be homeless, accepts her paranoia, and decides to stand naked in the cold, smeared with feces. No. These are unwelcome symptoms of non-treatment, not rational choices.

Had I encountered Carrie in the streets, talking to her hallucinations while exposed to the elements, it would have been nearly impossible to hospitalize her involuntarily, even though a hospital stay would promote stabilization. That is shameful.

On the streets, the homeless with severe mental illness are more susceptible to drug use, other chronic illnesses, and outbreaks of medieval diseases. According to one study, they are ten times more likely to die.

Meanwhile, when they seek refuge in emergency departments and hospitals or cycle through the criminal justice system, the per person service costs to taxpayers can reach $100,000 per year — more than the cost of comprehensive care in an inpatient facility.

California, and Los Angeles County, in particular, has programs that can divert the Carries of the world into full-time care before tragedy ensues. But it does not necessarily utilize them effectively.

Laura’s Law, for example, is the state’s version of assisted outpatient treatment — a tool to engage individuals into treatment who have a history of non-adherence to medication, and who often lack insight into their illness.

When the Treatment Advocacy Center assessed the implementation of this important program, it found that its services helped decrease psychiatric hospitalizations, crisis contacts, incarcerations, and homelessness. One might presume local governments would eagerly implement it with vigor. Yet a version of Laura’s Law is available in only 20 of California’s 58 counties, most of which underutilize the tools available under the law.

To stop people like Carrie from falling through the cracks of our broken mental health system, we need to change our approach. Until we do, our collective futures will remain obscured by muddied glass.

*Susan Partovi is Medical Director of Homeless Health Care Los Angeles. She has provided medical attention to the homeless in the streets and clinics of Los Angeles for fifteen years.*
PERSONALLY SPEAKING:

Schizophrenia is Scary but Survivable

By Steve Pryce

I have been hospitalized for schizophrenia, twice.

Given the bleak prospects for people with untreated severe mental illness — homelessness, fatal encounters with law enforcement, incarceration and suicide — that is actually the good news.

My illness manifested in extreme paranoia when I was an aspiring twenty-something professional. The FBI was after me. My food was poisoned. Or so I thought.

Such delusions contributed to poor customer service and subpar paperwork. I quit my job rather than face termination. I had to move in with my parents.

Back home, I left notes in our neighbors’ mailboxes, telling them to leave me alone. That prompted my first hospitalization.

At Mt. Sinai in Cleveland, a now-defunct facility, I received therapy and Risperdal, an antipsychotic drug. My condition stabilized.

After 18 months, I stopped taking my medication.

People were suspicious of me anew, keeping me at arm’s length. Or so I perceived.

Any relationships I had dwindled into voids.

A psychiatrist suggested that I remain unemployed and collect Social Security Disability Insurance. No thanks — a rising star like me needed a job.

I spoke with Dr. Fred Frese, a pioneering voice for consumers of mental health services. Fred actually became the chief psychologist for the very mental hospital system in which he had been previously committed. He, too, cautioned against me going out on my own. I ignored him and found work as a journalist.

Without anti-psychotic medications, my paranoia flourished.

In the newsroom, my colleagues tracked down story leads, talking to sources and scribbling notes. I was convinced they were investigating me!

I wrote articles that were nonsensical. I was fired.

Unknown to me then, I suffered from a condition known as anosognosia, or lack of insight. As the Treatment Advocacy Center explains, this symptom of untreated severe mental illness is caused by anatomical damage to the brain. Some 40 percent to 50 percent of people with severe bipolar disorder and schizophrenia have it. Like them, I was inhibited from appreciating the need for treatment and medication — diagnosis be damned.

For five years, I bounced around, trying to appear normal.

Then, three young men moved into the adjacent one-bedroom unit at my apartment complex. They were loud and partied each weekend.

They did not appreciate it when I reported the noise to the landlord. One night, they drunkenly beat me until my eye swelled shut.

Even when I was not the problem, I was vulnerable to abuse.

My parents called a crisis intervention center. A case manager encouraged me to accept inpatient psychiatric care. That was when I was hospitalized for a second time.

Again, I stabilized.

Upon discharge, I was told that I could rejoin the workforce. Easier said than done.

At an interview with a telemarketing company, I was asked why someone with a college degree had been performing manual labor for hourly wages. I balked. I was not hired.

I threw a tantrum, busting a wooden chair in my parents’ basement, and scaring my family. They sent me to a halfway house for the homeless and the mentally ill.

Being surrounded by other people enduring similar struggles helped put my predicament in perspective. I successfully charted a new path with realistic goals. I took my Abilify, another antipsychotic.

Alongside my parents, I volunteered with the local National Alliance on Mental Illness chapter, offering peer support to others. In 2012, the organization named me volunteer of the year.

With treatment, the persistent feeling of being different dissipated and my symptoms became manageable.

I now live on my own and have been steadily employed for more than a decade.

Illness chapter, offering peer support to others. In 2012, the organization named me volunteer of the year.

With treatment, the persistent feeling of being different dissipated and my symptoms became manageable.

I now live on my own and have been steadily employed for more than a decade. I even started dating.

I have come far, but I know many see schizophrenia as a character flaw, not a biological medical condition. The broken mental health treatment system exacerbates that stigma, neglecting the need for care.

Case in point: There are barely 1,000 public psychiatric beds for the nearly 300,000 Ohioans with illnesses like mine. The supply of beds is insufficient to meet demand. And when timely and effective treatment is unattainable, shame is the least of the problems.

However, if there is one takeaway from my personal experience, let it be this: With appropriate psychiatric care and the support of loved ones, a brighter tomorrow is possible for people with schizophrenia.

I am living proof.

Pryce resides in northern Ohio.
What Shaped My Career

DR. E. FULLER TORREY:
Pt is difficult to be certain what shapes our lives and careers. If we were born again with just one thing changed, such as our parents or birthplace, then we could determine the essential factors. Alas, we are each living a unique social experiment with an N of one.

My best guess is that my life and career were largely shaped by four seminal experiences. The first was my younger sister’s psychotic breakdown in 1957, at age 18. Rhoda had serious schizophrenia with anosognosia as well as treatment resistance. At one time she was suicidal and homicidal. She was hospitalized continuously in a New York State hospital for 25 years and spent the rest of her life in group homes and nursing homes. I was a third-year premed student in college when she got sick, and I envisioned myself practicing family medicine. Because my father had died when we were young, I accompanied my mother and sister as they sought a definitive diagnosis and treatment at psychiatric centers recommended by friends — Columbia, Massachusetts General, Silver Hill, the Brattleboro Retreat, Baldpate, etc.

I came away from the psychiatric consultations with two strong impressions. First, it seemed clear that nobody had any idea what caused schizophrenia. One nationally prominent psychiatrist told my mother that Rhoda’s illness had been caused by the death of my father. That made no sense to me whatsoever because my older sister and I had shared all of Rhoda’s childhood experiences and we seemed to be pretty normal — other than the time she broke a dinner plate over my head because I had called her a bad name. My mother, who had had only a high school education, was baffled by my sister’s ordeal and the lack of available information. These events certainly influenced my decision many years later, when I was working with patients at St. Elizabeths Hospital, to write Surviving Schizophrenia (1983) for their families.

The other strong impression these early consultations evoked about my sister’s illness was that the brain was a very mysterious place that appeared to be almost completely unexplored. I had always been attracted to geographically mysterious places, especially Africa, and the brain seemed to be the human body’s equivalent of Africa. I was able to understand my father’s illness and death from heart failure — the heart was a failing pump. But what could possibly cause the brain to hear voices that did not exist? Or to have delusional thoughts that British soldiers were attacking our house, as my sister had experienced? C. S. Sherrington was correct in describing the brain as “an enchanted loom.” My attraction to the brain as a mysterious and intriguing organ has lasted a lifetime and led me to establish the Stanley Brain Collection years later.

The second seminal experience that shaped my life and career was spending two years in Ethiopia as a Peace Corps physician prior to my training in psychiatry. I spent time in the country’s only psychiatric hospital with one of the three psychiatrists available for 25 million Ethiopians. Serious mental illness in general, and schizophrenia in particular, appeared to be uncommon in Ethiopia at that time. This circumstance piqued my interest in the epidemiology of schizophrenia and its distribution in the world. In later years I spent 3 months in the Highlands of Papua New Guinea, where schizophrenia was virtually unknown, and 6 months in western Ireland, where schizophrenia appeared to be prevalent. I also began exploring the idea that schizophrenia had been a relatively rare disease prior to the 19th century, when its prevalence increased sharply. I was impressed by several epidemiological aspects of the illness: the suggestion that cases were clustered by neighborhood, the increased risk of developing the illness among those born in a city, and the seasonal pattern of births among those with schizophrenia. My research led to the publication of Schizophrenia and Civilization (1980) and later of The Invisible Plague (2001). By the early 1970s the epidemiology had also led me to consider whether infectious agents were the cause of schizophrenia.

In Ethiopia I also began to spend time with indigenous therapists — so-called witchdoctors. One of the best known in Ethiopia at that time was Abba Wolde Tensae, a priest in the Ethiopian Orthodox Church. He was known throughout the country for his ability to cure individuals afflicted by zar spirits that were thought to cause anxiety, depression, psychosomatic symptoms, and other illnesses. He lived two hours from me, and on several occasions, I attended his group healing sessions. He was proud of his healing skills, believing that they came from God, and he willingly discussed his techniques with me. He seemed to be very effective in helping many people with various neuroses and personality disorders. This experience led me to pursue the study of other indigenous therapists. In 1969, for example, while on our honeymoon, my wife and I visited indigenous therapists (manangs) among the Iban people in Borneo — and even drank too much wine with one manang in his treehouse one evening.

This article was initially published in Psychiatric Services.

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The outcome of such experiences was my book *The Mind Game: Witchdoctors and Psychiatrists* (1972).

The third seminal experience that shaped my life and career was going to work at the National Institute of Mental Health (NIMH) in 1970 after completing my psychiatric residency. At the time, funding for John F. Kennedy’s community mental health centers (CMHCs) was at its peak. Over 600 million federal dollars had already been spent to fund 457 CMHCs. NIMH was full of young, idealistic mental health professionals who were excited to work to discharge patients from state psychiatric hospitals and create CMHCs to help individuals with mental illness receive treatment in the community, thereby averting most hospitalizations. In my opinion, in the history of social programs in the United States, rarely have so many well-meaning people known less about the task before them.

Although the CMHCs were not part of my official NIMH duties, I became interested in them. I reviewed site visit reports and visited one CMHC myself. Although there were a handful of CMHCs that were doing a good job, it was clear to me that most of them were using federal money to pay for services that were comparable to services delivered in private practice. My analysis of the situation was that the CMHCs had no interest in providing aftercare services for the thousands of individuals with serious mental illness who were being discharged from the state psychiatric hospitals.

Most discouraging to me was my observation that NIMH officials seemed uninterested in improving the CMHC program. Congress had appropriated the CMHC funds, which had to be spent in their entirety to preclude Congress from giving less money the following year. If NIMH threatened to cut off funds to a CMHC in a particular district, it would then have to deal with a member of Congress representing that district. In my view, the most important factor in the lack of improvement to the CMHC program was that the program was part of the legacy of President Kennedy and therefore had to be portrayed as a great success, details be damned. This was a valuable lesson in how Washington works — or doesn’t work. I became convinced that I was witnessing the beginning of a disaster and began keeping notes. These notes led to four books over the next 4 decades on the failure of deinstitutionalization, the most recent being *American Psychosis: How the Federal Government Destroyed the Mental Illness Treatment System* (2014).

The final seminal experience that shaped my life and career was going to work at St. Elizabeths Hospital in 1977. Working as a ward psychiatrist with patients, most of whom had schizophrenia and bipolar disorder, sharpened my clinical skills and my understanding of these diseases. It also allowed me to collect blood and cerebrospinal fluid (CSF) from my patients and to assess them neurologically. It was then that I first sought out infectious disease specialists who were willing to examine the blood and CSF I was collecting for evidence of infectious agents. These consultations were the beginning of research that I have pursued ever since. Working at St. Elizabeths provided an additional advantage: the NIMH research unit on hospital grounds, under the direction of Dr. Richard Wyatt, allowed me to collaborate on research projects with several members of that group. The most noteworthy project was a large study of identical twins in which one or both had schizophrenia.

In summary, it has been more than 60 years since schizophrenia began to dominate my sister’s life and, in different ways, my life as well. My experiences have left me with two strong impressions. The first is great admiration for people who must live with this most unpleasant illness. The second is inspiration from my colleagues who have dedicated their careers to providing clinical care, to researching this disorder, or both. And there is still a lot of work to be done.

The infectious agents of special interest for this research project were *Toxoplasma gondii* (*T. gondii*) and cytomegalovirus (CMV), a common herpes virus. In recent studies these infectious agents have been associated with various psychiatric disorders, cognitive deficits, suicidal behavior, and traffic accidents.

When the data was analyzed it was found that *T. gondii* was significantly associated with a diagnosis of schizophrenia. The association was especially strong in those individuals who had antibodies to *T. gondii* at the time they donated blood and then later were diagnosed with schizophrenia, suggesting a causal relationship.

A weak association between having antibodies to *T. gondii* and traffic accidents was found. CMV was significantly associated with having any psychiatric disorder and also with attempting or committing suicide. In summary, the Danish research provided further evidence that some infectious agents play a significant role in many psychiatric disorders.

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The Stanley Medical Research Institute is a supporting organization of the Treatment Advocacy Center. Dr. Torrey is the Stanley Medical Research Institute’s Associate Director for Research and the founder of the Treatment Advocacy Center.
The National Institute of Mental Health (NIMH) is the lead federal agency for mental disorder research and the largest scientific organization in the world dedicated to research on mental disorders. Consequently, the Treatment Advocacy Center was extremely concerned when, without warning, NIMH slashed its estimates of the number of Americans with schizophrenia — effectively making two million people with schizophrenia disappear.

This change was not an innocuous one. As Dr. Torrey and our Director of Research Elizabeth Sinclair explained in a front-page piece in Psychiatric Times, policymakers look to agencies like NIMH to understand the potential impact of their decisions. If schizophrenia suddenly impacted far fewer people, it would become much harder to justify demands for more federal and state attention toward addressing it.

Thankfully, our advocacy around this issue caught fire. Thousands of you heeded our call to action, writing to your members of Congress to demand a new national analysis of serious mental illness prevalence.

The glare of the spotlight caused the federal government to take rapid action. In June, the Substance Abuse and Mental Health Administration (SAMHSA) announced it was accepting proposals to undertake a 30-million-dollar study of the prevalence of serious mental illnesses — the first federal mental illness prevalence study in more than thirty years.

As the old saying goes, “what gets measured gets done.” Now, for the first time in decades, we will finally have a nationwide look at how many families are dealing with these debilitating illnesses. That information will help inform decision makers for years to come and allow advocates to make the case for increased resources and dedicated attention from federal and state governments.

An Update on Our Legislative Advocacy

During 2019, the Treatment Advocacy Center staff made steady progress across the country at improving inpatient and outpatient commitment standards. We worked alongside local activists and lawmakers to pass legislation in seven states: Alabama, Colorado, Hawaii, North Dakota, Texas, Utah, and Washington.

- Alabama passed a law allowing renewals of Assisted Outpatient Treatment (AOT) orders, which will assist in the implementation of its Substance Abuse and Mental Health Services Administration (SAMHSA) grant.
- Hawaii’s commitment standard was broadened to allow for mandated treatment to prevent psychiatric deterioration. Dedicated funds were also allocated for the petitioning of new patients.
- Following several high-profile investigative stories, Colorado passed two ambitious reform bills to address the state’s troubled competency restoration process.
- North Dakota amended its commitment standard to make clear that an individual’s history and recent behavior may be taken into account when determining their need for care.
- Texas expanded its AOT law to allow people to be diverted from jails into care, renew treatment orders up to one year, and require judicial training on AOT.
- Utah added detail to its AOT law and procedure based on the state’s experience as a SAMHSA grantee.
- Washington passed a number of Treatment Advocacy Center-supported bills, and appropriated significant new funds for beds and establishing a psychiatric teaching hospital at the University of Washington to address the dire shortage of psychiatrists and psychologists. The state also passed an amendment to broaden its treatment criteria.

Treatment Advocacy Center Advocacy Results in $30M in Federal Funding for Serious Mental Illness

The federal Interdepartmental Serious Mental Illness Coordinating Committee, of which our executive director is a member, took up the issue at its June meeting. The Wall Street Journal even published a debate on the issue between Dr. Torrey and the NIMH’s director, Dr. Josh Gordon.

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Survey Results
CONTINUED FROM PAGE 1

make clear that the status quo is unacceptable. Additionally, the hundreds of millions in costs being imposed on law enforcement are unsustainable.

Some of Road Runners’ key findings are shown.

Road Runners is available for download at TACreports.org.

Our survey respondents reported that their departments’ officers drove 5.4 million miles while transporting individuals with mental illness.

21% Staff time spent responding to or transporting individuals with mental illness.

3 hours is the average time an officer waits at a medical facility until transfer of custody occurs.

37 minutes is the average time an officer waits when transporting an individual to jail.

10% Overall budget spent responding to or transporting individuals with mental illness.

$17.7 million Spent in responding to and transporting individuals with mental illness from survey respondents.

$918 million Estimate of dollars spent each year on mental illness transport by law enforcement.

5 times longer is the average distance driven by law enforcement to transport an individual to a medical facility than to jail.

5.4 million miles driven by officers transporting individuals with mental illness by survey respondents.

The Dallas Morning News

Too late for Tony Timpa, Texas is Beginning to Take Serious Mental Illness Seriously

By John Snook

“You’re gonna kill me!”

The video of Tony Timpa’s tragic death at the hands of Dallas law enforcement has sparked a national outcry. Understandably so.

How could a call for help from a man in psychiatric crisis end with such an awful and unnecessary loss of life?

Unfortunately, tragedies like this are far too common.

A report by my organization, the Treatment Advocacy Center, found that people with mental illness are 16 times more likely to die in an encounter with law enforcement than other civilians. The reasons for such a disparity are numerous, but can be boiled down to one simple fact: law enforcement officers are not mental health professionals.

The absurdity of our system becomes apparent if you substitute any other health crisis into this scenario. Instead of a psychiatric crisis, imagine Timpa was suffering a heart attack. He calls 911 complaining of chest pains and shortness of breath. In response, we send a SWAT team.

Unfortunately, our mental health system is set up in just that manner - the expected response to a mental illness crisis is law enforcement rather than medical professionals. Local police officers have become ad hoc social workers.

In 2017, 21% of law enforcement staff time — more than 165,000 service hours — was spent responding to and transporting individuals with mental illness, at an estimated cost of nearly $1 billion annually, according to our recently-released national survey.

That is a massive expenditure of time and resources to prop up a misdirected system.

Law enforcement officers are among the first to voice frustration about the resulting dysfunction: Texans with mental illness behind bars.

Solutions lie in programs that recognize this dysfunction and drastically shift the system’s focus.

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New Initiative to Boost AOT Implementation

A new initiative is underway to improve care for individuals who have mental illness (SMI). It is called SMI Adviser. The mission of SMI Adviser is to advance the use of a person-centered approach to care that ensures people who have serious mental illness find the treatment and support they need. SMI Adviser is completely free to use and you can learn more right now at SMIadviser.org.

As a partner to SMI Adviser, the Treatment Advocacy Center is developing a learning curriculum focused on evidence-based principles of Assisted Outpatient Treatment (AOT). In the coming months, we will create a series of online learning modules and resources to educate communities on AOT implementation. They will be available on the SMI Adviser website in January 2020.

Tony Timpa
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In 2018, Dallas launched a program to create coordinated teams of specially trained paramedics, officers and mental health professionals to respond to psychiatric crises. The goal is straightforward and long overdue: recognize that mental illness is a medical condition requiring a medical response. This sort of response reduces costs while better serving those most in need of care, before tragedy strikes.

Tarrant County is also one of just 18 sites in the country that was awarded a special federal grant to stand up a mental-health treatment program that can serve these most severely ill clients, without the involvement of law enforcement.

The program, known as assisted outpatient treatment, marries intensive psychiatric treatment with a non-criminal court order. The program prioritizes the care of the most severely ill while helping ensure treatment compliance. Such programs can reduce the most damaging consequences of serious mental illness, while saving communities money.

Texas still has much to do. There are still far too few treatment beds available and far too few community care options. Until those gaps are filled, tragedies like that which befell Timpa could continue.

Texas is finally beginning to take serious mental illness seriously; a reckoning that is long overdue. Unfortunately, for Timpa and his family, that reckoning came too late.