No exit Candy and Al DeWitt felt they had no way to care for their son, a former high school football player who has schizophrenia.

Photographs by Mike Kepka
Dangerous Cases

Laws designed to compel those with serious mental illness into treatment are gaining traction

BY HALEY SWEETLAND EDWARDS
It was toward the end of his senior year in high school that Daniel DeWitt, a handsome, college-bound football player, began to slip into a world of paranoia, evil spirits and voices in his head. By the fall of 2007, a few months after his graduation, he was diagnosed with schizophrenia. “The worst part,” says Daniel’s mother Candy DeWitt, “was watching him suffer and having no way to help.”

Because Daniel was a legal adult, Candy and her husband Al couldn’t just make him take his medicine. But like many people with a serious mental illness, Daniel refused to seek treatment on his own. That left the DeWitts with little choice but to care for him as best they could as he deteriorated. Every so often, he would get sick enough to qualify under the law in Alameda County, California, as an imminent danger to himself or others, at which point he could be admitted, involuntarily, to a psychiatric hospital where he would be stabilized.

Daniel was hospitalized in that way at least nine times over the course of four years but was almost always released after two or three days. “He’d dump his medication at the door, and the process would start all over again,” Candy says.

The last time Daniel was hospitalized, in December 2011, he wasn’t doing well. Even his doctor thought he should continue inpatient care, but since Daniel no longer met the legal criteria for involuntary treatment and refused to stay voluntarily, he was released. Two months later, in February 2012, having yet again declined into what’s known as a floridly psychotic condition, Daniel wandered into a leafy neighborhood in Berkeley, Calif. There he encountered Peter Cukor, a 67-year-old retiree, and allegedly beat him to death with a flowerpot, according to police reports. Daniel was charged with murder, found incompetent to stand trial and sent to Napa State Hospital, a psychiatric institution, where he remains today.

Daniel’s story has become a tragic touchstone for the ongoing national debate about mental illness and violence. Fairly or not, it is often listed as yet another in a string of crimes in the years before and after Cukor’s death, in which other young men with serious mental illnesses killed dozens in Tucson, Ariz.; Aurora, Colo.; and Newtown, Conn. This year, in May, a young man suffering from mental illness stabbed and shot six in Isla Vista, Calif.

These events are rare; only a tiny percentage of violent acts in the U.S. can be attributed to mental illness, and most don’t involve guns. But every time one of these tragedies occurs, a version of the same public debate ensues. Many call for new gun-control laws to keep weapons out of the hands of unstable individuals. In September, in response to the Isla Vista tragedy, California Governor Jerry Brown signed a law that makes it easier to confiscate a gun from an individual deemed potentially dangerous.

But after Congress failed to pass comprehensive gun-control legislation in the wake of the Newtown shooting in 2012, national attention shifted toward reforming the mental-health system. A Gallup poll last September that asked about the cause of mass shootings found that more Americans blamed the mental-health system for failing to identify dangerous individuals than the availability of guns. At the heart of this new debate is a single idea: Should it be easier to compel adults with a serious mental illness, like Daniel, to receive involuntary psychiatric treatment?

It is a hugely controversial question—one that casts doubt on the validity of our country’s 50-year-old policy of deinstitutionalization. And disagreements over the answer have catalyzed a civil war in the mental-health community. On one side, there are those who argue that involuntary treatment will do nothing more than destroy patients’ civil rights, discourage them from voluntarily seeking help and further stigmatize mental illness. They say linking crime to mental illness is an unhelpful distraction: people with a mental illness, taken as a whole, are no more likely to be violent than anyone else, and a history of substance abuse is a much better predictor of who will pull a trigger next.

On the other side, a growing coalition of grassroots activists, led by parents like Candy DeWitt, say society has a moral obligation to help people receive treatment. They argue that ignoring higher correlations between violence and the tiny fraction of Americans—less than
At Risk

There are 9.6 million adults with a serious mental illness living in the U.S., but fewer than... 150,000 psychiatric beds available for them

THE EFFECTS

People with a serious mental illness make up about 4% of the U.S.’s adult population but account for...

15% of state prisoners

24% of jail inmates

30% of people who are chronically homeless have a mental-health condition

THE COST

$317 billion

Estimated annual cost to society of caring for the seriously mentally ill (a third comes from medical expenses, while the rest comes from disability payments and lost productivity)

Sources: NIMH; Substance Abuse and Mental Health Services Administration; Department of Justice; NIMH Director Thomas Insel, in a 2008 Psychiatry article

2%—who don’t receive treatment for a serious psychiatric disorder does more to stigmatize mental illness than addressing it head-on.

Whichever side prevails in this battle, unfolding today in county seats, state legislatures and Congress, will shape the publicly funded mental-health system for decades. “We’re asking, Do we help the sickest of the sick?” says Marc Fishman, a psychiatrist at the Johns Hopkins Bayview Medical Center and the University of Maryland Medical Center. “If the answer is yes, then how do we do it?”

A New “Moral Catastrophe”

In the 1960s, when the American public first became aware of the wretched living conditions and abuse inside government-funded mental institutions, the reaction was swift. States shuttered psychiatric hospitals, released hundreds of thousands of patients and erected formidable legal barriers, through both court precedents and new laws, to ensure that no one could again be forced into treatment. The specter of One Flew Over the Cuckoo’s Nest, the 1962 novel and subsequent film depicting the horrors inside a state hospital, became a rallying cry: beware the dark ages of institutionalization.

A half century later, health care workers, law-enforcement officials and parents of mentally ill adults say this reaction was too extreme. “It’s easy to see why the pendulum swung in that direction in the ’60s—it was a righteous impulse,” says Randall Hagar, an advocate for the National Alliance on Mental Illness in California. But it didn’t take into account the unintended consequences of mass deinstitutionalization. “What we’re seeing now is a course correction,” he says.

Hundreds of thousands of people with a serious mental illness today end up homeless, cycling through emergency rooms, short-term hospital stays, jails and prisons. Most land in the correctional system for the first time after committing a petty crime, like urinating in public, but then quickly become repeat offenders, racking up felonies for reacting aggressively to police officers or fighting with other inmates, says Michael Biasotti, a past president of the New York State Association of Chiefs of Police. Biasotti says he understands how complicated the issue can be since he has a daughter who suffers from schizophrenia.

Although people with serious mental illness make up only about 4% of the U.S. population, they account for 15% of state prisoners and 24% of jail inmates, according to government records. Three times as many people with a mental illness are incarcerated as are in psychiatric hospitals, according to a 2010 report co-authored by the National Sheriffs’ Association. People with a serious mental illness are also nearly 12 times as likely as the average person to be the victim of a violent crime, like rape, and as much as eight times as likely to commit suicide. People with symptoms of mental illness account for as much as 30% of the chronically homeless population.

Teresa Pasquini, who co-founded Right2Treatment, an advocacy group in California, calls this a “moral catastrophe.” Civil rights advocates were correct in the 1960s to demand respect for patients’ rights, she says, but their definition of rights was too narrow. “Leaving people to sleep on sidewalks and freeze and spend their lives in jail isn’t respecting their rights either,” she says.

Moral costs aside, allowing people with serious mental illnesses to bounce among
the streets, the ERs and the correctional system is expensive. While no single study has aggregated how much taxpayers spend caring for the seriously mentally ill, some have found that it costs roughly twice as much to incarcerate an inmate with a mental illness as one without and can run states up to $100,000 per inmate per year; multiply that by the estimated 356,000 seriously mentally ill inmates. Other studies suggest that it costs federal, state and local governments $40,000 to $60,000 to care for a single homeless person with a serious mental illness; multiply that by the estimated 250,000 mentally ill homeless people. Thomas Insel, director of the National Institute of Mental Health (NIMH), has said the total cost to the government—including things like Medicare, Medicaid, disability support and lost productivity—is as much as $317 billion per year.

None of those dollar figures takes into account the controversial issue of public safety. Part of the source of the controversy is the definition of mental illness. A broad term that includes everything from stress to serious psychosis. As a total population, the millions of Americans who suffer from a mental illness at some point in their lives are no more likely than anyone else to commit a crime. But narrow that population to only those with the most serious mental illnesses, like schizophrenia or bipolar disorder, who do not receive treatment, and it appears to be a different story. A widely cited 2005 study based on NIMH data found a violent-crime rate of 8.3% among those with a “major mental disorder,” compared with 2.1% among those without disorders. A 2008 peer-reviewed analysis that surveyed 31 academic studies found that 12% to 22% of inpatients and outpatients with serious mental illnesses “had perpetrated violence in the past six to 18 months.”

Only 3% to 5% of violent crimes in the U.S. can be attributed to mental illness, according to Duke medical sociologist Jeffrey Swanson. But such tragedies—like Cukor’s death or the 2007 Virginia Tech shooting, in which a student with a mental illness killed 33 people—tend to have a disproportionate impact. They earn headlines, anger the public and motivate politicians to action in a way that the mundane suffering of the homeless or convicted criminals does not.

Course Correction

These complex legal and ethical questions have shaken up the politics of the issue. Many liberals who once opposed any form of involuntary treatment on civil rights grounds now find the alternative—mass homelessness, incarceration and victimization—to be morally repugnant. They are joined by fiscal conservatives, who once decried the cost of government-run state institutions but now find it’s even costlier to provide for large populations of inmates with mental illnesses.

Law-enforcement officials and prison guards, who in many cities have the most interaction with the seriously mentally ill, have joined the fray as well. “Officers spend so much of their time responding to the same five or 10 people in a community who are seriously mentally ill,” says former police chief Biasotti. “It’s hard to put a dollar amount on that, but it’s significant.”

Opponents of involuntary-commitment laws are an equally mixed bag, politically. Traditional liberal organizations like the National Disability Rights Network strongly object to any encroachment on the rights of an individual patient. “It’s a slippery slope” back to institutionalization, says Daniel Fisher, a psychiatrist and the founder of the National Coalition for Mental Health Recovery.

These groups often find themselves on the same page as conservatives, including libertarians and officials from the gun lobby, who are concerned about government intrusions on individual rights. The National Rifle Association, for example, opposes the recent California law giving law-enforcement officials the power to temporarily confiscate a person’s firearm if he has been deemed potentially dangerous.

But regardless of strange political bedfellows, the question of reforming the mental-health system ultimately comes down to limited money and conflicting priorities. From 2008 to 2013, more than $4.4 billion was slashed from state mental-health administrators’ budgets, according to the National Association of State Mental Health Program Directors. Roughly three-fourths of the remaining funds have gone to community-based voluntary treatment and prevention programs. Robert Bernstein, a psychologist at the Bazelon Center for Mental Health Law in Washington, D.C., says that’s “nowhere near enough” to reach those with the most serious mental illnesses.

Others argue that voluntary treatment programs, no matter how well funded, will never reach those with the most serious illnesses for the simple reason that the sickest of the sick—those suffering from psychosis and delusions—often don’t realize they need help. “It doesn’t make sense to treat people with serious psychiatric illnesses as if they are autonomous operators making fully informed decisions,” says Fishman, the Maryland psychiatrist.

The problem underscores a tension in the field of brain science. As it is, the medical community categorizes psychiatric disorders under the umbrella of “behavioral” illnesses rather than physical ones, a distinction that often limits health care providers’ ability to treat patients without their consent, explains Mary Palaflox, a California nurse whose son suffers from schizophrenia. “If someone comes in disoriented...
or confused from a physical brain injury or with a disease like Alzheimer’s or autism, you’re required by law to treat them,” she says. “But if they’re disoriented and confused because of a behavioral illness, you can’t treat them without their permission. It’s an arbitrary distinction.”

Treatment as a Civil Right?
Fifteen years ago, Laura Wilcox, a 19-year-old high school valedictorian who was home from college on summer vacation, was killed in Nevada County, California, by a man with untreated schizophrenia. Three years later, California passed what became known as Laura's Law, giving judges the power to order a person with a serious mental illness into treatment. Similar laws are now on the books in 45 states, each named after a victim killed by someone with an untreated serious mental illness. There's Kendra's Law in New York, Gregory's Law in New Jersey and Nicola's Law in Louisiana, to name just a few.

While the details of those laws vary, most are similar in the broad strokes: in order for a judge to order an adult with a serious mental illness into what is known as assisted outpatient treatment (AOT), the person must have been recently and repeatedly hospitalized or arrested as a result of his illness, or committed or threatened a serious act of violence on himself or others. Under AOT, a patient can’t be forced to take medication; if he refuses treatment, a team of health care workers tasked with providing what’s known as wraparound care must simply monitor him to ensure that he remains stable.

In other words, AOT stops significantly short of reinstitutionalization. And yet, while most states have had AOT laws on the books for years, very few, with the exception of New York, have funded it at the local level. AOT is expensive; it typically requires states and counties to hire a team of health care professionals and invest in new inpatient infrastructure, most of which has been torn down or repurposed since the ’60s. In 1955, there was one psychiatric bed for every 300 Americans; in 2005, there was one for every 3,000, and there are even fewer today. While a handful of state and local studies suggest that AOT could end up saving taxpayers money in the long run by limiting the number of arrests and ER visits and reducing the number of homeless and incarcerated, that’s a tough sell when state and local coffers remain strapped.

The other reason AOT laws have not been implemented is that they remain wildly controversial. Many patient-advocacy organizations lobby against funding AOT laws by using powerful images depicting the abuse of patients in state hospitals in the 1950s in an effort, as one activist put it, “to remind politicians and citizens what’s at stake.” Debbie Plotnik, a senior director of state policy at Mental Health America, argues that AOT laws are unnecessary. Other programs like mental-health courts, which allow people with a mental illness to choose inpatient care over prison, offer more effective alternatives, she says.

Meanwhile, advocates for AOT, led by organizations like the Treatment Advocacy Center, say public support has grown in recent years, fueled by anger over acts of violence like Cukor’s death or mass shootings. This past summer, San Francisco, Orange and Los Angeles counties all voted to fund Laura’s Law. Both the DeWitt and Cukor families have called on Alameda County to follow suit.

Last year, Republican Congressman Tim Murphy of Pennsylvania, who keeps on his desk photographs of the children killed in Newtown, proposed a bill that would direct federal funding to state AOT programs. The bill received 90 bipartisan co-sponsors but never reached a vote. He plans to repropose it this year.

Candy DeWitt, a big supporter of Murphy’s bill, says it can’t pass soon enough. There are other young men just like Daniel out there right now, she says. “Do we wait until they do something terrible before we get them help?”
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