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SHOOTER EPIDEMIC?**

Buffkin, Kimberly L.

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**NAVAL
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MONTEREY, CALIFORNIA

THESIS

**THE MISSING LINK: HOW DO GAPS IN MENTAL
HEALTHCARE CONTRIBUTE TO THE ACTIVE
SHOOTER EPIDEMIC?**

by

Kimberly L. Buffkin

December 2019

Co-Advisors:

Robert L. Simeral
David W. Brannan (contractor)

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**THE MISSING LINK: HOW DO GAPS IN MENTAL HEALTHCARE
CONTRIBUTE TO THE ACTIVE SHOOTER EPIDEMIC?**

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Submitted in partial fulfillment of the
requirements for the degree of

**MASTER OF ARTS IN SECURITY STUDIES
(HOMELAND SECURITY AND DEFENSE)**

from the

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ABSTRACT

Active shooter incidents at schools have highlighted the prevalence of mental illness in our society. Although the United States has historically struggled with its mental health policy, continuous efforts have been made to improve the system. During the 1960s, asylums were overcrowded and public outcry for humane treatment of the mentally ill pressured the government for change. To give patients a more normal life, the idea of community mental health centers emerged. Deinstitutionalization happened quickly across the country. The intent of the plan was to provide a more community-based approach to mental health. Unfortunately, the implementation of the plan was fractured. Over the past 50 years, with each iteration to the mental health system, many of those patients have found themselves in jail, in prisons, and homeless.

This thesis explores a counterfactual analysis through an in-depth case study of Adam Lanza's life and navigation through the mental health system. Throughout his life, opportunities existed for intervention and treatment. Gaps in his mental health treatment allowed Adam to spiral into a deep state of mental illness in which he was debilitated by his obsessive-compulsive disorder and anxiety. The analysis suggests that the community-based approach to mental health could have provided early intervention that might have changed the outcome for Adam Lanza and the 26 lives he took at Sandy Hook Elementary on December 14, 2012.

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LIST OF ACRONYMS AND ABBREVIATIONS

ASD	Autism Spectrum Disorder
AHMAC	Australian Health Ministers' Advisory Council
AIHW	Australian Institute of Health and Welfare
AL	Adam Lanza
AOT	Assisted Outpatient Treatment
BCSO	Brazos County Sheriff's Office
CCATS	Center for Child and Adolescent Treatment Services
CMHC	Community Mental Health Center
EAP	employee assistance program
IEP	individual education plan or individualized education program
LPS	Lanterman-Petris-Short Act of 1967
MHISSC	Mental Health Information Strategy Standing Committee
MHPC	Mental Health Principal Committee
MHSA	Mental Health Services in Australia
NHS	Newtown High School
NIMH	National Institute of Mental Health
NMHPSC	National Mental Health Performance Subcommittee
NMHS	National Mental Health Strategy
NMS	Newtown Middle School
NOCC	National Outcomes and Casemix Collection
OCD	Obsessive Compulsive Disorder
PDD	Pervasive Developmental Disorder
PTSD	Post-traumatic Stress Disorder
R-FACT	Rochester Forensic Assertive Community Treatment
SHES	Sandy Hook Elementary School
SSI	Supplemental Security Income

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EXECUTIVE SUMMARY

This thesis examines some of the challenges facing the U.S. mental health system. Through a case study of one of the deadliest mass shootings in U.S. history, the Sandy Hook Elementary School shooting, a counterfactual analysis is performed to discover how the outcome may have differed under a system that prioritizes mental health. Through comprehensive care, mental illness can be treated, preventing the person from deteriorating into a more severe illness, such as psychosis. The thesis recommends a commitment to reforming the country's mental healthcare system.

Active shooter incidents committed by those with known mental illnesses have brought about long overdue interest in the U.S. mental health system. After-action reports try to explain how these gunmen, despite their illnesses, have remained untreated. In the 1800s, Dorothea Dix was one of the first pioneers for mental health.¹ Her commitment to creating a better system and advocacy for our mentally ill population changed lives.² In the early to mid-1900s, mental institutions became asylums where patients were subject to poor living conditions; abandonment exacerbated the state of their mental health.³ During the 1960s, President John F. Kennedy led changes to improve care for the mentally ill.⁴

The need to improve the lives of the mentally ill led U.S. states to close institutions, and the responsibility for the mentally ill shifted from the states to the federal government.⁵ The government developed a new plan for community-based care to serve the mentally ill that would allow them to assimilate into the community in hopes of improved quality of

¹ "Dorothea Lynde Dix," History.com, August 21, 2018, <https://www.history.com/topics/womens-history/dorothea-lynde-dix>.

² History.com.

³ Norman Siegel, "Homelessness: Its Origins, Civil Liberties Problems and Possible Solutions," *Villanova Law Review* 36 (1991): 1063–84, <http://digitalcommons.law.villanova.edu/vlr/vol36/iss5/3>. 1065

⁴ Mental Retardation Facilities and Community Health Centers Construction Act of 1963, 88th Cong., 1st Sess., S. Rpt. 180, May 21, 1963.

⁵ Richard Warner, "Deinstitutionalization: How Did We Get Where We Are?" *Journal of Social Issues* 45, no. 3 (1989): 17–30, <http://libproxy.nps.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=sih&AN=16407571&site=ehost-live&scope=site>.

life.⁶ Due to implementation challenges and legislative decisions, however, these community-based efforts never materialized.⁷ Overall lack of support, continual budget cuts, and absent lines of communication between stakeholders left patients to fend for themselves when making mental health decisions.⁸ Hospitals did not want to lose their funding and jobs to community centers once they discharged patients, and community centers were not briefed on the discharged patients they were supposed to serve.⁹ The lack of communication between caregivers created a gap in treatment. Transfer of care is an essential step in ensuring patients receive follow-up treatment. As a result, mental health problems in the United States are now eerily similar to those described by Dorothea Dix in the 1800s—people with mental health conditions are roaming the streets and being incarcerated.¹⁰ Iterative policy changes have not provided the full-scale mental health system reform the country needs to improve the lives of our mentally ill population.

If the mental health system in the United States makes patient outcomes and evaluation a priority, treatment will be available and encouraged. Mental health programs around the world are addressing the need for such care, in both minor and severe cases. Treating a minor mental illness is critical to overall health; left untreated, it may escalate to more severe conditions. Although there have been attempts over the last sixty years to address the mystery of mental health care in the United States, the country needs a focused, funded commitment to fill the voids in the system. This is needed now, before more untreated patients spiral into psychotic darkness. Cooperation from legislators, providers, and consumers together can lead the necessary change.

⁶ Warner.

⁷ Mental Retardation Facilities and Community Health Centers Construction Act of 1963.

⁸ E. Fuller Torrey, *American Psychosis: How the Federal Government Destroyed the Mental Illness Treatment System* (Oxford: Oxford University Press, 2014).

⁹ Torrey.

¹⁰ Warner, “Deinstitutionalization.”

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Any fool can know. The point is to understand.

—Albert Einstein

Writing this thesis has been one of the most difficult yet rewarding academic endeavors. What an amazing experience that will manifest itself through my role in the homeland security enterprise! To the Center for Homeland Defense and Security faculty and staff, thank you for taking me from knowing to understanding.

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I. INTRODUCTION

A. PROBLEM STATEMENT

Active shooter incidents in the United States have increased in both frequency and severity; some report it has become an epidemic. At the time of this writing, the upscale community of Parkland, Florida, is still recovering from the most recent school shooting. On February 14, 2018, Marjory Stoneman Douglas High School lost 17 students and staff members when a shooter opened fire after pulling a fire alarm to ensure that the hallways were full of people. The shooter had struggled with mental illness, a disease that has factored into other campus shooting events, as well. The two teenagers who took 13 lives at Columbine High School in 1999 suffered from mental illness. The shooter at Virginia Tech in 2007, where a devastating 32 lives were lost, had a history of mental illness. The gunman from Newtown, Connecticut, who opened fire at the Sandy Hook Elementary School killing 20 first graders and six adults in 2012, also had a history of mental illness. Aside from school shootings, mental illness has also played a role in active shooter events in malls, churches, and at recreational venues.

In 2015, the Healthcare and Public Health Sector Coordinating Council listed several common behaviors found among active shooters, including personal grievances, a recent family tragedy, loss or disruption, and no history of previous violent acts.¹ Those with mental illness who commit violent crimes usually have no history of criminal or violent behavior.² Firsthand accounts from friends, family, and acquaintances of the shooters discussed in this thesis show that they alerted authorities of suspicious behavior. In Newtown, the Brooks family alerted authorities several times with concerns about one of the Columbine shooters.³ Several professors were concerned enough about the Virginia Tech gunman that they voiced their concerns to campus authorities, including mental health

¹ Healthcare and Public Health Sector Coordinating Council, *Active Shooter Planning and Response in a Healthcare Setting* (Washington, DC: FBI, April 2015), <https://www.hsdl.org/?view&did=767515>.

² John Monahan, "Mental Disorder and Violent Behavior," *American Psychologist* 47, no. 4 (1992): 511–21, <http://psycnet.apa.org/doi/10.1037/0003-066X.47.4.511>.

³ David Cullen, *Columbine* (New York: Twelve, 2009).

experts.⁴ The Sandy Hook gunman had not only his mother reaching out for help for him but other school associates as well.⁵ Unfortunately, laws, regulations, and policies limit what and how schools can respond, how law enforcement can intervene, and even what the medical community can provide. An analysis of the three cases in this thesis may answer some of these questions.

B. RESEARCH QUESTION

Do gaps in the treatment of mentally ill patients suffering from mild disorders that then progress to more severe conditions without intervention or treatment contribute to the active shooter epidemic?

C. LITERATURE REVIEW

Lawmakers and mental health providers are challenged to resolve involuntary treatment protocols for the mentally ill while preserving civil liberties. The complex nature of mental illness, its diagnosis and treatment options as well as the social stigma all contribute to the problem of managing mentally ill patients. Mental illness has a long history of advocates that have worked toward advancing the study of and treatment options for psychiatric-related illness. Activist Dorothea Dix advocated for asylums in place of jails for the mentally ill.⁶ Hungarian-American academic, psychiatrist, and psychoanalyst Thomas Szasz argued for civil liberties and community care, and psychiatrist Dr. E. Fuller Torrey suggests evidence-based research should lead the decision making.⁷

The history of managing mental illness begins with Dorothea Dix (1802–1887), an advocate for mental health from the 1800s. She traveled the United States working toward building hospitals and refuge for the mentally ill where they could be cared for rather than

⁴ Lucinda Roy, *No Right to Remain Silent* (New York: Three Rivers Press, 2009).

⁵ Matthew Lysiak, *Newtown: An American Tragedy* (New York: Gallery Books, 2013).

⁶ “Dorothea Lynde Dix,” History.com, August 21, 2018, <https://www.history.com/topics/womens-history/dorothea-lynde-dix>.

⁷ Michael Schwartz and Osborne P. Wiggins, “Psychiatry Fraud and Force? A Commentary on E. Fuller Torrey and Thomas Szasz,” *Journal of Humanistic Psychology* 45 (January 6, 2005): 403–15, <https://doi.org/10.1177/0022167805277267>.

on the streets or incarcerated.⁸ Over the next 100 years, asylums were created by states but then were closed.⁹ In the early to mid-1900s, Thomas Szasz denied mental illness existed and believed patients could be treated on an outpatient basis. He stood on the side of civil liberties, considering the social stigma attached to mental illness, and believed medicating patients in addition to treating them against their will was unconstitutional.¹⁰ Conversely, Dr. Torrey believes that through medication and sometimes necessary involuntary treatment, mental health patients can live a more quality life. He explored evidence-based research to understand mental illness and has dedicated his life to studying and supporting brain tissue research.¹¹

Deinstitutionalization of mental health facilities occurred in the 1960s after discovery of egregious living conditions for mental patients and involuntary treatment and institutionalization.¹² The process called for the closing of mental health institutions and placement of patients into the community.¹³ The desired outcome would redirect patients from the institutional setting to an environment more conducive to independent living, therefore, receiving care from health centers and assimilating into society. A reallocation of mental health funding from the states to the federal government was budgeted to provide resources for the mentally ill.¹⁴ While well intentioned, the policy change was never implemented.¹⁵

⁸ History.com, “Dorothea Lynde Dix.”

⁹ Richard Warner, “Deinstitutionalization: How Did We Get Where We Are?” *Journal of Social Issues* 45, no. 3 (1989): 17–30, <http://libproxy.nps.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=sih&AN=16407571&site=ehost-live&scope=site>.

¹⁰ Thomas S. Szasz, “Civil Liberties and the Mentally Ill,” *Cleveland State Law Review* 9, no. 3 (1960): 399–416, <http://engagedscholarship.csuohio.edu/clevstlrev/vol9/iss3/2>

¹¹ Michael Winerip, “Schizophrenia’s Most Zealous Foe,” *New York Times*, February 22, 1998, <https://www.nytimes.com/1998/02/22/magazine/schizophrenia-s-most-zealous-foe.html>.

¹² Warner, “Deinstitutionalization.”

¹³ Warner.

¹⁴ H. Richard Lamb, “Deinstitutionalization and the Homeless Mentally Ill,” *Hospital and Community Psychiatry* 35, no. 9 (September 1984): 899–908, <https://doi.org/10.1176/ps.35.9.899>.

¹⁵ Caroline Knowles and C. Knowles, *Bedlam on the Streets* (New York: Routledge, 2014).

A growing concern emerged for effective mental health care. The notion of antipsychiatry began to surface, which is the idea that mental illness does not exist and patients can be treated through outpatient services.¹⁶ In some state institutions, patients were found living in poor conditions, with intermittent access to care. In response to the growing number of people incarcerated, jails dedicated entire floors to psychiatric patients. In addition, an unwillingness of providers to deliver care at community centers limited availability of services.¹⁷ Today, the same concerns exist for the mentally ill, but on the heels of devastating incidents and mass killings.

Imposing treatment on a mentally ill patient who under normal circumstances makes independent decisions is a challenge for providers.¹⁸ Clinicians must assume that the person would seek treatment in an otherwise lucid, alert state. In emergency situations, providers follow the law and wait until the patient has become a danger to oneself or others before imposing involuntary treatment.¹⁹ In other cases, the path to determine mental capacity can be time-consuming to the extent that the provider has to determine how in depth of an assessment to do.²⁰ The apprehension of providers to impose treatment comes as an unintended consequence of several significant neglect cases. For example, in some circumstances, severely mentally ill patients were found lying on the floors of mental health facilities in their feces.²¹ Incidents like these caused public outrage, and as a result, civil rights attorneys representing neglected patients paved the way for mental health rights.²²

¹⁶ Roger Peele, "Homeless in America; Out of Bedlam: The Truth about Deinstitutionalization; Madness in the Streets: How Psychiatry Abandoned the Mentally Ill," *American Journal of Psychiatry* 149, no. 1 (January 1992): 129, <https://doi.org/10.1176/ajp.149.1.129>.

¹⁷ Warner, "Deinstitutionalization."

¹⁸ Jillian Weinberger, "Courts Are Using the Powerful 'Black Robe Effect' to Treat Severe Mental Illness. Should They?" *Vox*, November 27, 2017, <https://www.vox.com/policy-and-politics/2017/11/27/16689142/courts-mental-illness-assisted-outpatient-treatment>.

¹⁹ Mike Biasotti, "Management of the Severely Mentally Ill and its Effects on Homeland Security" (master's thesis, Naval Postgraduate School, 2011).

²⁰ Lisa Rosenbaum, "Closing the Mortality Gap: Mental Illness and Medical Care," *New England Journal of Medicine* 375, no. 16 (October 20, 2016): 1585–89, <https://doi.org/10.1056/NEJMms1610125>.

²¹ Szasz, "Civil Liberties and the Mentally Ill."

²² Peele, "Homeless in America."

From the days of deinstitutionalization, the law enforcement community has been forced to handle a significant portion of the mentally ill with little training.²³ The literature suggests that a significant part of law enforcement officer's time is spent mollifying patients with mental illness.²⁴ Data collected by Mike Biasotti shows law enforcement personnel regularly spend hours dealing with the mentally ill and, with little training, making decisions on care.²⁵ His research utilized surveys completed by law enforcement agencies reporting their interactions with the mentally ill. He found that law enforcement personnel face challenges dealing with mentally ill patients. Unfortunately, many times the patients are sent to jail based on the officers' assessment that they may receive treatment or based on their judgment of the situation at the time.²⁶ Biasotti's research indicates that when law enforcement locates mental health facilities and can transport a patient there, the exchange may take several hours.²⁷ Facilities are not nearby, some are private, and the transfer of a patient is less than favorably met by uncooperative staff members.²⁸ Literature suggests continued coordination is needed from both law enforcement and mental health providers to handle mental health patients effectively.²⁹

Another unintended consequence of deinstitutionalization exists in prisons and jails. According to a 1997 study, as many as 16 percent of inmates in jails and prisons have mental illness.³⁰ For many patients, treating their mental illness could prevent a criminal act from occurring; instead, these patients without treatment end up in situations in which they have broken the law, ultimately serving time in jail as criminals.³¹ In turn, patients in

²³ H. Richard Lamb, Linda E. Weinberger, and Walter J. DeCuir, "The Police and Mental Health," *Psychiatric Services* 53, no. 10 (October 1, 2002): 1266–71, <https://doi.org/10.1176/appi.ps.53.10.1266>.

²⁴ Biasotti, "Management of the Severely Mentally Ill."

²⁵ Biasotti.

²⁶ Lamb, Weinberger, and DeCuir, "The Police and Mental Health."

²⁷ Biasotti, "Management of the Severely Mentally Ill."

²⁸ Biasotti.

²⁹ Lamb, Weinberger, and DeCuir, "The Police and Mental Health."

³⁰ Sasha Abramsky and Jamie Fellner, *Ill-Equipped: U.S. Prisons and Offenders with Mental Illness* (New York: Human Rights Watch, 2003).

³¹ Abramsky and Fellner.

need of actual mental health treatment are living in an environment detrimental to their condition. As described by Abramsky and Fellner, patients in cells beat their heads against walls, smear feces around the cell, and commit suicide.³² Officers are expected to mitigate psychiatric outbursts from inmates with minimal training.³³ In one case, corrections officers accidentally asphyxiated inmates while trying to restrain them.³⁴ These are less than favorable conditions both for those suffering from mental illness and for the corrections officers. Mental health treatment plans are not clearly defined or followed, once an inmate is released back into the public, resulting in recidivism and homelessness.³⁵ It can be argued that early intervention could help prevent a mentally ill patient from entering the prison or court system.

Civil liberties are also a topic passionately debated in the literature. Thomas Szasz argues that patients have the right to remain ill until they request medical attention.³⁶ Potentially, this can allow severely mentally ill patients to deteriorate until they develop psychotic episodes. *Anosognosia* is the term for patients who have mental illness but deny their condition.³⁷ Dr. E. Fuller Torrey argues that severely mentally ill patients do not have the mental capacity to recognize the need for help.³⁸ Dr. Lisa Rosenbaum, a national correspondent for the *New England Journal of Medicine (NEJM)* wrote part one of a three-part series on various topics surrounding mental health such as involuntary treatment, homelessness and civil liberties. In the *NEJM* article, Rosenbaum documents the experience of Jim O’Connell, cofounder of Boston Healthcare for the Homeless program is documented. The author discusses two very different experiences Jim had with patients

³² Abramsky and Fellner.

³³ Lamb, Weinberger, and DeCuir, “The Police and Mental Health.”

³⁴ Abramsky and Fellner, *Ill-Equipped*.

³⁵ Abramsky and Fellner.

³⁶ Szasz, “Civil Liberties and the Mentally Ill.”

³⁷ Lisa Rosenbaum, “Liberty versus Need: Our Struggle to Care for People with Serious Mental Illness,” *New England Journal of Medicine* 375 no. 15 (October 12, 2016): 1490–95, <https://doi.org/10.1056/NEJMms1610124>.

³⁸ “Serious Mental Illness and Anosognosia,” Treatment Advocacy Center, June 2016, <http://www.treatmentadvocacycenter.org/evidence-and-research/learn-more-about/3628-serious-mental-illness-and-anosognosia>.

who suffered from severe mental illness. One of his patients lived under a bridge throughout the bitter cold of winter and preferred that life to outpatient treatment because as a schizophrenic, he knew the voices he heard were his own, as opposed to the multiple voices he would hear if living in a facility.³⁹ The second patient suffered from anosognosia and lived on a cement stoop for several years, refusing food and clothing and becoming combative when anyone approached her.⁴⁰ This patient finally deteriorated to a point where she could not refuse treatment and was taken to a hospital.⁴¹ Three years later, Jim ran into her.⁴² She was a board member of a nonprofit organization, transformed from her days of living on the street.⁴³ She was openly angry with Jim for being left in her condition for years.⁴⁴ Examples like these show the challenges mental health providers regularly encounter when decisions are made weighing forced treatment against civil liberties. The reading explains that Jim struggled with deciding when to impose treatment in these situations. Many mental health providers face this same dilemma of knowing when to intervene. Because of the varying levels of illness and specific needs of each patient, it is difficult to make generalizations about when to impose treatment. In addition, when each patient has specific needs, moral and ethical issues arise about how and when to decide for a patient what an improved quality of life is.⁴⁵

Debates in favor of civil liberties strengthened after cases such as *Boggs v. Health & Hosps. Corp.* from 1987.⁴⁶ In this case, Joyce Brown, who went by Billie Boggs, was a homeless person wrongfully diagnosed with a mental illness and placed in Bellevue

³⁹ Rosenbaum, "Liberty versus Need."

⁴⁰ Rosenbaum, 1490.

⁴¹ Rosenbaum, 1490.

⁴² Rosenbaum, 1490.

⁴³ Rosenbaum, 1490.

⁴⁴ Rosenbaum, 1490.

⁴⁵ Allen Frances and Mark L. Ruffalo, "Mental Illness, Civil Liberty, and Common Sense," *Psychiatric Times*, May 3, 2018, <http://www.psychiatrictimes.com/couch-crisis/mental-illness-civil-liberty-and-common-sense>.

⁴⁶ Norman Siegel, "Homelessness: Its Origins, Civil Liberties Problems and Possible Solutions," *Villanova Law Review* 36, no. 5 (1991): 23, <http://digitalcommons.law.villanova.edu/vlr/vol36/iss5/3>.

Hospital's psychiatric ward.⁴⁷ The judge cited the previous case of *Rivers v. Katz*, and deemed Joyce Brown able to make decisions for herself despite the conditions in which she chose to live.⁴⁸ In 1989, the New York Civil Liberties Union (NYCLU) opposed New York City's attempts to remove the homeless population from the streets by moving people who were sleeping at night into a shelter.⁴⁹ This compounded the concerns from the civil liberties viewpoint because removing sleeping people who were not causing harm to anyone was a violation of constitutional rights.⁵⁰ The options provided were transporting to them a hospital or other shelter with no long-term plans for independence or transitioning out of a life on the streets.⁵¹ For the NYCLU, this was reminiscent of the 1960s when mental health patients were not getting the care they needed.

The history of the United States mental health care system justifies the apprehension to commit patients or impose treatment is justified. Asylums were overcrowded and understaffed. The stigma of mental illness could cause the loss of a job and even loss of housing.⁵² When New York tried to remove people from the streets and randomly diagnose homeless people with mental health issues that weren't medically confirmed, progress slowed for a real solution.

Current literature suggests that imposing involuntary medical treatment is risky. A declining number of providers in the mental health field prevents proper triage assessments, as happened at Virginia Tech in the months before that shooting in April 2007.⁵³ Many counselors have high caseloads, work long hours, and are unable to conduct thorough assessments.⁵⁴ In places such as Texas, there is limited access to psychiatrists. In some of

⁴⁷ Siegel.

⁴⁸ Siegel.

⁴⁹ Siegel.

⁵⁰ Siegel.

⁵¹ Siegel.

⁵² Siegel.

⁵³ Roy, *No Right to Remain Silent*.

⁵⁴ Roy.

the more rural areas, there is only one psychiatrist per 30,000 people.⁵⁵ In Brazos County, Texas, four deputies serve as mental health providers. Their primary responsibilities are managing mental health patients.⁵⁶ Data exist documenting situations in which mentally ill patients are incarcerated, homeless, and receive no treatment for long periods of time.

An American Civil Liberties Union (ACLU) position paper describes the following as benefits to the mentally ill:

- the right not to be confined unless they constitute a danger to themselves or others;
- the right to a court hearing to contest an involuntary commitment;
- the right to a lawyer during commitment hearings;
- the right to refuse medication;
- the right to “minimally adequate” treatment and training;
- the right to safe and secure conditions, including food, shelter, clothing and medical care.⁵⁷

Much of today’s literature on this topic lends itself to a description of a broken system.⁵⁸ Articles describe losses to families who have advocated in favor of treatment of their loved ones, only to watch them steadily decline, ending in early death.⁵⁹ The literature suggests that infringing on civil rights is not the desired outcome; however, the increased

⁵⁵ Whitney Miller, “Local Law Enforcement Agencies Experience Increase in Mental Health Calls,” KBTX-TV3, February 5, 2018, <http://www.kbtx.com/content/news/Local-law-enforcement-agencies-experience-increase-in-mental-health-calls-472859983.html>.

⁵⁶ Jessica Gruenling, “Crisis Intervention Team Helps Mental Health Patients Get Treatment, Not Just Jail,” KBTX, May 22, 2017, <http://www.kbtx.com/content/news/Brazos-County-Sheriffs-office--423760324.html>.

⁵⁷ American Civil Liberties Union, “Disability Rights” (position/briefing paper, ACLU, Winter 1999), <https://www.aclu.org/other/disability-rights-aclu-positionbriefing-paper>.

⁵⁸ Frances and Ruffalo, “Mental Illness, Civil Liberty, and Common Sense.”

⁵⁹ Richard Harris, “Mental Health and Civil Liberties: Unwell and Untouchable,” *StarTribune*, June 24, 2016, <http://www.startribune.com/mental-health-and-civil-liberties-unwell-and-untouchable/384332551/>.

limitations placed on involuntary confinement lead to homelessness, incarceration, and many untreated mentally ill persons.⁶⁰ Generalizations can be made that the laws and efforts to protect the civil rights of the mentally ill are well-intended and uncontested. However, today (2018) there are 300,000 mentally ill patients in jail and 250,000 homeless.⁶¹

One other critical piece of the discussion on mental health care is the lack of funding to provide the appropriate treatment centers. A recurring theme appears in much of the literature regarding financial support for community-based treatment facilities that were part of a planned resolution; however, they were never built and established. Subsequently, the funding was reallocated to various other areas outside of health care. Statistics are quoted outlining the decrease in available psychiatric beds by as much as 70 percent in some states.⁶² After deinstitutionalization, the budgets that previously funded mental institutions were supposed to be released to local authorities for development of a community-based mental health model. This larger plan was designed to allow community care to evolve, providing a more humane, socialized environment where mentally ill patients could live a normal life outside an institution. Without the funding, these resources cannot be pursued or utilized. As a result, the mental health system continues to see a rise in patients and needs with few resources to provide quality care.⁶³

D. RESEARCH DESIGN

The goal of this thesis is to determine if gaps in mental health care contribute to the ongoing active shooter epidemic. This research is focused on the analysis of circumstances involving a school shooting incident. Through research and discussion, policy recommendations may be necessary to invoke change for the U.S. mental health patient

⁶⁰ Meredith Karasch, "Where Involuntary Commitment, Civil Liberties, and the Right to Mental Health Care Collide: An Overview of California's Mental Illness System," *Hastings Law Journal* 54, no. 2 (January 2003): 493–523.

⁶¹ Frances and Ruffalo, "Mental Illness, Civil Liberty, and Common Sense."

⁶² Marjorie L. Baldwin, "Homeless, Mentally Ill, and Neglected," *Psychology Today*, August 27, 2016, <https://www.psychologytoday.com/us/blog/beyond-schizophrenia/201608/homeless-mentally-ill-and-neglected>.

⁶³ Frances and Ruffalo, "Mental Illness, Civil Liberty, and Common Sense."

population that is most in need. Analysis of the data may show that earlier interventions could prevent violent tendencies, including active shooter incidents in schools, ultimately affecting our homeland security.

This research involves studying the mental health treatment of patients using information gathered from several active shooter incidents. A case study method will be utilized examining the Sandy Hook Elementary shooting and the history of the shooter to determine if gaps exist in the treatment of the mentally ill. Gaps are suspected to exist between the time a patient deals with mild mental illness such as depression or experiences a traumatic event and the time the patient progresses to severely mental suffering from violent tendencies and psychotic episodes.

The case studies will be the shootings at Columbine High School, Sandy Hook Elementary School, and Virginia Tech. These were selected based on the history of the shooters having some form of mild mental illness. In addition, the mental health industry has struggled with funding cuts over the past several decades, and it is essential to determine how these cuts limit the ability to provide treatment. Mental health providers are interested in documentation that could result in financial support for their patient population and in improved regulations to allow for additional treatment options.

The limitations of this study have to do with the information already known about the shooters in the four events. The following topics are related but not central to this research:

- The underutilization of group homes
- The assimilation of mentally ill patients into society, forcing patients to conform to society when it may not be the best option for the patient or for citizens
- The effect of regulations on treatment and if there are unintended consequences of patient confidentiality rules
- Additional research on homeland security program successes such as “see something, say something”

The sources of the research will be scholarly literature on each event, active shooters, data on all shooting events, reports, and articles on all related topics. Existing literature will provide background information on studies done thus far.

This type of study utilizes the case study method. The steps of this data analysis will be preparing, distributing, collecting, and compiling the data into useful statistics.

The final thesis product will be a better definition of mental illness and how it progresses, an idea of the daily struggles of caring for a severely mentally ill patient, and the implications for homeland security. In addition, policy or legislative change recommendations may be presented. A reader will be able to apply this information to effect substantive changes in the care and treatment of mentally ill patients. Awareness of mental health illness and acceptance of its existence without discrimination and the stigma that goes along with admitting a mental health diagnosis is essential for progress in mental health care. Advancements in treatment and policy changes could be useful for any victims of active shooter incidents to better understand the effects and implications of mental illness. The research can also prove beneficial for the general public in understanding the need for persistent notification—for example, “see something, say something” to authorities when suspicious behavior is observed.

E. CHAPTER OUTLINE

- I. Introduction
- II. Community Mental Health Centers: The Promise and Evolution Over Time
- III. Complications Surrounding the Mental Health Crisis
- IV. International Perspective: Australia’s Mental Health System
- V. Case Study of the Shooter at Sandy Hook
- VI. Impact Evaluation of the Community Mental Health System: A Counterfactual Analysis
- VII. Conclusion and Recommendations

II. COMMUNITY MENTAL HEALTH CENTERS: THE PROMISE AND EVOLUTION OVER TIME

A. INTRODUCTION

Community Mental Health Centers (CMHCs) have been a focus of mental health care since the 1960s. Since deinstitutionalization began—that is, discharging mental patients into the community—the CMHC model has evolved from a desire to serve the mentally ill to a comprehensive community health resource. When President Reagan was elected, he cut funding and the commitment to mental health.⁶⁴ This shift in resources for the mentally ill from state to federal to local agencies over time has left the mentally ill population in need.⁶⁵ Some argue that the target group of mentally ill, the severely mentally ill who were originally envisioned for these centers, are not being served.⁶⁶ Instead, CMHCs provided many other services—for example, addressing local needs for marriage counseling or those struggling financially. The CMHC model has been redesigned time and time again by politicians with a special interest and new legislation. Although making progress, the system fell short in providing services to the most severely mentally ill. The problem has progressed over the past 40 years through legislative changes, oversight inconsistencies, and a lack of accountability.⁶⁷ This chapter describes the chronological evolution of the CMHC since 1963, the year the Community Mental Health Act became law.

⁶⁴ E. Fuller Torrey, *American Psychosis: How the Federal Government Destroyed the Mental Illness Treatment System* (Oxford: Oxford University Press, 2014).

⁶⁵ Roger Peele, “Homeless in America; Out of Bedlam: The Truth about Deinstitutionalization; Madness in the Streets: How Psychiatry Abandoned the Mentally Ill,” *American Journal of Psychiatry* 149, no. 1 (January 1992), 129, <https://doi.org/10.1176/ajp.149.1.129>.

⁶⁶ Torrey, *American Psychosis*.

⁶⁷ Peele, “Homeless in America.”

1. Mental Retardation and Community Mental Health Centers Construction Act

President John F. Kennedy watched his sister, Rosemary, progress into a severe mental health disorder. After a failed lobotomy, Rosemary was institutionalized, her condition requiring long-term care. As she deteriorated, his interest in caring for the mentally ill became a priority. In early 1963, he addressed Congress to raise awareness of the need for a reformed mental health care system.⁶⁸ The Mental Retardation and Community Mental Health Centers Construction Act of 1963 was the law that changed how mental health care is delivered.⁶⁹

In 1961, a 27-member panel appointed by the president produced a report titled *A Proposed Program for National Action to Combat Mental Retardation*.⁷⁰ The report resulted from a yearlong study, documenting the then-current conditions of the mental health system. Based on this information as well as on input from the American Medical Association and other patient advocacy groups, President Kennedy proposed a plan of action. The Mental Retardation and Community Mental Health Centers Construction Act of 1963 outlined a basic history of the mental health system but, more important, the needs of the patient population.⁷¹ The report exposed costs of the mental health system, treatment of patients, and the grim realities of institutionalized patients removed from their families and communities.⁷² The proposed changes included billions of dollars in funding to provide for research, construction of facilities, and staffing needs.⁷³

One of the most profound admissions in the report is the acknowledgment of limited evidence-based research on the mentally ill. The report states that in only 15 to 25 percent

⁶⁸ Patrick J. Kennedy, John F. Greden, and Michelle Riba, "The Next 50 Years: A New Vision of 'Community of Mental Health,'" *American Journal of Psychiatry* 170, no. 10 (October 2013): 1097–98, <https://doi.org/10.1176/appi.ajp.2013.13060827>.

⁶⁹ Kennedy, Greden, and Riba.

⁷⁰ Mental Retardation Facilities and Community Health Centers Construction Act of 1963, 88th Cong., 1st Sess., S. Rpt. 180, May 21, 1963, 4.

⁷¹ S., 4.

⁷² S., 4.

⁷³ S., 4.

of cases could a cause be linked to mental retardation as it was labeled at that time.⁷⁴ The commitment to medical research, including facilities and staff, consisted of a \$30 million allotment of funds over a five-year period.⁷⁵ The intent was to cover 75 percent of the research effort for many aspects of mental health, including behavior, social, biological, and medical issues.⁷⁶

2. Community Mental Health Centers

Over the next ten years, the idea of CMHCs started to take shape as a force to serve the severely mentally ill. Although funding controversies plagued the development and core functioning of CMHCs, progress in their development was seen.⁷⁷ Federal leaders realized that CMHCs in poverty-stricken areas would require additional and likely permanent federal assistance.⁷⁸ The original grants were extended, and the program goals were expanded.⁷⁹ During this time, substance abuse programs were added as well as programs for children and the elderly.⁸⁰ The CMHCs were required to provide at least five services to their geographic area: inpatient, outpatient, emergency, partial hospitalization, and consultation and education.⁸¹ The National Institute of Mental Health (NIMH), providing oversight for this program, reported a decrease in state hospitalizations.⁸² Because the CMHCs served patients in the community rather than their being institutionalized, the drop in hospitalizations demonstrated the programs' perceived success.⁸³

⁷⁴ S., 5.

⁷⁵ S., 5.

⁷⁶ S., 5.

⁷⁷ Health Facilities, Manpower, and Community Mental Health Centers Act of 1972, 92nd Cong., 2nd Sess., S. Rpt. 92-1064, August 16, 1972.

⁷⁸ S., 38.

⁷⁹ S., 38.

⁸⁰ S., 40.

⁸¹ S., 39.

⁸² S., 39.

⁸³ S., 39.

In the 1972 report to Congress, the Committee on Labor and Public Welfare (the Committee) stated children were being served in a limited capacity.⁸⁴ During this time, more than half of current CMHCs were planning to provide services and programs for children.⁸⁵ Comprehensive programs in the areas of prevention, social and health related needs, and outreach were needed.⁸⁶ The statistics collected for in-state hospitalizations and visits to CMHCs indicated that expanded services for children were necessary.⁸⁷ The Committee reported an increase of children in state hospitals, and 20 percent of all new visits to CMHCs were younger than 20 years old.⁸⁸ It was reported that 98 percent of the CMHCs offered consultation services to schools and “have developed extensive collaborative relationships with schools.”⁸⁹ To meet the demands for children’s services, the number of programs available to serve children was increased.

Support for the community approach to mental health was gaining momentum from politicians and communities. The idea of mentally ill patients moving from a life of institutionalization to any semblance of normalcy was supported by families of the mentally ill and the public. Generous funding in the form of grants assisted in several areas to augment development of CMHCs. The need for additional facilities was recognized by the Committee and in response, Sections 13 (a) and (b) as part of the Community Mental Health Centers Act were created.⁹⁰ This funding could be used for construction of new facilities or leasing and renovations to create a CMHC.⁹¹ Table 1 shows the funding dedicated to both mental health programs and facilities.

84 S., 41.

85 S., 41.

86 S., 41.

87 S., 42.

88 S., 42.

89 S., 42.

90 S., 43.

91 S., 43.

Table 1. Funding Dedicated to Mental Health Programs and Facilities⁹²

Project/Legislation	1974	1975
Construction/renovations	\$40 million	\$50 million ⁹³
Section 13 (c) staffing and operating costs	\$90 million	\$100 million ⁹⁴
Children services (Part F)	\$45 million	\$55 million ⁹⁵
Alcohol programs (Part C)	\$60 million	\$60 million
Narcotics abuse programs (Part D)	\$75 million	\$75 million ⁹⁶
Drug abuse education	\$14 million	\$14 million ⁹⁷
Construction and staffing for Parts C & D	\$90 million	\$100 million
Incentive grants (additional funding for Parts C, D & F)	\$5 million	\$5 million ⁹⁸

Along with support for funding, CMHCs were growing in number. In 1975, 507 CMHCs were operational.⁹⁹ As Figure 1 shows, by 1981, over 700 centers were open.¹⁰⁰ The catchment areas of these community centers served a population base between 75,000 and 200,000.¹⁰¹ Initial reports of the services being provided were positive. The growing numbers of state hospital discharges seemed to match the numbers of patients being seen at centers, which led to a false sense of success, see Figure 2.¹⁰² The population of mentally ill served at the centers were labeled as the “worried well,” a term used to describe patients

⁹² Adapted from S.

⁹³ S., 44.

⁹⁴ S., 44.

⁹⁵ S., 45.

⁹⁶ S., 45.

⁹⁷ S..

⁹⁸ S.

⁹⁹ Saul Feldman, “Reflections on the 40th Anniversary of the U.S. Community Mental Health Centers Act,” *Australian and New Zealand Journal of Psychiatry* 37, no. 6 (December 2003): 662–67, <https://doi.org/10.1111/j.1440-1614.2003.01268.x>.

¹⁰⁰ E. Fuller Torrey, *Nowhere to Go: The Tragic Odyssey of the Homeless Mentally Ill* (New York: Harper & Row, 1988), 136.

¹⁰¹ Feldman, “Reflections on the Community Mental Health Centers Act,” 663.

¹⁰² Feldman.

with minor psychiatric needs such as marriage or financial counseling with less than ten percent of the severely mentally ill being seen.¹⁰³ Omission of program insufficiencies prevented much-needed solutions.

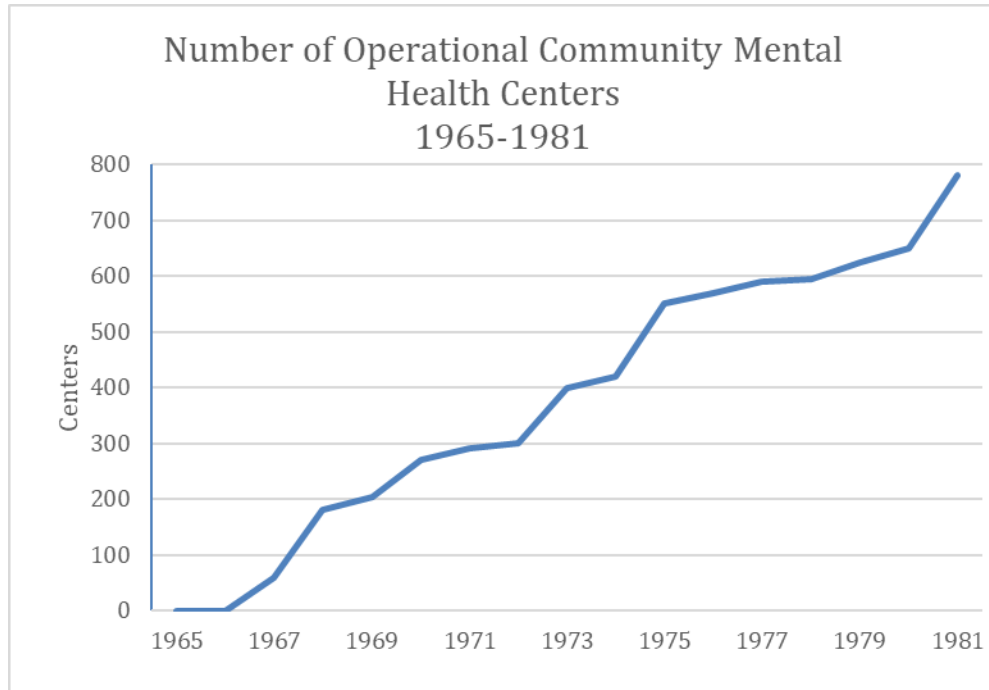


Figure 1. Operational Community Mental Health Centers from 1965 to 1981¹⁰⁴

¹⁰³ Torrey, *American Psychosis*.

¹⁰⁴ Adapted from Torrey, *Nowhere to Go*.

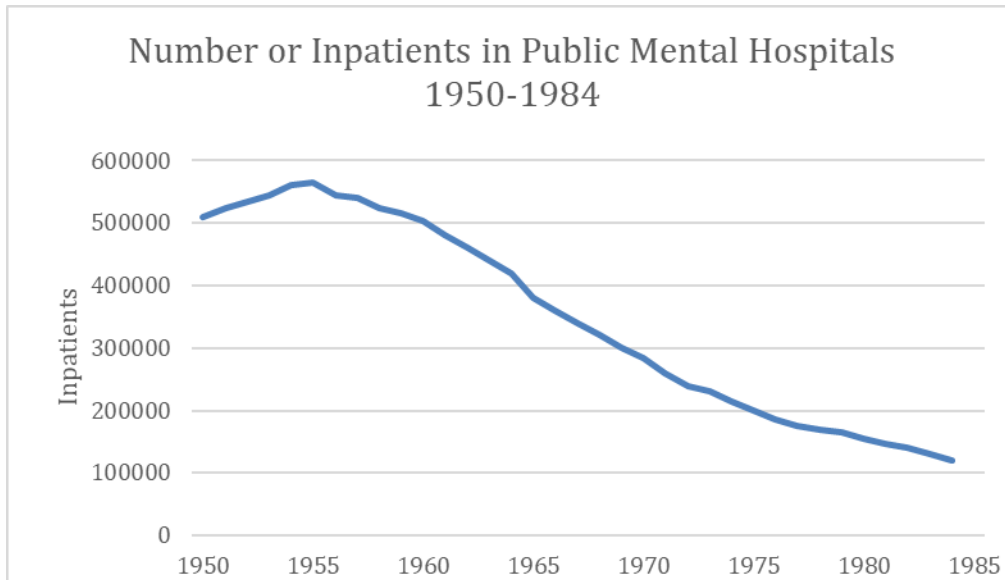


Figure 2. Inpatient Numbers in Public Mental Health Hospitals¹⁰⁵

3. Issues with Community Mental Health Center Coordination and Service

Unfortunately, the patients most in need were not being seen by the CMHCs. Deinstitutionalization was happening rapidly across the country. State hospitalizations were down by as much as 50 percent in some areas being served by CMHC.¹⁰⁶ However, the severely mentally ill were not being seen; instead, the patient population being served was the less acute “worried well.”¹⁰⁷ Part of the support for CMHCs was based on the intention of serving the severely mentally ill in a community setting. NIMH data showed that between 1968 and 1978, only 3.6% to 6.5% of patients seen at the centers were part of the patient population of severely mentally ill discharged from state hospitals.¹⁰⁸

¹⁰⁵ Adapted from Torrey, 140.

¹⁰⁶ Feldman, “Reflections on the Community Mental Health Centers Act.”

¹⁰⁷ Cornelia M. Donovan, “Problems with Psychiatric Practice in Community Mental Health Centers,” *American Journal of Psychiatry*, no. 139 (April 1982): 456–60.

¹⁰⁸ Torrey, *American Psychosis*, 76.

As mentioned, the premise of the CMHCs was to serve patients in a community setting rather than in an institution. One of the failures from the onset of the program was a lack of clearly defined transition plans for the discharged patients to the community centers. The CMHCs differed significantly from the state hospitals in development, funding, and who they were accountable to.¹⁰⁹ Federal funding was directed to the local communities instead of the states, and there was little common ground between the two systems.¹¹⁰ In 1972, legislation under “Linkage of Services” in the Health Facilities, Manpower, and Community Mental Centers Act required follow-up for patients discharged from state hospitals. The document goes on to acknowledge and express disapproval of reports of patients being transferred to nursing homes where services are “critically lacking.”¹¹¹ Dr. Torrey described these events in his book *American Psychosis*.¹¹² He reports there was no direction from the NIMH regarding the tense relationship between state hospitals and the CMHCs. One example cited by Dr. Torrey is of a state hospital in Kansas. Reportedly, when the state hospital was directed to share patient information with the CMHC, the records had the patient’s demographic information blacked out.¹¹³ The lack of continuity of care was well known, yet funding was continued because of the vision of a community system; in turn, facilities improvements bolstered support.

By the end of the 1970s, with the Community Mental Health Centers effort in need of direction, President Jimmy Carter took charge to move the mental health community forward. Along with the funding, coordination, and service issues surrounding the CMHCs, other factors contributed to the complexity of mental health problems. The proliferation of antipsychotic medications, debates and litigation over involuntary treatment, and reaching the desired patient population complicated efforts for progress. Improved coordination between federal, state, and local agencies was needed to realize the goals of building

¹⁰⁹ David A. Dowell and James A. Ciarlo, “Overview of the Community Mental Health Centers Program from an Evaluation Perspective,” *Community Mental Health Journal* 19, no. 2 (Summer 1983): 95–128.

¹¹⁰ Dowell and Ciarlo.

¹¹¹ Health Facilities, Manpower, and Community Mental Health Centers Act of 1972.

¹¹² Torrey, *American Psychosis*.

¹¹³ Torrey.

CMHCs and serving the mentally ill population. President Carter and his wife Roslyn responded to these issues by creating a commission to evaluate the current state of the mental health system.¹¹⁴

4. The Mental Health Systems Act of 1980

The resulting legislation of President Carter's commissions' recommendations was the Mental Health Systems Act of 1980. It was passed in October 1980 after much deliberation and debate.¹¹⁵ One of the most important recommendations was to assign accountability to state and local agencies. It required oversight in each area with a CMHC to ensure that each chronically mentally ill's patients' needs are met.¹¹⁶ In January 1981, President Reagan vetoed the law and removed oversight of the CMHCs from the federal government while cutting funding by 25%. These actions marked the end of the CMHCs as they were designed in 1963.

5. System Stagnates

Over the next 20 years, patients discharged from state hospitals found themselves with few consistent treatment options. A small percentage of patients were discharged back to their families. Many who did not have close ties to families were discharged directly into communities, living in halfway houses and other rooming houses.¹¹⁷ Others ended up homeless, some of whom developed substance abuse problems or jail. In 1989, local and state prison populations were composed of roughly 11% mentally ill.¹¹⁸ Up to half of the homeless in most large cities suffer from mental illness.¹¹⁹ A new collaboration between

¹¹⁴ Kenneth S. Thompson, "National Commissions on Mental Health in the United States: How Many Tried to Get it Right?" *The Mental Health Review* 17, no. 4 (2012) 260–66.

¹¹⁵ Thompson.

¹¹⁶ Torrey, *American Psychosis*, 85.

¹¹⁷ Torrey, *Nowhere to Go*, 140.

¹¹⁸ Richard Warner, "Deinstitutionalization: How Did We Get Where We Are?" *Journal of Social Issues* 45, no. 3 (1989): 17–30, <http://libproxy.nps.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=sih&AN=16407571&site=ehost-live&scope=site>.

¹¹⁹ Warner.

police, hospitals, and mental health professionals was necessary to assist this patient population.¹²⁰

B. SUMMARY

The promise of the CMHC was to serve the severely mentally ill in a community setting where they might enjoy a more meaningful life engaged with their families and communities while receiving treatment. The changes over the past 40 years and the resulting research have reflected the perceived concerns of the current situation at any given time, such as antipsychotic medications and therapy.¹²¹ Therefore, each mental health solution brought forward is based on the theories at a given time.¹²² This methodology has evolved with medical research on mental health. The mystery of mental illness continues to challenge the world of psychology. From lobotomies performed in the 1950s to the 1990s when it was believed mental health was a recoverable illness¹²³ to the present day when the medical community is beginning to acknowledge mental illness as part of overall health status.¹²⁴ Post-traumatic Stress Disorder (PTSD) has increased awareness of mental illness and is slowly lifting the stigma attached.¹²⁵ Due to the increase in active shooter events in all venues, efforts to are being made to recognize the importance of mental health care the same as for other chronic illnesses such as diabetes or heart disease. The community mental health model looks much different today with silos of treatment options and facilities. The vision remains, however, for a comprehensive program to serve an ignored population. The ideas for a reformed system continue to

¹²⁰ Lamb, Weinberger, and DeCuir, “The Police and Mental Health.”

¹²¹ Robert E. Drake et al., “The History of Community Mental Health Treatment and Rehabilitation for Persons with Severe Mental Illness,” *Community Mental Health Journal* 39, no. 5 (2003): 427–40, <http://dx.doi.org/10.1023/A:1025860919277>.

¹²² Drake et al., 428.

¹²³ Torrey, *American Psychosis*.

¹²⁴ Mike Nolting, “‘CureStigma’ Theme for Annual Mental Illness Awareness Week,” WRBI, October 3, 2018, <https://wrbiradio.com/2018/10/03/curestigma-theme-for-annual-mental-illness-awareness-week/>.

¹²⁵ “Army Troops in Iraq to Hold 5K Run to Promote PTSD Awareness and Ending Stigma of Mental Illness,” PR Newswire, April 14, 2010, <https://www.nami.org/Press-Media/Press-Releases/2010/Army-Troops-in-Iraq-to-Hold-5K-Run-to-Promote-PTSD>.

resurface under different names such as behavior health.¹²⁶ There is hope for collaboration among all disciplines as research continues to expose the shortcomings of mental health services.

¹²⁶ Feldman, “Reflections on the Community Mental Health Centers Act.”

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III. COMPLICATIONS SURROUNDING THE MENTAL HEALTH CRISIS

As CMHCs opened across the nation, several significant complications prevented the overall system from serving the mentally ill. Those barriers are not explored fully here; each one could merit an entire thesis. Instead, this chapter overviews vital aspects of the multifaceted problem. The unintended consequences of deinstitutionalization became visible as early as the mid-1970s. From then on, the debate over civil liberties versus involuntary treatment grew, and eventually, laws were put in place to restrict forced treatment. This chapter first addresses the issue of civil liberty. The debate still exists today; the fear of past practices such as misdiagnosis and forced treatment of patients in institutions has resulted in homelessness and criminalization of the mentally ill.¹²⁷ Second, it provides an analysis of the increased homeless population that occurred after deinstitutionalization, many of whom suffer from mental illness.¹²⁸ Last, the chapter examines the strain on law enforcement and the success of assisted outpatient treatment (AOT) as prisons and jails have become a repository for patients when no other options are available.¹²⁹ Although the treatment of the mentally ill has been challenged by policy changes, laws, and unresolved complex issues, agencies are coming together to provide solutions. The collaborative efforts are similar to the original goals of the Community Mental Health Act.

A. CIVIL LIBERTY/INVOLUNTARY TREATMENT

The debate on treating the mentally ill revolves around involuntary treatment and their civil liberties. Civil liberty is defined as freedom from undue government interference.¹³⁰ During the 1960s when deinstitutionalization was happening across the

¹²⁷ Frances and Ruffalo, “Mental Illness, Civil Liberty, and Common Sense.”

¹²⁸ Baldwin, “Homeless, Mentally Ill, and Neglected.”

¹²⁹ Lamb, Weinberger, and DeCuir, “The Police and Mental Health.”

¹³⁰ “Civil Rights vs. Civil Liberties,” FindLaw, accessed November 20, 2018, <https://civilrights.findlaw.com/civil-rights-overview/civil-rights-vs-civil-liberties.html>.

country, civil rights attorneys, rather than mental health professionals, argued for patients' rights and against involuntary treatment.¹³¹ Attorneys found rights violations similar to civil rights offenses imposed on mental health patients and represented them in court.¹³² The grave conditions in which the mentally ill were being held caused public outcry, and the debate over forced treatment grew.¹³³ Antipsychotic medication therapy was gaining support as a means to help patients live independently.¹³⁴ Having patients live and receive treatment in the community rather than in institutions provided a better quality of life for patients.¹³⁵ The planned oversight and follow-up at the CMHCs to assist those with independent living were never implemented, leaving mentally ill patients to manage their care alone.¹³⁶ Some patients could manage without assistance, but others could not and ended up homeless or in jail.¹³⁷ The argument remains that a balance must be found between forced treatment when necessary and respecting patients' rights to refuse treatment.

The debate over involuntary treatment runs deep and wide. Its roots lie in the legal decisions of the late 1960s and early 1970s. Several court decisions and the Lanterman-Petris-Short (LPS) Act of 1967 supported the idea of allowing the mentally ill the freedom to refuse treatment.¹³⁸ Most notably, in California the LPS Act and in Wisconsin the case of *Lessard v. Schmidt* led to the widespread acceptance that state commitment laws were unconstitutional.¹³⁹ Several schools of thought define this debate; the courts, however,

¹³¹ Meredith Karasch, "Where Involuntary Commitment, Civil Liberties, and the Right to Mental Health Care Collide: An Overview of California's Mental Illness System," *Hastings Law Journal* 54, no. 2 (January 2003): 493–523.

¹³² Karasch.

¹³³ Frances and Ruffalo, "Mental Illness, Civil Liberty, and Common Sense."

¹³⁴ Karasch, "Involuntary Commitment."

¹³⁵ Frances and Ruffalo, "Mental Illness, Civil Liberty, and Common Sense."

¹³⁶ Frances and Ruffalo.

¹³⁷ Frances and Ruffalo.

¹³⁸ Karasch, "Involuntary Commitment."

¹³⁹ Stephen J. Morse, "A Preference for Liberty: The Case against Involuntary Commitment of the Mentally Disordered," *California Law Review* 70, no. 1 (1982): 54–106, <https://doi.org/10.2307/3480182>.

consistently ruled on the side of civil liberty.¹⁴⁰ Many mental health advocates contested these decisions, some describing it as patients “dying with their rights on” or “the right to rot” because of unfortunate outcomes for patients who refused treatment.¹⁴¹ The shift from mental health providers deciding involuntary treatment to the legal system met resistance from providers who felt the system did not understand the clinical needs of mental patients.¹⁴²

Others, such as Dr. Thomas Szasz, an early advocate for patients’ right to refuse, believed a person with mental illness who is forced into treatment is similar to being accused of a crime or treated like a child, because of the loss of their rights.¹⁴³ He believes a patient’s liberty supersedes for example, the concerns of a family member who recommends involuntary treatment.¹⁴⁴ Dr. Szasz described the potential patient as being accused and questioned the motives of the said accuser, who may be requesting intervention to benefit themselves.¹⁴⁵ When involuntary treatment and misdiagnosis of psychiatric conditions were prevalent, Dr. Szasz was highly regarded. Today, the pendulum has swung in the opposite direction. Many patients who need psychiatric intervention do not receive treatment, or it comes through the court system after a crime has been committed.¹⁴⁶ The differing opinions have created sides where extreme examples outshine the majority of cases.

B. HOMELESSNESS

The rise in homelessness positively correlated with discharges from institutions beginning in the 1960s. Legislation during the 1970s stated that patients must show an immediate threat to themselves or others before any involuntary treatment could be

¹⁴⁰ Morse.

¹⁴¹ Morse.

¹⁴² Morse.

¹⁴³ Szasz, “Civil Liberties and the Mentally Ill.”

¹⁴⁴ Szasz, 416.

¹⁴⁵ Szasz, 401

¹⁴⁶ Frances and Ruffalo, “Mental Illness, Civil Liberty, and Common Sense.”

imposed.¹⁴⁷ With this ruling and with CMHCs opening across the country, the numbers of inpatients in mental health institutions declined significantly.¹⁴⁸ In the late 1960s, over 400,000 patients were in state institutions.¹⁴⁹ Within five years, those numbers were reduced by 35 percent, and in areas where CMHCs served entire regions or states, the in-state residencies were reduced by as much as 50 percent.¹⁵⁰ One study showed that the decline in length of stay in state hospitals where CMHCs existed was six times that of those where no CMHCs were built yet.¹⁵¹ In 2010, a study revealed that at least one-third of the homeless population in the United States was mentally ill.¹⁵²

New York City reached an all-time high homeless population in the early 1990s when people were noted sleeping on the streets and benches, making them highly visible to the public.¹⁵³ In 2005, the Los Angeles mayor stated skid row looked like a complete breakdown of society.¹⁵⁴ In Roanoke, Virginia in 2007, at least 70 percent of the homeless population had been treated for mental illness.¹⁵⁵ In areas where CMHCs were operational, many patients went from living in confinement to living on the streets. The evidence presented here is a strong indication these patients were not being served well enough in the community setting to support independent living.

Deinstitutionalization and the lack of a structured implementation plan contributed to homelessness.¹⁵⁶ The courts became the battleground where the mentally ill won their freedom from forced treatment. With each decision, institutions released more mentally ill patients from the sterile walls of asylums in hopes for a productive, interactive life in a

¹⁴⁷ Siegel, "Homelessness."

¹⁴⁸ Feldman, "Reflections on the Community Mental Health Centers Act."

¹⁴⁹ Feldman.

¹⁵⁰ Feldman.

¹⁵¹ Feldman.

¹⁵² Torrey, *American Psychosis*.

¹⁵³ Siegel, "Homelessness."

¹⁵⁴ Torrey, *American Psychosis*, 124.

¹⁵⁵ Torrey.

¹⁵⁶ Lamb, "Deinstitutionalization."

community. Unfortunately, where these patients ended up was merely a different form of poor living conditions.¹⁵⁷ Access to care was also a barrier because discharged patients were not connected with a CMHC and as a result did not follow up with treatment.¹⁵⁸ In some places, mental health centers were located miles away and open only during business hours. The communication between institutions and the CMHCs was sparse.¹⁵⁹ These patients found themselves with no place to go, many times ending up in the streets.

Along with the civil liberties debate and resulting homelessness, appropriate psychopharmaceutical treatment sparked heated controversy as well.¹⁶⁰ With mental illness not fully understood, the medical community continuously evaluated new treatment options for mental health. However, providers reached little consensus in determining the best treatment for these patients: coping strategies or medication. One school of thought believed that because of the high number of schizophrenia misdiagnoses, the developing culture of antipsychiatry was an accurate assessment of the times.¹⁶¹ The other school of thought believed medication could help control symptoms of mental illness.¹⁶² In addition to clinician resistance, some ex-patients released from institutions created groups such as the Insane Liberation Front and the Network Against Psychiatric Assault,¹⁶³ refusing to take medication and opposing involuntary treatment.¹⁶⁴

¹⁵⁷ H. Richard Lamb and Linda E. Weinberger, “Rediscovering the Concept of Asylum for Persons with Serious Mental Illness,” *Journal American Academy Psychiatry Law* 44 (March 2016): 106–10, https://www.researchgate.net/profile/Harry_Lamb/publication/298715236_Rediscovering_the_Concept_of_Asylum_for_Persons_with_Serious_Mental_Illness/links/56f5902408ae81582bf21531/Rediscovering-the-Concept-of-Asylum-for-Persons-with-Serious-Mental-Illness.pdf.

¹⁵⁸ Frances and Ruffalo, “Mental Illness, Civil Liberty, and Common Sense.”

¹⁵⁹ Torrey, *Nowhere to Go*.

¹⁶⁰ Drake et al., “History of Community Mental Health Treatment.”

¹⁶¹ Torrey, *American Psychosis*.

¹⁶² Torrey.

¹⁶³ Torrey, 116.

¹⁶⁴ Torrey.

Some of these patients also suffer from anosognosia, a condition in which because of physical changes in the brain, a patient has no awareness of his or her illness.¹⁶⁵ Involuntary commitment laws stated that patients could not be forced into treatment until they posed either a danger to themselves or others.¹⁶⁶ The decision to impose treatment on those who need it but do not acknowledge an illness is challenging, especially for the person making that decision. However, sometimes it restores freedom and quality of life for those who do not know what they are missing. An article in the *Psychiatric Times* discusses the application of common sense to the issues surrounding mental health. The authors of the article state the juxtaposition of different mental health treatment approaches succinctly here:

While psychiatric commitment can be a terrible evil when done carelessly and too often, it can also be life- and freedom-saving, both for the patients themselves and for those around them, when done rarely and properly.¹⁶⁷

The story of a woman who lived on a cement stoop for several years is an example of how civil liberties, anosognosia, and subsequent treatment can be life changing. The woman refused food and clothing, along with any social contact.¹⁶⁸ She had an injury that needed treatment, yet she continuously refused. Eventually, she deteriorated to a point where she could no longer refuse and was transported to the hospital.¹⁶⁹ With treatment, she was able to function independently—so much so that just three years later she served on the board of a nonprofit organization.¹⁷⁰

Mental illness alone or combined with other factors contributes to homelessness. Limited access to low-income housing opportunities, decreased Supplemental Security Income (SSI) benefits, and inadequate skill sets for employment also contribute to the

¹⁶⁵ “Serious Mental Illness and Anosognosia,” Treatment Advocacy Center, June 2016, <http://www.treatmentadvocacycenter.org/evidence-and-research/learn-more-about/3628-serious-mental-illness-and-anosognosia>.

¹⁶⁶ Siegel, “Homelessness.”

¹⁶⁷ Frances and Ruffalo, “Mental Illness, Civil Liberty, and Common Sense.”

¹⁶⁸ Rosenbaum, “Liberty versus Need,” 1490.

¹⁶⁹ Rosenbaum, 1490.

¹⁷⁰ Rosenbaum, 1490.

problem.¹⁷¹ In addition, people who do not have medical insurance and cannot receive psychiatric or other forms of medical treatment are at risk for becoming homeless.¹⁷² A school of thought exists that homelessness is a choice. For those who take ownership of their homelessness claim, it is a way to control their circumstances.¹⁷³ There are a select few who choose to live in their cars or retrofitted vehicles; these are usually college students trying to save money.¹⁷⁴ In a study on choices and behaviors by homeless people, many participate in risky behavior, have a smaller social support system, and are overall less healthy than nonhomeless people.¹⁷⁵ People who are not suffering from mental illness yet face any of the living conditions just mentioned have increased chances of becoming homeless. If mental illness is added to these conditions, even less severe mental illnesses, such as depression or anxiety, increase the chances of homelessness.

C. LAW ENFORCEMENT, JAIL OVERCROWDING AND MENTAL HEALTH TREATMENT

Deinstitutionalization and the court decisions allowing mentally ill patients to refuse treatment can lead to encounters with law enforcement on the streets. The homeless mentally ill, living in what some would call freedom, make poor life decisions such as discontinue using stabilizing medications.¹⁷⁶ Whether voluntarily or for lack of treatment, some of these choices can ultimately lead to substance abuse and other criminal activities.¹⁷⁷ Psychiatric emergencies often trigger the 911 system, in which law

¹⁷¹ D. Mossman and M. L. Perlin, "Psychiatry and the Homeless Mentally Ill: A Reply to Dr. Lamb," *The American Journal of Psychiatry* 149, no. 7 (July 1992): 951–57.

¹⁷² Mossman and Perlin.

¹⁷³ Cameron Parsell and Mitch Parsell, "Is Homelessness a Free Choice," *Fair Observer*, February 25, 2015, https://www.fairobserver.com/region/asia_pacific/homelessness-free-choice-65309/.

¹⁷⁴ Rachel Showalter, "Homeless by Choice, Two Cal Poly Students Opt for a Vehicular Lifestyle to Save Money," KCBX, April 25, 2018, <http://www.kcbx.org/post/homeless-choice-two-cal-poly-students-opt-vehicular-lifestyle-save-money>.

¹⁷⁵ Mark LaGory, Kevin Fitzpatrick, and Ferris Ritchey, "Life Chances and Choices: Assessing Quality of Life among the Homeless," *Sociological Quarterly* 42, no. 4 (Autumn 2001): 633–51, <http://www.jstor.org/stable/4121136>.

¹⁷⁶ Lamb, Weinberger, and DeCuir, "The Police and Mental Health," 1268

¹⁷⁷ Lamb, Weinberger, and DeCuir.

enforcement has become one of the primary providers for the mentally ill in crisis.¹⁷⁸ If no medical emergency exists, law enforcement officers must make critical decisions about the outcomes for mentally ill patients.¹⁷⁹ Dr. Lamb describes this as officer being used as “street-corner psychiatrists.”¹⁸⁰ Biasotti’s research on mentally ill and the effects on homeland security highlighted a 1998 study that showed as high as 15 percent of persons in jail had mental illness.¹⁸¹ In 2017, that number was up to 20 percent.¹⁸² In places such as Cook County, Illinois, and Orange County, Florida, mentally ill patients make up a third of the inmates.¹⁸³ The increased number of mentally ill outside of institutions has forced law enforcement community partners to triage psychiatric emergencies, which frequently results in less favorable options, such as jail.

In response to the high numbers of mental patients incarcerated, many jails have dedicated entire floors for the mentally ill. In 2015, 400,000 inmates in the United States suffered from mental illness.¹⁸⁴ One highly publicized jail that brought this issue to light was the Miami-Dade Ninth Floor. The conditions at Miami-Dade hit the news in 2006 when Michele Gillen, a CBS reporter, documented the conditions inmates were living in on a segment called “The Forgotten Floor.”¹⁸⁵ Tipped off by Judge Steven Leifman, an associate administrative judge in the criminal court division for Miami-Dade County, Gillen completed a series on the overcrowding, poor living conditions, and lack of medical

¹⁷⁸ Lamb, Weinberger, and DeCuir.

¹⁷⁹ Lamb, Weinberger, and DeCuir.

¹⁸⁰ Lamb, Weinberger, and DeCuir.

¹⁸¹ Biasotti, “Management of the Severely Mentally Ill.”

¹⁸² “Keeping Mentally Ill Out of Jail and in Treatment: Rochester Model Works in Breakthrough Study,” University of Rochester Medical Center, June 1, 2017, <https://www.urmc.rochester.edu/news/story/4785/keeping-mentally-ill-out-of-jail-and-in-treatment--rochester-model-works-in-breakthrough-study.aspx>.

¹⁸³ Matt Ford, “America’s Largest Mental Hospital Is a Jail,” *The Atlantic*, June 8, 2015, <https://www.theatlantic.com/politics/archive/2015/06/americas-largest-mental-hospital-is-a-jail/395012/>; Eric Welch, “In Crisis: Florida’s Jails Have Become ‘the Asylums of the New Millennium,’” *Orlando Sentinel*, 2013, <http://interactive.orlandosentinel.com/mental-illness/mental-illness-jail.html>.

¹⁸⁴ Ford, “America’s Largest Mental Hospital Is a Jail.”

¹⁸⁵ Pete Earley, “Forty Years Later Jail Still Violating Rights,” *Pete Earley* (blog), August 29, 2011, <http://www.petearley.com/2011/08/29/forty-years-later-jail-still-violating-rights/>.

treatment.¹⁸⁶ Images of naked inmates in cells with feces-laden walls and no running water were reminiscent of the poor conditions found in asylums in the 1950s, which ultimately led to deinstitutionalization. Cells in the Miami-Dade jail designed for one housed up to five inmates.¹⁸⁷ The conditions identified and unfavorable media attention were socially unacceptable after the closing of mental institutions years ago for similar problems.

The creation of a new facility brought new treatment options for the incarcerated mentally ill. In 2014, the jail was closed and replaced with the new Turner Gilford Knight Correctional Center.¹⁸⁸ The new multimillion-dollar center offers inmates yoga and meditation classes to assist patients with controlling their emotions. Thirteen psychiatrists replaced the single provider in 2006. Correction officers receive mental health training and monetary compensation when working the mental health units. Miami improved its crisis intervention program, which is now the largest in the United States.¹⁸⁹ Improvements in the facilities and staffing have provided a safe environment for patients who are also inmates.

Chicago addresses mental health treatment gaps through changes at the administration level in jails. In Cook County, Illinois, mentally ill are usually arrested for crimes of survival, which are typically crimes that relate to finding food or a place to sleep.¹⁹⁰ Psychologist Elli-Petacque-Montgomery, Cook County's deputy director for mental health policy, reports that some days three of four new inmates have a mental illness.¹⁹¹ In Chicago, police are faced with the same decisions when dealing with a mentally ill person—whether to take the person to the hospital or to jail. These corrections officers also receive an additional 60 hours of mental health training.¹⁹² To better serve

¹⁸⁶ Earley.

¹⁸⁷ “The Forgotten Floor: A New Chapter,” CBS4 News, July 14, 2016, <https://miami.cbslocal.com/2016/07/14/the-forgotten-floor-a-new-chapter/>.

¹⁸⁸ CBS4 News.

¹⁸⁹ CBS4 News.

¹⁹⁰ Ford, “America’s Largest Mental Hospital Is a Jail.”

¹⁹¹ Ford.

¹⁹² Ford.

this population, the sheriff appointed a psychologist, Nneka Jones Tapia, as executive director of the jail. As of 2015, she was the only mental health professional in the United States in charge of a jail.¹⁹³ This groundbreaking practice demonstrates a strong commitment to provide mental health needs at the policymaker level.

A special series in the *Orlando Sentinel* in Orange County, Florida, exposed the challenges in treating the mentally ill in Central Florida and the associated high recidivism rates. On the fifth floor of the jail in Orange County, Florida inmates with mental illness are housed for misdemeanor offenses or other minor infractions.¹⁹⁴ The Orange County jail is staffed with eighteen mental health providers that care for some of the 125,000 mentally ill patients incarcerated in Florida.¹⁹⁵ The special report on Orange County explains that the high numbers are due to the closing of state hospitals.¹⁹⁶ It further states that the system of community-based centers that were supposed to serve this population was never funded and, subsequently, never implemented.¹⁹⁷

Many of the mentally ill are in and out of jail due to the lack of available community services.¹⁹⁸ Forty-four percent of the inmates end up back in jail within three months.¹⁹⁹ In the jail, 140 beds are reserved for the most severely mentally ill.²⁰⁰ One of the severely mentally ill inmates, whom the CMHCs were designed to serve, was homeless and suffered from schizophrenia. He was quoted as saying “I hear these voices. When I want to kill, I want to kill a lot of people because some people just need it.”²⁰¹ The CMHCs were designed to take patients like this with severe mental illness who would have been in an

¹⁹³ Ford.

¹⁹⁴ Jeff Kunerth, “In Crisis: Florida’s Jails Have Become ‘the Asylums of the New Millennium,’” *Orlando Sentinel*, 2017, <http://interactive.orlandosentinel.com/mental-illness/mental-illness-jail.html>.

¹⁹⁵ Kunerth.

¹⁹⁶ Kunerth.

¹⁹⁷ Kunerth.

¹⁹⁸ Earley, “Forty Years Later Jail Still Violating Rights.”

¹⁹⁹ Kunerth, “In Crisis.”

²⁰⁰ Kunerth.

²⁰¹ Kunerth.

institution and serve them at a CMHC. A team of providers would monitor their progress, treatment, and follow-up. Some of the most severely mentally ill patients are being treated by jails today in the same way they were treated by institutions of yesterday.

The burden to care for a significant portion of mentally ill patients has shifted to the criminal justice system. An example of this is the story of a severely mentally ill man who made a home for himself by digging under an elevated parking lot. Eventually, the parking lot was compromised, and the man was arrested for damage to the property.²⁰² Journalist and author Pete Earley wrote the book *Crazy* after his personal struggles with navigating the mental health system in attempts to get his adult son treatment. His son refused medication for his Bipolar Disorder, and because involuntary treatment could not be imposed, the son went without treatment. Within a short time period he was arrested for breaking a glass bottle at Starbucks after announcing he had superpowers. He then broke into a home and took a bubble bath.²⁰³ His mental health treatment began as an inmate in jail. The criminal justice system has been forced to respond to the need for mental health care in their facilities; however, treatment before incarceration could prevent some of these crimes and provide stability for patients.

D. ASSISTED OUTPATIENT TREATMENT

Across the country, law enforcement is finding creative ways to address the mental health needs problem through additional training as well as by developing relationships with mental health providers. AOT is helping law enforcement address some of its obstacles in finding the appropriate route of care. The University of Rochester Medical Center's Department of Psychiatry, using its Rochester Forensic Assertive Community Treatment model (R-FACT), had success in keeping the mentally ill from repeated criminalization.²⁰⁴ Dr. J. Steven Lamberti, the principal investigator of a study on the program, found that by working closely with the mental health providers, the results led to

²⁰² Torrey, *American Psychosis*.

²⁰³ Pete Earley, *Crazy: A Father's Search through America's Mental Health Madness* (New York: Berkley Books, 2007).

²⁰⁴ University of Rochester Medical Center, "Keeping Mentally Ill Out of Jail."

compliance with treatment and keeping people out of jail. Lamberti argued that reducing the number of patients entering the criminal justice system required providing better mental health:²⁰⁵

If we want to fix the problem, we have to understand it. . . . People with severe mental illness have much higher rates of criminogenic risk factors, along with other issues that affect how they relate to others. The key to preventing recidivism is to engage these individuals in specific interventions that target the things driving their involvement with the criminal justice system.²⁰⁶

The study included the legal system, with attorneys, judges, and mental health professionals working together to guide patients toward participation. Treatment became available immediately after a court appearance, with all the stakeholders present, which gives patients a sense that the multidisciplinary team has their best interest in mind.²⁰⁷ The team updated the judge prior to a court appearance, which kept all levels of care informed of the most recent status.²⁰⁸ All contributing parties in the study agreed that success requires close collaboration across disciplines.²⁰⁹ The use of AOT has allowed law enforcement to work across disciplines for better mental health treatment.

Likewise, an interesting approach by police in Akron, Ohio, is having a positive impact on mentally ill patients. Police have partnered with the court system to provide AOT to the mentally ill. A mental health court, called New Day Court used the “black robe effect” to encourage patients to seek and accept treatment, keeping them out of the criminal justice system.²¹⁰ The black robe effect refers to mentally ill patients taking advice from a judge to seek treatment. Positive patient outcomes are seen at the New Day Court where Judge Elinore Marsh Stormer has a personal interest in helping the mentally ill. After

²⁰⁵ University of Rochester Medical Center.

²⁰⁶ University of Rochester Medical Center.

²⁰⁷ University of Rochester Medical Center.

²⁰⁸ University of Rochester Medical Center.

²⁰⁹ University of Rochester Medical Center.

²¹⁰ Jillian Weinberger, “Courts Are Using the Powerful ‘Black Robe Effect’ to Treat Severe Mental Illness. Should They?” Vox, November 27, 2017, <https://www.vox.com/policy-and-politics/2017/11/27/16689142/courts-mental-illness-assisted-outpatient-treatment>.

working over 20 years in the same system as an attorney, the now-judge started the court to make a difference in the lives of those facing the challenges that come with mental illness.²¹¹ The group of patients who routinely see Judge Stormer trust her. Prior to a case being called, all providers involved, including law enforcement, gather and discuss pertinent items. Judge Stormer knows these people and their stories. One of the patients who suffers from unspecified schizoaffective disorder believes he has a robot baby arm implanted inside him. He served three years for manslaughter committed at a time he was not medicated.²¹² Using incentives such as movie tickets encourages patients to celebrate treatment successes with their families. Thus, mental health providers and case managers agree that their patients would be in hospitals or in jail if they were not receiving treatment through the support of the court system.²¹³ It seems unorthodox to have a judge deciding treatment for patients, but after years of the system changing and many patients falling through the cracks receiving no treatment at all, this model is gaining popularity. Most important, it appears to be working; courts across the country using similar techniques see patients seeking treatment instead of returning to the system. With 350,000 mentally ill in prison and 250,000 homeless in 2018, common sense must be considered in deciding the outcomes for these patients.²¹⁴

Law enforcement agencies are recognizing the need for mental health intervention and taking steps to manage it within their own jurisdictions. In Texas, the Brazos County Sheriff's Office (BCSO) has partnered with a mental health crisis center to divert those with mental health issues from jail into treatment centers where they can receive necessary treatment. The BCSO has four dedicated officers who spend their day responding to mental health calls and performing follow-ups to known patients. Familiarity with patients gives them the ability to recognize abnormalities and indicators for crisis intervention before an

²¹¹ Weinberger.

²¹² Weinberger.

²¹³ Weinberger.

²¹⁴ Frances and Ruffalo, "Mental Illness, Civil Liberty, and Common Sense."

incident occurs.²¹⁵ The jails in Brazos County were overcrowded, causing them to send inmates outside their area. In 2016, the combined effort successfully diverted 317 people who would have ended up in jail.²¹⁶ As of 2017, 39 percent of inmates in Brazos County suffered from mental illness.²¹⁷ Law enforcement providing routine well visits for patients is another example of community partnerships for mental health and an approach that fits the specific needs for mental health care in that area.

The counterargument to AOT primarily concerns the human rights issue. The idea of forced treatment alone is problematic because some believe it violates civil rights.²¹⁸ In addition, there is fear that the targeted patient population will expand from those specifically needing forced treatment and expand to include those who are less a threat than a perceived inconvenience to society.²¹⁹ Others refute this, claiming there is no evidence to support AOT. The argument presented is that forced treatment is never appropriate, that patients should decide when and if they receive treatment.²²⁰ Unfortunately, a patient with mental illness may not understand the need for treatment.²²¹ Instead, the preferred suggestion is for less invasive methods such as group therapy, dialogue, and peer support-type programs.²²² Although resistance to AOT exists, many states have adopted different forms of AOT, and federal funding has been allocated to support it.²²³

²¹⁵ Jessica Gruenling, “Crisis Intervention Team Helps Mental Health Patients Get Treatment, Not Just Jail,” KBTX, May 22, 2017, <http://www.kbtx.com/content/news/Brazos-County-Sheriffs-office--423760324.html>.

²¹⁶ Gruenling.

²¹⁷ Gruenling.

²¹⁸ David W. Oaks, “Rise of Involuntary Mental Health: What Is Your Resistance Strategy?” *Mad in America* (blog), September 28, 2017, <https://www.madinamerica.com/2017/09/involuntary-mental-health-resistance-strategy/>.

²¹⁹ Tim Clement, “Assisted Outpatient Treatment Controversy,” Scattergood Foundation, January 16, 2014, https://web.archive.org/web/20190315000000*/http://www.scattergoodfoundation.org/activity/applicant/assisted-outpatient-treatment-controversy

²²⁰ Clement.

²²¹ Treatment Advocacy Center, “Serious Mental Illness and Anosognosia.”

²²² “Why Not Assisted Outpatient Treatment?” Western Mass Recovery Learning Community, accessed December 18, 2019, 4, https://www.westernmassrlc.org/images/stories/AOT_handout.pdf.

²²³ Oaks, “Rise of Involuntary Mental Health.”

E. CONCLUSION

AOT through the court systems and law enforcement share a common approach to mental illness in reimagining ways to serve this neglected population. They are reaching out and taking steps to intervene as they bear witness to a system that is not appropriately caring for the mentally ill. Through innovative management changes, jails are addressing problems with overcrowding and reducing recidivism. Mental health patients are finally receiving treatment options in place of criminalization and homelessness. The commonly known as “broken” mental health system has forced nontraditional agencies to deliver delicate mental care. Instead of a coordinated effort across the country, these silos have recognized the need and found ways to address it within their span of control.

The idea of deinstitutionalization is not unique to the c. At the time this country closed its mental institutions and attempted mental health reform, countries across the world were doing the same. Other countries have gone through mental health reform, most of them beginning with deinstitutionalization. Facing many of the same challenges as the United States, countries such as Australia, discussed in Chapter IV, have remained committed to their mission for reform and are at the forefront of successful mental health reform. Implementation of the program changes, treatment oversight, and reassessing the strategy has resulted in successful mental health care. Australia has established robust policies and procedures in a community setting to serve the population discharged from mental institutions.

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IV. INTERNATIONAL PERSPECTIVE: AUSTRALIA'S MENTAL HEALTH SYSTEM

A. INTRODUCTION

As the United States recognized the need for mental health reform, the same need was noted around the world. To identify best practices for American mental health care, it is important to evaluate systems that have worked through similar challenges. This chapter analyzes Australia's reform of its mental health system, policies, and current efforts that ensure the system is consistently improving as it relates to mental health reform in the United States. This review can serve as an opportunity for American mental health policymakers to consider alternative approaches from a country that has successfully reformed its mental health care system.

B. THE NEED FOR REFORM

Australia has spent the last 30 years addressing challenges involved with mental health reform, many of which parallel those in the United States. In the 1990s, Australia - made the transition to reform its mental health system.²²⁴ Like the United States, Australia was also trying to overcome the patient population that had been discharged from mental institutions through deinstitutionalization.²²⁵ With national discontent over the care for those patients, in 1992 Australia's National Mental Health Strategy (NMHS) was created. The NMHS was a five-year mental health reform policy outlining 12 specific areas in need of improvement.²²⁶ At the end of the five years, with positive changes visible, support for the continuation of reform was confirmed, and subsequent plans have been created every

²²⁴ Harvey A. Whiteford and William J. Buckingham, "Ten Years of Mental Health Service Reform in Australia: Are We Getting It Right?" *Medical Journal of Australia* 182, no. 8 (2005): 396-400.

²²⁵ Whiteford and Buckingham.

²²⁶ Harvey A. Whiteford, Bill Buckingham, and Ronald Manderscheid, "Australia's National Mental Health Strategy," *British Journal of Psychiatry* 180, no. 3 (March 2002): 210.

five years. The current reform efforts are based on the 2017 Fifth National Mental Health Plan also referred to as the Fifth Plan.²²⁷

Initially, the focus for reform was providing services to the severely mentally ill.²²⁸ Within the first five years, it was noted that access to care for early intervention was a challenge.²²⁹ The latest strategy, the Fifth Plan, has turned the focus to suicide prevention and workplace mental health.²³⁰ Each strategy was updated based on identified areas in need. One of the working goals is to remove the stigma of mental illness and treat depression, schizophrenia, and other mental health disorders as any other disease, which in turn will encourage patients to seek treatment.²³¹ Encouraging prevention as well as an early intervention will lead to overall mental health that matches the vision of Mental Health Australia (MHA) as stated in its annual report.²³² Australia has seen significant progress in its mental health system after efforts to reform its system for treating the mentally ill.²³³

C. IMPLEMENTATION

Australia has continuously seen improvement in its mental health system with every updated iteration of the NMHS. Much of Australia's success is due to effective implementation and oversight. The commitment to long-term changes of the system came

²²⁷ Australian Government Department of Health, *Australian Government Response to Contributing Lives, Thriving Communities: Review of Mental Health Programmes and Services* (Canberra: Australian Government Department of Health, 2015), 23, [https://www1.health.gov.au/internet/main/publishing.nsf/Content/0DBEF2D78F7CB9E7CA257F07001ACC6D/\\$File/response.pdf](https://www1.health.gov.au/internet/main/publishing.nsf/Content/0DBEF2D78F7CB9E7CA257F07001ACC6D/$File/response.pdf).

²²⁸ Whiteford, Buckingham, and Manderscheid, "Australia's National Mental Health Strategy," 214.

²²⁹ Whiteford, Buckingham, and Manderscheid.

²³⁰ Lachlan Searle, "Investing to Save: KPMG and Mental Health Australia Report," Mental Health Australia, May 1, 2018, <https://mhaustralia.org/publication/investing-save-kpmg-and-mental-health-australia-report-may-2018>.

²³¹ Mental Health Australia, "Mental Health Australia Annual Report, 2017–18" (report, Mental Health Australia, 2018), 18, <https://mhaustralia.org/publication/mental-health-australia-annual-report-2017-18>.

²³² Mental Health Australia, 4.

²³³ Mental Health Australia, 214.

early on from bipartisan support with initial acceptance of NMHS.²³⁴ Along with legislation requiring that incoming government officials continue to support the NMHS, the public, as well as mental health providers across Australia, agreed that mental health care was in need of reform.²³⁵ The national effort from all stakeholders has allowed the reform to evolve as needs are identified and serve the citizens of Australia.

Securing the funding necessary to cover the costs associated with reform was also a key factor for success. In less than 10 years, from 1993 to 2002, mental health spending in Australia increased by 65%.²³⁶ Much of the increase in spending was from the federal government at 128%; state and territory increases were at 40%.²³⁷ The cost of mental health services in Australia compared with the cost in other countries is very close in terms of percentages of funding allocation. In 2001–2002, the *Medical Journal of Australia* reported that in Australia, 6.4% of its health expenses were for mental health.²³⁸ In the Netherlands 6.6% of health expenditures were on mental health, and in the United States, 7.3%.²³⁹ To maintain financial support, a clause for funding was established that all federal funding not replace state funding needs but be specifically used for funding reform efforts.²⁴⁰ Any extra funding from the closing of state hospitals was to be used for expenses to support reform efforts.²⁴¹ To ensure that these funding activities were adhered to, accountability was held through the National Mental Health Report, which was prepared annually.²⁴² Federal funding was to support state efforts in developing community-level care facilities.²⁴³ States and territories contributed \$2.70 AUD for every dollar allocated

²³⁴ Whiteford, Buckingham, and Manderscheid, “Australia’s National Mental Health Strategy,” 213.

²³⁵ Whiteford, Buckingham, and Manderscheid, 213.

²³⁶ Whiteford and Buckingham, “Ten Years of Mental Health Service Reform in Australia.”

²³⁷ Whiteford and Buckingham, 396

²³⁸ Whiteford and Buckingham, 396

²³⁹ Whiteford and Buckingham.

²⁴⁰ Whiteford, Buckingham, and Manderscheid, “Australia’s National Mental Health Strategy,” 213.

²⁴¹ Whiteford, Buckingham, and Manderscheid, 213.

²⁴² Whiteford, Buckingham, and Manderscheid, 213

²⁴³ Whiteford, Buckingham, and Manderscheid.

by the federal government.²⁴⁴ Widespread support, from territories to the federal level with accountability through annual assessments, ensured not only sustained funding but the commitment to reform as well.

D. OVERSIGHT AND ACCOUNTABILITY

Australia uses a robust system of accountability, performance measures for service delivery, and continuing reassessment to ensure that reform efforts are meeting their goals. Through a commitment to success and a mission to obtain overall health care for all Australians, Australia has become a world leader in mental health reform. From the first NMHS, evaluations of system performance and patient outcomes have been performed.²⁴⁵ Surveys are conducted among patients to assess outcomes and access to care.²⁴⁶ Independent evaluations of the system were performed as early as 1997 to assess all aspects of the mental health system.²⁴⁷ Results from these evaluations generate additional studies to ensure that policy changes have been appropriate.²⁴⁸ Continuous reevaluation has enabled the system to identify necessary changes early and adjust policy as needed.

Accountability is applied to all aspects of the mental health system in Australia. Mental Health Services in Australia, part of the Australian Institute of Health and Welfare, compiles a report of the mental health care system, statistics, and how the system compares with mental health needs.²⁴⁹ The report is updated throughout the year and published in a web report. It is used to monitor the progress of the system on an annual basis.²⁵⁰ Such

²⁴⁴ Whiteford, Buckingham, and Manderscheid.

²⁴⁵ Whiteford, Buckingham, and Manderscheid.

²⁴⁶ Whiteford and Buckingham, "Ten Years of Mental Health Service Reform in Australia," 399.

²⁴⁷ Whiteford, Buckingham, and Manderscheid, "Australia's National Mental Health Strategy."

²⁴⁸ Whiteford, Buckingham, and Manderscheid.

²⁴⁹ "Mental Health Services in Australia; National Mental Health Performance Subcommittee," Australian Institute of Health and Welfare, accessed December 2, 2018, <https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/national-mental-health-committees/national-mental-health-performance-subcommittee>.

²⁵⁰ Australian Institute of Health and Welfare.

continual monitoring has proven to be successful in ensuring the improvement of programs as the country continues to work on mental health care reform.

To ensure that mental health benchmarks are on target with the needs of Australians, performance measures are also closely monitored through a layered system of advisory committees. The National Mental Health Performance Subcommittee is made up of clinicians, consumers, and caregivers. This group oversees the performance measure framework and offers advice for changes to service delivery.²⁵¹ Findings from this subcommittee are presented to the Mental Health Information Strategy Standing Committee, which then reports the findings to the Mental Health Principal Committee. Eventually, recommendations make it to the Australian Health Ministers' Advisory Council.²⁵² Those recommendations are considered when developing final policy changes.

From the original NMHS, areas of priority were identified for service delivery. To ensure that service delivery was meeting the needs of mental health patients, outcomes had to be measured. The National Outcomes and Casemix Collection, managed by the Australian Mental Health Outcomes and Classification Network, is a repository for outcomes from both clinicians and consumers (i.e., patients).²⁵³ This data collection is used to identify whether interventions from the mental health system have assisted with changes in patient outcomes.²⁵⁴ Analyzing the data provided can assist both patients and providers in creating care plans for patients as well as identifying successful treatment and therapy.²⁵⁵ These data also identify where gaps exist and needs for additional service.²⁵⁶ The comprehensive database provides evidence-based data to improve the mental health system.

²⁵¹ Australian Institute of Health and Welfare.

²⁵² Australian Institute of Health and Welfare.

²⁵³ "NOCC: What Is It?" Australian Mental Health Outcomes and Classification Network, accessed December 18, 2019, <https://www.amhocn.org/nocc-collection/nocc-what-it>.

²⁵⁴ Australian Mental Health Outcomes and Classification Network.

²⁵⁵ Australian Mental Health Outcomes and Classification Network.

²⁵⁶ Australian Mental Health Outcomes and Classification Network.

In 2015, in preparation for the Fifth National Mental Health Strategy, the Australian government requested a complete review of the mental health system. The National Mental Health Commission was tasked with the evaluation. The Australian government then composed a detailed response to the assessment, using input from mental health experts, caregivers, and patients to address specific areas identified as needing improvement.²⁵⁷ Considering the lengthy and detailed recommendations, Australia's response complemented the review with statements of commitment to system change. The following excerpt from the review reveals one of the recommendations and the government's response:

Recommendation 4.1:

An ideal, person-centred mental health system would feature more clearly defined pathways between health and mental health. It would recognize the importance of non-health supports such as housing, justice, employment, and education, and emphasise cost-effective, community-based care.

Response:

Carers should also be recognized as key partners in achieving better outcomes. . . . The Australian Government believes that reform must be based on the link and interdependencies between health and broader social support. . . . A vital element of this approach is ensuring providers at a national and regional level understand that, from the consumer's perspective, a failure in one part of the system will reduce their outcomes in another, and increase their demands on services and benefits.²⁵⁸

The Fifth National Mental Health and Suicide Prevention Plan, endorsed on August 4, 2017, provided the latest policy changes and goals for mental health from 2017 to 2022.²⁵⁹ Priorities were identified in eight areas, one of which relates to integrated regional planning and service delivery.²⁶⁰ Another area identified was "coordinated treatment and

²⁵⁷ Australian Government Department of Health, *Australian Government Response*.

²⁵⁸ Australian Government Department of Health, 7.

²⁵⁹ "The Fifth National Mental Health and Suicide Prevention Plan," Australian Government Department of Health, accessed December 3, 2018, <http://www.health.gov.au/internet/main/publishing.nsf/content/mental-fifth-national-mental-health-plan>.

²⁶⁰ Australian Government Department of Health.

supports for people with severe and complex mental illness.”²⁶¹ An implementation plan was created to ensure that efforts were made to meet the goals. The plan outlines actions needed, assigns committees or group to each action, and lists dates as well as coordination points.²⁶² The plan includes forming subcommittees that are required to report progress, along with a specific hierarchy of accountability.²⁶³ In addition, reassessment of the progress is scheduled to prepare the next mental health strategy.²⁶⁴ The detailed planning and structured implementation is part of the reason each mental health strategy yields results in and contributes to overall improvement in the mental health system.

E. ECONOMIC IMPACT OF MENTAL HEALTH

MHA partnered with the major corporate auditor KPMG to evaluate the expenditures associated with the mental health system in Australia. MHA received the final report, *Invest to Save*, which was released in May 2018. The report provides an evidence-based foundation for specific actions that not only will save the country money but improve the lives of those suffering from mental illness.²⁶⁵ *Investing to Save* describes in detail the importance of investing in specific mental health reform by identifying where gaps exist.²⁶⁶ The report’s introduction states that the human element must remain as the focus of all mental health reform, where positive outcomes have a ripple effect improving the lives of families, friends, and communities overall.²⁶⁷ The recommendations suggest that investing \$4.4 billion AUD in mental health would generate over \$8.2 billion return on investment.²⁶⁸

²⁶¹ Australian Government Department of Health.

²⁶² Australian Government Department of Health, 19.

²⁶³ Australian Government Department of Health.

²⁶⁴ Australian Government Department of Health.

²⁶⁵ Searle, “Investing to Save.”

²⁶⁶ Searle, 3.

²⁶⁷ Searle, 3.

²⁶⁸ Searle, 10.

From the report, three main recommendations were presented; under each, several sub-recommendations were made. One of the recommendations in the May 2018 report discussed mental health in the workplace.²⁶⁹ Analyzing positive mental health and those suffering from a common form of mental illness such as depression, then evaluating the effect on productivity has led Australia to encourage early intervention.²⁷⁰ Furthermore, the economic impact on the workplace due to changes in productivity can have a domino effect on the nation as a whole.²⁷¹ The report states that one-quarter of the workforce struggles with depression or stress. The report states further that 8% of employees suffer from a form of severe mental illness such as depression.²⁷² These disorders lead to a significant amount of leave time use, some up to 138 hours per person, per year.²⁷³ *Investing to Save* showed how investing in mental health can have a positive impact economically on the country through early identification and intervention.²⁷⁴

Australia is also considering a trial for workers' compensation insurance. *Invest to Save* reports that by providing insurance to state-based workplace health and safety regulators, employers could provide supportive measures.²⁷⁵ Employees receiving support in the workplace are more likely to seek treatment, which reduces time away from work and treatment for improved patient outcomes. This improvement translates to direct economic impact, saving employers possibly a half billion dollars.²⁷⁶ If successful, this could further place Australia as a leader in mental health.²⁷⁷

²⁶⁹ Searle, 10.

²⁷⁰ Searle.

²⁷¹ Searle, 30.

²⁷² Searle, 22.

²⁷³ Searle.

²⁷⁴ Searle.

²⁷⁵ Searle, 32.

²⁷⁶ Australian Government Department of Health, *Australian Government Response*.

²⁷⁷ Searle, "Investing to Save," 35.

F. COMPARATIVE ANALYSIS

The United States and Australia share similar challenges in efforts for mental health reform. Both countries faced the challenge of treating the patient population discharged after deinstitutionalization. In addition, both countries wanted to move to a system in which patients would be served in the community and function independently. Australia has experienced success and progressed in reform efforts, but attempts to reform the mental health system in the United States have met with resistance. The United States could look to Australia's reform efforts as an example for policy change.

Australia approached reform in the early 1990s with widespread support. Public criticism for better mental health services garnered support from the mental health community, consumers, and caregivers.²⁷⁸ New public officials coming into office were required to support the agreements made for mental health reform.²⁷⁹ The United States faced the same public criticism and agreement from the mental health community for reform, but goals varied between political parties. Over time, with each change in U.S. leadership, the goals for mental health reform changed. With fragmented long-term goals for reform, consistent support was difficult to maintain for the United States.

Australia's plans for funding the NMHS were solidified early on. State funding was written into the health care agreements to support reform activities.²⁸⁰ To ensure accountability for appropriation of funds, oversight through annual reports monitored budgets.²⁸¹ As a result of the unified support across Australia for reform, local territories as well as states ensured that funding was available for reform efforts.²⁸² With the broad support from consumers to lawmakers, funding was available where and when it was needed in Australia. In the United States, significant funding was available, but it was

²⁷⁸ Whiteford, Buckingham, and Manderscheid, "Australia's National Mental Health Strategy." 213.

²⁷⁹ Whiteford, Buckingham, and Manderscheid, 213.

²⁸⁰ Whiteford, Buckingham, and Manderscheid, 213.

²⁸¹ Whiteford, Buckingham, and Manderscheid, 213.

²⁸² Whiteford, Buckingham, and Manderscheid, 213.

misappropriated due to no oversight or accountability.²⁸³ In some places in the United States, funding for erecting new CMHCs was used to build facilities that within a year were sold or used for other purposes.²⁸⁴ Funding is still available in the United States for mental health reform. A strong commitment to oversight such as the strategies Australia employs, could help the United States manage spending.

Australia secured two critical aspects for successful reform—political and economic support. Through legislation that ensured bipartisan support, policy changes were supported even when leadership changes occurred. The commitment to improved service delivery and a commitment to change the lives of Australians led to strong financial support from consumers, state and territory leaders, and top policymakers. The United States has not experienced this level of support because of changes in the direction for reform that happen with every change in national leadership. Without proper oversight and accountability for funding, resources have not been appropriated to serve the reform efforts desired in the United States.

U.S. mental health reform is necessary to serve the needs of mentally ill. Without national support and a unified vision for change in the United States, the population of mentally ill will continue to experience gaps in treatment that lead to untreated mental illness. Untreated mental illness can lead to more severe forms, including psychotic episodes during which these patients can become public health threats. Identifying these patients early and having a system that cares for them is critical for overall homeland security.

G. SUMMARY

Countries around the world have made attempts for mental health reform; however, Australia has shown continued successful changes to its system. Annual internal evaluations on policy changes have demonstrated national support.²⁸⁵ An outside

²⁸³ Dowell and Ciarlo, “Overview of the Community Mental Health Centers Program.”

²⁸⁴ Torrey, *American Psychosis*.

²⁸⁵ Mental Health Australia, “Australia Annual Report, 2017–18,” 6.

evaluation by Canada documented favorable reform efforts.²⁸⁶ In an economic audit, KPMG identified several areas as leaders in workplace mental health reform efforts—Queensland, Victoria, and New South Wales.²⁸⁷ Australia continuously receives support from within the country, from other nations, and through outside evaluations, which show consistent improvement in reform efforts.

The KPMG study has provided the data needed to support continued aggressive mental health reform in Australia. MHA’s 2017–2018 annual report states that the mission of MHA is to “create the best mental health system in the world” and lists actionable items such as “meaningful participation by consumers and carers.”²⁸⁸ These are not merely items listed to encourage participation from their constituents; these are actionable items the country is dedicated to and striving for. Through endless evaluations of policies, service delivery, standards of care that must be adhered to, and commitment to improving mental health, Australia has become the example for the world to follow.

Australia delivers mental health through a community-based system that focuses on prevention, early intervention, and overall mental health.²⁸⁹ The Fifth Mental Health Strategy promotes prevention and early intervention to change the trajectory for those suffering from mental illness. Early interventions could have changed the outcome for Adam Lanza, the shooter who took 26 lives at Sandy Hook Elementary in December of 2012. The next chapter is a detailed recollection of Lanza’s life, filled with challenges associated with mental illness.

²⁸⁶ Whiteford and Buckingham, “Ten Years of Mental Health Service Reform in Australia,” 399

²⁸⁷ Searle, “Investing to Save.”

²⁸⁸ Mental Health Australia, “Annual Report, 2017–18.”

²⁸⁹ Whiteford and Buckingham, “Ten Years of Mental Health Service Reform in Australia.”

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V. CASE STUDY OF THE SHOOTER AT SANDY HOOK ELEMENTARY

To identify where the community mental health system should have intervened in the life of an active shooter, a thorough examination of the individual's life experiences must be performed. This chapter presents a short synopsis of the shooting that took place at Sandy Hook Elementary and then offers the detailed case study of the life of Adam Lanza. A counterfactual analysis of Adam Lanza's experiences compared with the care he might have received from a community mental health model will be presented in Chapter VI. For the purposes of this thesis, Adam Lanza is referred to as AL. The case study follows the life of AL from three years through 20 years of age.

A. SANDY HOOK, NEWTOWN, CONNECTICUT, DECEMBER 14, 2012

The official Connecticut State's Attorney Report describes in detail the events as they unfolded on December 14, 2012, at Sandy Hook Elementary School (SHES) in Newtown, Connecticut. AL, a 20-year-old male resident of Newtown, opened fire in this school killing 26 people. Twenty of those were young elementary school students in first grade. Six others killed were adult faculty members. Before killing the innocent lives at SHES, AL killed his mother in their home at 36 Yogananda Street of the same town. The weapons used included high-powered rifles and handguns purchased by his mother.²⁹⁰

The report explains the timeline and path of the killings, all transpiring in less than 11 minutes. Shortly after 9:00 a.m. on December 14, 2012, AL drove to SHES, shooting through the locked gates of the campus to gain entry, making his way to the school corridor. He killed the first two faculty members he encountered in the hallway, those being the principal and the school psychologist. He then entered the office, where several faculty members were hiding and left without firing any shots. Moving down the hall, he entered classrooms 8 and 10, where the remainder of the shooting took place, killing 20 students

²⁹⁰ Stephen J. Sedensky III, *Report of the State's Attorney for the Judicial District of Danbury on the Shootings at Sandy Hook Elementary School and 36 Yogananda Street, Newtown, Connecticut on December 14, 2012* (Danbury CT: Judicial District of Danbury, November 25, 2013).

and four adults. AL killed himself with a handgun in classroom 10.²⁹¹ Mrs. Lanza, AL's mother, was later found dead in her bedroom. The official report found AL to be responsible for this crime as well.²⁹²

B. THE LANZA FAMILY

The Lanza family had challenges, as many families do. According to the official report on Sandy Hook, the Lanza family lived in a modest home in Newtown, Connecticut. In 1998, Peter and Nancy Lanza, along with their two children Ryan (10) and Adam (6), moved from New Hampshire for Peter's new job.²⁹³ Nancy was a housewife, who stayed home to look after their children. In 2002, the Lanzas separated, and their divorce was final in 2009. A year later, Peter announced his engagement, the same year AL stopped responding to emails from his father.²⁹⁴ It is unknown why AL cut communication to his father; one source indicated he was unhappy about his father's impending marriage.²⁹⁵ The official report shows Peter discouraged AL from joining the military, which AL had dreamed about doing when he turned 18.²⁹⁶ Possibly, both the engagement and the advice against joining the military played a role. At that time, AL also ceased contact with his brother and uncle.²⁹⁷

C. BIRTH TO AGE NINE: ASSESSMENTS AND TREATMENT BEGIN

AL exhibited abnormal symptoms from an early age. According to records of his birth-to-age-three evaluation, he exhibited signs of delayed social–personal development. His articulation and expressive language skills were also underdeveloped.²⁹⁸ Nancy had to interpret AL's language during assessments because he had created his own language to

²⁹¹ Sedensky.

²⁹² Sedensky.

²⁹³ Sedensky.

²⁹⁴ Sedensky.

²⁹⁵ Lysiak, *Newtown*.

²⁹⁶ Sedensky, *Report of the State's Attorney*.

²⁹⁷ Lysiak, *Newtown*.

²⁹⁸ Sedensky, *Report of the State's Attorney*.

communicate. Being diagnosed with delays in articulation and expressive language skills qualified him for state services such as occupational and speech therapy.²⁹⁹

Beginning at the age of three years, AL had many evaluations and treatment plans interspersed with time periods of no treatment at all. Nancy and Peter were attentive parents, aware of AL's deficiencies and committed to assisting their son with any treatment plans necessary.³⁰⁰ From emergency room visits, school psychologists, specialists in autism, various inconsistent individual education plans (IEPs), and a few days of medication therapy, the parents and professionals exerted much effort to find a solution for AL's mental ailments.

The official report noted several instances when school evaluations erroneously removed or terminated services for AL. One of these evaluations was from the Sanborn Regional School District just before AL turned five years old, stating that his "challenges were not impeding his ability to learn."³⁰¹ As a result, speech and language support services that he had been receiving for two years, were discontinued.³⁰² At that same time, a neurological assessment of AL described additional symptoms such as making up his own language, severe temper tantrums, hitting his head against the wall, repetitive behaviors, and avoiding human touches such as hugs and kisses.³⁰³ After an additional evaluation a month later, therapy for speech and language support was started for sensory integration.³⁰⁴ AL received treatment throughout first grade.

In second grade, at seven years old, AL's occupational therapy was discontinued because of the assessment that he was "conscientious, quiet, but more talkative since he

²⁹⁹ Sarah Eagan, Faith VosWinkel, and Julian D. Ford, "Sandy Hook Report" (report, Office of the Child Advocate, State of Connecticut, 2014), 17, <https://www.documentcloud.org/documents/1368948-sandy-hook-report-office-of-the-child-advocate.html>.

³⁰⁰ Lysiak, *Newtown*.

³⁰¹ Eagan, VosWinkel, and Ford, "Sandy Hook Report."

³⁰² Eagan, VosWinkel, and Ford.

³⁰³ Eagan, VosWinkel, and Ford, 17.

³⁰⁴ Eagan, VosWinkel, and Ford, 17.

was grouped with another second-grade student.”³⁰⁵ During the same time, Nancy began spending afternoons at SHES daily to help AL complete assignments because of his trouble functioning in groups. The report goes on to say he was still struggling with skills such as tying shoes and zipping jackets.³⁰⁶

In May of 2001, AL was in the third grade and nine years old. AL’s mother wrote an e-mail to the school explaining her concerns about the third-grade year, indicating there was friction due to the teacher’s stricter style of instruction and classroom management. AL had frequently been sick throughout the year, and the mother offered an explanation that strict rules caused anxiety for AL. She requested a more casual environment that would match his learning style, which she stated would be beneficial for everyone. Less than six months later, when AL entered the fourth grade, he was once again taken out of the special education program after a speech report indicated “no error sounds.”³⁰⁷ These inconsistencies are notable considering the overall treatment needs for a patient exhibiting significant symptoms since preschool.

D. AGE TEN THROUGH FIFTEEN: NEW SYMPTOMS EMERGE

During the year AL turned 10, turmoil occurred in the family, and new symptoms emerged. His parents separated; however, there was no indication that AL expressed negative or positive feelings about the change. Peter moved out, and AL remained with his mother and sibling. AL’s brother, Ryan was four years older and moved away to college during AL’s teen years. At the time of the shooting, the brothers had not spoken in two years.³⁰⁸ The separation and ensuing divorce were amicable, and the parents collaborated to support AL. AL’s violent writings began in fifth grade when he created with a classmate “The Big Book of Granny” in which an elderly woman shoots kids with her cane. Reports show the story had imagery of cannibalism and taxidermy.³⁰⁹ According to the “Sandy

³⁰⁵ Eagan, VosWinkel, and Ford, 27.

³⁰⁶ Eagan, VosWinkel, and Ford.

³⁰⁷ Eagan, VosWinkel, and Ford.

³⁰⁸ Lysiak, *Newtown*.

³⁰⁹ Eagan, VosWinkel, and Ford, “Sandy Hook Report.”

Hook Report” from the Connecticut Office of the Child Advocate, it was undetermined whether or not any adults were aware of the drawings.³¹⁰ Additional violent drawings were identified during AL’s seventh-grade year, when teachers and the administration voiced concerns.³¹¹ During that year, AL developed excessive handwashing habits and the need to change clothes frequently. No reported mental health evaluations took place to address the new symptoms.³¹²

Over the next two years, 10 to 12 years of age, AL’s symptoms worsened. The official report explained that AL had anxiety, was frequently sick with sore throats, and had lost a significant amount of weight.³¹³ Peter noticed that AL recently was more anxious and that his disposition was less happy.³¹⁴ Nancy attempted to help AL by changing the environment to make him more comfortable.³¹⁵ In hopes of relieving his anxiety, she withdrew him from Newtown Middle School (NMS) and enrolled him in St. Rose of Lima in Newtown, Connecticut. AL composed more graphic writings while at St. Rose, to the extent that an alarmed teacher alerted the principal.³¹⁶ Along with the elaborate and extensively violent writings, the teacher identified antisocial behavior such as being quiet, rarely speaking, and not being receptive to classmate attempts to make AL feel welcome.³¹⁷ She felt the Lanzas had not been forthright about the severity of AL’s problems. The Lanzas quickly withdrew AL from the school. For eighth grade, AL enrolled back in NMS. His symptoms worsened to include not sleeping or eating, increased agitation, withdrawal, and overwhelming fear and anxiety. As a result, he was absent for a significant portion of the eighth-grade year.³¹⁸

³¹⁰ Eagan, VosWinkel, and Ford, 29.

³¹¹ Eagan, VosWinkel, and Ford, 34.

³¹² Eagan, VosWinkel, and Ford, 36.

³¹³ Eagan, VosWinkel, and Ford, 36.

³¹⁴ Eagan, VosWinkel, and Ford, 36.

³¹⁵ Reed Coleman, “Adam Lanza: Timeline,” *Sandy Hook Lighthouse (Blog)*, September 27, 2013, <https://sandyhooklighthouse.wordpress.com/2013/09/07/timeline-adam-lanzas-life-and-online-activity/>.

³¹⁶ Eagan, VosWinkel, and Ford, “Sandy Hook Report,” 37.

³¹⁷ Eagan, VosWinkel, and Ford, 37.

³¹⁸ Sedensky, *Report of the State’s Attorney*.

In September of 2005, when AL was 13 years old, Nancy took AL to the emergency room after an episode of anxiety. The physician noted that AL was anxious, withdrawn, hypervigilant, hesitant to be touched, and overwhelmed with fear.³¹⁹ The diagnoses of anxiety disorder, Asperger’s syndrome, and obsessive compulsive disorder (OCD) came with recommendations for more thorough evaluations.³²⁰ The report states Nancy declined a comprehensive medical evaluation as she had already scheduled AL to see a psychiatrist in three weeks.³²¹ It further notes that the crisis team recommended therapeutic support and a psychiatric evaluation, both of which Nancy declined, stating AL would do better at home in his own environment. She felt he was not at risk or “a danger to himself or others.”³²² The phrase refers to the involuntary commitment law that states police or a licensed physician can impose a 72-hour hospitalization for patients who exhibit behavior that is “a danger to himself or others.”³²³ Additional recommendations from the hospital included a fast-track evaluation for admission to the Center for Child and Adolescent Treatment Services. Nancy refused all treatment options, stating she had appointments scheduled. She merely requested a note to excuse AL from school.³²⁴

A community psychologist chosen by Nancy Lanza, Dr. Fox, evaluated AL and offered his recommendations. After three visits in late 2005, AL was formally diagnosed with Asperger’s syndrome.³²⁵ Dr. Fox provided the documentation for AL to be excused from school; he cited intense emotional rage with any disruption of his daily routine. He further explained that AL interprets the world around him literally and could not decipher metaphors, which induced anxiety and stress. Dr. Fox recommended a modified education plan with a specific curriculum designed to meet AL’s needs—for example, focusing on

³¹⁹ Coleman, “Adam Lanza: Timeline.”

³²⁰ Sedensky, *Report of the State’s Attorney*.

³²¹ Coleman, “Adam Lanza: Timeline.”

³²² Coleman.

³²³ Christopher Reinhart, “Involuntary Commitment Law” (research report, Connecticut Office of Legislative Research, 2002), <https://www.cga.ct.gov/2002/rpt/2002-R-0848.htm>.

³²⁴ Sedensky, *Report of the State’s Attorney*.

³²⁵ Sedensky.

specific skills such as grammar and choosing literature that is literal because AL had increased anxiety with metaphors and symbolism.³²⁶ The school district responded to these recommendations, offering an evaluation to help determine his needs. Nancy Lanza declined the offers as she felt they were not in his best interest. The report shows that nearing the end of the school year, the school district requested documentation from Dr. Fox regarding AL's ability to complete standardized testing. Dr. Fox's response stated AL was medically and emotionally unable to complete testing and was not attending school at all.³²⁷

Peter, AL's father, had become concerned with the continued decline of AL and reached out to his employee assistance program (EAP). An evaluation performed by Dr. Robert King and Kathleen Koenig, ARNP, at the Yale Child Study Center provided comprehensive recommendations for treating AL. The resulting detailed evaluation from Yale outlines AL's OCD behaviors such as refusing to open doors because they were dirty, excessive handwashing until his skin was raw, anxiety about germs and dirt that led to strict food practices, and correcting his mother's behaviors that he felt were improper. Significant asocial changes developed in seventh grade—for example, no longer using e-mail or talking on the phone. More striking is the Yale assessment of the treatment of AL at this point. The report states that creating a world that allows AL to function in, as had been done, is counterproductive to helping AL function out in the world.³²⁸ It goes on to state that the inability to communicate with others in social settings will have grave consequences for AL into his adult life, causing him to fall deeper into reclusive behavior. Yale recommended shifting the focus from education, as Nancy had requested, to the social integration delays. The diagnosis that ARNP Koenig believed was more appropriate was described as debilitating anxiety and OCD.³²⁹

³²⁶ Eagan, VosWinkel, and Ford, "Sandy Hook Report," 41–42.

³²⁷ Eagan, VosWinkel, and Ford.

³²⁸ Eagan, VosWinkel, and Ford, 50.

³²⁹ Eagan, VosWinkel, and Ford, 50.

After another evaluation, Nancy asked to combine providers for a focused treatment plan. Just two months after the Yale consultation, the Newtown High School (NHS) psychologist Michael Ridley concluded in his follow-up evaluation that “there is no evidence of a specific learning disability and that Adam’s issues relate to his identified emotional and/or Pervasive Developmental Disorder spectrum behaviors.”³³⁰ At this point Nancy consolidated the providers to devise a single plan of action asking Dr. Fox, the community psychologist, to head the treatment plan.³³¹ She believed Dr. Fox had the best rapport with her son; however, when AL resisted treatment options, Nancy appeased him by discontinuing treatment from those providers. ARNP Koenig’s notes of AL’s last appointment with her in 2007 as “emotionally paralyzed” with limitations on living a normal life, her diagnosis was OCD and Autism Spectrum Disorder (ASD). During the assessment, AL admitted to being paralyzed by his anxiety but did not believe it affected his life or that he suffered because of it. In a limited dialogue, AL asked Koenig about schizophrenia and depression but refused to discuss any symptoms he may have had. AL stated that their recommendations would not help him, and he would not comply with a medication treatment plan.³³²

In February 2007, when AL was 14, he agreed to try medication therapy. The temporary use of an antidepressant medication prescribed by ARNP Koenig was short-lived and marked the end of documented mental health treatment for AL.³³³ Peter reported to Koenig some improvement in AL’s behaviors after his visits with her.³³⁴ A few weeks passed, and AL agreed to try an antidepressant medication called Celexa. Just three days later, Nancy notified Koenig with concerns the medication was causing various side effects and that he was unable to lift his arm; she claimed he “sat in his room, doing nothing.”³³⁵ Although Koenig explained the medication did not cause the problems with his arm and

³³⁰ Coleman, “Adam Lanza: Timeline.”

³³¹ Eagan, VosWinkel, and Ford, “Sandy Hook Report.”

³³² Coleman, “Adam Lanza: Timeline.”

³³³ Coleman, 13.

³³⁴ Sedensky, *Report of the State’s Attorney*.

³³⁵ Eagan, VosWinkel, and Ford, “Sandy Hook Report.”

that dosing changes could help with some of the symptoms, Nancy did not follow the recommendations and took AL off the medication. Koenig reached out to Dr. Fox, the community psychiatrist and agreed that a single provider was the best plan. In 2007, school medical records showed that two months earlier, recommendations for additional speech, language, and neurological evaluations were disregarded.³³⁶ Records show that in 2008 AL was not receiving any psychiatric treatment and was developing signs of anorexia, standing 5'10" tall and weighing 112 lbs. The last record of AL receiving psychiatric care was in October of 2008 by the community psychiatrist, Dr. Fox. A well visit in 2009 noted AL's diagnosis of Asperger's and OCD, along with "well child/normal growth and development."³³⁷

E. AGE SIXTEEN THROUGH EIGHTEEN: HIGH SCHOOL YEARS

Over the next three years, AL somehow completed high school with special accommodations. During 10th grade, Newtown High School allowed AL to come to school early and leave late to avoid any anxiety associated with interacting with the students.³³⁸ AL continued to exhibit behaviors such as rocking and withdrawing when faced with anxiety from social interactions.³³⁹ Through the technology club at NHS, AL met Richard Novia.³⁴⁰ Richard ran the club and connected with AL through their shared tech interests. Nancy was relieved and hoped AL would thrive; he finally had someone in the school who was patient and saw the potential for him. Richard left the school at the end of 2008, which caused Nancy great distress.³⁴¹ She was optimistic about the progress she had seen in AL but worried that without Richard AL would not receive the same support.³⁴² Richard encouraged Nancy not to withdraw AL from NHS; he felt, too, that AL had made progress

³³⁶ Eagan, VosWinkel, and Ford, 61.

³³⁷ Eagan, VosWinkel, and Ford.

³³⁸ Eagan, VosWinkel, and Ford.

³³⁹ Eagan, VosWinkel, and Ford.

³⁴⁰ Lysiak, *Newtown*.

³⁴¹ Lysiak.

³⁴² Lysiak.

and expressed concern that pulling him out of school could cause him to fall deeper into isolation.³⁴³ At one point Nancy hosted a tech party for AL and the club at their home, where nothing unusual was reported.³⁴⁴ Traditional classes at NHS were not working out for AL. Nancy communicated to his teachers his increased anxiety and fears of being bullied and dying.³⁴⁵ Eventually, he earned high school credits through the community college and tutoring one-on-one at the high school and finally completed graduation requirements.³⁴⁶

The decline in AL's mental stability continued throughout his high school years of 2009–2010. Peter and Nancy frequently exchanged e-mails regarding AL's emotional outbursts and refusal to go to school or meet with tutors.³⁴⁷ The e-mails reveal weary yet committed parents trying to resolve the challenges of a child with mental illness. One e-mail describes an evening when AL moved all the furniture out of his room except for his bed and clothing dresser.³⁴⁸ Others include long episodes of emotional breakdowns in which AL is inconsolable.³⁴⁹ Nancy explained periods when AL refused to eat, had severe emotional breakdowns, and retreated to his room.³⁵⁰ She noted to a friend that AL spent time in his room playing video games and that it was difficult to bring him "out of his little world."³⁵¹ She admitted to being fearful of initiating discussions with AL that might induce anxiety instead of allowing him to remain in his room, where he felt most comfortable.³⁵²

³⁴³ Lysiak.

³⁴⁴ Sedensky, *Report of the State's Attorney*.

³⁴⁵ Eagan, VosWinkel, and Ford, "Sandy Hook Report."

³⁴⁶ Sedensky, *Report of the State's Attorney*.

³⁴⁷ Eagan, VosWinkel, and Ford, "Sandy Hook Report."

³⁴⁸ Sedensky, *Report of the State's Attorney*.

³⁴⁹ Sedensky.

³⁵⁰ Sedensky.

³⁵¹ Lysiak, *Newtown*.

³⁵² Sedensky, *Report of the State's Attorney*.

F. AGE EIGHTEEN THROUGH TWENTY: THE DECLINE IN MENTAL STABILITY

AL aspired to join the military and had an avid interest in guns and shootings. When he was home from school, AL spent many hours of the day playing video war games such as *Call of Duty*, *Combat Arms*, and *World of Warcraft*.³⁵³ By early 2010, he had spent over 500 hours playing *Combat Arms*.³⁵⁴ According to findings in the official report, in 2009 AL began participating in online forums for guns, school shootings, and video games.³⁵⁵ In addition, he frequented Wikipedia pages for the same.³⁵⁶ He even edited some of the Wikipedia pages.³⁵⁷ When AL announced his plans to enlist in the military, both Nancy and Peter gingerly explained that joining was not an option.³⁵⁸

In the last few years before committing the shootings at SHES, AL progressed into more profound social isolation. On several message boards, AL described himself as feeling schizophrenic and admitted to powerful mood swings.³⁵⁹ His posts provide insight into his state of mind. He denigrated himself in some message boards, describing himself as depressed. In others, his disconnect with society is apparent when he states, I “am left lying on the floor, numbly perplexed over the foreign concept of loving life.”³⁶⁰ The online persona replaced all socialization for AL. Nancy and Peter discuss via e-mail his nonresponsiveness to Peter’s emails and Nancy’s reluctance to address it for fear of pushing him into further isolation.³⁶¹

³⁵³ Sedensky.

³⁵⁴ Lysiak, *Newtown*.

³⁵⁵ Sedensky, *Report of the State’s Attorney*.

³⁵⁶ Sedensky.

³⁵⁷ Sedensky.

³⁵⁸ Sedensky.

³⁵⁹ Coleman, “Adam Lanza: Timeline.”

³⁶⁰ Coleman.

³⁶¹ Eagan, VosWinkel, and Ford, “Sandy Hook Report.”

Realizing she had exhausted all opportunities to find a resolution for AL, in 2012 Nancy began traveling.³⁶² With friends, she discussed her plans to move to a smaller home.³⁶³ She left AL home alone during her travels, sharing that he was fine as long as he had his computer.³⁶⁴ Nancy traveled 14 times throughout the year, describing the house as untouched upon her return, except for a pile of AL's laundry.³⁶⁵ In late November 2012, Nancy shared with a friend concerns about her discovery of violent and graphic drawings in AL's room.³⁶⁶ According to Nancy, he often dressed in camouflage and used a pellet gun for target practice on a makeshift range in his basement.³⁶⁷ In October 2012, Nancy recalled AL "shutting down" after losing power for several days when Hurricane Sandy hit.³⁶⁸ She found comfort in traveling and doing things for herself rather than her daily activities revolving around AL.

G. CONCLUSION

The events of AL's life detailed in this chapter outline a life filled with debilitating fear and suffering. Furthermore, his parents carried a burden, exhausting every option to find help for AL. Although the mental health system and the school system at times offered several solutions, they were temporary and performed in silos without any coordinated follow-up. Repeatedly, AL's parents found themselves dealing with the emerging symptoms and experiencing feelings of hopelessness in the search for solutions to help AL. Eventually, Peter and Nancy grew doubtful any treatment would help their son and allowed him to find comfort in the confines of his room where he fell into deep social isolation. By choice, AL spent his last days in extreme paranoia, suffering from OCD and anorexia in a world isolated to four walls where the only interaction was with violent video games.

³⁶² Lysiak, *Newtown*.

³⁶³ Lysiak.

³⁶⁴ Lysiak.

³⁶⁵ Lysiak.

³⁶⁶ Sedensky, *Report of the State's Attorney*.

³⁶⁷ Lysiak, *Newtown*.

³⁶⁸ Sedensky, *Report of the State's Attorney*.

Mental health services offered in a community setting through collaboration, oversight, and follow-up can improve the quality of life for mentally ill patients and their families. One of the essential services in the original community mental health system discussed in Chapter II, “History of the Community Mental Health Centers” is education.³⁶⁹ Education is to include family counseling, along with oversight and follow-up for patients with severe mental illness.³⁷⁰ These goals are designed to identify patients in crisis, provide treatment, education, and counseling for families. Chapter IV, “International Comparison of Mental Health Reform,” showed that countries such as Australia have successfully reformed their mental health system using similar program goals. The next chapter explores the thought process and methods of counterfactual analysis. In this case, the analysis addresses the life events of severely mentally ill Adam Lanza and assesses how an engaged and functional community mental health system would identify and treat mentally ill patients. The author posits that pointed, intentional mental health care can positively alter outcomes that could foul active shooters’ plans for mass murder.

³⁶⁹ Dowell and Ciarlo, “Overview of the Community Mental Health Centers Program.”

³⁷⁰ Dowell and Ciarlo.

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VI. IMPACT EVALUATION OF THE COMMUNITY MENTAL HEALTH SYSTEM: A COUNTERFACTUAL ANALYSIS

A. BACKGROUND

Impact evaluation is a research framework used to evaluate public health policy.³⁷¹ The purpose of impact evaluation is to evaluate the effectiveness of policy-based public health interventions.³⁷² Data from the policy or programs—such as outcomes, indicators, and goals—are evaluated over time through monitoring and evaluation.³⁷³ Monitoring and evaluation assesses the implementation and evolution of a project. Whereas operational research is designed to improve the quality of a program,³⁷⁴ Monitoring and evaluation works to identify obstacles and challenges during the implementation of a program.³⁷⁵ By answering the question, “What works for whom in what circumstances?” impact evaluation helps determine the effectiveness of a project.³⁷⁶

To evaluate the CMHC system over time and assess the success of the program as well as patient outcomes, impact evaluation can be applied using a counterfactual analysis. The Neyman-Rubin counterfactual framework was developed to estimate causal effects using observational data.³⁷⁷ Within the impact evaluation framework, the counterfactual analysis compares events that actually occurred with outcomes in the *absence* of an intervention. This type of analysis is beneficial when trying to observe data from the effects of treatment.³⁷⁸ Causality and counterfactual analysis are complex, offering several what-if scenarios. Therefore, analysis of a case study is presented here. —psychotic episodes

³⁷¹ Miguel-Angel Luque-Fernandez, A Counterfactual Approach for Impact Evaluation (presentation, Harvard School of Public Health, Department of Epidemiology, July 19, 2014), https://scholar.harvard.edu/files/malf/files/jhsph-ie-2014_-v10.pdf.174.

³⁷² Luque-Fernandez.

³⁷³ Luque-Fernandez, 12.

³⁷⁴ Luque-Fernandez, 13.

³⁷⁵ Luque-Fernandez, 13.

³⁷⁶ Luque-Fernandez, 11.

³⁷⁷ Luque-Fernandez, 20.

³⁷⁸ Luque-Fernandez, 24.

that elevate to a public health threat through mass killings. Based on these findings, “conditional ignorability” is applied to these cases. Conditional ignorability assumes that treatment for the shooters is randomized, with the outcomes independent of each other. Therefore, any missing data or treatment is conditional on the observed behaviors and outcomes.

For Adam Lanza, the mental health system had several opportunities to intervene if the CMHC system had operated as it was initially designed. The analysis presented in this chapter discusses the possible alternate outcomes in the presence of interventions provided by a collaborative mental health system. With complex circumstances, it can be challenging to predict what would have happened in the absence, or presence in this case, of interventions.³⁷⁹ On the basis of the history of CMHCs presented earlier and the original design of the mental health system noted throughout this thesis, the author posits that critical interventions from the mental health system can change the life trajectory of the mentally ill and prevent mass shootings. This chapter explores the missed opportunities for intervention that could have changed the path of AL’s life and ultimately prevented the Sandy Hook Elementary Shooting.

B. BIRTH TO AGE FIVE

1. Situation

At almost three years old, AL had his first of many evaluations for developmental delays. The birth-to-three evaluation identified delays in language that led to speech and occupational therapy provided by the school system.³⁸⁰ AL’s initial treatment, ordered by his physician and delivered at school, continued for over a year but then was stopped by the school district.³⁸¹ There is no indication the school consulted any of AL’s providers before discontinuing the therapy. The school record noted that AL had no challenges

³⁷⁹ “Compare Results to the Counterfactual,” Better Evaluation, accessed October 18, 2018, https://www.betterevaluation.org/en/rainbow_framework/understand_causes/compare_results_to_counterfactual.

³⁸⁰ Eagan, VosWinkel, and Ford, “Sandy Hook Report.”

³⁸¹ Eagan, VosWinkel, and Ford, 17.

affecting his education, so the therapy was ended.³⁸² Just a few months later, a neurological/developmental assessment showed significant symptoms, such as repetitive behavior of hitting his head, severe outbursts, and intolerance for textures and touch.³⁸³ Recommendations for additional assessments followed these findings,³⁸⁴ and other symptoms were identified, including auditory processing problems indicative of autism.³⁸⁵ Over the two-year period, AL's mental health care stopped and started several times.

Over these first years of interaction with mental health providers, the Lanzas complied with all requests. AL had assessments from a local hospital, the school, and neurologists. The providers in these cases did not appear to share or discuss their findings. As a result, therapy was discontinued even while new symptoms were emerging. The final report states that the school should have evaluated the findings from the occupational therapy and neurology assessments.³⁸⁶

2. Counterfactual Analysis and Possible Intervention

In the CMHC model, services would be linked and delivered with consideration for all previous evaluations and treatment. The school would have used all evaluations from the physicians in designing the appropriate individualized education plan (IEP). Schools do not have the resources to oversee all treatment needs of students, nor is it reasonable to expect schools to oversee treatment needs when students change schools with family moves or other life events. Therefore, AL would have been referred to child services where a treatment plan would be managed, identifying critical needs early along with treatment recommendations. Family education, support, and counseling, one of the essential services the CMHC was to provide, would begin to assist the family in understanding A's needs treatment options. These services would work closely with families such as the Lanza's

³⁸² Eagan, VosWinkel, and Ford, 17.

³⁸³ Eagan, VosWinkel, and Ford.

³⁸⁴ Eagan, VosWinkel, and Ford, 17.

³⁸⁵ Eagan, VosWinkel, and Ford, 18.

³⁸⁶ Eagan, VosWinkel, and Ford, 18.

who are new to dealing with mental illness. The CMHC would educate them on the long-term needs of a patient with autism, as well as the importance of follow-up and treatment.

During a formal evaluation of CMHCs in 1983, the purpose of these centers was reiterated, which was to improve mental health through a coordinated effort of providers.³⁸⁷ Comparing this mental health service model with the needs of AL, his family, educators, psychiatrists, and family physicians would have been working together to meet his needs.

C. AGE SIX THROUGH NINE

1. Situation

The cycle of identifying significant symptoms and subsequent treatment interruption continued throughout AL's early elementary years. In his first-grade year, the school assessment showed deficiencies in articulation and fine motor skills.³⁸⁸ Treatment included 30 minutes of speech and occupational therapy, delivered once a week.³⁸⁹ The official report showed that this therapy was limited and did not meet AL's needs in view of the known deficiencies.³⁹⁰ In 1999, when AL was in second grade, Nancy Lanza started regularly coming to AL's school to help him as he struggled in group settings.³⁹¹ At the same time, the school discontinued his occupational therapy, and his IEP was adjusted to no longer address sensory integration needs.³⁹² There is no indication that a formal assessment, in addition to school evaluations, was completed. As AL entered third grade, school reports showed that the IEP indicated improvements in speech; however, his problems with speech continued to affect his performance in the classroom.³⁹³ Throughout the third-grade year AL was out sick often. The official report notes positive comments

³⁸⁷ Dowell and Ciarlo, "Overview of the Community Mental Health Centers Program."

³⁸⁸ Eagan, VosWinkel, and Ford, "Sandy Hook Report," 26.

³⁸⁹ Eagan, VosWinkel, and Ford, 26.

³⁹⁰ Eagan, VosWinkel, and Ford, 26.

³⁹¹ Sedensky, *Report of the State's Attorney*.

³⁹² Coleman, "Adam Lanza: Timeline."

³⁹³ Eagan, VosWinkel, and Ford, "Sandy Hook Report," 27.

from what appear to be teachers or school faculty, who refer to AL as “neat and thoughtful” and “a good citizen.”³⁹⁴ Over the three years, symptoms worsened as treatment occurred less frequently with no medical oversight.

Over the period from 1998 to 2001 the bulk of AL’s treatment was based on school evaluations and education plans. The official report showed that at the end of the third-grade year, Nancy Lanza sent an e-mail to the school explaining the challenges her son had faced throughout the third-grade year.³⁹⁵ She discussed the anxiety and depression that AL faced and how teachers had been accommodating these needs in the classroom.³⁹⁶ In the e-mail she requested that an alternate, more casual teaching style be considered for AL for the next school year.³⁹⁷ Strikingly, she also asks that the school focus on AL’s *learning* rather than *coping*.³⁹⁸ As a mom looking out for the best interest of her son, this request seems reasonable. However, as the experts from Yale warned in their assessments later in 2006, changing the world to fit AL’s needs would only contribute to social isolation and restrict his ability to function independently.³⁹⁹ This critical advice should have been provided to Nancy Lanza when AL was nine years old and began exhibiting signs of social withdrawal as described in the official report, such as the inability to participate in class and increased anxiety in groups. The report shows no evidence that additional evaluations were performed. The school system, with resources limited to address educational needs, was ill-equipped to guide and direct Nancy to the appropriate resources that could address AL’s needs, a fact confirmed in AL’s fourth-grade year when school documents indicate he met all speech requirements and speech therapy was no longer needed.⁴⁰⁰ There appears to be no medical intervention from 1998 to 2001.

³⁹⁴ Eagan, VosWinkel, and Ford, 27.

³⁹⁵ Eagan, VosWinkel, and Ford, 28.

³⁹⁶ Eagan, VosWinkel, and Ford, 28.

³⁹⁷ Eagan, VosWinkel, and Ford, 28.

³⁹⁸ Eagan, VosWinkel, and Ford, 28.

³⁹⁹ Eagan, VosWinkel, and Ford, 50.

⁴⁰⁰ Eagan, VosWinkel, and Ford, 28.

2. Counterfactual Analysis and Potential Intervention

The above-mentioned 1998 to 2001 period of three years represents a gap, or lapse, in the mental health system's support of AL, evidenced by (a) a student who developed anxiety and depression so severely his mother must attend school daily to assist her son, (b) no psychological evaluations performed or recommended, and (c) termination of the minor treatment that was being delivered. Under the CMHC model, these three years would have had continuous follow-up care from the treatment therapy provided in preschool, monitoring progress with thorough evaluations by qualified mental health professionals. It is reasonable to draw a nexus between educators and the medical community that they have AL's best interest in mind. Furthermore, if available, educators would recruit assistance from psychological experts when witnessing a student exhibit symptoms of asocial behaviors and anxiety. Therefore, under the CMHC model, where child services are available, AL would have received at a minimum, a thorough assessment. The assessment would have identified the most critical and apparent challenges for AL, anxiety and asocial behavior. A mental health provider would have likely recommended psychopharmaceutical treatment recommendations such as antidepressants. Those findings would have led to family counseling and education for Nancy Lanza, who was making decisions for her son that later proved only to advance his mental illness.

Although following this thought process may seem pertinacious, it is just as confounding to know that these symptoms went untreated, even though they were well known to exist. The last documentation dated in the fall of AL's the fourth-grade year, succinctly stated he had "no error sounds," which was enough to discontinue all treatment.⁴⁰¹ A patient exhibiting symptoms of life-altering anxiety would not have been removed from all therapy under the care of a team of providers such as the school and mental health professionals. In this case, a full school year goes by without treatment, but when AL turned 10 years old, significant symptoms developed that demanded attention.

⁴⁰¹ Eagan, VosWinkel, and Ford, 28.

D. AGE TEN THROUGH THIRTEEN

1. Situation

The next opportunity for a critical intervention presented itself during AL's middle school years. At the age of 10 years, AL's first violent graphic writing is exposed. Later that year, OCD symptoms began to surface along with unusual clothing habits.⁴⁰² No mental health assessments were performed even though new symptoms were identified. As a result, AL received no treatment. By the time he was 11 years old, education records had shown that academic performance was acceptable but that socializing remained a challenge.⁴⁰³ AL's father, Peter, recognized new symptoms. He noticed AL had become more anxious, had a difficult time focusing, and had trouble handling daily activities, which developed into panic attacks.⁴⁰⁴ Again, no mental health assessments were performed. The seventh grade was marked with increased doctor visits for various sicknesses, sore throats, and weight loss.⁴⁰⁵ These symptoms all indicated the progression of a mental illness. Although multiple medical assessments were completed, no psychological assessments are documented.

At a new school, AL's violent writings surfaced once again, where teachers were significantly more concerned than NMS had been. These concerned teachers pointedly described the writings AL had composed, as well as his antisocial behavior. Again, no mental health evaluations are documented. Instead, Nancy withdrew AL and reenrolled him at NMS.⁴⁰⁶ By eighth grade, AL was debilitated by his anxiety, OCD, and anorexia.⁴⁰⁷ He spent most of the school year at home. Almost three years went by with significant symptom development without any psychological interventions. When AL

⁴⁰² Eagan, VosWinkel, and Ford, 36.

⁴⁰³ Eagan, VosWinkel, and Ford, 29.

⁴⁰⁴ Eagan, VosWinkel, and Ford, 36.

⁴⁰⁵ Eagan, VosWinkel, and Ford, 40.

⁴⁰⁶ Coleman, "Adam Lanza: Timeline."

⁴⁰⁷ Eagan, VosWinkel, and Ford, "Sandy Hook Report."

began eighth grade, additional symptoms emerged, and a psychological assessment was scheduled, which led to treatment.

2. Counterfactual Analysis and Potential Intervention

The multiple medical providers who assessed AL throughout 2004–2005 did not collaborate or communicate with the school or recommend mental health evaluations. Part of the breakdown could be attributed to the school’s perfunctory assessments that described a student very different from the person the parents saw. School reports showed a student performing well academically, likable, with appropriate behavior in a school setting.⁴⁰⁸ A student with excessive absenteeism, significant weight loss, and consistent generalized illness should have alarmed school faculty. Reports from a psychologist of an evaluation performed in 2006 indicate that AL developed significant communication changes, along with other symptoms during the seventh grade, such as not using e-mail or talking on the phone.⁴⁰⁹ These symptoms went undetected because no mental health evaluation was performed. Although they were necessary to consider during the brief period at the St. Rose of Lima Catholic School, Nancy Lanza was not receptive to the school’s concerns about AL’s violent and alarming creative writing assignments. Rather than address the issues, Nancy withdrew AL from the school, keeping him home.⁴¹⁰

Although the totality of these events throughout this period begs the question of why no additional assessments were performed or recommended, reviewing a series of events in retrospect allows one to arrive at broader conclusions about how severe mental illness was affecting AL. However, it cannot be ignored that with any of these events occurring in isolation, it would be reasonable to require consultation with another provider, whether it be a mental health professional, an evaluation from the school, or even a short-term counseling inquiry for the repeated violent writings. In a system in which mental health is an element for success and overall health, these incidents would have required evaluation at a minimum by community mental health providers. By exposing the incidents

⁴⁰⁸ Eagan, VosWinkel, and Ford, 29.

⁴⁰⁹ Eagan, VosWinkel, and Ford, 50.

⁴¹⁰ Eagan, VosWinkel, and Ford, 38.

through counseling and evaluation, the system would have linked the issues at school with AL's physical symptoms and history and identified a need for treatment and follow-up. Instead, he received no mental health services over the fifth through early eighth grade years, despite his development of symptoms.

E. AGE THIRTEEN THROUGH FIFTEEN

1. Situation

Beginning in the eighth-grade year, when AL was 13 years old, his symptoms worsened, and providers took notice of AL's mental capacity. In the fall of 2005, Nancy turned to the emergency room with AL, with a long list of severe symptoms, including her concern that he was developing autism. AL was not eating or sleeping; he was agitated, withdrawn, and filled with fear.⁴¹¹ He was diagnosed with anxiety, Asperger's syndrome, and OCD.⁴¹² The hospital accurately identified the critical condition AL presented and recommended treatment and additional evaluations as well as assistance in enrolling him in an education program that would also offer treatment.⁴¹³ Records from the ER visit note that Nancy declined the additional evaluations because of a prescheduled appointment with a psychiatrist in the next few weeks.⁴¹⁴ The psychologist also diagnosed AL with Asperger's syndrome and recommended alternative curriculum choices in school to avoid circumstances that may aggravate his condition.⁴¹⁵ AL's symptoms had progressed so severely that they affected his day-to-day living.

Treatment goals for the remainder of the eighth-grade school year were centered on education, with new IEPs created but not delivered due to his absences.⁴¹⁶ Because of the severity of his symptoms and inability to function in a classroom, private tutoring and

⁴¹¹ Eagan, VosWinkel, and Ford, 29.

⁴¹² Eagan, VosWinkel, and Ford, 29.

⁴¹³ Eagan, VosWinkel, and Ford, 39.

⁴¹⁴ Eagan, VosWinkel, and Ford.

⁴¹⁵ Sedensky, *Report of the State's Attorney*.

⁴¹⁶ Eagan, VosWinkel, and Ford, "Sandy Hook Report," 41–42.

homeschooling were discussed as options.⁴¹⁷ The school recommended against the homeschooling option that Nancy requested and offered to discuss alternative ways to meet her son's educational needs. It is necessary here to acknowledge the effort by the school district in identifying a parent in need. Nancy had expressed how fearful AL was throughout evaluations and that his place of comfort was at home. The school recognized her desire to provide comfort but advised against homeschooling.⁴¹⁸ However, Dr. Fox, AL's psychiatrist, provided a note to excuse him from school, and AL stayed home for the remainder of the year.⁴¹⁹ Although Dr. Fox and the school district communicated with one another about AL's educational plans, there is no indication that any discussion took place about what would be in his best interest. At the end of the year, when Dr. Fox responded to a request from the school district regarding testing, he reported that AL was not receiving any schooling whatsoever.

The difference of opinion between the school district and Dr. Fox is an example of how working in silos does not benefit the patient. While Nancy Lanza was directing the treatment of her son, the school district and psychiatrist were working independently of each other, and the result was another year of AL's receiving no treatment therapy other than an IEP that was not fully delivered because of excessive absences. The school district requested updates on AL and offered additional midyear evaluations. Nancy continued to decline offers for evaluations and tutoring because any interactions caused AL severe anxiety. Although delicate to address, direct conversations with parents of mentally ill children may be necessary. In this case, Nancy was able to decline services *she* deemed detrimental to AL. The school district made multiple efforts, including evaluations by psychiatrists, which were appropriate and needed but coming late regarding AL's needs. Even in the CMHC model, overriding a parent when making medical decisions would have been difficult. However, with a team of providers in agreement on treatment needs, convincing a parent to do the right thing would be a more manageable task.

⁴¹⁷ Eagan, VosWinkel, and Ford, 39.

⁴¹⁸ Eagan, VosWinkel, and Ford, 41.

⁴¹⁹ Eagan, VosWinkel, and Ford.

When ninth grade began and AL was 14 years old, more psychological examinations were performed, including long-term treatment plans. This time frame exposed a turning point that could have provided AL a path to relief from mental illness. New symptoms emerged, such as the inability to maintain eye contact along with increased anxiety. Through Peter’s employee assistance program, two psychiatrists—Dr. Fox and a team from Yale, Dr. Robert King and Kathleen Koenig, a nurse practitioner—evaluated AL. In addition, Newtown High School’s psychologist, Michael Ridley, also performed an evaluation. The Yale group performed detailed assessments and addressed the severity of his symptoms with candid notes on his prognosis. The Lanzas were provided specific concerns regarding his treatment plans and what the predictive results would be by attempting to create an environment comfortable for AL rather than helping AL learn to adapt to the world. The diagnosis from Dr. King at Yale, along with Kathleen Koenig, the nurse practitioner, was Pervasive Developmental Disorder (PDD) or ASD.⁴²⁰ In addition, he was “emotionally paralyzed” by anxiety, a conclusion AL agreed with.⁴²¹ When AL expressed discontent with the line of questioning in the assessment by Kathleen Koenig and refused to take the prescribed medication, Nancy requested all treatment consolidate to come from a single provider.⁴²² From then on, Dr. Fox was AL’s main psychiatric provider.

Yale provided many recommendations, one of which was a trial of an antidepressant and participation in a therapeutic study group. This was offered as an alternate for Asperger’s treatment because a long wait list for treatment existed.⁴²³ The protocol was new to the Lanzas and somewhat difficult for them to adhere to. After just three days Nancy discontinued the medication therapy. AL believed he would not benefit from the treatment, and Nancy complied to make him comfortable. The Yale group contested this decision and explained to the Lanzas that AL’s illness caused him to be

⁴²⁰ Eagan, VosWinkel, and Ford, 49.

⁴²¹ Eagan, VosWinkel, and Ford, 70.

⁴²² Sedensky, *Report of the State’s Attorney*.

⁴²³ Eagan, VosWinkel, and Ford, “Sandy Hook Report,” 52.

irrational.⁴²⁴ This lack of awareness is consistent with anosognosia, which describes patients who do not recognize they are ill. Many mentally ill patients suffer from this condition and subsequently go untreated. In addition, AL did not want to attend therapy sessions without his father. Again, the Yale team explained specifically that his illness clouded AL's ability to make rational decisions. With the multiple psychologists, medication trial, and AL's intolerance for the process, Nancy wanted a single point of contact for AL. She stated in an e-mail that her goals related to keeping him comfortable and making it through each day.⁴²⁵

2. Counterfactual Analysis and Potential Intervention

The CMHC model would have provided precisely what Nancy Lanza was asking for—a collaborative effort. Nancy asked that all providers contribute their suggestions, and Dr. Fox would consider them all and decide what action to take. This request was the ideal opportunity for an integrated effort to provide treatment to AL but, more important, explain to his parents the dire need for AL to receive treatment. The community mental health model would have taken this one step further by providing the family counseling necessary to maintain treatment imperatives for patient improvement, even when it seems the patient is uncomfortable. During this time, questions were being answered by various participants, but they isolated from each other within respective silos. The critical missing component was the integrated effort that would have provided the foundational support to the family to continue with necessary therapy. The overlap between disciplines would have provided not only a clearer picture of AL's needs but also of the needs of his parents in coping with a child suffering from mental illness.

It is important to note that after a year of attempting to address AL's mental health concerns through multiple providers, the efforts were soon dismissed. The assessments, group therapy, medication trial, and discussions with the Lanza's did not add up to holistic, integrated medical and mental health services; therefore, the momentum and commitment

⁴²⁴ Eagan, VosWinkel, and Ford.

⁴²⁵ Sedensky, *Report of the State's Attorney*.

to maintain treatment and recovery dwindled. The official report from the state’s attorney for the Judicial District of Danbury stated that AL continued to receive treatment from medical doctors for ailments secondary to his OCD; however, follow-ups with specialists and psychiatrists are undocumented.⁴²⁶ The ninth-grade year marked the end of AL’s documented mental health care. The official report from the state’s attorney showed no indication that follow-ups on recommendations for speech and language were completed.⁴²⁷ Professional mental health literature and practice indicates that psychiatric rehabilitation is noted to be most effective when delivered by integrated clinical services.⁴²⁸ It further states that treatment split into silos are ineffective. Instead, collaboration and coordinated efforts among all disciplines are necessary.⁴²⁹ Patients and families cannot be expected to coordinate these efforts on their own.⁴³⁰ Nancy and Peter Lanza tried to coordinate these efforts for their son; they *wanted* help for their son. However, they never understood the importance of therapy and the critical need for treatment. They missed essential counseling that would have helped them remain steadfast in providing treatment for their son.

F. AGE SIXTEEN THROUGH EIGHTEEN

1. Situation

As AL transitioned into the 10th grade, he once again tried to assimilate back into the mainstream school system. However, his mental illness had progressed, limiting his interactions with others outside his home. Eventually, the symptoms of OCD, anorexia, and severe anxiety debilitated AL, keeping him from attending regular classes at the high school.⁴³¹ School records from the summer before 10th grade indicate that the school had

⁴²⁶ Eagan, VosWinkel, and Ford, “Sandy Hook Report,” 61.

⁴²⁷ Eagan, VosWinkel, and Ford, 61.

⁴²⁸ Drake et al., “History of Community Mental Health Treatment.”

⁴²⁹ Robert Paul Liberman et al., “Requirements for Multidisciplinary Teamwork in Psychiatric Rehabilitation,” *Psychiatric Services* 52, no. 10 (October 1, 2001): 1331–42, <https://doi.org/10.1176/appi.ps.52.10.1331>.

⁴³⁰ Liberman et al.

⁴³¹ Coleman, “Adam Lanza: Timeline.”

made special accommodations for him before and after school as well as curriculum changes.⁴³² Although a psychologist noted he was ready to start school full time, within just a few months, he could not attend classes.⁴³³ AL fell into further mental decline without treatment.

For the 11th grade, AL enrolled at NHS but did not attend. Instead, he received tutoring and earned high school credits through classes taken at Western Connecticut University.⁴³⁴ His attendance at the university lasted only a year before he withdrew.⁴³⁵ His mental anguish intensified and began to affect his mother Nancy. She noted in e-mails how every day was a challenge; some were filled with descriptions of AL experiencing long crying episodes and periods of sitting listlessly.⁴³⁶ AL began to transfer his OCD tendencies onto his mother and restricted her activities to what was comfortable for him. The only evidence of any interaction with psychiatry noted in the official report was a payment made to Dr. Fox in late 2008.⁴³⁷ There is no indication that any treatment took place after the short antidepressant medication trial and a few sessions with the Yale group.

2. Counterfactual Analysis and Potential Intervention

By the time AL was nearing 18 years old, he had a lengthy, consistent record both in school and from various psychiatric providers indicating significant mental illness. At this point, with AL missing nearly all of high school, it is probable that the community mental health system would have intervened. One intervention would have come from the education system's noting the lack of attendance and the opposing recommendation from

⁴³² Eagan, VosWinkel, and Ford, "Sandy Hook Report," 65.

⁴³³ Eagan, VosWinkel, and Ford.

⁴³⁴ Andrew Solomon, "The Reckoning," *New Yorker*, March 10, 2014, <https://www.newyorker.com/magazine/2014/03/17/the-reckoning>.

⁴³⁵ Sasha Goldstein, "Adam Lanza College Records: Newtown Shooter's Bizarre Questionnaire Answers, Good Grades, and Creepy ID Photo Paint Shocking Portrait," *New York Daily News*, April 2, 2013, <https://www.nydailynews.com/news/national/lanza-college-records-suggest-troubling-state-mind-article-1.1305968>.

⁴³⁶ Solomon, "The Reckoning."

⁴³⁷ Eagan, VosWinkel, and Ford, "Sandy Hook Report," 39.

Dr. Fox that AL be homeschooled.⁴³⁸ The Yale team recommendations of pharmaceutical treatment and group therapy would have been a third voice in the conversation. The school district disagreed with Dr. Fox on education delivery methods and keeping AL home. A meeting would have occurred to discuss these differences and the patient history as well as the proper treatment options. In addition, a follow-up would have been necessary with the oversight requirements of the CMHC system to evaluate patient outcomes. It is likely that short-term hospitalization would have been discussed as a viable treatment option. His OCD was affecting his mother's daily activities because he required 24-hour supervision. AL's condition and lack of treatment would have been exposed through communication between providers and the school district, and the issues at a minimum would have been addressed.

G. AGE EIGHTEEN THROUGH TWENTY YEARS OF AGE

1. Situation

Between 18 and 20 years old, AL's condition deteriorated further, and he fell into deep social isolation. He cut all contact with his father and spent most of his time alone in his room in which no one else was allowed. Nancy shared with friends that she had trouble getting AL out of the house for any reason.⁴³⁹ Most of his days were spent on his computer playing video games and exploring the Internet.⁴⁴⁰ The state attorney's official report showed heavy activity on mass shooter websites and chat rooms.⁴⁴¹ Nancy also shared concerns with a friend about graphic drawings she found in his room showing the murder of a woman and child.⁴⁴² No psychiatric evaluations were scheduled or new treatment options pursued. His emotional outbursts continued as the Lanza parents struggled to come up with solutions.⁴⁴³ His mother was either in denial about the severity of his mental

⁴³⁸ Solomon, "The Reckoning."

⁴³⁹ Lysiak, *Newtown*.

⁴⁴⁰ Lysiak.

⁴⁴¹ Coleman, "Adam Lanza: Timeline," 26.

⁴⁴² Lysiak, *Newtown*.

⁴⁴³ Coleman, "Adam Lanza: Timeline."

condition or simply resigned to allowing him to remain in what she believed was comfortable for him. AL was crippled by his illness and unable to acknowledge the truth of his mental health needs.

In looking at the last two years of AL's life, one can surmise that Nancy carried a burden handling an untreated mentally ill patient who was also her beloved son. Treatment was undoubtedly necessary, based on his refusal to leave his room and communicating with his mother only via e-mail, the only family member with whom he communicated. Peter believed in these last years that Nancy wanted others to believe things were better than they actually were.⁴⁴⁴ Through e-mails from Nancy in the official report, it is obvious she was struggling daily with unpredictable incidents brought on by AL's severe paranoia and mood swings.⁴⁴⁵

2. Counterfactual Analysis and Potential Intervention

If the community mental health system had been in place as it was designed, AL would not have progressed to this level of mental instability. However, if it were discovered at this stage, AL could have been hospitalized for a short time to stabilize his anxiety and begin therapy necessary to prepare him to function in the community. At this point, therapy would have been forced treatment because AL was uncooperative and held captive by his mental illness. Nancy had expressed her concerns about AL's many symptoms; however, she was fearful of disrupting what had become AL's norm of isolation within their home. The system not only failed AL but failed to provide adequate resources or education to help the people most familiar with the hard truth of his condition. As a mother, watching her son in extreme mental instability, she was incapable of action, nor did she understand the severity of his illness. Many fault Mrs. Lanza for not heeding the advice of the providers throughout AL's life. However, consider the place a mother must submit to, clouded by love for her son, to impose treatment—treatment that in her eyes, which she witnessed daily, caused him extreme distress. The gap could have been filled with counseling and

⁴⁴⁴ Solomon, "The Reckoning."

⁴⁴⁵ Coleman, "Adam Lanza: Timeline," 28.

education to help Nancy Lanza understand the benefits of treatment. Could the Lanza parents have been more diligent in demanding therapy? Yes. Did they understand to the level necessary that treatment was imperative? No. Did the providers know how vital and necessary treatment was? Yes. Not that any of the providers could have predicted the ultimate outcome of mass murder, but they could have, and would have, provided treatment to get AL on the path to healing.

H. SUMMARY

The details describe the life of a child who was crippled by his mind. Doctors, his teachers at school, and even his family knew he was suffering, but no one was able to help him. Eventually, many families were affected by his illness when he took 26 lives and as well as his own. The mental health system, designed to help the severely mentally ill, could have changed the outcome. U.S. legislators, together with mental health professionals in a progressive and innovative way, identified the need for reform back in the 1960s. A comprehensive system was developed that would serve the mentally ill and improve the lives of millions of people. If the system had been fully implemented, this shooter who suffered from OCD and severe anxiety would have received treatment and would not have progressed to the level of psychosis, becoming homicidal and suicidal. Several times throughout AL's life the system designed in the 1960s, using CMHCs, would have intervened. It is probable that those interventions would have changed the progression of his mental illness. What has been learned through this analysis can serve to help answer questions about how patients who are apparently in need of treatment, remain untreated. Several points can be drawn:

- Mental illness was observed progressing throughout AL's life.
- Treatment recommendations were declined on occasion by Nancy Lanza.
- Untreated mental illness can lead to volatile events.

In a counterfactual analysis, alternative outcomes are considered by changing a series of events. In this analysis, if a patient suffering from mental illness received treatment, it is likely that the treatment would have improved the patient's symptoms. A

change in symptoms could have led to the patient's being able to function independently in groups and in life. By functioning independently, a patient would live a normal life, participating in school and employment and would be less likely to fall into deep depression and psychosis. Evidence-based research indicates that treating mental illness yields positive patient outcomes such as patients leading independent lives. What this analysis underscores is the complex nature of this series of events. The author cannot attest that each intervention would have led to the next. However, based on the evidence of mentally ill patients who receive treatment, it is evident that lives are changed. The components of the CMHC system as it was created but not implemented, would have provided a care plan for treatment and a life free from the holds of mental illness.

VII. CONCLUSION AND RECOMMENDATIONS

A. CONCLUSION

The increase in active shooter incidents by those with known mental illness has captured the public's interest in the current U.S. mental health care system. After action reports attempt to explain how these shooters remain untreated. The question is asked time and time again, "Why did this happen?" When reports surface showing a history of mental illness, more questions arise, not only about why but about how people suffering from mental illness go untreated?

The literature on mental health care and the U.S. mental health system indicates that policy changes over the past 60 years have attempted to address key service delivery challenges.⁴⁴⁶ Policy changes were enacted, and over time, efforts were made to better serve the mentally ill population. Funding to create new community mental health facilities was allocated. Calls for change from the public, mental health advocates, and mental health professionals have pushed for continued mental health reform.⁴⁴⁷ While some positive change has occurred, the U.S. mental health system still needs improvement.

The research in this thesis set out to answer the question of why mentally ill patients go untreated. A more in-depth look into the lives of many active shooters shows the gaps in mental health treatment. A case study analysis of the shooter Adam Lanza, a young adult who suffered from untreated mental illness for most of his life and took the lives of 20 children and six adults on December 14, 2012, exposes the gaps where the mental health system could have intervened.⁴⁴⁸ With every mass shooting, the impact goes beyond the lost loved ones and extends to the survivors and the circle of friends, coworkers, and others who knew someone involved. The emotional and economic impact is detrimental. However, the mass shooting at Sandy Hook is particularly egregious because the targets were young elementary school children. It is plausible to conclude that treatment through

⁴⁴⁶ Warner, "Deinstitutionalization."

⁴⁴⁷ Dowell and Ciarlo, "Overview of the Community Mental Health Centers."

⁴⁴⁸ Sedensky, *Report of the State's Attorney*.

interventions at crucial points in the shooter's life would have changed his direction in life, thus preventing the loss of innocent lives at Sandy Hook Elementary.

1. U.S. Mental Health System

The mental health system in the United States has evolved since the days of Dorothea Dix. A pioneer for mental health, her commitment to creating a better system and advocacy for the mentally ill population changed lives.⁴⁴⁹ In the early to mid-1900s, mental institutions became asylums where patients endured poor living conditions and where abandonment exacerbated their state of mental health. During the 1960s, with the advent of antipsychotic medications, then President Kennedy led a change to again improve the care for the mentally ill.⁴⁵⁰

The need to improve the lives of the mentally ill brought about deinstitutionalization, closure of institutions, and a shift of responsibility for the mentally ill from the states to the federal government. A plan for community-based care would serve the mentally ill, allowing them to assimilate into the community in hopes of a better quality of life.⁴⁵¹ These efforts never materialized, and mental health in the United States is now eerily similar to that described by Dorothea Dix in the mid-1880s when people with a mental health condition roamed the streets and were incarcerated.⁴⁵² Iterative policy changes have not provided the full-scale mental health system reform required to have an impact on the lives of the mentally ill population in the United States.

The idea for a mental health system based on community-centered care was developed and funded during the 1960s, but because of implementation challenges and legislative decisions, the system became fragmented.⁴⁵³ The overall lack of support and continuous budget cuts left patients to fend for themselves when making mental health decisions. The initial lines of communication between stakeholders were missing, creating

⁴⁴⁹ History.com, "Dorothea Lynde Dix."

⁴⁵⁰ Mental Retardation Facilities and Community Health Centers Construction Act of 1963.

⁴⁵¹ Rosenbaum, "Liberty versus Need," 1490.

⁴⁵² Warner, "Deinstitutionalization," 18.

⁴⁵³ Rosenbaum, "Liberty versus Need," 1491.

a gap in treatment.⁴⁵⁴ The hospitals discharging patients did not support action that meant the loss of funding and jobs to community centers, and community centers were not briefed on discharged patients or who they were supposed to be serving.⁴⁵⁵ Transfer of care is a critical step in ensuring patients receive follow-up treatment.

2. Mental Health Reform in Australia

Australia’s successful mental health reform is an example the United States can learn from. The policy changes in Australia have been welcomed by caregivers and providers. With broad-spectrum support and an unmatched national commitment to success, Australia has become a leader in mental health reform. This same level of support is necessary in the United States before significant changes can be effective. Bipartisan support of mental health policy change in the United States is a necessary first step. Australia’s National Mental Health Strategy is revised every five years, with reported continued policy improvements.⁴⁵⁶ The United States has also performed policy and system evaluations; however, they are not matched with a commitment for change. By adopting the same approach Australia uses—that is, considering healthy citizens a priority—the United States could encourage early intervention. As demonstrated in Australia, these steps would lead to prevention and a healthier society.

The importance of a citizenry with overall health is the positive ripple effect for general life outcomes. For example, healthy citizens are sick less often and therefore miss work less often. People who go to work have fewer financial hardships.⁴⁵⁷ Those with fewer financial hardships are less likely to become homeless. All this, in turn, affects mental health by reducing stress and anxiety, which can lead to depression.⁴⁵⁸ By treating mental health as any other disease and reducing the stigma of mental ill-health, the United

⁴⁵⁴ Torrey, *American Psychosis*, 77.

⁴⁵⁵ Torrey, 77.

⁴⁵⁶ Whiteford, Buckingham, and Manderscheid, “Australia’s National Mental Health Strategy,” 210.

⁴⁵⁷ Searle, “Investing to Save.”

⁴⁵⁸ Searle, 10.

States will not only have overall better health, but more important, people's lives will be changed for the better.

Australia paved the way for successful reform in several key areas. Concerning support, legislation ensured bipartisan support for mental health reform.⁴⁵⁹ Any changes in government leadership do not change reform efforts. Funding for system changes was also secured. Australia uniquely values its constituent's quality of life, regularly surveying consumers and gaining real data on the success of its programs. Policy changes are based on survey results, providing the changes citizens are asking for. In addition, a complete perspective of the system is gained by looking at provider surveys and those from families of the mentally ill.⁴⁶⁰ This has led to overwhelming support for mental health reform, resulting in continued momentum. A healthy system that provides treatment for those with mental ill-health can prevent the progression of minor mental illness such as depression and anxiety.

Consider the possible outcomes for patients with a traditional medical condition such as diabetes that goes untreated. Prolonged hypo- or hyperglycemia can lead to poor circulation, loss of limbs, and unconsciousness. Compare those outcomes with untreated patients with mental illness, and the differences are striking. The prognosis for diabetic or cancer patients who do not receive treatment is grim. Patients will deteriorate until they are unconscious or eventually die. When people with diabetes have an altered mental status, they are treated via implied consent, with medication, as a reasonable person would expect. However, for patients with a mental illness, the discussion for imposed treatment changes. Is living in severe paranoia, crippled by anxiety, as uncomfortable as having low or high blood sugar? What if people with paranoia do not understand they are paranoid and refuse to get help? Diabetic patients with very low or high blood sugar often do not realize they have become irrational, yet medical professionals impose medication therapy and treat those patients. We know, through medical research, that once blood glucose is back within

⁴⁵⁹ Whiteford, Buckingham, and Manderscheid, "Australia's National Mental Health Strategy," 213.

⁴⁶⁰ Whiteford and Buckingham, "Ten Years of Mental Health Service Reform in Australia," 399.

normal limits, patients can make rational decisions. This research argues that the same medical attention should be given to patients with mental illness.

3. Gaps in the U.S. Mental Health System

Adam Lanza lived almost his entire life in fear. By second grade, his fear and anxiety escalated, requiring his mother make daily visits to the school to help him cope.⁴⁶¹ By middle school, his OCD exacerbated his condition so that he could no longer attend classes.⁴⁶² Eventually, this caused a progression into deep depression and social isolation.⁴⁶³ By the time he was a young adult, he had developed severe OCD and debilitating anxiety and was asocial. He had shut out the world around him, including his immediate family.⁴⁶⁴ Adam Lanza spent the last months of this life within the four walls of his bedroom, where he studied mass shootings and played video games. He was in solitary confinement that ended with the mass shooting and his suicide on December 14, 2012.⁴⁶⁵

To answer the question in this research about how a patient with mental illness goes untreated, a counterfactual analysis was performed. The analysis provided a thought process using the reformed mental health system designed in the 1960s. Due to poor implementation and political support that ebbed and flowed with elections, the system never reached full potential. However, what if it had? What if the system, which U.S. leaders identified needed reform over 50 years ago had been supported as the system is in Australia? The clear answer to these questions is that by placing the same child in a system that supports mental health and provides access to care, the outcomes change.

Mental health treatment was missing in Adam Lanza's life at several critical times. In a developed mental health system in which providers are accessible and offer comprehensive treatment plans, patients receive treatment. When educators and mental

⁴⁶¹ Coleman, "Adam Lanza: Timeline.

⁴⁶² Coleman, 7.

⁴⁶³ Eagan, VosWinkel, and Ford, "Sandy Hook Report," 53.

⁴⁶⁴ Eagan, VosWinkel, and Ford, 97.

⁴⁶⁵ Eagan, VosWinkel, and Ford, 98.

health professionals collaborate for the patient, families are provided necessary information to ensure treatment occurs. Adam Lanza was identified as needing therapy at less than three years of age.⁴⁶⁶ With consistent occupational therapy, the years of nontreatment during which his symptoms progressed would have been filled with regular and timely evaluations. The evaluations, accompanied by subsequent treatment recommendations, would have provided an updated history for all stakeholders to consider when making treatment plans. Instead, the school system and various mental health experts worked independently of each other. This seesaw of evaluations and treatment continued throughout his life.

Early intervention during Adam Lanza's elementary school years would have encouraged Adam and his parents to manage his mental illness. The IEPs provided in early elementary, in conjunction with psychiatric evaluations would have led to regular treatment throughout middle school. Collaboration between providers would have identified new needs or changes in treatment as they arose, allowing providers to continually address any changes in his disease process. In addition, consistent family counseling for Nancy and Peter Lanza would have ensured a solid understanding of necessary and appropriate treatment plans. Questions about how patients respond to medication therapy would have been answered, and when faced with concern about side effects, family counseling would have been provided to help them through Adam's adjustment to medication. The Lanza parents could have received full support from a team of providers with their son's best interest in mind. When therapy options are understood, parents are better equipped to become part of the treatment team rather than attempting to make decisions based on a partial understanding of mental illness. This team approach would have provided Adam Lanza the opportunity to participate in life and attend school rather than taking a path to isolation.

⁴⁶⁶ Eagan, VosWinkel, and Ford, 16.

B. RECOMMENDATIONS

The large-scale problems that exist within the mental health care system in the United States require a call for service and policy change that is beyond the scope of this thesis. Through the various times pointed out in the case study, gaps were identified when Adam Lanza could have received treatment. The recommendations presented here are based on the findings from the case study and apply to both the system as a whole and the provider level for mental health, where the breakdowns begin. Active shooter events are happening more frequently; since the devastation at Sandy Hook, there have been more than 2,300 variations of mass shootings across the United States, many of them at the hands of people who have a mental illness. By focusing on the prevention and treatment of mental illness, the United States can reduce the occurrence of active shooter incidents.

1. Large-Scale System Reform

A full large-scale system reform requires several essential priorities. One is a long-term commitment from the federal and state leaders in conjunction with Mental Health America (MHA), a nonprofit that works to improve overall mental health in the United States. To identify the deficiencies in the system, an initial assessment is necessary by an independent consultant such as KPMG, as Australia has used, to determine the baseline condition of our system. Both a commitment to funding and, most important, a commitment to oversight are necessary. Accountability for allocations of funding is imperative for successful reform. A complete mental health care system reform in the United States will take years of continuous, consistent work, including follow-through. Until formal commitments are made through legislation and fully supported campaigns, mental health providers can begin taking steps toward better service delivery.

2. Provider-Level Reform

The solutions can start with providers who take a complete 360-degree view of a patient's condition when determining treatment. In Adam Lanza's case, the providers recommended appropriate treatment. However, individually, each provider did not have a complete picture. Some aspects of Adam's condition were understated by the school, causing treatment interruptions. Services declined by his parents were done so in silos,

without complete oversight. When parents become part of the obstacles in treatment delivery, direct, pointed conversations that compel them to get treatment for their children should occur. When a patient is a plausible public health risk, discussions must happen between schools, providers, family, and the community to explain the specific risks involved. These discussions must go beyond the physicians involved. An option to consider when parents refuse treatment for a child in a severe state of mental illness is imposing compulsory counseling.

C. CLOSING

At each gap in Adam Lanza's life, both an opportunity and a failure presented itself. Throughout his life, he traveled a convoluted route of treatment options. When the next mass shooting happens, families and loved ones need more than platitudes to answer questions about why the shooter suffered from untreated mental illness. When failures of the system put the public at risk, a new commitment must be made for change that deals with the specific challenges that leave the public vulnerable. In these events, part of the blame falls on the system, part on the family, and part on the providers and the private sector; it is imperative that a new commitment be made to handling these cases more effectively before yet another shooting occurs.

In a mental health system in which patient outcomes are evaluated and remain a priority, treatment is available and encouraged. Mental health programs around the world are addressing the need for mental health care, both minor and severe. Treating minor mental illness is critical to overall health because when it is left untreated it escalates to more severe conditions that may put both the patient and public at risk. Attempts have been made throughout the past 60 years to address the mystery of mental illness in the United States. The need for a focused, funded commitment to fill the voids in our mental health system is urgent before more untreated patients spiral into psychotic darkness.

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