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PSYCHIATRIC CRIMINOLOGY

A Roadmap for Rapid Assessment

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Foreword by David Boyd

Dr. Liebert was a classmate of mine at McGill University Faculty of Medicine, and, although we pursued very different career pathways after graduation from the "then-most international medical college in North America," our paths would cross later in life. I realized that we had common interest and experience in emergency medical care, public safety, and the healthcare delivery systems. John asked me to review the latest book he has authored with William Birnes, PhD. This will be their latest of four books addressing the needs and solutions across the spectrum of social, political, and socioeconomic crises in public health and safety. They write on important and perplexing issues that confound society, clinical and public health experts, law enforcement officials and politicians in both practice and academic discourse. Uniquely, in this new book the authors not only document with research-based evidence and multiple case studies the needs and solutions to today's new epidemics, but they present convincingly the benefits of their solutions.

Dr. Liebert and I shared the unique opportunity to learn neuroscience at McGill's Montreal Neurological Institute. We learned from the legendary pioneers; in neurosurgery by Dr. Wilder Penfield, neurology by Dr. Herbert Jaspers and psychology research by Donald O. Hebb, PhD. These great scientists and excellent teachers literally wired our brains for future growth and comprehension that is now of increasingly critical importance. Dr. Liebert became a psychiatrist and continues to practice psychiatry and psychotherapy based on complex psychopharmacotherapeutics from the solid foundation of neuroscience he learned at McGill.

As our med-class president I recognized a group of class colleagues who trained and excelled in their initial chosen fields and subsequently had the secondary vision, energy, and perseverance to explore and succeed at another new and broader societal impacting career. I recognized my classmates who took the road less traveled who made a major impact in a different condition or field and awarded them McGill Med-Class 1963 Percival Pott Virtuous Physician Award. This award was based on the discovery by a solo practitioner, Dr. Pott, of scrotal cancer occurring in the young male chimney sweeps of eighteenth century London. He recognized for the first time an occupation caused cancer, and fought in Parliament to regulate this child abuse and eradicate a lethal disease.

I selected Dr. Liebert for this award for his pioneering work in addressing our public health and safety epidemics of suicide, violence, and invalid diagnostics for both chronic psychiatric impairment within 22% of our population and common medical errors with altered states of consciousness causing both death and chronic disability within the emergency services system.

My career started as a general surgical resident with a special interest in injury and became aware of report "Accidental Death and Disability, *The Neglected Disease of Modern Society*" (Accidental Death and Disability, 1966). I conceived the idea that we needed intensive care Trauma Units in selected hospitals and these should be arranged in large geographic regions with upgraded prehospital emergency medical services. I convinced Illinois Governor Richard B. O'Gilvie to support a Statewide Trauma Center and Emergency Medical Services System in 1971 (Flashner and Boyd, 1971). Invited to Congress to testify on our experiences, I argued for a similar national program based on our model. I authored the clinical and programmatic aspects of the Emergency Medical Services Systems Act(s) of 1973 (PL-93-154), 1976 (94-573), and 1979 (96-142). Subsequently I was appointed the National EMSS director by President Ford, and served under the Carter and Reagan administrations. Based on the proven Illinois model I established 304 contiguous regional trauma and EMS systems that covered every state and territory of the United States. Within each state I developed an EMSS "Lead Agency" in the State Health Authority to appropriately and flexibly implement the operational EMS components to support essential clinical systems for

- Major trauma
- Burns
- Spinal cord injuries (SCI)
- Acute cardiac attacks
- Poisonings and clinical toxicology
- High-risk infants and mothers
- Psychiatric and behavioral emergencies

All of these important clinical problem areas could be and were supported by the organization and public health orientation established from the instructive regional trauma systems. These were used as the basis for access and uniquely developed interventions for all of the other acute clinical programs.

I recognized early in my career as a trauma surgeon that consistent emergency psychiatric evaluation and treatment was inadequate or nonexistent in most of our developing trauma regions. During an interview with an emergency department nurse in one of our well-functioning trauma centers, I asked, "How do you handle psychiatric emergencies?" She replied, "We have much improved our program for trauma and the other types of emergencies, but not for psychiatric cases. Once we drug them and restrain them and put them in the back cubical, we don't know what to do for them." Unfortunately this was true for both the privileged and disenfranchised patients. Assessment, diagnosis, and treatment were not available or were extensively delayed. In the other clinical areas I identified

a knowledgeable and expert specialty physician and we would work out how to provide the emergency services system for that clinical area.

What did exist was primitive emergency room practices and complex interactions with law enforcement, social service and referral agencies. These are slow and dissatisfying. Large numbers of agitated and mentally disorganized patients clogged the inadequate facilities in hospitals severely impacted by a lack of a systems approach. Although psychiatry is not my field of expertise, I could not help but recognize that something better needed to be done. I included psychiatric patients as an important group who could benefit from our success in a comprehensive and regionalized Emergency Medical Services System.

I needed to find an interested psychiatrist; however, I found none. I did a national search through our growing body of "systems" experts that participated at our regional and national technical assistance (TA) conferences. We did as was our custom and asked the local conferees to point out their leaders which they did. I got the same result. Many were psychiatric nurses and social mental health workers and a few psychiatrists. In 1983 we published our landmark text, *Systems Approach to Emergency Care* (Boyd, 1983). This textbook laid out the conceptual development of EMS Systems in the United States. It presented chapters on the seven critical patient groups identified for regional EMS planning and the transferability of the "systems methods" for varied emergent medical conditions. We included a chapter on "Systems Approach to Behavioral Emergencies" (Resnik and Hudak, 1983).

"For each clinical category an in-depth knowledge of the incidence, demography, epidemiology, and clinical aspects associated with these critical patient categories is mandatory to address EMS regional planning and operations. General as well as specific planning for a regional EMS response for the overall patient population and particularly for the critical target patient groups provides a system of care for both routine critical medical conditions and other emergencies so that all would receive better care and benefit from sound regional EMS system planning and operations. Responsive region wide system plans and operations in both the general and critical care areas provided a basis and an opportunity for evaluating these goals and impacts with an aim toward prevention" (Boyd, 1982). For psychiatric and behavioral emergencies, we need to find leadership psychiatrist and mental health workers and introduce them to systems and the experience of trauma surgeons, nurses, and hospital administrators. Psychiatric systems like trauma should not be centralized but developed nationally and within a regional concept that anticipates the many obvious differences of urban, suburban, rural, and remote areas in the country. Each of these regional conditions share common demographics and cultures that need compatible rules and guidelines for psychiatric and behavioral emergency medical services.

Dr. Liebert picked up on these concepts during his second career as a traveler working in emergency psychiatry from Maine to San Diego and many sites in the Midwest, both remote and inner city. He correctly reiterates in his books to date that the Emergency Medical Services System has saved millions of lives and prevented chronic disability in many millions more; he states, "dialing 911, I assure you, was not a presidential edict. It was a fight all the way from local

hospital campuses fearful of sicker patients arriving at their ERs and thus escalating their DOA rates to vested interests afraid of a regionalized system of best practices that, as simply the case in medicine and public health, always follows discoveries. One is now shocked to see the blood soaked surgical tables at Guy's Hospital in London and the sink where surgeons washed their hands after surgery! Then came Dr. Joseph Lister who translated the bacteriological discoveries of Pasteur into best surgical practices—namely aseptic surgical practices, now taken for granted."

As Dr. Liebert and Dr. Birnes consistently assert in their various publications and books, the public institution of Psychiatry today is like surgery returning to colonial practices in denying the translational research of aseptic best clinical practices. Today hardly any informed citizens of this country would tolerate such denial and ignorance in the name of a budgetary shell game that shifts public psychiatry to law enforcement as the authors correctly point out in case after case. The emergency services gateway that was modernized with implementation of the Emergency Services Act nearly 50 years ago is open and will accept rational "Systems" concepts to their local behavioral health problems. The scope of both public health and safety now covers a broad spectrum of fragmentation from community services to academia. Criminal justice or health and social sciences simply cannot embrace the systems concepts under their current departmental and disciplinary structures. The scope of this new textbook extends from the battlefields in Iraq to the streets of American cities; from solitary confinement in primitive jails to emergency departments swamped with both non-emergent and emergency care and with school health and counseling services confronting unprecedented violence and suicides on campus with a system made for the silent generation of the '50s.

Psychiatric Criminology: A Roadmap for Rapid Assessment, should be a first step for both college departments responsible for educating our new clinicians and public safety officers, as well as public health and safety officials in active roles. As of now there is no strategy in place. I included behavioral emergencies as a major category for our national modernized Emergency Medical Services System decades ago. As Liebert and Birnes assert, it is time to read again what I said back then and start doing it. It certainly has worked for trauma, heart attacks, and strokes.

Dr. Liebert practices at the cutting edge of psychopharmacology one day in North Scottsdale, Arizona, but he must see the disenfranchised psychiatric patient in Sheriff Joe's jails the next day in Phoenix; he reports in his latest textbook this strange and threatening dichotomy of managing malfunction of our brain's neuronal pathways, both in the twenty-first century and seventeenth century, that he personally experiences every week as a practicing psychiatrist. Read the book—better yet, for professors with students hungry for understanding the current public health and safety crises of our land, adopt this textbook for your course, and remember rapid assessment is critically important. Trauma care, whether surgical or neuropsychiatric, is an amazingly complex and demanding field. Every case is different. People get shot differently, they are critically injured

in varying ways and you have to know your field, to think fast and have a pre-planned rapid, accurate response to the situation.

Dr. David Boyd, MDCM
Fellow American College of Surgeons, author of Emergency Services Act and founder of The National Emergency Medical Services System

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Foreword by Cloyd Steiger

When I became a homicide detective in 1994, the first murder I was assigned was the killing of a seven-year-old girl named Angelica. Angelica lived in a ramshackle, hastily-erected shelter with her mother, who was otherwise homeless. Gang members fired guns indiscriminately in the structure. Angelica, asleep inside, was struck and killed by one of the bullets. She should have not been there, but in a safe, secure home.

During my 36-year career with the Seattle Police Department, including 22 as a homicide detective, I saw the violence committed against and by the homeless population. Many of the people I've encountered were homeless veterans. I've seen these veterans murdered on the streets, and other times I've arrested them for murder.

I've investigated the senseless murders of innocent victims by psychotic people, seemingly at random on the street, from a baseball fan walking back to his car after a game being stabbed by a deranged suspect who'd been in and out of the court systems, to a soccer fan meeting the same fate on the street by different, but equally deranged individual. I investigated several mass-shootings committed by the mentally-deranged, including the Café Racer shooting by Ian Stawicki, detailed by Dr. Liebert in this book.

The common denominator in these cases is the revolving door failure of the psychological evaluation process.

Police officers are often the first contact with people suffering from severe psychological impairment; many are dangerous. Even when these people are taken in for involuntary mental evaluation, they are released after a few hours, with little or no evaluation actually done. Is this because of concern for the rights of the patient, the lack of facilities or both? By pushing a seriously mentally ill person out of the door and back onto the street you do a disservice both to them and the public at large.

Dr. Liebert is a passionate advocate for humane and effective treatment for the invisible population on the streets of America, and a tireless advocate for taking

care of the American veteran who volunteered to serve their country, only to be later pushed into oblivion by the government they served.

Cloyd Steiger
Chief Criminal Investigator
Washington Attorney General
Homicide Investigation Tracking System

Authors

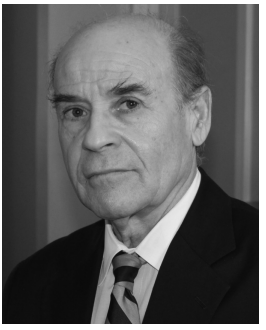
John A. Liebert, MD, completed his residency training in psychiatry at the University of Washington and served as chief resident at the Seattle VA Medical Center. He practiced psychiatry in Bellevue, Washington for 25 years before becoming an author while traveling the country as a locum tenens psychiatrist. In that capacity he practiced in every type of point of entry to the health-care system and studied a broad spectrum of patient populations from Eastport, Maine, to San Diego, California, with every region of Wisconsin and California—rural and inner city—in between. He served on both the clinical faculty of Harvard at Cambridge Hospital and the forensic psychiatry team at the Security Housing Unit (the SHU) of Pelican Bay Prison, California.

Following his last assignment performing fitness-for-duty examinations on troops returning to Joint Base McChord/Fort Lewis from the surge in Iraq, he returned to private practice in Scottsdale, Arizona, where he specializes in the diagnostics and treatment of psychiatric disorders via evidence-based criteria demonstrated online at www.digitalclinician.com.

He is a Master of Psychopharmacology from The Neuroscience Education Institute of Carlsbad, California with membership for both continuing education and consultative services with the Massachusetts General Hospital Psychiatry Academy of Harvard University. He combines psychopharmacotherapy with psychotherapy in treatment and has extensive training and clinical experience in both treatment modalities.

Dr. Liebert completed his premedical training at Amherst College, Massachusetts, with a BA in English and received his MD CM degree from McGill University Faculty of Medicine in Montreal, Quebec. He completed a rotating medical-surgical internship at Santa Clara County Hospital in San Jose, California, where it was customary for interns to manage the emergency room alone for two months. He was drafted for the Vietnam War during internship

and served as the flight surgeon in a unique air transport mission with the 7th Logistics Squadron. Following his military service, he completed his training in psychiatry and neurology at the University of Washington. He is licensed for practice of medicine in Arizona and Washington State and a member of both the King County Medical Society and Washington State Psychiatric Association. He is the Consulting Board Psychiatrist for the American Investigative Society of Cold Cases and recipient of the Percivall Pott Virtual Surgeon Award from McGill University, based on his discoveries in the field of medicine as a solo practitioner. (Pott, an eighteenth century solo practitioner in London, discovered cancer in chimney sweepers.) In addition to this book, he has authored three books with attorney and investigative reporter William Birnes: *Suicidal Mass Murderers: A Criminological Study of Why They Kill* (Taylor and Francis/CRC Press) based on the Virginia Tech massacre and anthrax attacks associated with the events of 9/11; *Wounded Minds: Understanding and Solving the Growing Menace of Post-Traumatic Stress Disorder* (Skyhorse Press) based on the Fort Hood rampage murders by Nidal Hassan, the Great Bear Lake suicidal mass murder by Los Angeles Police Department Officer Christopher Dorner, and the Afghanistan atrocities of Sergeant Robert Bales from Joint Base McChord/Fort Lewis; and *Hearts of Darkness: Why Kids Are Becoming Mass Murderers and How We Can Stop It* (Skyhorse Press) based on the Sandy Hook Elementary School, Tucson Safeway Plaza, Utoya Island/Oslo, and Aurora Theater suicidal rampage murders.



William J. Birnes, JD, PhD, is the chairman of the Board at the Sunrise Community Counseling Center in Los Angeles, a New York Times bestselling author, and a National Endowment for the Humanities Fellow. He was a member of a research team for the U.S. Department of Justice on cold case sexual offender data analysis and a coauthor, with Dr. John Liebert, of *Suicidal Murderers, A Criminological Study of Why They Kill, Wounded Minds, Hearts of Darkness*, and, with Robert Keppel, of *Serial Violence, The Grisly Business Unit, Signature Killers*, and *The Riverman*. His first work in this field was *Serial Killers* with coauthor Joel Norris. His book, *Dr. Feelgood*, was an Los Angeles Book Award finalist.

1

Through a lens darkly

We live in the age of the all-seeing eye of the video camera, surveillance cameras on ATM machines, at convenience stores, at street corner locations, and on mobile phones of all types. The all-seeing eye of the video camera captures events of every type from children diving into swimming pools, to piñata events at birthday parties, to police interactions with citizens on freeways, country roads, and city streets. And the all-seeing eye of the video camera has become part of our daily lives, turning up in the most inconvenient ways on the evening news. And so it was all the way back in 1992, when Los Angeles Police Department (LAPD) officers chased, cornered, restrained, and then beat Rodney King with their batons in such a way that even LAPD Chief Darryl Gates said publicly that he was "disgusted" by what he saw. Whether Rodney King was acting strangely because he was mentally ill or because he was high on a particular drug, we do not know. But, we do know that as a result of that videotape the officers involved were tried, acquitted by a California jury, and became the poster images for the Los Angeles (LA) riots after their acquittal.

The cameras keep on recording as if the citizenry wants to maintain a public record of police interactions that may go swiftly and horribly awry. Interactions between police and citizens caught on random cell phone videos galvanize our attention because the camera frames the moment, takes a slice out of reality, and in a McLuhanesque moment of clarity, isolates it and raises it to a form of art where it becomes cathartic to individuals watching it and to their entire communities. Is it any wonder that demonstrations break out in the streets after each shocking event bursts into our collective consciousness? This is new. This is how technology now moves the politics of policing and the justice system.

One of the most recent examples of this took place in North Charleston, South Carolina, when passerby Feidin Santana noticed what seemed to be an altercation between North Charleston police officer Michael Slager, a 5-year veteran of the department with at least two citizen complaints against him for excessive force, and motorist Walter Scott, an African American whom Slager said he stopped because a taillight was out on Scott's Mercedes. Then through the dashboard cam on Slager's police unit, we see Walter Scott fleeing. Slager catches up to him and then the two men seemed to be struggling, and Santana, as he told NBC news anchor Lester Holt, felt that things were going to go down very badly.

Thus, he aimed his cell phone camera at the pair and captured on video Scott struggling with Slager and then running away as Slager aimed his weapon at the fleeing individual and fired eight shots into his back. Scott went down, Slager handcuffed him, seemed to drop a device beside his body, and called for backup. Scott died from his gunshot wounds.

At first, Officer Slager filed a report indicating that he made a routine traffic stop for a taillight violation, at which point, Scott exited the car and struggled with the officer for his Taser, then ran away. At that point, Slager said, he felt justified in firing his weapon, because he believed his life had been in danger. The police report, Santana said, appeared in the newspaper, but because Santana was an eyewitness and what he saw contradicted what the police report said, he was very disturbed as well as frightened for his own safety. But after much soul-searching, he told Lester Holt and then MSNBC's Chris Hayes, Santana turned over to Scott's family the video he had taken of the officer shooting the fleeing Walter Scott in the back. From the victim's family, the family lawyer sent the video to *The New York Times* (NYT), who published the story and the video, after which publication, the South Carolina Law Enforcement Division opened an investigation, and Officer Slager was arrested and charged with murder.

He is now in jail awaiting trial (Schmidt and Apuzzo 2015). According to the NYT story, Walter Scott had been arrested numerous times in the past, mostly for failure to pay child support and at least once for assault and battery. Anthony Scott, Walter Scott's brother, told the NYT that Walter Scott might have believed he was about to be arrested again because he owed child support. Nevertheless, commentators have pointed out, the U.S. Supreme Court has held—and this is current and established law—in *Tennessee v. Garner* (471 U.S. 1 [1985]) that using lethal force against a fleeing suspect is unconstitutional unless that suspect poses a threat to life. The ruling states that the Tennessee law authorizing use of lethal force was, "unconstitutional insofar as it authorizes the use of deadly force against, as in this case, an apparently unarmed, nondangerous fleeing suspect; such force may not be used unless necessary to prevent the escape and the officer has probable cause to believe that the suspect poses a significant threat of death or serious physical injury to the officer or others." Hence, when Scott fled Slager, regardless of Scott's belief that he might have been arrested for failure to pay child support, Slager's use of lethal force was a crime.

It is likely, Santana and the Scott family have said, that this case might never have come to light but for the video that Santana took with his cell phone, an ever-present device, an all-seeing eye. There is no escape from a cell phone camera, which also brought to light the case of Eric Garner on Staten Island, New York, in July 2014.

In another recent case, Freddie Gray was arrested by Baltimore city police, shackled and cuffed after being swarmed and tackled, and then, with his legs dangling loosely, dragged off to a police van. Shortly after his arrest and while in police custody, Gray died from a severed spinal cord. What happened to him in that van and in police custody? All the camera sees is a limp and shackled Freddie Gray dragged off by police. But the resulting fury of the African American community in West Baltimore fueled the worst riot in Baltimore since 1968. Now,

however, the Baltimore medical examiner ruled Gray's death a homicide, and State's Attorney Marilyn Mosby announced that all six Baltimore police officers who arrested Gray, an arrest she alleged was unlawful because it was absent probable cause, will be charged with manslaughter in Gray's death. One wonders if the officers' defense, however, will assert *Terry v. Ohio* (1968), in which the Supreme Court ruled that officers may stop and frisk an individual without violating that individual's Fourth Amendment protection against unreasonable search and seizure if they believe that a crime is likely afoot. When Freddie Gray fled the police and was chased by a bike patrol officer, Lieutenant Brian Rice, was that flight cause enough to afford Rice and fellow officers who joined the chase the legitimacy of their arrest? Mosby announced that because Gray's fatal injuries took place while in police custody in a police van transporting him to the police station, during which he was not belted in as the law requires, the officers were responsible for the injuries that caused Gray's death. In a related story concerning one of the charged officers, Lieutenant Brian Rice, who was on bike patrol on April 12 and pursued Gray, according to the Associated Press, Gray had been hospitalized in 2012 for concerns about his mental health and had his guns seized by county sheriff's deputies because of fears he was acting irrationally.

Then there was the death of Eric Garner on Staten Island, who was allegedly illegally selling individual cigarettes—"loosies"—on a street corner when he was confronted by New York City Police Department (NYPD) officers trying to arrest him. He claimed he was doing nothing wrong and tried to walk away from the confrontation and then was placed into a choke hold from which, according to the New York Medical Examiner, he died. The case has been ruled a homicide by the Medical Examiner's office. A grand jury found all officers not guilty, sparking outrage in New York and engendering yet another crime, the point-blank cold-blooded murders of two uniformed NYPD officers, Rafael Ramos and Wenjian Liu, by a mentally ill man, Ismaaiyl Brinsley, who, on the run from shooting his girlfriend in Baltimore, had vowed revenge for the killings of Garner and Ferguson's Michael Brown. This case, among others—particularly white police officers shooting black citizens—has initiated a movement to require all police officers to wear cameras in order to know what really does happen in their encounters with citizens.

We do not know whether Garner, the father of six and a neighborhood fixture, was even borderline mentally ill, but it is clear from the video shot by a bystander that he was reacting strangely—at least behaving unexpectedly to officers—to the police confrontation as he sought to talk his way out of an arrest. The police swarmed him while one officer placed him in a choke hold, a maneuver that is illegal under NYPD procedures, took him to the ground, and, as Garner, an asthmatic, screamed he could not breathe, kept him in the choke hold while other officers piled on until Garner lost consciousness. Other officers did nothing to revive him. The Emergency Medical Technician (EMT) responders did nothing to revive him. This video of Garner's arrest and death has galvanized world opinion and resulted in demonstrations around the United States. Of course it did because the camera lens memorializes the event, raises it to a level of catharsis in the viewer's mind. We realize in that moment that police were crushing his chest

as he screamed, "I can't breathe" 11 times, that Eric Garner could have been any one of us, believing himself to be innocent yet struggling for at least one breath under the weight of a swarm of arresting officers. And no amount of explanation by the police union or by the officer's own attorney can wipe away what millions of people saw, repeated over and over again on news channels around the world, with their own eyes. We ask, could this confrontation have turned out another way?

Of course, we know that we are only seeing what the camera has captured. What transpired before and what happened afterward are not captured on the processor embedded in the smartphone's digital imaging device. But what makes this a cathartic event is the medium itself, by framing and elevating it to a form of theater. Like a stage play that depicts only what the audience can see within the frame of the stage and the invisible fourth wall, the events preceding and subsequent are defined by the events portrayed. Thus, even though authorities may exclaim that, "we don't know the whole picture," they miss the fact that what we do not see carries far less impact than what we do see. And that is the problem with seeing police confrontations through a camera lens.

For months, the public at large did not know the full story of the death of Michael Brown in Ferguson, Missouri, even as protestors, some of whom were violent, crowded the streets and the Department of Justice pursued its investigation. Maybe the conflicting stories of eyewitnesses to the shooting were confusing even to the St. Louis County grand jury that refused to indict Officer Darren Wilson as did the Department of Justice after its review of the case. But the camera captured the uncovered corpse of Michael Brown lying unattended in the street as if he were a piece of roadkill carrion and not a human being. And that was infuriating. If you were an African American resident of Ferguson watching the way authorities treated Brown's body, depriving it of the dignity you would give to your own pet who had died, you, too, would experience a seething rage because how they treated Brown would be how they treated you regardless of the cause of death. No amount of official explanation could explain away the perception that in the eyes of the authorities, Brown was considered by them to be less than human. And this is not the way to govern or seek respect from those whom you expect to be governed.

After reviewing the events in Ferguson, including the results of the grand jury hearings, and after an initial U.S. Department of Justice probe of the events subsequent to a visit to Ferguson during the demonstrations by Attorney General Eric Holder, according to CNN, the Attorney General "said this week he expects to announce the results of the department's investigation of the shooting death of Michael Brown and a broader probe of the Ferguson Police Department before he leaves office in the coming weeks" (Perez and Jaffe 2015). Local departments may complain about federal review and intervention in their operations, but, looking at the events in Ferguson and the police department's response to them, sometimes the local departments are their own worst enemies. After the shooting of Michael Brown, the department's decision to leave his body lying in the middle of the street for hours is not just an example of extreme incompetence, it is bad police work and demonstrates to the community that the police whom they licensed to serve instead demonstrate complete contempt. Why humiliate the

community you are supposed to serve, which humiliation is perceived as racial bias? And that is one of the reasons the Department of Justice (DoJ) launched a broad probe into the Ferguson police department and found endemic racism there, including a pattern of what amounts to financial extortion of the city's African American citizens by the police and court system. In the aftermath of this disclosure, the state has taken over the justice administration of the local court to remedy the problem.

In the wake of the DoJ report, other people began leaving the Ferguson administration, including Police Chief Thomas Jackson and City Manager John Shaw, both of whom resigned after the report became public. After the announcement of the chief's resignation, residents engaged in more protests, during which a man identified by police as 20-year-old Jeffery Williams shot and wounded two St. Louis police officers. Williams, who was arrested, explained that he was not shooting at the officers. Instead, he told police, he had been in a dispute with another individual and took shots at him from across the street. But the shootings were alarming just in themselves and broke into the national consciousness, even causing President Obama and Attorney General Holder to condemn them. The shootings, though, if motivated by rage and frustration at the police, fall into the category of the assassination of two NYPD officers by a mentally ill individual who fled from police in Baltimore, stalked the officers on a Brooklyn street, and killed both of them before killing himself. It was a murder/suicide, and it could have portended a wave of police shootings, the very worst thing community police departments fear.

As *Washington Post* columnist and MSNBC analyst and guest host Jonathan Capehart wrote on March 16, 2015, after reviewing the DoJ report and the grand jury testimony that exonerated Ferguson police officer Darren Wilson, "'Hands Up, Don't Shoot,' was built on a lie." The evidence, he wrote, showed that Wilson did, indeed, receive the report of a strong-arm robbery at a local store and that Brown had gone for Wilson's weapon while they struggled through the car window and that after the two were outside the car, Brown charged Wilson and refused to stop or obey Wilson's commands. Hence, Wilson shot him in self-defense.

Another aspect of this overview of police/community relations came from the special panel of experts assembled by President Obama to come up with recommendations for establishing a greater level of trust between police and the communities they protect. Based in part on recommendations put forward by aviation experts who applied their oversight of the aviation industry and the types of accidents that sometimes occur therein, their suggestions included independent investigations of police shootings by outside counsels. The panel also called for better training to help police deal with stressful situations. In addition, the panel called for better and more complete record-keeping about police use of lethal force, and they called for use of police body cameras. These, the panel and the president said, would not only provide for independent review of police use of lethal force, but would protect police from false claims of abuse. The panel recognized that these recommendations were a form of prevention to throw light on a growing problem.

Across the country from Baltimore and New York, on July 1, 2014, California Highway Patrol (CHP) Officer Daniel L. Andrew, amid the rush-hour evening traffic on LA's freeway maze, got the call, in response to several 911 calls, of a woman walking barefoot on the shoulder of the 5 Freeway.

"She has no shoes on," one caller said. "She's just standing there with her arms in the air," another said. Two of the callers mentioned trying to help the woman, who was now, we know, named Marlene Pinnock. One woman said she pulled her car next to the woman to ask her something, but that Pinnock started walking faster. Another said she tried to pull over to help, but there was too much traffic. "Honestly, I caught her out of the corner of my eye and I was like, 'Whoa, that's weird,'" the caller said. "And then I couldn't get over—I was several lanes over. I wanted to get over to like, help her off the highway or something."

> 911 Calls Reported Woman Walking on Freeway Before CHP Beating, Nine 911 calls were made in the moments before a woman was beaten by a CHP officer in an incident caught on cellphone. (Jason Kandel and Beverly White, Channel 4, Los Angeles on-air New Coverage)

Had CHP officer Daniel Andrew received any training in handling the resistant or noncompliant mentally ill behaving strangely or even potentially dangerously? The CHP reported that the officer would most likely have had received the standard training in the management of a mentally ill offender the prior month, and it is just as likely that he had experienced his share of tragedy, encounters with the seriously mentally ill, homeless, and mutilation on California freeways. He may have even encountered Marlene Pinnock or her fellow residents under the LaBrea overpass of I-10 in downtown LA. Certainly other police officers had encountered her. She lived in squalor there for a long time, a condition of living making sense through only the narrow legal perspective of a constitutional defense attorney asserting that she had a right to live as she wanted and where she wanted as long as what she did was not a trespass upon the rights of others or did not present a danger to others or to the public safety. Unfortunately Pinnock's walking in traffic on the 10 Freeway did present a danger to drivers who could have been injured in car accidents while trying to avoid hitting her, hence a danger to public safety. She was in extreme danger, herself, too.

According to agency incident reports, when Andrew arrived, the woman ignored him and instead walked right into oncoming rush-hour traffic lanes. The officer ordered Pinnock to stop, but she repeatedly ignored those commands, and then began walking against the flow of traffic and into the traffic lanes. Officer Andrew ordered her off the freeway, but she ignored his order and walked onto the busy freeway and began wandering between the lanes like a stray dog who had run loose into the thick of commuter traffic as darkness was approaching. The officer waited for the opportunity to sprint onto the freeway, and when he did, she resisted, calling him the devil. Was she delusional at that point? On the video, the officer can be seen attempting to hold her arm. Pinnock appeared to try to twist away from him. At that point, the officer took her to the ground and began hitting her with his black-gloved fists as she covered her head with her

arms in a defensive posture. After a matter of seconds, an off-duty officer helped subdue Pinnock, but not before the first officer landed at least nine blows.

"She then became 'physically combative,' the CHP report said, and 'a physical altercation ensued'." The video shows the officer pinning the woman to the ground and punching her at least nine times. Technically, because the woman was trying to wrest herself away from the officer, this would be resisting arrest, the CHP has said, because the officer was trying to keep the woman from hurting herself or others by walking into rush-hour traffic.

Officer Andrew later reported that Pinnock was talking to herself. But as speeding cars whizzed by the officer and the woman he was trying to restrain, he had no time to reason with such gross insanity because, probably, he believed that both their lives were in danger, as well as the harm to passing drivers who might swerve to avoid them and cause a serious pileup. But what did he do? More than likely, pumped with adrenaline, he dragged her, fighting him all the way, until safely off the road. She called him "the devil," he later reported, and most likely many other names that made no sense, and despite suspecting she was out of her mind, she likely aggravated him more.

Did the officer know Pinnock had been arrested before for one of the dozen of her prior misdemeanors of trespassing, petty theft, and a battery charge or theft? Theft could have been the charges filed against her for rummaging through a garbage can. What about trespassing? That could have been anything. Battery? A simple battery under California's tort statutes can be filed against an individual for that individual's nonconsensual touching of another person. How dangerous was this person and what was her intent in her resisting arrest? Most likely at least one other California police officer had taken her to LA County Hospital for psychiatric examination under a 5150 Emergency Detention order for grave disability. Might that mean that she was gravely disabled at the moment of her confrontation with the officer—delusional, and oblivious to the flow of traffic? If so, that would have meant she was presenting imminent danger to herself and others.

We can only surmise what her mental state might have been at that moment. However, after Pinnock's several prior arrests, was there ever time or professional expertise to ask her, what did she think she was doing to get arrested a dozen times, mostly in the same neighborhood of downtown LA? And what are the police supposed to do when confronting such a strangely acting individual? Are police officers simply trolling the streets for the helpless to exercise their powers of arrest? We do not believe they are, even though it is probably true that there are psychopathic police officers and ones obsessed with punishing misbehavior. What we do not know is whether CHP officer Daniel Andrew was one of those problem officers. We also do not know for certain his state of mind during confrontations in frantic rush-hour traffic on LA's freeways, but clearly he lost it when finally immobilizing the struggling woman on a safe roadside concrete mat and kept punching her.

A passerby videotaped Andrew delivering sidewalk justice to Pinnock with at least nine punches to the head. After several arrests, probably a few of which were equally dangerous to life and limb, was the officer going to provide the ultimate treatment to save her, himself, and the public's safety? Would he have risked his

own life to drag her to safety? Did she do the unforgivable and spit in his face? Whatever the nature of the incident and what psychological issues precipitated it, once captured within the frame of a camera, it became memorialized as a confrontation between a white officer beating up a black woman. Officer Andrew was subsequently exonerated of any criminal liability in this case.

The camera lens is not restricted to police confrontations, but also can be transformational when capturing events during wartime. The photos of U.S. Army prison guards at Abu Ghraib prison in Iraq, standing over piles of naked prisoners, so enraged the Iraqis, as did the sounds of prisoners being tortured, that the seething Sunni residents rose up in fury. We are seeing the results of what we did in Iraq with the rise of ISIS or ISIL, perpetrating violence so beyond the bounds of previous human experience that we are shocked at the level of cruelty. But for the camera capturing the torture and humiliation at Abu Ghraib who knows what might have resulted?

When we look at images of the mentally ill, the dangerously mentally ill, or even those acting strangely so as to be perceived as a threat, through the lens of the camera, often what we see antagonizes us even though the person we see being managed or arrested by the police is incapable of managing himself or herself. What is the nature of these types of individuals and how can society protect them while protecting itself from them? And what are the roles of first responders, emergency personnel, teachers and school counselors and administrators, health-care practitioners, corrections officers, veterans groups, and officers of the court in dealing with these individuals? These are the questions we seek to answer in this study.

EPIDEMIOLOGY OF VIOLENCE, SUICIDE, AND ALTERED STATES OF CONSCIOUSNESS

Suicidal violence—or, harm to self and others—has reached epidemic proportions in the United States, particularly among teens and young adults, including military veterans. Because of the mainstreaming of the mentally ill and the closing down of public psychiatric facilities, most of the mentally ill are left untreated and have to fend for themselves under unmanaged survival situations. With a large population of the mentally ill at-large on streets, they have frequent encounters with police and public safety officials, resulting in violence. We have witnessed just such violence in states like California, Wisconsin, New Mexico, New York, Arizona, and more recently in Washington, DC. How can we prevent this problem from getting worse?

The cases of Marlene Pinnock and Eric Garner are just the tip of the iceberg in incidents of police confrontations with the mentally ill or with those "acting strangely." To be fair, many times responding officers simply do not know who is actually mentally ill and delusional with auditory hallucinations or who presents a real intentional and perhaps deadly threat. What we do know, from cases dating back to the Columbine High School shooting, is, at the very least, that suicidal violence, harm to self and others, has reached epidemic proportions in the United States, especially among young teens acting out in high school

and college. This cohort includes, most disgracefully, combat veterans returning from our Middle Eastern wars with posttraumatic stress disorder (PTSD) or traumatic brain injury (TBI) and, quite inexcusably, waiting for treatment from the Veterans Affairs' (VA) medical centers, but have nowhere to go and nothing to help them support themselves (Liebert and Birnes 2013).

There are many contributing factors to this rise of the mentally ill on the streets and the perceived threats they may pose to emergency responders, particularly police, threats we have documented in our prior *Hearts of Darkness* (Liebert and Birnes 2014) and *Wounded Minds*. The following are contributing factors.

One is the mainstreaming of the mentally ill and the closing down of public psychiatric facilities resulting in many of the mentally ill being left untreated and having to fend for themselves in unmanaged living situations or on the streets. This social crisis is known as deinstitutionalization of the seriously mentally ill, which, in Daniel Moynihan's words, could be considered to have reached its level of maximum feasible misunderstanding: inpatient psychiatric beds are diminishing as fast as new cases needing them present in a growing population that is more distressed on the average since the Great Depression and ensuing World War II. There is no more margin for error in deinstitutionalization. Releasing more patients from the few remaining state institutions for the seriously mentally ill would likely be perceived as a threat to everyone.

After all, one seriously mentally ill homeless veteran, recently returned from Iraq, made it, while brandishing a knife, almost all the way into the living quarters of the president of the United States before he was stopped by an off-duty Secret Service agent before he could get upstairs to the second floor of the White House. Another mentally ill person, Miriam Carey, who insisted on speaking with the president, led multiple Washington, DC, police agencies on a wild chase around the National Mall? She was unarmed but was suffering from delusions of postpartum depression and was ultimately shot dead by Capitol Police with her child sitting right next to her in the car.

In parallel to the social shock of deinstitutionalization that has followed the trend of urbanization—thus the concentration of formerly hospitalized psychotic patients in our city cores—is that of criminalization of mental illness, as presumptively advocated by Thomas Szasz in his book, *The Myth of Mental Illness* (1974). Szasz argues that because there is no such thing as mental illness, it is an invented condition. Attorneys have used it to argue that detention of the mentally ill for forced observation or involuntary commitment is subject to a detainee's Fourth and Fifth Amendment rights to search and seizure and due process. This has resulted in situations where the police and other emergency responders are forced to deal with the mentally ill as violators of the public peace and public safety, effectively criminalizing the mentally ill. The seminal decision creating this situation was the *Lessard* ruling in Wisconsin.

THE *LESSARD* CASE

The *Lessard* case in Milwaukee, Wisconsin (*Lessard v. Schmidt* 1974, 1975, 1976), resulted from a suit filed on behalf of Alberta Lessard by her court-appointed

attorneys, which suit was expanded into a class action on behalf of all residents of Wisconsin 18 years or older, asserting that involuntary commitment of the mentally ill absent a due process hearing was unconstitutional. The federal court held for the plaintiffs in *Lessard*.

In holding for Alberta Lessard, the federal judiciary, while setting aside Wisconsin's involuntary commitment law, ruled in essence that there was no such thing as mental illness and set a new standard for "dangerousness." It held that commitment required a finding that, "there is an extreme likelihood that if the person is not confined he will do immediate harm to himself or others." In so doing, the federal court required that an individual facing a hearing for involuntary commitment be afforded the same constitutional rights afforded to a criminal defendant including, but not limited to, Fourth Amendment protections against search and seizure, Fifth Amendment guarantees of due process, and Sixth Amendment guarantees of right to counsel. Included in this package of rights was also the right to remain silent in the face of an inquiry into an individual's mental health, which was, in essence, a *Miranda* protection to the suspected mentally ill individual, along with an exclusion of hearsay evidence. The court believed that mental illness was simply a label enabling psychiatrists to "shoehorn" certain people into medical diagnosis to "line their pockets" with fees based on the American Psychiatric Association's diagnostic codes (*Diagnostic and Statistical Manual of Mental Disorders*).

Along came sociologists with big data to convince politicians, policy makers, and the judiciary alike that behavior cannot be predicted by psychiatrists and clinical psychologists, particularly in the case of behaviors of suicide and violence. This was also an argument set forth by John Monahan (1994). Monahan has since backed off on his views considerably, recognizing his assertions were based on flawed databases and analytics. He was notably quiet during his attendance at the governors' investigation of the Virginia Tech massacre. His voice, however, is still one given dominance in arguments over preventive detention of such dangerous suicidal psychotic people like Elliot Rodger, who was interviewed by the Santa Barbara County Sheriff's officers, released, and then soon after went on his suicidal mass murder rampage at the University of California, Santa Barbara. The officers who found no abnormal psychology warranting preventive detention for 36 hours for psychiatric examination at the hospital at Ventura/University of California, Los Angeles would likely be supported in his release of this known madman—one who had terrified his own family—by the statistical mystique of John Monahan's treatises. Rodger died with his rights on, which rights were of no help to him whatsoever. Many innocent people were killed. More were seriously injured, and even more were traumatized psychologically for life. And, but for the presentations of data and the arguments of those saying aberrant or dangerous behavior is unpredictable, the Rodger mass murders and prior mass murders in Colorado, Arizona, Virginia, and Texas were all preventable.

Monahan's earlier preachings from large databases and recent retreat to more cautious interpretation of cold numbers from the computer warn us to use caution with analyses and conclusions from databases. In all encounters between clinicians and patients, for example, the individual patient rarely fits

cookie-cutter-like into constructs, such as extreme dangerousness, parsed in huge numbers into computers. In fact, rarely does a psychiatrist examine and treat a patient who actually would have been accepted into a large controlled treatment trial. Most real patients would have been excluded for common reasons, such as childhood trauma, and similarly with dangerousness and suicide. Their occurrences are too uncommon in large databases to capture what the clinician is likely encountering with any single patient.

Such operational response to databases—in this case the clinician's turning blind eye to suicidality—is reminiscent of the interpretation of data from North American Air Command following the 9/11 attacks on the World Trade Center. Fighters were scrambled and blindly sent toward the Atlantic, if one stretches one's imagination enough to believe the explanation put forth by the government, only being returned too late to intercept the hijacked jet about to crash into the Pentagon. It is hard, therefore, to assess and predict threats with big databases. We know that. But, as Seymour Halleck sensibly warns in his *Psychiatric Aspects of Criminology* (Halleck and Bromberg 1968), and *Psychiatry and the Dilemmas of Crime: A Study of Causes, Punishment, and Treatment* (Halleck 1971), we must cull out those seriously mentally ill who are more likely than not dangerous to themselves or others. There will be false negatives and false positives. As we have learned from 9/11, such threat assessment will never be 100% perfect. But, in lieu of the fiasco in our nation's military and security response to the attacks of 9/11, are we simply to shut down the radar screens, close North American Air Command, and wait for the attack to find out who our enemy is? Only the lunatic fringe in this nation would buy into such folly, but the public is kept dismayed by the maximum feasible misunderstanding known as deinstitutionalization and criminalization of the seriously mentally ill, along with the deprecating clinical nihilism of John Monahan.

None of those responsible for the demolition of the public psychiatric system or preventive detention of dangerous and suicidal mentally ill has anything to say about the medicalization of presumed organ and system deficiencies of cancer and atherosclerosis. In fact, there is great momentum to predict in order to select the best intervention for the best outcome. Such prediction is at the heart of the Affordable Care Act and the just-enacted Clay Hunt Act for prevention of military suicides, that incentivizes physicians by improving outcomes, rather than increasing utilization of expensive testing or encounters with patients. Nobody argues that to do this, doctors have to diagnose clinical presentations when showing before them. Nobody argues that to get better outcomes, more research has to be done. No ethical researcher, however, is going to draw conclusions about cancer of the lung based simply on everyone who has a cough. Researchers at multiple sites in different regions of the country need to agree on criteria for lung cancer. It is no different with central nervous system and neuropsychiatric impairment. There needs to be reliability of diagnosis for the problem requiring research, such as now, for example, the epidemic of memory loss with aging. That is the purpose of *DSM* manuals. The improvement of criteria that enable researchers to agree on what problem they are studying, whether dementia, suicidal ideation, or first-episode schizophrenia, of which there are 300,000 first psychotic breaks every year in this country.

Should we stop involuntary commitments altogether? Professors and self-proclaimed cable news pundits claim nothing could have been done to have prevented the Santa Barbara suicidal mass murder by Elliot Rodger through preventive detention, an assumption with which we vociferously disagree and will present fact-based evidence in support of our contention. Yet, these same pundits have no problem with their clinical colleagues practicing psychiatry in jail and prisons where, in fact, they are required to predict violence and suicide. This is paradoxical as well as hypocritical. These pundits neglect the very basis of diagnosis which has prediction embedded in it. "For what purpose is differential diagnosis, if not at least partly, to predict clinical course and treatment response?" asks Donald Klein, a dominant figure in the field of treatment science and a prime mover in the improvement of diagnosis and our understanding of psychiatric illness for over half a century. His pioneering work applying both psychological and pharmaceutical approaches to therapy has become standard procedure in the treatment of psychiatric disorders and chronic emotional distress (Klein and Wender 1982).

Like the metaphor of national security threats and preparedness after 9/11, do we simply let life take its course, suffer, and die? Not with cancer, heart disease, infections, and strokes, but that is essentially what has happened in public psychiatry. The courts have seemingly taken the position that aberrant behavior, if not specifically diagnosed by neurology as a disease of the brain, is always a person's choice, either learned or simply idiosyncratic, thus not medical but subject to the law only, and people are dying in great numbers as a result. Suicide now exceeds motor vehicle accidents as a cause of death, and our military veterans and service personnel are committing suicide at the rate of 22 per day, almost one every hour. Almost as seriously, suicide attempts and other forms of violence threaten to drive up cost of health care.

In southeastern Michigan this prevalence has been labeled "The Hidden Epidemic," by the *Detroit Times*, because it cost $42.3 million to save those who try to kill themselves in just one metropolitan area. This cost for medical treatment to spare life and function of suicide attempts alone, therefore, represented about 40% of the $210 million hospital bill to treat violence in Southeast Michigan during the 2 years of 1998 and 1999. Over 10% of direct hospital costs went to treating pediatric victims of violence, or $22.5 million, during 1998 and 1999. Violence against children, in fact, ranked among the top five causes of death for all children under 14, regardless of race. Bullet wounds also took a big share of the bill for hospital care in southeastern Michigan, and fistfights and beatings continue to keep hospitals busy and are the most common form of violence treated in the Detroit metro area. Fifteen years more, with the great recession bankrupting Detroit, has likely made these numbers look relatively small. Detroit has just emerged from bankruptcy, and we will see if that has any effect on the levels of violence there.

Nationally, 10% of homicides are committed by a small percentage of the few million of our population suffering from severe neuropsychiatric impairment and helpless in coping with even minor stresses of life, mostly in our downtowns. This is still a high number of people who are in great need of court-monitored

case management under "assisted treatment," most often medicated with mood stabilizers, antipsychotics, or both (Torrey 2010).

SUICIDAL EPIDEMIC ISSUES

We examine some of the medical and policy issues that we believe have contributed to what is nothing less than an epidemic of suicides and suicide/mass murders over the past 20 years.

CORRECTIONS FACILITIES

Because of the criminalization of the mentally ill, dumped back into society by the courts and the states, police and corrections officers have become the primary guardians of the mentally ill, often to the detriment of those they are supposed to protect. The Cook County Jail, for example, is now our largest psychiatric inpatient unit nationally. Most police officers, like the deputies clinically evaluating Elliot Rodger, have little or no background in dealing with the mentally ill. There are newly formed special mental health police units in the LAPD and the Phoenix Police Department. Hospitals cannot find enough psychiatric beds to house the mentally ill, even for short periods. And the VA is still desperately trying to scare up the funds to hire more psychiatrists and mental health professionals to deal with the flood of psychiatric cases.

Psychiatry, and particularly preventive emergency psychiatry, has been pushed back into barely visible recesses of our health-care system like a shameful closet case, and the public safety is at risk from severely ill and dangerous individuals capable of committing, as we have seen, horrendous mass violence. They are a small percentage of the severely impaired neuropsychiatric population, but 5%–6% of millions is a lot of people who can do a lot of damage if simply left to their own accord, whether the school kid posting threats on Facebook or the homeless psychotic obeying his command hallucinations to push somebody off the platform into an oncoming subway train.

Pinel, an early founder of modern psychiatric treatment, was credited for removing the chains from seriously mentally ill patients at the Pitié-Salpêtrière in Paris circa the late 1700s. Now, however, public psychiatry has essentially been reset in this country to colonial America because of the criminalization of the mentally ill. For example, incarcerated at Riker's Island, homeless Marine veteran Jerome Murdough died of hyperthermia while on suicide watch for schizophrenia and bipolar disorder, a combination of diagnoses that makes no sense, other than diagnostic sloppiness or ignorance. Nonetheless, he was medicated, presumably with mood stabilizers and antipsychotics that made him more heat intolerant. Unfortunately, auditory hallucinations that drive autistic behavior–disruptive individuals to the jailhouse are treated now with solitary confinement, which makes their disease even worse. This is the practice of psychiatry in the cloak of Corrections Therapy. Murdough died a horrendous death. The Marine Corps is silent regarding his last tour of duty in Asia in 1975. New York City quietly settled with his family for over a million dollars, a sealed settlement, of

course, so that nothing changes in the treatment of either the seriously mentally ill, homeless, or veterans neglected by our Department of Veterans Affairs (DVA).

VETERANS AFFAIRS

The returning combat veteran population, many of whom are suffering from PTSD and TBI, absent health management or support from the VA, are a public health and safety crisis today.

Most veterans lacking timely and easy access to care are dumped into the public safety net with little or no access to treatment or funds to sustain themselves. The Boise, Idaho, Chief of Police is one of a few leaders in the civilian community bringing this surging crisis before those in Congress, which has the power to do something. His letter addresses the issues of the massive, unrecognized, and untreated neuropsychiatric impairment from our war on terror:

> Dear,
> Several Boise Police officers were confronted recently by an armed man later identified as a military veteran. Issues revealed to myself, my officers and the community since then prompts me to share some concerns with you.
>
> On July 28, 2009, Boise Police responded to a call from a woman stating a man with a "machine gun" was at her front door demanding to be let in. Police dispatchers heard gunshots and the woman said the man had broken down the door of the apartment across the hall. As officers arrived, they heard another gunshot and saw the armed man ducking in and out of the broken doorway.
>
> The officers called to the man to peacefully surrender and tried to engage him in conversation, offering help if he would put the gun down. Instead the man used, what appeared to be "military tactics" and a bright light to spotlight the officer's positions and aim a handgun in their direction. Four officers fired. None of the shots hit the man as he used the doorway for cover. After the officers fired, the man surrendered.
>
> In a report released January 13, 2010, the Boise Community Ombudsman wrote: "Considering all that these officers personally witnessed and were told, any reasonable officer in similar circumstances would believe that his life, the lives of his fellow officers, and the life of the calling party were in immediate danger from a deadly threat. Given the totality of the circumstances and the subject's lack of compliance with repeated commands to show his hands and surrender, the use of deadly force in response to this imminent threat to human life was both reasonable and necessary."
>
> The armed man currently sits in the Ada County Jail awaiting sentencing on felony charges. He is George G. Nickel, Jr., 38, a decorated Iraqi war veteran. Unbeknownst to my officers at the time, Mr. Nickel is the sole survivor of an explosion in Iraq that killed

three other Idaho U.S. Army Reservists. Mr. Nickel was awarded the Purple Heart and Bronze Star for bravery in Iraq.

Mr. Nickel has also been diagnosed with traumatic brain injury and posttraumatic stress disorder from his time in Iraq.

Following the media publicity of Mr. Nickel's Iraqi war experience and subsequent revelation of his diagnosis, my office received numerous emails and phone calls from citizens and veterans groups highly critical of the officers' actions. Each citizen wanted to know how the officers could justify shooting at a war hero.

I responded to each call and email. I described our department's Crisis Intervention Team (CIT), a large group of officers specially trained to respond to individuals in emotional or mental crisis. I explained to the concerned citizens that we work with the Boise VA Hospital and local veterans support groups to identify veterans in need and connect them with those who can provide them with services. I also explained that, like our veterans, my officers have chosen to serve and protect their community, and that means taking decisive action when faced with an immediate and violent threat to themselves and fellow citizens. The officers did not know who Mr. Nickel was, nor about his military background, and Mr. Nickel's actions did not give the officers time to find out.

What I cannot explain is how the military identifies and treats psychological disorders, and why there appears to be a lack of such identification and treatment. Mr. Nickel's case may or may not be isolated. I have no way to track the number of veterans who, for any number of reasons, come into contact with my officers. I am aware of a recent case where officers were called to respond to a man later identified as a veteran, armed with a shotgun threatening suicide. Fortunately, that case was resolved peacefully. There are, however, indications that veterans struggling with war-related emotional issues are growing in number and severity. A recent study by the Veteran's Affairs Department (published by the Associated Press, January 11, 2010) shows the suicide rate among young veterans has increased significantly.

I have many veterans in my own police department. I share with them a pride in the service they delivered to their country and the service they continue to provide to the citizens of Boise. I also share with citizens a sincere concern for veterans struggling with combat-related disorders, who are in need of professional assistance and for whatever reason, are not getting it. I have been told by veterans, including my own officers, that there are perceived barriers within the military that inhibit individuals from self-disclosing emotional issues, ranging from fear of being labeled, to being passed over for promotion. Veterans tell me military evaluators screening those leaving the service are overwhelmed with sheer

numbers, no time is made for thorough screens, and critical post-combat evaluations are offered but not required.

And sadly, the struggles don't appear to be new. Again, just within my own police department, an employee recently revealed the emotional struggles he was aware of with vets who served in World War II and Vietnam.

Whatever the issues and explanations, I am concerned that without more careful identification and treatment, these individuals may indeed pose a threat to their own safety and that of their families and community. My greatest concern is Mr. Nickel's case is not isolated, and other police officers, not only in Boise but in Idaho and across the nation will be forced to confront a troubled veteran with weapons drawn. Any or all those involved will be chastised for doing what they felt they must for self-preservation or public safety, and worse, the outcome will be lives lost.

One citizen who wrote me said, "These veterans are our people. We need to care for them like they took care of us!"

As a Chief of Police of Idaho's largest and Capital City, I urge you to work with all branches of our military, our Veteran's Affairs groups and VA hospitals, and strive to improve and expand the safety net that must cover our veterans. It is the duty of the country they served to now serve and protect them, and indeed enhance their opportunities as they rejoin civilian life.

Thank you for your time and service you give to the citizens of Idaho.

Sincerely,
Michael F. Masterson
Chief of Police
(www.police.cityofboise.org/home/news-releases/2010/02/chief-urges-idaho-congressional-delegation-to-enhance-services-for-vets/)

Chief Masterson was unaware of the true gravity of the situation at the time of this incident and letter, because the whistle-blower at the Phoenix VA Medical Center had not yet come forward with the fraudulent secret wait lists that proved to be system-wide in sweeping the true scope of the Department of Veterans Affairs' lack of preparedness for the injuries from this war. The double wait lists were used to show operational efficiencies that gained financial bonuses for administrators while hiding the true list that showed recklessly long lists for necessary treatments.

Chief Masterson is referencing the problems or potential problems of nearly 3 million young men and women having served multiple deployments, few of whom did not involve exposure to combat. Only a minority of these veterans receive diagnosis and treatment. One of them was Oscar Gonzalez, discharged at Fort Hood with partial service connected disability of $1600/month—not nearly enough to provide him with adequate shelter and support for his family—who

became homeless and finally, in the ultimate explosion of paranoid fear, jumped the White House fence, staggering across the south lawn with one foot seriously blown to pieces from an improvised explosive device (IED) explosion. Like Miriam Carey, a postpartum psychosis patient shot by the Capitol police, Gonzalez was compelled to get "the message" to the president. Fortunately, the president and first family were not home, because Gonzalez got as far as the stairway leading to their living quarters in the East Wing with a knife. What he intended to do is unknown, except that he told the Secret Service he had an urgent message to deliver to the president.

Gonzalez was likely suffering from a malignant form of combat-induced PTSD and likely associated TBI similar to that described in the incident Chief Masterson cites in Boise. Although one of a small minority discharged from the military via a Medical Evaluation Board for PTSD and partial amputation of his foot, he complained of severe back pain and was on one of those VA wait lists before its fraudulent system of rejection was exposed at Phoenix VAMC, when he decided enough was enough. He moved into his car and headed to the White House to tell the president how bad things were.

Although the Secret Service gets much of the headlines on this case, the authors take it far upstream to Fort Hood, scene of two suicidal mass murders associated with deployment. One was perpetrated by Major Hasan, a military psychiatrist, who was being deployed, but should have been labeled "unfit for duty," especially because of his exchange of messages, involving the ethics and morality of jihadi suicide/murder, with a radical Al-Qaeda affiliated sheik, Al-Awlaki. These messages had come to the attention of Army brass, who allowed Hasan to continue in his post at Fort Hood. The Army's explanation for allowing Hasan to continue his messaging and to review soldiers before deployment actually defies credulity: they believed he was studying up on the nature of jihad and suicidal mass murder. The other Fort Hood alumnus was Ivan Lopez, also unfit for duty, whose discharge, unlike Gonzalez, was burdened with indecisiveness and dangerous delay to avoid a potentially expensive Medical Evaluation Board. Lopez, who claimed to authorities he had studied the Adam Lanza mass murder in Sandy Hook, attacked other soldiers at Fort Hood in a mass murder rampage.

Indeed, the Boise police chief is correct and might not know about the stack of files at Madigan Army Medical Center containing Idaho Guardsmen diagnosed with PTSD, facing possible alteration of their diagnosis to noncompensable diagnoses to save the government money on long-term disability payments. Nearly one million young men and women are at risk for being forced out with various discharges that deny them the benefits of treatment and long-term disability support for which they are entitled by their enlistment contracts. A corrupted system getting little attention is cutting that wait list also; that process in this case is claims denials and appeals. The longer the appeal, the more drop out—or drop dead or commit suicide at the rate of one per hour. We describe in detail below what is known about the plight of our veterans and the shear incapacity transformed into corrupt administrative practices and worse medical practices. We detail the solution that is urgent.

The Secretary of Health for our Department of Defense and the Secretary of the Department of Veterans Affairs are either knowingly or not charged with the responsibilities of operating two-headed monsters, neither tolerated nor legal in civilian health-care systems—that is, running a medical care system that is grossly understaffed and short of resources, while also judging the extent of long-term disability from war. This is not only a conflict of interest for these secretaries but a responsibility guaranteed to fail or end up in their forced resignations, one after another, just like the former DVA chief, General Eric Shinseki.

Military/VA health and disability services are run as if they are insurance companies, but they operate on faulty actuarial statistics from either misdiagnosis or avoidance of diagnosing the "invisible wounds of war"—namely, PTSD and TBI. Furthermore, as the nation just learned with congressional investigation of the fraudulent wait lists, they are insurance companies run on cost plus basis. The reserves are the maximum depths of U.S. taxpayers' pockets that can be emptied with political expediency.

Congress had better address the polite and salient pleadings of Chief Masterson. There are malignant cases of PTSD in the Idaho bush too—not just in Boise—cases in which victims can metastasize into self-destructive violence in the absence of treatment. The Idaho National Guard, for example, did a lot of heavy lifting in the War on Terror but has been ambiguously brought into the entitlement tent of their combat peers who were regulars.

We argue that claims examiners must be eliminated from DVA. Medical Evaluation Boards (MEBs) are not only costly, but they are ineffective. Oscar Gonzalez had an MEB, but Navy Yard shooter Aaron Alexis did not. Aaron Alexis was discharged with the delusion that his mind was under the control of low-intensity waves emanating from deep inside some bureau within the Department of the Navy. Without case management for his paranoid psychosis, he was given short shrift by the VA twice before taking matters into his own hands in what is now known as the Navy Yard shooting. It was more than that. It started with reckless endangerment in shooting out tires in Seattle, more reckless endangerment in the Navy—called "pattern of misconduct"—and culminated in a fraudulent discharge process negotiated with a mentally incompetent sailor who accepted an honorable discharge instead of a general discharge stripping him of VA benefits. It is the responsibility of the delegates of the Secretary of Health, Department of Defense to perform MEBs on obviously psychotic soldiers and sailors before dumping them onto Main Street United States. Gonzalez had an MEB. Alexis did not. What was the difference? Apparently none. Thus, the authors have advocated for the immediate cessation of disability exams in the military and VA. Instead the military should simply buy out the contracts of all soldiers recruited with entitlements that cannot be paid without bankrupting the Department of Treasury.

As the VA is already doing, let these discharged veterans get help immediately instead of in prison, jail, homeless shelters, gutters, or, worst of all, after they kill themselves, hopefully without taking anyone with them. The Marine Corps did not officially respond to the family's request for support of Murdough's burial after Rikers Island Jail baked him to death. Ideally, the settlement from New York

City should help them out. But this case points to the need for the government to weigh in immediately to prevent veterans from winding up on street corners or in jail. Veterans should not have to wait in line to sign up for Medicaid. They should be required to carry Platinum Obamacare fully paid for by the Department of Defense (Liebert and Birnes 2013). Perhaps the recently enacted Clay Hunt Suicide Prevention Act will help to ameliorate this situation of military veterans suffering from mental illness so severe that suicide seems their only option. We have to wait to see what the results of the act will be.

SCHOOL AND CAMPUS PSYCHOTIC BREAKS

There is a generation of teenage and young adult children in college and high school suffering from unrecognized and untreated psychotic illnesses who have immersed themselves in the fantasy worlds of violent online gaming so as to earn psychological satisfaction and rewards from peers from digital perpetration of unbelievable acts of violence (Liebert and Birnes 2014).

Parents of the children killed in the Sandy Hook Elementary School massacre by Adam Lanza are suing, and unlike the two families whose children died in the Virginia Tech massacre who are suing the university, the Sandy Hook lawsuits seek to lay liability upon the defendant manufacturer of the AR-15 assault rifle, regardless of the immunity granted gun manufacturers by Congress, as well as the gun shop that sold the rifle that Lanza wielded. If the lawsuit is not dismissed and there is a settlement, that settlement may be sealed. We may never hear the real story, therefore, of Adam Lanza and his mismanagement, both in public elementary and high school, as well as the state university system of Connecticut, where he matriculated as a precocious student before dropping out. His evolving psychosis was managed as if he were simply a bit weird. The school psychologist was assigned to protect him from bullying, as he slid along the school corridors literally hugging the wall to protect himself from coming into contact with other students while, at the same time, clutching his computer to his chest to protect it as well.

Adam's mother, Nancy Lanza, was allowed to determine the nature of his case management, even though she was probably as delusional as her son. She made sure he knew how to shoot, took him to a gun range, and allowed him plenty of shots. He learned well. Lanza also was studious when it came to warcraft, learning anything he deemed necessary from researching the most grisly of mass murderers like infamous Anders Breivik in Norway and the Unabomber. He was allowed to live in total isolation in what became his basement man cave in Nancy Lanza's large New England colonial, its yellow imitation barn wood prettied up with decorations for the joy of Christmas, well back from the street beyond a broad grassy lawn. He communicated only online, even with his mother. Unlike some mass murderers, he did not need to learn combat skills online, because his mother believed in helping him feel like a man by taking him to the range and allowing him access to deadly weapons. Still, he was able to download the video game, *School Shooter*, in which he likely rehearsed for his rampage through the corridors of Sandy Hook Elementary School. He was allowed total isolation

beyond that grassy knoll in Newtown to merge his psychotic mind within the only medium—online warcraft—that hooked his brain cells together, just like Cho did. And like Cho, Lanza studied up on the Columbine massacre along with many more suicidal mass murders since the Virginia Tech massacre. He had all day and all night to lose his mind in the insanity of mass shootings and suicide, all of which are in these games.

For very sick young people like Adam Lanza, there is no boundary between what is the illusion of the video game and his own reality. His mother, whom he had already informed that he could care less if she were gone, would be the first on his execution list. Sandy Hook Elementary School would be wiped out, like the helpless kids and adult patrons on Utoya Island in Brevik's wild game hunt for humans. Lanza performed the challenge of blasting away at people as if they were targets at a shooting range. Then he would commit suicide. Was this a game, or was it reality? From what the investigation has released to date, no professional seemed aware enough of his descent into extreme madness to ask. Or, when he became nonadherent with treatment, nobody was there to take over from a mother who now, in retrospect, was totally incompetent, if not merged psychologically in his psychosis with her own death wish. Shockingly, her estate on probate is $64,000—hardly enough to pay for residential treatment she had shared with friends as a possible solution to her son's growing threats.

The basic problems behind these school shootings and rampage murders continues to be obfuscated by researchers who simply do not believe seriously mentally ill patients can do anything like Cho, Lanza, or Aurora Colorado's James Holmes did, or that they were simply "bad" and not "mad." Except in the rampage murder at Northern Illinois University, which we cover below, none of the suicidal mass murderers were diagnosed before their rampages. Nonetheless, official reports and expert interviews with the press make claims based on their histories of mental illness, which essentially do not exist until after apprehension, if there is serendipitous survival, or upon informal suicide autopsy, if dead—the usual outcome (Liebert and Birnes 2014).

Many of these suicidal mass murderers, like Lanza, Holmes, and Rodger, had access to adequate psychiatric care that could have prevented their rampage massacres. Tucson's Jared Loughner, who shot Representative Gabrielle Giffords, is the only living witness to this testimonial to date, and perhaps Holmes will become one. But if only a small percentage of Americans believe that psychotic behavior and suicide is caused by genetically influenced diabolical learning of the brain's neurocircuitry, there seems little hope that public psychiatry will have any impact. We do not know about private psychiatry, because successful interventions are not reported. That means, as the Boise chief said, it is his officer's responsibility to care for the combat veteran in need. Similarly, with the scores of millions of American youth on campus today, it is considered first and foremost a security matter. In the wake of the massacre at Northern Illinois, where there was a robust history of psychotic illness from adolescence in the suicidal mass murderer, Steven Kazmierczak, a campus safety bill was introduced in Congress that included hiring psychiatrists to evaluate psychotic and suicidal students on campus. The bill died in Senate committee.

The frontline of care for students from Marysville, Washington, to Newtown, Connecticut, will remain the school nurse, some security people, and counselors with minimal training and experience in the management of serious mental illness. This will be occurring in environments where psychotropics are both misunderstood, or in amazing consensus, considered more dangerous than duration of untreated psychosis with their use (Liebert and Birnes 2011).

GANG-RELATED MASS HOMICIDES AND ANTISOCIAL CRIMES

Conduct-disordered children too often find their best role model for success is the local gangster, oftentimes enforcing his mob from inside the walls of prison.

The plight of Central American children sent unprotected on an extremely dangerous trek the length of Mexico to escape the violence of cartels in their homelands, now has this nation on the ropes fearing they will staff gangs on our own streets. Anyone doubting the police are at war with street gangs missed the recent news of 100 people being shot in Chicago over the July 4, 2014, weekend, most victims being tagged from rival gangs encroaching on others' turf or threatened with extortion that's called "insurance" in the ghetto. Additionally, most of those surviving are too scared to testify.

Like the violence in the Gaza strip, where the local fighters know the terrain and the populace better than the Israel Defense Forces (IDF) and, so far, to Mayor Emmanuel's dismay, are able to hold it against the law enforcement authorities trying to wrest control back to the city. But this is not a decades-long war between citizens of warring peoples, like Israelis and Palestinians. These are kids and young adults who aspire to the same good life in America we all do. It is hard to convince them to stay in their apartments, go to school hungry, and see their families and friends fighting off rats in the hallways when the local street lord pays them $5000 a day to sell drugs and pimp for him.

Child psychiatrists used to call this Conduct Disorder, Socialized Type—as compared to Conduct Disorder, Non-socialized, which we witnessed on the video of CHP Officer Andrew's punching Marlene Pinnock in the face. Was the group of officers from NYPD immobilizing and killing Eric Garner the flip side of the same coin as Andrew and the CHP with Marlene Pinnock—or—Conduct Disorder, Socialized Type? Many experts in psychiatry and clinical psychology would look at it that way, as vulnerable egos merge into collective brutality under stress, as in the atrocities of war.

INNER CITY SYNDROME

Robbery and assault victimize 3% of Americans every year, and Inner City Syndrome, an indirect health-care cost, has been introduced as a psychiatric defense in felony cases. In fact, violence is apparently so prevalent in urban America that researchers studying the impact from terror of the Atlanta Child Murder Case in a multicity study were unable to differentiate Atlanta's inner-city cohort from control communities not having a child killer on the loose,

whether the Atlanta Child Murderer Wayne Williams, Milwaukee's Jeffrey Dahmer, or a hate group like the KKK. Most robberies are drug associated and, therefore, preventable. For $5 billion, enough substance abuse slots could be created to absorb the 80,000 convicts now on waiting lists. They will strike again and, if for the third time, will be wards of the departments of corrections for life. They oftentimes go hand in hand with conduct disorder easily identified and diagnosed by school psychologists with validated testing requiring parental and teacher cooperation. Most criminal offenses today are associated with substance abuse and or illicit drug trafficking. Consider the costs to the noncriminal insured in higher premiums, as taxpayers and metro hospitals cited in the Detroit News study, "Bullet wounds take a big share of bills," for hospital care in southeastern Michigan, and "Fistfights, beatings keep hospitals busy…and are most common form of violence treated." The costs only took into account public expenditures without assessing third-party insurance payments.

ATTENTION DEFICIT DISORDER

Attention deficit disorder (ADD) afflicts over 20 million Americans in the United States. With few exceptions, as in brain injuries, attention deficity-hyperactivity disorder (ADHD) is a congenital disorder of cerebral dysfunction, formally known as cerebral dysfunction syndrome. Most of these children will not recover, and residual attention deficit disorder will afflict them in adulthood. Of all adolescents with well-diagnosed attention deficit disorder, 50% are arrested for a serious offense, and 25%–45% are arrested for multiple, serious offenses. Conduct disorder in childhood, usually associated with comorbid attention deficit disorder, frequently progresses to antisocial personality disorder in adulthood, generating a prevalence of over 6% of antisocial personality disorder in our population.

Research demonstrates that aggression can be reduced in 60% of this adolescent population. Chronic depression in the mother, spouse abuse, bad schools, and delayed diagnosis in early childhood—all remedial—predict a bad outcome—oftentimes incarceration. A small minority of Americans incarcerated in prisons and jails do not have attention deficit disorder, but state authorities discourage prison doctors from examining for it. Attention deficit disorder is not a difficult diagnosis with current real-time diagnostics. It is a controversial diagnosis, which, when made in childhood, places demands on our schools, but ultimately saves both child and adult lives. Furthermore, when identified in the adult male patient, along with history of childhood conduct disorder, it greatly reduces the risk of imminent violence after release from points of entry to the health-care system. In the female patient, identification with appropriate treatment can dramatically and effectively reduce the morbidity of chaotic family lives they too often create.

Such epidemiological knowledge is imperative for best practices of emergency psychiatry for all those required now to practice psychiatry and clinical psychology on the frontlines. The street landscape of destructive behavioral processes

on which you walk, therefore, is, on average, worse than threats of accidents. An increasing number of young black males are being killed, particularly in the inner city. Direct treatment costs for gunshot wounds alone in this country have doubled since 1990 and now exceed $20 billion; this is probably way understated in the latest annual FBI crime statistics, due to underreporting. In the nation's capital, an African American youth has a 10% chance of being shot before turning 18. He has a better chance of protecting himself anywhere as a soldier in the war on terror than within the few miles' radius of our national congressional offices. Homicide is the most common cause of death among black males ages 15–24.

Behavioral neurologist Gary Tucker found high percentages of brain injury and seizure disorders in the prison population, even before they were filled with combat veterans and seriously mentally ill patients with psychoses. Many of the latter cohorts also had high risk for brain injury. Marvin Wolfgang's study of a cohort of 10,000 young males in Philadelphia found that one-half were arrested, and then one-half were rearrested (www.icpsr.umich.edu/icpsrweb/RCMD/studies/7729). Ultimately rearrests cleared all but a small percentage of young offenders from serious crime. Most of the serious violent felonies were caused by a tiny fraction—about 100—of the original cohort. Although this study seems to run parallel to arrest rates with well-diagnosed ADHD, no correlation has ever been found between the two cohorts studied. In fact, no correlation has been examined, because the first arrest with ADHD is not dependent on socioeconomic class. The second, however, is, suggesting that third and subsequent arrests could hold a very high number of youth with undiagnosed ADHD. This is unlikely to be studied, because prisons, even when under court order to examine inmates for psychiatric impairment, do not include ADHD as an index neuropsychiatric impairment.

Although frequently missed as a diagnosis in higher socioeconomic cohorts of children—particularly girls—it is missed en masse in the lower socioeconomic cohort, which is a high percentage of Wolfgang's recidivists. The ultimate correlation between ADHD, antisocial personality, and psychopaths is unknown and unstudied. Thus, we do not know how many of the serious offenders in Wolfgang's research had ADHD. We do know that there is a genetic transmission of antisocial personality disorder from father to son, which disorder can manifest, according to epigeneticists, depending on the nature of the stimuli that the son encounters. Daughters, interestingly, are not antisocial but suffer Briquet syndrome with multiple and debilitating physical complaints. This cohort of peculiar genetic transmission is too small to draw any conclusions, other than speculating that there are conduct disordered children without ADHD who become hard-core, destructive sociopaths. The explanation for the lack of interest in government and academia for such research could, however, lie with the Congress's choking off funding to research into violence, which research was high on the agenda of then Surgeon General Satcher.

Satcher generated significant research before the alleged lobbying efforts by National Rifle Association (NRA)-sponsored politicians fearful that correlation would be proven between violence and gun ownership and by authorizing such

research would get a negative rating from the NRA. In other words, the gun manufacturers, for whom the NRA lobbies, feared a negative impact on their bottom line. Therefore, any science about a correlation between firearms and violence was chucked out of Congress like a piece of garbage. However, if we are to recapture the streets from gangsters so that good community policing can protect the innocent forced to reside there, we need such translational research informing on epidemiology of injury and death from unremitting clinical states of human destructiveness. Similarly, the Emergency Medical Services (EMS) legislation made possible by Surgeon David Boyd, must at least be read by politicians before all the hype over Ferguson and West Baltimore results in worse reinventions of the wheel.

We take heart attacks and strokes as part of the responsibilities of EMTs when calling 9/11. What is unknown, however, is that behavioral emergencies were given equal status for translational research and operational interventions, just like heart attacks. But, for David Boyd's category of behavioral emergencies, although prophetically foreseen by Boyd—a surgeon—as a necessary component of emergency medicine and public health and mandated by law, Congress chose not to fund them as a necessary equivalent to cardiac emergencies. Again, the distortions of public perception of aberrant behavior as possibly a product of neuropsychiatric impairment from diabolical learning in the neurocircuitry of many brains, is another foundation stone for much of the death, injury, and psychological trauma of violence in this country, whether suicide, apparently pure violence itself, or murder-suicide, including the current epidemic of suicidal mass murder (Liebert and Birnes 2011).

In light of court decisions, such as the *Lessard* ruling in Wisconsin, and in light of not only the lack of public funding for public emergency psychiatric services, as well as the "new age" denial of the existence of mental illness itself, we find ourselves in a bind. Worse, those tasked to protect society are at a loss to develop coping mechanisms to replace public psychiatry as caretakers of the seriously mentally ill. Are the mentally ill on the streets dangerous? Do they pose a threat to police or to civilians? What types of force can police use to restrain them from causing harm? Is lethal force ever required? What training should police have and should the state provide for the management of the mentally ill?

What we have found, and what we shall explore, is a huge gap between what many in the psychiatric community know and what they can offer to first responders, both in law enforcement and in emergency health care. This is tragic because lives are put in jeopardy every day by those individuals who, because of a mental illness, are divorced from reality, cannot comport their behavior to the strictures of the law, and often cannot understand why police are confronting them. Hence, it is the purpose of this book to close this gap.

DOCS VERSUS GLOCKS

There was a time in the 1980s when the Center for Communicable Diseases under Satcher funded a productive division that studied violence as a public health issue. And the late Everett Koop, also as Surgeon General, found that violence was a public health issue as well. No more. The NRA took care of that. Congress