In Crisis

A special report on the mental-illness epidemic in Central Florida

Part One: Florida’s mental-health epidemic reaches crisis point
By Kate Santich and Jeff Kunerth

An epidemic is spreading in Florida.

At its worst, mental illness asserts itself in paranoia and delusions that can explode into violence, which happened last month when a lawyer shot three people at Florida State University before police killed him.

But more commonly, it resides in the private and personal anguish of those who struggle daily with a mind at war with itself.

It does not discriminate.

It’s Sierra Denniston, a teenager battling bipolar disorder. It’s Joe Mendoza, a middle-age man who, suffering from depression, tried to kill himself. It’s A.C. and Jo Ann Carson, who lost their son after two decades of schizophrenia.

It’s the police officers who serve as the first responders in our mental-health system. It’s corrections officers who deal with mentally ill inmates every day. It’s neighbors struggling with a mentally ill homeowner.

We never notice how wide and deep mental illness has spread until it reaches a state of crisis in our communities. From the state’s highest court to the front lines of emergency care and treatment, there’s an urgent call for change in how we treat the growing numbers of people with mental-health problems.

“About 70 percent of the people who need mental-health treatment in this state can’t get it,” says Donna Wyche, manager of mental-health and homeless issues for Orange County.
“Either the resources aren’t available or, sometimes, people can’t figure out how to navigate the system to find the resources. We have to do a better job.”

In Florida, some 660,000 adults and 181,000 children live with serious mental illness — bipolar disorder, severe depression or schizophrenia — and nearly half the population will struggle with less devastating forms at some point in their lives. An insidious epidemic, it reaches into every class of neighborhood and touches every public agency.

Yet Florida ranks 49th among the states for mental-health programs, spending $37.28 per person last year. Mississippi spent four times as much on its mentally ill.

Altogether, Florida devotes $718 million a year to mental-health programs, but it pours nearly $1 billion a year into jails and prison for housing and medicating mentally ill inmates.

Other costs of untreated mental illness — to homeless shelters, emergency rooms, police officers, court systems, employers, communities, families and individuals — have become prohibitive.

When James Earl Jones killed his girlfriend, her brother and mother with a baseball bat in Tavares in July, he left behind two grieving families: his victims’ relatives, and his own parents. Jones, a schizophrenic who was off his medications, was later found dead in a nearby lake.

When Myron May went on a shooting rampage at FSU, he not only wounded three people — one of them a promising young student from Apopka who’s paralyzed from the waist down — he left behind a wide circle of friends trying to understand what went wrong.

Such high-profile attacks are drawing attention to the crisis, the roots of which began more than half a century ago.

That’s when a national movement began to close mental hospitals that inhumanely warehoused patients — a movement that was supposed to be followed by the establishment of community-based treatment programs. People with mental illness were supposed to receive counseling, medication, case-management and sometimes shelter while living with or near their families.

But the funding to fully support those community programs never materialized. Some states have tried belatedly to develop those programs, but in Florida the effort is still in its infancy.

As a result, the number of mental-health calls to law-enforcement agencies in Central Florida has increased 30 percent during the past five years. Entire wings of the Orange County Jail have become treatment centers. The waiting list to see a doctor at the primary mental-health
care provider in Orange County is four to six weeks. Frontline care centers, designed to treat those in crisis, are overrun.

No one with any knowledge of the crisis suggests there is a panacea — or that money alone will solve a complex problem that has been building for decades. But there’s little debate on one point: It’s time for solutions.

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Part Two: Young and bipolar - an Orlando teen’s odyssey
By Kate Santich, Orlando Sentinel

If you look closely, you can still see the thin scars along the pale underside of her forearms — precise, parallel cuts made in the misplaced hope that bleeding would ease the pain. For months, Sierra Denniston had patched them with Band-Aids and worn long sleeves to cover the evidence.

“I hate them,” the 17-year-old says, drawing a finger across the marks.

Sierra is an operatic prodigy — a smart, talented teen who grew up in Orlando and won a scholarship to one of the most prestigious performing arts schools in the country. She once had a way of making everything she tried, in academics or dance or music, look effortless.

But when she was 14, she began withdrawing from friends. She struggled to concentrate and found herself crying uncontrollably.

And she was terrified she knew the truth about herself.

“My dad was bipolar, so I saw it growing up,” she says. “I never wanted to end up like that.”

In the past three years, she has been detained by police, hospitalized for a suicide attempt, Baker Acted twice, misdiagnosed by at least four doctors and put on a dozen medications, sometimes six or seven at once.

Researchers have found that half of all serious adult psychiatric problems — including major depression, anxiety disorders and substance abuse — start by age 14, and three-quarters are present by age 25. Yet, according to the New England Journal of Medicine, most mental illness in children and teens goes unrecognized and untreated, leaving them vulnerable academically and socially at a critical time in their lives.

For Sierra’s grandparents, who have raised her since she was 3, seeing the teenager in the grip of such a struggle was heartbreaking. They had already witnessed their son’s decades-long battle with drinking and drug abuse — substances he used to self-medicate for underlying mental problems. Sierra’s mom, still a teen when she gave birth, had given up parental rights.

“At first, we wanted to believe that Sierra was just being a teenager,” says Patti Denniston, the teen’s grandmother. “You never want to admit to yourself that there’s something wrong with your child.”

Especially one with such promise.
Signs of a prodigy

At 2, Sierra began taking ballet. At 4, she joined her church choir. At 6, she saw a movie about a young dancer who goes to Juilliard, and for years afterward, she told anyone who would listen that’s where she was headed.

“At her initial audition, those were the first words out of her mouth,” says Bach Festival Youth Choir Director Devon Kincaid. “I thought, ‘OK! I like your ambition.’ And she had a lot of raw talent.”

Sierra decided in middle school that she wanted to attend the Interlochen Arts Academy boarding school in northern Michigan. When she won a scholarship covering 75 percent of the tuition, her grandparents and supporters scraped together the balance — nearly $13,000.

In September 2011, at 14, she flew 1,100 miles away from everyone and everything she knew to pursue her dream. She also hit puberty at roughly the same time — an age when mental illness often strikes.

Patti Denniston began to worry. “I saw some really quick reactions and grandiose ideas that just weren’t right,” she says. “I called her pediatrician and said, ‘Do you think we need to bring her home?’”

Instead, the doctor recommended a psychiatric evaluation. But even though the Dennistons had insurance, they couldn’t find a doctor to see their granddaughter for at least six months. When they finally flew her home for the meeting the following spring, Sierra was diagnosed with chronic anxiety, depression and attention-deficit hyperactivity disorder. She was put on three prescriptions before heading back to boarding school.

“I lost 40 pounds in a month,” Sierra says. “I basically stopped eating. Just the smell of food made me want to throw up. … My [grand]parents were scared, but I was happy because I was thin.”

Eventually, she needed higher and higher doses of the drug to feel good. She grew angry, hypersexual and volatile. With her boyfriend, she was clingy and jealous. Several times a day, she suffered panic attacks so debilitating that sometimes she couldn’t bring herself to perform in class. She went from feeling like she could conquer anything to a crippling sense of failure.

She saw more doctors.

“At one point I was on Vyvanse, Adderall, Abilify, trazodone, Seroquel XR and I can’t even remember what else,” she says. “Every time I went to a doctor, they would never take me off anything. They would just add more.”
In the summer of 2013, as she was about to return to Michigan for her junior year, her boyfriend of one year broke off the relationship. Sierra went back to school “a wreck.”

She started cutting. She would call home, sobbing. Patti — desperate to give the girl the stability she needed to succeed — left the family printing business and temporarily moved to Michigan to be with her. The school let them stay in a cabin on campus. Sierra could barely get out of bed. After two months, they came home to Orlando.

When Sierra wasn’t crying, she was hostile. One night, she called police ranting, accusing her grandmother of child abuse. The 911 operator listened for a half-hour as police were dispatched. But it was Sierra they took into custody and sent to a mental-health hospital for 72 hours of observation.

“I hated it,” she said. “I threw up on myself and they wouldn’t even give me clean clothes.”

**Finally, a diagnosis**

A month later she was Baker Acted a second time — after swallowing a bottle of Patti’s high-blood-pressure medication. After the emergency room, she was sent to University Behavioral Center, where doctors took her off all medication so they could make an accurate diagnosis. And for the first time, they diagnosed her as bipolar — a brain disorder characterized by alternating periods of euphoria and extreme depression.

The doctors prescribed Latuda, a newly marketed medication for bipolar depression.

“It has been a miracle for me,” Sierra says. “I started to feel like myself again. It was such a relief.”

Earlier this year, after earning a high school diploma by passing the GED test, Sierra was accepted into Interlochen’s post-graduate conservatory program. But in late October, barely two months into the semester, she called home.

“Mom, it’s happening again,” she told Patti. It seemed like the only way to save herself was to return to Orlando.

She hasn’t given up her dreams, but they have changed. She is working part time while taking lessons from a voice coach at Rollins College and applying to colleges with top music programs. She hopes to find one a little closer to Orlando.

Sometimes, she admits, she misses the old version of herself — the one who felt so confident and fearless. But she has another dream now, too. She wants to speak out for the legion of
young people with mental illness who are too afraid or ashamed or introverted to speak out for themselves.

“There has been plenty of research to know that this is a chemical imbalance in the brain, but some people don’t seem to care,” she says, shaking her head. “They think you’re just not trying hard enough to be happy — as if you’re choosing to feel this way. Well, guess what? I didn’t choose this. I would never choose this. But I’m not ashamed of it, either.”

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Part Three: A son’s life lost to schizophrenia

By Kate Santich, Orlando Sentinel

The call came just after 4 a.m. on Father’s Day, waking the Rev. A.C. Carson with the news: His only son, just 38 years old, was dead.

Jonathan Carson’s body had been found curled on the bathroom floor of a state mental hospital outside Jacksonville.

“My son was mentally ill, but he deserved better than to die like that,” the father says.

In some ways, Jonathan’s parents had been bracing themselves for a middle-of-the-night phone call for more than two decades.

Jonathan had been a sweet-natured kid. At 7, he could recite all 66 books of the Bible — in order. He taught himself to read music and, by adolescence, he played piano for his father’s small church, the Christian Focus Center, and trombone for the Edgewater High marching band.

But in his junior year at Edgewater, he began showing signs of trouble. He skipped school. He started drinking. He hung around with kids his father didn’t approve of. His grades plummeted.

As his behavior grew more erratic, his parents checked him into a treatment facility for mental illness and substance abuse.

Just before Jonathan’s 18th birthday, doctors diagnosed him with schizophrenia — a chronic, often disabling disorder that affects about 1 percent of the population.

Thought to be a result of genetic mutations in the brain and environmental triggers — including, perhaps, a virus — schizophrenia is one of the most severe types of mental illness. People with the disorder may hear imaginary voices or believe others are reading their minds, controlling their thoughts or plotting to harm them.

Untreated, they often withdraw or become extremely agitated. Adhering to a medication schedule is a particular challenge.

When Jonathan managed to take the drugs doctors prescribed, he could work, drive and even live on his own. When he didn’t, there was chaos.

Over the years, he cycled in and out of emergency rooms, had minor brushes with the law and sought treatment at various outpatient programs. He sometimes wandered the streets so aimlessly that his father worried he would be hit by a car.
For all his parents’ efforts, they could see him slipping further away. Last fall, they relinquished medical guardianship of their son to the state. Jonathan was court-ordered to Northeast Florida State Hospital in rural Macclenny.

A.C. Carson had begged a judge to find a placement for his son that was closer to Orlando — a place he and his wife, Jo Ann, a registered nurse, could easily visit — or a supervised group home where Jonathan could be monitored. There were no openings.

“Parents’ voices are not heard,” A.C. Carson says, “even when we scream.”

Jonathan spent the final seven months of his life at Northeast, one of only a half-dozen state mental institutions left in Florida, the rest having been shuttered after allegations of abuse and lack of treatment.

The community-based programs that were supposed to replace the hospitals were never given the funding and support advocates initially envisioned. And people like Jonathan Carson — too unstable to live on his own, but a danger only to himself — had few options.

Jonathan would always beg us to come home,” Jo Ann says. “I can still hear him begging to come home.”

What ... happened?

One day this past June, Christian Fletcher Thompson — a Lake Mary loan officer — was flipping through the newspaper when a photo on the obituary page stopped him cold. It was the senior picture of Jonathan Carey Carson, once his good friend, from their days at Edgewater High School.

“I thought, ‘What the hell happened?’” Thompson says.

The two first became buddies in 1990, their freshman year, when Thompson’s family moved to Rosemont, then an up-and-coming Orlando suburb.

Just days after the move, Carson had come rolling up on his skateboard as Thompson was shooting baskets, and their mutual competitiveness cemented a friendship.

Carson was always well-mannered and sharply dressed, and he seemed to be popular enough at school.

“He was very outgoing and a pretty good basketball player,” Thompson says. “And he was an amazing piano player. He’d play at my house, and it was just effortless. I remember this one
piece — Oleta Adams’ ‘Get Here,’ this slow R&B song. I wasn't musical like that, but it made me want to learn piano.”

But around their junior year, Carson retreated from his friends and began getting into trouble, Thompson says. He figured his buddy was just rebelling against the conservative religious values of his father.

Thompson graduated, went off to Valencia, got married and bought a home. Once in a while, he’d see Carson working at a convenience store. He always seemed to be lost in his own thoughts.

About seven years ago, Thompson drove his wife by the Rosemont home where he’d spent his high-school years. As he rounded a corner, he saw Carson checking his mailbox. His old friend walked over to Thompson’s car cautiously, peered in the window and spoke.

Thompson couldn't understand a word of it.

“The conversation — or whatever you want to call it — was just gibberish,” Thompson says.

As he drove away, Thompson turned to his wife. “That’s not the same Jon Carson I knew,” he told her.

It would be his final encounter with his friend. The next time he saw Jonathan’s face, it was on the obituary page.

Last day

The last time Jo Ann Carson saw her son, eight days before his death, the two talked about his homecoming.

“I told him he just needed to keep taking his medicine and cooperate with the therapists,” she says. “And I said, ‘When we come up to see you on the 17th, they’re probably going to be getting your discharge papers ready.’”

She pauses, crying. “But he didn’t make it.”

One week after that visit, Jonathan’s sister went to see him.

Her brother came to the waiting area and lay on the floor. He looked sickly and gaunt. At 5-foot-11, his weight had dropped from 150 pounds to about 130. The staff insisted he was eating. Felicia Carson called her parents.
They were on the phone moments later, Jo Ann begging the staff to take her son to a medical hospital. A nurse insisted he was fine.

About 2:30 a.m., hospital records show, a worker found Jonathan curled on a bathroom floor, unresponsive. He was transported to a hospital emergency room, where he was pronounced dead at 3:56 a.m. A medical examiner would later find hemorrhaging in Jonathan’s gut, part of which had become necrotic. It happens when the intestines develop a strangulating obstruction — a possible complication of psychiatric drugs.

The death was ruled “natural causes.” A Florida Department of Children and Families inquiry found “no issues that would warrant a formal investigation.”

A.C. Carson saw his son for the last time at the funeral home, on a table. “

Jonathan had the biggest grin on his face,” the father says. It had been a long time since he had seen any sign of happiness in his son. “I guess he was just glad to get out of that place.”

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Part Four: The real face of mental illness

By Kate Santich, Orlando Sentinel

SHARELINES:

- The struggle with suicidal thoughts is more common than you might think.
- Face of mental illness: Middle-aged, depressed, suffering quietly
- Depression is the most common form of mental illness. Read about one Central Florida man’s fight

It was the night before New Year’s Eve, and Joe Mendoza sat on the edge of the bed in his Altamonte Springs apartment, staring at the collection of old sleeping-pill prescriptions in the drawer of his nightstand. He counted the pills. Thirty-four. It seemed like enough. The notion had bumped around in his brain for months: At 53, the once-successful sales executive was unemployed, getting divorced and convinced he had become expendable. In that moment, sitting on the bed, looking at the bounty of medications, the plan made perfect sense. He didn’t bother with a note.

“I can just take all these pills,” he thought. “I can go to sleep and not wake up and somebody will find me.”

Mendoza swallowed the drugs and closed his eyes. Angry young men who open fire on college campuses and schoolyards are often represented as the face of mental illness. But a vastly more common image is someone like Mendoza: depressed, middle-aged, suffering quietly. As a group, adults 45 to 64 who are either unemployed or disabled are most likely to suffer major depression, the federal Centers for Disease Control and Prevention reports. Depression is the most common form of mental illness, affecting more than a quarter of Americans at some point in their lives.

And though women are more likely than men to report the problem, men are four times more likely to kill themselves. In 2013, the CDC reported that the suicide rate among middle-aged Americans climbed a startling 28 percent in a decade — to 17.6 per 100,000 — perhaps partly due to financial burdens of the economic recession.

SIDEBAR: How to tell normal sadness from clinical depression

Depression is one of the most common forms of mental illness, affecting roughly one in every 10 Americans at any given time. But symptoms, severity and duration vary widely.

The Mayo Clinic defines clinical depression as having five or more of the following symptoms over at least a two-week period, most of the day, nearly every day:

- Feeling sad, empty or tearful
- Loss of interest in previously pleasurable activities
- Significant decrease or increase in appetite
- Insomnia or sleeping excessively
- Restlessness or such slowed behavior that others notice
- Fatigue
- Feelings of worthlessness or excessive or inappropriate guilt
- Difficulty concentrating or making a decision
- Recurrent thoughts of death or suicide, or a suicide attempt
- Major depression is a more severe form that significantly impairs a person’s ability to function. Persistent depressive disorder is a depressed mood that lasts for at least two years and can vary in intensity. Researchers believe depression is caused by a combination of genetic, biological, environmental and psychological factors.
- Depression also can manifest as body aches and pains, headaches, cramps or digestive problems that do not ease with treatment.

For more information, including an online screening test and advice on finding help, see mentalhealthamerica.net

If you are having suicidal thoughts, call the local United Way crisis line at 211 or the national suicide-prevention lifeline at 1-800-273-8255.

Looking back at that night in 2007, Mendoza, now 59, can see the pattern. He was the son of a World War II veteran, a stoic man who, his son says, was likely depressed but never treated.

Mendoza himself remembers first feeling profoundly sad as a freshman at the University of Florida. He went to classes dutifully but wrote brooding poetry about the pointlessness of life. He did little else.

He dropped out of grad school at 21 and dabbled in retail before getting a job with the fast-growing telephone industry, where he would work for the better part of three decades. Soon married to his high-school sweetheart, Mendoza fathered three children while quickly climbing the ladder as a sales executive. From the outside, it looked like success.

From the inside, it felt like something was starting to crack.

One morning in 1999, as he was dressing for work, he dropped a suit hanger — and began screaming at it.

“I knew this wasn’t normal behavior,” he says. “My wife had been telling me for months that she thought I needed help.”
After years of trying to ignore his emotions, Mendoza didn't know where to start. He couldn't even say what exactly he was feeling.

“Where in your body do you feel it?” the therapist asked.

“In the pit of my stomach,” he said.

The therapist never mentioned depression. For a long time, no one did — not until after his mother died, after he was downsized, after his children moved out and his marriage began to unravel. Though he quickly landed a new job as a regional marketing manager, he couldn’t function.

His primary-care doctor prescribed medication for depression, anxiety and insomnia. The drugs helped, but not enough. At the office, he would call his estranged wife several times a day, asking what he should do next. His weight plummeted by nearly 45 pounds. He would sit in front of his computer, staring blankly at the screen. In mid-2007, he resigned, saying he needed the time to get himself together. Six months later, he swallowed the 34 sleeping pills from his nightstand. “I had been walking down that gradual, inviting, inexorable slope of the abyss for a long time,” he would write later, part of a therapy assignment.

What happened in the hours and days afterward is a blur. He remembers hurting his back, thrashing around his apartment, ripping down a shower-curtain rod. He remembers being carried away on a stretcher by paramedics. He remembers having to suck on a vile-tasting charcoal solution, his children visiting, having his shoelaces confiscated so he wouldn’t hang himself and sleeping on a mattress on the floor of the isolation room. He remembers, a few days later, looking around at the other residents of the hospital psych ward and thinking how much sicker they seemed than he was, how he didn’t really belong there. And he remembers having a dream in which a bright light appeared and seemed to beckon him to grab hold. In the dream, he did.

“It was a like a surfer seeing a wave and deciding: I’m going to ride it for all it’s worth,” he says. “I don’t know now if I was hallucinating or visualizing, but it seemed to me to be a transitional moment.”

It seemed the light was life, and he was choosing to live.

It helped that he was put on a new pair of antidepressants that, for the first time in years, allowed him to see the world without the lens of hopelessness. It helped that his grown children, his estranged wife and his extended, extensive family rallied around him.

It helped that he still had health insurance that covered a three-week outpatient program where he went every weekday. And it helped, when the insurance ran out, that he found the Greater Orlando chapter of NAMI, the National Alliance on Mental Illness, where he attended
support groups, workshops and conferences. Since then, he has become an advocate. And, finally, it helped enormously that he joined a meditation group, which taught him how to practice being grateful for the moment. There, he met Kitty White, a psychotherapist, whom he married this May.

It helped that he had advantages, luck and abilities many don't.

Joe Mendoza will turn 60 this month. He now works as an insurance broker. He is close with his children. He speaks out on matters of mental illness — for more understanding, for more resources, for encouragement. He takes a trio of antidepressant medications that keeps him stable and capable. He knows he'll need to take them for the rest of his life.

Many middle-aged men, he says, often define themselves by their jobs and their roles as providers. Many would never admit depression or seek help. Many would shut themselves away, as he did, and suffer.

“I now think of my life in two parts: before the suicide attempt and after,” he says. “I still get down about things once in a while, but it doesn't last long. As clichéd as it sounds, I know I'm on borrowed time. All of this is just a bonus.”
Part Five: Police balance empathy, danger on the front line of Florida’s mental health crisis

Jeff Kunerth, Orlando Sentinel

SHARELINES:
- Police balance empathy, danger on the front line of Florida’s mental health crisis
- Cops face potential danger when called to help someone who is mentally ill

This image will remain forever in the mind of Orlando Police Corporal Manny Varela: The small, young, zoned-out woman hiding in the darkness reminded him of his teenage niece.

She looked so helpless. In that moment, the face of mental illness became personal: This could be someone I know, someone I love.

He felt compassion, but also a sense of danger. It was 5 in the morning and he was responding to a call about a woman who was threatening to kill herself.

Cops think like this: People willing to kill themselves are capable of killing someone else. Only later would Varela learn about the two loaded guns in the front seat of her car.

“Going to a call with a mentally ill person, officer safety is just heightened because of the unpredictability,” Varela said. “We want to try and help that person. They legitimately want help. But you have to think safety first.”

In 15 years, Varela has responded to hundreds of calls involving mental illness: a suicidal woman straddling the railing of a bridge over Interstate 4; a man with a machete chasing his wife from their house; a belligerent homeless man in Lake Eola; a son threatening to kill his mother.

In those years, he took more than 113 people for emergency psychiatric evaluations under the state’s Baker Act — including 51 from his 2-1/2 years on the downtown bicycle patrol. It’s almost a routine part of the job for police, as their calls to help distressed mentally ill people reach the breaking point.

Throughout Central Florida, the number of mental illness-related calls to law enforcement agencies has increased by more than 30 percent over the past five years. And it’s getting more dangerous, as cops become the front line of Florida’s overburdened mental health system.

Since 2009, the Orlando Police Department has answered more than 8,000 calls related to mentally ill people — 33 percent of them involving threats or acts of violence.
Cops are the ones who are called when someone threatens suicide or succumbs to depression. They are the ones parents call when they worry about their teenagers’ state of mind, or when a homeless man frightens people strolling around Lake Eola.

And they are the first ones called when mental illness erupts into violence.

‘What have you done?’

James Earl Jones stood outside the duplex he shared with his girlfriend, Shannon Ratliff, both hands wrapped around a blood-spattered aluminum baseball bat. He was breathing hard. His eyes were wide. Tavares Police Officer Michael Woods, the first on the scene that muggy July 14 afternoon, recognized the look of a man in the middle of a psychotic episode. Woods tried to calm Jones down.

“James, what’s going on? James, we’re here to help you,” Woods said.

Six feet apart, eyes locked, the two men began slowly circling each other. Woods knew Jones, a stocky round-faced man with short-cropped hair. And he knew Shannon Ratliff’s family, especially her brother Eddie, who worked for the city of Tavares.

**SIDEBAR: What is the Baker Act?**

*Enacted in 1972, Florida’s Baker Act allows for the involuntary examination of an individual for mental illness initiated by law enforcement. Family members can also have a person Baker Acted if they receive an order from a judge.*

To fall under the Baker Act, there must be evidence that the person is a danger to himself or others. This includes a person who has endangered himself through severe neglect.

The Baker Act requires that the person be examined by a mental health professional, often a psychiatrist, within 72 hours. If the health care professional finds the person to no longer be a threat, the person can be released or sent to a community-based treatment facility. If the professional finds the individual a danger or mentally incompetent, a judge can sign a commitment order for involuntary placement in a treatment program.

*The primary purpose of the act is to provide the individual with mentally health treatment rather than an arrest and incarceration.*

*Source: Sentinel research*

“Can you put down the baseball bat?” Woods said. “James, nobody wants to hurt you. We want to help you.”
Jones jabbed his bat toward Woods twice. Woods activated his taser and pointed it at Jones’ chest.

“Come on, come on,” Jones said. “Go ahead and tase me.”

Woods remembers stepping backward as they continued to circle. He was ready to use the taser when Jones dropped the bat to the ground and ran away. Woods didn’t give chase.

In front of the apartment was a van that belonged to Shannon’s mother, Mavis. Woods walked around the van and found Mavis on the ground, still alive, but her head bashed in. In the nearby brush, he found Eddie Ratliff face down, also dying from a head wound.

“Oh, Eddie,” he said. “James, what have you done?”

What James Earl Jones had done, while off his medications for schizophrenia, was bludgeon his longtime girlfriend, her brother and her mother to death before drowning in Lake Harris.

**Training is crucial**

Because of this shifting intersection of the troubled mind and the public’s well-being, police officers such as Woods and Varela are being trained to understand mental illness, its causes and symptoms, and the people who suffer from it.

Woods, a 56-year-veteran of law enforcement, used that training when confronting Jones: talking calmly, referring to him by his first name, trying to engage him in conversation, trying to get him to put the weapon down before hurting anyone else, reassuring Jones that he was there to help.

Since 1999, 1,700 police officers, sheriff’s deputies and corrections officers from throughout Central Florida have undergone weeklong training through Lakeside, the receiving center in Orange County for the mentally ill delivered by law enforcement under the Baker Act.

There are many reasons cops have been cast into this role — including the deinstitutionalization of the mentally ill, cost of treatment and resistance among the sick themselves to seek help.

“You are the de facto ambassadors for mental health in this county,” Lakeside mental health counselor Zach Hughes tells law enforcement personnel. “You are the first contact with these people and will always be the first contact with these people.”

Officers who complete the Crisis Intervention Training know the criteria necessary for taking the person to Lakeside for a mental health evaluation and treatment instead of jail.
“From our end, you are getting someone the help they need instead of making the jail the dumping ground for the mentally ill,” said Capt. Sue Brown, who heads the Orlando Police Department’s Crisis Intervention Team of officers who have been trained in dealing with the mentally ill.

“It’s so volatile,” said Varela, 40, who underwent the mental health training six years ago. “When you are dealing with a paranoid schizophrenic, you are already talking to someone who distrusts the government, who doesn’t trust the police.”

So on the day Varela responded to the call of the suicidal woman who looked like his niece, he knew that every call involving the mentally ill is a balance between empathy and danger. He was the third officer to arrive at the parking lot between Jefferson and Washington streets in downtown Orlando.

One of the officers approached her in a cautious, conciliatory manner, and engaged her in conversation. Her face was blank, her voice without emotion.

She was an Army veteran who served in Afghanistan. Before she entered the service, she had suffered from depression. When she came back, her family said, it became worse. To her family, who had called the police, she seemed to no longer care what happened to her. She told her parents she was thinking of suicide.

“How long have you been having these thoughts?” the officer asked her. “How do you want to hurt yourself?”

“I’ve got two guns in the car,” she replied.

In Varela’s mind, the suicidal woman and the guns on the front seat highlighted all the things that can go wrong: She could have shot the officers, the officers might have shot her, she could have killed herself.

“Suicide by cop is an actual phenomenon,” he said. “They want to kill themselves, but they need someone else to do it.

"Instead, she listened to one of the police officers who talked to her about going to Lakeside.

“Listen,” the officer said, “you have to speak to someone. We’re going to take you there. You are not under arrest.”

She agreed to get into the patrol car.

“She wasn’t argumentative,” Varela said. “She understood she needed some help.”
It has not always been this way — cops who are trained to think and act like mental health counselors. But if it were his niece in crisis, Varela said, he would hope the officer answering the call would treat her the same way, with caution and compassion.

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Part Six: Florida’s jails have become ‘the asylums of the new millennium’

By Jeff Kunerth, Orlando Sentinel

The most dangerous time of day on the Fifth Floor is 6 a.m.

Long before nurses make their daily rounds dispensing meds to those suffering from schizophrenia, bipolar disorder and depression, staffers like Greg Dawkins must check to see if anyone has died during the night.

They knock on doors, call the person’s name. If there’s no response, they enter.

“I’m waking them up early in their rooms and I’m inside their space,” said Dawkins, who worked the Fifth Floor for years. “I have to be alert and watch them very carefully. When you tap a person to wake them up, they wake up fighting.”

Dawkins works at the largest mental health institution in five Central Florida counties: the Orange County Jail.

In Florida, jails and prisons have replaced mental hospitals. They are “the asylums of the new millennium,” according to the Florida Supreme Court.

And every year, they house and treat more and more people like James Coleman.

“I hear these voices. When I want to kill, I want to kill a lot of people because some people just need it,” said Coleman, 55, a homeless man who says he suffers from schizophrenia. “I’m angry all the time.”

He is among 125,000 people with mental illness who are incarcerated in Florida jails and prisons annually, most of them for misdemeanor and low-level felonies, according to a recent report by the state’s high court.

A third of the Orange County Jail’s 3,000 inmates have some form of mental illness, and 700 are on psychotropic medications. To help them, the jail employs a staff of 18 — including a psychiatrist, a psychologist and 12 mental health counselors — with a budget of $2.7 million and a pharmacy that dispenses 7,000 prescriptions a month.

There are 140 beds for those who have moderate to severe mental illness. For those who are the most dangerous to themselves or others, there are padded cells.

No bed. No sink. No toilet. Just beige rubberized walls and a drain in the middle of the floor.
The padded jail cell has replaced the padded room since the state began closing mental institutions in the 1970s. The large institutions were supposed to be replaced by community-based centers, but the funding never came and the system was not developed.

“We got them out of the big state hospitals, but now they are showing up in the correctional facilities,” said Leonard Branch, chief psychologist with the Orange County Jail.

Prisons and jails were never designed to treat the mentally ill and are limited in what they can do. They can’t control when inmates are released or prolong their stay until they are mentally stabilized. They cannot force an inmate to take medications.

“They are not brought to a jail because of mental illness, but because someone said they broke a law,” Branch said.

While the offenses that put them in jail are often minor — loitering, disturbing the peace, public intoxication — their mental illnesses are often severe. Ninth Judicial Circuit Public Defender Bob Wesley estimates that 90 percent of the jail’s mentally ill “frequent fliers” suffer from schizophrenia.

“Schizophrenia has become the Ebola of behavioral disorders. This is the one that dissolves families,” said Wesley, whose office represents the indigent mentally ill.

No place to go

As a mental health institution, jail is a temporary residence.

The longest a person can spend in the jail is one year. The shortest stay is as long as it takes for someone to post bail. The judicial system, not mental health professionals, determines when a mentally ill inmate is released.

And like Coleman, many will be back. He says he has been in and out of the Orange County Jail at least a dozen times during the past 10 years.

When he’s in jail, he receives the psychotropic drugs that silence the voices and calm the anger. Once he’s out, he lives under an overpass.

“I need medications, but I can’t afford it,” he said. “I have a prescription, but I don’t have insurance.”

Forty-four percent of mentally ill inmates are back behind bars within three months. There is one man who has been in and out of the Orange County Jail more than 100 times during the past 20 years.
In the jail, there’s no therapy, no deep digging for the root cause of the psychosis, no psychoanalysis on the chief psychiatrist's couch. It's mental illness triage aimed at keeping that person from hurting, or killing, another inmate, himself or a corrections officer. Mentally ill inmates can be irrational, belligerent, manic and psychotic — and those emotions can erupt within seconds.

Dawkins, 53, has worked in the Orange County Jail for 15 years, most of that time on the Fifth Floor where the most severely mentally ill inmates are held in 42 individual cells with glass doors and a common area that contains beds and chairs with leather restraints.

He’s dealt with inmates who accused him of poisoning their food, demanded their car keys so they could drive home, and attacked him without warning or provocation. Any officer inside the cell of a mentally ill inmate leaves the cell by walking backward. You never turn your back on a Fifth Floor inmate.

On May 18, Dawkins tried to wake a man on his bunk. He didn't respond to Dawkins' knock on the door or the calling of his name.

“I have to open the door and go in and shake him. I’m calling him by his name. I move closer to tap him on the shoulder. He rolls over and punched me in the left eye,” Dawkins said.

The punch sent Dawkins to the emergency room. It was his last day on the Fifth Floor.

**Changing battle zone**

Dawkins is one of about 400 Orange County corrections officers trained in the causes and symptoms of mental illness and the best techniques in dealing with a person experiencing a psychotic episode.

Lesson one: Whatever the person sees and hears is real. You don’t tell them what they see is not there.

Instead, Dawkins said, you navigate around the delusion. Once, an inmate refused to leave his cell that needed cleaning because he was still visiting with his imaginary sister.

“Can my sister go and buy me a pack of cigarettes?” the inmate asked.

Sure, said Dawkins: “While your sister is gone, we can clean your cell before she gets back. Once the cell is clean, I'll let her back in.”
SIDEBAR: A way forward

In response to the number of mentally ill inmates in the Orange County Jail, a group of leaders in judiciary, law enforcement, corrections and mental health have formed a subcommittee to recommend ways of improving mental health care inside and outside of jail.

Solutions under consideration by the Criminal Justice Coordinated Public Safety Council’s mental health subcommittee include:

- Target the homeless and unemployed for intensive case management, transitional housing and residential recovery modeled after the Assertive Community Treatment program in Alachua County
- Expand the Crisis Intervention Training program to include EMTs and firefighters and make it mandatory in training academy curriculum
- Provide jail staff, case managers and mentally ill clients with an updated resource list that includes housing programs, mental health services, treatment programs and other social services.
- Create "mental health courts" within the judicial system that provide mental health care services outside the jail to mentally ill inmates contingent on resolving criminal charges.
- Implement a program for adults and youth started in Australia that trains Mental Health First Aid facilitators to identify, understand, and respond to signs of mental illness and addictions. Facilitators would include family members, caregivers, treatment professionals, teachers, and community support agencies including faith-based organizations.

Source: Criminal Justice Coordinated Public Safety Council’s Mental Health Subcommittee draft recommendations.

There was no such training in 1986, when Kenneth Adkins was assigned to work the new wing with the "crazies" who were transferred from the Orlando jail.

Back then, they brought in the biggest, toughest corrections officers to deal with the mentally ill.

“Most of these guys back then were not on medicine so they had volatile behavior. It was a very on-edge experience,” said Adkins, 49. “We had no idea we were signing up for the mental health business back then."

The bust-heads approach has been replaced with training that emphasizes understanding the nature of mental illness and anticipating problems before they erupt. It’s a battle zone in a constant state of truce.
Adkins has been off the mental wings of the jail for years now. He rarely sees the familiar faces that cycle through the jail. But every now and again, he meets someone he recognizes and who remembers him.

About four years ago, while making rounds on the Fifth Floor, Adkins came across an inmate he first met when both were in their 20s. It had been years since they had seen each other.

Both were middle-aged now, veterans of the revolving door of mental illness and the criminal justice system.

In a rare moment of lucidity, the old inmate looked at Adkins and said, “We’re both getting too old for this.”
Part Seven: One woman, one neighborhood struggle with mental illness

By Jeff Kunerth, Orlando Sentinel

Over the years, the neighbors watched the 1922 College Park bungalow deteriorate and, with it, the sanity of the woman who lived inside.

A small, thin, blonde in her 40s, she was the only child of wealthy parents who bought her the house on a street of middle-class homes in 2002.

At first, she seemed to fit in well: a woman of intelligence, style, and class.

Later, she just seemed eccentric. Eventually, she became the neighbor from hell.

She hung an ice skate beside the front door that was wired to the lighting fixture so that anyone who touched it would get a shock. She bathed in a garbage can. She parked her car on her front yard, doors open, music blaring, draped with clothing. She became belligerent to the point that her next-door neighbor feared for his wife and child.

Between 2005 and 2012, Orlando Police were called to her house 139 times, often by neighbors who complained of everything from bizarre behavior to the condition of the house that was becoming a blight on their street. The front porch was cluttered with clothes and furniture and appliances. Her front lawn came to look like a perpetual, chaotic yard sale.

Code enforcement was called to her house by neighbors 36 times. Entering the home, they found it piled so high with garbage, clothing and household debris that they condemned it as unfit for human habitation. She would clean up the house enough to make it livable.

Her relationship with the neighbors became poisonous and hostile. The house and yard filled again with junk and garbage. The cycle kept spinning — complaints, reports, citations — like an endless loop of madness.

Living in garbage

Orlando Police Captain Robert Anzeuto was in his car when the call came over the radio about someone driving backward at a high speed down a residential street. As soon as he heard the address, he knew who it was.

Anzeuto knocked on the door and called her name. He knocked some more. Then he looked between the curtains into the living room. What he saw was a mound of trash, clothing and garbage. Then the mound moved. He saw the woman, unclothed, emerge from the trash heap
He told her to get dressed and come outside. They needed to talk.

Until this point, over all those years, all those calls, all those visits, Orlando police had never been able to take the woman into custody under the Baker Act and get her into treatment.

The criteria is simple: Is the person a danger herself or others, or incapable of taking care of herself? The woman was always too composed, too rational, too smart to meet the test.

But now she was crawling out from beneath a mound of garbage inside her house.

Anzeuto called Lt. Sue Brown, who headed the police department’s team of officers trained to deal with the mentally ill. When Brown arrived, she called Laura Gailey, who managed the Central Receiving Center where people who are Baker Acted are taken.

Gailey said she would be right over. This is not normal procedure. Mental health professionals do not make house calls. But Gailey knew Brown through their work together in the Crisis Intervention Training program that taught police officers how to deal with the mentally ill.

When Gailey arrived, nothing the woman said or the way she presented herself met the criteria of the Baker Act. Gailey needed to see inside the house.

Another Officer, Phil Peet, who had established a rapport with the woman, told her they couldn’t leave until they looked inside her house. She opened the door. There was a narrow passage through the piles of trash that led to a kitchen with the mess and disorder of a garbage dump. There was a pillow in the dishwasher, a book inside the stove. In the living room, a fur stole hung from a ceiling light fixture.

Laura Gailey saw enough. She signed the Baker Act papers to bring the woman in for treatment. But the woman had three dachshunds she said she couldn’t leave behind. Brown left and came back with a crate, dog food and the promise she would take the dogs to Pet Rescue by Judy.

The woman slid into the police car that would take her to the Central Receiving Center at Lakeside. Within 72 hours, she would be eligible for release.

**A broken mind**

Mike Rhodes has been here before. His job, as head of Orlando’s Code Enforcement, is lined with people who live in homes overrun with dogs and cats, convert their houses into warehouses for hoarding, turn their front lawns into junkyards. The task of code enforcement is to ensure the ordinances of orderliness are enforced — not to determine whether those violations are the manifestations of mental illness. But Rhodes knew the woman in the 1922
bungalow and understood that sticking within the limits of code enforcement wouldn’t solve the problem for her or the people who lived on her street.

She had been in his office, protesting her previous eviction following code enforcement’s condemnation of her house. He also knew that condemnation didn’t work. Condemning the homes of the mentally ill creates mentally ill homeless people.

And she had enough money to clean the place up and move right back in.

Something more had to be done. The woman’s parents are dead, so Rhodes and Anzeuto set up a meeting with the trustees who managed the woman’s money and convinced them that while she was undergoing treatment at Lakeside, and her house was under condemnation once again, that they should find her the help she needs. Their argument was pretty simple: If she had a broken arm, would you be responsible for her medical care? Yes. Well, this woman has a broken mind.

The trustees arranged for the woman to receive mental health treatment following her release from Lakeside. In July 2012, a judge ruled her mentally incompetent and assigned her a guardian. After the home was cleaned out, the guardian arranged for its sale. In October 2013, a new owner bought the property for $352,000.

The mentally ill woman who once lived there is in a treatment facility. Today, the house blends in with the rest of the neighborhood, a classy craftsman-style bungalow with potted plants, lamps and stylish patio furniture on the front porch.

The neighbors have their street back. This house could be in any neighborhood. Mental illness affects the community on all levels: neighbors, police, code enforcement, mental health providers, the courts. But working independently, residents can only complain, police can only arrest, inspectors can only condemn, mental health counselors can only treat and release.

When agencies help residents by working together, solutions happen. “We all had to change the way we were looking at it,” Rhodes said. “Here we needed to take a different approach.” Because doing the same thing over and over and expecting a different result is the definition of insanity.

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Part Eight: Solutions to mental illness crisis: New approach, money
By Jeff Kunerth and Kate Santich, Orlando Sentinel

Mental illness is a disease — not a crime.

Every serious call for reform in Florida’s care and treatment of the mentally ill starts with that premise.

And until it’s widely accepted, warn experts from the Florida Supreme Court to caregivers on the front lines, local jails will be packed with mentally ill inmates, children in need of immediate intervention will be overlooked, and those seeking help at overburdened community mental-health treatment centers will be turned away.

“We have to look at mental illnesses as the diseases they are ....,” said South Florida judge Steven Leifman, chairman of the State Supreme Court task force targeting mental-health issues. “Not only will we provide care more effectively, we could reduce crime, save taxpayers money and give hope and opportunity to people with these illnesses.”

In Florida, Leifman said, a person with mental illness is nine times more likely to be arrested than hospitalized — three times the national average. The crisis must be addressed with a spectrum of care from preventative to life-threatening, advocates say. And that will take money — more money than the state has been willing to allocate and few legislators are willing to advocate.

Florida’s lackluster financial commitment to the crisis is widely known: We rank 49th among the states in per-person spending for mental health programs.

“The state of mental health in Florida is a disaster. It’s a tragedy. And it’s not just a matter of funding. It’s how the funding we do get is spent — where the money goes,” said Dr. Rajiv Tandon, a psychiatrist and president of the National Alliance on Mental Illness in Florida.

Tandon is joined by State Rep. Kathleen Peters and Senate President Andy Gardiner, who are calling for the Legislature to begin a comprehensive review of the $718 million spent on mental health care in the state.

“We have to look at the entire system. It’s not just a matter of more dollars, but we have to look at how the money is allocated and we have to look at expanding it,” said Peters, a Pinellas County Republican.

“This is my No. 1 priority,” she added.
A call for action

The state Supreme Court’s mental illness and substance abuse task force, created in 2010, reached pretty much the same conclusion in its recent report on the crisis. Here are some of the key recommendations the group made to the state Legislature:

Keep the mentally ill out of jail by diverting them to community programs that offer counseling, medication and sometimes housing — which actually saves money in the long run.

Duplicate early-intervention programs from other states that identify symptoms of mental illness in schoolchildren so that they can get help as soon as possible. A program in California, for instance, works with teens showing early signs of schizophrenia to stop the disorder from progressing.

Create more local intake centers and mobile teams that can immediately treat mentally ill people who are in crisis.

Expand permanent housing programs for adults with mental illness who are stable but need someone to check on them periodically.

Gardiner, an Orlando Republican, wants to know how effective state funding has been before there are any new allocations.

One of the programs he wants to consider for potential expansion is the mobile “Community Action Teams” that bring psychiatrists, counselors, case-managers and mentors to the homes of kids and young adults with a history of mental-health problems. The goal is to keep them out of the juvenile-justice or foster-care systems or in-patient mental facilities — all of which are more costly to taxpayers and more traumatic to the individuals.

Gardiner was a key backer last year in additional funding to establish teams in Central Florida.

“I don’t know that we’ve ever had a real deep-down review of what we’re doing and whether it’s working,” Gardiner said. “I think we need to look at the effectiveness of the Baker Act, the effectiveness of CAT and the financial impact of the current system not only on the jails and prisons, but on the hospitals as well.”

But it wouldn’t take a massive amount of new money to begin the changes necessary to deliver the help the mentally ill need, Leifman argues.
The state currently spends more than $200 million a year — a third of its total mental-health budget — to treat 2,500 inmates who were found incompetent to stand trial because of their mental illness.

Just using $48 million a year of the money now dedicated to the state institutions, Leifman said, could fund any one of the these programs statewide:

Mental health care for more than 260,000 children or 60,000 adults.

Psychotherapeutic medications for nearly 15,000 people a year.

Annual housing subsidies for nearly 15,000 individuals or families.

Thirty-seven new community-based teams to provide 24-hour support for severely mentally ill individuals.

Florida also could better spend its money to expand cost-effective programs that are already in place.

Orlando-based Dave’s House, for instance, has used a charitable foundation to buy and renovate four homes in the region. Then it partners with Aspire Health Partners, owner of Lakeside Behavioral Healthcare, to select the residents and help them live as independently as possibly. Demand for more such housing has been huge.

Orange County’s Central Receiving Center is a model for redirecting some mentally ill from jails and hospital emergency rooms, saving millions in medical and police manpower costs. The only one of its kind in the state, the CRC provides police, deputies and jailers with a single place they can take the mentally ill for evaluations, crisis management and treatment instead of jails and hospitals.

In Pinellas Park, the nonprofit Vincent House pairs staffers with “members” whose mental illness is under treatment in an effort to develop employment skills. Last year, participants earned more than $575,000 at 52 Pinellas County employers — including St. Petersburg-Clearwater International Airport, the Fresh Market, Publix, the Coast Guard and St. Petersburg College.

“It’s an amazing place,” said Donna Wyche, manager of Orange County’s Mental Health and Homeless Issues division and a champion of the program. “When you can help people get well and give back, that makes the whole community better.”

But in Florida there is no consistent funding source to sustain and replicate pilot programs that work, said Valerie Westhead, medical director for Aspire Health Partners-Seminole: “The problem is we can get the program going but they only want to fund it for a year.”
The seed money for mental health care reform in Florida could also come from programs that have proven to save taxpayers money.

In Miami-Dade County, the Eleventh Judicial Circuit Criminal Mental Health Project created a program that targets adults with mental illness who have the most frequent arrests and cost taxpayers the most money, identifying 97 individuals with a $12.6 million tab over five years. Another program has kept 4,000 nonviolent defendants out of jails, saving nearly $785,000.

The proponents of reform contend there is no more time to waste, or lives to lose, in committing the resources to provide the care the mentally ill need, their families want, and community safety requires.

Acts of violence around the state involving the mentally ill — including the shooting of three people at Florida State University — sound the alarm for change, said Belvin Perry Jr., former chief justice of the Ninth Judicial Circuit Court.

“It is clear as a bell that we can’t continue to not fund this critical need we have,” Perry said, “and the price of non-funding is what we have seen at FSU and elsewhere.”

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