POLICE-MEDICAL COLLABORATION: DEALING WITH MENTAL HEALTH

INTRO

Law enforcement officers have become the front line responders to "treatment resistant" mentally ill individuals who fail to adequately access supportive community services. During California's basic police academy, officers receive six and one-half hours of training on issues relating to mental illness and developmental disability, yet most officers acknowledge that approximately one-half to seventy-five percent of law enforcement calls involve emotionally disturbed or substance abusing individuals. While traditional police training focuses heavily on defensive tactics and legal issues, officers are increasingly likely to rely on assessment and crisis interventions skills for which they are poorly trained.

While most mental health professionals acknowledge that psychiatric difficulties and substance abuse tend to respond best to long-term interventions and supportive services, police officers in the field are often only able to provide an expedient often-ineffective response. Since law enforcement is unable to provide the long-term interventions needed to improve the situation of a mentally ill person, individuals are often contacted repeatedly without positive results. These repeated calls for police service drain needed emergency resource, clog our courts and over crowd our jails. Individuals who do not demonstrate criminal or anti-social characteristics soon begin spending time in jails and eventually prisons as the criminal justice system begins case managing and treating the mentally ill.

Michael's Story Part I

Michael graduated from high school and college in three years each at the top of his class. Michael earned a Master's of Business Administration from a major California university and provided professional accounting and financial services for over twenty years with great success. During Michael's career, his fierce dedication, passionate commitment and ability to work long hours earned him tremendous respect and financial reward.

In retrospect, Michael's tireless dedication to duty was an early sign of his developing mental illness. Michael soon began to overextend himself, stay awake for several days at a time and became lost in his work. Michael's marriage suffered and his wife eventually left him due to his erratic behavior and mood swings. Michael was first noticed on the streets of San Rafael in 1995 after losing his job and becoming homeless. Michael has bi-polar disorder, but refused to accept his illness or supportive treatment. Law enforcement encounters with Michael were generated by his manic symptoms which presented with paranoia, verbal abuse and occasionally physical assault. Over time, Michael's symptoms began to include psychosis and he soon believed people were conspiring against him and attempting to hurt him. Michael's delusions included a belief

that people were stalking him and threatening his life. Michael attempted to make numerous police reports and often confronted the citizens he believed to be stalking him with accusations and delusional threats. When police officers refused to take actions on Michael's unfounded accusation, Michael filed formal complaints against the officers and threatened civil action.

Setting & History

In 1995, Marin County, located just north of San Francisco, reported a median household income of $86,800 and the highest housing costs in the State of California. Since many mentally ill citizens live on monthly SSI payments, they often become homeless and frequently come into contact with law enforcement. In 1999, 4,281 people in Marin County were homeless at some point during the year and at least 425 were mentally ill.(1, 2) As in many areas, the homeless become invisible, often camping on hillsides, in abandoned buildings, cars or vacant lots. Homeless and multiply diagnosed persons often avoid treatment and can languish for years in isolation and illness before they become acute enough to require restrictive long-term care. Unfortunately, many are convicted of crimes along the way and some are imprisoned. During the three-year period from January 1997 until December 1999, four hundred and twenty-two people with histories of mental health treatment were arrested in Marin County; one hundred and seventy-one had serious mental health conditions and experienced multiple arrests. "Survival crimes" such as petty theft, failing to appear for court appointments, crimes associated with mental health crisis episodes or the effects of substance abuse accounted for sixty-four percent of arrests but only 6% of the crimes could be classified as seriously violent. Marin's Mentally Ill Offenders (MIO) did not "age out" of the criminal justice system in their late 20's or early 30's like non-mentally ill offenders with their frequency of arrest peaking in their late thirties and not dropping off significantly until the population reached its 50's.

Problem Definition

Contributing factors in California include the severely under funded community mental health system which accounts for only 3.5% of all Medicaid dollars spent in California where Medicaid expenditures rank 50th in the united states. In addition to fiscal insufficiency, California's LPS law, enacted in the late 1960s, prior to the development of atypical anti-psychotics, which was created to protect the rights of mentally ill citizens has been so liberally interpreted that only the most severely compromised individuals receive medium to long term involuntary treatment and only in inpatient settings. Acknowledging the steadily growing numbers in mentally ill persons in the streets, many officers refer to the LPS act as the law that declares, "Let People Suffer."

As mental health withdrew outreach projects from the streets, law enforcement became the primary management agency for the homeless mentally ill.(4) Patrol officers gradually assumed the role of community case managers for numerous well known mentally ill citizens. Marin County jail became one of the county's mental health

inpatient treatment facilities spending approximately ninety thousand dollars on psychotropic medications during the 1999-2000 fiscal year. The system became reactive and stopped working in the best interest of the client; instead of coordinated community treatment, mentally ill citizens were being treated through frequent incarceration and containment in the county jail. For many mentally ill persons incarceration became the primary avenue to adequate long-term mental health care.(3) Legislative and fiscal changes in the mental health system limited services to emergency and long-term care for the chronically ill.(6) The resistant, dually diagnosed homeless mentally ill continued to cycle through the criminal justice system.

Mental illness and homelessness contribute to large numbers of police contacts with mentally and dually diagnosed individuals. These contacts result in frequent arrests for minor crimes that rarely result in more than a brief jail stay. In the absence of effective, coordinated intervention, many individuals are repeatedly arrested without hope of improvement and at tremendous cost to systems and communities.

Contributing Causes

A. GOVERNMENTAL AND PROGRAM LIMITATIONS

Public mental health services are often under-funded and over-utilized. Government funding and competitive grants often limit service and client selection criteria by narrowly defining target groups. Limitations in target groups and compressed resources encourage some agencies to informally ignore the chronically arrested, labeling their behavior criminal instead of symptomatic. Difficult clients are often ineligible for housing or support services because of historical events or inability to follow through with treatment. Excluded clients often wait in a gray area, between not sick enough for involuntary treatment and too sick for anything but homelessness and desperation. The population of homeless dually diagnosed citizens is abandoned to languish in the streets under the assumption that a fundamental respect for a client's right to ignore or refuse services must come before compassionate and creative interventions or long-term solutions.

In the absence of effective outreach and treatment, the criminal justice system becomes a reluctant clinician providing care to mentally ill clients who are unlikely to remain in treatment outside of jail. Despite the growing number of mentally ill inmates, the criminal justice system continues to specialize in episodic disposition, whereby persons are arrested, adjudicated and either incarcerated or released. Persons are unable to get into the system which is best designed to serve them but instead land in a system that has neither initiative nor capacity to care for a compromised and forgotten population.

B. CLIENT LIMITATIONS

Many homeless and multiply diagnosed individuals do not desire treatment and actively seek to avoid it. The side effects of outdated drugs, past experiences in treatment, and previous hospitalizations discourage individuals from seeking mental health care. Many homeless people manage the symptoms of their mental illness with street drugs,

developing dependencies that further limit their access to mental health care. Dual Diagnosed clients are often required to stop using drugs or alcohol before medication can be provided to treat the symptoms of their mental illness. Outdated treatment methods and barriers to traditional services maintain homeless and mentally ill people in a cycle of substance abuse, desperate poverty, arrest and incarceration.

C. INTERAGENCY LIMITATIONS

Instead of emphasizing a working partnership, law enforcement and mental health professionals ceased to work together. The two systems were working side by side, with the same clients, but viewed each other with suspicion, both believing the other to be incompetent. Contacts between law enforcement and mental health were perceived as a series of frustrating encounters with few positive outcomes. Fragmenting into disconnected service units, mental health providers focused on long-term care and viewed police as hired muscle for emergencies. (7) Despite this dependence on law enforcement as crisis intervention specialists, mental health providers often chastised police for dealing harshly with mentally ill persons or incarcerating resistant clients. Despite the common police frustration with the seemingly fruitless mental health call, officers often did not attempt to educate themselves on mental health issues and many blamed the clients, misjudging symptoms of mental illness for defiance and addiction.

Even within the criminal justice system there exists a tremendous degree of mistrust and frustration. Police officers often criticize the District Attorney's office for failing to file criminal charges and accuse the Public Defender's office of only trying to have their clients released from jail without consideration for the long-term consequences. The Public Defender's office often-express frustration at the repeated arrests of their clients while the District Attorney's office tries to explain the reasoning behind their decision not file certain cases. It is not a system used to working together or even trusting the other parties.

D. LAW ENFORCEMENT LIMITATIONS

For many years, law enforcement officers responded to mental health emergencies by placing clients involuntarily into psychiatric emergency centers or defusing the situation in the field. Mental health services seemed confusing and ineffective to most officers, and calls for service to mentally ill people became frustrating. In the absence of an innovative outreach program, law enforcement attempted, without success, to solve the problem through traditional methods of arresting and re-arresting the mentally ill homeless. As an example, the authors estimate that various agencies spent nearly four hundred thousand dollars booking, housing, criminally prosecuting and medically stabilizing one individual without success. Since most mentally ill homeless people are arrested for symptom-influenced behavior, a lifetime of jail days can never substitute for effective treatment. In Marin County, law enforcement acknowledged that for many mentally ill persons an arrest without a plan was not an effective use of resources but an arrest as part of a plan could change the outcome of a treatment program.

- **System reinforcement for booking over psychiatric evaluation.**

- **Inadequate mental health outreach.**
- **Inadequate long-term mental health care.**
- **Inadequate emergency and low cost housing.**

Previous Attempts

Literature review here, mental health courts, stand-alone CIT programs. Mental health & police partnership units etc.

Innovative Attempts

Michael's Story – Part II

Despite numerous attempts by law enforcement and mental health workers to speak with Michael about his mental illness he refused to acknowledge his need for help. On one occasion Michael confronted a citizen and accused her of following him. During his tirade he threatened to kill the woman, who immediately reported the incident to the police. Instead of ignoring the incident as another "Michael being Michael" call the police decided to pursue the matter criminally and sent a report to the district attorney for review. A San Rafael Police Department officer then met with the District Attorney's office and explained the situation and expressed a desire to use the criminal charges to encourage Michael to receive mental health treatment. The officer also met with the Public Defender's office and explained the situation to them asking for their assistance in the matter.

While waiting for the case to be reviewed by the district attorney's office Michael behavior continued to escalate. Michael went to the Sheriff's department and demanded action on a non-police matter. When the deputies refused to assist, Michael became combative and was wrestled to the ground, handcuffed and arrested. While walking Michael to patrol car he kicked out a taillight. Michael was booked into the county jail but his behavior was so erratic that he was soon transferred to a psychiatric facility for evaluation. Michael calmed down on a minimum amount of medication and was soon released to the streets. Michael did not attend any follow-up appointments.

III. INNOVATIVE LAW ENFORCEMENT RESPONSE

In response to the growing concern among the downtown merchants and citizens about the mentally ill homeless population, the San Rafael Police Department decided to try a innovative approach. In November 1999, San Rafael Police Officer, Joel Fay, PsyD, began a new program to reintegrate mentally ill homeless persons into the community. Dr. Fay developed an inter-agency collaborative specializing in mentally ill persons who frequently contact law enforcement. The effort involved shifting the law enforcement focus from arresting the mentally ill offender to challenging the treatment status quo in the mental health and criminal justice systems. The first step in the process began with revising the police perspective of the homeless mentally ill. Officer Fay suggested that the mentally ill citizen was a victim of an inadequate service system and not a problem person, shifting the blame and beginning the process of engaging a severely marginalized

population. This decriminalization of illness began the process of recognizing the contributing role of mental illness in maintaining homelessness and causing arrest.

A. FOCUSING ON A SOLUTION

In Marin, the recent implementation of Dr. Fay's, law enforcement driven collaborative provides the required linkages to engage and treat the community's most difficult clients. However, before officers could engage clients, they needed to engage the social service system. In order to change this, Fay spoke with every appropriate service agency and explained why law enforcement wanted their help and how working together could change the lives of mutual "clients." He proposed a partnership with law enforcement which would allow community service providers to gain the type of outreach and community presence required to intervene with homeless mentally ill persons while assisting police departments with their most difficult citizens. It should not surprise police or mental health groups that in the end they need one another.

Marin County's collaborative allows law enforcement to bring cases directly to the mental health system requesting assistance and intervention in the life of a client who may be known to the police or jail system. Moving toward a solution requires law enforcement and mental health providers to trade perspectives by encouraging treatment providers to shift their focus away from organizational and fiscal issues and towards treatment goals while helping law enforcement consider a longer view. An infusion of police philosophy has allowed community mental health to successfully treat persons who were previously considered "untreatable." Simultaneously, a new collaboration with mental health has allowed law enforcement to drastically reduce fruitless calls for service, to gain compassion for the mentally ill and successfully intervene in the lives of persons they once thought of as bums or vagrants.

B. FORENSIC MULTIDISCIPLINARY TEAM (FMDT):

Each month, twenty-three agencies meet to discuss law enforcement initiated case management requests under the umbrella of the FMDT. Participants in the FMDT include criminal justice, mental health and community service agencies. At monthly meetings, FMDT members review law enforcement requests for innovative client services and develop individualized case management plans.

The dynamics within the meetings, which began as cautious collaboration, have developed into partnership. Adopting a "no-give-up" policy, the FMDT never rejects a referral and keeps open clients on the roster until their case is resolved. A successful resolution involves transferring the client from criminal justice to effective treatment. The guiding philosophy has developed into a collaborative immediate action oriented approach instead of a long-term inter-agency strategy committee. Allowing law enforcement to refer cases directly to mental health and community based organizations may not seem revolutionary, but the continued involvement of mental health liaison officers in the care, planning and case management of the mentally ill provides a unique and effective method for working with the communities most difficult and often most compromised persons. The effectiveness of the FMDT depends upon law enforcement officers not only intervening more skillfully in the moment of the crisis but in following

up after the incident to advocate for arrestees or detainees and ensuring that treatment providers deliver adequate services to prevent further law enforcement contacts.

C. MENTAL HEALTH LIAISON (MHL) OFFICERS

To assist the FMDT each local law enforcement agency assigned a Mental Health Liaison officer who participates in case planning and other project meetings. Using a community policing model, these officers become familiar with the team's clients and their treatment plans. They assist FMDT members in locating clients, checking in on their placements, becoming a visible extension of the treatment team. Clients and mental health professionals have come to rely on the MHL officers as a resource and frequently call on the services of the MHL officers to assist them. Families with a mentally ill member are also aware of MHL officers in their community and frequently ask to speak with the officers when efforts to engage a mentally ill relative have failed.

Michael's Story Part III

The Forensic Multi Disciplinary Team met and discussed Michael's situation. It was agreed that the criminal justice system would use jail sanctions to motivate a shift in Michael's behavior while at the same time the Mental Health Liaison Officers and mental health workers would conduct joint outreach efforts. During these outreach meetings with Michael, the FMDT offered to assist Michael with the criminal justice system if he were willing to accept their offer of treatment in lieu of incarceration. A mental health client, who had been trained as a peer provider, met with Michael and discussed what it was like to have and live with a mental illness. Michael was given books on mental illness and started to attend a Community Mental Health sponsored group on recognizing the symptoms of mental illness.

In court the charges were reduced from felony to misdemeanor and Michael pled guilty to several charges. He received no additional jail time and was placed on three years probation. Michael engaged in the treatment program and began taking medication and following through on other treatment recommendations. When Michael was unable to find a job the Mental Health Liaison Officer contacted a local job-training program and arranged for them to admit Michael to the program.

Michael has never violated probation and remains active in treatment and recovery. He is now in housing and working an almost full time job while attending school to become a peer provider. There have been no additional calls for service regarding Michael.

Outcomes

-Update outcome data.

REPLICATION

The authors recognize that this approach may not be appropriate for every community. It is, however, possible to reproduce this program. Larger jurisdictions may

need to divide their community into smaller segments to ensure the ability to focus on individual clients. The primary barriers to successful replication are a lack of interagency cooperation and trust. Long standing cultural tensions between law enforcement and mental health must be reduced and successful partnerships must be developed. Organizational structures which limit continuity of care also contribute to widening the cracks that clients fall through by hindering the type of collaboration necessary to proceed with replicating the described programs. Communities interested in developing similar programs should identify primary participating agencies to become part of the solution. Including additional agencies occurs naturally during treatment plan implementation. Some agencies may attend a few meetings and realize their mission does not fit with the goals of the program; others will come to depend on the forum as an essential part of their service delivery matrix. The shape and personality of the team evolves during the progression of each case, developing partnerships and nurturing the growth of a cohesive group.

Participation and team building is best supported by actively involving members in the development of current case plans. As innovative and successful practices develop, previously uninvolved parties will welcome the opportunity to try new approaches and will readily join the group. Eventually, a core group of individuals and agencies will develop and lead the team. It is important to remember that interpersonal and interagency relationships make the system work. The goal is a comprehensive interdisciplinary approach that blurs the traditional boundaries between involved agencies thereby assisting clients in overcoming the traditional barriers to care.

B. CONFIDENTIALITY AND CONFLICT OF INTEREST

ISSUES

The issue of confidentiality remains an ever present concern. Under California's Welfare and Institution Code, law enforcement is authorized to be part of a multidisciplinary team consisting of "persons who are trained in the prevention, identification and treatment of abuse of elderly or dependent persons" (15753.5 WIC). During team meetings, team members are advised that confidential information must not be disclosed to non-team members and that the confidential information discussed cannot be used for purposes other than those activities consistent with treatment goals. Even with these guidelines, the confidentiality issue remains. The multi problem circumstances of clients presented in team meetings often exacerbate concerns about confidentiality. As an example, a clinician may report at a meeting that his client is using illegal drugs. A police officer may be aware that drug use is a violation of a client's probation but cannot use that information to arrest the client because of the team's agreement that treatment is the only viable objective. The agreement to share information must be supported by strict adherence to a philosophical understanding that arrest and criminalization will not solve a client's problem any more effectively in the future than it has in the past.

During the two years the described program has been in operation, no law enforcement agency has mishandled confidential patient information, and no client has been criminalized because of his or her involvement in the team. For some individuals (both law enforcement and mental health) the concept of a law enforcement, mental health collaborative is difficult to accept, the concept is inconsistent with their

organization's traditional environment and they are unwilling to assume the risks necessarily associated with innovation. Active inclusion of law enforcement personnel in a mental health treatment process is likely to be resisted by some mental health professionals on an ideological basis alone. The authors recognize that redefining the traditional nature of mental health outreach is likely to meet resistance. The mental health and treatment staff involved must represent themselves assertively and honestly describe what they are legally able to do and what legal limits must guide their practice. Law enforcement staff must be willing to adopt a new perspective and set aside some of the cultural assertiveness they are trained to rely on.

Another potential difficulty in developing criminal justice and mental health collaborative is the issue of conflict of interest (COI). To prevent conflicts, forensic team clients scheduled for discussion are identified at the beginning of each team meeting allowing team members to identify potential conflicts prior to the beginning of a client's presentation. Team members whose role or affiliation prevents their participation in a client's review are able to excuse themselves from the meeting or curtail their participation in accordance with their individual professional or ethical mandates. An example of another conflict of interest based on role confusion occurred when one client threatened to shoot a law enforcement team member. This crime resulted in the arrest and prosecution of the client. Some team members were upset that a client was arrested; however, a person's involvement in the team does not protect the individual from prosecution. This situation was handled with honest discussions about the issues among the concerned team members. During the client's adjudication, every effort was made to engage him in treatment and use the arrest as an engagement opportunity in accordance with the team's goals.

The authors recognize that for some people or organizations the concept of the described collaborative effort is abhorrent. It is important to locate the people in a community who are willing to support a new outreach approach and to nurture those relationships. "If an idea is contrary to or inconsistent with the traditions of its environment, its life is much more hazardous, its rate of growth is slower and it's chances of growing strong enough to bear first fruit reduced."(7)

RESULTS/OUTCOMES

To date the FMDT has treated 41 clients. Two clients left the area and have not been located. One client was sentenced to prison. Of the remaining 38 clients, 21 have been successfully diverted to treatment. The remaining 17 cases are still activewith clients in varying stages of their treatment plan. A successful diversion means the client is no longer being arrested and the primary treatment agency is outside the criminal justice system.

FIGURE 1

ORGANIZATIONAL ISSUES

CONCLUSION:

Many people are homeless and generally do not spend time in jail. Many people are mentally ill and live happy productive lives. Some people are even homeless and mentally ill and they stay out of jail and generally out of the way of law enforcement. There are, however, a growing number of people who are homeless, mentally ill, dually diagnosed and repeatedly in custody or being managed by law enforcement. The data and perspectives presented in this work demonstrate that multiple recurrent arrests of mentally ill persons does little to alleviate their clinical symptoms or improve their situations. Further, the data shows that in the absence of innovative approaches, mentally ill offenders grow older, continue to be regularly arrested and develop increasingly severe medical and mental health complications. We hope that we have provided an outline for a sensitive and effective approach to assist these citizens.

REFERENCES

1. Marin Continuum of Housing and Services' Community Interaction Partnership Report. 1999Marin County: San Rafael, CA.

2. The 2000 Marin Continuum of Care Plan. 1999. Marin Department of Health and Human Services: San Rafael, CA.

3. Milton JW. Idealism gone awry. The Catalyst, 2001Volume3 May/June.

4. Moreno K, Sobel L. California's Mentally Ill Offender Crime Reduction Grant: Reducing Recidivism by Improving Care, 2000. John F Kennedy School of Government, Harvard University.

5. Marin County Sheriff's Department. 2000 – 2001 Mentally Ill Offender Crime Reduction Demonstration Project Application to The California Board of Corrections. Prepared by Resource Development Associates, 2001. Lafayette, CA.

6. Seager SB. Street Crazy, 2000, Westcom Press. Redondo Beach, CA.

7. Stein LI. Assertive community treatment of person's with severe mental illness. WW Norton and Company, New York, NY 1998