

Restorative Policing - A Community Wide Response to Mental Illness

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Introduction:

Recent public policy failures and fiscal decisions have dramatically increased the frequency of law enforcement contacts with mentally disturbed individuals. With the enactment of Community Oriented Policing, law enforcement's role has changed from reactive enforcers of laws and rules to proactive community peacekeepers and caretakers, transitioning police officers into the front line response for the "treatment resistant" mentally ill.

Severe and persistent mental illnesses, especially those compounded by substance abuse, are traditionally treated by long-term supportive services, psychiatry and ongoing case management. Police officers in the field provide expedient, ineffective, and short-term emergency intervention. Law enforcement is unable to provide the interventions needed to improve the situations of mentally ill persons or even prevent future calls for service. Repeated calls for police service drain needed emergency resources, clog our courts and crowd our jails. Compounding the problem is an under-funded and overwhelmed mental health system struggling to meet the needs of its clients and fulfill its legal mandates. Police officers quickly learn that arrest is more immediately effective than psychiatric commitment. Eventually, mentally ill individuals who are not by character, criminal or anti-social spend time in jail and eventually prison as the criminal justice system struggles to case manage and treat mentally ill persons. Sadly, once involved in the criminal justice process, mentally ill offenders will remain involved twice as long as undiagnosed persons (RDA, 2001).

Michael's Story Part I

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

In retrospect, Michael's dedication to duty was an early sign of his developing mental illness. Michael soon began to overextend himself and stay awake for several days at a time and he eventually 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 his home. Michael has bi-polar disorder, but refused to accept the reality of his illness or his need for treatment. Law enforcement encounters with Michael were generated by his manic symptoms, which presented as paranoid verbally abusive outbursts and occasionally physical assaults. Michael soon became psychotic, and believed people were conspiring against him. Michael's delusional beliefs convinced him 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 threats. Fed up with police officers ignoring his delusional complaints, 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 of approximately \$650.00 per month 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 (Marin Continuum of Housing and Services Report, 1999 and Marin Continuum of Care Plan, 1999). Homeless and multiply diagnosed persons often avoid treatment and can languish for years in a cycle of isolation, incarceration and illness before they become acute enough to require restrictive long-term care. 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 and 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-MIO's. Instead their frequency of arrest peaked in their late thirties and did not drop off significantly until the population reached its 50's (RDA, 2001).

Problem Definition

Factors in California that contribute to or maintain the frequent meetings between police and the mentally ill include the severely under funded community mental health system. The community mental health system accounts for only 3.5% of all Medicaid dollars spent in California where Medicaid expenditures for mental health rank 51st in the United States (Cervine, 2002). California's involuntary psychiatric commitment process as authorized by the Lanterman, Petris, Short (LPS) law, was passed prior to the development of atypical anti-psychotics. The LPS law was created to protect the rights of mentally ill citizens but 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 of mentally ill persons in the streets, officers refer to the LPS act as the law that declares, "Let People Suffer."

Law enforcement has become the primary management agency for the homeless mentally ill (Moreno, 2000). Patrol officers assume the role of community case managers for many 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 it's 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 health care (Milton 2001). Legislative and fiscal changes in the mental health system limited access to emergency and long-term care for the chronically ill (Seager, 2000), and the resistant, dually diagnosed homeless mentally ill continued to cycle through the criminal justice system (Treatment Advocacy Center, 2001.)

Contributing Causes

A. GOVERNMENTAL AND PROGRAM LIMITATIONS

Public mental health services are underfunded and overutilized (Szegegy, 2001.) However, since 1999, state grant funds have improved mental health programs. Despite these grants, California continues to be the worst funded Medicaid community mental health program in America (Cervine, 2002). The current national fiscal crisis and California's own 38 billion dollar deficit will undoubtedly reduce available mental health services to the legal minimums in

many counties. Current reductions in mental health funding are especially damaging as the last few years have seen tremendous successes among grant funded initiatives targeting at risk children, homeless adults and mentally ill offenders. Traditional 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 symptom based. 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, not sick enough for involuntary treatment and too sick for anything but homelessness, incarceration and desperation. The population of homeless dually diagnosed citizens is abandoned to languish in the streets under the assumption that respect for a client's right to ignore or refuse services must come before compassionate and creative interventions.

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, experiences in treatment, and previous hospitalizations discourage individuals from seeking mental health care. Many homeless people manage the symptoms of their mental illnesses with street drugs, developing dependencies that further limit their access to mental health care. Dually Diagnosed clients are often required to stop using drugs or alcohol without treatment 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 (Hustead et al, 1995).

Traditional mental health programs have embraced a "client-centered" approach that maximizes self-determination over safety and early intervention. While creative outreach programs abound, many mental health professionals feel that reacting to crime among the mentally ill is a law enforcement responsibility. Monahan (2001) clarifies the primary concern of the field of forensic mental health, presenting the simple and disturbing fact that mentally ill persons who remain untreated are five times more likely to commit violence than persons without diagnosable mental illness. Diagnosed persons, who abuse alcohol, behave violently twelve times more frequently than undiagnosed persons. The low cost and rampant availability of methamphetamine has likely provided the most disturbing statistic increasing the likelihood of violence among mentally ill persons who abuse drugs to sixteen times that of undiagnosed individuals (Monahan, 2001). Clearly, Monahan's (2001) findings must compel mental health professionals into action on behalf of clients whose risk of committing acts of violence is predicted entirely by the acuity of their symptomatology.

"Thus, almost all of the difference in rates of violence between patients and nonpatients could be accounted for by the level of active psychotic symptoms that the patients were experiencing." (Monahan, 2001)

C. INTERAGENCY LIMITATIONS

Instead of emphasizing a working partnership, law enforcement and mental health professionals failed to work together. The two systems worked side by side, sharing clients, while viewing 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 (Stein, 1998). 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.

Within the judiciary of the criminal justice system a tremendous degree of mistrust and frustration exists. Police officers often criticize the District Attorney's office for failing to file criminal charges when a mental illness exists. Prosecution often accuses defense counsel of exaggerating symptoms to facilitate a release from jail without consideration of the long-term consequences for an untreated client and an unprotected community. Due process regulations and overburdened systems force courts to manage each incident as a discrete episode minimizing a person's long-term clinical history to adjudicate the current case. Both sides of the judiciary are under tremendous pressure to process cases quickly and cost effectively developing a system that is efficient but wholly ineffective for any of the involved constituencies. When clients fail to receive treatment, the severity of their criminal behavior increases predictably until an individual is finally committed to state prison.

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 situations in the field. Mental health services seemed confusing and ineffective to most officers and calls for service to mentally ill people who seemed to get worse became frustrating. With a minimum of training and without the proper tools law enforcement attempted, without success, to solve the problem through traditional methods of arresting and re-arresting the mentally ill homeless (Hales & Borum, 2003). 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 (Monahan, 2001).

Statistics show that treatment is more likely than incarceration to result in positive outcomes however, police officers quickly learn that treatment is a suspect process and provides little immediate relief for the problems they are dispatched to handle. Police culture values rapid and decisive problem solving over long-term solutions. A distrust of the mental health system often leads an officer to arrest an individual rather than attempt to engage the person in treatment through the use of an involuntary psychiatric hold (Patch and Arrigo, 1999). Most officers learn early in their careers that mentally ill people don't get better in a single episode and some may be back on the street after a trip to psychiatric emergency rapidly enough to continue causing problems on their shift. California's laws provide tremendous discretion to civil hearing officers, and even the most mentally ill person may be returned to the street in a very short period of time. For police, arrest and booking is comfortable familiar and rewarded. On a busy shift, booking takes only a fraction of the time and paperwork an involuntary psychiatric detention requires. Police officers are rewarded for rapid decisions, handling difficult situations and efficiently returning to an available status. Therefore, if a police officer selects the institutionally supported option of booking a mentally ill person, they are more likely to be rewarded and praised by their superiors, and their peers. If a police officer correctly identifies an individual as a mentally disabled person and seeks an involuntary psychiatric detention they risk being considered slow, indecisive or lacking sufficient courage to autonomously problem solve. This pattern of officers selecting incarceration over hospitalization is institutionally supported by the tremendous cost of a single day of hospital care compared to the cost of a jail day.

In the absence of effective outreach and treatment, the criminal justice system becomes a reluctant clinician providing inadequate care to mentally ill clients who are unlikely to remain in treatment outside of a confined setting. Despite the growing number of mentally ill inmates, the criminal justice system continues to specialize in episodic dispositions. Mentally ill persons who are unable or unwilling to enter the appropriate system of care land instead in a system that has neither initiative nor capacity to care for a compromised and forgotten population. As a result law enforcement and especially jail custody have become a reluctant witnesses to a public health nightmare caused by a public policy tragedy.

Michael's Story - Part II

Despite many 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 prosecutor for review. A San Rafael Police Department officer met with the Prosecutor and expressed a desire to use criminal charges to encourage Michael to accept mental health treatment. The officer also met with Michael's defense counsel, to ask for assistance.

While waiting for the case to be reviewed by the prosecution, Michael's behavior escalated. Michael went to the Sheriff's department and demanded action on a non-police matter. When the deputies refused to assist, Michael became combative, was wrestled to the ground, handcuffed and arrested. As deputies brought Michael into custody, he kicked out the taillight of a patrol car. 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.

Restorative Policing:

A. An Alternative 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. The first step was to acknowledge that for many mentally ill people, an arrest without a plan was nothing more than a temporary incarceration and an ineffective use of resources.

In November 1999, San Rafael Police Officer Joel Fay, PsyD, began an innovative program, creating a paradigm shift in modern policing. Dr. Fay's needs assessment of the San Rafael community encouraged an approach, which sought 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 law enforcement's focus from arresting mentally ill offenders to challenging the treatment status quo. The process began by 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. Shifting schematic blame from a person to the system began a process of engagement with a severely marginalized population. Dr. Fay's perspective recognized the role of mental illness in maintaining homelessness and criminal behavior.

B. Focusing on a Solution

In Marin, the implementation of Dr. Fay's law enforcement driven collaborative provides the required links to engage and treat the community's most-difficult clients. However, before officers could engage clients, they needed to engage the social service system. Dr. Fay proposed a partnership between law enforcement and treatment providers that 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.

Moving toward this solution requires law enforcement and mental health providers to shift their focus away from organizational and fiscal issues and towards treatment goals while helping law enforcement consider a longer view. It should not surprise police or mental health groups that in the end they need one another to accomplish their goals.

Dr. Fay named his concepts and methods for working with mentally ill persons "Restorative Policing." A Restorative Policing Project (RPP) has three basic goals:

To maintain public safety.

- To reduce harm to individuals and the communities.
- To restore marginalized individuals to a supportive natural community.

To accomplish its goals, a Restorative Policing project increases community awareness using community outreach and public speaking, encourages clients to use treatment and supportive services, instead of criminal justice services, and uses individual advocacy as a primary intervention.

Marin County's RPP collaborative allows law enforcement to bring cases directly to the mental health system requesting intervention in the life of a client. A synergy of police philosophy, social work and psychiatry has allowed community mental health to successfully

treat persons who were previously considered untreatable. This new collaboration with mental health has allowed law enforcement to reduce fruitless calls for service, to gain compassion for the mentally ill and to successfully intervene in the lives of persons they once thought of as bums or vagrants. Clients now see police as concerned public assistants instead of bullies and brutal enforcers. Police build relationships and become compassionately involved in the lives of persons they once felt to be subhuman. Police become essential advocates, filling the gaps in a service system that has been divided into silos by maintaining accountability among the mentally ill and the agencies chartered to serve them.

C. Forensic Multidisciplinary Team (FMDT):

Marin's Restorative Policing Project (RPP) has two major components. The first is the FMDT. Each month, twenty-plus 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. Law enforcement officers become substantially involved in the case management of difficult clients bridging a gap between clinic and community once thought to be insurmountable.

The FMDT, which began as cautious collaboration has developed into a true partnership. Adopting a "never-give-up" policy, the FMDT never rejects a referral and keeps open clients on the roster until their cases are resolved. A successful resolution involves transferring the client from criminal justice to effective treatment. A client is removed from the FMDT roster once he engages in treatment. The guiding philosophy has developed into a collaborative action oriented, client focused workgroup 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. The unique aspect of Marin's FMDT is the continued involvement of mental health liaison officers in the care planning and case management of the community's most difficult and compromised persons. The FMDT effectiveness depends on law enforcement officers not only intervening more skillfully in the moment of the crisis but also following up after the incident to advocate for arrestees or detainees and ensuring the delivery of treatment services that are adequate to prevent further law enforcement contacts. The FMDT is not a treatment team, but a "get people into treatment" team.

C. Mental Health Liaison (MHL) Officers

The second component of the RPP is the Mental Health Liaison Officer program. To assist the FMDT, each local law enforcement agency assigned an officer who participates in case planning and other project meetings. Using a specialized community-policing model, officers become familiar with the team's clients and their treatment plans. In this role police assist FMDT members in locating clients and checking in on their placements, thus becoming a visible extension of the treatment plan. Clients and mental health professionals have come to rely on the MHL officers 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 these 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 conducted coordinated outreach. During these meetings with Michael, the FMDT offered to

assist with his criminal justice problems if he accepted treatment in lieu of incarceration. A mental health client trained as a peer provider met with Michael to discuss the experience of life with a mental illness. Michael was given books on mental illness and started to attend a Community Mental Health sponsored group on recognizing symptoms.

Michael's charges were reduced from felonies to misdemeanors and Michael pled guilty to several charges. He received no additional jail time and was placed on probation. Michael engaged in treatment and began taking medication and participating in counseling. When Michael was unable to find a job, a Mental Health Liaison Officer contacted a local job-training program and advocated for Michael's admission to the program.

Michael has never violated probation and remains active in treatment and recovery. He is now in housing and working almost full time while attending school. Today, Michael's contacts with police take place regularly over a cup of coffee among friends.

REPLICATION

The authors initially published their early efforts in Restorative Policing in early 2001, when the Marin County based program was the only one of its kind. Since this earlier writing, the program has been successfully replicated in three other California counties. While the authors recognize that this approach may not be suitable in every community, it has been successfully replicated in communities with different dynamics but similar challenges. Larger jurisdictions may need to divide their communities into smaller segments to ensure the ability to focus on individual clients. The primary barriers to successful replication have been inadequate 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, widen the cracks in the safety net by hindering

necessary collaboration. Communities interested in developing similar programs should identify primary stakeholders challenging institutional resistance by highlighting clients that illuminate an agency's failure to fulfill its mandates. Including additional agencies occurs naturally during treatment plan implementation as needed resources require expanded cooperation. Some agencies may participate briefly and then withdraw; others will come to depend on the RPP as an essential part of their service delivery matrix. The personality of the team and the critical partnerships develop as stakeholders work together. 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. Eventually, a core group of individuals and agencies will institutionalize the RPP and efforts to ensure its longevity will follow. It is important to remember that interpersonal and interagency relationships make the system work and forming these relationships requires risk taking and innovation. The goal is a comprehensive interdisciplinary approach that blurs the traditional boundaries between involved agencies, assisting clients in overcoming traditional barriers to care.

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 information discussed cannot be used for purposes other than those activities consistent with treatment goals. Despite the institutional history of the RPP, concerns about confidentiality remain and must be

constantly revisited to ensure the highest ethical standards. When legal limits about information sharing are present, it is essential that participants declare them openly educating team members that legal boundaries exist but partnerships prevail. As an example, a clinician may report at a meeting that they suspect a 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. Arrests that occur outside of FMDT interventions are incorporated into ongoing plans.

During the two years the described program has been in operation in Marin County, no law enforcement agency has mishandled confidential patient information, and no client has been criminalized because of his or her involvement in the team. Officers carry with them legal release of information forms and are encouraged to contact potential FMDT clients, explain the FMDT program and have the clients sign an authorization for release of information. In our experience, the vast majority of potential clients will sign the release form.

For some individuals (both law enforcement and mental health) the concept of a law enforcement mental health collaborative is difficult to accept. For some the Restorative Policing 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. Involved mental health and treatment staff must represent themselves assertively, honestly describing the legal limits that guide their practice.

Law enforcement officers must be willing to adopt a new perspective and set aside some of the cultural assertiveness they are trained to rely upon in favor of partnership and problem solving.

"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 its chances of growing strong enough to bear first fruit reduced"(Stein, 1998).

Another potential difficulty in developing a criminal justice and mental health collaborative is the issue of conflict of interest. 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 before the beginning of a client's presentation. Team members whose role or affiliation prevents their participation in a client's review 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, using the arrest as an engagement opportunity in accordance with the team's goals.

RESULTS/OUTCOMES

To date the FMDT has treated 99 clients. Twelve clients left the area and have not been located. One client was sentenced to prison. Of the remaining 86 clients, 26 have been successfully diverted to treatment, 14 have been conserved, 18 are living in the community without treatment or police involvement and 2 are deceased. The remaining 26 cases are still active with clients in

varying stages of their treatment plan. A successful diversion means the client is no longer being arrested and the primary treating agency is outside the criminal justice system.

CONCLUSION:

Recently representatives from California Department of Mental Health came to Marin County to view our programs. After a presentation we were asked to diagram how the information and cooperation flowed between the various agencies. While the many professionals in the room discussed how to create such a diagram, one of the mental health peer providers commented, "I got it. Imagine a circle - we're all inside it."

We recognize that developing interagency cooperation isn't easy, but over time with appropriate support, with recognition and emphasis on common goals, governments can reduce the criminalization of the mentally ill. As one defense counsel stated, "We are both working towards the same goals from opposite side of the same table."

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