

MENTAL HEALTH IN THE UNITED STATES THROUGH THE LENS OF ONE  
CITY'S MENTAL HEALTH SYSTEM: ORGANIZATIONAL ROLES AND INTER-  
ORGANIZATIONAL DYNAMICS OF A MULTI-INSTITUTIONAL SYSTEM

by

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System: Organizational Roles and Inter-Organizational Dynamics of a Multi-Institutional System  
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The final copy of this thesis has been examined by the signatories, and we  
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Of scholarly work in the above mentioned discipline.

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## ABSTRACT

Deyell, Tracy Anne (Ph.D., Sociology)

### Mental Health in the United States Through the Lens of One City's Mental Health System: Organizational Roles and Inter-Organizational Dynamics of a Multi-Institutional System

Thesis directed by Associate Professor Stefanie Mollborn

In this dissertation, I take a multi-method qualitative approach to examine one city's ("Elkgate") adult mental health system. Using a combination of observation and in-depth and informal interviews of police officers, jail employees, private and public outpatient mental health clinicians and emergency room staff, and archival analysis of official forms and state and federal legislation, I consider this Elkgate's mental health system an amalgamation of correctional and medical organizations based on environmental necessity as opposed to organizational will. Beyond providing a detailed examination of one mental health system and identifying effective and strained inter-organizational interactions in place—an important contribution in the present political climate criticizing the "broken" mental health system nationwide—this research questions traditional beliefs surrounding health disparities and applies a multi-level analysis to examine and explain complaints and frustrations of professionals. For example, I analyze the benefits of Elkgate's public mental health services available to the poor and indigent over private services. Contextualizing the structure of care of these two service types within the role of a federal Act regarding patient information and privacy (Health Insurance Portability and Accountability Act), I also question how continuity of care may both positively and negatively affect patient care. This research also considers the consequences of poor inter-organizational integration across the system on consumer populations identified by professionals as disproportionately underserved. Combining organizational and intersectionality literatures, I propose that underserved populations in Elkgate's mental health system are the result of gaps between organizations that do not serve populations located at intersections of mental health who are both mentally ill *and* have other needs. I argue that this results in consumers who face greater disadvantage across multiple statuses. Finally, the timeliness of this research in terms of national and international interest in mental illness and systems of mental health, lends itself to significant policy implications presented in this dissertation for organizations involved in mental health, mental health systems and state and federal legislation

## DEDICATION

To my parents, Marsha and David Deyell, and my brother, Sean. Thanks for putting up with me, slugging through the hard times, and for your never-ending love and support. I owe everything to you.

## ACKNOWLEDGEMENTS

“Everyone lies about writing. They lie about how easy it is or how hard it was. They perpetuate a romantic idea that writing is some beautiful experience. . . . The truth is, writing is this: hard and boring and occasionally great but usually not.” I start with this quote from Amy Poehler’s 2014 book *Yes Please* because it is painfully true. Writing is hard, but so was the whole process leading up to the writing. In fact, the writing may have been the easiest part when compared to the years of education, project planning and data collection that culminated in this dissertation. My name may be the one credited to this work, but I could have never gotten here without the help of so very many people over the span of my entire graduate career. Thanks to everyone who has had a role in getting me here academically and otherwise.

I most certainly have to give special thanks to my advisor and role model, Stefanie Mollborn. You are one of the most amazing people I have ever met and my biggest cheerleader throughout this entire process. I will never understand how you manage to do everything that you do. To my writing partner, Jenny Vermilya, sitting across a coffee shop table from you was immensely important to my productivity and sanity during the writing process. I couldn’t be happier that we made it to the finish line at the same time. Academically speaking, thanks also goes to my entire graduate cohort and every faculty member I have worked with throughout my graduate career.

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## CHAPTER I: INTRODUCTION

Dr. Jay<sup>1</sup> sits across the table from me at an Asian restaurant on a February afternoon. He is in his mid-60s and has been a practicing psychiatrist in the area for longer than I have been alive. In the late-1960s he and his “then-girlfriend’s” cross-country road trip ended here: Dr. Jay had just finished his residency in psychiatry and they had taken the road trip looking for a place to settle down and for Dr. Jay to begin his career. I listen to Dr. Jay go into detail about the various programs and agencies involved in the county’s mental health system, about which he has vast knowledge. At one point he pauses, then says:

Dr. Jay: So, I’m a little disorganized [talking] about all this because it’s a million different pieces.

Me: Yes, I know. Imagine me trying to put it all together.

Dr. Jay: Well, that’s partly because it’s such a disorganized system. And it’s sort of put together in a jury-rigged kind of way, and there’s some pluses about that because you can do a lot of different things and there’s a lot of different mixes, but it’s a negative when you have someone coming to you saying: ‘I just need somebody to talk to and I need some anti-depressants because I’m lying on the couch 24/7.’ From that perspective there’s just this whole disorganized system to deal with.

The present national consensus is that the mental health system is in a grave state of disrepair having been treated as a stepchild of the medical system in practice, funding, and policy. Although spending on mental health treatment has increased over the last three decades, the increases in mental health spending are minimal when compared to physical health. In 2009 public and private spending on mental health in the U.S. totaled \$150 billion. After adjusting for inflation this represents over a 100 percent increase in spending since 1986; however, because

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<sup>1</sup> The names of all people, locations and organizations have been changed, and pseudonyms applied, to protect participants’ identities with the exception of “Colorado” and “Denver.” Only participants referencing organizations in the city in general terms use “Denver” (ex. “The Denver police”). No data was collected in Denver and no individuals in the city identified, so I felt it unnecessary to use a pseudonym.

the economy also doubled during the same period, mental health spending remained at 1 percent of the gross domestic product. During the same time period—between 1986 and 2009—total health spending increased from 10 to 17 percent of the gross domestic product. This indicates that while mental health spending remained at one percent, all other health spending increased from 9 to 16 percent of the gross national product over that 23-year period (Levit et al. 2013). In an interview with *The Fiscal Times*, community health professor Judith Bentkover evoked civil rights-era imagery to compare the disparities between mental and physical health to discrimination towards people of color in the United States: “We need affirmative action for mental health since it’s been at the back of the bus for a long time” (Pianin 2013:n.p.).

Various mental health consumers<sup>2</sup> and advocates have voiced that disparities exist across health services and have called for increased spending and improved treatment services for over a hundred years (Rothman 1980). Although there have been substantial changes to the mental health system over the last century, and periods when mental health treatment and services have gained national attention, calls for change have largely landed on deaf ears.

Within the last five years mental health has received substantial attention. For the first time since the 1960s, federal and state politicians, Republicans and Democrats alike, are in support of administrative, policy, and spending changes to mental health. The issue is so agreed upon that in January 2014, the Federal House of Representatives, which is overwhelmingly critiqued for its steadfast partisanship throwing the federal government into a state of paralysis (Angerholzer 2014; Grumet 2014), unanimously passed a \$1 trillion budget bill (H.R. 3547) that

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<sup>2</sup> Across medical and correctional contexts, and even within medical contexts, people receiving mental health services are referred to differently, including “inmate”, “patient”, “client”, and “consumer.” In order to simplify terminology, I use “consumer” when referring to the system as a whole, “patient” when referring to medical consumers and individuals directed to medical services, and “inmate” when referring to consumers in or en route to jail.

included significant spending boosts to mental health and substance abuse research, education and treatment.

Why the sudden shift? In the words of legal scholar and Black feminist theorist, Kimberle Crenshaw: “. . .the political demands of millions speak more powerfully than the pleas of a few isolated voices” (1993:1241). Within a span of three years, multiple mass shootings occurred. Each one linked one cause of the crime to diagnosed but untreated mental illness. These events garnered significant national and international media attention, and thrust two major issues into the national spotlight: gun control and mental illness. Both have received significant media and political discussion and debate; however, to date we have seen more political support for mental health reform than changes to gun laws. Whereas efforts surrounding legislation related to increased gun control have been squashed due to the gun lobby’s resistance to change and political power, there is no comparable mental health lobby, and if there were, it would be in support of the national attention and propositions for change.

The four mass shootings during this period that received the greatest attention<sup>3</sup> are not the first time criminal events have been attributed in part to mental illness (following the Virginia Tech mass shooting in 2007 media reports revealed the offender’s court-ordered mental health counseling) but their accumulation has led to the first time that blame is placed on the mental health system, rather than individual psychopathology. Although we have a long, rich cultural history of attributing some of the most violent, heinous, criminal acts to individual mental instability (Metzl 2011); these events hit a particular chord in the national psyche. Rather than

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<sup>3</sup> The four incidents, listed chronologically, are: 1) The grocery store shooting that injured Congresswoman Gabrielle Giffords in January, 2011; 2) The Aurora, Colorado movie theater shooting in July, 2012; 3) The Sandy Hook Elementary School shooting in December, 2012; and 4) The Washington Navy Yard shooting in September, 2013. See Appendix A for a more detailed description of each crime.

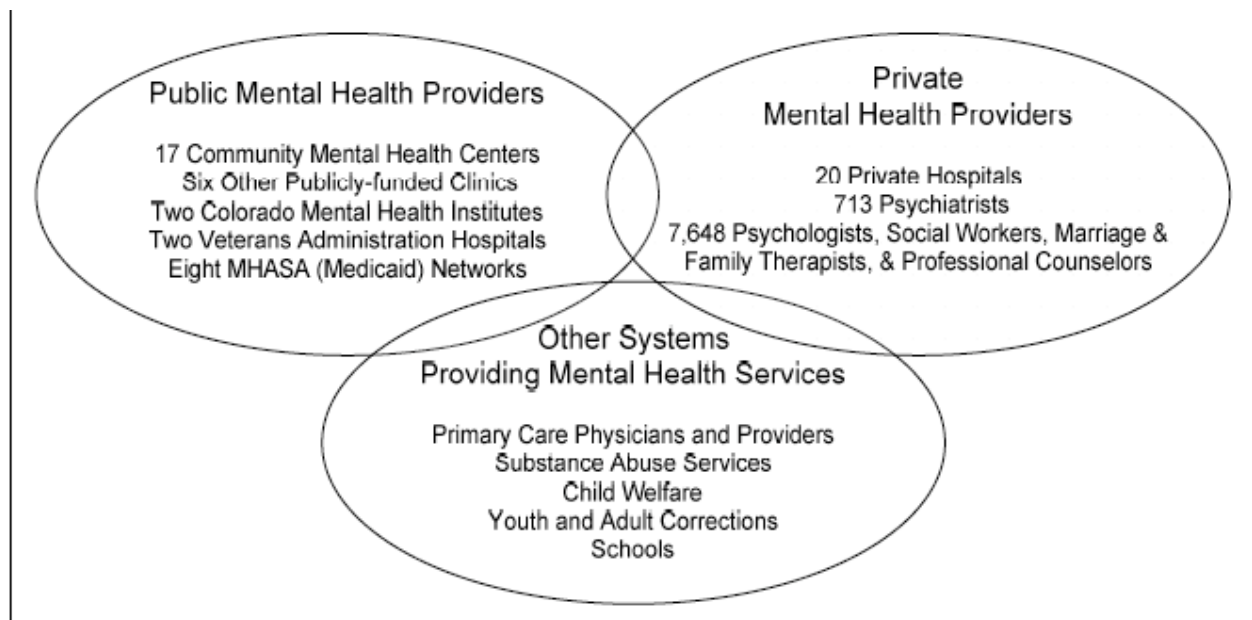
using individual mental illness and taking the “bad apple approach” in offering explanations as to why these events occurred, information surfaced in each case that forced the public and politicians alike to consider the role of the mental health system. For every new tragedy it seemed as though the offender’s recent history leading to the incident was some combination of the same elements: history of psychiatric diagnosis and/or treatment; reports by professionals indicating signs that the would-be offender may pose a risk; and family who recognized the offender’s deterioration and attempts to seek help. In the wake of these and other violent criminal events, there is continued national debate over what is most to blame – gun availability, bullying, mental illness, bad parenting, etc. – but, for the first time in the United States, we do agree that the underfunded, overworked, and fragmented mental health system plays a role.

While the majority of focus given to the mental health system has been more funding and more programs, there has been relatively little attention given to the current system in terms of who the players are and what each are doing. In one of my early attempts to capture the state of funding in Colorado’s mental health system, I went through the state’s budget and tracked funding earmarked for mental health. I soon discovered this was impossible to accomplish because mental health services are, in Dr Jay’s words, “a million different pieces.” The mental health system is distributed across a broad range of services, most of which do not dedicate a portion of their funding for mental health, nor does it have a line item in their annual financial reports. For example, the public education system, which is the primary source of mental health care for children (American Academy of Child and Adolescent Psychiatry 2009), does not have a mental or behavioral health line item in its state funding.

The term we’ve been using, “mental health system,” is a misnomer because that indicates some level of uniformity. In reality there are *systems of mental health* that stretch across various

public and private, related and unrelated, social agencies and institutions. For this reason, Dr. Jay refers to mental health as a “disorganized system” that can be incredibly difficult for the average person to navigate. Figure 1 lists some of the major contributors to mental health in Colorado.

Figure 1: The Colorado mental health system (From: TriWest Group. 2003. *The Status of Mental Health Care in Colorado*. The Mental Health Funders Collaborative.)



Not only does the mental health system cross state and federally funded public agencies, but also the private-public spheres. As Dr. Jay points out, in some ways this is to the benefit of individuals living with mental illness because they can receive services for a wide range of issues related to their illness (ex. housing, education, interactions with corrections, substance abuse); however, this will only be effective if there is cooperation and coordination across agencies working with the same individual. In order to understand the mental health system, we need to understand the role of each mental health organization and the interplay across organizations. Only then can we pinpoint where federal and state funding and policy initiatives should be directed to address and begin to repair the state of mental health care in the U.S.

In the following chapters, I attempt to understand how the mental health system functions in a single Colorado community that I call Elkgate. Due to time and access and monetary constraints, I was unable to take all the organizations listed in Figure 1 under consideration; however, at least one from each of the groupings (public providers, private providers and other systems) are included. Using an inductive, qualitative approach, I combined observation, interviews, and archival record analysis of organizations and their frontline professionals<sup>4</sup> to uncover how Elkgate's mental health system operates through its inter-organizational dynamics and interactions. In order to simplify which systems of mental health would be under consideration, I only included the adult mental health system, and organizations located within Elkgate including the police department, jail, public mental health center, hospital, and providers in private practice. These agencies provide a cross section of professionals who work with individuals with mental illness in the community and institutionalized settings, and across medical and correctional institutions.

Although the population represented in the data is professionals working in the various organizations, the experiences of individuals with mental illness navigating through the system are considered by analyzing organizational roles and inter-organizational interactions through the lens of how they would impact patient experience and outcomes. The aforementioned events that brought the mental health system to the nation's attention for the first time in fifty years are violent crimes. Although individuals with mental illness can be violent, they are the minority. Individuals living with severe mental illness are significantly more likely to be victims than offenders of violence, and are more likely to pose a risk to themselves than others (Hiday et al.

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<sup>4</sup> I will use the term "professional(s)" to refer to any person(s) working in medicine or corrections.



1999; Pandiani et al. 2007). Even those who do end up in jail are typically non-violent, and incarcerated for minor offenses (James & Glaze 2006). With this in mind, I am focusing my attention on these populations that represent the more typical case of individuals with severe, chronic mental illness than those who commit violent crimes.

## RESEARCH QUESTIONS

This dissertation is guided by four major research questions addressed across three empirical chapters (Chapters 4-6). In order to answer each question, I examined Elkgate's mental health system from different levels of analysis. This produced a dissertation sensitive to the individual, organizational-, community-, and state- and federal-level forces at work that interact with one another within the system in order to produce the outcomes of the system I found.

Listed by chapter, the questions are as follows:

- Chapter 4: What are the relationships among the organizations making decisions across the mental health system? How do agencies interact, and what are the barriers to communication in these situations? Who informs whom in terms of best practices?
- Chapter 5: To what degree does macro-level policy impact inter-agency communication and interaction?
- Chapter 6: How do inter-agency interactions and communication affect individuals who are the most likely to have contact across agencies?

I employed an inductive approach to data collection and analysis, which means that these research questions were altered and refined at multiple points during data collection, analysis and writing. Although these research questions are focused primarily on the mental health system and its organizations, the system is in place for the mentally ill population. This fact did not escape me during data collection or analysis. As a result, observed and inferred consumer experiences

within the system, and impacts of how the system operates across organizations, are reflected in my analysis of each question. Additionally, my own lived experiences as an individual with mental illness negotiating mental health systems, which I discuss in Chapter 3 also inform my analysis in relation to the system's impact on consumers.

## CONTRIBUTIONS OF THIS DISSERTATION

This project and my analysis offer multiple theoretical and empirical contributions to sociology, health policy and, more specifically, mental health policy. First, the multi-level approach I take to data collection and analysis that takes both individual actions and organizational, community, state and federal contexts under consideration addresses a call made across the entire field of sociology to study social phenomenon “from micro to macro” (Huber 1991). Particularly in medical sociology, there has been a lack of research focusing on organizations with a multi-level perspective. Although academics agree that context matters, we are lacking the empirical evidence describing the pathways through which this is true (Currie et al. 2012). Second, I combine principles of intersectionality with organizational literature to examine how and why individuals become lost in complex organizational systems. Finally, by offering a description and analysis of inter-organizational interactions in a mental health system, I present a much-needed snapshot of a mental health system in action: its players, organizations, and inter-organizational interactions. This allows me to offer suggestions for both health policy in general and mental health policy in particular at the community, state, and federal levels of government.

## CHAPTER-BY-CHAPTER OVERVIEW

In the proceeding chapters I use the case of Elkgate's adult mental health system as a case study to present a multi-level and multi-organizational understanding, critique, and analysis of mental health.

### *Chapter 2: Background*

I present both the substantive and theoretical literatures and background that led me to this project and my sociological orientation to the subject matter. First, I establish the theoretical importance of this project through a review of the sociological literatures on institutions and multi-level analysis and highlight recent calls for qualitative multi-level research in medical sociology. Second, I present relevant history of the treatment and management of mental illness in the United States, recent developments in mental health policy, and describe some of the unique elements of Colorado's mental health system.

### *Chapter 3: Methods*

This chapter describes the lengthy road I took to eventually developing this project, the research tradition employed, data collection and analysis. I further narrow the mental health system down to the city-level by describing the Elkgate-based organizations included in my data collection and analysis, and the process of gaining entrée into each. Throughout the chapter I insert some of my personal biography to situate myself within the project.

### *Chapters 4-6: Empirical Chapters*

In my three empirical chapters I alternate between a macro- to micro-level and micro- to macro-level approach to understanding and analyzing mental health through using Elkgate's system as a case study: Chapter 4 is primarily located in the meso-level with linkages to the

micro- and macro-levels; in Chapter 5 I begin with the macro-level and work down to the micro-level; and Chapter 6 is an interplay between micro- and meso-levels.

*Chapter 4:* I take organizational and individual-level perspectives to outline the elements of Elkgate's mental health system considered in this dissertation, the organizations involved, the context of inter-organizational interactions, and pathways patients may take through the system during a psychiatric emergency. By providing a roadmap through the correctional and medical institutions that compose the system and the various points of interaction, I further the policy discussion of the current mental health system and steps that need to be made to improve it. I then examine a particular inter-organizational interactional context between police and hospital emergency room staff. Finally, I further the literature on inter-organizational interactions and communication and how the structure under which organizations operate independently and interact together affects their ability to communicate.

*Chapter 5:* I continue with the importance of organizational structure and take state- and federal-level perspectives to examine the system through the lens of a federal act that impacts the entire system. Using the Health Insurance Portability and Accountability Act (HIPAA), I examine how the Act plays into inter-organizational interactions and its impact on Medicaid versus non-Medicaid care delivery. The analysis produces contributions to literature on healthcare disparities and privacy in medicine in the context of a stigmatized illness.

*Chapter 6:* From the state and federal, macro-level analysis in Chapter 5, here I combine concepts from organizational literature and intersectionality and apply an intersectional framework developed by Winker and Degele (2011) to take a meso- and micro-level approach to consider how the mental health system and its organizations operate within the context of the community (meso) to create individual-level (micro) outcomes. With a focus on Elkgate's

homeless mentally ill population and individuals with co-occurring mental illness and substance abuse or developmental disability, this chapter considers some of the community's most disenfranchised citizens and identifies some of the mental health system's most significant organizational gaps wherein groups of people are unable to access services.

#### *Chapter 7: Policy*

Taking the findings of the four empirical chapters, in Chapter 7 I offer suggestions for policy changes and new policy initiatives related to mental health and mental health systems at the local- state-, and federal-levels.

#### *Chapter 8: Conclusion*

The final chapter reviews the major contributions of this dissertation, the project's limitations and directions for future research, and reiterates the overall importance of critical studies of mental health systems as we move forward in the administration and delivery of mental health care.

In these chapters, I hope to shed light on the current mental health system, its complexity, and its players through stories, observations, and analyses from the field. As this is a dissertation in sociology, I hope to make the requisite contributions to the field. On the other hand, I also hope that the academic contributions over the following pages do not muddle my passion for mental health and those living with mental illness.

## CHAPTER II: BACKGROUND AND CONTEXT

This chapter introduces the substantive and theoretical background information I employed and expanded upon in my analysis and assessment of one city's (herein referred to by its pseudonym "Elkgate") adult<sup>5</sup> mental health system and presents the research questions that guided my analysis. Theoretically, I draw from institutional, organizational and medical sociological literatures to demonstrate the need for and benefits of multi-level analyses of institutions and organizations. Substantively, I use trends in mental health care in the United States beginning in the 19th century to the present to situate this dissertation and demonstrate its relevance to both the academic and policy realms.

### THE SOCIOLOGICAL STUDY OF INSTITUTIONS

The central theme of this dissertation is the institution of mental health care. In the field of sociology there is no single agreed upon definition or description of an institution. The two primary definitions used are institutions as cultural constructs versus institutions as structural bodies. There is much iteration on these and alternative definitions proposed by institutional researchers in sociology and other disciplines, but I will focus on these two.

In its cultural definition an institution is ways that society is organized that have been legitimized through shared values, beliefs and norms (Douglas, 1986), whereas the structural definition takes a bricks and mortar approach focusing on actual places wherein social activities

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<sup>5</sup> As in most health services, mental health services are divided into two groups determined by age; adult (18 and over) and pediatric (17 and under), which are sometimes subdivided into narrower categories based on lifecourse and developmental ages (child, adolescent, young adult, adult, geriatric). Adult and pediatric mental health services are typically kept separate from one another and considered two entirely different systems. Due to the complexity of both individual systems, time constraints, and the additional difficulties of gaining access to institutions of the pediatric system (such as schools), I have only considered the mental health system as it applies to adults. Herein, any reference to the mental health system should be implicitly read as the adult mental health center unless otherwise noted.

occur. The former definition of institution broadens the scope of the concept to include social groups held together by common ideas, which can be located within the physical institutions. Using this definition the family, marriage, and sexism are considered institutions, while the physical definition would exclude these because there is no overarching place that houses them. In the structural definition an institution is isolated to the physical locations wherein society organizes itself, such as the church, prisons, or hospitals. What both these approaches to institutions have in common is their focus on social patterns and the value placed on the practice or object where meaning is created (Jepperson 1991).

I will use the cultural definition of institutions to describe and analyze the mental health system (herein I will use the term “institution” for “social institution”). I regard the system as an institution composed of the correctional and medical institutions: arguably the most influential and powerful social institutions in modern society (Foucault 1973; 1977). Although I do include physical institutions (jail and hospital), I also expand beyond these physical places to their extensions in the community (police and outpatient providers), which, when taken together, are more representative of institutions. For example, we associate police with the jail, but they are a separate body with no single location in the community. Outside of the physical locations of care, such as asylums and today’s psychiatric hospitals and in-patient units, mental health is not considered an institution unto itself. With the growth of psychiatry, the introduction and expansion of psychopharmacology, and a call for cultural recognition of mental illness as conceptually identical to any physical illness among some of the most organized and wide-reaching anti-stigma campaigns (ex. National Alliance for Mental Illness; Treatment Advocacy Center), mental health and illness have been largely medicalized. The consequence of this is mental illness’ association with, and belonging to, the institution of medicine.

In sociology we believe that individual beliefs, values, and behaviors are primarily shaped through interactions and experiences with institutions, yet we are unable to interact directly with them because institutions are abstract. Taking medicine as an example, the medical institution encompasses not just the locations where medicine is practiced, but also the science of medicine and our knowledge of it; community and social factors; professional associations regulating clinical practice, education and membership; its administration through private and public sectors; and its regulations through state and federal governments, among others. Rather than interacting with the social institution, individuals interact with the physical institutions and organizations and individuals representing the institution. In other words, physical institutions “are the mediators for [social] institutional forces” (Irvine 1999:68). Using this logic, in order to understand individual beliefs, values, and behaviors within a social institution, one must understand the people working in each individual physical institution composing the institution, the physical institutions’ roles, relationships across physical institutions, and how they combine to create the institution. Therefore, we can only begin to understand individual behavior, beliefs and values through multi-level analysis. In order to better understand the system I consider all three levels of analysis:

- The micro-level role of professional behavior, inter- and intra-professional and professional-consumer interaction.
- The meso-level role of organizations and physical institutions with which the professionals are associated, inter-organizational interactions within and across correctional and medical institutions, and the community context of Elkgate.
- The macro-level role of state and federal government context in regard to their administration, funding and regulation of mental health through policies specific to



mental health and those applied broadly to healthcare with unique implications to mental health.

By taking multiple levels of analysis into account during data collection and analysis, I have been able to answer a long-standing call for multi-level research in the sociologies of medicine and organizations.

## THEORIES AND CALLS FOR MULTI-LEVEL RESEARCH

In many ways sociology was created out of a desire for a multi-level perspective that extends beyond the individual to explain human phenomena. For example, in one of the discipline's seminal works, Emile Durkheim (1997 [1897]) regarded suicide as a response to religious and governmental, cultural and institutional factors as opposed to simply the behavior of an individual. Today's multi-level researchers take this principle one step further and attempt to examine social phenomena at multiple levels of interaction, arguing that individual behavior is the sum of interpersonal (micro-level), community and organizations (meso-level), and institutions of formal control (macro-level) interactions (Ferree and Hall 1996; Yuval-Davis 2006). Although sociologists frequently postulate consequences and effects, and call for future research to examine the same phenomenon above and below a study's level of analysis, there is a dearth of multi-level sociological research, and qualitative research in particular, that spans the full macro- to micro-level spectrum (Huber 1991).

Quantitative research can more easily accommodate multiple levels of analysis by combining data sets or aggregating data than can qualitative data, where researchers need to go into the field with the intention of multi-level analysis. Although this deductive element is easily done, qualitative researchers also face greater hurdles to multi-level research during data collection. In order to make claims at multiple levels of analysis, a qualitative researcher must

spend time at each level and collect multiple types of data (Choo and Ferree 2010) using a variety of gathering techniques making large-scale multi-level research time prohibitive. Although some academics have made claims that qualitative methodology is by its very nature multi-leveled (e.g., Robert Zussman's (2004) explanation that qualitative researchers study "people in places"), I would argue that it is somewhat rare for qualitative researchers to factor all three levels of analysis into a single data collection effort, and they most ultimately focus on a single level. Where we do see more qualitative multi-level research is in studies of organizations where projects are located within a single physical institution.

Organizational researchers were among the earliest to employ multi-level analysis because their subjects (organizations) are inherently multi-leveled. Further, some have argued that multi-level analysis is the key element separating organizational research from other disciplines (Behling 1978). Considering its history and centrality to the discipline, it is not surprising that many theories of multi-level analysis originate in organizational research.

Denise Rousseau (1985) created a widely accepted typology of "mixed-level models." In her typology, Rousseau describes three major orientations to mixed- or multi-level research and analysis: composition, multi-level, and cross-level. The composition model focuses on "relations among nondependent variables at different levels" (12). In this model the researcher would examine a single variable across a variety of organizational levels.<sup>6</sup> The multi-level model proposes that interactions at one level can be generalized and occur in the same way at two or more levels. This model is least frequently used and applied to broader concepts and theories as opposed to the specific variables of composition. Parsons' (1951) attempts at creating theory to

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<sup>6</sup> For an example, see James' (1982) composition theory for climate, or Blood's (1974) examination of employees' interpretation of company policy.

explain all social interaction represent an “elaborate example of multi-level theory” (Rousseau 1985:17). Finally, cross-level models “specify causal models of the effects phenomena at one level have on those at another” (pg. 14). These models often take a top-down approach, offering explanations for individual behavior based on contextual factors located above the individual and represent the majority of mixed-level work in sociology.

The findings of this dissertation represent cross-level models of Elkgate’s mental health system. Using the micro-, meso-, and macro-level perspectives discussed above, I will present an interconnected institution where organizational, inter-organizational, community, state and federal contexts regarding mental health have direct implications on the individual-level care and interactions with professionals of individuals living with mental illness. This approach also addresses an issue presented by organizational sociologists that the discipline has provided a solution for studies representing a single unit of analysis, yet has created a problem of its own by creating a micro-meso and meso-macro divide. Further, the present research addresses critiques of research in inter-organizational networks that “studies have ordinarily failed to exploit data on the full variety of ties that constitute network structures” (DiMaggio 1991:91).

Organizational research uses an organization or group of organizations as the level of analysis. From the organizational level, researchers will uncover processes that both impact and are impacted by elements within the macro- or micro-levels. Focusing on the micro-level, organizational researchers recognize that interactions among workers are located within the organizational and institutional contexts, but also that repeated interactions following a similar pattern solidify the organizational norms and expectations. Ellen Pence (1996) describes this using the process through which documents flow through an organization:

Processing interchanges are organizational occasions of action in which one practitioner receives from another a document pertaining to a case...and then makes something of the

document, does something to it, and forwards it on to the next organizational occasion for action. It is the construction of these processing interchanges coupled with a highly specialized division of labor that accomplishes much of the ideological work of the institution. Workers' tasks are shaped by certain prevailing features of the system, features so common to workers that they begin to see them as natural, as the way things are done and in some odd way as the only way they could be done, rather than as planned procedures and rules developed by individuals ensuring certain ideological ways of interpreting and acting on a case. (pg. 60)

While workers or professionals at the micro-level are an important component of any organization, the organizational research tradition dictates that researchers must consider the context within which interactions occur. Examining any interaction, whether it be between peers, a superior and subordinate, or between organizations, without considering the structural context within which the interaction occurs results in "an analytic understanding of the interorganizational (and intraorganizational) relationships [that] will be most deficient, however well those relationships are understood descriptively" (Strauss 1978:364).

The medical system and its organizations provide great fodder for organizational researchers because of their highly diversified and specialized roles and central location in modern society. As a result, there is a rich tradition of studying organizations in health care within medical sociology (ex. Davis 1963; Foucault 1975; Glasser & Strauss 1968; Goffman 1961; Parsons & Fox 1952). However, in the face of access difficulties, time constraints placed on research, and an increasing emphasis on individual health outcomes and risks, there has been relatively "very little" work in medical sociology with a focus on organizations (Currie et al. 2012:275) in recent decades. The result is a general agreement that the multi-level contexts are important, yet few sociologists are able, or choose to analyze them as part of their research.

#### *Multi-level Analysis in Medical Sociology*

As in organizational sociology, medical sociologists recognize the importance of context on individuals as they relate to health and illness. There is a general consensus that "health care

systems are shaped by historical precedents and embedded in larger institutions and specific cultural contexts” (Quandagno 2010:126), which also impact individual experiences, yet a great deal of the research done in this field is located in a single level of analysis. Although both the micro-level studies evaluating individual risk and determinants of health and meso- and macro-level studies evaluating health organizations and systems provide valuable information, these are pieces of a much larger puzzle. Without considering all levels within a single health or medical context we cannot see the entire causal chain that leads to the observed outcomes (Matteson, Burr, and Marshall 1998).

There have been repeated calls for an increase of multi-level analysis in research on both medical systems and, more specifically, mental health, with the general consensus that “context matters” (Mendel et al. 2007; Proctor et al. 2008). In other words, we cannot make effective policy and change to the healthcare system without understanding how the entire system fits together. However, there are few examples of scholarship that has been able to do so (Provan and Milward 1995; Ringeisen, Henderson, and Hoagwood 2002). As a result, the bulk of research in mental health in particular continues to include three separate bodies of work: individual and interactional (ex. Adler 2011; Cooper, Corrigan, and Watson 2003; Goffman 1961; Nordt, Rossler, and Lauber 2006); organizational (ex. Glisson 2002; Glisson et al. 2007; Kripalani et al. 2007); and policy (ex. Frank and Glied 2006; Mechanic 1987; Pilgrim 2008; Rochefort 1993).

In each chapter I consider the interactions between levels of analysis in the mental health system and demonstrate how “processes at each level depend on processes at other levels” (Armstrong, Hamilton, and Sweeney 2006:485). In the mental health system consumer care and professional practice depend on: the provider’s affiliated professional or organizational rules, norms, and expectations, inter-organizational communication and cooperation, and applicable

state and federal policy (Rapley, 2007). The remainder of this chapter will address aspects of the mental health system that provided the empirical background and context for this dissertation.

## SOCIAL INSTITUTIONS AND THE MANAGEMENT OF MENTALLY DISORDERED BEHAVIOR: A BRIEF HISTORY

The relationship between corrections and medicine to manage mentally ill populations can be best described as one of give and take. Behaviors indicative of mental illness have longtime been categorized as socially deviant, or criminal. Depending on the time period, communities have managed mental illness as deviant, non-criminal behavior through a variety of formal and informal interventions including ostracism, banishment, religion, seclusion in insane asylums, and most recently medical and psycho-social treatment and care (Foucault 1965; Rothman 1980). When mental illness is categorized as criminal, erratic and unexplained behaviors are believed to pose a real and imminent danger to the social order and citizen safety, and are managed through criminal confinement. Over the last two centuries, individuals categorized as mentally ill have faced both types of interventions. People in the United States have been more or less likely to face criminal confinement as an intervention for mental illness depending on the time period.

In the early 19<sup>th</sup> century the first proponents for separating the insane<sup>7</sup> from the criminal claimed that criminals should not be subject to the disruptive and bizarre behavior of the insane in jails and prisons (Rothman, 1980). Not only were behaviors indicative of mental illness<sup>8</sup> considered deviant and disruptive in the community, they were also deviant and disruptive in the

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<sup>7</sup> I use the term “insane” here to reflect the language used at the time.

<sup>8</sup> It is not possible to definitively attribute historical accounts of individual behavior to modern mental illness. Apart from definitions and diagnostic criteria of mental illnesses changing drastically, physical illnesses unknown at the time including mercury poisoning and syphilis among others, produced behavioral and psychological changes. People with these illnesses were indistinguishable from individuals with psychosis from a mental illness recognized today, and received the same treatment.

prisons. From these earliest calls for separate insane and criminal institutions, further support for the notion gained attention through early medicalization attempts led by Dorothea Dix who advocated for humane treatment over punishment for the mentally disturbed and was among the first in the United States to declare insanity a sickness. Although there had been insane asylums in the United States since the early-19<sup>th</sup> century, the movement for state run asylums did not take off until the mid-19<sup>th</sup> century, credited to Dix's advocacy, and by 1900 every U.S. state had funded and was operating at least one (Earley 2006).

This marks the first transition between incarceration and a medicalized approach to mental illness in the United States, and proved to be mutually beneficial for corrections and early mental health professionals. The prisons were beginning to fill up: insane asylums gave prison officials a place to transfer their most difficult inmates and open up needed space for criminals. At the same time asylums were in need of patients in order to prove their worth (Conrad, 1992), and the prisons provided the majority of their earliest patients. This practice of diverting mentally ill away from incarceration to psychiatric facilities continued until the state run psychiatric hospitals significantly reduced their patient populations or closed altogether in the 1960s during a social and political movement known as deinstitutionalization.

#### DEINSTITUTIONALIZATION OF MENTAL HEALTH CARE

Asylums were created and run with no legal oversight. Patients were admitted based on familial accusations of insanity and held until superintendents, later replaced with psychiatrists, determined that they were cured of their insanity. There was no legal recourse available to patients to avoid admission or force discharge, and patients were frequently warehoused without treatment. Although patient autobiographies began to emerge in the 1850s recounting stories of "being forcibly committed to an insane asylum by greedy relatives, and suffering horrible

indignities” (Rothman 1980:298), patient accounts of overcrowding, victimization, and inhumane living conditions in state run psychiatric facilities remained largely ignored by the general public until 1946 when *Life* magazine ran a cover story, “Bedlam: Most U.S. Mental Hospitals are a Disgrace” that investigated the conditions in state hospitals, which was followed by other popular media exposés (Raphael 2000). Beginning with these accounts, psychiatry went through a significant professional and cultural shift over the next 15 years that lead to the eventual release of a majority of patients from state hospitals: in 1954 the first anti-psychotic medication was introduced to the American market; the 1960s counterculture produced an anti-psychiatry movement that gained popularity in academia, led by Thomas Szasz and Ronald David Laing’s independent critiques of psychiatry, and popular culture, led by Ken Kesey’s *One Flew Over the Cuckoo’s Nest* (1962).

Deinstitutionalization began with the public uproar from the media accounts and subsequent political intervention, but the introduction of medication was a key factor in its early stages. Touted as a miracle drug, the first anti-psychotic, Thorazine, appeared to completely eliminate symptoms, allowing patient discharge and return to their communities. The final push for the nation-wide mass exodus of psychiatric patients from state hospitals came from federal legislation.

#### *The Community Mental Health Centers Act (CMHCA)*

In 1963, under the Kennedy administration, Congress signed the CMHCA into legislation as part of the Mental Retardation Facilities and Community Health Centers Construction Act (Public Law 88-164). Initially, the primary intent of the Act was to limit the necessity of state mental hospitals by treating individuals in the community. The idea was to use federal funds to create mental health centers, available to all persons regardless of economic status, where people



would receive treatment and care in their communities. In an 1975 amendment, centers were also responsible to provide “assistance to courts and other public agencies in screening individuals being considered for admission to State mental hospitals” (Bailey, 1978:1), which removed the decision-making for commitment from behind the closed doors of state hospitals to the more public community and judicial realms. Individual states were financially incentivized to rapidly release thousands of psychiatric patients from state hospitals and close multiple facilities: state hospitals were state-funded whereas the community centers would receive federal assistance; community centers were more cost-effective to run by eliminating housing costs; and multiple states were facing millions of dollars in renovations to their psychiatric hospitals following investigations and law suits regarding patient living conditions and treatment (Rothman 1980).

The CMHCA had a utopian vision in its goals to successfully treat the majority of psychiatric patients in the community with equal access to care regardless to geography and socio-economic status. Unfortunately this vision has not been fulfilled in the years since. As early as 1972 it was clear there were not enough centers to service the population, and many centers were slow to become functional. Where functional centers existed, the number of people admitted to state hospitals significantly decreased; however, very little change was observed in areas without community mental health centers. The major problem that arose with the CMHCA was funding. When Kennedy signed the Act, \$3 billion was promised to “create a safety net” for mental health facilities; however, Congress soon turned its attention to other issues, and “mental health ended up going hungry when the federal pie was gobbled up” (Earley 2006:71).

### *Consequences of Deinstitutionalization*

In 1955 there were approximately 560,000 Americans in state hospitals. By 1970, the figure had dropped to about 400,000 (Earley 2006). As deinstitutionalization continued, the

streets of many cities became inundated with the recently released. At the onset of deinstitutionalization it was both assumed and promised that this population would return to their families and receive continued treatment and support from community mental health centers; however, this was not the case, and by the late 1970s terms such as “the homeless mentally ill” and “the chronic mental patient in the community” begin to appear in health literatures (Bloom 2010).

Although deinstitutionalization eliminated the warehousing of the nation’s mentally ill in psychiatric hospitals, and certainly granted freedom to many people who should not have been admitted to begin with,<sup>9</sup> the overwhelming opinion across academia (Isaac and Armat 1990; Mechanic and Rochefort 1990; Rhoden 1982; Shadish, Lurigio and Lewis 1989), psychiatry (Gralnick 1985; Paulson 2012; Torrey 1997; 2008), and mental health workers (Brown 1980; French 1987; Sheth 2009) is that it was massively unsuccessful. In 1979, John Talbott identified the transinstitutionalization of psychiatric patients in an editorial for *The American Journal of Psychiatry*. He claimed that the patients released from the state hospitals were passed off to other institutions, including nursing homes and jails.

#### *Note on terminology*

The negative consequences of deinstitutionalization were, and continue to be, felt most by persons, and families of persons with severe mental illness. As I am addressing the current mental health system and inter-agency interactions, including those across medical and correctional institutions, many of the situations observed and experiences professionals draw from in interviews involve patients categorized as suffering from severe mental illness. This is a

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<sup>9</sup> For an example, see Kneelan and Warren’s (2008) study of women seeking divorce who were hospitalized based on their husbands’ requests and given electroconvulsive shock treatments against their will.

term used frequently in clinical practice, government policy, advocacy campaigns, the media, and general public, yet rarely defined. Part of the reason is there is no single agreed upon definition of a clinically based criteria for severe mental illness, although there is a general consensus that this population should be the target of mental health policy and reform (Ruggeri et al. 2000). Specific mental illnesses that could fit under the severe mental illness category have varied from major depression, schizophrenia, bipolar disorder, obsessive compulsive disorder, panic disorder, post traumatic stress disorder and borderline personality disorder (National Alliance on Mental Illness 2014) to only those causing psychosis (schizophrenia, bipolar disorder type 1 and major depression) (National Institute of Mental Health 1987).

Throughout this dissertation I reference individuals with severe mental illness as a target population facing positive and negative consequences of organizational interactions within, and the structure of, the mental health system. I use the definition of severe mental illness created by the Substance Abuse and Mental Health Services Administration with “an advisory group of technical experts” (Epstein 2002) that includes: 1) a diagnosed psychiatric illness, 2) over one year duration, and 3) the illness creates “serious impairment.” Clinically, impairment is measured using the Global Assessment of Functioning tool (see Edicott et al. 1976), but for my purposes I will consider those with psychotic symptoms (visual or auditory delusions due to mental illness) seriously impaired. When I apply the term to an individual I have not independently diagnosed someone as “severely mentally ill,” but use the term to reflect the information given to me by a medical or correctional professional working in the system, or repeat the terminology used in cases where a professional describes the person or population as “severely mentally ill.”

## THE CURRENT STATE OF MENTAL HEALTH CARE

Today it would appear as though Talbott's observations were correct, as the responsibility of containing and treating the most severely mentally ill citizens has largely returned to the criminal justice system (Torrey et al. 2014). The trend of closing state hospitals and reducing the number of beds in those that remain open continues today. Between 2005 and 2010 there was a 14% reduction in psychiatric beds nationally (Torrey et al. 2012). While there were 400,000 people in state hospitals in 1970, the most recent available data (2012 numbers) estimate that 35,000 people are in some kind of inpatient or residential psychiatric facility per year, while 356,268 individuals with severe mental illness are in jails or prisons (Torrey et al. 2014). With individuals with severe mental illness facing incarceration at ten times the rate of inpatient hospitalization, the correctional institution, including police, jails and prisons, have undoubtedly become part of the mental health system.

### *The Colorado Context*

The scene in Colorado reflects this larger trend. Recent statistics paint a picture of a medical system that is overburdened and underfunded, resulting in the criminal justice system housing large numbers of seriously mentally ill individuals. A report released by the Treatment Advocacy Center used 2004-2005 statistics to answer the question of "the odds of a person with a serious mental illness being in a jail or prison compared to a psychiatric hospital" (Torrey et al. 2010:6). In Colorado, for every 4.1 people with a severe mental illness in jail or prison, there was *one* in a public or private inpatient psychiatric setting (1,325 to 5,433). With nation-wide rates from a high of 9.8:1 in Nevada to a low 1:1 in North Dakota, and a national average of 3.2:1, Colorado's rate places it in the bottom quarter of states. Although these data are a decade old, there is no indication that the ratio has improved in Colorado or nation-wide. In the same period

of time from 2005 to 2010 when psychiatric inpatient beds fell 14% nationally, beds in Colorado were reduced by 23% with no comparable decrease in prison and jail populations (Torrey et al. 2010). The fact that at least 25% of institutionalized individuals with severe mental illness are in correctional rather than medical placements places a significant burden on correctional authorities statewide. At a conference of the County Sheriffs of Colorado in 2007, a southern Colorado Sheriff noted, “by default, [county jails] have become the mental health agencies of the individual counties” (Torrey et al. 2010:5). Recent data provide additional evidence to the Sheriff’s comment. In 2012, an estimated 20% of Denver County Jail’s 2,730-inmate population was comprised of individuals with severe mental illness. These 546 inmates give the jail the title of “largest de facto ‘mental institution’ in Colorado”; the largest psychiatric hospital in the state, one of the two remaining state hospitals, has 398 patients (Torrey et al. 2014).

### *Mental Health in the Medical Institution*

For those who do not face the criminal justice system, individuals who access mental health care are monitored and treated through what I refer to as the medical institution of mental health. This includes both institutionalized (non-correctional hospital or residential) and community services provided by multiple professionals including psychiatrists, psychologists, nurse practitioners, and licensed and unlicensed social workers and counselors. Many community services are focused on mental health as opposed to mental illness, meaning that patients accessing services may not necessarily have a diagnosed or diagnosable mental illness, but are seeking assistance with individual and/or relationship struggles. For example, individuals seeking marriage or couples counseling may not have any symptoms of mental illness, yet they are still accessing care through one element of the mental health system. In contrast, the majority of patients who see a psychiatrist, are admitted to an institutionalized psychiatric setting, or jail

and prison inmates who are the focus of issues surrounding mental illness in these correctional settings are considered mentally ill and have a psychiatric diagnosis. Although I do include both mental illness and mental health services in this dissertation, I focus on services directed toward the mentally ill patient population because this group is more likely to be involved in situations requiring inter-organizational interactions. To this end, all data obtained from mental health focused providers was in the context of interactions with patients identified as mentally ill.

A significant issue in the medical institution's delivery of mental health care is the role of the emergency room. Emergency rooms across the country have noted an increase in psychiatric patients out-pacing the general increase in overall emergency room visits. Between 1997 and 2007 total annual ER visits in the U.S. increased by 23% (Tang et al. 2010), whereas visits due to mental health increased 75% between 1992 and 2003 (Larkin et al. 2005). Psychiatric patients pose a unique difficulty in ERs because many have an on-going issue without community resources, and the lack of inpatient services means that they remain in the ER for longer periods of time (Nicks & Manthey 2012; Snowden et al. 2014) or are released prematurely (Baraff, Janowicz & Asarnow 2006). Patients unable to access services arrive in ERs once they have deteriorated to a point where psychiatric assessment is a necessity. Since state hospitals have eliminated the majority of their beds, the private sector has added some through privately run psychiatric hospitals and units in otherwise physical health hospitals; however, there still remains a substantial deficit.

When patients are referred to an inpatient placement they must be transferred to a psychiatric unit. When all the beds in the state are full, which happens with some frequency in Colorado, psychiatric patients have no option but to wait in the ER. This issue of "psychiatric boarding" is a concern across the nation: a 2014 national survey by the American College of

Emergency Physicians found 84% of emergency physicians reported psychiatric boarding in their ER. Although widespread, patient advocacy groups and mental health professionals have critiqued the practice (Nicks & Manthey 2012; Snowden et al. 2014) because ERs do not offer psychiatric care and patients are forced to stay in the chaotic ER, often without seeing a psychiatrist or other mental health professionals, for multiple days or even weeks (Zeller 2013). In August of 2014 Washington State's Supreme Court denounced the practice as unconstitutional, stating that it was in violation of the state's Involuntary Treatment Act because ERs "are not certified to deliver psychiatric care" (Glatter 2014:np). The practical outcome of this ruling is uncertain – if there are no available inpatient psychiatric beds and waiting in the ER is not an option, where do these patients go – but it does lay legal precedent that we could see used in other states.

Unlike corrections, this segment of the mental health system is a culmination of multiple systems of service delivery where patients have access to various available care providers, programs and placements based on insurance type, which, with the exception of Medicare (a federal health insurance program for all U.S. citizens 65 or older), is largely determined by income. As a result, the medical arm of the mental health system is significantly more fragmented than it is in corrections.

### *The Private Insurance System*

Every state in the union has the same combination of publically and privately provided health insurance. People with private insurance, whether employer-provided or independently purchased, navigate their plan to find covered providers, facilities, or programs. It is unlikely that all providers in a community will be covered; patient choice is curtailed unless people can afford out-of-network (partial coverage) or out-of-pocket (no coverage) costs. Patients are also often

limited in the quantity of care (number of appointments or days in hospital or residential treatment) their plan will cover per year. Prior to the passage of the Mental Health Parity and Addiction Equity Act of 2008 (H.R. 1424—117) it was common practice for insurance companies to cover mental health costs, including hospitalization, at lower rates than physical health. With the implementation of insurance parity this practice has been largely eliminated.

### *The Public Insurance System*

Since the introduction of Medicaid and Medicare in 1965, state and federal governments in the United States have taken on the healthcare costs of certain portions of the population. Today government-granted insurance is offered to the poor and disabled through Medicaid,<sup>10</sup> senior citizens (65+ years of age) through Medicare, and children in families above the Medicaid cut-off<sup>11</sup> through Children's Health Insurance Program (CHIP), and individuals in the military through the Veterans Administration. Beyond these federally mandated and funded programs, individual states have created their own public insurance programs. Each public insurance program is administrated differently in its funding and care delivery.

Though all public insurance programs provide funding for, or delivery of, mental health services, I have only considered Medicaid in this dissertation. My rationale for this decision was that Medicaid recipients include those receiving benefits for disability, including disability due to

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<sup>10</sup> States determine their own income cut-off for eligibility. The most recent federal Medicaid expansion was a part of the Affordable Care Act of 2010, which extended eligibility to those living at or below 133% of the federal poverty level. To date 26 states, including Colorado, and the District of Columbia have chosen to expand their Medicaid eligibility. As of July 1, 2014, eligibility in Colorado as a percentage of the federal poverty level is as follows: 142% for children (0-18 years), 195% for pregnant women and 133% for all other adults (19-64 years) (Centers for Medicare and Medicaid Services 2014).

<sup>11</sup> Each state determines their cut-off for eligibility and whether or not pregnant women can participate. As of July 1, 2014 eligibility in Colorado is between 143% and 260% of the federal poverty level for children (0-18 years) and between 196% and 260% for pregnant women (Centers for Medicare and Medicaid Services 2014).



mental illness, and represent an insurance population disproportionately living with severe and chronic mental illness. Since states are responsible for Medicaid delivery, each state has its unique system. I will outline the Colorado system in order to situate the project within the context of Elkgate's position in Colorado.

### *Medicaid Mental Health Delivery in Colorado*

Colorado is one of 21 states that currently use a “carve-out” approach to Medicaid mental health care delivery for inpatient care, and one of 18 for outpatient care (Morgan 2014). In these states, mental health is administrated entirely separate from physical health. Whereas physical health is largely provided through a fee-for-service program, mental health decisions are made by Behavioral Health Organizations (BHOs) that have been contracted by the Department of Healthcare Policy and Finance, the arm of the government that manages Medicaid. BHOs are specialized managed care organizations for behavioral (mental) health. These for- or non-profit organizations bid for the Medicaid contract in a given geographic, or catchment, area. Colorado has divided the state into 5 catchment areas with a different BHO running each (Colorado Department of Human Services 2014). BHOs receive a set amount of money per individual per year in their catchment area receiving Medicaid and are responsible for allotting and paying for all mental health care (Hamblin, Verdier & Au 2011). In this way BHOs act as an insurance company for mental health services: pay out more than what they received from the state in a year and the organization makes up the difference; pay out less and the remainder becomes profit. In this process, the organization takes on a financial risk for their subscribers; pay out too much for too many patients, the organization goes into debt.

Managed care programs, such as the BHO model, are used in other realms of medicine in the U.S. and have been critiqued for transforming the medical system from care seeker (patient)

and giver (doctor), to consumers of care (patients) and gatekeepers (doctors) with the additional role of managed care plans as “commercial enterprise from which a service is obtained” (Kronenfeld, 2000: 293). In this model doctors are required to follow protocol and procedure from the managed care organization that serves its interest in return for a guaranteed number of patients (Bolen and Hall 2007; Scott et al. 2000). Managed care has changed the doctor’s role in medicine from physician dominance to physicians as employees of managed care organizations (Kronenfeld 2000).

One of the main foci of managed care organizations to decrease healthcare costs is by limiting hospitalization. Due to the federal government’s role in eliminating the large state psychiatric hospitals and push for treatment in the community, Medicaid has historically excluded payment for any services received at an institution for mental disease, defined by the U.S. Department of Health and Human Services as any facility with more than 16 beds that primarily provides “diagnosis, treatment, or care of persons with mental diseases” (Tuttle 2008: 2). This provision has been considered one explanation for the national decrease in psychiatric beds. Prior to Colorado’s decision in 1995 to carve out mental health spending and management from the rest of Medicaid and rely on BHOs to make mental health spending decisions, it was already difficult for Medicaid patients to gain access to inpatient services. It is possible that this carving out and the reliance on managed care for mental health has put further pressure on psychiatrists and hospitals with inpatient units not to admit Medicaid patients.

The administration of mental health care in the United States has a history of abuse, misuse, and neglect. There is a recent spotlight on the current state of mental health and demand for change from various sources, and it appears as though there are forthcoming funds and attempts at change. I believe that without a multi-level analysis and understanding of the

organizations and institutions involved, we have very little hope of repairing this broken system. Although I first became interested in mental health care delivery prior to this recent national attention, it did have an impact on my approach to research on the topic. In the following chapter I will explain my research process from this project's conceptualization to data collection and analysis.

### CHAPTER III: HOW I GOT HERE AND WHAT I DID

My interest in mental health and the mental health system begins with personal experience. Between the ages of 13 and 17 I was hospitalized multiple times in the psychiatric ward of a children's hospital in Canada, and between hospitalizations received a great deal of outpatient treatment. After this experience with mental health I was certain that I wanted nothing to do with the topic for years. What did interest me was criminology. The criminal justice system was something with which I had no personal experience as a client, but did have a great deal of empathy for individuals in the criminal justice system. Using my experience with mental illness, I had an understanding of elements outside the individual that could lead a person to a mindset and behaviors they otherwise may not have. Coming into graduate school I was not sure of the exact topic I wanted to research, but I was certain that it would be criminology related. However, my interest in the criminal justice system and criminology led me back to mental health.

My first year of graduate school I purchased *Crazy: A father's search through America's mental health madness* (Earley 2006) at an airport bookstore over spring break. The book examines the situation of individuals with mental illness overwhelmingly ending up in jails and prisons across the United States rather than in-patient or community mental health-focused programs. Along with the frightening description of the Miami-Dade county jail's psychiatric unit and the stories of select inmates, Earley delves into the history of mental health treatment in the United States with an emphasis on the 1963 Community Mental Health Centers Act and deinstitutionalization, which he argues was the impetus to the criminalization of mental illness we are seeing today—a position that is supported by a number of scholars. I could not put the book down. It shocked and angered me, and made me think more about mental illness, how we treat the mentally ill, and its fragmented system.

This spark initiated a project in one of my graduate classes the following year. In the class Health Disparities, we were to develop and carry out our own empirical research. At the time the project I had thought would turn into my dissertation was irrelevant to the course topic, so I was brainstorming project topics and came up with the first project that would eventually evolve into this dissertation. Taking disparities into consideration, I wanted to interview individuals who had gone to ERs with injuries resulting from self-injurious behaviors (hurting oneself without suicidal intention). Having been in that situation myself, and heard many horror stories, I wondered what others' experiences were and how they perceived their interactions with the non-psychiatric medical staff.

As the semester progressed I went from considering this as a side project to a potential direction for my dissertation. Although I found the project I had been working on interesting, this seemed more important. The initial interviews were really powerful. I found participants through a self-injury on-line support group I was a member of, and took a complete membership researcher role (Adler and Adler 1987): participants were aware of my participation on the site, and I openly shared my history with self-injury and mental illness when asked. This created more of a peer-to-peer interaction during interviews than participant-to-researcher, and participants were extremely open with me, many qualifying stories with "I've never told anyone this." But the defining feature that convinced me that this was the direction I should go was participants' excitement about the research topic. They felt it was important and could mean a lot to both self-injurers and the medical community because these were stories rarely shared. At the end of the semester I changed directions in my graduate trajectory from a criminologist with some interest in mental health to a health researcher with some interest in criminology.

Now that I had a project concept and some initial data, the idea needed to expand. Although I had found enough participants to write a paper, individuals who had self-injured severely enough to go to an ER were not easy to find, and my participant pool had dried up. I broadened the project to include any individual who had gone to an ER for any psychiatric-related reason, but also narrowed it from anywhere in the world (the self-injury participants included people in the United Kingdom and Australia) to the United States.

The second semester of my second year of grad school I began interviewing people locally through various support groups I approached. I soon came to the conclusion that I needed to know more about the insurance, medical, and mental health systems surrounding these doctor-patient interactions. The majority of participants was aware of funding issues resulting in fewer psychiatric beds available in Colorado, and had theories relating to how doctors and hospitals decide who gets a bed. The following summer I applied for and received funding to examine Colorado's mental health system's structure and funding over a ten-year period. What I thought was going to be a relatively simple project examining state budgetary documents in order to follow the money from the state to mental health care recipients turned into a maze. This was my first realization of the complexity of the mental health system: there is no single system; nearly every social service sector has some role in mental health care delivery, and some are connected, but most are not. Furthermore, a retired Colorado state Senator with a particular interest on the topic informed me that "no one knows" how much money we spend on mental health treatment and care. I found this shocking, and it was an important turning point in my research from individual-level doctor-patient interactions to considering the meso- and macro-level impacts on these interactions.

What I learned that summer, in conjunction with the patient interviews, evolved into my first dissertation proposal. I was planning on beginning with the individual doctor-patient interactions by interviewing ER doctors, asking about their considerations when making their decision to admit or not. Expecting that there were factors beyond the individual patient, my intention was to follow those considerations, anticipating that it would take me through hospital policy, insurance company decisions, and ultimately the state and federal-level funding decisions that impact the psychiatric bed deficit in Colorado. The feedback from my committee was this was too big and too vague a dissertation project. Focusing on one figure in the proposal, my committee members suggested a project where I examine the role of the various agencies and departments in mental health care. Taking their feedback, I came back with the current project that considers how the various organizations across the corrections and medical systems coordinate and create the adult mental health system in a single town.

In order to get a picture of both the institutionalized<sup>12</sup> and community settings, I chose four contact points: a county jail, police department, outpatient mental health providers, and the hospital emergency room. As mentioned in the previous chapter, I could have examined a wide range of settings to study the institution of mental health. For example, advocacy groups, insurance companies, or the legislative branch of state or federal government would have all captured elements of the institution. I chose these four because I wanted to study the system and institution while still remaining close to consumers. By focusing on locations within mental health where consumers have direct contact I was able to accomplish this. These four contact

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<sup>12</sup> Because the phrases “inpatient” and “incarceration” are unique to the hospital and jail, respectively, I feel it would be inappropriate and misleading to apply either term to the other placement (ex. referring to the jail as an “inpatient setting”). An alternate term I could use is “residential.” Although factually accurate, I feel its connotation is also misleading and inappropriate. For this reason, I use the term “institutionalized” as a category for the jail and hospital.

points were chosen because they matched up for comparison purposes: a community and an institutionalized setting within both medical and correctional institutions. Additionally, other consumer contact points, such as the Veterans' Administration or prisons, would require a great deal more time and administrative difficulties in gaining access. Finally, only mental health professionals (social workers, psychologists, psychiatrists, and licensed counselors) in the community were considered. Although I recognize a substantial amount of mental health services are provided by other members of the community (ex. religious leaders, general practitioners, professors, friends and family members), by limiting the project to mental health professionals I felt that I was more likely to access experiences of inter-organizational interaction, and get a fuller picture of the medical mental health system.

The history and present state of mental health and gaps in the sociological literature outlined in the last chapter both indicate a need for a multi-level analysis of the two major institutions that compose the adult mental health system: corrections and medicine. However, this project began with an interest in patient experiences interacting with medical professionals whilst labeled "psychiatric patient" that was rooted in personal experiences. In order to both understand and analyze the complex interworking of the mental health system, and stay close to patient experiences, I have employed the principles and methods of institutional ethnography.

#### METHODOLOGICAL FRAMEWORK: INSTITUTIONAL ETHNOGRAPHY

Over a three-year period what began as an interview study evolved into an institutional ethnography. The data collection and analysis was never driven by any particular qualitative methodological tradition. I followed what interested me most in the various settings, and I endeavored to understand them in ways that made most sense to me to further investigate and understand the mental health system.



An institutional perspective drawing from the institutional ethnographic method allows researchers to examine aspects of individuals' lives that are considered problematic and understand them through uncovering existing power structures which may be known or unknown to the individuals. The purpose of institutional ethnography (IE) is "to uncover the macro foundations of a micro sociology" (Burawoy et al. 1991:282) by examining macro systems and processes while still keeping the individual, micro-level in mind (Campbell & Gregor, 2004). Health research is one area for which IE is particularly well suited because decisions and policies made in any institution are partially directed by decisions and policies made at other levels, which have direct implications on individual behaviors:

A health care system's constitutional and regulatory specificities – including policy and financing, monitoring and reporting practices, scientific therapeutic, and professional discourses, and the design and implementation of management and accountability measures, create its particular shape. It is that range of institutional effort that establishes how any participant in the system, whether policy-maker, administrator, health care professional, health care recipient, or other, is expected to and does orient their respective health-related actions. (Campbell, 2010:499)

Over the next five chapters, I will alternate between working from the macro- (state and federal government) to micro-level (inter- and intra-professional and professional-consumer interactions) and vice versa. As mentioned in the previous chapter, a multi-level approach is crucial in developing a more complete understanding and analysis of an institution. By taking multiple levels of analysis under consideration, I can unveil and demonstrate "just how [mental health professionals'] doings in the everyday are articulated to and coordinated by extended social relations that are not visible from within [Elkgate] and just how [professionals] are participating in those relations" (Smith 2006:36).

Another defining feature of IE is its focus on power within relationships. Building from feminist methodologies, when pioneering the IE methodology Dorothy Smith strived to create a

research method that examines macro-level realities that result in micro-level power relationships and “takes the standpoint of those being ruled” (Campbell and Gregor 2004:17). In order to accomplish this, institutional ethnographers often begin projects in settings in which they are already a participant or are already familiar with the setting’s institutional order, so they can identify the ruling relations present and from whose standpoint the research will take.

Through the evolution of the project from an interview study to its current state, my focus has always been on consumers. What began as examining patient experiences from their perspectives became an examination of the interactions within the mental health system and its institutions between professionals and consumers. Then, once I began considering professional perspectives more, I became aware of the power relations between them and their organization’s expectations of them, and state and federal-level forces impacting their autonomy in decision-making. Although the current project’s focus is on the organizations and professionals, and is missing the voice of consumers, I argue that consumers have not been left out. The purpose of examining a system and its organizations and professionals is to understand the backstage (Goffman 1959) interactions, and meso-level (organizational, inter-organizational, and community) and macro-level (state and federal government) influences on providers, which strongly impact their interactions with consumers, and therefore consumer experiences.

Since I came to the setting with the experience of a patient, I could not ignore that standpoint; however, because consumer voices are not represented here, I cannot claim that this is for consumers in the same sense as Dorothy Smith referred to her work as “sociology ‘for women’” (Campbell 2006:91). Nonetheless, I would argue that the consumer’s perspective should always be under consideration when we examine any system or procedures that aim to offer a service because the consumers are the target population. Therefore, by examining the

complexities of the mental health system and the power relations its professionals have to negotiate, I can offer insight to consumer-professional interactions and consumer experience. Using frontline professionals, as I've done here, in order to understand institutional elements both above (inter- and intra-organization, and policy) and below (consumers) them is a common practice in IE. "[Frontline professionals] are especially important [to institutional ethnographies] because they make the linkages between clients and ruling discourses, 'working up' the messiness of an everyday circumstance so that it fits the categories and protocols of a professional regime" (DeVault & McCoy 2006:27).

Whereas my project aims align with IE, some would argue that my data collection techniques are IE adjacent. Traditional institutional ethnography is primarily textually driven based on "the recognition that text-based forms of knowledge and discursive practices are central to large-scale organization and relations of ruling in contemporary society" (DeVault & McCoy 2006:33). The research process is focused on official documents and texts to unveil institutional order and power, and the researcher follows a paper trail asking, "What documents go where?" "Who fills them out?" "Who reads them?" "How are they used to assign meaning to an event?" "How are they interpreted?" My research does include examination of some archival records and textual analysis of official documents, but these documents did not drive data collection. In fact, the opposite is true: interviews and observation drove my data collection and directed me to the relevant official documents. In this way, my data collection does not align with the traditional IE data collection procedures; however, mine is also not outside its realm.

Although the cornerstone of performing IE is document analysis and following documents' paths through an organization, both interviews and observation are prevalent, and accepted, elements. Most IE research, including Smith's work (ex. 2002), involves

“interviewing...in some form” (DeVault & McCoy 2006:22). IE interviewing includes formal, planned interviews, though many are “perhaps better described as ‘talking with people’” (ibid) in both observational settings and the researcher’s everyday life: “because institutional ethnographers are investigating widespread institutional and discursive processes in which the researcher is located as well as the informants, opportunities to talk with people about institutional processes can arise for the researcher serendipitously, as it were, in her or his daily life” (DeVault & McCoy 2006:22-3).

In the following section I will explain both my intensive and unstructured interviews for this project. The unstructured interviews were conversations with a variety of professionals during observation. Additionally, I used my experiences and standpoint as a psychiatric patient to become involved in a variety of mental health advocacy efforts in the community that were not intended to be research activities. Becoming involved with these groups, situations arose where I was able to discuss aspects of Colorado’s mental health system outside my formal field research. Finally, formal observation is also widely recognized as an important aspect to IE because it offers researchers the unique opportunity to “[explore] the social, *in motion*, as an ongoing concerting of activities,” which “is foundational to the social ontology of institutional ethnography” (Diamond 2006:60, emphasis in original). This project uses observation to examine how organizational interactions and professional practices play out in the field.

Although I have not made textually mediated social organization, or the question of how texts coordinate individual actions (Smith 1987) the primary focus, I have produced a project that follows the principles of IE in two ways: 1) the process through which I developed the project and proceeded through data collection with an eye on power relations both within and across levels of analysis aligns with the theory and ideology behind IE, and 2) all the accepted

data collection techniques are represented. Through a triangulation of observation, interview and textual analysis, institutional ethnography “attempts to discover and analyze institutional relations of power” (Campbell & Gregor, 2004:40) thereby uncovering how individual behaviors and decisions are “dominated and shaped by forces outside of [the individual]” (Ibid:24). This three-pronged approach to data collection allows a researcher to understand how individuals perceived their actions through the interviews, how individuals are told how they are supposed to act through textual analysis, and also how individuals actually behave through observation. Through an examination of the institution in terms of how it shapes individuals, institutional ethnography does not focus its research on the individual, yet “the individual does not disappear” (Smith, 2005:59). I have accomplished these goals through my data collection and analysis of my setting.

## RESEARCH SITE

Although this is a multi-site project composed of the various organizations, the data were collected in a single town, Elkgate (pseudonym),<sup>13</sup> over the course of a year. The single city approach does make the project a case study of a single mental health system, which was necessary based on time and resource constraints. Additionally, there are innumerable mental health systems across the United States, which further supports a case study approach. Individual states and the District of Columbia work within regulations set by the federal government to autonomously administer and direct funds to publically provided mental health care and regulate the private insurance industry. This creates 50 permutations of mental health systems, which are further individualized at the community level (often by county) by access to and availability of medical mental health services, and the culture of local correctional agencies regarding citizens

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<sup>13</sup> With the exception of the state of Colorado, all locations, organizations, and individual names have been changed to protect participants’ identities.

with mental illness. Nonetheless, a case study approach to a system as universally fragmented and agreed upon as in need of a structural and policy overhaul as mental health in the United States is appropriate in order to acquire an in-depth examination of common issues, and how they play out in this setting (Sjoberg et al. 1991).

At the outset I chose the town for the project primarily due to convenience, and because it contained all the requisite organizational elements (jail, hospital, police department, and outpatient public and private mental health providers). However, as the research progressed, in many ways I came to consider the city of Elkgate as a “city organization,” as the impact of its social and political contexts on the organizations became more evident. Elkgate is a mid-sized Colorado town with a population of about 100,000. In addition to its stable population, there is also a significant rotating population of students who attend one of its two universities, a large transient homeless population for a town its size, and a number of upper-class dwellers who split their time between Elkgate during the summer months and elsewhere over winter. Although there is a range of socio-economic status, the town is disproportionately upper-class and highly educated, making the gap between the average resident and the transient population that much more stark. A significant feature of Elkgate, which may mediate relations between the two groups, is the town’s leftist political leaning that leads to services and individual acts of charity that may not be as common in other cities (this will be examined and questioned in Chapter 6).

In regard to mental health services, Elkgate is home to the main campus of the area’s Medicaid-contracted<sup>14</sup> Community Mental Health Center (MHC), and one of the highest number

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<sup>14</sup> Medicaid is the federal health insurance program, run jointly with each state, for low-income Americans. Because Medicaid is federally overseen, though state run, each state’s program is different, and may offer more than the federal minimum requirements for eligibility and care. See chapter 5 for a detailed discussion of the specifics of Colorado’s Medicaid mental health program.

of mental health counselors per capita in the country. Based on the combination of large populations noted for high service use (college-aged and transient), and number and types of services available, Elkgate is a strong subject for a study of a mental health system in action.

## DATA COLLECTION

Switching from interviewing patients to examining the mental health system as a whole created some additional difficulties in the research process. Whereas patients could be approached through support groups and advertising in a variety of public forums, the mental health system is composed of various organizations, each with official gatekeepers, which meant I had to gain entrée to each individually (Morrill and Fine 1997). Additionally, whereas I could approach the patient interviews as an insider through self-disclosure of my psychiatric patient history, I was an outsider to all of the organizations (Loftland et al. 2006) and felt that the same disclosure was more likely to be damaging than helpful. The research process and issues were unique to each organization; however, data collection techniques were very similar, using a between-method triangulation (Denzin 1970) of intensive, semi-structured (meeting someone strictly for the purpose of an interview) and informal, unstructured (impromptu interviews during observation) interviews (see Table 1) (Loftland et al. 2006), observation, and archival records.

Table 1: Informal and formal interviews by agency affiliation (observations not included)

Agency	Informal Interviews	Intensive Interviews	Totals
Police	13	2	15
Jail	3	2	5
Hospital	2	2	4
Mental Health Center	1	3	4
Outpatient provider (non-MHC)	0	6	6
Totals	19	15	34

Intensive interviews were planned in advance with the participant over phone or e-mail. I met participants at a location of their choosing, which included coffee shops, their workplace,

and restaurants. Through a small grant from the Department of Sociology, I was able to offer participants \$20 cash or provide them with a meal in exchange for participation. All but three rejected the offer. Participants signed a university ethics committee approved informed consent form before the interview began. On two occasions participants verified that the interviews were confidential and their identities would be protected, but none asked to end the interview, request that I not audio record the conversation, or refuse to answer a question. I used a semi-structured interview format with a separate interview schedule for each professional category (jail, police, community mental health and hospital – see Appendix B through E for the full schedules). Interviews lasted between 55 and 130 minutes. I conducted informal interviews during observation with the police department. Participants did not sign an informed consent, but the police department was aware of my presence and research and participated in the ethics committee review process by providing a letter indicating from the Chief of Police indicating that the department was aware and cooperative with the project. Further, each professional informally interviewed was made aware of my role as a researcher and the project prior to the discussion. These interviews typically took the form of a discussion rather than an interview, were not audio recorded, and were much briefer than the intensive interviews, lasting between 15 and 30 minutes.

Between-method triangulation across the four data types affords greater reliability to the data because “the flaws of one method are often the strengths of another” (Denzin 1970:244). For example, interviews are inherently biased because they reflect one person’s perception. An issue with asking professionals about procedures and events on the job is participants may give you an ideological, or by-the-book, response, when that is not what actually occurs. I could overcome some of these issues by crosschecking interviews with observation as well as, in some



cases, the official documents where the policy is written. This afforded my data greater reliability. I could understand how professionals perceived their actions through the interviews, how professionals are told how they are supposed to act through textual analysis, and also how professionals actually behave through observation.

### *Police*

Depending where you are in Elkgate, one of three police departments has primary jurisdiction. The larger of the two universities in town has its own department, University Police Department (UPD). Although UPD's jurisdiction ends at the edge of university property, the department also patrols and offers assistance to the residential and commercial areas surrounding the university. Elkgate Police Department (EPD) has jurisdiction within Elkgate's city limits, which means that their territory overlaps with UPD. Lastly, Colorado State Patrol has statewide jurisdiction. All three police departments interact within Elkgate and often work together on calls. Although I did have interactions with officers from all three departments, I targeted EPD for my primary department contact because they would give me a cross-section of Elkgate from a police perspective.

Gaining access to EPD was the most straightforward of the organizations. The department has a ride-along program open to the general public that allows citizens to ride with a patrol officer for a portion of any of the three patrol shifts: day (6am-4pm), swing (3pm-1am), or night (9pm-7am). I planned on using this program as my initial entrée to EPD; however, the university's Institutional Review Board wanted me to get explicit written permission from the department that they knew I was using the ride-alongs for research and they approved of the project. In seeking approval from the Chief of Police I also discovered that the ride-along program typically only offers one ride-along per resident per year. After a number of back-and-

forth phone calls and e-mails with the Chief and his administrative assistant, I was able to negotiate approval for ten ride-alongs: one per month for ten months.

My ride-alongs totaled 80 hours of observation with EPD. I rode with officers as long as they would let me on a given shift, which ranged between four and nine hours. The ride-along application form states that ride-alongs last five to six hours. Some officers would bring me back to the station and inform me that the ride was over in that timeframe, whereas others asked me how long I wanted to ride with them. Each ride-along was with a different police officer. The officers I rode with were all different in their years of experience; opinions on social, political, and police-related matters; views on mental health and illness; and background. I did not receive any statistics on the police department; however, the variety across officers I rode and/or interacted with leads me to believe that my data represents an adequate cross-section of EPD's officers. The officers I rode with ranged in experience from 11 months to 35 years; there were three women and seven men. Three had completed specialized mental health training. EDP is in the minority of departments in the U.S. that requires new recruits have a Bachelor's degree. Many patrol officers have a Master's degree, and some sergeants and other upper administrators have a Ph.D. Only the most senior officers I rode with, who were hired prior to the Bachelor's requirement, did not have a post-secondary degree.

Over nine ride-alongs I observed all of the regular patrol schedules (2 day shift, 5 swing shift, and 2 night shift), and covered all of the primary, assigned patrol districts in the city. The other ride-along was with an officer on a special unit that works from 10am to 8pm because the unit is mostly on-foot (as opposed to in a patrol car) in a busy pedestrian area of Elkgate.

At the beginning of each ride-along I reported to the police department 15 minutes before the scheduled ride and told the person working at the lobby front desk my name and that I was

there for a ride-along. I was then told to wait in the lobby for an officer to come get me after shift report (briefing of main events of the prior shift, persons of interest to keep an eye out for, and any other administrative information relevant to the shift). I wouldn't know who was assigned to me until an officer would emerge from a locked door separating the lobby from the rest of the building, which was restricted access and required an ID badge. Although I did ask a few officers, I never got a clear answer to how riders are assigned. I did not have a say in the officer, or district; however, I was able to choose the day and shift of each ride. I used this flexibility to ride all shifts and a combination of weekdays and weekends, but did pick more weekends and swing shifts after discovering through experience, and speaking with officers, that these were generally the busiest. Observing each shift was valuable because shifts and districts are assigned annually. Officers put in requests, and duties are given based on seniority. This creates a distinct culture and character to each shift; the night shift is disproportionately younger officers, day shift older, and swing had a combination of the two. This was partially due to the undesirability of night shifts, and how much action officers wanted to see: day shifts are generally the quietest, and the older officers I spoke with were content with shifts that were more commonly quiet, whereas younger officers wanted more action.

While in the patrol car with the officer I wrote jottings in a notebook (Emerson, Fretz, and Shaw 1995), which served to refresh and provide additional detail to my mental notes (Loftland et al. 2006) when I wrote fieldnotes within a day of the shift. After completing my ten ride-alongs I had over 100 pages of typed fieldnotes. For the first few ride-alongs I wrote extremely detailed notes. This was the first time I had spent that much time with a police officer, and ridden in a patrol car, so I tried to capture as much as possible whether related to mental health or not. After the third ride I began writing fieldnotes more selectively. Although I did not

yet know exactly what the themes were, or where my analysis would focus, I was sure that things like responding to an uneventful noise complaint or traffic stop were unnecessary to document.

Ride-alongs gave me many opportunities to conduct impromptu, informal interviews (Loftland et al. 2006). On every ride-along my intent to collect data, as well as the project topic, were established within the first 10 minutes, and officers were aware that I was taking notes periodically throughout the shift. Nine of the ten ride-along officers were very talkative and volunteered a great deal of information, told stories of memorable calls, and were happy to answer questions as we patrolled neighborhoods, so the interviews had the feel of a naturally evolving conversation (DeVault & McCoy 2006). Since many of the officers I rode with had advanced degrees and were familiar with academic research, it was not uncommon for officers to ask more about the project's methodology and preliminary findings. I used these opportunities to test out early patterns, themes, policy proposals, and theory, and elicit feedback from participants (Denzin 1970).

During quiet shifts most officers seemed empathetic that I wasn't seeing any action, and would go out of their way to bring me to people I could speak with including other officers, ER nurses, detox and jail employees, and, on one occasion, a chronically mentally ill transient in recovery. On these occasions the officer acted as a key informant, introducing and vouching for me to the individual(s), and explaining my research and why they thought the person would have information for me. During the interviews I took notes when possible, and included the discussion in that shift's fieldnotes. None of the informal interviews were audio-recorded. Finally, six of the ride-alongs also granted me access to observe Elkgate's emergency room or jail from the police officer's perspective. I was unable to gain observational entrée in either

location through the hospital or jail administrations, so ride-alongs became critical to both observing these settings and inter-organizational interactions in action.

Spending four to nine hours with a single officer gave us a lot of time to interact with one another. With the exception of one officer who spent the majority of the ride on his cell phone dealing with what sounded like family issues, officers appeared receptive to my presence, but the rapport with each was slightly different. Outside of the police officer role, the two youngest officers I rode with could have been my peers. Both were within two years of my age, one being younger, and those rides (both night shifts) were the most enjoyable and social because the conversation never felt forced, and we discussed topics outside of just policing and my research. After a few hours with both these officers it seemed as though we became very comfortable with one another, and, while patrolling between calls or when the officer decided to take their meal break, it did not feel like there was the civilian-officer status differentiation. This was especially beneficial when interacting with other on-duty officers. For example, one shift Officer Marsh and I were sitting in the patrol car positioned outside a downtown bar just after 2am, when bars close in Elkgate, when a EPD SUV pulled up alongside us carrying one of the only 2-officer patrol units. Officer Marsh and the officers in the SUV were discussing that downtown was surprisingly calm for a Saturday night, and joking that everyone was tired after fighting the night before (Officer Marsh had informed me earlier that the previous night had been extremely busy and that she personally had to break up multiple fights) when one of the officers in the SUV made a comment about “cap[ping] some asses” if anyone were to give her a hard time tonight. As soon as she made the comment, this officer noticed me sitting in car, stopped the conversation, and asked Officer Marsh if I was a “recruit or a rider.” Once she found out I was a civilian rider, she spoke directly to me, clarifying what I had already gathered from her tone, that

she was joking, stating “she didn’t want to shoot anyone and she really likes the citizens in Elkgate” (ride-along fieldnotes). Before I could get the words out that I knew she was joking, Officer Marsh told the officer “it’s okay, she’s fine” and said that if she was at all concerned about my reaction, she would have signaled that to them. Although I was not ever expecting to be anything but a peripheral member researcher (Adler and Adler 1987) because I was not an officer and had not received police academy training, situations like this one indicate that I was a ‘social’ member to some officers, meaning I was “accepted as [a regular] in the social crowd” even though I could not participate in police work (Adler and Adler 1987:38).

On the other end of the continuum, there were officers who placed me in a ‘researcher-member’ role (Adler and Adler 1987) where I was a complete outsider (Loftland et al. 2006) The two ride-alongs I felt this most was with senior (25+ years on the force), male officers who had children around my age or older. On both these rides the officer and myself would discuss topics related to my research, they ask me for my opinion on a topic, and would dismiss my opinions as idealized or naïve in their responses. What made these situations particularly difficult was that it didn’t appear as though I had any control over my range of roles. Officers assigned me the role, which seemed to be highly influenced on their perception of our social distance; age being a major determinant. The finite and predetermined time I had with each officer presented an additional challenge to my relationship with officers. I did see some of the officers I had rode with on subsequent shifts, but never rode with the same officer twice, and the interactions were limited to responding to the same call, or crossing paths on patrol and at the station.

Another aspect that made my interactions with these officers more challenging was the officers’ desire to talk politics. The majority of ride-alongs were spent alone with the officer patrolling their district. With this much time together in a car, we would have conversations

about a variety of topics outside of the scope of mental health and police work. My approach to all the ride-alongs was to follow the officer's lead: more talkative officers asked a lot of questions about me and seemed to want to get to know me and chat about a wide variety of topics, whereas others were content riding in silence. Knowing I was a graduate student, most officers asked me very early on in the ride-along where I was from. In my ten years being a Canadian in the United States, I've learned that saying I'm from Canada generally leads into a joke about Canadians, questions on Canadian geography, and/or the person telling me about their "Canada connection." This was often each officer's initial response, but over the course of the ride-along, my nationality seemed to gain significance. The time period I did ride-alongs coincided with the on-going Affordable Care Act<sup>15</sup> rollouts, discussion, and debate, and many of the officers I rode with wanted to know my opinion on Canada's versus the United States' healthcare systems.

This and other political questions from officers put me in a difficult position where I felt I had to tread lightly. In my researcher role I did not want to say something that would risk the officer acting differently with me, or saying or not saying something, because of our shared or opposing political ideologies (Pepinsky 1980). Oftentimes politics did not come up until I had spent a few hours with the officer: I had a feel for them, our relationship, and felt I knew how much of my opinion I could put in my answer, yet still present my response as neutral as possible. Other times I was amazed at how quickly officers wanted to talk healthcare and

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<sup>15</sup> The Affordable Care Act, commonly referred to as "Obamacare", represents some of the broadest changes to the United States' medical system in decades. Some of the provisions include limits to insurance companies' ability to deny coverage, a private insurance marketplace, expansions to Medicaid and Medicare, and a highly contested individual mandate requiring all persons to carry some form of health insurance. Signed into law by President Obama in March 2010, the Act's provisions were gradually implemented between September 2010 and January 2014.

politics. For example, after telling one officer I am from Canada, he immediately asked me what I thought about “socialized medicine.” We hadn’t even left the parking lot of the police station. In this situation and others where I hadn’t yet established any kind of relationship with the officer, I used the question as a clue of where the officer stood (in this case, “socialized medicine” was all I needed to know that Officer O’Keeley was significantly to the right of myself politically, which proved correct), and would answer as vaguely and neutrally as possible. I told Officer O’Keeley that the systems were very different and there were positives and negatives to both. Other sociologists (ex. Pepinsky 1980) have reported very similar personal and ethical dilemmas as a researcher riding with police officers, which leads me to believe they are somewhat unavoidable in this situation with this population.

Finally, another ethical issue I faced was with the public with whom the officers and I were in contact during ride-alongs. When officers interacted with the public, I was a silent observer. People would either ignore me entirely or ask who I was and what my position was. When people asked, I would say that I was doing a ride-along and assure them that I was professionally unaffiliated with the police. Generally the officer would also step in and tell them the same thing, though on a few occasions the officer would answer the person before I could. In these scenarios the officer gave vague answers like “she’s just riding with me today” or indicate they should be ignoring me, like when one officer told an individual who was getting upset with the officer “forget about her. Don’t talk to her.”

Members of the public we contacted never knew I was a researcher, and some of them were under the impression that I was a plainclothes officer, detective, or even the officer’s boss, due to their own assumptions and the officers stepping in and neither confirming, nor denying, them. Since some citizen behavior and comments are part of my data, this may raise some ethical



questions, because none of the citizens were given the opportunity to give consent and were not aware that research was taking place. However, I argue that these police interactions represent a quasi-public setting (Lofland et al. 2006). None of the observed interactions with citizens were in private locations. However, they were also not fully public settings because the spaces become police-mediated. The majority of police interactions I observed occurred in public spaces where other bystanders could also observe the interactions, although in most scenarios officers tried to establish space between the citizen contact and the general public in the vicinity by directing people away. While the general public was ushered away from the scene, officers allowed me to follow them to the scene in every interaction with the exception of traffic stops and two incidents when we were dispatched to arrive on the scene with lights and sirens. In these instances the officers instructed me to stay in the car because of the higher risk of the situations. Finally, police interactions can also be considered a public setting because any interactions due to criminal activity become public information through local newspapers' crime blotter and publically available reports.

The opportunity for observation afforded to me through ride-alongs was a critical component of data collection. These rides were the only time I was able to see any of the organizations in action and observe inter-organizational interaction between police departments, EPD and Elkgate General Hospital (EGH), and EPD and the jail, which gives more reliability to the intensive and informal interviews (Lofland et al. 2006) with professionals across the mental health system. Although ride-alongs were through the police, calls that brought us to EGH's emergency room with individuals in psychological crisis or to investigate possible assaults gave me the opportunity to observe the ER and its patients. The rides resulting in arrest brought us to the jail, where I observed the intake process. On two separate quiet shifts officers brought me to

the jail for a tour where I was able to see the cellblocks, including the Special Management unit, where inmates with severe mental illness who are unable to manage in the general population are kept, and speak with cellblock deputies. These opportunities allowed me to use ride-alongs as a point of observation of the correctional and medical inpatient mental health systems in addition to police interactions with individuals with mental illness.

One potential risk of using the police for access to the rest of the system is the potential of becoming biased: favoring the police perspective and interpretation of the mental health system over those of the other organizations. Admittedly, my general impression of police did become more favorable over data collection when compared to my understanding before the ride-alongs, but I do not believe that my data or analysis offers evidence of bias for the police perspective. Going into the field I had a strongly held negative view of all police and their dealings with individuals with mental illness from my reading, knowledge, and advocacy efforts surrounding mental illness, which often painted police as woefully uninformed on mental illness. In speaking with EPD officers, I saw the range of officer knowledge and attitude toward mental illness and the subpopulations of individuals with mental illness. Although a few officers did fit my preconceived notions of officers as uninformed on mental illness and the mental health system, and appeared, at times, apathetic toward individuals living with mental illness; the majority of officers displayed a level of knowledge and empathy I had not anticipated. Considering my personal bias against the entire correctional institution and its treatment of individuals with mental illness upon entering the field, if a medical organization had provided me with the same entrée to the mental health system and its inter-organizational interactions, this dissertation would present a biased account of the system. Observing the system through police entrée gave me a more neutral perspective of the mental health system, which allowed me to

consider the perspectives of all the professionals with equal weight. Additionally, my analysis in the next four chapters, where I present and critique correctional and medical perspectives equally, further supports a lack of bias in favor of the police perspective.

Although ride-alongs made the police a unique focal organization in regard to data collection, I conducted intensive interviews and collected archival records in a similar manner to the other organizations. Since I interviewed every officer I rode with, and interacted with many others during observation, there was less need to conduct intensive interviews with police than with professionals in the other organizations. The two intensive interviews I did were with officers who had completed and then advanced in Crisis Intervention Training (CIT), meaning that they were certified to assist or lead the training. I met Officer Sarnecki during one of my ride-alongs, and asked him if he would be willing to be interviewed after he told me about his CIT qualifications. We met in the empty lobby of the PD and spoke for 75 minutes. Officer Marsh is the only non-EPD officer I interviewed, intensively or informally. She was referred to me by EPD officers as someone extremely knowledgeable in CIT with a lot of experience. I contacted her via her work e-mail, told her about the project, mentioned the referral officer by name, and asked for an interview. We met at a local coffee shop and had the longest interview of the project, nearly 2.5 hours. In both interviews I asked questions about their personal experiences in situations involving a psychological crisis, their role in regard to mental health in Elkgate, their thoughts on the inter-organizational interactions in which they are involved and perception of inter-organizational co-operation in Elkgate. I also asked Officer Marsh to explain CIT in detail: what it is, how it works, who takes it, who pays for it.

Finally, I collected archival data from EPD during ride-alongs. Over the course of a ride I would ask for any document I felt was pertinent to the processing of an individual with mental

illness who makes contact with police. Officers never indicated there was an issue with giving a civilian any of the documents, gladly gave me a copy, and explained who filled out what portion and the information required. All the forms I received were unused, so there was no issue of citizen privacy or confidentiality.

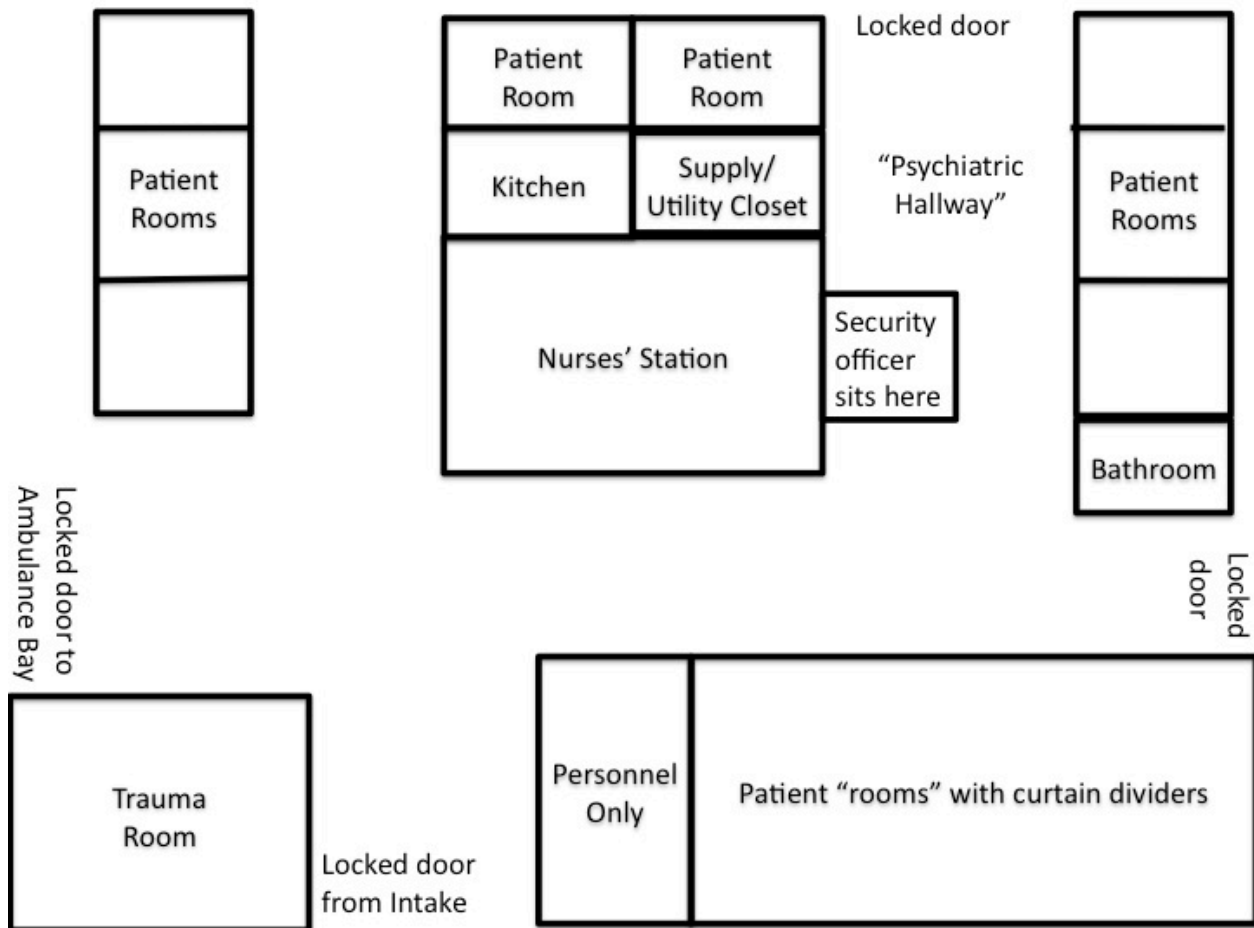
### *Hospital*

Elkgate General Hospital (EGH) is the only hospital in Elkgate, and has two campuses in town and an assortment of outpatient clinics. All data were collected at the main campus, which holds the larger ER, and all in-patient units, including a locked, 15-bed psychiatric unit. I decided to use the ER of the hospital rather than its psychiatric unit for three reasons. First, access to the latter would have been extremely difficult to negotiate. Psychiatric in-patient units are notoriously difficult to gain access to as an outside researcher because psychiatric patients represent a vulnerable population with a history of abuse in the name of research. Without any association with the hospital or psychiatric unit, and no personal connection to any doctors or administrators, gaining access within a reasonable timeframe was improbable, whereas I could gain access to the ER through ride-alongs. Second, the ER was a better site to capture inter-organizational interactions. This is where patient responsibility changes hands between organizations, and police, jail deputies, outpatient providers, and hospital employees are most likely to interact with one another. Once patients are admitted to an in-patient unit the inter-organizational interactions are isolated to the medical side of mental health, and will only include police or jail in the case of a criminal event on a unit. Finally, the ER is where the decision to admit a patient is made, which was a topic that still held my interest.

EGH's ER is divided into two spaces, intake and treatment. Non-emergent patients enter the ER through the front doors and check in at one desk, then will speak to a second nurse at a

triage desk, where they do an initial assessment and information gathering, including insurance information. Once patients are checked-in and triaged, they are directed to a seating area outside a set of locked double-doors that lead to the treatment area. A nurse calls patients back to the treatment area and leads them to their bed (see Figure 2). The treatment area is secure: all the doors to other areas are locked. Hospital staff have to let all visitors in and out by placing their personnel badge in front of a small, square, grey scanner on the wall next to the doors.

Figure 2: Elkgate General Hospital's Emergency Room Treatment Area



The treatment area has three corridors with the nurses' station in the middle.

As you walk in there is a trauma room to the left and doors leading to the ambulance bay to the left of that. To the right is a room with computers and light boxes for doctors to examine test results and a closed-off break room and staff bathroom (labeled “Personnel Only” in Figure 2). Right of that is the largest room that can hold multiple non-critical patients separated into individual areas by curtains. Straight ahead is a nurses’ station with a 4-foot partition around three sides to denote a private space that is still open for staff to monitor the area. The nurses’ station is sandwiched between two short hallways, each with three individual patient rooms. At least one security guard is in the emergency room at all times. When security guards are not roaming the ER, they are stationed on the left side of the nurses’ station in front of a computer monitor where they can bring up video from any of the security cameras located in the hallways and each patient room. Ideally, psychiatric patients are placed in the rooms in hallway by the security guard for additional monitoring, and so they can be isolated from other patients, yet grouped together. For this reason, these rooms are sometimes referred to as the “psychiatric rooms,” but the rooms themselves, and the equipment in them, are no different than the other patient rooms. When this hallway is full, they will place psychiatric patients in one of the private rooms in the parallel hallway. When all the private rooms are full, the ER will go on deferral, and psychiatric patients are taken to another ER.

Ride-alongs brought me to the ER on four occasions: twice to investigate alleged assaults, once to transport a woman to detox, and once taking someone on a psychiatric hold. Depending on the call and how busy the shift was we stayed at the ER between 20 minutes and 2 hours. I used the time to observe interactions between the officer(s) and doctors and nurses, the setting itself, and, for psychiatric patients, any discussions about the patient between hospital staff. The call involving the psychiatric hold had the officer and myself at the ER the longest, not

because the call necessitated it, but because the officer knew my research interests, and it was not a busy shift, so we stayed much longer than he would have otherwise. During this call, the officer brought a teenager to the ER who was placed on a psychiatric hold. While we were there, the officer introduced me to two nurses who had the time for an informal interview, at which point two State Troopers brought in an aggressive psychiatric patient via ambulance who was acutely psychotic, restrained to the bed with a spit mask, and speaking in nonsensical letters (“A-A-A-B-B-C-C”).

Apart from observation and informal interviews, I did formal interviews with one nurse and an ER mental health evaluator. The nurse did not work at EGH, but had worked at one of the state psychiatric hospitals, and was currently working at an ER in another city in Colorado. I met her doing mental health advocacy work in the community, and she provided a lot of information regarding psychiatric nurse training, the atmosphere of ERs and the role and difficulties of psychiatric patients in it. Although she was unable to comment on EGH specifically, she did provide a lot of context on common procedures and attitudes she had experienced. When cross-checked with the EGH interviews and observation, I believe a lot of what she said did also apply to the Elkgate context. I obtained the evaluator interview through a mutual friend who is a doctor at EGH. He connected us via e-mail and we were able to set up an interview. We met for the interview in her office in the psychiatric in-patient unit, so this also gave me an opportunity to have a quick glance of the unit. During this interview she told me about the assessment process in the ER, what factors into her recommendation for admission, interactions with, and perceptions of police and the jail, personal experiences with patients, and communication with outpatient providers from both the ER and in-patient unit. She also gave me archival records including a blank assessment form they use to determine in-patient suitability, and three

pamphlets they had just received to distribute to ER doctors, patients, and family members of a suicide attempt survivor.

Following my interview, it appeared as though the lines of communication were open with her, and I felt very optimistic about getting interviews with other evaluators and doctors at EGH. I thanked her for the interview and she told me to contact her with any further questions, or if there was anything she could help me with. I tried multiple times to take her up on this offer; however, my phone calls and e-mails went unanswered.

Access to EGH was further stymied after a personal experience at the hospital. Towards the end of data collection I had my own psychiatric crisis that landed me at EGH for evaluation and referral to an in-patient unit. Although I was not admitted to EGH's psychiatric unit (no available beds), I did not feel comfortable approaching anyone at the hospital to request a formal interview, fearing that someone would look me up and see my history prior to an interview. Although I would have preferred to have not had the experience, it did give me an insider, patient, perspective of EPD (police brought me to the ER), EGH's ER and assessment as a psychiatric patient, and an in-patient unit. Ever the field researcher, and partly as a coping strategy to separate myself from the situation, over the course of these events I took research notes from this perspective on my phone in the ER, and on a notepad intended for journaling on the in-patient unit. Although this autoethnographic data (Reed-Danahay 2001) is not included anywhere here, it did serve an important role of keeping patients and their experiences in mind while focusing on the mental health system's professionals, organizations, and policies.

### *Jail*

The county jail located in Elkgate is in its third location, and the second built in order to accommodate an expanding inmate population. Built within the last two decades, the building is



relatively new, yet has already had one expansion, and is consistently over-capacity. During the first ride-along the officer told me that a notice had gone out to officers from the Chief telling them, by Sheriff's order, officers were not to take citizens to jail unless absolutely necessary. Apart from warrants and domestic violence, where officers have no discretion, only violent felony charges should lead to arrest and jail transport.

Elkgate's jail has recognized the increase in inmates with severe mental illness for quite some time. Jail administration has kept statistics on the numbers of inmates with severe mental illness, and percentage of the total inmate population they represent, for about a decade, and has encouraged other Colorado jails to do the same. According to their numbers, Elkgate's jail has a larger percentage of inmates with severe mental illness than the national or state average, at about 25 percent.

In order to more efficiently run the jail, Elkgate jail administration has made attempts to cope with the uniqueness of the mentally ill inmate population. The facility has four licensed social workers (two full time, two part-time), and one part-time nurse practitioner on staff. There is also an established relationship with the Medicaid Mental Health Center: released inmates on psychotropic medications are directed to MHC for follow up, and the jail faxes an information sheet on these inmates' medications and other pertinent psychiatric information there in order to ease transition and maximize efficiency for the released. Additionally, the jail contracts with MHC to provide a psychiatrist twice a week, totaling 6 to 8 hours, so the jail psychiatrist is a MHC employee.

Data collection for Elkgate's jail was very similar to EGH in terms of research access. I was able to do some observation in the context of ride-alongs when we brought citizens to jail, (all for outstanding warrants). When this occurred I observed the interactions between jail

deputies and police, and the paperwork officers had to fill out in order to transfer custody from police to jail. All the individuals we brought to jail were co-operative, so getting them there and into the jail's booking process was uneventful.

I also did three different tours of the jail; two during ride-alongs and one with a group of students as part of the *Crime and Society* class I was teaching. The first ride-along tour and the class tour were somewhat similar. Both were geared towards people outside of the system and seemed aimed to give the best possible version of the jail, its treatment of inmates, and programming available. The second ride-along tour was more directed to the officer I was riding with, who told me he had not been past the booking area. The deputy giving the tour was "a buddy" of the officer, and seemed to act as though I was not there, telling stories of "roughing up" inmates and practices in the high security unit that were not part of the more civilian-directed tours.

Apart from the observation I did an intensive interview with a jail administrator, and mental health provider. I read a local newspaper article where a retiring administrator was asked about challenges the jail will face in the future. In his response he mentioned issues associated with the mentally ill population in jail. After reading this, I was able to find an e-mail contact for him and used the article as a jumping off point to introduce my research and request an interview. Much to my surprise, he responded within a day and put me in contact with the administrator I did end up interviewing. When I arrived for the interview, he had asked the mental health professional to sit in to fill in any procedural or practical gaps about mental health services, practice, and the mentally ill jail population. During the interview the administrator also gave me data from the jail on its annual mental health-related counts including referrals for mental health care, inmates on suicide watch, and completed suicides. Following the interview

the administrator said that he did not have the time that day, but would be happy to give me a tour of the jail and introduce, and let me talk to some of the deputies working in the unit used for seriously mentally ill inmates. I left the interview feeling very hopeful about the potential for a relationship to develop between the jail and myself; however, like the hospital, my repeated follow-up attempts went unanswered.

### *Outpatient Providers*

Outpatient providers represent private and state-provided, or public, mental health care delivery. The data for this group are formal, semi-structured interviews with both types of providers, and archival documents in the form of blank copies of required paperwork. Observing providers was not possible as that would have required observing patient sessions, or discussions between professionals about protected patient information. The public providers in this study work for the Medicaid contracted Mental Health Center (MHC), which has multiple offices and programs throughout the county with its main campus in Elkgate. All Medicaid recipients living in the county receive their primary mental health care through MHC, and are referred out to other services, as needed, by MHC. Whereas public providers are associated with an organization, there is no single organization of private providers. Although some do work in larger practices or provider networks, many have solo practices that are unaffiliated with any larger organization. As previously noted, Elkgate has one of the largest concentrations of mental health providers in the nation. Most of these are private providers who range from unlicensed life coaches and counselors to licensed psychologists, social workers, and psychiatrists. Depending on the provider, their services may be covered by a variety of insurance types, including Medicaid, or they may only accept fee-for-service.

Since there was no formal organization, private practitioners were, in some ways, the easiest group to gain access to. Once I had a single contact willing to vouch for me I was able to utilize snowball sampling (Biernacki and Waldorf 1981) to find additional participants. Through talking about the project with friends and acquaintances, one of these contacts was connected to a group of social workers in Elkgate who meet monthly to discuss issues related to their work and practices and the social work field. She offered to send a request for participation advertisement to their e-mail list, which got me my first few interviews. At the end of these interviews I would ask if they knew of other people who might be willing to participate, got their contact information, and asked those people. Since my entry point was through social workers, nearly all the referrals were also social workers. I ended up interviewing 5 licensed social workers and one psychiatrist.

I began interviewing MHC mental health professionals in much the same way as the private providers. A friend of mine knew someone who worked in MHC's emergency psychiatric services department who then put us in contact with one another. After interviewing her, I asked if she wouldn't mind distributing a flier or e-mail to her colleagues, which she did. Three more emergency psychiatric services workers contacted me for interviews; however, after completing the first two interviews, I received an e-mail from the head of the department informing me that I could not interview anyone else until MHC had more information about my project. There was also an e-mail sent out to MHC providers informing them that the project had not been cleared by the organization, and they were not to speak with me.

Having been formally blocked by the organization, I spoke with a number of administrators in an effort to gain MHC approval. I met with their research director, outlined the project, highlighting that I was not interested in any confidential information nor was I trying to

Speak with clients, and sent him my University Institutional Review Board human research proposal and approval. I left the meeting feeling extremely hopeful. His reaction was that the project was something MHC would be very supportive of because it was in line with their mission to best serve the community's mentally ill population and support its mental health efforts. He also expressed personal interest, telling me that he would personally connect me with a variety of MHC professionals and department heads. However, he could not give organizational approval on his own. In order for this to occur it needed to be approved by the majority of a group of administrators. He did not foresee any potential for any issues in getting approval, saying that I already had one vote (his), and assured me that he would be in contact within a few weeks. I do not know what ended up happening in that meeting, or if the project was even brought to the necessary group of administrators, because I never heard from the research director again, and, once again, my repeated attempts at contacting him went unanswered.

#### *Other Data Sources*

As I got further along in data collection through the organizations I also became more interested in mental health advocacy and efforts on the state and national levels. On a personal note, I was also working through some of my own mental health history and experiences and wanted to start telling my story to various support groups. Through these efforts I became connected with the Colorado Protection and Advocacy for Individuals with Mental Illness (PAIMI) advisory council, and became a counsel member. Each state has one of these groups, and they act as a federally mandated watchdog organization over state and national policy and treatment of individuals with mental illness. Apart from personal interest and passion, being on

the advisory counsel kept me in tune with the most recent proposals and discussions coming out of the Colorado legislature.

Working with PAIMI made me more aware of the various laws, acts, and other pieces of legislature that directly impact the mental health system's structure. This greater awareness led to more consideration and analysis of legislative documents of Colorado House and Senate Bills and Task Force reports as they related to the observation and interview data from the organizations. These were all publicly available on government websites and gathered electronically.

## ANALYTIC STRATEGY

Formal interviews were audio-recorded and transcribed verbatim. Informal interviews were written up alongside that ride-along's fieldnotes within two days of the ride, both of which included as much detail and verbatim phrases as possible from the jotted notes. I collected and archived archival records in a combination of electronic and paper files. With the exception of fieldnotes from two of my students' police ride-alongs for a class assignment, I did the entire data collection process, transcription, and analysis solo. Throughout data collection and analysis I used memoing (Charmaz 2001; Miles and Huberman 1994; Strauss and Corbin 1990; Glaser 1978) to organize the data into patterns, possible themes, and build theory. Memoing and coding was an ongoing, interchanging process; sometimes memos guided coding and other times coding guided memos.

Analysis in institutional ethnography (IE) is somewhat different from a traditional ethnography due to its approach to data: researchers use data "not as the topic or object of interest, but as 'entry' into the social relations of the setting" (Campbell 2006:92). Data are analyzed by making connections between participants' (in this case, mental health

professionals') lived experiences and perceptions from interviews and observations and social organization (Ibid). I followed this tradition in my analysis where themes evolved from a combination of interviews and observations that I followed as I continued data collection while memoing along the way. By the time I left the field I had a number of possible themes, which were then narrowed down and developed to create the following three empirical chapters through coding.

I coded the data by hand using a combination of inductive coding techniques (Glaser and Strauss 1967; Strauss and Corbin 1990) including in-vivo (Glaser and Strauss 1967), emotion (Goleman 1995; Prus 1996), and descriptive codes (Wolcott 1994). My approach to coding closely resembled Charmaz' (2002) description of a two-step process comprised of initial and focused coding. In initial coding I inspected the data line-by-line and assigned codes. Once complete, this provided me with a very large number of distinct codes that were then selected and combined based on my conceptual framework through focused coding.

From its beginnings to the conceptualization of the following four chapters, this project was 4 years in the making. The following three chapters represent the end result of this set of analysis, and are a minute grouping of themes, theories, and conclusions relative to the number that could be found within the data.

## CHAPTER IV: THE MENTAL HEALTH SYSTEM: INSTITUTIONS, ORGANIZATIONS, AND PATIENT PATHWAYS

In this chapter I will tell the story of the mental health system in two parts. First, I give an overview of the organizations involved and pathways patients can be directed through the system in the event of psychiatric crisis. Second, because the police and ER are the organizations most frequently interacting in these situations, I will focus on police-ER interactions, the frustrations felt toward one another, offer explanations for why these frustrations exist, and their consequences for to the mental health system as well as the population living with mental illness who are directed through it.

Taken together, the two parts address the following research questions: What are the relationships among the organizations making decisions across the mental health system? How do agencies interact, and what are the barriers to communication in these situations? Who informs whom in terms of best practices? By focusing on the answers to these questions, I am able to broaden the scope of the chapter from this mental health system to more unique and complex organizational structures than previously considered in organizational sociology in the chapter's conclusion.

By examining the system through the context of psychiatric crises I can better observe inter-organizational interactions while keeping a patient's experiences in mind. Similar to physical health crises, in psychiatric crisis people and professionals other than the patient make a lot of the decisions on behalf of the patient, hopefully while keeping the patient's wellbeing and best interests in mind. Furthermore, psychiatric patients are legally assessed, held, and treated against their will with greater ease and frequency than physical health patients. In the mental health system, where there are many more players and players much more varied than in the



physical medical system, the inter-organizational interactions are more complex and stakes higher in their outcomes with regard to patient rights and freedom. As a result, by focusing on these interactions while also considering the patient experience, I will present a substantively important topic to those interested in creating an improved mental health system, while also addressing and adding to the extant literature on inter-organizational interactions and negotiations.

When considering mental health systems, there needs to be an acknowledgment of their place across a multitude of public and private agencies and institutions and how patients may funnel through, or avoid, each. From the more traditional providers (psychiatrists, and other dedicated mental health professionals, institutions, and agencies) to the state and federal departments of corrections, the Veterans Administration, housing services, schools, religious communities, and medical doctors, most social agencies perform some degree of mental health management, treatment and care. Due to time and monetary restraints, I was restricted to the traditional and correctional agencies; however, it is important to highlight that these are not the only agencies that have a role in mental health.

With so many separate, and somewhat unrelated, agencies potentially involved in an individual's mental health care, pinpointing a place where they could all plausibly converge becomes critical in order to examine the system as a whole. For individuals in crisis (in emergent need of psychiatric assessment and/or intervention as determined by the individual and/or professional or non-professional others), the emergency room (ER) is that place. At a point when a person's safety is in question (by being a danger to themselves or others, or gravely disabled due to mental illness), professionals in every one of the above listed agencies will refer either to

a local hospital emergency room for evaluation and clearance for inpatient placement, or the police to manage a hostile situation, who also may then refer to the ER.

For individuals in crisis who go to the ER, in most places, Elkgate included, they will go to the same ER where people would go for any non-psychiatric issue; however, in some large cities psychiatric ERs operate to direct these patients away from traditional physical health-focused ERs to a location where all professionals and staff specialize in psychiatry. Patients go to ERs for psychiatric and medical evaluation for psychiatric in-patient admission. It is extremely rare for people to be admitted without going to an ER. Even when patients are psychiatrically evaluated elsewhere, they are still sent to an ER in order to receive a physical assessment and clearance for a psychiatric ward or facility because most psychiatric units will not accept patients whose physiological health would require medical hospitalization. The only people in psychiatric crisis who will not go through the ER are those whom police take directly to jail, and those not considered acute enough for inpatient care by someone outside the hospital. Based on this fact, the ER is an invaluable location to observe the mental health system in action in the context of patient psychiatric crises, and assess intra-system interactions.

## PATHWAYS THROUGH THE MENTAL HEALTH SYSTEM DURING CRISIS

During a mental health crisis, individuals are frequently directed to one of two locations: an ER or jail. As presented in Chapter 2, it is fair to say that jails and prisons are de facto mental health centers: the number of people with severe mental illness in correctional systems outnumber those in mental health facilities in the U.S. This creates the premise for the mental health as a system composed of two social institutions—medical and correctional—explained in Chapter 2.

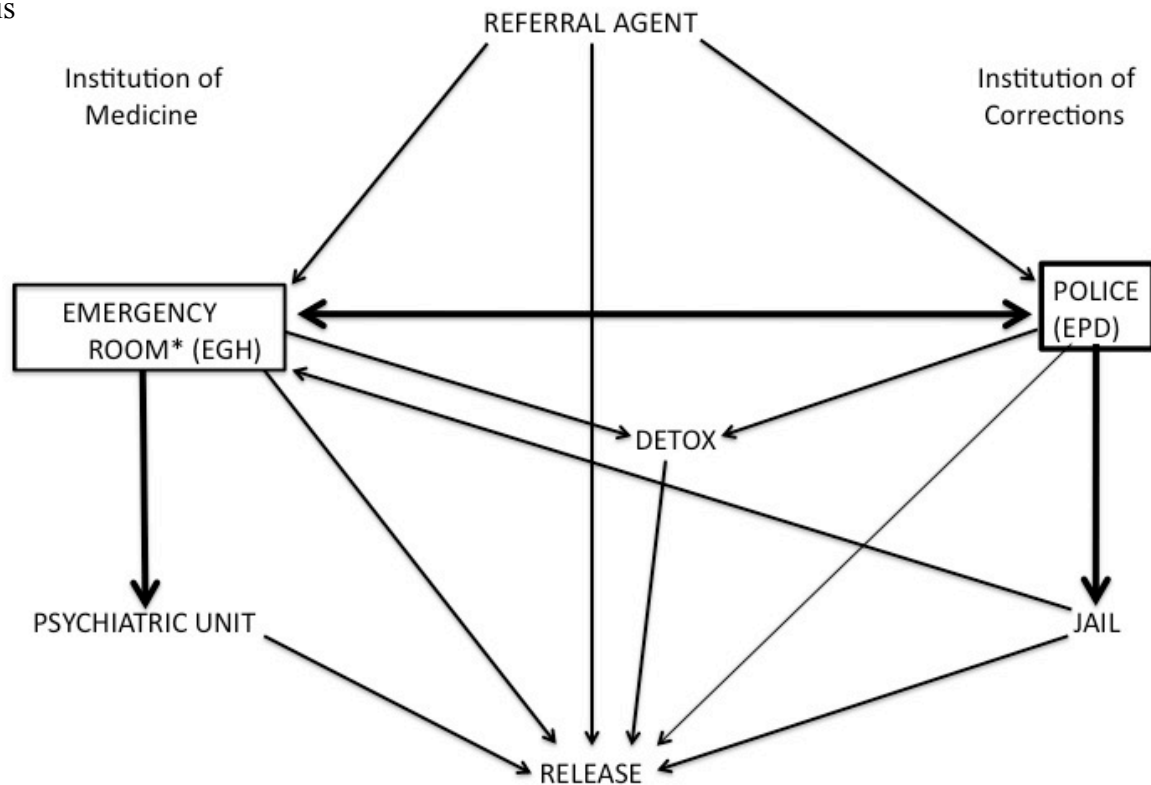
How and why a person in crisis is placed in and processed through the medical versus correctional institutional arm of mental health is important for researchers and community leaders to understand. This information is central to building policy, professional training, and treatment programs that will more effectively defer more people from correctional to solutions within the medical side of the mental health system: an agreed upon goal across correctional and medical professionals (ex. Osher et al. 2012). Jails are of particular interest here because many mentally ill individuals in jails are there for minor crimes such as trespassing, public intoxication, disturbing the peace, and other charges considered nuisance offenses, as opposed to violent offenses that receive the media's attention. In order to decrease this arguably misplaced population in jails, we need to understand how and why police decide whether they will take someone to jail as opposed to the hospital. Granted, there will always be individuals with mental illness who need to go to jail based on their actions; however, the ideal situation would minimize this through a more collaborative and cooperative system that would identify individuals showing signs symptomatic of these acts and funneling them to appropriate resources in advance of the act. By all accounts, the vast majority of criminal acts committed by an individual with severe mental illness occurred following diagnosis and recognition that the individual posed a threat due to a spike of the illness prior to the crime (Torrey 2012). Police, the medical arm of the mental health system, and police-medical interactions before and after a criminal event occurs all play critical roles in explaining the number of individuals with severe mental illness in jails.

The data presented represent Elkgate's mental health system, organizations and professionals. Although each community's system will vary, Elkgate is typical to most others in the major organizations involved, and the role of each. As such, the avenues through Elkgate's

mental health system are similar to most other communities' (Deane 1999; Steadman et al. 2000).

Figure 3 uses Elkgate as a model to depict the major organizations involved in mental health systems, grouped by affiliated institution, and the common pathways through the system for individuals in psychiatric crisis. The arrows indicate both where a patient is transported and represents a point of interaction either between an individual and an organization, or between organizations (bolded). The exception to this is “release” where there may or may not be an interaction with regard to the patient’s mental health.

Figure 3: Organizations and Pathways through the Mental Health System During Psychiatric Crisis



\* Includes players from two mental health organizations: Hospital and Medicaid mental health agency (MHC)

Regardless of the pathway a patient is directed through, the vast majority will reach release in less than a year. Patients directed through the medical institution (ER and psychiatric unit) will overwhelmingly reach release faster than their counterparts in the correctional

institution (police and jail). As I will discuss later, most patients are released directly from the ER. For those who are transferred to a psychiatric unit, nationally, the average hospitalization is 7.2 days (Centers for Disease Control 2010), and rarely exceeds one month. Although the severely mentally ill are disproportionately incarcerated for low-level offenses, they spend more time incarcerated for the same offenses as their counterparts without severe mental illness. On both the medical and corrections sides, there could be a transfer from the institutionalized location to another placement for those who are directed to a long-term placement: from jail to a prison or state hospital forensic unit, or from a psychiatric unit to a long-term facility or nursing home. Some individuals directed to these placements will not reach release. I have omitted them here because neither were considered or included in data collection because they are placements outside the scope of a community-level mental health system. Next, I will explain each label's role with regard to the patient and the system, and offer context to their organizational interactions.

### *Referral Agents*

The referral agent recognizes a crisis, and makes contact with an individual or organization in order to help. A referral agent can be anyone who has contact with the individual including, among others, a friend or family member, health provider, stranger, or the individual themselves. Since I am focusing on organizations that can lead to an institutionalized placement, only the police and ER are represented as possible avenues in the figure; however, a referral agent could choose to contact the individual's mental health provider, a crisis line, or any other resource.

Referral agents may not refer to the hospital or police. If the referral agent believes the person would benefit from available outpatient care rather than hospitalization, and does not

want police involvement, they will be “released.” Any referral agent can make this decision. Mental health or medical professionals are better connected and have the literacy to refer individuals to particular professionals and/or programs; however, a family member or friend may also recognize that the circumstances would be better served through non-hospital or police interventions to which they have access.

If the referral agent does refer to an organization capable of institutionalization, s/he will go to the ER or police. The situation will dictate which agency a referral agent will approach. If the individual in crisis is willing to go, or takes themselves to the ER, police involvement is less likely than if they are not. Additionally, the referral agent’s relationship to the individual will impact the organization to which they refer. For example, a stranger may not even recognize odd or threatening behavior as a psychiatric crisis. If s/he does choose to become involved in the situation, rather than ignoring the behavior, they are likely to call 9-11 and request police presence. On the other hand, a family member or close friend would be more likely to recognize an event as related to the person’s mental illness and actively avoid police involvement if possible. Since referral agents initiate entrance into the mental health system, the actions they take and how they perceive the situation influences whether the consumer’s pathway in this crisis will flow through the correctional or medical institution.

### *Emergency Room*

Depending on the precipitating circumstances and events that led to the patient’s ER referral, individuals will arrive at the ER by ambulance, police, or on foot in the same way non-ambulance physical patients would enter an ER. As previously mentioned, in most places this is also the same ER as physical patients. Once there, patients at Elkgate General Hospital (EGH) are medically assessed by an ER doctor and psychiatrically evaluated by either a hospital or

Mental Health Center (for Medicaid recipients only) evaluator. EGH does have a psychiatric unit, so the hospital has the appropriate staff on location to complete the evaluation. The majority of hospitals do not have a psychiatric unit (American Hospital Association 2007); these hospitals contract with an agency that they call in to complete their evaluations. Agencies work with many hospitals in an area and are not located within any one hospital, so evaluators travel between hospitals or from the agency's location to do evaluations, which can drastically increase patients' already lengthy stay in the ER. Based on the evaluation, patients are transferred to a psychiatric unit or released (I will go into greater depth on this decision later in the chapter).

If released, patients are referred to their current outpatient providers. In cases where patients do not have a community provider, in Colorado patient insurance dictates whether there is a referral upon release or not: Medicaid patients are directly referred to a point of care<sup>16</sup> (Mental Health Center in Elkgate), whereas non-Medicaid patients are referred to their insurance and may, depending on their evaluator, have a direct referral to a psychiatrist (see Chapter 5 for a detailed explanation and comparison of these two systems of care). When I asked an EGH evaluator if she would give non-Medicaid patients a list of community contacts so they would know where to go for outpatient care, she told me:

. . . [providers in the community] may be driven by insurance because, depending on their insurance, the providers on their plan [will vary], so oftentimes they are referred to their

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<sup>16</sup> This will not be uniform across the nation. In many states, including Colorado, mental health care is delivered to Medicaid recipients through managed care organizations contracted by the state for administrative and financial management, and to oversee the provision of all inpatient (18 states) and outpatient (21 states) care. In states where this model is in place, patients will have locations in their region of the state where they will receive their mental health care. In states that have not separated the administration of behavioral health from physical health, Medicaid patients would not have the same direct referral and provider organization observed in Elkgate, and would go through the same process to find a community provider as described for non-Medicaid patients. See Hamblin, Verdier and Au's (2011) *State Options for Integrating Physical and Behavioral Health Care* for a more detailed description of the various administrative approaches to state-provided behavioral health care used in the U.S.

insurance plan to find out who the providers [covered by their insurance] are. We do know lots of providers in the community. . .because I've been doing this for so long, so I know most of the psychiatrists in the community. So I will oftentimes call them to see if they're taking any new patients and let them know that I'd like to refer someone to them, and that's if I can get a hold of them. So, you know, that's an option, too.

Referral of psychiatric patients from the ER to police is less common than police to the ER; however, ER staff will call police based on mandatory reporting requirements (applies to child abuse or endangerment; see C.R.S. 19-3-304 for the full statute), or if the patient commits a crime (generally assault) while in the ER. For example, Officer Sarnecki told me about taking a man to EGH for evaluation. The man had demonstrated aggressive behavior before arriving at the hospital, and while in the ER spat in a nurse's face. He was charged with assault and Officer Sarnecki transported him to jail.

Generally speaking, once consumers arrive in the ER their pathway will flow through the medical institution whether or not they are admitted. Release will look different depending on the evaluator and insurance status. There are no state or federal requirements for what information or services ERs must provide patients upon discharge (League of Women Voters of Colorado 2014). In Elkgate the expected practice is that the patient will be directed to seek services in the community with a medical mental health professional. On the other hand, if a consumer's initial organizational contact is the police, their pathway is less certain.

### *Police*

Police contact is the primary source of divergent consumer pathways through the mental health system. Although there are situations involving individuals in crisis that are obviously criminal (ex. assault with a deadly weapon) or obviously medical (ex. suicide attempt), there are also many situations that fall somewhere in between. Because police are more involved in both the medical and correctional institutions than most other organizations and literally direct people



to one or the other through transport to the ER or jail, in many ways they act as the gatekeepers of both institutions.

Police become involved if the referral agent calls 9-1-1, or a patrolling officer happens upon a situation in progress. Upon arrival to the scene, officers often do not know whether the call is related to an individual with mental illness or not. Officers estimated between 10 and 25% of calls are related to mental illness, yet when I spoke with a 9-1-1 dispatcher during a ride-along she said she would only classify “about 3%” of calls as mental illness related. The discrepancy indicates two facts related to emergency response: 1) A 9-1-1 dispatcher receives a wide array of calls, not all of which are directed to police; and 2) Police will discover mental illness on the scene that was not indicated or known by the 9-1-1 caller. The latter was substantiated during observation and interviews with officers. The discrepancy across police can be attributed to officer variance in awareness and sensitivity to more subtle cues of mental illness, and their ability and willingness to communicate with citizens before imposing a solution on the situation.

Once police conclude that an individual’s mental illness is relevant to a situation, they need to determine the severity of the individual’s current mental state, and determine what should happen, taking into account the circumstances surrounding the precipitating event that initiated police involvement. When I asked Officer Sarnecki, who had done Crisis Intervention Training and was an advocate of the program, how he makes the decision to transport individuals in crisis to the hospital or jail, I barely finished asking the question before he said:

That’s actually very simple. Umm I don’t have the right to take someone to jail who’s not committed a crime. Now, if an individual who is mentally unstable commits a crime, I cannot erase the fact that they committed a crime. I will take them to jail, and then they will have the opportunity through whoever makes the decision if they can be found guilty of that. If a crime occurs, more than likely they will be going to jail. If a crime hasn’t occurred then they will be going to the hospital. . . .So it’s pretty defined.

This response was typical of all officers I interviewed. However, the decision is not as “simple” as Officer Sarnecki states. Many officers, including Officer Sarnecki, gave examples of scenarios when a crime had occurred, yet the officer decided based on the scenario that it would be more beneficial to the person to go to the hospital than focus on the crime. Officer Sarnecki described a recent “. . . call that there was a transient in the library who was approaching patrons explaining to them that if the patrons of the library didn’t give that individual money, that she was going to call the police, and tell them that ‘you sexually harassed me.’” If true, this is aggressive panhandling, which is eligible for a \$100 ticket. Officer Sarnecki spoke with the man who called the police and the woman and found that the event described did occur; however, in his discussion with the woman, her affect “was very spikish” and her explanation for the behavior made him conclude that she should go to EGH for evaluation. Although the facts did indicate aggressive panhandling, Officer Sarnecki explained: “[the woman’s explanation] was a little odd to me, so okay, I understand what I’ve got. This is not aggressive panhandling.”

The distinction between all the examples officers gave like this one and their initial hard line approach to what is a crime is that the examples all involved low-level offenses where the officer uses discretion and chooses to transport the person to EGH over writing them a citation. On the other hand, two officers also described situations where they realized an individual’s actions were due to their mental status, and spoke of regretting that they had to take the person to jail. During one ride-along Officer Hugo told me about a call he responded to involving a veteran who had violated a restraining order his ex-girlfriend had placed on him. The man had forced himself into her apartment, but when Officer Hugo arrived on the scene the veteran was under a table in a fetal position. Officer Hugo explained that it was obvious that he was suffering from severe post-traumatic stress disorder, and the veteran’s father, who had also arrived at the

apartment, begged him not to take his son to jail, saying that he “needed help.” Officer Hugo said that the situation was particularly difficult because he could see the veteran’s need for mental health care, but the man had violated a restraining order and forced his way into a dwelling. Considering the severity of the situation of a violated court order and additional felony crime, Officer Hugo felt he needed to take corrective action, stating “I had to take him to jail.”

A more apt delineation in the jail versus hospital decision than “if a crime occurs, they’re going to jail” is that individuals who commit crimes severe enough that they need to go to jail will go to jail regardless of their mental status. Police generally have discretion in whether they take someone to jail or not. However, EPD, like every other police department, has organizational norms that influence the decision. Elkgate’s jail is over capacity, and during data collection police had additional instructions to only bring outstanding warrants, domestic violence, and violent felony charges to jail. The only arrests I observed were for outstanding warrants for people who had not appeared to their court dates.

When officers choose not to bring someone to jail, they can choose to ignore the crime and focus on an individual’s mental state, ignore their mental state and focus on the crime, or acknowledge the crime and their mental state. Some officers I spoke with had been involved with one or more M-1 holds (allows for involuntary transportation to and placement in an ER and psychiatric unit for up to 72-hours for the purpose of psychiatric evaluation and assessment) every shift in the weeks prior to the interview, whereas others could recall only one or two in the last few months. EPD does not utilize a mental health team approach (call out to particular officers when a call comes in involving a known psychiatric crisis), which makes the disparities between officers more striking. I speculate that these disparities between officer involvement with M-1 holds is due to officer willingness or ability to identify mental illness and then

transport to the ER. The fact that officers with Crisis Intervention Training had more recent calls resulting in an M-1 further supports this speculation. Officers who do not recognize mental illness, or do not feel the individual meets M-1 criteria (danger to self, others, or gravely disabled due to mental illness), are likely to give the person a citation or let them go with a warning.

If no crime has occurred, the officer has two choices based on M-1 criteria: 1) If the officer feels the individual does not meet criteria, mediate the situation and “release”; or 2) If they do meet criteria, transport to the ER. In contrast to the ER, when officers release someone (end citizen contact without transporting them anywhere) the individual most likely will not receive any referral for services. Of the police I spoke with, Sergeant Hart was the most dedicated to the mentally ill population and had taken a leadership role of Crisis Intervention Training for all the area police departments. Although she also was a tactical instructor who taught officers hands-on strategies for physically taking people down, in our formal interview she reiterated multiple times the importance and benefit of using every possible communication tool available to defuse and fully understand a situation before risking injury or trauma to officers and/or citizens by going “hands-on” (physical, forceful take downs and/or restraints). She had dedicated herself to the strategies of Crisis Intervention Training and had made many community contacts within the medical arm of mental health. When I asked her about partnerships between Elkgate’s police departments and mental health professionals or organizations where officers could refer individuals, her response indicated that officers need to take a lot of initiative to refer someone to a reliable resource.

There are, like resource cheat sheets, and some people like laminate them. The problem with that is that they change. . . .then the information that [officers] have is incorrect and it’s an ugly cycle because then you can’t reach anybody, so then hopefully at least going through [Crisis Intervention Training], you’ve met some people, you have business cards, and you can start somewhere. Umm or you can call whoever in your department who is [Crisis Intervention Training] certified, or runs your [Crisis Intervention Training]

program, which is generally your training sergeant. . . .Easier thing to do, though, is to actually just [contact Mental Health Center], or the psych ward at [EGH] and just call somebody and they will help you. So we almost always tell officers, like “we’ll give you some resources. . .but it’s going to be tough to rely on this, because people move around, and so you don’t want to just hand this to somebody and then have them be frustrated, so you’re going to be giving out numbers like it’s probably a good idea to have your partner, you know, call somebody, unless you know them personally and you’ve worked with them.”

Sergeant Hart mentions a list of resources given to officers during Crisis Intervention Training training, yet none of the patrol officers I spoke with, including those with Crisis Intervention Training certification, mentioned having a list. Nor did they have any knowledge of the existence of one. Officers found it particularly frustrating when they had no choice but to release an individual because they had not committed a crime and the officer felt they didn’t fit M-1 criteria. Many of these involved repeat calls for the same person, leaving officers increasingly frustrated with both the individual and the situation because they felt there was nothing they could do until either a crime occurred or the individual’s psychiatric state diminished. Whereas people who arrive at the ER and do not meet criteria are still directed towards community mental health resources upon release, police did not have the ability to do this, which risks placing a greater burden on the system in the future. This was especially prevalent among the city’s transient population, an issue I will discuss in detail in Chapter 6.

Police are an important, and often overlooked, player in today’s mental health systems. They are frequently the first contact individuals have with the mental health system, are responsible for recognizing a possible psychiatric issue, and represent the fork between mental health’s corrections and medical institutions. Police have a great deal of power over citizens in their interactions. Especially involving situations with individuals in crisis, appropriate police interaction and communication can escalate or de-escalate the situation, which can make the difference between a correctional versus medical pathway through the mental health system.

Additionally, because police will often encounter the same individuals multiple times over a period of months or years, if they are able and willing to take the time to understand and get to know the individuals who have frequent police contact, police are in a position where they can ease some burden off the entire system. For example, one man I will discuss in detail in Chapter 6, Nick, is chronically homeless, severely mentally ill and an alcoholic. He has been in Elkgate for a very long time and EPD officers know him well. Officer Ekeley, an EPD officer of 3 years, told me about his approach to interacting with Nick:

When making contact with officers, [Nick] will refer to himself in the 3<sup>rd</sup> person and also talks about ‘The Colonel.’ [Officer Ekeley] didn’t know who The Colonel was and had come to learn that questioning Nick about who or where The Colonel was would agitate him, so it was best not to do that. . . . [Officer Ekeley] said he didn’t understand it [Nick’s psychosis], repeatedly referring to [Nick’s] behavior as ‘strange’, but had come to recognize that working with [Nick] in his delusional state was going to be easier than fighting with him or disputing it. (Fieldnotes)

Through Officer Ekeley’s interactions with Nick, he had learned how to best communicate with and approach Nick, making interactions as smooth as possible by not “agitating” Nick. Although Nick was typically jovial and cooperative with police (see Chapter 6 for more information), officers could unintentionally escalate interactions with Nick that result in an avoidable use of ER and/or jail resources because they have not gotten to know him.

Sergeant Hart connected the dots between what she considers good police work, rooted in strong communication, and the benefits to the rest of the community:

Long term I am saving time. I am saving money: government money; tax money. And I’m doing “Bob” a favor. I’m doing him justice because I’m getting him what he needs versus making assumptions and taking him somewhere [jail] where he doesn’t need to go. And ultimately that’s—it’s not just my time, it’s [Mental Health Center’s] time; it’s [Elkgate] hospital’s time; it’s jail time, and I’m saving people time by taking the time to figure out what I’m actually dealing with. I get paid the same whether I’m dealing with a barking dog or somebody who’s having a manic break. Why not give that person the time I can, within reason, and give them what they need? . . . Versus just doing the bare minimum and running into the same people over and over and over again, and creating

more and more of this reputation that the police don't care, and I'm not doing anybody a service.

Since police are already responding to calls regarding individuals with mental illness, Sargeant C argues that taking the extra time in initial contacts will assist police, the mental health system, and the community as a whole in the long run. She also points out the central role of police to the mental health system, justifying the need for increased funding and training for officers to better recognize, interact with, and respond to individuals with mental illness.

### *Institutionalized placements*

When referral agents go to the hospital or call police, their goal is often to get the person in psychiatric crisis institutionalized. As previously mentioned, whether a person is placed in a medical or correctional facility is largely determined by police with consideration of the aforementioned factors including whether a crime has occurred, the type of crime, and officer discretion. Facility placement is important for individuals with mental illness because facility type relates to the quantity and quality of specialized mental health care offered both in the facility and once released, which has the potential to either ease or add to the burden of the entire system.

*Psychiatric Unit:* Patients are admitted to a psychiatric unit based on their crisis evaluation, typically performed in the ER. Evaluators recommend the least restrictive placement possible where the patient will be safe from harming themselves or others, which makes hospitalization a last resort.

As mentioned in Chapter 3, EGH does have a 15-bed psychiatric unit, which is the first choice for admission of patients in their ER; however, patients will be sent to any inpatient psychiatric location when this unit is full, which is a frequent occurrence. Conversely, EGH will accept patients from other ERs when there are available beds. With only 5.5 psychiatric beds for

every 100,000 Coloradans (American College of Emergency Physicians 2014), it is not uncommon that there is no bed in the entire state. In these scenarios, patients have to wait in the ER until one becomes available. Reflecting the lack of psychiatric beds in Colorado and legal and ethical factors that dictate treating patients in the least restrictive setting possible, EGH head evaluator, Carol, estimated that about 75% of EGH's psychiatric unit's patient population is involuntary (on a psychiatric hold) at any given time. With the lingering cultural trauma created by state insane asylums up until the first half of the 20<sup>th</sup> century, the emphasis on treating people in the community, and number of patients on holds waiting days in ERs, increasing psychiatric beds in Colorado is unlikely to have an impact on the breakdown of involuntary versus voluntary patient numbers. Patients are held short-term (typically less than a week) until their behavior and/or medication stabilize, then return to their outpatient treatment provider(s) and/or program(s), or are referred to them.

*Detox:* In Figure 1 detox is located between the medical and correctional institutions' columns because the facility is similar to, yet different from, both institutions. On one hand medical staff work at the center, and part of its purpose is to ensure people are medically stable while detoxing. On the other hand, police most frequently take people there after breaking the law (e.g., public intoxication, minor in possession), yet people are not forced to stay there and can walk out at any time without legal consequence. The unlocked facility holds individuals if a crime necessitating jail has not occurred and/or someone is "significantly impaired" by drugs or alcohol, though not in medical distress, so the ER and police both refer people here. Mental illness and substance abuse are often comorbid (National Institute of Health 2007), so detox staff frequently work with individuals with severe mental illness, but since the facility is primarily used to contain people only until they are sober (less than 24 hours), as opposed to a



rehabilitation facility, the center does not offer any mental health treatment or programming. For these reasons, the detox center is located on the figure, but was not a targeted organization in data collection.

*Jail:* As mentioned in Chapter 3, on any given day about 25% of Elkgate's jail population are inmates with severe mental illness. Jail administration considers this group a special population and readily acknowledges the difficulties of balancing the conflicting duties of a jail and mental health center. Richard, an Elkgate jail administrator, made multiple remarks throughout our interview that the jail needed more resources to effectively manage and assist its inmates with severe mental illness.

As much as jails do not want to be mental health centers, we are, by the nature that we have [the severely mentally ill] all here. So we've got them either way [whether we want them or not], so it would probably be better that we have a better facility and staffing to manage them more effectively as a mental health unit.

People generally arrive at the jail under police escort and are screened at multiple points for physiological and psychiatric illness during intake. If at intake, or at any point during incarceration, severe psychiatric symptoms are noted that would prevent an inmate from managing in one of the general population units, male inmates will be placed in the jail's Special Management unit, reserved for inmates with significant physical, medical, or psychiatric impairment. In accordance with national trends, Elkgate jail's female inmate population is significantly smaller than its male population. For this reason, there is only one female housing unit, which presents multiple challenges to jail administration and staff: "...the challenge [with housing females] is maybe we're managing a number of different classifications that are very different from each other all within one unit. . . . we don't even have the ability to isolate [the severely mentally ill] into a classification with other women with mental health [issues]" (Richard, jail administrator).

If an inmate's psychiatric state becomes acute to the point that jail administration feels that the individual is too sick to safely remain in jail, they are assessed for transfer to a hospital by a Mental Health Center evaluator. The admission is a civil, as opposed to criminal, commitment, so it is unrelated to the person's criminal charges or sentencing. Mental Health Center's evaluation process and admission criteria are identical to those in the ER with the exception that MHC will not do an evaluation unless they have already found an available bed. After getting stabilized on a psychiatric unit, these patients are discharged to jail custody.

Getting inmates admitted is especially difficult because of psychiatric unit policies. Each unit has rules surrounding patients they will and will not accept that are created by hospital administration and are unique to that unit. One of the jail's mental health staff, Miguel, explained that "every facility has started changing their criteria and it's made it harder to get folks in." As an example, he said that one of the two state hospitals no longer accepts inmates with felony charges (violent or non-violent), which is nearly the entire inmate population. Counties are assigned to one state hospital and have a certain number of beds reserved for them. Elkgate's is the hospital that will no longer accept patients with felony charges, so placing anyone from Elkgate in the other hospital means taking a bed from another county. This puts Elkgate's inmates very low on the hospital's priority list. This reinforces the divergent pathways between medical and correctional mental health. In the same way that ER patients are unlikely to cross over to corrections, those in the jail are unlikely to cross over to medicine; however, whereas the hospital professionals are in charge of the decision to transfer a patient from medicine to corrections, in the jail the decision to transfer an inmate from corrections to medicine is largely outside the power of corrections, and is made by the medical context and individual medical professionals.

EGH's psychiatric unit is one of the few that does accept inmate transfers, so there is communication and interaction between these two residential placements. Like all other psychiatric units, EGH's does have guidelines surrounding whom they will accept, but they seem less stringent than most other private units. Miguel understood why BGH wouldn't take certain inmates and their rationale behind those decisions:

...[Elkgate General] does take a fair amount of our people. But if they're really aggressive people then they don't want them because it's a small unit, they would have to hire somebody 24/7 to keep them in seclusion and watch them. So it's a cost they don't want to take on because they're most likely not going to be getting paid [for the additional costs] anyway.

When inmates are placed at BGH, they still go to the ER for medical assessment and clearance even though they have already been assessed for inpatient placement and have a bed. Once medically cleared, they are placed on the psychiatric unit.

Most inmates with mental illness will not be transferred to a mental health facility and rely on the jail for psychiatric treatment or care. According to Richard, a senior jail administrator, they do the best they can with the resources they have to provide assessment, programming, and assistance for their mentally ill population.

One of our philosophies is that people should not deteriorate in jail. That people should not leave jail worse off than when they came in. That we have a responsibility to manage people and provide opportunities for people to improve themselves and we have a lot of programs, some of the people who are Axis I,<sup>17</sup> but also all the other people that we manage, trying to expose them to ways of helping them to address their issues and we do a lot of that here.

In addition, they have jail deputies assigned to the Special Management Unit take the same Crisis Intervention Training certification course as police, and have developed a working partnership with MHC. They do not have the funds from the state or grants for a full-time jail psychiatrist, so

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<sup>17</sup> Richard is referring to the American Psychiatric Association's categorization of mental illness in the *Diagnostic and Statistical Manual of Mental Disorders*. Axis I is any non-personality disorder clinical diagnosis (American Psychiatric Association 2013).

they have contracted with MHC for one to work in the jail 3 to 4 hours a week. The jail also contracts with MHC for a mental health counselor for 15 hours a week who acts as the official liaison between the two organizations. Richard considers the partnership with MHC most valuable upon release and transitioning back into the community, pointing out that what they have is not ideal, and cities with larger populations and more resources are able to provide more, but it is better in Elkgate than in many other communities.

For instance, Denver has a pilot program where they will actually give either a paid [prescription] or actual meds when they leave the jail for, I'm not sure what they do now, but at one point it was 30 days. Other jails were giving written [prescriptions] and said, "Here. Good luck trying to pay for it." And then that's when we came up with our—we [tell them to go] directly over to [Mental Health Center] and if they show up they'll give them bridge meds until they're actually intaked into their system and see a prescriber because [the jail psychiatrist] works there, we have a copy of their record, their eval[uation] but they [Mental Health Center] do, too. . . . That—that's our way of kind of working through that [psychiatric] re-entry process.

By incorporating elements of medicine within the jail and referring released inmates to medical resources, the hope is that people will receive assistance in the community and reduce future interactions with corrections.

Richard gave a picture of a jail with an understanding, empathetic staff and a professional partnership providing effective, though not ideal, continuity of care to its inmates with mental illness. Considering his position as an official representing the jail, it is not surprising that Richard would give such an account; however, other interviews and observations provided another version of the jail's mental health care quality.

Every mental health provider I spoke with believed that Elkgate's jail is better with inmates with mental illness than a lot of other places in Colorado and elsewhere; however, there were still substantial challenges. Dylan, an Emergency Psychiatric Services worker at Mental Health Center who had worked with many clients who had spent time at the jail, and had gone to

the jail herself to do evaluations, said that a main issue was clients getting their medication needs met at the jail:

One of the huge issues that I have is actually with the jail and our clients getting medication in jail. That can be a really, really hard thing. And I know that a lot of the times the clients aren't getting the medications they need, or they're not getting enough of them, or they'll be having psychiatric issues and they're not getting the support they need. And I've heard that from a number of sources. . .

Although there is a partnership and information exchange between the jail and Mental Health Center, the co-ordination appears to be lacking while Mental Health Center clients are in jail considering that Mental Health Center clients do not receive their medications in jail.

Considering medication is the primary form of mental health treatment available to people in jail, not providing clients with this is problematic. In addition to the physiological issues associated with discontinuing, or abruptly changing the type or quantity of many psychotropic medications, this can also produce an increase in problematic psychiatric symptoms including psychosis, mania, and suicidal or homicidal ideations. If left unchecked, these symptoms can escalate to the point where admission to a psychiatric unit is needed.

An issue I found more problematic than medication was jail deputies' attitude toward protocol and procedures intended to maintain inmate safety. Incarcerated individuals are at a much higher risk of suicide than the general population regardless of mental illness, and inmates with severe mental illness are at a particularly high risk (U.S. Department of Justice 2010). Richard explained to me that the Elkgate jail takes any threats or indication of suicidal intent very seriously, believing that the jail's "culture" around its suicide protocol is positive and in place to protect inmates:

We have a culture here as well that. . . I think is a good thing that. . . if an inmate makes any kind of overture of any type that they're suicidal or thinking of harming themselves, they immediately are put on suicide watch, which requires [Miguel] and his peers to then

do that [jail mental health evaluation]. . .and that [suicide watch] involves taking everything out of the room and they have nothing but a kind of suicide smock on. . .

In his explanation, Richard is saying that not only is it good that jail staff are quick to ensure inmate safety by doing what they can to avoid suicide, but suicide watch is also a positive because it does initiate a mental health evaluation by the jail mental health staff, who are the only people who can release an inmate from suicide watch. The practice of leaving inmates in an empty room with a piece of clothing made of a thick canvas material that cannot be ripped is debated on human rights grounds, but is still common in jails and prisons.

During my second ride-along jail tour, the officer I was riding with, who had only been on the force for eleven months, had not done a tour of the jail and had asked a jail deputy “buddy” to show him around.

We stopped at the Behavioral Unit, a unit adjacent to Special Management used for inmates who have gotten into trouble in jail. The deputy pointed to one cell in the lower level and said that the inmate was “a pain in the ass” and spent a lot of his time yelling at the deputies. The deputy then commented that he “can’t wait,” and was really hoping, that the inmate would make the slightest suicidal remark so that he could go into the cell, and strap him down in the restraint chair (essentially a wheel chair with arm, leg, and torso restraints used to forcefully move uncooperative inmates). (Fieldnotes)

This deputy’s comments indicate that, in some situations, putting someone on suicide watch may have another motive than inmate safety. In this case, the deputy was looking forward to a potential suicide as punishment or revenge on the inmate and as an excuse for him to use force and restraint on the annoying and difficult inmate. The fact that the Behavioral Unit is next to Special Management is also significant because deputies are assigned to both. While Richard’s version of the entire staff culture cannot be debunked based on a single deputy’s comments, myself and the officer were present, as well as another deputy, and he did not lower his voice or make any verbal or body language indication that he was expressing a faux pas.

Everyone I interviewed agreed that the jail isn't the best place for many mentally ill inmates. Though there was disagreement between police and mental health providers as to where the line between jail and the ER should be drawn, no one claimed that the Elkgate jail, nor any other jail, would better serve individuals with severe mental illness than the medical arm of the mental health system. This means we need to explore the other options for this population and the roles of the decision makers to uncover why so many individuals with severe mental illness are placed in a location that everyone agrees is not the best solution for the consumers and professionals alike. With this in mind, I focused on the two organizations that determine residential placement (police and ER) and their interactions with a particular interest in police, who, as mentioned, are the primary bridge organization between the corrections and medical institutions of the mental health system.

## ELKGATE POLICE DEPARTMENT AND THE EMERGENCY ROOM

### *Police Perspective*

My first sense of issues across Elkgate's mental health system was the relationship between the police and the ER, which came up within the first 20 minutes of my first police ride-along:

As we walk through the back area of the police department Officer Gabor asks me if I have done any other ride-alongs with Elkgate, and mentions that I have gotten permission from the Chief to do 10. She asks why so many and I tell her about the project. Without missing a beat, she tells me that I'll like this first call and that we're going to arrest a man. . . .Last night Officer Gabor had responded to a call and made contact with him. He was in the bathroom of a grocery store so drunk that he could not even talk. Officer Gabor asked him why he was so intoxicated, if he was trying to drink himself to death. He said he was. That meant he was actively suicidal, a mental health case, and she put him on a mental health hold and took him to Elkgate General Hospital. The doctors had obviously released him from the hold much sooner than the hold's 72 hours, as EPD had received a complaint from the man's mother, with whom he lives, just before the beginning of the shift. I asked if that happens a lot, getting a call about someone she had placed on a hold the night before, and I don't even get the question out before she tells me "all the time" and often even the same night. She tells me that it happens but "it's

their [hospital's] responsibility". She takes people off the street, but it's on the hospital to release them back, and if something were to happen, it would be on the hospital. . . . Officer Gabor pointed out that he would have been released from the hospital at most 9 hours after she brought him there. Based on her experience, Officer Gabor estimated that when she took him to the hospital, the man's blood alcohol content was around 0.3. After that period of time there was "no way" he was sober. Using a "police officer perspective" she believed that was not responsible on the part of the hospital. They should not be taking people off holds while they are still intoxicated. (Fieldnotes)

As I interacted more with police officers during ride-alongs and interviews, I found that officers all had multiple examples of taking people to the hospital on an M-1 hold who were taken off the hold and released only to have police contact again that same shift, or within the next 24 hours. Not surprisingly, officers found it unanimously frustrating. Every officer I spoke with mentioned at least one of these situations. It was such a common frustration that when my ride-along officers would introduce me to other officers and tell them that I was looking at mental illness in Elkgate while we were either on patrol or at the police department, they would often tell me about this issue first, saying things like "they're walking out before we're done with the paperwork." Finally, on two occasions I overheard conversations between officers at the police department who did not know about my research discuss the issue.

From the police perspective, when they choose to take an individual to the hospital they have made a decision on the street that an individual is a danger to themselves, others, or gravely disabled. The process of placing someone on an M-1 hold requires a great deal of paperwork and time, and means taking someone into police custody without having committed a crime, so it is not a decision they take lightly. Sargent C explained the responsibility she felt officers had in making the decision:

[Police] have to be very careful. . . .we have the right to take someone's freedom away because of their mental health. That is a huge amount of power. . . . it's huge to say, "well, you haven't committed a crime, but I see that you're not well to the point that I am making the decision that you are going on a 72-hour hold." That's huge. That's a lot of responsibility to be on an officer's plate and to make the decision.



Police officers are not doctors, nor are they traditional mental health providers, but they are using the same legislation used by these professionals in the ER and on psychiatric units to determine whether a person stays or walks out the door. The fact that officers do not feel that they are applying the M-1 legislation lightly, which requires that individuals pose an “imminent danger” to themselves and/or others, or are gravely disabled (see Appendix F for the most recent Colorado legislated M-1 criteria), adds to the frustration officers feel toward the hospital when, by their accounts, more often than not individuals are released from the ER in a matter of hours.

Although unanimous in identifying the hospital’s pattern of quickly releasing patients, officers do interpret it differently. Like Officer Gabor in the scenario above, some officers take less offense to the practice. These officers consider it a hospital issue. They have done their duty, and now, as Officer Gabor said, it is the hospital’s responsibility. Using an administrative perspective, Sergeant C explains that, as police, they are required to do their job: take people to the hospital if they feel the person meets criteria regardless of whether they assume the person will be immediately released from the ER or not:

And what I tell officers in [Crisis Intervention Training] all the time is “I don’t care. I don’t care if they don’t even get admitted. I mean I care from a human standpoint, but from a sergeant standpoint, I don’t care. Your job is to make sure that you did everything you could to keep that person safe. And if you’re mindset and attitude is. . . ‘yeah they meet the criteria, but I don’t really think they’re going to kill themselves, so I’m not going to worry about it because they’re going to be out before I’m done my paperwork.’” That’s not okay with me. . . . ‘I don’t care if the paperwork sucks, or that person gets out before you’re done.’ Its, it’s hard. It’s happened to me, too, but I at least know that person didn’t die because of *my* lack of due diligence or *my* not caring about that person. That’s on somebody else now and I can only do my part. I can’t be the doctor also . .

Other officers voiced similar perspectives to Sergeant Hart in that they had done all they could and done their “due diligence” as officers: they had assessed the situation to the best of their ability and taken action to ensure the safety of an individual. Although still frustrated with the

outcome, these officers focused more on who would be legally and morally responsible. As long as they are making an informed decision to place someone on an M-1, they were professionally and personally guilt free. Officer Beckel, the most senior officer I rode with, believed that what he did for individuals with mental illness when he brought them to the hospital was similar to most police duties, stating that police “don’t solve problems, we really just take them to the next stage.”

Rather than focusing on their role as police, in other situations officers responded to their frustrations by pointing out structural issues in the mental health system. The most significant example of this I observed during my first ride-along. While sitting with Officer Gabor in a computer room in the police department where officers write and submit their official reports, Officer Queue entered the room and began speaking with a shift sergeant.

The sergeant mentioned a name, and [Officer Queue] began talking much louder and sounded angry. She had taken a man to [Elkgate General Hospital] on an M-1 hold and the hospital had released him 5 hours later. [Officer Queue] said that the man had been higher than a kite when she had brought him to the hospital and there was “no way” he was sober 5 hours later. [Officer Queue] stated: “I do *not* agree with how they [hospital staff] do evaluations” saying that a person with no degree talks to the person and then calls someone else who is not even there to report on what they see. The person on the other end of the phone makes the decision. [Officer Queue] continued saying how wrong it was that the person evaluating doesn’t even have a psych[ology] degree, and probably went to “ITT tech.” (Fieldnotes)

The female officer here uses the evaluation process and personnel to explain why someone would be released from a hold before she believes that person should have been released. She was speaking with her sergeant in an area of the police department reserved for staff and officers and initially did not notice my presence, nor did she know any specifics about my research, so this was a backstage conversation (Goffman 1959), which may partially explain why her statements were expressed with more exasperation and anger than any other I encountered during interviews or ride-alongs. However, her statements echo Officer Gabor’s thoughts regarding the

hospital's decision to release the man from the first call of the shift discussed earlier: she also believed there was "no way" he had been sober when released, and the hospital had acted irresponsibly.

When officers spoke of systemic issues, rather than focusing solely on their responsibilities and duties as police, they became more animated by displaying more emotion, oftentimes raising their voices slightly. The topic elicited much more frustration, and anger at times, than any topic regarding their own or the police department's role with psychiatric crises because they felt they were doing their due diligence as police while the hospital was not doing theirs. This was problematic and frustrating for police because it then led to more police work when they have to respond to calls for the same person within 24 hours of their hospital release.

As the officer demonstrates in the above scenario, frustration directed towards the ER manifests in a distrust of ER policy and the competence of the mental health evaluators. These frustrations have the potential to make future interactions more difficult. This was the only officer to directly denigrate evaluators; however, statements like Officer Gabor saying the hospital was acting irresponsibly releasing the drunk man before she believed he would have been sober, questions ER personnel decision-making and competency in ensuring individual and community safety.

#### *Emergency Room and Mental Health Center Professionals' Perspectives*

Out of fear of inciting further problems across police-ER interactions, I did not relay Officer Queue's remarks in my interviews with mental health evaluators. If I had, I am certain that their responses would have been uniformly negative mostly because some of Officer Queue's claims were factually incorrect. While her description of the process of the evaluator speaking with the patient then calling a third party – a psychiatrist – is correct, this

communication is more nuanced than Officer Queue suggests. Evaluators need to contact the on-call psychiatrist because: 1) only physicians can remove M-1 holds, and 2) psychiatrists have admitting privileges and need to sign off on any admissions. However, all four evaluators and the psychiatrist I interviewed would disagree with Officer Queue when she says that the psychiatrist makes the decision, as each of them said that the psychiatrist will agree with the evaluator's recommendations in most cases. Additionally, the ER doctor also needs to be in agreement with the decision to admit or discharge, so there is a doctor who sees the patient that is part of the decision-making process. Finally, Officer Queue's description of the education and knowledge of the evaluators as not having any formal education in psychology or a university degree is also incorrect. MHC evaluators, who are called in to evaluate patients on Medicaid, must have a graduate degree in psychology, and EGH requires their evaluators have at least a 4-year university degree.

Officer Queue wasn't the only officer to demonstrate that they were unaware of hospital procedure and the work of evaluators. During a ride-along with Officer O'Keeley we brought Curtis, a 16-year-old runaway, to the ER with some cuts on his face, and he was subsequently placed on an M-1 hold. When the teenager's mother arrived, she spoke with Officer O'Keeley:

She asked Officer O'Keeley what would happen next. Officer O'Keeley told her that Curtis would still need to see a doctor to get his face checked out and cleaned up, and then a psychiatrist would need to come talk to them. I know I made a face at that comment, but knew it wasn't my place to step in; however, felt a little torn because Officer O'Keeley was giving incorrect information to the mother. Curtis would be seen by someone from psych, but an evaluator, not a psychiatrist. (Fieldnotes)

Soon after this interaction, I spoke with Officer O'Keeley about what would happen to Curtis from here and learned that there were other aspects of the system he was uninformed on:

Officer O'Keeley motioned towards Curtis's room and said that he would probably be sent to [a nearby hospital-owned facility]. I was confused and asked him if there was a private facility there. Officer O'Keeley said he didn't know. I told him that [EGH] had

outpatient mental health clinics and programs there, but no inpatient. The inpatient unit had been at there, but was moved to a unit in this building. Officer O’Keeley said that’s where he thought all the psych patients went. I told him that the unit was here wouldn’t take Curtis anyway, because it was an adult-only unit. Officer O’Keeley asked me where adolescents would go, and I told him the closest location, but it sounded like they were full, so maybe Denver, and if that’s full, there’s another unit in Colorado Springs they sometimes send kids. Officer O’Keeley sounded surprised that they would send someone to Colorado Springs. I was surprised that Officer O’Keeley didn’t know the details of the system: he hadn’t known the full evaluation process, and now he doesn’t know where people went or who would go where.

I found this especially surprising considering that Officer O’Keeley was not a rookie officer: he had been at EPD for 14 years. Additionally, later on during the ride-along Officer O’Keeley disclosed that he and his wife had struggled with his 17-year-old son’s psychological and emotional problems and substance use since he was 12.

Throughout data collection I was repeatedly surprised by how often officers were unaware or uninformed of aspects of Elkgate’s medical mental health system. Here there was a distinct difference between officers who had gone through the voluntary Crisis Intervention Training and those who had not. Part of EPD’s Crisis Intervention Training includes tours of local mental health facilities and lectures by local professionals, so these officers had a much greater awareness and appreciation of the system and its professionals. Although all officers displayed some degree of frustration, Crisis Intervention Training certified officers did not appear to get as angry with the hospital.

### *ER Perception of Police*

Police were not alone in their frustration and misinformation in police-ER interactions. Mental health evaluators claimed that there was a continuum across officers in their ability to manage incidents with individuals in psychiatric crisis. Carol, a senior EGH evaluator, explained: “there are some police officers that are excellent, and I can tell that by the way they’ve written their report and what they say and how they describe things. And others that

<b>Confidential Record</b>									
<input type="checkbox"/> <b>Detoxification</b> <b>Hold – C.R.S. 27-81-111</b> <input type="checkbox"/> <b>Emergency Mental Illness Report – C.R.S. 27-65-105</b>					Case # _____				
Date of Occurrence _____			Time of Occurrence _____			Address of Occurrence _____			
<b>Persons Involved:</b> <b>C:</b> Complainant <b>R:</b> Respondent <b>W:</b> Witness <b>O:</b> Other									
<input type="checkbox"/> C  <input type="checkbox"/> R  <input type="checkbox"/> W  <input type="checkbox"/> O	Name (Last, First, Middle) _____					Alias, Nickname _____		D.O.B. _____	
	Residence Address _____ City _____ State _____ Zip _____							Phone _____	
	Business Address _____ City _____ State _____ Zip _____							Phone _____	
	Race _____		Ethnicity _____		Sex _____	Height _____	Weight _____	Hair _____	Eyes _____
	Occupation _____			DL# / ID# _____		State _____		Scars/Marks/Tattoos/Piercings _____	
<input type="checkbox"/> C  <input type="checkbox"/> R  <input type="checkbox"/> W  <input type="checkbox"/> O	Name (Last, First, Middle) _____					Alias, Nickname _____		D.O.B. _____	
	Residence Address _____ City _____ State _____ Zip _____							Phone _____	
	Business Address _____ City _____ State _____ Zip _____							Phone _____	
	Race _____		Ethnicity _____		Sex _____	Height _____	Weight _____	Hair _____	Eyes _____
	Occupation _____			DL# / ID# _____		State _____		Scars/Marks/Tattoos/Piercings _____	
<b>Hold Information</b> <input checked="" type="checkbox"/> <b>DETOX</b> <input type="checkbox"/> Involuntary Hold <input type="checkbox"/> Voluntary Transport									
<b>Alcohol Indicia</b> Odor on Breath    Y <input type="checkbox"/> N <input type="checkbox"/> Unable to Stand/Walk    Y <input type="checkbox"/> N <input type="checkbox"/> Eyes Bloodshot/Watery    Y <input type="checkbox"/> N <input type="checkbox"/> Admits to Drinking    Y <input type="checkbox"/> N <input type="checkbox"/> Speech Slurred    Y <input type="checkbox"/> N <input type="checkbox"/> Unresponsive    Y <input type="checkbox"/> N <input type="checkbox"/>					Medically Cleared    Y <input type="checkbox"/> N <input type="checkbox"/> Respondent Left at Hospital <input type="checkbox"/> Transported to _____ By: _____ Employee# _____				
The respondent appears to be intoxicated and/or incapacitated by alcohol and clearly dangerous to the health and safety of self, and/or others. Pursuant to the provisions of C.R.S. 27-81-111, the respondent was taken into protective custody by the undersigned and transported to: <input type="checkbox"/> <input type="checkbox"/> Other: <span style="float: right;"><i>Elyse detox facility</i></span>									
<b>Emergency Mental Illness Hold Information</b>									
Previous Psychiatric Care – When: _____					Where: _____				
Medications: _____									
The Respondent appears to be mentally ill and, as a result of such mental illness, appears to be an imminent danger to: <input type="checkbox"/> self <input type="checkbox"/> others or <input type="checkbox"/> gravely disabled. Pursuant to C.R.S. 27-65-105 the Respondent is taken into custody by the undersigned and detained for seventy-two hour* treatment and evaluation at: <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> Other: _____ *If the evaluation and treatment facility does not have evaluation and treatment services on Saturdays, Sundays or holidays, then the facility may exclude those days in calculating the 72 hour period.									
Narrative: _____ _____ _____ _____ _____ _____									
Reporting Officer _____					Employee# _____		Reviewed By _____		

White — [Redacted] / Mental Health     Yellow — Law Enforcement Records     Pink — Hospital     REV (12/10) RO#7

level of understanding is at least not reflected in what they write [in their report].” Multiple evaluators commented similarly about the detail and quality of police reports.

Figure 4 is the M-1 form used by all police departments in the county. After hearing police say that people walked out of the ER before they had finished their report and evaluators criticize the information police provide in their reports, I was shocked by the length and structure of the M-1 forms. They are one page that is two-thirds patient information and boxes officers check off and only seven lines for police to give their “narrative” of the event and any other information that would support the hold. MHC evaluators, who would do client home checks or assessments with police back up, believed that police were least likely to understand the gravely disabled criteria. They found that police often did not recognize an individual met the criterion when evaluators believed they did when both parties were at a scene. On the other hand, both Elkgate General Hospital and MHC evaluators indicated that some officers would bring people to the ER when the evaluators felt it was obvious they did not meet M-1 criteria. Emily, an MHC evaluator who began shaking her head halfway through my question of whether she believed police had an understanding of mental illness, indicated that she thought officers could be quick to jump to conclusions regarding placing people on M-1s:

[A] lot of times when I go to the ER, I’ll read a mental health hold, and it’s like a lot of times I see mental health holds that it’s like, obviously someone was put on this just because [the police] just didn’t know what was going on, or it was, like, so little, like, how do I explain? Like, someone just looked weird, or something. There wasn’t, like, a lot of evidence for them to be on it, they just looked weird.

Although Emily told me she found this frustrating at times because she would need to take the time to go to the ER and do an evaluation on someone who she immediately knew did not meet criteria for hospitalization—danger to self and/or others or gravely disabled—she still felt officers were doing their job. She continued, saying:

[M]aybe a lot of people might say that's—[police are] putting too many mental health—writing too many mental health holds, like, just too easily, and at the same time, it's not their job to figure out if there's something going on. Like, if they feel like something is off, it's their job to put that person on a mental health hold, send them to the ER, and let us suss out is this mental health or is it not. So, I think they're kind of doing their job for that. Like kind of a funneling system.

Although evaluators felt that officers could better understand mental illness in order to more appropriately assess suitability for M-1 holds, they did not hold the same level of frustration towards officers as officers did toward them and the ER as a whole. Unlike police, mental health evaluators pointed to the group of uninformed officers, rather than the entire police department, for issues. None of the evaluators I spoke with had witnessed any officer mistreatment toward psychiatric patients, and spoke highly of EPD for officer comportment in interactions with individuals with mental illness, though each did indicate that they had heard otherwise from clients or knew of colleagues who had witnessed negative interactions.

In each evaluator interview I mentioned the police frustration I had encountered with regard to patient release well before 72 hours. None of the evaluators had heard specific complaints or indications of frustration from police, but did understand why officers would be frustrated. Evaluators felt that police did not understand the evaluation process, and the nature of many psychiatric crises, which would lead to frustration.

As previously mentioned, evaluators are using hospitalization as a last resort. In other words, during the evaluation process they are looking for reasons not to hospitalize just as much, if not more, than reasons to hospitalize. This is especially true for mental health hold decisions when evaluators and psychiatrists are deciding whether someone who has not committed a crime should be held against their will. Placing people in the least restrictive treatment environment possible, and the danger to self and/or others requirement for commitment, was implemented by the 1975 U.S. Supreme Court decision *O'Connor v. Donaldson*. I asked each of the evaluators



what percentage of patients they recommend for admission versus discharge from the ER. None had exact numbers, but gave estimates of between 50 and 60 percent of patients brought in on M-1s, and closer to 80 or 90 percent of all patients they evaluate, are discharged from the ER. The latter figure is comparable to data from Denver University Hospital, where of the 9,000 patients evaluated in the ER for psychiatric admission each year, just under 1,000 (11.1%) are admitted on holds. Based on the relatively low percentage of patients held on holds after evaluation, evaluators could understand why police would be frustrated, but were unapologetic for their discharge rates. They explained that patients often calmed down once in the ER and had the opportunity to speak with an evaluator. Dr. Jay, a psychiatrist who has practiced in the Elkgate area for 35 years, said that this was especially the case with patients brought in by police. Although he did not critique EPD in their actions or comportment towards individuals with mental illness, he did acknowledge that the circumstances that lead to police involvement and transportation to the ER can make patients more agitated than those who walk in on their own:

[S]ome people are more oppositional or deviant, and don't want anything to do with getting to the emergency room "by this cop who put my hands in handcuffs and made my wrists sore." They always handcuff people. So, so you're starting with people who are going to be resentful or feel hurt or feel taken advantage of. So you have to factor in all that, too [in your evaluation] when they've dealt with the police.

Police displayed the greatest frustration with the hospital when dealing with intoxicated individuals who had indicated suicidal intent. Their perspective was that these individuals were released from hospital before they were sober. The issue of intoxicated individuals on a hold had the least consensus in practice and policy. I was unable to decipher between perspective and reality in practice for these issues because I did not have the opportunity to observe any events with M-1 holds for an intoxicated individual. Some police and mental health professions told me the hospital did not take patients for detox, whereas Carol, the senior evaluator at EGH, said they

would admit patients to the psychiatric ward for detox when people required medical monitoring during their detox. Another disagreement I was unable to get a definitive answer for was whether the ER released patients while still intoxicated or not. According to hospital policy, and ER professionals, patients were either transported to the detox facility or remained at the ER until they were sober, and patients brought in on an M-1 were not evaluated until they were sober. However, police perspective was that the hospital frequently released people while they were still intoxicated. From the evaluator perspective, Dylan, an MHC evaluator, explained that patients brought in on an M-1 were frequently released from the hold because they rarely fit criteria once sober. In her explanation, she voices the hospital perspective in regard to procedure with intoxicated individuals:

After the reality check. . .once you end up at the hospital, once the evaluator gets there, you're not suicidal anymore. And I'm looking at both collateral information, but primarily how is the client presenting to me the moment I'm seeing them? That's what I make my determination on. And so after 24 hours in the hospital - we won't even go to do the evaluation until the person has been medically clear - so that means that all their medical conditions are pretty stable, and they're, like, pretty much ready to leave the ER, and their tox screen is zero, and. . .their blood alcohol level is pretty much zero, and so many of these issues are like. . . "I was drunk. I did overdose. Now I feel stupid. I don't know why I did that". . .you know, it's like, yeah, so the person no longer meets criteria, you know? I can see why [police would] be frustrated.

Dylan sympathizes with police frustrations surrounding discharge, but presents the situation in a way that there is nothing else she could do: the person is medically stable and no longer meets criteria for a hold. Dr. Jay agreed that individuals whose issues are primarily substance abuse are particularly difficult, and frustrating, because there isn't an adequate system in place: "we don't have a very good treatment system for people whose main issues are drug or alcohol problems, especially involuntarily. [People] really have to want to get past [addiction] to get help for those things. . . . the system's not geared up to help those folks. It's a big hole in the system." The detox facility in Elkgate is mostly just detox: individual rooms with beds where people are held

and can be monitored until they are sober. The facility also has a residential treatment program, but it is small, predominantly voluntary, and does not meet the number of beds needed in Elkgate.

Based on conversations with police, they would agree that most intoxicated individuals who say things that make them fit M-1 criteria while intoxicated will not maintain that state once sober; however, they would disagree with Dylan when she says they stay in the ER and are not evaluated until they are sober, or 24 hours after being admitted. Officer Gabor's account of the drunk man discussed earlier supports the police perspective; however, I have to rely on police perspective, rather than physical evidence (blood alcohol level), that he wasn't sober when released.

The primary explanation evaluators presented to explain, from their perspective, why police would be frustrated with them and the ER was the mentality of mental health professionals in regard to the decision to discharge versus hospitalize and its clash with their perception of police mentality. Police bring individuals in psychiatric crisis to the ER because police believe they should be admitted, whereas mental health professionals involved in the evaluation process are looking for evidence that patients do not require admission. Dr. Jay explained this dynamic, and the mental health professional mentality with regard to the decision to admit:

[Police frustration is] an inherent conflict [between police and mental health professionals] because [police] usually decide somebody is enough in trouble to bring them to the emergency room that they want to see them get hospitalized, and the [evaluator] will admit probably about half of the people who come in on a hold, and release the other half. And some people can talk their way out of a hold. Some people are people that we already know as clients of [MHC] and they get it together over a couple of hours, and maybe get them a little [anti-anxiety medication] to calm them down, and get them set up to come in [to MHC] the next morning to see their therapist, and have some kind of tight follow-up plan that doesn't mean hospitalization and three hours later they're walking out of the ER. And the [evaluators] also have a bit of, "well, we'll let

them go if it's marginal. And if they really can't make it on the outside, bring them back in and we'll hospitalize." So it's kind of—and I don't know if the police know that, this “well we'll see if they'll make it because it's pretty iffy” and if they don't [manage in the community] then we recognize that they really can't, so sometimes the cops have to [bring people to the ER] twice or even 3 times over a couple of days before putting someone [inpatient]. But eventually that gets recognized, so [police] just have to understand that they may have to go through this 2 or 3 times before this person really can get sucked into the system. From your perspective, do they know that?

From my perspective, clearly officers do not know this mentality from mental health professionals. The police perspective is just as Dr. Jay explains it: they would not go through the trouble of the paperwork and transporting someone to the hospital if they did not think it was necessary, or, in other words, the person needed hospitalization. The fact that Dr. Jay, a psychiatrist with over three decades of experience in the area, thirty with Mental Health Center, does not know whether Elkgate police are aware of the thought process mental health professionals go through when deciding whether to admit or discharge patients from the ER points to the issues surrounding communication between Elkgate's ER and the EPD.

#### *An Alternate Explanation for the Police-Mental Health Disconnect*

What Dr. Jay and the mental health evaluators are describing does not address police officers' primary complaint that people are released so rapidly that it is not possible that they were evaluated. If people are, as multiple officers stated, walking out of the ER before the officer has completed his/her paperwork, then people are being released without a mental health evaluation. Figure 3 showed the M-1 hold officers use. It is a single page with a small space for officers to describe the event leading to the hold. MHC and EGH each have their own evaluation forms (see Appendices G and H). EGH's evaluation is eight pages long and MHC's is two. The difference in length is due to the structure of MHC's form using more shorthand and expecting evaluators to take notes that they later use to write a full report and because MCH evaluators have access to patient histories that EGH does not (I will discuss why this is the case in the

following chapter ). Procedurally, this should not be happening. The Colorado civil commitment legislation states that the 72-hour hold can only hold someone against their will for the 72-hour period (with some loopholes for weekends or holidays) or until they are evaluated. However, it is possible that ER physicians at EGH do discharge patients brought in on an M-1 without receiving a mental health evaluation.

Mental health professionals indicated that it is not uncommon for ER medical staff to lack compassion or a basic understanding of mental health. This was particularly evident to Mental Health Center evaluators who traveled to a number of hospitals in the Elkgate area. One evaluator, Emily, used a recent example as evidence of the issue she identified:

I would like to see nurses, doctors having a little more, you know, I'm not saying that they should be required to know a lot about mental health, but having some compassion for mental health clients, or people with mental health issues, or not more compassion even the ability to say 'I don't really know what's going on, but something is off and therefore, like, I feel for that person', you know? We recently had . . . a situation that was reported about a staff at a hospital and they were basically laughing and were gathered around a monitor watching a client and then it gathered attention of other people in the ER. And they were reacting to how the client was acting off due to mental illness.

Rather than attributing the behavior of the patient to their illness and affording the same level of care they would, for example, to a patient withering in pain from a broken bone, the medical professionals at this ER considered a mentally ill patient's behavior a source of entertainment.

Another Mental Health Center evaluator, Heather, offered her general impression of many medical staff in ERs.

Some of the ER staff think that mental illness is not a quote unquote 'real' illness, or [mental health patients are] taking up beds in their ER, or, it's kind of like since the ER staff aren't really directly involved with them—I mean they are in terms of medical part, but they're not in terms of really talking to them or really what happens to them. Sometimes some tension there because they expect things to happen more quickly than they can or they're just, sometimes when they get really busy in the ERs they feel like that person's taking one of their important beds or something, so they don't always value that patient as much as others in terms of being in the ER.

Heather also points out that the relationship between mental health and medical staff in ERs can be strained because of the lack of understanding the medical staff has for mental health.

While mental health staff professionals felt that medical staff should have a greater understanding and compassion for mental health, some medical staff felt some resentment toward mental health for the time and energy it took to work with these patients in the ER.

The nurse talked about psych patients in the ER and how difficult they can be. She felt that they were a major cause of burn out for people working in the ER and thought they shouldn't be there. Psych patients make things more difficult for ER staff because their needs are entirely different and what needs to be done for them are entirely different. She talked about another hospital she had worked at that had a separate ER for psych patients and that was really great because she never had to deal with a single psych patient the whole time she was there. She thought that system was really better for everyone: medical and psych patients, and staff. The people who worked in the psych area were trained to work there as emergency mental health workers and knew how to best communicate with them and get them the treatment they needed. (Fieldnotes)

This nurse I spoke with during a ride-along blamed mental health patients for ER burn out and identified the group as an entirely separate population of patients from medical patients with whom she would rather not work. Based on her experience in hospitals where medical and mental health patients were together and separate, she believed ERs operated much more smoothly, to the advantage of all parties involved, when mental health and medical patients and staff remained separate.

Based on police officer accounts of people discharged before a mental health evaluation could be completed and the negative attitude towards psychiatric patients observed by evaluators and expressed by the ER nurses, it is possible that some police frustration and anger is misplaced on mental health evaluators. Psychiatric patients are considered a nuisance, difficult, and at times even lesser than patients who arrive in the ER for physiological reasons. It is not outside the realm of possibility that ER physicians would immediately discharge an individual who they do not believe meets M-1 criteria based on intoxication or past interactions without ordering a

mental health evaluation to free up the bed in the ER and save themselves and the entire ER staff from having to manage the individual.

#### POLICE-ER (LACK OF) COMMUNICATION

Overall, Officer Beckel's assessment was that between the police department and mental health professionals, "communication is not the greatest." He agreed that neither agency really knows what the other is doing and what they perceive their own role to be. (Fieldnotes, Officer Beckel has worked at EPD for 35 years)

The central issue leading to frustration and issues across the police and evaluators are due to a lack of communication across these agencies, which was an issue noted by correctional and medical professionals alike. Both parties want the same for people in psychiatric crisis and the larger community: they want to keep everyone safe. Every professional I interviewed voiced safety, and most also said that helping people were their professional goals, and recognized that both the ER and police were striving for the same. The discrepancies between organizations surrounded how to best accomplish this. Police believed more residential placements were necessary whereas the medical mental health professionals believed that there were more effective solutions than hospitalization.

Speaking with both groups of professionals, it became clear that they were observing the outcomes of the ER and evaluations from very different perspectives that result in two contradictory visions of the same system: ER evaluators considered it a positive outcome when people did not have to be admitted, whereas police considered it a failure of the evaluation process. The evaluators and Dr. Jay believed that mistakes will happen, and they have been made, but that they typically arrive at the correct decision for patients because most don't immediately come back to the ER. Police, on the other hand, are in a position where they disproportionately have to deal with the failed outcomes where people are released from the ER only to return soon thereafter, and never see the outcomes when patients are released from the

ER and aren't immediately once again in crisis. Considering an officer's perspective, it is not surprising that they are frustrated and some feel that the ER is ineffective and acting irresponsibly. The result is a system that includes frontline professionals working under two different sets of ideologies (i.e. management and control versus treatment), across three different organizations (hospital, Mental Health Center, and police department), observing two opposing outcomes, without an understanding of what each are doing.

The difficulty in establishing communication in the ER setting is the structure surrounding the interaction. Police bring patients to the ER with their paperwork (see Figure 3), hand off the patient to the ER, and leave the paperwork with the ER doctor or nurse. Police rarely speak with an evaluator because patients are physically evaluated before the doctor requests a mental health evaluation, and as long as patients are not acting aggressively, there is no reason for police to stick around the ER waiting for an evaluator who may take hours to get to the patient. The most senior officer I rode with, Officer Beckel "said he never spoke with a mental health worker at the hospital. He thought it would be nice, but it's just not possible because it takes the mental health worker so long to get to the people he brings in" (Fieldnotes). This means that, if communication and understanding between the ER and police is to occur, it needs to happen at the organizational level, from EGH, Mental Health Center, and Elkgate police administration, because the process of ER admissions prevents direct communication across frontline professionals. Possible options for this to occur will be explored in Chapter 7.

### *Consequences of Negative Communication*

We turned our attention to Steven who was still face down on the ground. I had noted early [sic] that from inside of the car he appeared to be crying. I was now able to clearly hear him and realized he was, in fact, singing to himself. I tried to make out his words but he was simply chanting gibberish. We then noticed the two men who were involved were still sitting in the van. One of them was Steven's father who appeared exhausted. The other was the woman's boyfriend who was able to pull Steven off of her. She had not



sustained any serious injuries and neither had the two men. The paramedics were now sedating Steven so that he would not injure any of them.

We returned to the woman who was inquiring about court ordered medication. The officers explained to her how hard those are to get and they told her that the best way to do that would be to press an assault charge against Steven. They told her that if she could show the judge evidence that Steven had escalated and was becoming a danger to himself and others, she had a better shot. She looked at the officer with a glimpse of hope and told him “court ordered meds would be a miracle! He has a gifted brilliance but his mind is just mush when he’s off his meds.” She watched as the paramedics loaded him onto the ambulance and then agreed to press charges. (Student fieldnotes)

When police become frustrated with the ER to the point that they are convinced of its ineffectiveness in offering individuals with mental illness any assistance there is the risk that police will choose or endorse, as in the case above, pathways through the correctional over the medical institution. I did not personally observe any instances of this, and none of the officers indicated that they had ever done this when I asked, which I took as an example of responder bias in my data. However some of my students who choose to do ride-alongs and fieldnotes for a class assignment reported that they had observed police directing people towards corrections and away from medical mental health pathways. In the above fieldnotes, an officer tells a woman that she should press charges against her grown son because the officer believes he is more likely to get the help she is seeking if he has the criminal history: the mother can go to a judge with “evidence that Steven is escalating and was become a danger to himself or others” based on the assault charge.

More evidence that police may believe that the jail is a better option for individuals with mental illness comes from an Elkgate judge’s presentation at a public event on the criminalization of mental illness:

Police can take people to the emergency room where they. . .feel that these individuals are probably going to be not admitted or treated with [anti-psychotic and/or anti-anxiety} medication and be released immediately. Or they can take them to jail where they know they will be safe, where there will be a high quality mental health jail and where they will have access to medication. So if you were a police officer, what would you choose?

As a representative of the corrections institution, this judge supports the jail's efforts with their mentally ill population and presents the facility as a place where inmates will receive treatment and support. The judge also supports police decisions to transport individuals to the jail over the hospital given the circumstances in the ER and does not refute the police perception of the ER as an ineffective in offering assistance for individuals in crisis. However, during the same presentation, the judge also indicated that changes should be made to the system in order that fewer individuals with mental illness are referred to the jail:

Our efforts need to be focused towards keeping people from going in the doors of the jail as much as possible. We have developed over the years some really wonderful and robust programs related to the criminal justice system...and I'm really proud of that. But we need to make sure...that we don't make the criminal justice system be entrée into quality mental health services.

After observing and speaking with professionals from both the correctional and medical institutions of Elkgate's mental health system, I would argue that the police would be less likely to use the criminal justice system as an "entrée into quality mental health services" if there were increased communication between the two institutions so that there could be mutual understanding across organizations and more inpatient placements available for psychiatric patients in Colorado. Without efforts to increase communication and understanding between police and the medical arm of the mental health system, police frustration will not change, and the practice of choosing corrections over medical pathways for individuals in crisis will not change. This has the potential to decrease the jail population, and save money to the benefit of the entire community, and individuals with severe mental illness could avoid the criminal justice system that places additional social barriers on their ability to succeed in the community once released.

## CONCLUSION

There are striking similarities between Elkgate's mental health system and Strauss and colleagues' (1964) organizational analysis of a psychiatric hospital. Half a century ago this research team observed interactions between the various professionals working in the same institution and came to the conclusion that "[e]ach professional tended to *represent* some ideological position. . . . Sometimes their beliefs were congruent or identical; sometimes they were very divergent and even in great conflict. When negotiations over them were unsuccessful or the results were dissatisfying to one or more parties, then the personnel became frustrated" (Strauss 1978:111, emphasis in original).

Although there continues to be negotiations and professional group alliances within today's mental health care in the medical context, as evidenced by the admission process in the ER, the increasing expansion of mental health beyond psychiatric hospitals to the community and correctional organizations and institutions has further complicated mental health systems, involving more players and more diverse ideological positions. In this way, the mental health system has become a complex interorganizational field (Warren, Rose, and Bergunder 1974) wherein multiple community organizations operate within a structural context. What Warren et al. did not consider was the additional issues when an interorganizational field incorporates social institutions traditionally independent of one another (this will be discussed and explored in greater detail in Chapter 7). In contrast to Warren et al.'s original depiction of the interorganizational field, the mental health system in Elkgate involves minimal direct negotiations and agreements between organizational players, and instead negotiations are largely structural (Zartman 1976). In other words, the interactions and outcomes between police and the ER are created and determined by how the system is organized more than how an individual

officer interacts with ER staff. This makes negotiation and consensus across the field more difficult.

There are inherent differences between medicine and corrections in the ways that each will approach and interpret safety. Increased collaboration and communication between these organizations in Elkgate is needed in order to limit frustrations that lead to greater interpersonal and interorganizational issues rooted in mismatched ideological positions. Most of the issues voiced by police toward the hospital and those by evaluators toward police can be partially explained by structural barriers to communication between these players at the ER. When officers take individuals to the ER and pass their paperwork over to the staff, they have completed their legal responsibility by ensuring the person is somewhere they can be prevented from causing harm to themselves or the community. There is no requirement from the police or the hospital that officers verbally communicate with a doctor or mental health evaluator, just that the paperwork gets passed off. Interpersonal relationships between individual officers and doctors or other ER staff are variable. During one ride-along the officer and an ER doctor discussed their personal lives—spouses, kids—whereas during another the officer and ER doctor seemed to make an effort to each do their duties while staying out of the other's way and only spoke to one another very briefly. Some officers will take it upon themselves to speak with a doctor when they bring psychiatric cases to the ER; however, the process at the ER is too lengthy in most cases for an officer to wait to speak with the mental health evaluator, who will make the recommendation whether to release an individual from a hold or not. This process creates a situation where any negotiations between police and evaluators are through paperwork alone.

The lack of face-to-face communication, and brevity of the paperwork communication, has negative consequences for both police and evaluator attitudes toward the other with both

parties believing that the other is not doing their job, putting more work on the other, and doing a disservice to individuals with mental illness. In the end individuals living with mental illness in the community risk the consequences when their mental health pathways are partially determined by some officers' perceptions of the medical institution's inaptitude and ineffectiveness.

## CHAPTER V: FROM MACRO TO MICRO: THE HEALTH INFORMATION PORTABILITY ACCOUNTABILITY ACT, INTER-ORGANIZATIONAL PROFESSIONAL COMMUNICATION AND PATIENT CARE

The current discussion surrounding mental health care in the United States exemplifies that “health care systems are shaped by historical precedents and embedded in larger institutions and specific cultural contexts” (Quandagno 2010:126). With recent extreme cases of violence where the perpetrator was found to have a diagnosed mental illness and had fallen through the cracks of the mental health system, mental health care, an area repeatedly vulnerable and victim to significant spending cuts, partly because they were largely unnoticed (Kelly 2006), has received national attention in the United States. After decades of cuts to mental health services, states have come to realize that saving money by cutting mental health can have disastrous consequences that can be significantly more than what was saved through the budgetary cuts. With mental health on politicians’ and policymakers’ radar, it is clear that the current state of mental health is inadequate and ineffective. However, before making sweeping changes to the system, there needs to be an understanding of what elements of the system are the most dysfunctional and why, as well as an exploration of practices that are effective.

The mental health system in the United States is frequently criticized for its fragmentation (Brown, Isett and Hogan 2010). Apart from the fragmented nature of the larger healthcare funding structure that provides funding and insurance from federal, state, and private sources, mental health care delivery is then also divided into various categories: medical and correctional; inpatient versus outpatient; public versus private. Each of these pieces must be understood in order to have a full grasp of the system. In order to fully understand mental health in the United States, there needs to be an understanding of its composite systems so we can understand how they come together as a whole, and then make changes accordingly.

With a system as fragmented as mental health, it is necessary to search for common ground across organizations, and target where shared elements are actually resulting in further fragmentation (Imershein, Rond, and Mathis 1992). Considering the mental health system is a collection of organizations and professionals with varying organizational-level norm and values, and roles and expectations for services from the community, it becomes necessary to examine the macro-level influences on the system as a whole through policy and legislation. Additionally, with the numerous divergent organizations involved in the care and management of mental illness, inter-organizational, intra-system communication is key for an efficient and effective system. The Health Information Portability Accountability Act (HIPAA) is a federal act that in part regulates the protection and privacy of patient medical information, including how the information is kept and who has access, which makes it the perfect lens through which to examine and critique the mental health system in action. In this chapter I examine the impacts of HIPAA on Elkgate's mental health care system, how the Act impacts each element of its system, how the structure of the provision of care mediates or aggravates the barriers created by HIPAA, and which patient populations are helped or harmed as a result.

Enacted on August 21, 1996, HIPAA was the first federal legislation to outline to patients and healthcare providers standards for the protection of patients' medical information. An integral part of the Act, HIPAA's privacy rule specifically addresses "the use and disclosure of individuals' health information. . .by organizations. . .as well as standards for individuals' privacy rights to understand and control how their health information is used" (U.S. Department of Health and Human Services, 2003:1). The Act is applied uniformly across all disciplines and locations of health care and systems of delivery, including government and non-government provided medical care.

To date a substantial amount of HIPAA literature in academia is research-focused, examining its impact on a medical researcher's ability to access data (Armstrong et al. 2005; Kulynych and Korn 2003; Ness and Joint Policy Committee 2007; Wolf and Bennett 2006). Most patient-focused research is in the legal literature, continuing an ongoing debate of the effects of information sharing on patient rights (Annas 2003; Baumer, Earp, and Payton 2000, and possible consequences of too much, or too little information sharing (Jacobson 2001; Scott 2006). A question left unanswered is how HIPAA may affect medical systems, and how these affect interactions with patients. This approach is particularly relevant to mental health care delivery because of its particularly fragmented system, reliance on patient interactions in making diagnosis and treatment decisions, and increased concerns surrounding patient privacy due to mental illness and psychiatry's ongoing social and cultural stigma (Horvitz-Lennon, Kilbourne, and Pincus 2006). I will examine two such systems' structures of care, Medicaid (federally mandated, state run health insurance for the poor) and non-government provided care (hereon referred to as non-Medicaid),<sup>18</sup> and HIPAA's impact on each.

## MENTAL HEALTH CARE THROUGH MEDICAID

In the state of Colorado, government-provided Medicaid has separate structures of care for mental and physical illness. Beginning in 1995, the state implemented a "carve-out" approach to mental health. Whereas physiological health is provided through a fee-for-service program, mental health decisions are made by Behavioral Health Organizations (BHOs) contracted by the Department of Healthcare Policy and Finance, the arm of the government that

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<sup>18</sup> The Veteran's Administration and Medicare are the two other major forms of government provided health insurance and care, neither of which are considered in this analysis. Like Medicaid recipients, the VA system delivers mental health care through organizations and providers that serve only VA patients. Medicare patients receive mental health care in the same way as non-Medicaid patients.



manages Medicaid (Verdier et al. 2007). BHOs work in the same way as a Health Maintenance Organization; the organization receives a set amount of money per individual under the health plan and decides who will receive care and how much money the organization is willing to risk on any given patient.

The Department of Healthcare Policy and Finance has divided the state into five catchment areas, each managed by a different BHO. All Medicaid patients are automatically assigned to a BHO based on where they live, and that BHO will be responsible for any mental health-related costs they incur. BHOs are then also responsible for overseeing the community mental health centers located in their catchment area. These mental health centers provide Medicaid recipients with all their mental health services including psychiatry and medicine management, counseling, drop-in centers, school-aged programming, crisis evaluation, and in-patient care. In other words, BHOs administer payment for services, and community mental health centers deliver the majority of services.

Whereas the Medicaid program provides a lineated system for mental health care where patients go to a single agency to receive all care, individuals with private or employer-provided insurance access mental health care through a process of finding providers covered by their plan. This involves accessing a list of covered providers, researching each to determine whose specialty areas best suit their needs, and calling each office to find one accepting new patients. For each additional provider an individual sees, they must go through the process again. By examining both systems, which are structured very differently and cater to different populations, through the lens of a federal policy relevant to both, I will give some insight into elements of each system that work to enhance or diminish effective mental health care.

## HIPAA'S ROLE IN THE MENTAL HEALTH SYSTEM

The first participants to mention the barriers HIPAA posed to their work with patients were private outpatient mental health professionals: licensed social workers, psychologists, or psychiatrists whose clients either paid out-of-pocket or had private insurance. These professionals felt HIPAA could be extremely constraining, particularly when clients were in a crisis situation resulting in an emergency room visit and, in some cases, inpatient hospitalization. Every private mental health professional I spoke with commented on difficulties they had incurred as a result of HIPAA guidelines.

HIPAA's requirements for patient consent in order for any provider to speak about a patient's case to anyone, including other care providers, are very strict. Community providers can be effectively shut out from their client's case while in hospital unless the client signs a release of information allowing the hospital to speak with the provider. Even in cases where the provider has third-party knowledge from a family member of the client that the client is hospitalized, the hospital is not allowed to discuss the client's status or give any other information regarding him/her unless there is a signed release form on file. Regardless of a community provider's credentials, treatment history with the patient, or role in patient treatment, those unaffiliated with the hospital holding the patient can be denied access to all patient information, including verification or denial of the client's admission.

. . .like right now I have someone in a psych hospital, and it was frustrating because, what happened was he didn't show up for his appointment and he was extremely depressed, and so I called and left a message at his home to call me. And his mother called me...and said you know, "I had an ambulance come and take him to the ER." And I'd not known where he was, and there's no way to find out because I can't really call his mom because I don't have a release to talk to her. And I ask her to let me know what happened, but she didn't. And so I called a psych hospital in this area, and just yesterday, and I said, "is so-and-so there?" And they said, well we can't release that information. Do you have the patient ID number? And I said, no I don't. Well are you a family member? No, I'm not. Ummm well I said, well I'm a mental health clinician, should this individual be there,

could you please take my name and number? [laughs] They said okay. . . .So those are the kind of hurdles that we end up having to deal with, you know. Should it have been something really crucial, you know, I don't know what I could have done. (Margerie, private practice outpatient social worker, 18 years experience)

Many providers discussed situations where they had no idea that a client had been admitted until either discharge planning occurred at the hospital, or even until the client returned for an office visit. Ralph, a licensed social worker with 25 years of experience, described one client with whom he has repeatedly experienced this:

Another client who's coming in this afternoon just came out of the hospital. She goes in and out of the hospital and she's involved with [other mental health services]...so she's sort of being redirected to different parts of the system and I just kind of take umm information when she brings it herself rather than trying to get reports, and in this case I could get a hospital report to find out what was happening, but they didn't contact me when she was admitted and I didn't know she was in the hospital until she was called to say 'I want to come back in.'

When community mental health providers are blocked from communicating with inpatient providers this does a disservice to the patient because the inpatient team does not get the full picture of the progression and possible patterns of the patient's mental illness as well as the progress the patient has made with the provider in the community. The hospital team is also left with an acute snapshot of the patient based on how they present in the Emergency Room and on an inpatient unit. This is especially problematic for first-time patients at a facility where there is no prior interaction or relationship with the patient.

Margerie described another case wherein a woman she had worked with had a sudden, and unexpected, psychotic break as a result of acute depression. Following this episode she was assigned a caseworker who knew nothing about the woman's social or psychiatric history. "But it ended up, after many, many months, that she got a really good caseworker who communicated with me to find out the history. Nobody else had inquired. And so when she signed a release for that individual to speak with me, then I felt like we could connect all the dots." Further

information and context from a community provider, who may have a long-standing relationship with the patient, would assist the inpatient team to better understand the patient, and would serve the community provider to have a better understanding of the current crisis in order to better assist the patient in the future, thus establishing continuity of care across inpatient and outpatient settings.

Taking a very different approach to the management of mental illness in the community than the outpatient providers, police also had frustrations and difficulties as a result of HIPAA-imposed knowledge and communication barriers. Although there are loopholes provided in HIPAA for police, these only apply when an individual's medical records are pertinent to an investigation or evidence of a criminal act. In most mental health crisis situations where police bring an individual to the hospital for evaluation, rather than jail, a crime has not occurred. Police bring individuals they believe are in immediate danger to themselves or others as a result of mental illness to the emergency room under state legislation, known as an M-1 hold, which provides for a 72-hour hold of such persons. When police bring an M-1 hold to the hospital, the patient may not have committed a crime, yet they are still held involuntarily until either the 72-hour period is exhausted, or a doctor releases the hold. Although the officer is the first professional contact and assessment, once M-1 patients arrive at the hospital all further information becomes medically protected, which police may only access when relevant to a criminal investigation (U.S. Department of Health and Human Services 2014). This means that even if they wanted to, officers could not check up on the majority of individuals they had placed on an M-1 hold, nor would they get any updates as to what happened to the person.

The issue with this lack of information is that police are unable to receive any feedback on their decisions to use M-1 holds, which is a problem considering the already existing mutual

frustration felt between the hospital and police. Mental health evaluators claimed that some officers really did not understand the criteria for mental health holds, and others would not give enough detail on their paperwork to assist evaluators in making their decision. In these situations, regardless of what occurred on the street with police, evaluators have no choice but to make decisions in accordance with what the patient is telling them, whether it is true or not. As described by a senior mental health evaluator at the hospital:

Even if I can't get collateral information [about an individual's recent mental health from family, friends, or care providers], I have to go on whatever they're telling me. Because I can't say, I can't say that "they're really not telling me the truth." I have to go on what they're telling me, and, you know, facilitate the appropriate level of care based on what they're telling me.

On the other side of the interaction, every officer I spoke with expressed frustration that the hospital very rarely kept people longer than a few hours. If officers were able to get feedback from the hospital, the two agencies could begin to facilitate a mutual understanding of the decisions made on the street and in the hospital. Such feedback would have the potential to influence decision making by police on the street, keeping in mind the type of individuals likely to be retained on a hold, and the key information and level of detail needed on the paperwork. One police sergeant described the possibility of opening this line of communication as a learning tool for officers, and the current frustration due to legislative barriers:

But if you know—like if it's this direct line [between the hospital and police], you know if. . . this person really did need serious help, because then we're learning from it, too, you know, but we never get to have that opportunity. Very few of us do. It's like "okay. I made a judgment call here. Did I do the right thing? . . . Because at that point [when police take individuals to the ER] it becomes medical protection. But what are they protecting it from? So you see what I'm saying? I just wish there was this better line so if I wanted to follow up on somebody, so "I was really worried about this person, I'd just like to know where they went."

HIPAA was a source of frustration for police and community mental health providers alike. While working under different circumstances, both found it frustrating that they could not

receive information from the hospital, and felt that they could do better work if they were unimpeded by HIPAA-imposed barriers.

In a context where HIPAA does not pose these structural barriers to communication across professionals, we can see how efficiency and patient care is improved by the allowance of shared information. For the Medicaid-contracted Mental Health Center (MHC), HIPAA was a non-issue. During their initial intake, patients are informed that MHC will protect their privacy from external individuals and agencies, but providers and programs within the agency have open access to the majority of patient information.<sup>19</sup> This is particularly helpful when a client receives services from MHC's Emergency Psychiatric Services department and an evaluator can access the individual's medical record with the agency. As one emergency evaluator explains, "we generally, generally see people who are [MHC] clients, so in that case the [health] record is open to [evaluators]...anyone [MHC] works with will be part of our [patient record] system."

In addition to better facilitating the crisis evaluation, any mental health professionals the client is working with at the time of the crisis will also receive immediate notification and a full report of the emergency evaluation: "whenever [providers] come in in the mornings, they have a list of whoever's been seen [by Emergency Psychiatric Services] that's their client, and so they'll be alerted of who's been seen and can read the report." By providing a closed agency where professionals working in various departments and programs are able to share information freely without the constraints of HIPAA, Medicaid patients benefit from improved continuity of care.

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<sup>19</sup> The HIPAA Privacy Rule assigns additional protections to psychotherapy notes: "notes recorded in any medium by a mental health professional documenting or analyzing the contents of conversation during a private counseling session." When kept separate from a patient's medical record, these notes cannot be released to a third-party without specific patient, or authorized representative, and professional authorization. In most states, including Colorado, mental health professionals are not even required to honor requests by the patient to access their psychotherapy notes (Holloway, 2003:22).

## PROFESSIONAL INFORMATION EXCHANGES IN MEDICAID AND NON-MEDICAID STRUCTURES OF CARE

Medicaid patients, who are financially underprivileged relative to their insured, Medicaid ineligible counterparts, are more likely to experience a higher level of continuity of care in their mental health care because their providers at MHC are able to freely communicate with one another. This is true of more commonplace outpatient appointments and programming; however, the gap between the two systems becomes much more prominent in crisis or emergency situations. To explain this disparity, I look to the differences in the structure of the two systems.

MCH applies a case management model to client care. As described by one participant who has worked both in private practice and at MHC, “case management is essentially the coordination [with other providers] of work that you do. [For example] it is talking to teachers at a kid’s school when a kid is having behavior problems at school.” This model strives to ensure that all providers working with a single patient are aware of what each is doing with the patient, and updating one another on progress, setbacks, or any notable event. In private practice, providers do significantly less case management, and can only do as much as their patients allow. With the exception of situations related to patient safety where providers can choose, or are legally mandated, to provide patient information to a third party without patient consent, each contact with another provider must be approved by the patient, or legal guardian, and a HIPAA release signed.

A more significant barrier than HIPAA to case management cited by private practice providers was the payment structure in place. In private practice providers are paid either out-of-pocket by the patient, or through insurance companies. In either case, providers bill for time they spend with patients directly, which means that there is no way to compensate any time spent on the patient that does not involve direct communication for the purpose of counseling or therapy.

This payment structure significantly limits providers' ability to utilize case management. The only ways a provider can accomplish thorough case management are by either extending their workday, or seeing fewer patients. Sally, a licensed social worker and registered nurse, who has had her own practice for 17 years, explains the difficulty of coordinating communication with psychiatrists.

Some of the psychiatrists are very hard to get a hold of, and it's again that case management. When you're making those calls, how many people are they seeing in a day? They may want to stay in touch with you, but that can easily take away 2 or 3 hours of their revenue, okay? So until there is a sort of organizational support for that, what happens in the agencies is [case management is] valued and seen as important and you're paid no matter if you see 20 clients today or 5. And if you're in a job where you're trying to coordinate with a lot of [professionals], you can't see many [clients] because all those other [professionals] you're coordinating with are just as damn busy as you are. So technology has the potential for being really helpful with that, but you have a lot of HIPAA violations when you're using technology, so you know, that's a problem.

Sally also brings up that HIPAA does have a role in the difficulty of case management in private practice because of the difficulties of communicating via technology. Most private practitioners do not have a secure messaging system through e-mail, so they have no other option but to coordinate with other providers over the phone at mutually convenient times. Medicaid patients are more likely to be severely mentally ill than non-Medicaid patients (individuals qualifying for disability, including disability due to severe and persistent mental illness, also receive Medicaid), and therefore access more services and providers. However, a combination drug and psychosocial therapeutic approach is increasingly prescribed for, and considered the most effective treatment of, mild to moderate mental illnesses (Mayo Clinic 2012). As a result, private practitioners' clients will also frequently access mental health services from multiple providers.

Private practice is not the only option for non-Medicaid patients to seek treatment. Individuals may also see a therapist and psychiatrist at an outpatient clinic or agency where providers would have a similar environment of patient information exchange as MHC. I was



unable to gain access to any such clinics for this project, but examples would include outpatient psychiatric clinics affiliated with hospitals, and university psychiatric services. These services do allow for an increased level of provider communication; however, there is still a gap between outpatient care and the hospital in the event of a crisis requiring hospitalization because nearly all patients must go through an emergency room for psychiatric and physiological evaluation to determine suitability for inpatient care. Whereas non-Medicaid patients' emergency room visits involves evaluation by a separate agency from their outpatient care, MHC staff members, who have access to patient records, evaluate all Medicaid patients entering any hospital within MHC's state-assigned geographic region.

MHC is structured to be an umbrella provider for Medicaid patients: the vast majority of mental health-related care patients require is met through MHC and their partnerships with other social agencies in the region. A former provider at the Mental Health Center explains,

The Mental Health Center is actually put together in a really good way that all of these collateral places are sort of used to being able to talk to people [at the Center. . . . Particularly people with major mental illness. . . when you have people who have a multiplicity of needs, you know, they have housing needs, they have socialization needs, they have oftentimes personal hygiene, just grooming, they don't know how to cook for themselves, you know.

One important collateral place is the local emergency room, where Medicaid and non-Medicaid patients, although arriving at the same location, are processed very differently.

#### MEDICAID AND NON-MEDICAID PSYCHIATRIC STRUCTURES OF CARE IN PRACTICE: THE ER

When a non-Medicaid patient arrives at the local hospital emergency room with psychiatric concerns, once physiologically cleared, a mental health evaluator will assess them to determine if they are safe enough to be released or should be placed on an inpatient psychiatric unit. As described by a hospital evaluator:

So we're looking at what's the presenting issue; why are they there? We're gathering lots of history. We're determining whether drugs or alcohol are involved, generally we do a urine tox screen and a breathalyzer and assess—most of the time what we're doing is assessing suicidality. So we have the patient complete a Beck depression inventory...so if they check number 9, that they're suicidal, then we have them do the Beck suicide scale, so that gives us a lot of information about their suicidal ideation or plan and intent at this time and we can go further with the patient about that...And then of course if they're brought in on a [M-1] hold, we have that hold information on that mental health hold to help us make that assessment. And we rely upon collateral contacts, too, to provide us information like family. Doctors who are treating them. Therapists.

When I asked evaluators about using providers as collateral contacts, the response was they might try to contact a therapist or psychiatrist if they felt they needed the additional information. In situations where patients were not cooperative with evaluators in contacting individuals for further information, HIPAA did not pose a barrier. A pamphlet for emergency department medical providers developed by the U.S. Substance Abuse and Mental Health Services Administration ([2006] 2011) I received from an interview participant, explains that emergency physicians are permitted “to communicate directly with a patient’s family or other caregiver, even if a patient objects” when they believe “that disclosure is in the patient’s best interest” (pg. 3). HIPAA also allows for ER physicians and evaluators to “share information about the person with other medical providers who are involved in the person’s care, both within and outside your institution” (pg. 4).

Although the HIPAA provisions theoretically allow emergency room personnel to speak with a patient’s outpatient mental health provider(s), this also requires that a patient arrive at the ER during the small window of time when providers are in their office and able to answer the phone. Not one of the outpatient providers I interviewed reported ever having been contacted by an ER evaluator. Furthermore, even when patients were admitted, every outpatient provider said they were rarely contacted until a patient was planning for discharge at the end of their hospital stay, and some reported instances, as mentioned above, when they had no idea a patient was in

hospital until after their discharge. These accounts were contrary to hospital practice of involving community providers described by a senior mental health evaluator at the hospital. “Once they’re admitted we always, that’s part of their treatment, the outpatient providers we have them involved, totally. So we’re working together with them to get the patient the best care, and to get them then referred back to them at discharge.”

Non-Medicaid patients are in a system where the hospital and outpatient care are two independent units that have minimal interaction with one another, even while they have overlapping patients. As described by an outpatient provider:

The hospital is a free-standing unit. They do their stuff. They don’t contact you as a private clinician. You know, they don’t contact you because this person is going into the hospital. They contact you because the hospital is going to release this client tomorrow or the next day and “we have to have on our piece of paper that they have an appointment,” and they have a client call and set up an appointment. And so as long as they have that, they’re fairly comfortable, you know. I always get releases [for medical information] and I always try to talk to someone [at the hospital], but the quality of that information is pretty variable.

Having the ER and inpatient care so fragmented from outpatient care means little to no continuity of care through information exchange at a time when patients, and the system as a whole, stand to greatly benefit from the practice, by assisting with effective care when patients’ illnesses are most acute.

On the other hand, Medicaid patients have that continuity of care in crisis situations through MHC, which has a 24-hour Emergency Psychiatric Department (EPD) for patients in crisis. Not only do EPD staff conduct in-office evaluations, but they also will travel to patients unable to get to MHC. The other major function of EPD is performing all mental health evaluations of Medicaid patients in all emergency rooms within MHC’s geographic region. EPD does encounter patients who have Medicaid and no prior interactions with MHC, but the majority of patients they evaluate are already in the patient information system. As a result,

evaluators typically enter into patient interactions with information on clients' psychosocial and psychiatric history, which may provide context for the current crisis. When I asked one MHC evaluator to detail the evaluation process, she began with the patient interaction, but quickly adjusted her response to account for the information gathering prior to seeing the patient.

When you sit down with a client, well, [the evaluation] starts even before that. An evaluation, usually you want to, if they're an open client of ours, umm at [MHC], you want to open up our [electronic patient information] system and look and see if any other evaluations have been done recently, or even to a year ago. I usually go back and I look and I read any previous evaluations, up to 2 or 3, and just see what the presentation was and what they were being evaluated for. I look at their diagnosis. I look at their current medications. And then I look up at if they've missed any appointments recently and why. Did they call and cancel? Did they just not show up? ... Then I go to the hospital, and then I usually meet with a nurse for the client, and I ask how they've been since they've arrived here? How did they get here?

This allows for a more effective evaluation and assessment of the patient than a non-Medicaid patient would receive at the hospital because evaluators have more than the information they are able to gather from the patient and, when available, collateral contacts to draw from when making their recommendation for the level of care required. As long as a Medicaid patient has previously made contact with MHC, they will have a degree of continuity of care due to MHC's care provisions and information exchange that the non-Medicaid patient lacks.

The one exception where there would be some continuity of care for a non-Medicaid patient is a severely mentally ill patient who frequents the same ER. During a police-ride-along with Officer O'Keeley I observed one such case involving Curtis, a teen reported as a runaway found sitting on the curb in a wealthy residential area by a resident of the neighborhood who reported the unusual scene. Based on his name brand clothing from head to toe, I assumed that Curtis is from a privileged family. Initially Officer O'Keeley was bringing the boy to the hospital to get medically cleared before releasing him back to his parents; when we made contact with Curtis he had scratches and superficial open wounds on his face. However, once at the ER, the

first nurse to evaluate Curtis requested that Officer O’Keeley put him on a mental health hold largely based on Curtis’ prior interactions with the ER.

The nurse spoke with Curtis, asking questions about his injuries, medical history and personal information. The nurse had to repeat a lot of the questions multiple times and he didn’t know the answers to some of the questions, like the name of his general practitioner, which surprised me that someone his age wouldn’t know that. After looking him over a bit, she asked to speak with Officer O’Keeley outside the room. After stepping out, she asked what he was brought here for: a mental health hold? Medical clearance for the jail? . . . Once we were out of the room the nurse looked at Officer O’Keeley and said “are you sure you don’t want to put him on a hold?” Officer O’Keeley asked if that’s what she thought was best, and she answered in the affirmative. She said that they had seen him multiple times at the ER and he has an extensive psychiatric history, referencing the three or four psychotropic meds Curtis had told her he was on. (Ride-along fieldnotes)

However, with frequent non-Medicaid ER patients, like Curtis, the continuity of care comes from his frequent visits to the same ER so that staff are aware of his issues and history, along with his standing medical record at that particular facility. He sees the same people when he is in crisis and then sees a different set of professionals as an outpatient. There is no evidence of communication between these two groups, and therefore, in Curtis’s case there is no bridge to establish the kind of continuity of care across these sources that MHC provides for Medicaid patients.

#### PITFALLS OF ORGANIZATIONAL CONTINUITY OF CARE?

While the general consensus across studies addressing continuity of care indicate its positive correlation to patient satisfaction (Saultz and Albedaiwi 2004), treatment effectiveness, and health outcomes in both physiological and mental illness (Adair et al. 2005; Cabana and Jee 2004; Saultz and Lochner 2005), most research focuses on relational continuity (an ongoing relationship between a single provider and patient) as opposed to management or informational continuity of care, which focus on providers’ ability to access and follow patient history, and coordinate care across providers (Haggerty et al. 2003). Each care provider discussed here offers a

different type of continuity: MHC's structure of care provides patients with both management, informational, but a lesser degree of individual; private community providers offer a high degree of individual, but the structure of care and HIPAA restrictions make informational and management more difficult; the ER only has informational for repeat patients through patient records. Traditionally, the focus of continuity of care has been solely relational; however, with the evolving medical system into a greater number of sub-specialties and agencies or organizations as providers rather than a single physician, there is greater need for understanding and the study of continuity of care as it relates to "coordination and the sharing of information between different providers" (Gulliford 2006:248). MHC and the ER offer glimpses into the provider and organizational focused continuity of care typologies as they relate to individuals with mental illness in crisis.

The situation with Curtis was an atypical scenario. As stated earlier, officers generally expressed frustration and exasperation over the ER releasing holds. Here a nurse actually requested one. Towards the end of the ride-along Officer O'Keeley and I had returned to the police department and an officer stopped Officer O'Keeley in the hall asking about the call, and remarked on its uniqueness.

The nurse, who has access to Curtis' medical history, essentially instructs Officer O'Keeley to place Curtis on an M-1 after speaking with him for no more than five minutes. At that point Officer O'Keeley and myself have spent about 30 minutes with Curtis in the patrol car and at the hospital. Officer O'Keeley clearly did not believe Curtis met M-1 criteria, as he had not already placed Curtis on the hold, and had made no mention of even considering it. I also had not noticed anything in Curtis' demeanor or behavior that would indicate an M-1 was necessary. He had run away because, in his words, "I couldn't stand my parents," and appeared as though

he had not showered in a few days, but the status of disgruntled teenage runaway in need of shower is far from sufficient to meet criteria. Although more suspicious, nor were the scratches on his face that he admitted in the patrol car were self-inflicted, because there was no evidence that Curtis had any suicidal intention or desire based on his injuries or when “Officer O’Keeley asked him if he wanted to hurt himself or anyone else, and Curtis emphatically said he did not” (Ride-along fieldnotes). Officer O’Keeley’s completed M-1 read like a justification for Curtis to *not* be placed on the hold:

Officer O’Keeley gave me the form to look over. I read through what he had written and was confused as to how it fulfilled the requirements for a hold. On the narrative section of the form, he had written what had happened: the “reporting person” had called in about a person sitting on the curb, we arrived and saw Curtis had the cuts, which he admitted were self-inflicted, and when asked Curtis says he does not want to hurt himself or anyone else. Although he had written that Curtis says he does not want to hurt himself or anyone else and had not given any other information about why he would think otherwise, on the space on the form where he had to check a box indicating the reason for the hold, Officer O’Keeley had checked off “appears to be an imminent danger to self.” (Ride-along fieldnotes)

We left the hospital while Curtis and his parents, who had arrived soon after Officer O’Keeley completed writing the M-1 hold, were speaking with the mental health evaluator, so I cannot say whether the M-1 was released or not, but it did appear as though Curtis would likely be transferred to an adolescent psychiatric unit. Once his parents arrived we learned that Curtis had “‘severe bipolar’ and was on some new meds, but there were obviously problems with these meds because he became unmanageable, which culminated with him leaving the house” (Ride-along fieldnotes). Before coming to the hospital, Curtis’ mother had been able to contact his psychiatrist, who wanted Curtis admitted.

As Curtis’ story unfolded, it did appear as though the nurse had made the correct call to place the M-1, triggering the process of a mental health evaluation and consideration of admission; however, I still questioned her rationale given what she knew at the time. At one

point I was able to do an informal interview with her. She believed Curtis met criteria for gravely disabled, not danger to self or others, because “he’s not speaking clearly and can’t answer some basic questions, and left his home without adequate clothing” (Ride-along fieldnotes).

Although the nurse did not reference his mental health history, or current psychotropic medications, when she told me her rationale for wanting Curtis’ hold, they were the only things she mentioned to Officer O’Keeley when she requested the hold. It would seem by the way that the story unfolded that the nurse was not incorrect in her desire to place Curtis on a hold; however, the evidence suggests that her request was done prematurely and based strongly on his history at the ER. Curtis’ presentation of mumbling, not answering basic questions, and leaving home without a jacket could just as easily be attributed to teenage behavior; however, with his mental health history known, the nurse views these actions as evidence of Curtis’ need of a mental health hold. In other words, due to the informational continuity of care available at the ER, Curtis’ rights and freedoms have been substantially curtailed before the providers had the information or any evidence that would indicate that he met criteria for a mental health hold at that moment.

In other cases, the ER may discount an individual’s claims based on their prior interactions with them. One officer told me that in his most recent M-1 hold, the hospital refused to take a homeless man who had made suicidal claims because of his intoxication and frequency at the ER.

Officer C did tell me a story about the last M1 he did, which had been a few weeks prior. The man was drunk, and someone who has frequent contact with officers, so Officer C knew who he was when he asked him what was going on. The drunk man made a comment that “I don’t want to do it anymore” and said other things that indicated to Officer C that he was suicidal, including describing how he would kill himself by jumping in front of a bus. Based on what he had said, Officer C took the man to the ER on an M1, but once he arrived at the hospital he was told that he can’t be on an M1 because he is drunk and the hospital staff sent him away to take the man to detox. Officer



C figured this was because people often say things when they're drunk that they really don't mean, so once he sobered up, he most likely would no longer meet the M1 criteria, and this was someone the hospital was very familiar with. Officer C hypothesized that perhaps they were also not willing to keep him there under an M1 because they knew him and this was something he did a lot, but he didn't know if what the hospital had told him, because the man was drunk he could not be on an M1, was true or not. (Ride-along fieldnotes)

In this story, the hospital assumes that the man's suicidal comments are entirely attributed to his intoxication, and refuses him access to a mental health evaluation, because he is "a regular" and the ER has repeatedly dealt with him under similar circumstances. Many officers had similar stories of the ER either refusing to take intoxicated "regulars" they had placed on an M-1, or officers believed the ER would release them prematurely (before they were sober). These are cases where individuals are stigmatized based on their prior interactions with the hospital resulting in a decreased level of care.

Similar to the status of "intoxicated regular," a patient's status based on their diagnosis can result in preconceived notions of the patient resulting in differential assessment and treatment (Corrigan 2007; Nordt et al. 2006; Sartorius 2002). Since every psychiatric diagnosis is based on some combination of interactional, behavioral and/or affective symptoms, patients can begin to both see themselves, and be seen by others, through the lens of their diagnosis (Corrigan 2007; Goffman 1961; Link 1987). Although this can still occur with providers with whom patients have established a longtime relationship, providers who have only "met" a patient by way of their records may be more likely to interpret current presentation as a symptom of their mental illness, thereby illegitimizing patient accounts. One MHC EPS worker described a scenario where an ER doctor was certain a patient was "faking" suicidality based on evidence of a personality disorder.

So one situation that comes in is the person's like, the doctor's like "this person's faking it. They're saying that they want to commit suicide but I don't really believe it." But then

I do the evaluation, and this person does have a personality disorder, but they also have a number of situational stressors, that they're not willing to keep themselves safe. If they leave the hospital I'm very concerned that they won't be [safe], that they might actually make an attempt, even if it's out of vengeance and spite for being released.

Finally, even when there is relational continuity of care it is possible that a previous negative or traumatic experience with a patient will impact future interactions. Another MHC EPS worker told me about a scenario when she and the on-call psychiatrist disagreed in their view of the required level of care a patient needed. Whereas the EPS worker believed that the patient could have safely gone home with follow-up appointments, the psychiatrist believed she should be admitted based on the psychiatrist's past interactions with the patient.

When I called the psychiatrist I was recommending discharge. And it just so happened that this particular person had a pretty severe suicide attempt in which that psychiatrist was present for. And [the patient] had come within, probably, minutes of actually taking her life. And so he decided that he didn't want to discharge her. She was a little unstable. I think she would have been fine [if she had been discharged].

During crisis evaluations evaluators speak with patients and any collateral contacts (people with them in the ER, family, friends, and/or current providers), gather the information from the patient, collateral contacts and medical records, and make a recommendation of what they believe should happen to the patient. They then call the on-duty psychiatrist who has the authority to either admit or discharge a patient, and, when necessary, release a hold. In this case the evaluator had spoken with the patient, believed that she would be safe if released, yet the psychiatrist, due to his prior traumatic interaction with the patient, vetoed the evaluator, opting for admission.

These cases question the benefits of continuity of care for psychiatric patients. While provider knowledge of patient history is generally considered important and beneficial, particularly for chronically ill patients, it could also be detrimental when applied to patients with stigmatized medical histories.

## DISCUSSION AND CONCLUSION

HIPAA has an impact on the entire mental health system. Police interested in what happens to individuals they bring to the ER find it constraining because they are unable to receive any feedback on the individual's outcome, whether admitted or released. Some officers found that difficult because they had a vested interest in certain cases, and would like to make sure the person gets help, while others just wanted to get the feedback from the hospital that they had made the right call to place a person on hold. Non-MHC community providers found the same Act made it difficult for them to co-ordinate with other providers working with their patients, and were particularly frustrated with the communication barriers when patients were admitted to hospital. In this regard MHC has an advantage over the rest of the system because they have a closed system of providers who have access to patient records, and care that extends beyond the center to emergency rooms.

Although HIPAA addresses and is largely enforced by healthcare providers, institutions, and administrators, the Act is intended to benefit patients. Using MHC and the ER, where there is ready access to patient information, there are two possible, and contradictory, implications of broadening provider access to psychiatric patient records in regard to patient care.

### *Broadening HIPAA Benefits Patients: "Compensatory Conversion" and Continuity of Care*

In their seminal work exploring some of the processes behind the fundamental cause theory (Link and Phelan 1995), Lutfey and Freese (2005) assert that one of the "intervening mechanisms" (pg. 1327) in the positive correlation between health and socioeconomic status (SES) is compensatory inversion. This means that populations that most need increased health resources, education, and tools, actually receive fewer than those who have less need. The way that MHC operates relative to treatment opportunities of non-Medicaid patients does not support

compensatory inversion as an intervening mechanism in the health-SES relationship. On the contrary, the Colorado Medicaid carve-out structure has created, what I have termed, a *compensatory conversion* for eligible individuals with mental illness in Colorado.

By providing a “one-stop-shop” for individuals with mental illness with uninhibited information exchange between providers, MHC is able to establish continuity of care to Medicaid patients. What makes this structure of care unique to Medicaid mental health services is the continuity of care extends beyond outpatient services to inpatient suitability evaluations and admissions, effectively bridging the gap between community and hospital treatment services. The hospital is a particularly important juncture for continuity, as proper and informed follow-up care reduces the chances of patients returning to the ER, and subsequent inpatient treatment (Gill et al. 2000), and results in improved patient outcomes. Apart from rare cases, psychiatric patients will have a different set of mental health providers when they are in the ER and hospitalized than their outpatient providers, so the only way to establish continuity of care is through provider communication and information exchange.

MHC’s single-provider organization for all mental health services, including emergency mental health, means that HIPAA is a non-issue for provider communication and information exchange. This may place Medicaid patients at an advantage over non-Medicaid patients in terms of continuity of care because all providers working with the same individual are able, and encouraged to communicate with one another. When done effectively, it is possible that MHC providers have a better picture of their patients’ mental health, and can utilize a team approach to mental health care.

Medicaid eligible individuals are by definition a low SES population. Individuals qualify for the government provided insurance due to their low income and/or disability status. Medicaid

mental health patients are also disproportionately living with severe, persistent mental illnesses and represent a majority of the lowest-functioning individuals with mental illness. This is one important distinction between these two mental health systems and the two diabetes clinics examined by Lutfey and Freese (2005). Whereas the primary distinction between the diabetes' clinics was the SES of the patients of each clinic, the SES disparities between the patient populations of the two mental health systems examined here are further complicated by illness severity. The findings of this project cannot lay claim to whether the greater continuity of care provided to Medicaid patients is the result of MHC's structure of care geared toward a low-income population, or a function of the population's greater need for services. This is an area for future research.

#### *Broadening HIPAA Disadvantages Patients: Stigma in Psychiatric Records*

Although HIPAA may create barriers to communication across providers, the result is a greater degree of privacy protection, and control over medical information, for non-Medicaid patients. It is also important to note that Medicaid patients are also subject to increased surveillance because they have no choice but to submit to reduced medical privacy within the confines of MHC providers, giving them less autonomy in their mental health care. Whereas non-Medicaid patients receiving care through private practitioners have the choice whether they want their providers to communicate with one another outside of HIPAA-provided loopholes for emergency situations, Medicaid patients are not given this choice. Representing a population receiving state welfare benefits, Mental Health Center patients are subjected to increased state surveillance (Moffatt 1999) and a decreased right to privacy in exchange for mental health care.

Both the ER and MHC are spaces where patient history is available to any professional with access to the facility's patient records. This represents continuity of care at the

organizational level, as opposed to individual providers in private outpatient care. Provider knowledge of patient history has long been established as important and beneficial (Hampton 1975; Sandler 1980), particularly for patients with chronic illness (Castrejón et al 2012), as can be the case in mental illness. However, it could also be detrimental when applied to patients with stigmatized medical histories. In the case of mental illness, where stigma and preconceived notions of patients based on history by providers exist, it is possible that organizational continuity of care may serve to harm patients by either placing or maintaining a hold when there is not adequate evidence, or perceiving patient complaints or concerns as invalid.

Whereas mental illness writ large is widely documented as a stigmatized status in the larger society (Cooper et al. 2004; 2003; Fink and Tasman 1992; Markowitz 1998) its stigma is more nuanced and complicated within psychiatry. In psychiatry, mental illness is stigmatized based on diagnosis and patient history (Corrigan and Kleinlein 2005; Nordt et al. 2006; Sartorius 2002). Although education and personal contact are generally considered strong mediators of negative attitudes towards a stigmatized group (Livingston et al. 2012; Spagnolo et al. 2008), mental health providers are not free from stigmatizing individuals with mental illness. In fact, some research suggests that mental health professionals display *increased* negative attitudes towards the mentally ill than the general population (Nordt et al. 2006). In this sense, psychiatric spaces vis-à-vis the provider-patient relationship are best represented, in Goffmanian terms, as a “civil place” where individuals with mental illness are “carefully, and sometimes painfully, treated as though they [are] not disqualified for routine acceptance when in fact they somewhat are” (1963:81). Although hospitals, and their psychiatric staff in particular, may attempt to create an atmosphere where mental illness is an illness like any physiological one, in reality it is

possible that when patient medical histories are available to professionals, they are stigmatized and treated differently based on professional perception of their history.

A debate exists surrounding HIPAA in regard to patient privacy. On one side is the argument that the Act creates barriers to providers, which ultimately does a disservice to patient care (Salem and Pauker 2003). The other side argues that the Act does not do enough to protect patients' medical information, allowing too many loopholes that grant access to patient medical information (Scott 2000). The former would argue that Medicaid mental health offers patients an improved system by allowing for increased continuity of care, while the latter would state that Medicaid patients are at a disadvantage because of their lack of control over information exchange and its consequences in light of on-going stigma facing mental illness.

#### *Directions for Future Research*

This chapter presents two possible consequences of HIPAA and the structure of care delivery as they apply to mental health and illness. First, HIPAA is too stringent, resulting in a mental health system where the players are unable to communicate. Second, when the structure of care is adjusted so that HIPAA does not create these barriers, patients receive a lower level of care and discriminatory treatment because of stigma toward particular psychiatric diagnoses and patient histories. Before we can move forward with policy, we need a clearer picture of these two contrasting outcomes.

The present research considers how professionals interpret the current Act and its impact on their practice in that professional role; however, there is some concern that health professionals may not fully understand the limits of HIPAA and may be actually over-applying it, meaning that they are not disclosing information that could be shared (Matthew 2014). Future research should take into consideration both the legal intensions and meanings of HIPAA as it is

written, and its interpretation by providers. Second, I was unable to examine the patient records available to providers, nor did I ask about what details are written into reports that go into patient medical history. In order to establish a stronger linkage between professional stigma towards patients and the medical record, future research should focus on the medical record itself: how is it created, what goes into it, and how professionals interpret it. More insight into both of these issues would present a better picture of HIPAA as it relates to mental health, as well as other stigmatized illnesses, and medical record sharing and communication across providers.

### *Finding a Home for Mental Health in U.S. Medicine*

Mental health in the United States has long struggled to find its place in the health system and medical landscape. Although medicalized through separate “treatment” facilities and medical doctors beginning in the mid-19<sup>th</sup> century and the discovery of effective psychotropic medications beginning in the 1950s, psychiatry has continued to be apart from physiological health to some degree. Within the last two to three decades there has been some push, led by members of the psychiatric and patient advocacy communities, to consider mental illness as a neurological illness created by variations in brain chemistry that should be treated no differently than any physiological illness (Hawes 2013). On the other hand, from a medical standpoint, mental illness is not the same as most physiological illnesses because diagnoses and treatments are subjective based on behavioral and affective symptoms reported by the patient and interpreted by providers (Kendell 2001).

The tension in mental health and illness between being equal to, and yet also separate from, physiological health and illness is evident in the health policies discussed here. HIPAA is applied blindly across all sectors of health care without regard to the unique symptomatic elements of mental illness that can periodically render patients unable to make health decisions



that could be in their best interest. For example, paranoia, a common symptom of multiple mental illnesses, may cause a patient to refuse to sign a disclosure between an inpatient facility and their community provider(s). In such a situation, even if the facility wanted to, HIPAA can prevent any inpatient provider from contacting outpatient providers involved with the patient. In this way, issues with patient refusal to consent to medical disclosure can be unique with mental illness, yet HIPAA does not allow for any alterations in its application based on area of medicine, with the exception of a distinction between psychotherapy notes and medical record that applies greater protections to the former. At the same time, Colorado's decision to implement the carve-out program for Medicaid mental health funding and treatment indicates that there is also some belief that mental health is unique from physiological health. This fragmentation of Medicaid delivery indicates a desire to separate mental from physiological health, at least in its administration. As we move forward with national and state mental health policy and practice, we need to recognize this incongruence. Based on the evidence provided here, I would argue that mental health should be separate from traditional medicine due to its ongoing stigma and uniqueness in presentation and diagnosis. Until mental health diagnosis, treatment, and practice is more akin to physiological health, future health-related policies should recognize mental as separate from physiological illness.

Mental health and illness is of national concern. Although the detrimental results of an underfunded and overburdened system have received attention recently, the United States is at a point where there is an understanding that the system is not working, and the majority of calls for change involve significant increases in spending and allocation of funds to mental health programs and systems. Although more money has the potential to improve both the quality and quantity of mental health services, issues in patient care related to legislative barriers will

continue unchanged. As the nation moves forward in its examination, and possible overhaul, of the system, we need to consider the multi-level dimension of mental health care. This is a massively complex system that includes the medical and corrections systems, private and public care delivery, and institutional and community dimensions of care. Finally, we also must consider the multi-level impacts of changes in policy, legislation, and practice in terms of a downward trajectory from the macro- to micro-level, meaning that the doctor-patient interaction, and patient experience particularly, need to be an on-going consideration to all proposed changes. If the intention is to create a system that better services individuals with mental illness, thereby better servicing the entire community, we need to hear and understand patient experiences.

## CHAPTER VI: “LOST IN THE SYSTEM”: POPULATIONS LOCATED BETWEEN ORGANIZATIONAL SILOS OF THE MENTAL HEALTH SYSTEM

Up to this point I have focused on Elkgate’s mental health system and its component organizations. While useful in conceptualizing and understanding the mental health system, this approach offers minimal insight into distinct populations within the array of individuals living with mental illness. In this chapter I consider how the structure of Elkgate’s mental health system is a series of organizational silos and how missing bridges between silos leads to certain populations at the intersections of the mental health system becoming disproportionately lost in the system. I look at two unique patient populations identified by professionals: the homeless mentally ill and dual diagnosed (diagnosed with mental illness together with substance abuse or developmental disability). Using Winker and Degele’s (2011) multi-level intersectional analysis, I examine how and why these populations become, as multiple professionals described them, “lost in the system” and offer explanations for why this is occurring in Elkgate. Finally, I examine how their locations at intersecting silos are often mismanaged in the system due to poor communication and coordination.

### THE MENTAL HEALTH SYSTEM AS “SILOS OF SERVICE”

The first time I began thinking of the mental health system as a series of silos was during an interview with Roberta, a nurse and licensed social worker who had worked at the Mental Health Center for over three decades and was now expanding her longtime sideline, psychotherapy private practice into fulltime work. When I asked Roberta about her interactions with the hospital when she had patients who went to the ER and/or were placed in an inpatient psychiatric setting, she said:

It’s you know, it’s more like silos of service, because that’s that sort of business model that says that there are these free-standing units. The hospital is a free-standing unit. They

do their stuff. They don't contact you as a private clinician. You know, they don't contact you because this person is going into the hospital. They contact you because the hospital is going to release this client tomorrow or the next day and 'we have to have on our piece of paper that they have an appointment,' and they have a client call and set up an appointment.

Roberta had many insightful and interesting thoughts on how the mental health system operates and many more anecdotes from over 30 years in the field, yet her description of "silos of service" stuck with me most after the interview. This was somewhat early in data collection: I had mapped out Elkgate's system and was beginning to understand the connections across organizations. At this point I understood who the players were and some of the circumstances under which they would interact, but could not figure out how to describe these connections across the entire system. Possibly in part due to my small town upbringing surrounded by farms, silos made sense to me. In agriculture silos are used primarily for grain storage and to keep different grain types isolated from one another. In the same way, the organizations within the mental health system all work with the same population, individuals living with mental illness, but each organization is working within its own practices and ideologies. Although there is interaction between organizational players, as Roberta points out in her description of a patient's discharge from the hospital, these are typically superficial and a necessary part of a consumer's pathway through mental health service use. Upon examination of the system and its organizations it is clear there are very few partnerships in Elkgate at the organizational level where policies and procedures require that players of one organization have in-depth knowledge and understanding of one of the other organizations.

The silo metaphor to describe elements of a system that work to accomplish the same task, yet operate independently of one another, is a well-established concept in business and management fields, and has been used by many other disciplines. Studies of medical systems,

research in nursing, health care services, sociology, and specialty-specific medicine have all used the silo metaphor to describe gaps between inpatient and outpatient care, end-of-life care in intensive care units (Curtis and Shannon 2006), rural health (McNair 2005), chronic illnesses (Owen 2004), professional cultures (Hall 2005) and education (Kim et al. 2006; Margalit 2009). In each of these studies, silos within a health organization or system were considered a hindrance to effective patient services and care, and the author(s) called for increased collaboration and communication across professional workgroups. Looking at mental health in particular, organizational silos have been blamed for poor integration across behavioral and physical healthcare (Horvitz-Lennon, Kilbourne & Pincus 2006; Kilbourne et al. 2010), mental health service delivery in universities (Shuchman 2007; Voelker 2003) and fragmented children's mental health systems (Barwick et al. 2005; Burns & Goldman 1999; Isaacs et al. 2005; Lyons 2004; Ungar 2005; Waddell et al. 2005), yet I only found a single mention of silos in adult mental health as an aside to the focus of the article on children's mental health (Weist and Christodulu 2000). Considering my observations and interviews in Elkgate that indicate a system defined by its organizational silos, I find the concept's absence in adult mental health systems in the extant literature surprising.

#### *Silos of Service in Elkgate's Mental Health System*

Roberta was the only participant who labeled the disconnect between organizations as "silos," but other participants pointed to the same phenomenon. Dylan, an emergency worker at Mental Health Center, believed that medical organizations had similar goals for clients, but their approaches were all different:

We all are making an effort to provide client care. That's clear to me. And we all have different ideas about what that means, I think . . . . I mean, I feel like in the end we're all trying to do the right thing. We're all trying to limit time in the ER. We're all trying to limit hospitalizations, inpatient. You know, we're all trying to be clear on whether it's a

psychiatric issue or criminal issue, and like getting that clarified. Like, we're all working on those things.

Dylan describes unified goals, but that different organizations attempt to achieve these through different means that are unclear across agencies. She found this particularly evident going to different ERs in and around Elkgate: "Some hospitals the energy in the ER is just like, almost like towards me, like why are you here. And that feels frustrating." Her experiences demonstrate the separation, and silos, within medicine between ERs and Mental Health Center.

Silos appeared particularly evident, and isolating, in private practice outpatient services.

Whereas the other groups work in the context of an organization, private practice providers primarily work alone. Rodger, a licensed social worker in private practice describes this:

Ok, so there's this kind of idea that people in private practice are fairly isolated because we sit in our little kingdom here and people visit us and we have less and less contact with other professionals. Different than on a team, like when I worked at the Department of Social Services or at [Mental Health Center], you're surrounded by other people doing casework or, you know, there's a lot of interaction with other professionals and referrals back and forth. And so here in private practice it's lonely in that way.

The result of this isolation and reduced contact with other professionals in private practice is that the gaps between groups become more pronounced. In Chapter 4 I described the communication gaps between the ER and inpatient facilities and outpatient providers. Rodger also pointed to the gaps in communication and practice between providers and corrections when working with patients who are also involved with the correctional system:

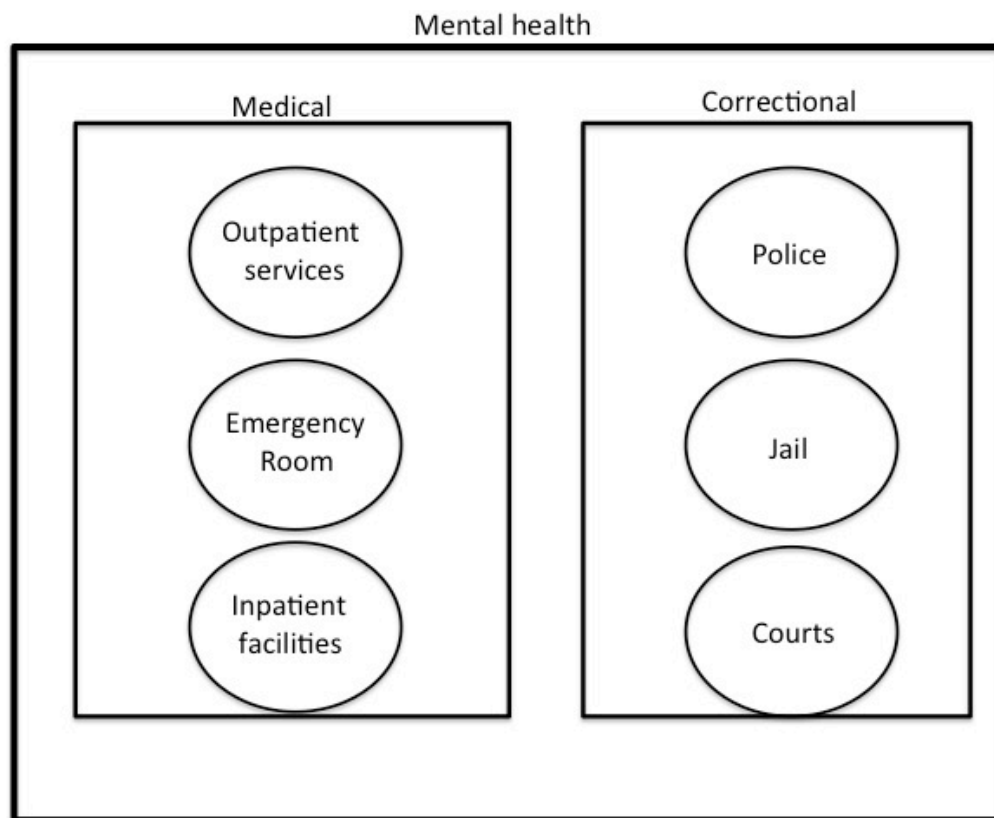
. . . on the one hand [patients] like the fact that I have no connection [with corrections] because they can talk freely knowing that they are not going to get turned in for doing something. So like I used to run those groups that were sponsored by the department of social services for perpetrators. They were afraid to talk because they thought if they really said anything that I could turn them in and they'd have to go back to jail. So that's kind of bad. So you want some independence so that you can actually help the person. The downside is that the person really needs to be helped in all these different agencies, interagency coordination and teamwork would probably be the best case scenario. But the police aren't really interested in treatment. They're there just to document the crime that was committed and everyone just kind of has their focuses with their areas.

Rodger is hinting at two different types of connections between himself and correctional organizations. He believes open information and lines of communication between himself and correctional agencies regarding the specifics of patient therapy would be to the detriment of his patients. People will be afraid to talk if there is a chance that what they say will get them into trouble. On the other hand, Rodger believes that more coordination would also be to the benefit of patients. He points to the lack of interest of police in treatment and organizations that maintain “their focuses within their areas” as explanations for the lack of coordination. Organizations that are only focused on their areas with no understanding of or interest in the organizations with which they interact is what creates these organizational silos. This is an issue across much of Elkgate’s mental health system and is all the more evident across organizations with differing institutional affiliations.

As described in great detail in Chapter 4, Elkgate’s mental health system is composed of an assortment of organizations and professionals with varying levels and frequency of interaction that can be grouped according to their primary institutional affiliation. Each of these organizations operate independently of one another and have their own set of services, practices, values and norms, so represent one silo. What further complicates the system is the spread of organizations across institutions. Figure 5 depicts the institutions and organizations involved in Elkgate’s mental health system. Organizations located within the same institutional grouping (ex. police and jail or outpatient mental health and hospital) may not have any more communication or interactions than with those located across institutional groupings, as evidenced by Roberta’s account of interactions between outpatient and inpatient professionals; however, organizational silos within the same institutional grouping are more alike than organizational silos across

institutional groupings because they share the same basic correctional or medical philosophy and ideologies.

Figure 5: Elkgate's Mental Health Institutional and Organizational Silos



While the interactions between police and the ER described in Chapter 3 demonstrate silos lacking bridges in practice or communication that would allow for mutual understanding, the relationship between police and the jail demonstrate successful organizational bridges. One factor that makes bridge building easier across these organizations is their shared institutional ideologies evident in inmate traffic to and from the jail.

As previously mentioned, Elkgate's jail is perpetually at or over capacity. At the beginning of my observational period police officers had just received notice from the Chief of Police that they were to employ alternatives to bringing people to jail whenever possible to cope



with jail overcrowding. Nonetheless, the seven arrests I observed during ride-alongs were homeless individuals who had not appeared in court nor paid their ticket(s) for minor offenses against city ordinances: camping, public urination, open container. Although minor offenses, the “failure to appear” (FTA) in Elkgate’s county equates to a warrant and mandatory jail following the next police contact. In other words, if a police officer runs an individual’s information with dispatch and they have a warrant because they did not appear at their scheduled court date, the officer has no choice but to arrest the individual regardless of the original offense or the circumstances surrounding the current police contact. Police have no discretion here once contact is made and a person’s information is run through the system.

Regardless of criminal history or prior police contacts, once arriving at the jail, jail staff go through the same basic set of procedures booking and finding a bed for people brought in on FTA warrants as they would any other inmate. In the five ride-alongs that brought me to the jail, not once did I hear a jail employee complain, or make any mention, of officers bringing people to jail for minor offenses. The closest to this was jail intake staff teasing officers and making friendly, sarcastic remarks to officers about bringing them inmates who were particularly difficult due to their behavior and/or inebriation and/or lack of personal hygiene, but even then the jabs were about the individual, not the reason why officers had brought him/her to jail. On the other end, not one police officer made any comment about the court system or District Attorney’s Office not keeping people in jail long enough in reaction to multiple contacts with the same people that resulted in repeated transports to the jail, sometimes multiple times a week.

While the relationship between the police and hospital and their perceptions of one another described in Chapter 3 surrounding many of the same issues as those with the jail—when and under what circumstances should people go and when and under what circumstances should

they be released—are somewhat problematic and riddled with mutual misunderstandings, this is not the case between the police and jail. Because the police and jail share an institutional grouping, they have a mutual understanding of one another’s work and organizational and political constraints on decision-making. This facilitates bridge building between silos: both organizations are still independent of one another, but are able to work together and understand one another when they do interact.

When I asked jail administrator, Richard, about police arrest decisions for more minor offenses, his response illustrated his understanding of and empathy toward police work:

So, what we see here is we get a lot of offenders in here for minor crimes for FTAs. And they could be FTAs for silly things. For, you know, camping, illegal camping, or whatever, but the dilemma is that the arresting officer is somewhat obligated to make the arrest because he has a warrant. So, even though we, and I look at a lot of these reports, see the contact that was made and think ‘this guy shouldn’t have gone to jail’ but then I look, ‘yeah, but he’s got a warrant for fail to appear.’ . . . It’s a tough dilemma because if you look at the big picture the police officer who is dispatched to deal with this person, because you have to call to complain, they’re obligated to do something to fix the problem to get [the person] away from the situation, so [police] do the best they can in terms of trying to talk to them and trying to remedy the problem or trying to get them to sign a summons. But when none of those remedies work, then they go to jail, you know, unfortunately, and so, I don’t think it’s any overt attempt to arrest people who shouldn’t be in jail, I think it’s trying to manage what [police are] trying to manage

While recognizing that people do end up in jail for minor offenses, Richard looks to the structural constraints of FTAs in Elkgate’s county, and demonstrates an empathetic understanding of the nature of police work and civilian contacts to offer an explanation. Police officers utilized similar tools in discussing their orders to limit jail admissions. Stating that: “They’re [the jail] having a problem, which means we’re [police] having a problem.” Officer Gabor understands the interconnectedness of the jail and police. Although locating the problem on the jail for not having enough space, Officer Gabor does not place blame on the jail, but rather identifies the jail’s problem as their problem as well. I also overheard one officer’s comment to

another officer on the same topic while at the Police Department during that ride-along: “Did you see the Chief’s e-mail that the jail’s full? Is the roof still on?” Although said with an air of sarcasm, this officer’s quip indicates that he did not agree with the directions to avoid arrests on the basis of the legislative limits to overcrowding in the jail. Similar to Richard’s description of police bringing people to jail over FTAs, his objection to the situation is targeted toward structural constraints affecting the jail. Neither in this comment nor the brief conversation preceding it did the officer place the blame on jail staff or any individual or other correctional agency.

Organizational silos without bridges in Elkgate’s mental health system not only results in frustrations among professionals, but also results in the mental health system under serving populations of individuals with mental illness or missing them altogether. In the next section I identify these underserved populations.

#### WHO GETS LOST BETWEEN SILOS?

Interviews with mental health professionals revealed four major underserved groups in Elkgate: the homeless, individuals with dual diagnoses (mental illness and substance abuse or developmental disability), children and youth, and the housed underclass. During ride-alongs, I personally observed instances of homeless and dual diagnosed individuals, and one youth, who were unable to access what I would consider appropriate services. National data also supports these categories as among the most underserved populations for mental health care in the United States (American Psychological Association 2015; Kushel, Vittinghoff and Haas 2001; McGovern et al. 2014; Quintero and Flick 2010). Although each group is facing the same predicament of being underserved, the reasons for each are unique and a result of their individual social statuses and structural barriers to services, partially as a result of organizational silos. I

examine two of these groups—the homeless mentally ill and dual diagnosed—in terms of their intersection of social statuses and associated structural barriers that put them at a disadvantage to accessing and receiving mental health care in Elkgate. I chose these two populations because, as previously mentioned, I have more observational data that applies to these two populations. Additionally, as I will present, patients at these intersections have difficulties accessing care in Elkgate due, in part, to the relationships between organizations already discussed in previous chapters. As a result, I can provide a more thorough examination of the homeless mentally ill and dual diagnosed than I could of children and youth and/or the housed underclass without going beyond the purview of the intended research scope of this project. Before I begin my analyses of these populations, I must first describe the influences behind them and my analytic framework.

#### ORGANIZATIONAL SILOS AND INTERSECTIONAL ANALYSIS

From the beginning of this project I was interested in the organizational silos of the mental health system and the role they play in creating a more comprehensive or fragmented system. Considering this, it is no surprise that I came to consider populations who become lost in the system as people with overlapping statuses that spread their needs out across multiple silos and/or systems of silos. Because I considered an individual's likelihood of becoming lost in the system as directly related to—according to the system—divergent statuses, my analytical approach to this chapter was heavily influenced by intersectionality.

Kimberle Crenshaw solidified intersectionality as its own theoretical perspective in 1989. Crenshaw, a black feminist scholar, argued that white women dominate feminist theory and activism, and black men dominate the same antiracist activities. As a result, black women, located on the intersection of these, are not only doubly disenfranchised—black in a racist society *and* women in a patriarchal society—but are also lacking recognition in identity politics.

Although Crenshaw is most famously credited with the term, the ideas behind intersectionality were not novel as “black feminists have been writing about intersection of race/class/gender, and documenting the presence of these ideas/this perspective back to the Seneca Falls convention” (Mojola 2015).

My analysis of Elkgate’s underserved populations living with mental illness is inspired by the ideas of intersectionality; however, I cannot present this work as an example of intersectionality. As with intersectionality, I consider the impact and consequences individuals located across multiple disenfranchised statuses: the homeless individual with a mental illness, the individual who is living with both a mental illness and substance abuse or developmental disability. Where this analysis does not align with intersectionality is my homogenous sample of white men. Gender and race are fundamental statuses in intersectionality due to “the *force* of these categories, especially in the U.S., and the way they function as master statuses through which everything else (e.g. the body, disability, attractiveness, health. . .) is filtered” (Mojola 2015 – emphasis in original).

Throughout this project I did not pay particular attention to consumer race or gender, and it never unearthed itself as an important factor in organizational interactions with consumers during data collection; differentiations related to class and body appeared more important in determining how easy or difficult it was for consumers to access services suited to their needs. There is a substantial body of research examining the influence of race/ethnicity and/or gender on care seeking behavior and interactions with mental health professionals (ex. Fernando 2010; Mackenzie, Gekoski and Knox 2006; Sentell, Shumway and Snowden 2007; Tang et al. 2014; Watson and Hunter 2015). I question how factors related to class and health play a role in patient experiences within Elkgate’s mental health system. Lucas and Phelan’s (2012) experiment

exploring status characteristics supports the importance of the mental illness label relative to physical disability and education level. They found that subjects paired with a person labeled mentally ill were less likely to question or change their answer to questions asked and significantly less likely to choose the same partner for a second phase of the study than those who partnered with someone identified as physically disabled or having obtained a low level of education. I argue that homeless and dual diagnosis individuals with mental illnesses are disproportionately becoming lost in Elkgate's mental health system because of their locations within body and class social categorizations that place them across multiple silos with weak or nonexistent bridges.

In the following analysis of populations identified by mental health professionals as “lost in the system” or people who “fall through the cracks” in Elkgate's mental health system, I will apply a version of Winkler and Degele's (2011) intersectional analytic framework. They outline an eight-step approach to examine and analyze social phenomena through an intersectional lens that forces researchers to consider their data on three levels of analysis:

Starting out from the social practices of a person, we are able to reconstruct identities they construct, as well as the structures and norms they draw on: in the process of subjectivization, which categories do social actors relate to? Which norms, principles and interpretive patterns affect them? What are the structure contexts their agency is embedded in? (pg. 57)

The major departure I take from Winkler and Degele's (2011) methodology is in their individual-level identity constructions. Because I approach this analysis with minimal interactions with, and no interview data from these patient populations, I cannot say how individuals located in these intersections construct their own identities with relation to their social positions; however, I can address how these identity categories, as assigned to them by mental health professionals, are relevant to the Elkgate community and its mental health system. I use this approach to illustrate

the locations of the mental health system's gaps and explain how these gaps are not happenstance. On the contrary, the populations are located at these intersections across organizational silos of the mental health system, and are missed by or "lost in" the mental health system, are in this situation as a result of larger cultural and structural norms in play in Elkgate and elsewhere that create these systemic issues. In the following sections I describe how and why this has occurred to the homeless and dual diagnosed.

## HOMELESS INDIVIDUALS

Officer Jakobs told me that we had spoken with some "homeless drunks" and now we were going to go see "the homeless stoners." She made a comment that everyone in Elkgate talks about doing something about the homeless. Her reaction is "which homeless population?" because there are distinct subpopulations – teenagers, drunks, stoners, mentally ill. (Fieldnotes)

Community approaches to homeless populations are perfect examples of the need for intersectional analysis and application in public policy (Hankivsky and Cormier 2011). In the quote above, Officer Jakobs, who patrols exclusively in Elkgate's downtown core and knew more homeless individuals by name than any other officer I rode with, identifies the reality of Elkgate's homeless populations versus the public perception.

Correctional professionals (police and jail) identified the homeless population as a group that most reflects the need for bridges across organizational silos between city and county resources and programs because the homeless represent the highest resource consumption of social services and have a wide range of needs. Richard, a jail administrator, described a meeting of community organization representatives where he "was asked to attend to talk about the frequent flyers that come into the jail":

I walked into this room and I think the number of people were like 30 or 40 people in this room, and even though I've been in this business for a while I was surprised by the number of agencies, private agencies and private foundations as well as public entities, that are all touching the same people. . . . So a lot of energy put into these resources for

the same people that, when they're not [in jail] they're somewhere else and impacting another group.

In addition to recognizing the high resource use of the homeless, many, though not all correctional professionals classified the homeless population into distinct groups based on social statuses related to the body—age, illness, disability, addiction—and, as demonstrated by Officer Jakobs, recognized that their heterogeneity means that no single solution will “fix” the “homeless problem” in Elkgate.

While most correctional professionals interviewed indicated their own awareness of the diversity of the homeless population, they felt that the general public in Elkgate, as in many communities (Institute for Children, Poverty & Homelessness 2011), considers the homeless population a single group who are uniformly unwanted and problematic. The result of this attitude toward the homeless population in Elkgate is city- and county-level ordinances—camping bans, trespassing, and public urination among others—that disproportionately target behaviors related to homelessness. But when we consider those at the intersection of homelessness and mental illness, it is evident that this doubly, and in many cases multiply disenfranchised population is especially vulnerable to cultural denigration and subsequent legislative attempts to push the homeless out of Elkgate, resulting in increased interactions with corrections and higher rates of incarceration.

The homeless mentally ill are among the lowest socio-economic groupings in the United States. While most people experience homelessness only temporarily, the homeless population with severe mental illness represents 30 percent of the chronically homeless (SAMHSA 2011). In addition to the amount of time spent without housing, the quality of life for the homeless mentally ill compared to their non-mentally ill counterparts can be substantially lower. Whereas most homeless individuals rely on others for safety and survival, homeless mentally ill are more



likely to be alone (Craig and Timms 2000; Padgett et al. 2010; Ware et al. 2010), which both makes them more invisible and more vulnerable to victimization (Sullivan et al. 2000; Walsh et al. 2003; White et al. 2006). Further, the likelihood that someone will be isolated while homeless increases with the acuity and severity of their mental illness.

Ride-alongs provided ample evidence of the existence of these chronically homeless, severely mentally ill individuals in Elkgate who were alone and isolated from other homeless people and groups. These individuals were well known to police in Elkgate in part because they were generally not transient. Officers had a general idea when some of them had arrived, whereas others had been a fixture in Elkgate for as long as anyone could remember. One of the best known homeless men to Elkgate's correctional system, Nick, fell into the latter category.

I did not personally meet Nick until my second-to-last ride-along, but by that time I already knew him well by reputation. Every EPD officer knew Nick, and upon hearing my dissertation topic, every officer said I should meet Nick. He has been in Elkgate for as long as anyone could remember, and most officers forecast that he will eventually die here. He lives with what officers assume is untreated schizophrenia, and is also a chronic alcoholic. Nick never associates or socializes with other homeless individuals and is always alone. What made Nick somewhat unique was that many police officers had a soft spot for him because he typically does what he is asked, is jovial and pleasant when interacting with officers, and does not cause any major problems. The night I met Nick, we arrested him on a warrant for failing to appear in court for a public urination ticket. This occurred early in the shift. Over the course of the night, multiple officers we encountered teased Officer Beckel, calling him "mean" for taking Nick to jail and left me with the impression that they were sincerely sorry to hear that Nick was back in jail.

Officers described Nick as an “interesting character,” “schizophrenic,” someone who is “lost in the system,” and would have lived in a state hospital a few decades ago. One officer believed that most of the homeless population would be able to get jobs, get off the street, and “stay out of trouble” with a combination of tough love and a little public assistance, but not Nick. He referenced Nick as a representation of a small minority who would never be able to succeed without “intense, long-term supervision” that no longer exists. As described in Chapter 3, deinstitutionalization has substantially decreased the number of available inpatient psychiatric placements, and virtually eliminated long-term institutionalization of the mentally ill, regardless of severity and chronicity. Interactions with Nick described by officers indicate that he is in a nearly perpetual psychotic state:

When making contact with officers, Nick will refer to himself in the 3<sup>rd</sup> person and also talks about “The Colonel”. Officer Ekeley didn’t know who the colonel was and had come to learn that questioning Nick about whom or where the colonel was would agitate him, so it was best not to do that. During officer contact, Nick will tell the officers that ‘The Colonel doesn’t want any trouble and the officers will let him go’, basically voicing his wishes by a combination of talking about the immediate future and telling the officers what they should do. . . . Officer Ekeley said he didn’t understand it, repeatedly referring to Nick’s behavior as “strange”, but recognized that working with Nick in his delusional state was going to be easier than fighting with him or disputing it. (Fieldnotes)

Sitting at the intersection of homelessness, severe mental illness (including psychosis and anosognosia),<sup>20</sup> and alcoholism, Nick is multi-disenfranchised. The result is that Nick and homeless individuals similarly situated to Nick are marginalized across all these groups

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<sup>20</sup> Anosognosia is a condition wherein a person’s mental illness prevents them from acknowledging the mental illness. Experienced by an estimated 50% of people with schizophrenia and 40% of people with bipolar disorder type I, the difference between anosognosia and denial is that patients with anosognosia display a lack of awareness that is neurologically, rather than psychologically, based (see Treatment Advocacy Center Backgrounder (2013) for a meta-analysis of anosognosia and brain anatomy). For example, a person who refuses to take medication because “they’re not sick” while presenting as obviously severely mentally ill to others is not simply denying their condition; their neurochemistry and brain function prevents them from any awareness of their condition.

(Crenshaw 1993). In the following sections I discuss county and city ordinances that apply to Elkgate's homeless and state-level legislation addressing mental illness. Using the cases of Nick and other individuals encountered during ride-alongs, I demonstrate how homeless mentally ill in Elkgate are disadvantaged and marginalized across both their mental illness and homelessness. This is also indicative of the gaps between the organizational silos with which these individuals interact. Although I use a few individual cases, the individuals and situations described are not unique; they represent many others in Elkgate and numerous other cities across the United States (Earley 2005).

### *Homelessness*

Elkgate has a complicated relationship with its homeless population. Within the community there are both “pull” and “push” factors that simultaneously attract transients to the area and attempt to force them out. As mentioned in Chapter 3, Elkgate is an overwhelmingly upper-class, educated community, and categorized as “liberal” and even “socialist” by people both within and outside of the city. These characteristics contribute to the many organizations and services available to assist the homeless and individual acts of kindness. There are multiple community resources targeted to assist the homeless, and police officers shared multiple stories of citizens providing homeless individuals with expensive groceries and large amounts of cash. At the same time, some of Elkgate's ordinances targeting the homeless are among some of the strictest in the nation. One of the most controversial, Elkgate's “camping” ban, prohibits anyone from sleeping in a public space using any object as a blanket. This, paired with a homeless shelter that is only operational during winter months, means there is nowhere for the homeless to legally sleep at night between April and October. Even people sleeping on park benches without

a blanket may be sleeping illegally because community parks are “closed” between 11pm and 5am. Anyone in these spaces between those hours can be ticketed for trespassing.

Enforcing these ordinances is up to the discretion of police to some extent. During the year I did ride-alongs, Elkgate’s city government was placing a lot of pressure on the police department to enforce these ordinances and closely monitor the homeless population in general. On one ride-along I met three plain clothed (out of uniform) police officers in one of the parks downtown. They told me they were assigned to this location to “keep an eye on things.” This is a popular meeting and hangout location for homeless groups and the city had recently put sod down in one area. Part of the officers’ assignment was to make sure people did not go on the newly planted grass. At one point, one of the officers pointed at the city building that backs onto the park and indicated that the police department was following orders from the city. During one night shift ride-along, myself, the officer I rode with and one other officer spent nearly two hours walking along a popular path downtown, trekking through bushes, and going into ditches checking drainage passages for people sleeping. When we did encounter people, the officers would wake them up, ask for identification, and dispatch would run their information through the system to check for warrants.

Police did have some pressure to enforce the ordinances, but they had a lot more discretion when it came to giving tickets for these offenses. In the above situation, the officers only gave tickets to people who were “giving them a hard time”: talking back, complaining, or taking what officers thought was too long packing up their things and moving on. Tickets for these and other offenses that homeless individuals commit with some frequency—public urination, public intoxication, open containers—cost \$100 on average. If people cannot or do not pay, they are expected to appear on the court date listed on the ticket and will be given a few

hours of community service in lieu of the fine. People who do not pay and do not appear in court receive a Failure to Appear, which, as previously described, means that a warrant is put out for their arrest and they will go to jail the next time they have police contact. All seven arrests I observed during ride-alongs were for FTAs issued to homeless individuals.

These are the same circumstances under which many homeless mentally ill end up in jail. When we arrested Nick, the officer stopped him because Officer Beckel noticed Nick had an open beer in his coat pocket. When Officer Beckel called in Nick's information to dispatch, they came back with a warrant for a FTA from a public urination ticket. What separates Nick and other homeless mentally ill individuals from other homeless populations is that they are more likely to attract attention resulting in police contact, thereby placing them at higher likelihood of receiving tickets and going to jail.

While the homeless as a whole in Elkgate and other locations are both a highly visible and invisible population reflected in both pull and push factors (see Table 2), the homeless mentally ill are even more so.

Table 2: Interactions with the Housed and Visible and Invisible Pull and Push Factors on Elkgate's Homeless

	VISIBLE	INVISIBLE
PULL FACTORS	<ul style="list-style-type: none"> <li>• Multiple organizations providing services</li> <li>• Generosity and charity → money, food and other goods</li> </ul>	<ul style="list-style-type: none"> <li>• Safety → they are left alone</li> </ul>
PUSH FACTORS	<ul style="list-style-type: none"> <li>• Congregate in public areas and considered a blemish on the city's image</li> <li>• Blamed for criminal acts</li> <li>• Focus of city ordinances</li> </ul>	<ul style="list-style-type: none"> <li>• Ignored → avoid eye contact or any type of acknowledgement</li> <li>• Lack representation on city council → no say on city ordinances</li> </ul>

People like Nick are more visible due to a variety of reasons. First, during ride-alongs I noticed that transients received a lot less police attention than the homeless who had settled in Elkgate. To some degree this was to the benefit of the settled homeless: officers knew them by name and, with some officers, there existed a sign of mutual respect between these homeless people and groups and officers. At some point during ride-alongs nearly every officer said they would rather deal with the homeless than undergraduate students because the homeless showed them more respect. Officer Marsh described a situation wherein, after contact with a particularly argumentative and verbally aggressive individual, one homeless man Officer Marsh knew well approached her to say that he “had her back”: observing the interaction from a distance and ready to step in if the contact had turned violent. On two separate occasions during my ride-along with Officer Jakobs, she approached groups of homeless people she knew well in a park because she saw an open container of alcohol. Rather than displaying any hostility or arguing, they immediately obligated to Officer Jakobs’s request that they pour out the container and engaged in pleasant conversation and mutually jovial banter with her.

As I said before, officers liked Nick, and would even go out of their way to stop and check in with him when they saw him during patrol. This was to Nick’s benefit in two ways: 1) Police recognition and frequent contact may enhance his safety when he is alone on the streets (an issue I will discuss in detail later); 2) Depending on individual officer discretion, police may be more willing to forego a ticket in favor of halting the behavior and delivering a warning because they know Nick does not pose a threat. In the abovementioned example of Officer Jakobs requesting people pour out open containers, she did not issue a ticket to anyone involved. On the other hand, increased police contact, even when under a friendly pretext, runs the risk of getting in trouble. Whether pleasant and well liked or not, when Nick is behaving in a manner

that is against any laws or ordinances, legally, officers are not in the wrong when they ticket him. Taking this into consideration, on the night I observed Nick's arrest, it may not have occurred if Officer Beckel had not noticed Nick's hidden beer. And Officer Beckel may not have noticed Nick's hidden beer if he had not pointed him out to me and approached Nick to say hello.

Second, whereas a housed individual with severe mental illness can be paranoid, ranting, and display a wide range of other symptoms behind closed doors, the homeless mentally ill display their symptoms in public. One police Sergeant I interviewed put the consequences of this in practical terms when he said: "Being crazy isn't criminal, but it can affect your call level." Outward appearances of the stereotype of homelessness—disheveled and poor personal hygiene—can be amplified in individuals with mental illness because poor self-care and hygiene is a symptom of multiple mental illnesses (American Psychiatric Association 2013), which is more likely to arouse suspicion and fear in residential areas, resulting in calls to police.

According to police, the more common reason for mental illness resulting in police calls was ranting and yelling. I did not observe Nick displaying this behavior, but officers said that they do occasionally get these types of calls for Nick. In these cases, it was often business owners or employees calling because the individual was scaring customers away. I observed this occur one day walking downtown. I passed by a man who I did not recognize from ride-alongs, but he appeared homeless and was yelling outside a store (I was later introduced to him during my ride-along with Officer Jakobs who described him as "schizophrenic" and a "frequent contact"). I walked past him and carried on to my destination. When I walked past the store again 20 minutes later, the man was handcuffed in the back of a police car. A few weeks later I interviewed Officer Sarnecki, who I recognized as the officer on the scene. I told him that I had seen him and described the event. Officer Sarnecki did not remember that specific encounter,

explaining “we get a lot of calls for people ranting outside of stores.” I observed another instance of symptoms displayed in public resulting in police contact during my ride-along with Officer Beckel. During that one shift, there were four calls made, two of which we answered, about one man, Harold. The calls were all very similar: Harold was being a nuisance, bothering people with his incessant, nonsensical ranting, and refusing to leave when asked. Our second interaction with Harold was outside a convenient store where the attendant had called police.

Arriving at the gas station, Harold is in the store. Officer Beckel enters and asks him to come outside. Harold walks out of the store without any argument, but talks the whole time. Outside the store, Harold continues talking. He asks Officer Beckel if he’s going to arrest him. Officer Beckel says no, that he just needs to go somewhere else and when he’s asked to leave a store, he needs to leave. Harold begins talking. . . .Harold’s blue eyes are wide open and dart from side to side as he speaks. His speech is rapid, never pausing to give Officer Beckel a chance to interject, and he jumps from topic to topic without any transition. Some of the stories he tells are far-fetched, others are impossible, though he tells them all without a hint of sarcasm. I’m pretty sure Harold believes what he’s saying is true. As Harold talks, Officer Beckel is trying to get across the message that Harold needs to go elsewhere, but Harold continues to talk. After a few minutes of this, Officer Beckel begins to raise his voice slightly, and changes from trying to speak with Harold to giving him orders. Officer Beckel interrupts Harold, pointing out that he still hadn’t left the area, and he needed to leave or Officer Beckel would arrest him. Harold finally understands, and walks away. (Fieldnotes)

Harold was so caught up in his psychosis-fueled rant that he had great difficulty following directions and, if Officer Beckel’s threats were true, risked jail as the result. Police contact is a potentially precarious situation for individuals with severe mental illness who may not be able to understand or follow instructions due to their condition. Based on my observations and interviews with police, and supported by prior research on police-civilian interactions (Klinger 1994; Novak and Engel 2005), one important factor in police decision-making is the attitude and behavior of the civilian. Mental illness has the potential of clouding people’s judgment, reducing impulse control, and causing people to lose control of reality (American Psychiatric Association 2013). These are many of the same consequences as substance use; however, in the sense that



they occur without the ingestion of mood altering substances, in mental illness these are largely outside the control of the individual. This means that individuals with mental illness may face higher-level legal consequences due in part to their mental illness (Brekke et al. 2001). For the homeless, who already have substantially more police contacts than the housed, having a mental illness not only has the potential of further increasing police contacts, but also receiving harsher legal consequences. As a result of the combination of homelessness and mental illness, this population is more likely to arouse suspicion and fear in the general public. In these situations, police contact is a result of their symptoms of mental illness that make them highly visible.

While more visible than the general homeless population, the homeless mentally ill in Elkgate are simultaneously more invisible. As previously mentioned, the majority of the homeless in Elkgate are in groups: bands of varying sizes who live together and support and protect one another. The most severely mentally ill homeless were alone. Officers said that they had never seen Nick with anyone else, and all the individuals officers pointed out to me as people I should see or meet based on my dissertation topic were also alone. Both the general population and other homeless persons can reject homeless mentally ill: their erratic and unpredictable behaviors make them untrustworthy and make others fearful. Isolation is also a common feature of mental illness, particularly in those who experience psychosis (American Psychiatric Association 2013), so even if the rejection were not present, it is likely that many of these individuals would still be alone. The homeless population in general is vulnerable to victimization from both other homeless people and the housed because they are considered easy targets who are unlikely to call police or press charges (Walsh et al. 2003). An individual who is homeless, mentally ill, and alone is at even greater risk because of their invisibility: no one would notice if they were to disappear. With the camping and trespassing ordinances in Elkgate

and no operating shelter six months of the year, the homeless are forced into more secluded spaces to sleep, which presents a greater danger to people who are alone. Officers said they did not know where Nick went at night and said he never used the shelter.

Elkgate city ordinances, their lack of representation in city government, the general population's attitude towards the homeless and the resulting visibility and invisibility make the homeless in Elkgate vulnerable to fines, incarceration, and, at times, violence at higher rates than the housed. The homeless mentally ill are at an even higher risk due to their mental illness creating a situation in which this population faces greater disadvantages in their homelessness than their non-mentally ill counterparts. At the same time, policies directed toward mental health and illness do not adequately support or assist the homeless.

### *Mental Illness*

The homeless mentally ill population highlights some of the most significant issues surrounding the mental health system's especially pronounced silos across institutions both within and outside of mental health. As discussed in Chapter 4, the correctional and medical arms of mental health interact with one another, but do so minimally; apart from programs shared between Mental Health Center and the jail, most interactions occur in the context of crisis situations. For the homeless mentally ill, who typically interact with the correctional system far more than the medical system, the lack of bridges between organizational silos and their consequences on consumers are particularly evident and show how individuals with mental illness who are also homeless face greater disadvantages than their housed counterparts.

Police play an important role in the mental health system as first responders and assessors, yet the gaps between some of the organizational silos in the areas of corrections and medicine in Elkgate prevent a more complete integration of police into mental health. Medical

professionals use police during crisis situations to transport patients to the ER, provide back up for home checks, or assist if a patient becomes violent, but police are not considered a resource at other points. For example, in our interactions with Harold, he mentioned that he had been to Mental Health Center. This meant he was receiving some level of care and was in the system. Officer Beckel could have easily contacted Mental Health Center to inform them that he had contacted Harold and describe his mental state; however, police do not initiate contact with outpatient providers. This would not have been any different if Harold had been housed; however, those with severe mental illness who are housed are significantly more likely to have a functioning support system of family and/or friends than the homeless, who are often completely isolated and estranged from any support system they may have had in the past. This means that people who are housed are more likely to have scheduled appointments with mental health professionals, be involved in programming, and have family or other supportive people in their lives who would recognize changes and possibly communicate with the mental health providers. Officer Beckel did not ask Harold any questions about his treatment at Mental Health Center, so had no way of knowing whether he was currently connected or not. Based on some of what Harold said, it appeared as though he did not have a support system. When police contact related to mental illness occurs that does not result in transport to the hospital or jail, it is left to the consumer and their support system to address the events that led to police involvement and hopefully avoid further deterioration that does lead to hospitalization or jail. For police officers, being professionals in the correctional field places them in a position where they are generally considered as responders during a crisis as opposed to a tool and resource for medical mental health. In cases where someone has previously accessed treatment, the consequences of police

not being used as a tool in Elkgate's mental health system are disproportionately felt among homeless mentally ill.

Harold, like many homeless individuals with mental illness in Elkgate, had accessed mental health services from Mental Health Center. Because Mental Health Center offers services to people on Medicaid, Disability, and those who are both indigent and uninsured, all of Elkgate's homeless have access to mental health services. However, there are people who do not want treatment and/or do not believe they are mentally ill. Prior to deinstitutionalization and the civil rights movement of the 1960s that minimized coercive treatment of the mentally ill, some of these people would have faced long-term psychiatric institutionalization. Although limiting coercive treatment was a big legal victory for many people, it has also had negative consequences, particularly for individuals who are severely mentally ill and homeless.

Nick is a good example of someone who would have been institutionalized in the past, but due to his unwillingness or inability to recognize he is mentally ill and seek treatment he is, as described by one police officer, "lost in the system." Although consistently displaying symptoms of severe mental illness, Nick's behavior and demeanor are not severe enough to meet criteria for a mental health hold. Officers had multiple stories of interactions with Nick and taking him to the jail or detox, but not one mentioned placing him on a mental health hold or taking him to the ER. By all accounts Nick does not acknowledge that he has a mental illness and does not receive any treatment. One employee at detox, where Nick is also well known, said that Nick had never taken medication as far as she knew, and predicted, "He never will."

Nick represents one of what Richard, a jail administrator, claimed is "a large group of people, and a growing population not likely to be functional in society." This group of people either does not want any help for their mental illness or cannot acknowledge they need help.

Most are homeless and, potentially as a method of self-medication, have high levels of substance abuse, and become “frequent fliers” in the correctional system and other available social services at a great cost to the system. In his description of this population, Richard says that there is no currently available solution:

...when you deal with people who their mental illness is at a level where they are dysfunctional, maybe they will not be able to function in society without assistance, I don't know what you can do. I think we do the best we can. ...they are not likely to obtain housing on their own; they're not likely to find work and maintain a job, or exist as we'd like them to. I think that's the reality of a lot of those people we're dealing with. And so I don't know what the long-term solution for that is, other than it's going to require probably some kind of long-term assistance.

The end result is these individuals do become “lost in the system” in part because the current mental health system cannot adequately accommodate them: they are too sick to realize they are sick, yet are not displaying the symptoms required for coercive treatment. This is one major critique of mental health. As stated by Moe Keller, vice president of public policy for Mental Health America of Colorado: “It's the only condition for which we wait until stage 4 to try to treat” (as quoted in Brown 2014). While those with families and other support systems have a chance at receiving treatment if someone petitions the court to become their medical decision maker or place them in treatment, for people like Nick and other homeless mentally ill who do not have resources—primarily family members—willing to access care and services on their behalf, there is nothing that can be done until they are in crisis and require coercive treatment.

Some may say that Nick and others in his position are not lost in the system. They are using their agency and choosing not to access services. While it is true that many people choose not to engage with the mental health system and actively avoid it, Nick and others like him, who are among the most severely mentally ill, are in a different set of circumstances. Due to their severe and chronic mental illness, particularly when paired with chronic substance abuse, people

lose the ability to recognize they are psychologically impaired. This condition, anosognosia, puts an individual's degree of agency into question because the illness, as opposed to the individual, has taken over. One woman profiled in a *Denver Post* article on Colorado's mental health system described her experience in a state of anosognosia: "It sucks to think you are OK [sic] but you are not and everybody else knows it. It feels like everybody is against you. The illness itself was blocking my head from realizing I was sick" (Brown 2014). The gap in the mental health system here is that as long as Nick's disposition remains jovial, he is not a danger to himself, and manages to even minimally function (feed and clothe himself), he is not gravely disabled, and can therefore continue to "choose" to avoid mental health care. The scenario I found most disturbing on ride-alongs was during my shift with Officer Beckel while we were looking for people illegally camping.

Officer Beckel led me down a ditch that ended in a drainage underpass. He said he wanted to look here because he knew one guy typically stayed there. As we approached, a wall of stench hit me that was so bad I felt like I was choking on the air. Officer Beckel approached the opening to the underpass and I stayed back, not wanting to go any closer to that smell. I was thinking: 'There's *no way* someone is down here.' When I glanced over into the underpass, all I saw was a pile of trash, so it took me by surprise when Officer Beckel starts saying a man's name in a stern voice. I look over at the underpass again and I see someone sitting against the far concrete wall moving. He is surrounded by trash. As he slowly gets up Officer Beckel is speaking to him: "C'mon. You know you can't be here. How many times do we have to go through this? Get up. You've got to move." The man is moving very slowly and Officer Beckel doesn't appear to have any patience for it and continues to tell him to "get up", "move." Nine ride-alongs, and this is the first time I'm really bothered by what I'm seeing. Between the stench and the sight of a person living in the worst conditions I have ever witnessed, I'm feeling my eyes burn with tears and have to look away. Once the man comes out of the underpass and begins to walk away our job is done. Officer Beckel knows this man and doesn't bother asking for ID. We walk back up the ditch to the road and I feel angry, thinking: "That's it?! How is this helping anyone? How is this okay?!" (Fieldnotes)

Granted, I do not know anything about this man. Officer Beckel mentioned that he was a sex offender but said nothing about his mental health. That was the only ride-along I saw him and no other officers mentioned anything resembling this man, nor his living conditions.

However, based on accounts of individuals living in similar situations in other cities (Earley 2005), it is fair to assume that this man was severely mentally ill and experiencing anosognosia. The gap in the mental health system in these types of cases is a legal one that gives people the freedom to choose whether or not to access treatment and to live however they wish as long as they are not a danger to themselves, others and are not gravely disabled. But to see someone living in these conditions, it does not take an expert to question whether a person who is mentally fit would ever choose this for him or herself.

This population does not access medical mental health services, but does interact with corrections. One may assume that inmates who are obviously mentally ill would receive mental health services in jail; however, this is not always the case. When people are booked in jail, the police officer files an arrest report outlining the details of arrest and any information about the individual that would have an impact on their incarceration, including medical conditions, disability, or mental illness. This gives the intake staff at the jail an idea of where to direct an inmate for services in the jail and in which unit of the jail they should be placed. When we brought Nick to the jail, Officer Beckel did not check off the box for mental illness on his intake form. When I asked him why, he told me that Nick's mental illness was not directly related to his incarceration, and that it wouldn't make a difference because the jail staff knew Nick well.

In reality, it probably did not make any difference whether Officer Beckel made note of Nick's mental illness or not. Beyond the jail staff already knowing Nick, all mental health services in jail, other than suicide precautions, are voluntary, so Nick is no more likely to receive mental health services in jail than in the community. This is another missed opportunity, and gap, in the system. As Richard, the jail administrator, explained, jail staff are working with a very limited amount of mental health resources for the number of inmates they have, so they are not

going to go out of their way to try to provide services to people who “don’t want help”: “some people don’t want help, so you’re gonna not do very well with those folks, so you take the limited resources and try to put as much in to people who are new into mental illness, want help, are willing to do some work, cuz it’s a lot of work to maintain yourself.”

Richard is essentially saying that the most severely mentally ill individuals who need mental health care the most are the least likely to receive it. In the previous chapter I proposed that the Medicaid mental health system is actually providing superior care to a disadvantaged population creating what I called a *compensatory conversion*. When we consider individuals such as Nick and the man I encountered in the underpass, it is the legal rights of individuals with mental illness intended to protect mental health consumers that is actually resulting in compensatory inversions (Lutfrey and Freese 2005). By all accounts, Nick’s mental illness has made him unconscious to his altered state. If we consider individuals in this situation unconscious, we can see the absurdity of voluntary treatment. As stated by Dr. Poitier, a psychiatrist in the Miami-Dade county jail, discussing a severely mentally ill inmate in a state of anosognosia who was a frequent flyer of the jail: “If this man’s arm was fractured, we’d be accursed of negligence and cruelty if we didn’t help him. But because he’s mentally ill, we’re not supposed to interfere until he asks us” (Earley 2005:88).

The lack of options for coercive treatment and lack of placements for chronically severely mentally ill individuals disproportionately affects the homeless because they are overwhelmingly without a support system to advocate on their behalf. As a result, they become “lost in the system” of cycling through the jail and other social services without accessing treatment for the underlying cause of their homelessness: their mental illness (U.S. Conference of Mayors 2013). As Richard put it, these are people who may “not be able to function in society



without assistance.” People like Nick not only are lacking the assistance of mental health care but also the assistance of a support system.

The homeless mentally ill are disadvantaged in their homelessness due to their mental illness and disadvantaged in their mental illness due to their homelessness. Considering the disproportionate number of severely mentally ill in the homeless population (30% versus 5% of the housed population) and mental illness consistently cited as one of the top reasons for individual homelessness behind unemployment and lack of affordable housing (U.S. Conference of Mayors 2013), Elkgate may have more success in reducing its homeless population by targeting the homeless mentally ill population with services for their unique needs than its current attempts to drive the homeless away through punitive legislation. An additional issue with Nick and many other homeless mentally ill is that they are not only homeless and mentally ill. They also suffer from substance abuse, which may present barriers to treatment even when and if they seek out mental health services. In the following section I discuss another population frequently cited as falling through the cracks of the mental health system: those with co-occurring disorders.

#### CO-OCCURRING MENTAL HEALTH AND “QUASI-MENTAL HEALTH”

Populations identified as particularly difficult to work with in medical mental health, and likely to fall through the cracks, were people with a diagnosed mental illness and either a developmental disability or substance abuse. The term “dual diagnosis” is used in the medical literature to refer to both populations; however, it is more often used in the U.S. to describe people with co-occurring mental illness and substance abuse (Tang et al. 2008). I refer to developmental disabilities and substance abuse as “quasi-mental health” because they overlap with mental health, but both have their own systems providing treatment and services.

Historically, people with developmental disabilities were placed in the same institutions as mentally ill people, and their neurological disability was considered a mental illness. Until 1957, Colorado legislation did not differentiate mental illness from “mental retardation.” Both were grouped together in the same civil commitment legislation, at the time called “lunacy proceedings” (Fox et al. 2013). Substance abuse has been predominantly criminalized in the U.S. Since the mid-20<sup>th</sup> century there have been increasing efforts to medicalize addiction (Conrad & Schneider 2010). As this has occurred, substance abuse and addiction are increasingly grouped alongside mental health under the “behavioral health” umbrella in health policy and legislation; however, in practice they are often two separate entities.

These two groups represent vastly different patient populations, yet their experiences negotiating the medical mental health system are quite similar. Individuals with dual diagnosis developmental disability are likely to receive social services and supports through county, state and federal funding for developmental disability-specific programs and services that create social and housing security. Dr. Jay, a psychiatrist who works with patients with developmental disabilities, explained that this population is particularly well supported in Elkgate: “[Individuals with developmental disabilities] tend to be in stable living conditions, at least in [Elkgate], usually they live with a host home provider in a group home and have care, so they don’t need to worry about car insurance and ‘am I going to have a job’ and relationship issues and all that stuff.” While this population receives services from a system that has integrated care across housing, education, social and life skill needs, those with dual diagnosis substance abuse disproportionately face financial, social, and housing insecurities and represent the majority of the chronically homeless population (Canton, Wilkins and Anderson 2007).

Groups with substance abuse dual diagnosis and developmental disability dual diagnosis may often approach the mental health system from different class positions, yet both groups encounter barriers accessing medical mental health care. In the case of dual diagnosis patients, organizational silos without bridges between medical mental health services and the quasi-mental health condition is the primary barrier. Mental health providers consider quasi-mental health diagnoses separate from, yet also linked to mental health treatment differently from physical illnesses. Whereas providers generally accept that many mental health patients have co-occurring physical illnesses and do not alter their care on this basis (Sartoris 2007), it is not uncommon for medical mental health providers to consider substance abuse or developmental disorder diagnoses additive to the complexities of mental illness to the point that they disrupt treatment attempts, and providers will refuse to treat dual diagnosis patients (Quintero and Flick 2010).

Although the mental health field has at various points overlapped with these quasi-mental health fields, the gaps between these organizational silos are so substantial that patients with dual diagnosis can find themselves between two competing systems with neither one wanting to accept them. When asked about consumers “who slip through the cracks: who aren’t able to get mental health services,” Emily, a social worker at Mental Health Center, responded:

Well I think that sometimes when a person has dual diagnosis. I’ve seen, so someone has a drug abuse or alcohol abuse and then they also have a mental health diagnosis, sometimes, you know, I get a call from someone on the crisis line, and they say ‘detox, won’t work with me because I have mental’, or whatever, and ‘you won’t work with me because I have drug and alcohol issues’, you know. Sometimes that happens. . . . Some cases, people with a developmental disorder and then another, like maybe schizophrenia, or major depression, or something, can get tricky. And sometimes organizations will fight over it, or fight and say ‘no I’m not working with them because they have primary developmental disorder.’ ‘No, we’re not working with them because they have pri—you know, the mental health, like the mental health issue should be worked on first and then you should work with their developmental disorder.’ So, yeah, I think sometimes people slip through the cracks in those situations. Umm I notice that a lot, like when someone

has more than just, like one thing going on. They have like multiple things. I also think sometimes those are harder cases, and people don't want to take it on because it is difficult. I can't think of any other situations right now when someone falls through the cracks.

Situations like the ones Emily describes demonstrate the complete lack of any kind of bridge between silos. The fact that Emily highlights these two populations as groups likely to have additional barriers to access based on inter-agency dynamics and disagreements over whose treatment should go first is particularly problematic because of the proportion of the developmental disability and substance abuse populations with co-occurring mental health concerns. Estimates report the prevalence of mental illness as high as 40% of adults with developmental disability (Cooper et al. 2007), and substance abuse dual diagnosis is so common that it "could be considered as more the expectation than the exception when assessing patients with serious mental illness" (Buckley 2006:5). Further, inter-agency disagreements in which neither system is willing to take a consumer create a situation in which an individual with two issues is unable to seek assistance for either one.

In Chapter 4 I discussed Officer Gabor's experience taking an intoxicated man who had indicated his desire to commit suicide to the hospital the previous night. This man, Jack, is a good example of the lack of coordination between the mental health and substance abuse systems.

This case Officer Gabor finds especially frustrating. Jack used to work at the detox center, so that facility won't take him. She believes Jack's alcoholism is his primary concern, and that something is going on with him, so he's struggling with that. There are a few different places she could, and has, transported people from the hospital to for detox and treatment, if people want it, but none of them would take Jack. Officer Gabor says that "it's frustrating that institutions won't take him" and she can only take him to the hospital. Once he's sober enough that he is no longer a danger to himself and tells the hospital that, they release him. The hospital is not a detox center. This is a problem Officer Gabor encounters frequently with people who are rejected for whatever reason from the detox center. For these people it can be "tricky to take them to a safe place". (Fieldnotes)

Jack's situation is slightly more complicated than the typical case because he had been an employee at the detox center; however, as Officer Gabor explained, she encounters other people who detox will not accept for a variety of reasons. Jack's mental health is a concern because he becomes suicidal while intoxicated, but once sober he becomes psychologically stable. As a result, it is assumed that Jack's alcoholism is his primary issue. Since he appears to be barred access from substance treatment, the mental health system could potentially offer him assistance, but this is not being done. Because he is stuck between these two silos, his problems persist.

Individuals with dual diagnosis substance abuse and mental illness face homelessness and incarceration as a result of their illnesses at higher rates than those with substance abuse or mental illness alone (Brekke et al. 2001). Jack lived with his elderly mother, so he was not homeless, but had multiple interactions with police and a few arrests because of threats and signs of aggression toward his mother. On this occasion, within 18 hours: Jack had gotten drunk and suicidal, Officer Gabor had taken him to the hospital on a mental health hold, local detox and substance abuse facilities refused to admit him, the hospital released him after about six hours, and Jack returned home where he became aggressive and threatening towards his mother. On our way to arrest Jack, Officer Gabor made the comment "that domestic violence isn't a good charge to have, but that it 'might be good [for Jack] to be locked away for a few days to protect himself'" (Fieldnotes). Because neither the medical mental health nor substance abuse systems could offer him assistance, Jack was in this "dead zone" between silos. This is a potentially dangerous situation because there are only two ways out: people can either pull themselves out without the assistance of either system, or get worse so that either: a) The mental health system or substance abuse system would feel obligated to accept him, or b) He acts out and ends up in

jail. Because Jack was in this dead space, a preventable crime occurred and the jail was the only “safe place” left for him to go.

The organizational issues surrounding individuals with either substance abuse or developmental disability dual diagnosis are twofold: professionals state that the individuals can be harder to work with, and bridges need to be built between these organizational silos. Dr. Jay, a psychiatrist who has worked extensively with the developmentally disabled community, said that he began working with this population because “I wasn’t afraid of it. Other people, other psychiatrists, just felt like ‘it’s not my area of expertise. I don’t know what to do with these people.’” At the time, individuals with developmental disabilities with mental illness were seen at Mental Health Center, where the majority of providers did not want to work with the population. These individuals were also considered an unfavorable group of clients by the organization as a whole: “they were a little bit of a second class population because they didn’t do very well in outpatient individual psychotherapy and patient follow-up, and you had to coordinate with another agency.” Since that time the primary social agency in Elkgate working with individuals with developmental disabilities has opened its own mental health clinic for clients to receive treatment, which has largely moved the population out of Mental Health Center. According to Dr. Jay, “they do better in that system because the coordination is better with their therapist, with their case manager, with their host home provider, the behavioral therapists they have out there who are specialists in developmental disabilities, that’s worked quite well, actually. I’m amazed at how well that clinic has done.”

The fact that Elkgate’s primary developmental disability agency created its own mental health services diverting patients away from Mental Health Center indicates substantial issues coordinating care across the two organizations. Although the clinic does work “in collaboration”

(agency website) with Mental Health Center, the developmental disability agency oversees all aspects of the clinic, including hiring professionals and running individual and group treatment programs. Rather than coordinating with Mental Health Center, a well-established organization devoted entirely to mental health treatment and care, this agency put forth the energy and funding to create its own mental health clinic for Medicaid recipients with dual diagnosis developmental disability and mental illness. According to Dr. Jay, this was the best possible outcome for this population. Moving psychiatric care for individuals with developmental disabilities to the agency overseeing social services related to developmental disabilities resulted in greater coordination of care because it condensed services from two organizations to one, eliminating the issue of silos, and ensuring that only professionals willing to work with individuals with developmental disorders would provide the bulk of mental health services. This is an example of successful intersectional policy. The developmental disability agency recognized that this subset of their clients who were both developmentally disabled and mentally ill were disadvantaged in the available mental health services and created a service built around their unique needs.

Unlike physical and mental health comorbidity, where a physical illness diagnosis is not considered prohibitive to mental health treatment, a quasi-mental health diagnosis is both a structural and cultural barrier to medical mental health care in dually diagnosed consumers. Physical and mental illnesses have high rates of comorbidity, particularly in individuals with severe mental illness (Dixon et al. 1999; Satorius 2007). Based on this, and provider accounts in interviews of patients with physical conditions, it is fair to say that the majority of providers had worked with patients who also had physical diagnoses. Not one provider indicated they had ever seen or heard of a patient who was denied access to mental health care due to a physical illness,

while the majority of medical and correctional providers indicated instances of patients denied mental health care due to their quasi-mental health diagnosis.

Culturally, dual diagnosis presents a barrier to mental health care due to provider stigma towards the quasi-mental health diagnosis. In the previous chapter I discussed stigma from professionals towards individuals based on psychiatric diagnosis and history. Stigma from professionals is again an issue here for individuals with a dual diagnosis, but rather than stigma based on their psychiatric status, these consumers are stigmatized for their quasi-mental health diagnosis. Whether abusing substances or developmentally disabled, many providers consider the diagnosis a significant obstacle to treatment for mental illness, so they either refuse to work with the population in private practice, or do so begrudgingly in the public mental health system.

The professional culture within mental health promotes this stigma because dual diagnosis patients are earmarked as “special populations,” meaning that these patients should be approached differently from those with a mental illness mono-diagnosis. Additionally, both quasi-mental health diagnoses have their own system of care and professionals who specialize in each respective field. This creates resistance in mental health providers to accept these patients without having additional training in dual diagnosis patients. In other words, professional culture perpetuates the gaps between these organizational silos. Dr. Jay explained that he began treating more patients with developmental disabilities mainly because he was the only psychiatrist at Mental Health Center willing to work with the population without any prior experience or training:

In [Elkgate] I used to see, I used to deal a lot with developmentally disabled. . . I just stepped back from the line of volunteers and said, ‘if you don’t want to do it I’ll do it,’ and I didn’t have any special expertise in it but it turns out that it’s not that difficult and developmentally disabled people have the same kind of issues that anybody else has with being bipolar or schizophrenia or obsessive compulsive disorder, or whatever.



According to Dr. Jay, and other mental health professionals interviewed, providers avoid dual diagnosis patients because of a perception that their quasi-mental health diagnosis make them more difficult and they represent a unique patient populations that require specialty training. Providers speculated that the resistance to accept dual diagnosis patients was rooted in a combination of avoiding difficult patients and provider fear of doing a disservice to patients. However, by refusing these populations, providers are unable to gain experience and exposure to these groups, which further solidify the “otherness” of dual diagnosis from mono-diagnosis patients. If more providers were willing to accept dual diagnosis patients, they may also find, as Dr Jay did, that these groups “have the same kind of issues that anyone else” with mental illness face.

In addition to the cultural barrier to medical mental health treatment stemming from stigma, dual diagnosis patients also face structural barriers to treatment rooted in inter-organizational dynamics. In a prior chapter I discussed issues in private practice with coordinating care with other professionals: providers are only paid for the time spent with patients, so any time spent on a patient via communication with other providers is unpaid. This would apply to mental health providers or any other professional or agency with which a patient is involved. In other words, mono-diagnosis patients with multiple mental health providers pose the same issues in terms of coordination of care and inter-organizational communication as dual-diagnosis patients: the payment structure also encourages silos. On the other hand, in Elkgate’s public mental health, where many dual diagnosis patients access care, dual diagnosis patients require a more involved coordination of care than mono-diagnosis patients receiving multiple mental health services at Mental Health Center. According to Dr. Jay, coordination of care was problematic between Mental Health Center’s providers and the developmental disability

services, which contributed to the patient population's undesirability to providers and their treatment "as a little bit of a second class population."

Finally, coordinating across the mental health and quasi-mental health systems becomes especially problematic when patients are denied access to both systems because they are equally suitable for both. Presumably in an effort to most effectively treat patients, providers and agencies want to treat the most immediate issue first. The problem with dual diagnosis patients is this can become a question of chicken and egg: did substance abuse lead to the mental illness, or did the mental illness lead to substance abuse? The result is one version of Elizabeth Martinez's "oppression Olympics" in which oppressed groups "contend for the title of 'most oppressed'" (pg. 23). The difference in this case it is the professionals arguing which condition is worse. The result mirrors Martinez's caution against oppression Olympics because "pursuing some hierarchy of competing oppressions leads us down dead-end streets where we will never find the linkage between oppressions or how to overcome them" (pg. 23). If providers refuse patients because they honestly do not feel that they could effectively treat them, then this would not apply. On the other hand, it does if providers are avoiding these patients because they are perceived as "too difficult" to work with. Whatever the reason, dual diagnosed patients stuck in the gaps of these organizational silos can get caught in a position in which services for both diagnoses are telling them to seek help from the other one first. When this occurs, the social service system has effectively failed because a patient has fallen through the cracks of both systems. As Emily, a social worker at Mental Health Center, explains: "I find that sometimes it gets tricky because there are so many systems. . . .And there are all these little caveats, or rules. They're rules. And sometimes someone just doesn't fit in any of them." Considering the overlap of mental illness with substance abuse and developmental disabilities, better coordination and communication

across these systems and understanding of these patients at these intersections has the potential to drastically reduce the number of patients who cannot access mental health services due to systemic issues and gaps.

## CONCLUSION

The structure of Elkgate's mental health system creates a system of organizational silos that are overly focused inward on their own individual roles, responsibilities and professional culture. Many organizations have little to no outward perspective on how their actions affect other organizations, and while there is evidence of organizational awareness of how other organizations' actions have an effect on them (for example, the police reaction to ER discharges), it is not productive in Elkgate. Rather than using that awareness as a starting point to working together to improve the situation, it is used to place blame on another organization or as a source of frustration. Not only do these silos create frustration between professionals, but more importantly, consumers at intersections of the mental health system that place them between two, or across multiple silos become caught in the crossfire or lost in the dead space between silos.

For consumers in these positions, the mental health system becomes even more complicated and difficult to navigate, particularly when their intersecting needs place them between two or more separate systems, as is the case with the populations discussed here. The homeless mentally ill and dual diagnosed populations are dually-, or in some cases, multiply disenfranchised. That the positions of both these populations along the intersections of the mental health system result in further disadvantages across both statuses show that populations who need greater care do not in fact always receive greater care in Elkgate's mental health system.

In addition to organizational silos, power relations between organizations and the mentally ill population's relative lack of power are an important factor of the inequalities faced by both mentally ill populations discussed in this chapter. For the homeless mentally ill, the city and county ordinances show the political power of a segment of the housed population represented by the city council who want to force the homeless out of Elkgate. The police following and enacting these ordinances in practice demonstrate the power city council has over the police department, which is rooted in funding. Police officers not being utilized as a tool or resource for the medical mental health system in cases where people are not transported to the jail or hospital is an indication of the power the medical system has over mental health. We see this again when dually diagnosed patients refused by both mental health and quasi-mental health services end up in jail: whereas these treatment services are allowed to refuse difficult patients, correctional organizations have no choice but to manage and interact with people no one in the medical mental health and quasi-mental health systems would accept. I would argue that in cases like Nick, where people who are unconscious of their condition as a result of their severe mental illness yet are able to refuse services, the mentally ill are given too much power, or autonomy, over their care (Torrey 1996; 2008). Finally, police discretion based on civilian attitude and comportment during interactions is one of many examples of police power over civilians. For the dual diagnosed, the standoff that occurs between agencies results because neither agency has the power to give directions to the other. In this case it is actually a lack of some hierarchy in place that allows patients to be refused by both services. Finally, this population also demonstrates the power relationship between providers and patients. In some circumstances, patients are at the mercy of their providers. When a provider refuses to take on a patient, the patient does not have any recourse available.

These power relationships and their subsequent consequences to affected populations are the result of the societal contexts under which they occur (Winkler and Degele 2011): the attitudes, norms, values and relevant events that impact the community. Further analysis of Elkgate is needed to fully understand why a community with a leftist reputation and identity has some of the harshest policies against the homeless and why a police department that prides itself on “taking [social work] calls other departments never would” does not involve itself more with the medical mental health system. Dual diagnosis patients can look to the education and professionalization of mental health professionals for answers as to why they face such barriers in accessing care. As previously discussed, treating these populations as sub-specialties in mental health means that professionals are socialized into believing that these are difficult patients that require specialized training in order to adequately treat.

In this chapter I have combined principles of intersectionality and the organizational concept of silos to explain how and why individuals with mental illness who are also either homeless or dual diagnosed are among those most likely to slip through the cracks of Elkgate’s mental health system. While I chose to focus on these two groups, it is important to note that they are not the only populations who lack services or access to services due to a lack of bridges across organizational or system silos. Others mentioned by professionals included children and youth (across the education, corrections and mental health care), and the housed underclass (between mental health and insurance providers). Elkgate has a substantial mental health system: a hospital with a psychiatric unit, a jail with a special management unit, a large public mental health center, and one of the highest rates of private mental health professionals per capita in the country. If groups of people are falling through the cracks here, it is likely that even more are missed by mental health systems elsewhere.

## CHAPTER VII: WHERE DO WE GO FROM HERE? POLICY IMPLICATIONS AND SUGGESTIONS FOR MENTAL HEALTH SYSTEMS IN THE UNITED STATES

“[s]imply changing the locus of bad care does not produce good care” (Streimer 1989 – as quoted in Krupinski 1995).

In the three preceding chapters, I presented how the micro (professionals), meso (community and organizations) and macro (state and federal) levels operate together and individually in Elkgate to create the positive and negative consequences to professionals and consumers observed. In this chapter, I take the findings and conclusions from those chapters to propose policy changes and present successful programs in practice in other systems and recent advancements in policy related to mental health in Colorado. Elkgate’s mental health system is not unlike many other mental health systems across the United States. Its structure of organizational silos, intersecting institutions, and influences from local, state, and federal governments is similar to most other systems one would find in the United States. What separates one community’s system from others is a system’s ability to build bridges across these organizational silos and work together on matters regarding mental health. Changes to mental health care are especially important today. With additional funds being directed to mental health in many states and from the federal government, throwing money at mental health without addressing the structural and cultural barriers mental health systems face will create systems with more programming and resources with the same fragmentation and frustrations across organizations. In order for Elkgate and other mental health systems to improve, changes need to be made at the meso-level of organizations and the community, and at the macro-level of state and federal government. Although mental health professionals often receive the blame for problems in the mental health system, in order to create significant change the focus needs to be

moved upwards to the meso- and macro-levels. For this reason, in this chapter outlining policy suggestions I have not included a section on the micro provider level.

#### MESO-LEVEL: ORGANIZATIONS AND COMMUNITY

In order for individual systems to build bridges between the organizational silos described in the previous chapter, significant attention needs to be focused at the meso-level of mental health systems: the individual organizations and the community. This is especially important for systems similar to Elkgate where the resources are there – a hospital with an inpatient psychiatric unit, the large and well established Mental Health Center, a significant number of private mental health resources, and a jail and police department aware of and sensitive to the issue of mental health in corrections – yet the system as a whole does not optimally utilize the resources due to the lack of cooperation and communication across organizations.

Silos are unavoidable in complex systems such as corrections or mental health. Each organization has its own role in the system with its own administration, professional expectations and culture. The way for these systems to operate most effectively is by building bridges that allow for increased cooperation and shared understandings across silos. One way this can be accomplished is through organizational integration (Horvitz-Lennon, Kilbourne and Pincus 2006), defined as “the extent to which distinct and interdependent organizational components constitute a unified whole” (Barki and Pinsonneault 2005:166). While the correctional institution in Elkgate has established strong organizational integration between its organizations, such as police and the jail, this is less established betwixt other organizations of the mental health system, and particularly between organizations across institutional groupings. In the following section I will apply the organizational integration literature to Elkgate’s correctional system to

illustrate how organizations are able to build bridges and areas where the organizations of Elkgate's mental health system could implement changes in order to build more bridges and strengthen those already in practice.

*Organizational Integration: What Elkgate's Correctional System Can Teach Its Mental Health System*

Applying practices of organizational integration has great potential to successfully bridge Elkgate's mental health system. Organizational integration is applied to a variety of organizational types and systems of organizations, so it is not surprising that it has multiple types and forms. Organizational integration is typified based on three categories of organizational interdependence established by Thompson (1967): pooled, sequential, and reciprocal. Pooled interdependence involves each part contributing to the whole and each is supported by the whole, but every part "does not necessarily depend on, or support, every other part directly" (Barki and Pinsonneault 2005:167). In sequential interdependence, each part works sequentially where one picks up where the other left off. Finally, reciprocal interdependence appears similar to sequential, except that in reciprocal interdependence the relationship between parts is cyclical. In this type of interdependence "reciprocity [is] the relationship between units, each unit constituting a contingency for the other units, its outputs serving as inputs to others and vice versa" (Barki and Pinsonneault 2005:169).

According to Thompson (1967), all organizations and organizational systems have pooled integration; some will have both sequential and pooled; and "the most complex have reciprocal, sequential, and pooled" (pg. 55). Unsurprisingly, Elkgate's correctional and mental health systems are a combination of all three types. In both systems the individual organizations, or parts, involved contribute to the system by playing out their individual roles and are supported by the system through its legitimacy granted by the state or professional bodies (ex. police are



authorized to place mental health holds; psychiatrists and trained mental health professionals work in the jail), exemplifying pooled integration. As described in Chapter 4, an ideal case for an individual interacting with the mental health system would be sequential: the emergency room to an inpatient unit to outpatient providers. In reality, the mental health system is more typically reciprocal, where individuals will interact with and cycle through a variety of organizations. Elkgate's mental health system can be categorized using an organizational integration type; however, this does not mean that the system is integrated. The nature of its organizational integration type (pooled) means that fully integrating the organizations of Elkgate's mental health system would require "greater implementation effort" and overcoming more significant barriers to integration than any other organizational type because of its complexity (Barki and Pinsonneault 2005:170).

. The two types of barriers to organizational integration identified in the literature are specialization and political. Both of these barriers are actively working against the organizational integration of Elkgate's mental health system. Specialization occurs when individual organizations are overly focused on their own goals or frames of reference (Hitt et al. 1993) to the point that they lose sight of, or are never able to see, those of their partner organizations. This is evident in Elkgate's mental health system across multiple organizations. In Chapter 4 I discussed the difficulties between police and the emergency room surrounding mental health holds. The root of the tension between police and hospital staff in these interactions is specialization. Although both organizations approach individuals and situations with the same goals of individual and public safety, their means of achieving these goals differ significantly: police through a law and order approach and the hospital through treatment. One place where this is evident is the percentage of patients brought in by police on mental health holds who are

discharged from the ER. As described in Chapter 4, while using the same legislative criteria, the two organizations evaluate individuals differently: the police looking for a reason to place an individual on a hold and crisis evaluators looking for evidence that they do not need to be hospitalized. Police and emergency room staff hold vastly different frames of reference regarding their own and each other's responsibilities to individuals in psychiatric crisis and their role in the mental health system more generally. Further evidence of specialization is located in the lack of knowledge police have of the ER and the medical mental health system generally, and ER staff have of police training and work involving individuals with mental illnesses. Finally, the role of specialization as a barrier to integration across these organizations is evident in police officer reactions to people's release from the ER. In the previous chapter, I quoted jail employees reacting to police decisions and police reacting to changes they would have to make as a result of an issue in the jail. Although specialization is still evident across police and the jail, these two organizations demonstrate their shared frame of reference in their mutual understanding of the other's work environment and structural constraints. In contrast to the police and jail, the police and emergency room staff had very little, if any, understanding of each other, which resulted in mutual frustrations and blame placed on the other for systemic and structural faults.

A second point of organizational integration affected by specialization is between inpatient and outpatient providers and services. Although these professionals have a more shared frame of reference than police and ER staff, specialization is evident in the lack of communication between inpatient and outpatient providers and the perceived goals of each service. In Chapter 5 I discussed the lack of communication between these providers: patients enter an inpatient unit or facility, and outpatient providers are oftentimes unaware until their patient is ready for discharge or the patient returns to the outpatient provider. This is indicative

of specialization because inpatient and outpatient providers are for the most part operating entirely independently of one another. Finally, we can see the effects of specialization between these two groups in their perception of what the other is supposed to accomplish. One Mental Health Center evaluator, Dylan, described this struggle:

What I feel like one of the issues is like systemically, though, is more an issue of this thing where I'm like: 'Okay, I'm going to send him off to the hospital,' you know. That's my job to determine whether they're going to the hospital or not. But then once I think the hospital, the inpatient hospital idea is like: 'Oh, well they're going to get their stuff treated outpatient.' And then what ends up happening is that we're all just sort of passing the ball. There's this idea of like 'this is going to fix the client: if I put them in the hospital that's going to fix them.' And then the client gets to the hospital and they're kind of like: 'Well okay, we got the meds stabilized, but you're going to really get fixed in outpatient treatment.' And so we sort of take these clients and it's like toss toss toss toss.

In worst-case scenarios, specialization between inpatient and outpatient care can create mismatched perceptions of care with each group assuming that the other will “fix the client.” The result of this lack of organizational integration is not only frustrations between individual or groups of providers, but much more significantly, patients who end up passed between inpatient and outpatient services with no one assuming the responsibility of “really fixing” them.

Closely related to specialization, politics is the second major barrier to organizational integration. This barrier encompasses power relations and resource sharing and allocation. In previous chapters I have addressed both of these elements in various forms within Elkgate's mental health system and their relation to systemic issues. Because this mental health system is structured along organizational lines with a great deal of specialization, power relations are pervasive with many being structurally imposed. In the previous three chapters I discussed such power relations as police as gatekeepers of the medical versus correctional mental health system; the jail choosing when inmates require psychiatric assessment for transfer to an inpatient placement; the decision to admit someone to a psychiatric unit or discharge them from the ER;

and an outpatient provider's decision to accept or reject a dual diagnosed patient. Each of these situations places the power of one organization over the others and has the potential of impacting the entire system. One benefit to the organizational structuring of Elkgate's mental health system is that most of the organizations do stand independently of the others in their mission and goals and are not competing for the same federal, state, or local expenditures. The one exception to this was public outpatient programs and services where there was direct competition for funding and relevance in the public mental health system. While monetary resources did not appear to cause significant inter-organizational issues in Elkgate's mental health system, knowledge resources did. Highlighted in Chapter 5, information sharing was limited across organizations due to the structural restrictions created by HIPAA. This created frustrations among some professional groups—particularly private outpatient providers and police—when they did not have access to patient information they felt was necessary or potentially beneficial for patients and/or organizational integration of the mental health system.

The effects of the barriers to organizational integration as a result of specialization and politics served to further isolate the organizations of Elkgate's mental health system. These two barriers are interrelated and mutually reinforcing: the structural factors dictating power relationships, decision making, and limits placed on information transmission reinforced the system's strict organizational boundaries separated by specialization, which further entrenched organizational actors in specialized frames of reference, thereby encouraging othering between organizations and further legitimating the perceived need and rationale for the power relationships, decision making and limits placed on information transmission within each organization. These barriers can only be overcome, and greater organizational integration achieved, by applying a variety of mechanisms shown to facilitate integration.

In ascending order of effectiveness, direct supervision (one body responsible for coordinating activities); standardization of output (clearly specified results); and standardizing norms, skills, and knowledge are the mechanisms that best facilitate integration in a complex, multi-organizational system (Glouberman and Mintzberg 2001). From his position as a jail administrator, Richard describes Elkgate's correctional system as having applied these mechanisms and achieved significant organizational integration:

. . . it's a, kind of a culture that's evolved over a lot of years. I mean Elkgate's been kind of on the leading edge in terms of how we manage people and you see it with our relationship with the public defenders, who are the defense attorneys for the inmates. They work with us. We don't have an adversarial relationship with the public defenders. Or the [District Attorneys], or the courts. So I think that as a county, I think Elkgate's known for having a very—just work relationship with each other is very strong and we all interact, look for common ground in which to resolve things . . . I serve on a criminal justice management board as well. We meet once a month, and that's the board that involves the sheriff and the chief judge, and the district attorney, and the head of justice services, and head of probation, and the head of the public defender's office, and all of the players are there. And what we talk about is, is really what's going on in our jail. That's our biggest focus. And we talk about the issues we're dealing with in mental health issues and over jail overcrowding, and the FTAs that we were referring to, these are all the issues that we're having. What can we do collectively to address those issues. And we've got buy-in from everybody, all [correctional] agencies in the county.

Richard offers one nebulous and one concrete inter-organizational process that led to the organizational integration of Elkgate's correctional system defined by its inter-agency cooperation, search "for common ground in which to resolve things," and "collectively" addressing systemic issues. First, he describes "a culture that's evolved over a lot of years" that eventually led to a system where the jail works as a collective with the other agencies. Presumably, if this culture "evolved" to this point, the standardized norms and knowledge required to sustain the level of cooperation and mutual understanding Richard describes were not always present. However, Richard does not offer any specific events or actions that led to or encouraged this cultural evolution. Next, he describes the criminal justice management board,

which offers some direction for other inter-organizational systems. Every month upper-level correctional administration from “all agencies in the county” gather to discuss issues that—although focused in the jail—affect everyone in the system. Meetings such as these, wherein representatives from every agency in the system discuss systemic issues and work collectively to find solutions at the administrative level, are hugely beneficial to the establishment of standardization of output (agreed upon desired results and the process to achieve them) and direct supervision over a system composed of a variety of agencies.

Similar meetings and programs that involve equal contributions of agencies do exist in Elkgate’s mental health system; however, none of these have successfully incorporated “all agencies in the county” or even representatives of each mental health sphere (private practitioners, public organizations, the hospital, jail and police). The most successful of these, a voluntary outpatient program for individuals with severe mental illness who are on a minimum of one year probation, integrates probation, social services and Mental Health Center: “[The program] will work with [participants] with a primary [counselor] to get them housing . . . obviously medications, the probation officer is actually there in the facility, so you don’t have to go from one facility to another facility. . . .for the most part, it’s tried to be as much of a one-shop stop as much as possible” (Miguel, jail mental health provider).

The criminal justice management board and the probation-mental health program have one critical component in common: Elkgate’s Chief Judge, Judge Kaplan. Over the course of data collection multiple professionals in the mental health system, both correctional and medical, referenced Judge Kaplan as an agent of change in Elkgate with a particular interest in the mental health system and individuals with mental illness in the correctional system. Judge Kaplan spearheaded the criminal justice management board, and “Judge [Kaplan] and the former sheriff

got the grants initially” to begin the probation-mental health program (Miguel, jail mental health provider). Mental health and corrections in Elkgate are both complex systems that encompass multiple organizations. Although inter-organizational interactions occur, the structure of these systems and their politics can reinforce organizational specializations, which work against integration at both the frontline and administrative levels. When this occurs, a powerful and respected individual or group is needed in order to single-handedly provide direct supervision over the system for a period of time in order to get all parties around the same table. Judge Kaplan is that person in Elkgate. When considering these complex systems, only once representatives of the various organizations are seated at the same table can the system begin to work toward establishing and executing the mechanisms that facilitate organizational integration.

Techniques of organizational integration are critical to building bridges across the organizational silos and institutional groupings that constitute Elkgate’s mental health system. However, increasing integration and implementing change is exceedingly difficult in the mental health system for two reasons: First, the mental health system is a bureaucracy, which means “change is incremental” (Barki and Pinsonneault 2005:173). Second, this bureaucracy is a patchwork of organizations located at the intersections of mental health, medicine and corrections. While these factors do present challenges to organizational integration of mental health systems, it is possible to create highly integrated mental health systems as evidenced by San Antonio, Texas and other cities and towns that have implemented successful programs and strategies.

#### *Case Study: San Antonio, Texas*

Prior to developing a mental health system and resources that fully integrate medical and correctional organizations, San Antonio was in a similar position as Elkgate: “none of the county

or city agencies and nonprofits that deal with people with serious mental illness was talking to one another. The jails, hospitals, courts, police and mental health department all worked in separate silos” (San Antonio Director of the community mental health system, as quoted by Gold 2014:n.p.). Initiated by the director of the community mental health system and a county judge, they were able to establish a forum where everyone could talk about the issue and each organization heard. This step was “the most challenging piece” primarily because of the institutional gap between corrections and medicine: “If you think law enforcement and mental health workers have anything in common, we don’t, except people with substance abuse and mental health problems. We speak a different language, we have different goals, there’s not a lot of trust there” (Ibid). In order to entice organizational players to come together and recognize mental health as a shared issue, the community mental health system director contracted an analyst to provide a breakdown of mental health spending city-wide. The results of the study convinced organizational administrators of the need to come together: “the players realized they were spending enormous sums of money to take care of people. And they were doing a bad job of it” (Ibid).

From these meetings, stakeholders developed a solution that would benefit both correctional and medical organizations. First, following the analyst’s recommendation, the organizations pooled their resources together. Rather than each organization approaching serious mental illness from their organizational framework with their funding, they established a joint approach and funding stream. The result was a facility dedicated to mental health and addiction that includes: “a 48-hour inpatient psychiatric unit, sobering and detox centers, outpatient primary care and psychiatric services, a 90-day recovery program, housing for people with mental illnesses, and even job training and a program to help people transition to supported



housing” (Gold 2014:n.p.). Recognizing the overlapping needs of the homeless with mental illness and substance abuse, they built the new facility across the street from the pre-existing homeless shelter to also integrate homeless services and organizations. Following the mental health and addictions’ facility’s 2003 opening, the success of the unified effort is evident in their outcome measures. The facility serves over 18,000 people each year. More than 17,000 people have been diverted from jail and ERs (Gold 2014). The county jail—a facility with a capacity of 4,563—has gone from overcrowded to an average of 1,000 empty beds (Bexar County Sheriff’s Office 2015). The combined savings of the integrated system have been over \$10 million per year (Gold 2014). Today, San Antonio’s mental health system is widely considered one of the best in the U.S. and serves as a model for organizational integration for mental health across corrections and medicine. This accomplishment is made all the more impressive by the fact that Texas is consistently ranked among the lowest states in mental health funding (NASMHPD Research Institute 2012).

Applying this case to organizational integration, the stakeholders of San Antonio’s mental health system successfully applied previously mentioned strategies to significantly reduce, if not eliminate, their previously existing political and specialization barriers to organizational integration. In the same manner that Judge Kaplan acted as a direct supervisor in Elkgate by initiating the partnership between the jail and MHC, the director of San Antonio’s community mental health system initiated cooperation between organizations that did not trust one another by enticing decision makers with data showing inefficient spending and potential savings. The output, or desired result, was always standardized across organizations, in the sense that administrators are always looking to save money. What changed was the reference. Instead of focusing only on their own organization, administrators instead were considering the system

as a whole. Finally, though I do not have information on the process of standardizing norms, skills and knowledge, it is clear that the organizations involved have accomplished this feat based on their outcomes. The drastic shift in the jail population alone is evidence that the corrections system trusts the medical mental health system to appropriately manage and treat individuals they would have taken to jail in the past. As a result of applying these strategies, San Antonio's mental health system was able to open lines of communication and cooperation, thereby substantially reducing specialization. Granted, there will always be a degree of specialization because they still are separate organizations with unique responsibilities that are equally important to a functional mental health system: "Neither the mental health system nor the law enforcement system can manage mental health crisis in the community effectively without the help from the other" (Lamb, Weinberger and DeCuir 2002:1270). The level of specialization remaining allows each organization to focus on itself but also considers its position and actions relative to other organizations. Finally, the political barriers have also been substantially eliminated through pooling funds and resources directed to mental illness and addiction.

### *Other Successful Initiatives*

San Antonio's efforts to create a streamlined mental health system and its subsequent success provide evidence for the importance of organizational integration, particularly between correctional and medical organizations. But it is important to point out that not all mental health systems have the resources or ability to build and staff a facility similar to San Antonio's. Communities across the U.S and internationally have used various approaches to creating collaborations between mental health and corrections. Examples include: San Antonio's fully integrated system; mental health teams of either officers with specialized training who request the assignment, or mental health professionals and police officers; specialized mental health

triage centers where police can drop-off individuals in crisis; mobile crisis units police call to a scene (Dean et al. 1999; Steadman et al. 2000); and jail diversion programs, like Elkgate's, where individuals are diverted either pre-trial or post-trial to a specialized mental health program (Case et al. 2009) Programs vary in the amount they save cities, but every approach builds bridges between silos and result in saving cities money and reducing the number of individuals with mental illness ending up in jail (Case et al. 2009; Deane et al. 1999; Steadman et al. 2000).

The issues with implementing programs are two-fold. First, correctional and medical mental health organizations need to be able to come together. This is the specialization barrier to organizational integration. As previously mentioned, there is no clear hierarchy between the organizations of mental health systems. This means that either mutual trust between organizational decision makers must be present in order for the organizations to come together on their own, or a third party steps in with enough power, legitimacy, and evidence to convince decision makers to come together. Second, to use an old business adage: "You've got to spend money to make money." This is the political barrier to integration. All of these require that organizations put money into creating the program. This can be extremely difficult when no one seems to have any money. Additionally, social organizations and government agencies have the tendency to be shortsighted by prioritizing cuts over spending in order to save money now, and ignoring the possibility that it will ultimately cost more in the future, as opposed to spending money now in order to save in the future.

#### *Meso-level Policy Suggestions for Elkgate*

Elkgate has established a strong back door (after jail) integration between corrections and medical mental health; however, it is lacking front door (before jail) integration. Ideally a mental health system would have programs in place to avoid jail altogether and also have programs for

people who do end up in jail that will reduce the possibility of them returning to jail in the future. As previously mentioned, Elkgate's post-trial diversion program bridges the jail and Mental Health Center. This is a successful back door integration between corrections and medical mental health: analyses of program outcomes show significant reductions in ER visits, repeat incarcerations, and an increase in employment rates among program participants and graduates. Elkgate is in need of a partnership between its police department and medical mental health to more effectively divert people away from the jail and also to improve this relationship in general. Elkgate Police Department does offer Crisis Intervention Training on a voluntary basis, but it does not apply a mental health team approach on the streets where these officers would be automatically dispatched to any mental health related calls. Additionally, the department does not have any policies in place dictating a certain number of CIT certified officers be on patrol every shift.

A police mental health team is likely to result in some improvement to interactions and situations involving the police and individuals with mental illness (Deane 1999; Steadman et al. 2000) and would involve minimal effort on EPD's part: they already have officers trained, so it would be a matter of having enough officers volunteering for the position, changing dispatch procedure so that all mental health calls are directed to the mental health officer(s), and possible schedule changes for the mental health officers. The remaining unresolved issue that may prevent a more substantial change is police-ER interactions and relations.

Every person I spoke with indicated that a psychiatric ER, or even a crisis center, would be an invaluable addition to Elkgate's mental health system. A psychiatric ER would move all psychiatric patients from the present general ER at Elkgate General Hospital to this location, whereas a crisis center would remove only those patients who require minimal or no physical

medical care from the ER. At the moment only Mental Health Center has a crisis center, but even those patients need to go to the ER to get medical clearance if they are going to be admitted to a psychiatric unit. Police have no other option than to take people on mental health holds to the ER. This means that it is critical that Elkgate General Hospital and Elkgate Police Department develop some level of integration. In some cities this has been accomplished through police in-service training where ER physicians and mental health evaluators and psychiatrists educate police on exactly what they are looking for when they determine whether to discharge a patient or not. This would also educate police officers on the evaluation process, which was woefully misunderstood by some officers. Finally, this type of forum would also give participating medical mental health professionals and ER physicians an opportunity to better understand the police perspective.

Meso-level changes that build bridges between organizational silos and increase organizational integration can be extremely effective. The case of San Antonio demonstrates the substantial impact that this level of change can have on a mental health system, and the city in general, both socially and economically. However, meso-level changes can only have an impact on one mental health system at a time. We need to look to the macro-level for more sweeping changes to mental health systems.

#### MACRO-LEVEL: STATE AND FEDERAL

The National Alliance on Mental Illness is cautiously optimistically considering this “a time of great transition in America’s health care system” (2014:6). As discussed in the opening chapter, mental health has gained a great deal of attention since 2012, and healthcare in general has been one of the main foci of the Obama administration. For the second year in a row over half of states have increased spending on mental health, and the 2013 and 2014 legislative

sessions saw multiple states ratifying legislation applauded by mental health advocates. Progress has certainly been made, but, as the National Alliance on Mental Illness also points out, in order to see major changes in mental health care in the U.S., we will need “sustained attention and funding” (2014:6).

### *Changes Abreast*

The most significant federal changes to mental health care are those already discussed in Chapter 2. The combination of the expansion of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act and the Patient Protection and Affordable Care Act (ACA) has extended insurance access to mental health care to many Americans. In 2014, the first year the ACA’s requirement that individuals have insurance was in effect, the uninsured rate dropped from 17.1% to 12.9% (Gallup 2015). Mental health is one of the 10 Essential Health Benefits insurance plans are required to provide. Beginning in July 2014, Mental Health Parity extended to individual and small group plans, which means that all insurance providers are now required to provide equal coverage for mental health and addictions as medical and surgical care. While promising, these expansions mean that more people have access to coverage, which does not automatically equate to care and actually has the potential of stretching already overburdened mental health systems even thinner. Individual states will need to address this issue in order to prevent this from happening.

Colorado is among the 22 states that have increased mental health funding in both of the past two legislative sessions. Shocked into action by the 2012 Aurora theatre shooting, the state government has made mental health a priority. Mental Health America of Colorado named 2013 the “year of mental health at the Colorado legislature” (Loft-Manier 2013:2). For the first time since 1974 the state revisited and amended its civil commitment statutes. Colorado was the only

state with three different civil commitment statutes for drug use, alcohol, and mental illness. As discussed in Chapter 4, the statutes were vague and did not readily translate to language used by physicians. Of particular concern was the standards did not define “danger” when “imminent danger to self or others” are two of the three possible qualifications for commitment. The third qualification, “gravely disabled” was also in need of amendment because the statute was unclear, leading to both false positives and negatives.

In May of 2013, Governor John Hickenlooper signed HB13-1296 into law creating the Civil Commitment Statute Review Task Force. The task force is significant because the bill lists the designation of the 30 members that include representatives from the criminal and medical mental health system, the substance abuse system, organizations who advocate for disadvantaged groups, individuals with recent lived experience as mental health patients, and politicians (see Appendix I for the full bill). This indicates that the State government is actively considering populations at intersections of the mental health system and seeking patient input when developing new law related to mental health; however, it is also worth noting that among the advocacy organizations included, there was not one representing the homeless population.

The Task Force presented its suggested amendments to the statute (see Appendix I for the full amendments) in November of 2013. In the 2014 legislative session the revised statute did not pass due to controversy over removing “imminent” from the standard. The fear was that this would expand the standard and result in an increase of involuntary hospitalizations.

The second major piece of legislation in 2013 was \$20 million to fund the development of a network of crisis response centers that provide walk-in crisis services and stabilization units, residential and respite crisis services and mobile crisis services, a statewide 24-hour telephone crisis service, and a public information campaign. Senate bill 13-266 established a bidding

process “to entities with the capacity to create a seamless behavioral health crisis response system” (SB 13-266:1). In October 2013, Crisis Access of Colorado, a newly created conglomerate of three out-of-state companies, was awarded the contracts over the already established community mental health centers. Within two weeks the State had revoked these contracts, and upon review was calling the bidding process a failure. Crisis Access of Colorado responded with a lawsuit against the state. The legal battle delayed progress on establishing crisis centers until June of 2014 when a judge allowed the State to begin a second bidding process. This time the decision makers went with the existing community mental health centers. The first statewide crisis hotline was finally launched August 12, 2014; serendipitously, the same week as actor and comedian Robin Williams’ suicide, which, was once again, placed mental health and suicide in the national headlines. The crisis centers began operation in December 2014 in twelve locations across Colorado. Time will tell their impact on the mental health system.

#### *Future Policy Recommendations*

Changes in the federal government and in Colorado indicate that we are moving in the right direction in addressing some macro-level issues of mental health care. Not surprisingly, there are other areas that still require attention. On the federal level, the exact implications of HIPAA as they apply to mental health providers need to be clearly communicated. The Colorado Civil Commitment Task Force dedicated significant time in attempting to fully understand the limits of HIPAA on providers. Meeting minutes made it clear that none of the Task Force members could precisely say when providers were expected or allowed to speak with other parties and what information they could divulge. The issue was repeatedly brought up and attempts were made to invite representatives from the Office of Civil Rights, which oversees HIPAA practices, to meetings to answer member questions relating to HIPAA guidelines (Fox et



al. 2013). If there is this much uncertainty surrounding HIPAA in this group, it is all but certain that mental health practitioners also do not know the exact limits HIPAA places on them. There needs to be widespread clarification and education of HIPAA from federal government agencies to mental health professionals.

In Colorado, the state government needs to continue pursuing amendments to the civil commitment statute. Without definitions and clarity of critical language in the statute such as “dangerous” and “gravely disabled”, there will be continued ambiguity and disagreements over whether individuals meet criteria or not. This is one step in improving dynamics between police and ERs in mental health systems such as Elkgate, who are without other bridges between these organizational silos. Additionally, having three separate statutes for drugs, alcohol and mental health adds unnecessary confusion and complication to civil commitment and is furthermore impractical considering the frequency that these are co-occurring and overlapping conditions. Colorado used to provide funding for Crisis Intervention Training and it was a requirement of all police officers to be certified within the first five years on patrol. I recommend that the State re-introduce this funding and requirement among the funding increases to mental health.

## CONCLUSION

In order to improve mental health care in the U.S., changes need to happen at the federal, state, community, and organizational levels. In this chapter I have presented policy suggestions based on my research findings and described current policies and programs in practice that have proven effective or are expected to improve mental health systems. The primary goals of policy should be to improve organizational integration and the experiences of consumers across the mental health system. At the organizational and community level, this means that stakeholders need to work together across both organizational silos and institutional lines. At the state and

federal level, this means creating policy with input from organizations within mental health systems and individuals with lived experience as consumers, and finally, an awareness and representation of populations along the intersections of mental health.

## CHAPTER VIII: CONCLUSION

Mental health care systems are massively complex. They involve the medical and correctional systems, private and public care delivery, and institutional and community dimensions of care. Through my examination of Elkgate I have taken apart and put back together one mental health system. First, I have modeled the system by identifying the key player organizations and professionals and examining each organization's role independently and in relation to other organizations. Second, I identified problem areas of the system and their consequences for consumers, organizations and the functionality of the system as a whole. Third, I analyzed problematic inter-organizational interactions and situations, contextualizing them within the multi-level forces acting upon the events. Finally, I offered solutions at the individual, organizational, community, state and federal levels to improve the system. In this final chapter, I provide a brief recap of the previous seven chapters; present methodological, empirical and theoretical implications of this dissertation; discuss the project's limitations; and present directions for future research.

### SUMMARY

In my interview with Dr. Jay, the 35-year veteran psychiatrist, he aptly introduced Elkgate's mental health system as "a million different pieces. . . sort of put together in a jury-rigged kind of way." Mental health care in the United States is widely considered underfunded, overburdened, and in a state of disrepair partly as a result of its significant fragmentation referenced by Dr. Jay. Following decades of cuts to mental health, with the most significant between 2009 and 2012, a series of mass shootings committed by individuals with untreated mental illness diagnoses led to widespread attention to mental health care in the U.S. from state and federal leaders and the general public. Beginning in the 2013 legislative session the federal

government and many states made mental health a legislative and funding priority. The primary solutions to our woeful mental health system thus far have been increasing funding and programs. In comparison, the current mental health systems in place, their organizations, and the roles of each have received very little attention. The reality is that there are multiple systems of mental health care across a variety of public and private organizations crisscrossing multiple social institutions. I examined Elkgate's public and private adult mental health care systems in order to understand one mental health system's organizational stakeholders, roles, and inter-organizational interactions. In so doing, I answered the following research questions:

- What are the relationships among the organizations making decisions across the mental health system? How do agencies interact, and what are the barriers to communication in these situations? Who informs whom in terms of best practices?
- To what degree does macro-level policy impact inter-agency communication and interaction?
- How do inter-agency interactions and communication affect individuals most likely to have contact across agencies? Which populations have the most difficulty in the mental health system? Why and how are these populations disproportionately underserved?

Chapter 2 provided necessary theoretical and empirical background information for the project. Institutional research in sociology and multi-level research and analysis, particularly as applied to qualitative and medical sociology, provided my theoretical and analytical orientation. Next, I presented an overview of the present and recent history of mental health care in the U.S. including social institutions historically and currently involved, the importance and consequences of deinstitutionalization in creating the current mental health system characterized

by a lack of inpatient psychiatric beds, ERs who have no other option but to hold psychiatric patients for days at a time, and the transinstitutionalization of the mentally ill to jails and prisons nationwide. Medical mental health care is largely mediated by insurance coverage, which varies substantially across insurance providers and private, individual or employer-provided insurance versus Medicaid.

In Chapter 3 I described the methods and approach to data collection and analysis I took to complete this multi-site, multi-method case study of Elkgate. In order to factor in multiple levels of analysis (professional, organizational, community, state and federal contexts) of the mental health system I used a variety of data collection techniques including informal and intensive interviewing, observation, and archival data. I collected data from the Elkgate Police Department, Elkgate's jail, Elkgate General Hospital, the Medicaid contracted Mental Health Center located in Elkgate, and private practice mental health outpatient providers. Much of my data came from 80 hours of police ride-alongs where I was also able to access the jail and hospital ER, observe inter-organizational interactions, and conduct informal interviews with police. I approached data collection and analysis employing the methodological framework of Institutional Ethnography and inductive coding techniques.

Chapter 4, *The Mental Health System: Institutions, Organizations and Patient Pathways*, described the actors and organizations involved in psychiatric emergencies. Patients are directed through one of many possible pathways largely chosen by professionals. Police play a key role in many psychiatric emergencies. By using their discretion to determine whether an individual's pathway will go through corrections or medical mental health, police are gatekeepers to both systems. Inter-organizational interactions can also influence patient pathways. This was particularly evident in interactions between the ER and police, which were characterized by

mutual frustrations that are primarily the result of structural barriers to communication between the two organizations and further exasperated by differential ideologies between corrections and medicine.

Chapter 5, *From Macro to Micro: The Health Information Portability Accountability Act, Professional Communication and Patient Care* considered how HIPAA impacts patients with private insurance and those with Medicaid differently. While providing Medicaid patients with a higher degree of continuity of care than other patients, Mental Health Center's structure also creates a situation where Medicaid patients are required to forfeit medical privacy and control over their medical information that non-Medicaid patients maintain. If increased continuity of care is to the benefit of patients, then this provides evidence for a *compensatory conversion*, where a traditionally disadvantaged population receives better medical care than traditionally advantaged populations. On the other hand, it is also possible that the organizational continuity of care provided by Mental Health Center may also lead to a lower level of care based on provider preconceptions and stigma based on patient psychiatric history and/or diagnosis.

Chapter 6, *"Lost in the System": Populations Located Between Organizational Silos of the Mental Health System*, applies an intersectional analysis to consider populations at the intersections of the mental health system. Elkgate's mental health system is structured around multiple organizational silos. Because there is a lack of bridges across silos, particularly those between correctional and medical organizations, certain populations within the mental health system are further disadvantaged due to their intersecting status(es) with mental illness.

In the previous chapter, *Where do we go from here? Policy Implications and Suggestions for Mental Health Systems in the United States*, I discussed policy implications of this project

and possible solutions for Elkgate and other mental health systems at the individual, organizational, and state and federal levels.

## IMPLICATIONS OF THIS DISSERTATION

This project and my analyses and conclusions throughout this dissertation have implications to a variety of areas of sociology methodologically, empirically and theoretically.

### *Methodological*

Qualitative health systems research has become increasingly difficult to accomplish in the academy due to time constraints on faculty, access issues to health facilities, and difficulties with Institutional Review Boards. This has resulted in less research of complex health systems and more focus on individual organizations (Mendel et al. 2007). I was able to overcome these obstacles in this project by using the police as a gatekeeper organization to other organizations. Qualitative health systems research is certainly more complex in the planning phase of research and involves more hoops with Institutional Review Boards, but with some creativity and flexibility while working with organizations and the IRB, it can be done. In projects such as this, where there is a high degree of interactions between organizations, using a single organization to gain access to the others was highly effective.

This project also demonstrates the importance of multi-level analysis in order to contextualize findings and data triangulation (Denzin 1970). For example, Chapter 5 could have been an interactional analysis of police and ER professionals; however, collecting the appropriate archival data, including HIPAA and the Colorado M-1 statute, and contextualizing the observation and interview data with these and organizational considerations in my analysis, gave a much broader picture of these individual interactions that then became more generalizable than if I had not used these multi-level data and applied a multi-level analysis. Data triangulation

with these three data types was also crucial for a project like this. Each professional group felt that their version of the mental health system and what they thought the major causes for its problems were correct. My data collection methods allowed me to: 1) see for myself what was happening through observations; 2) get the perspective of professionals through interviews; and 3) compare both what was happening and professional perspectives to the written legislation.

### *Empirical*

As mentioned multiple times throughout this dissertation, mental health systems are exceedingly complex and highly fragmented. This means that few people understand the various components and the impacts they have on one another, which is crucial as we move forward with efforts to fix the system. As I will discuss in the following section, the specifics of Elkgate cannot be generalized to all other systems; however, the key points of interaction identified at ERs and jails do occur in nearly every other system and are noted points of contention. Understanding the system in detail; identifying the key stakeholders, how and where recognized issues are developing at various levels of the system, and populations who are not receiving adequate care; and offering explanations for why this is the case are all important contributions to mental health research, particularly in this time of change.

### *Theoretical*

In addition to the methodological and empirical implications, this project also provides a number of theoretical contributions. First, Elkgate's mental health system presents a scenario in which disadvantage is turned upside down: many Medicaid patients actually have a greater and more streamlined access to mental health care than those with private insurance. This puts Link and Phelan's (1995) fundamental causality into question in the context of mental health and



introduces the concept of *compensatory conversions* where the population in need of increased support and services actually receives them.

On the other hand, it is difficult to say what constitutes “better” care. Over the course of this project, I encountered both professionals and family members of individuals on Medicaid who believed that the Medicaid mental health system, even in Elkgate, is not a better system. Addressing this issue, I am critical of the general agreement that continuity of care is always to the benefit of patients and providers alike. We need to recognize that continuity of care can take multiple forms—continuity with a single provider, continuity between providers, and continuity within an organization—and have different consequences. In the case of stigmatized illnesses that leave patients vulnerable to negative preconceptions and assumptions from providers prior to providers meeting patients, provider to provider and/or organizational continuity of care may result in a lower level of care than if the continuity of care was not there and providers met patients for the first time without already knowing patient histories and diagnoses.

Second, the concept of organizational silos is extremely helpful in order to conceptualize the mental health system and better understand the relationships between its multiple pieces and should be applied more frequently. Additionally, “difficult populations” are better described as groups who fall victim to silo gaps and are indicative of a system that is not serving groups who are located at intersecting points of that system. Once we understand the gaps and bridges between silos, theories and techniques of organizational integration can be applied to develop possible explanations for gaps, understand how functional bridges are formed, and develop possible solutions to filling gaps.

Finally, this dissertation also questions the degree to which mental health is separate from or integrated with physical health. Mental health in the United States has long struggled to find

its place in the health system and medical landscape. Although medicalized through separate “treatment” facilities and medical doctors beginning in the mid-19<sup>th</sup> century and the discovery of effective psychotropic medications beginning in the 1950s, psychiatry has continued to be separate from physiological health to some degree. The tension in mental health and illness between being equal to, and yet also separate from, physiological health and illness is evident in the health policies discussed in this dissertation. HIPAA is applied blindly across all sectors of health care without regard to the unique symptomatic elements of mental illness that can periodically render patients unable to make health decisions that could be in their best interest. For example, paranoia, a common symptom of multiple mental illnesses (American Psychiatric Association 2013), may cause a patient to refuse to sign a disclosure between an inpatient facility and their community provider(s). In such a situation, even if the facility wanted to, HIPAA can prevent any inpatient provider from contacting outpatient providers involved with the patient. In this way, issues with patient refusal to consent to medical disclosure can be unique with mental illness, yet HIPAA does not allow for any alterations in its application based on area of medicine, with the exception of a distinction between psychotherapy notes and medical record (greater protections are afforded to the former). At the same time, Colorado’s decision to implement the carve-out program for Medicaid mental health funding and treatment indicates that there is also some belief that mental health is unique from physiological health. This fragmentation of Medicaid delivery indicates a desire to separate mental from physiological health, at least in its administration.

In practice, mental health is separate from the rest of medicine. First, psychiatric patients are considered difficult and undesirable patients in the ER (where mental health and physical health is integrated into the same space) because of their unique needs compared to physical

patients, and both physical and mental health professionals interviewed agreed that psychiatric patients and professionals would benefit from having a separate psychiatric ER. Mental health professionals who worked in the ER expressed their dissatisfaction with ER staffs' lack of knowledge of and empathy for psychiatric patients. Second, mental health is not just psychiatry. If we focus on only psychiatry, there is a more substantial case for mental health being part of medicine; however, there are more non-medical professionals (ex. psychologists, social workers, counselors) working in the mental health field than medical professionals (Bureau of Labor Statistics 2013).<sup>21</sup> This has a substantial impact on the practices and ideologies of mental health that maintain its separation from medicine.

## LIMITATIONS OF THE PROJECT

While making a number of contributions, the project does have a number of limitations as well. First, relying solely on Elkgate without any comparison city does put this project's generalizability into question. As stated in Chapter 1 and repeated throughout this work, there are multiple mental health systems. Each state has its own legislative climate that results in differential funds and policies directed toward mental health state to state. Each community then operates its own system with their own combinations of organizations and cultural and political climate. Mental health systems are then multiplied even at the community level with separate systems for adults versus children, insurance type, and military status. This dissertation focused on one adult system that certainly cannot be generalized to the Veterans Affairs mental health system or the child and adolescent mental health system. Further, since every community's adult

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<sup>21</sup> As of May 2013 the Bureau of Labor Statistics reported there were 25,040 practicing psychiatrists in the U.S., and 820 nurse practitioners and 34,690 registered nurses working in psychiatric and substance abuse hospitals. With 115,580 mental health counselors, 110,010 mental health and substance abuse social workers, and 29,060 marriage and family therapists practicing at the same time period, non-medical mental health professionals overwhelmingly outnumber medical mental health professionals.

system is unique, many findings in Elkgate may not necessarily be generalizable to other communities. Elkgate is in a privileged position that sets it apart from many other areas in the U.S. due to the considerable mental health resources at the city's disposal: 55% of U.S. counties (all rural, they have a combined population of about 91 million) have no practicing psychiatrists or social workers (SAMHSA 2007), and only 27% of county hospitals have inpatient psychiatric units (American Hospital Association 2007). On the other hand, while Elkgate's system is not identical to any other adult system, its structure shares many similarities with other systems in Colorado and the rest of the U.S. For example, HIPAA is a federal act that provides the same barriers to communication across providers and organizations in any other mental health system. The mental health hold criteria police and the ER use in Elkgate applies to all of Colorado, and each state has its own variation of this criterion that requires professionals from various organizations to interpret the same legislation and apply it to patient presentation. Finally, all present-day mental health systems incorporate both medical and correctional institutions, requiring coordination across these institutional boundaries in order to create the most effective system for consumers and professionals alike.

In addition to concentrating on only one community's mental health system, one organization—Elkgate's police department—dominated the data due to time, resource, and access constraints. While I approached the data with an effort to examine issues from the perspective of all organizations involved, it is possible that some viewpoints were one-sided or favored the police perspective given its weight in the data. On the other hand, considering my personal bias against police and their ability and/or willingness to effectively interact with and manage situations involving individuals with mental illness prior to data collection, focusing data collection around police may have resulted in a less biased view and analysis of Elkgate's mental

health system. On the other hand, exploring the mental health system from the police perspective meant that the individuals with mental illness observed were disproportionately of lower socioeconomic status and homeless, whereas if I had been able to do more observation at the ER, I would have gained a better perspective of the mental health system for a wider range of socioeconomic levels.

Finally, I relied primarily on observations of professionals and their accounts of consumers to deduce consumer experience in the system. Consumer stories are missing. Without data from consumers themselves, I cannot fully present the consequences of the mental health system on consumers. However, I would argue that my personal experiences living with mental illness and my status as consumer gives me a unique and insider perspective (Adler and Adler 1987), which further legitimates my analysis and conclusions of how consumers may experience the system.

#### DIRECTIONS FOR FUTURE RESEARCH

The limitations and findings of this project offer many possibilities for future research. First, comprehensive studies of other mental health systems should be done in order to better understand mental health in practice in the United States and to assist a variety of systems to create more effective and collaborative mental health systems with the resources and organizations they have in place. As previously mentioned, Elkgate is in a very privileged position in terms of resources, but has significant gaps in its coordination of services and organizational silos where people are unable to access care. Based on these factors, I would place Elkgate in the middle to upper level of mental health systems. Similar studies as this one should be done in systems both better than Elkgate, such as San Antonio, and systems worse off than Elkgate in order to determine both what the most successful systems are doing right, issues

resulting in the least successful systems, and the community and organizational factors that lead to successful versus unsuccessful systems. Future studies taking the same multi-organizational approach I used should attempt to establish relationships and partnerships with multiple organizations in order to have a more well-rounded perspective of the mental health system. Partnerships between researchers and city governments would be an important step to gaining access to many of the organizations under consideration.

The public and private adult mental health systems are two of many distinct mental health systems, including child and adolescent private and public systems and the Veteran's Administration. Future research efforts should examine these systems in a similar, multi-organizational, manner as I have Elkgate's adult mental health system. In addition to examining organizational stakeholders and inter-organizational interactions and cooperation within each of these systems, the systems' interactions and cooperation with the adult mental health system is also a key intersection. Because children and adolescents who experience mental illness are at a greater risk of more chronic and severe mental illness than those who do not (National Scientific Counsel of the Developing Child 2008), and veterans have higher rates of mental illness due to the consequences of active duty and are especially vulnerable to problems when transitioning back to civilian life (Ackerman, DiRamio and Mitchell 2009; Hoge et al. 2004), the transition from these systems to the public or private adult system is a key intersection for consumer health as well as public health and safety.

As discussed in the previous chapter, there are many operational programs in the U.S. and abroad working to establish a collaborative approach to mental health across medical and correctional institutions and others working to build better bridges between medical mental health professionals and programs. More evaluative research is needed on these programs in

order to direct funding and initiatives at the federal-, state-, and local-level to effective practices and programs shown to benefit communities, mental health organizations, and consumers.

In all of the abovementioned suggestions, consumers as well as organizational professionals and administrators should be included in the data. If the goal of this research is to establish best practices in mental health systems and/or policy recommendations for organizations or any level of government, it is vital that consumer experiences, pathways through the system(s) and their perspective of the quality, effectiveness, and positive and negative consequences of treatment received are considered. Without these, mental health systems run the risk of establishing ineffective yet coordinated systems that only serve administrators and professionals and that are guaranteed to fail. Access to consumer records would also be beneficial to see what information is passed between providers and organizations and what, if any, information providers have about consumers before their first meeting. The latter would be especially useful for organizations such as Mental Health Center where electronic patient files allow any provider within the same organization to look up any patient.

Turning to theoretical, as opposed to applied, research, one of the surprising findings of this dissertation was the cases of *compensatory conversion* in Elkgate's mental health care where individuals who are traditionally disadvantaged based on socioeconomic status and/or disability arguably received better care and had access to a greater number and wider variety of services through Medicaid and Mental Health Center than the vast majority of people on individual or employer-provided private insurance who have a higher socioeconomic status and are not disabled by Colorado's state standards. More research is needed to determine if mental health, or only mental health in Colorado, is unique in this respect or if there are other examples of this phenomenon in medicine and other elements of social life. Future research should question what

the cultural, structural and political factors are that allow this to occur in some areas of social life but not others. Further, the outcomes of such programs need to be examined to see if compensatory conversion in some aspects of social life neutralizes the impacts of compensatory inversion in others.

While socioeconomic and disability statuses inversely benefitted some of Elkgate's mentally ill population, another interesting consideration was the people who were still underserved or lost in Elkgate's mental health system. Future research of organizational practices, systems of care delivery, and/or policy outcomes should consider the experiences of individuals and groups at intersections of the larger population of interest when identifying how and why practices, systems, and/or policies are unsuccessful. By identifying relevant intersections, researchers and evaluators can uncover competing or incongruent structural pressures based on (an)other status(es) preventing the affected group from being successful (Crenshaw 1993). Specifically related to mental health, future research should apply intersectional theory by overlaying race/ethnic, gender, and sexual orientation statuses with the groups identified in Elkgate as lost in the system to see the degree to which these additional status positions affect individuals' access to care and experiences in the mental health system.

As previously mentioned, Chapter 5 presented two possible, and unresolved, consequences of HIPAA and the structure of care delivery as they apply to mental health and illness. The first is that HIPAA is too stringent, resulting in a mental health system where the players are unable to communicate. Second, when the structure of care is adjusted so that HIPAA does not create these barriers, patients receive a lower level of care and discriminatory treatment because of stigma toward particular psychiatric diagnoses and patient histories. Before we can move forward with policy, we need a clearer picture of these two contrasting outcomes and



mental health systems' orientation toward HIPAA. Future research should take into consideration both the legal intensions and meanings of HIPAA as it is written, and its interpretation by providers (Matthew 2014). Additionally, in order to establish a stronger linkage between professional stigma towards patients and the medical record, future research should focus on the medical record itself: How is it created? What goes into it? How do professionals interpret it? Finally, I feel that we should be more critical of continuity of care, particularly organizational or provider-to-provider continuity of care, and question whether it is always in the best interest of patients, particularly those with stigmatized illnesses. Also, comparisons should be made of the negative consequences of continuity of care between mental health and other stigmatized illnesses (ex. HIV/AIDS, obesity, Sexually Transmitted Infections).

The final area for future research is in complex inter-organizational and inter-institutional organizational fields. As societies are becoming increasingly bureaucratized (Weber 1946), globalized, and product and service systems of delivery increasingly complex and large in both the public and private sectors, organizational fields in all areas of social life are becoming larger and are more likely to overlap with an increasing number of organizations and blur the borders between social institutions (Powell et al. 2005; Zietsma and Lawrence 2010). In order to keep up with this growth we need to understand how to best operate these systems and manage competing and/or contrasting institutional ideologies and perspectives. Future research needs to more closely examine institutional and organizational intersections and under what conditions they operate most smoothly. In mental health specifically, this needs to be applied to the intersection between physical and behavioral health and medicine. If the direction and goal in medicine is integrated health, research needs to critically evaluate where and why exclusionary attitudes and practices persist between physical and behavioral healthcare in the education,

professional socialization, and healthcare delivery of providers and develop solutions to close the gap. The government is another institution worth greater consideration in further research. Considering the impact of state and federal legislation on professional behavior and inter-organizational interactions,

Finally, researchers must consider the multi-level impacts of changes in policy, legislation, and practice in terms of both a downward trajectory from the macro- to micro-level and, though to a lesser degree, an interplay between levels. For example, organizations influence individual professional behavior, but individual professional behavior can also influence organizations. In mental health policy this means that professional-consumer interactions, and consumer experience in particular, need to be an on-going consideration to all proposed changes regardless of the level: organizational, community, state, or federal. Further, no social event at any level of analysis happens in a vacuum. In order for researchers to best understand and explain social phenomena, any event needs to be contextualized in its micro-, meso-, and macro-level processes. Social research must continually strive toward, and place a premium on, multi-level research.

As a graduate student, the inevitable question that comes up when in any social situation, academic or otherwise, is what are you studying and/or what is your dissertation on. One thing that has been especially surprising and exciting for me while doing this project is the excitement and interest of non-academics when I would give my two-minute spiel on this topic. People not only found it interesting, but I was told multiple times how important this work is. In fact, just a couple months ago while at the gynecologist for my annual exam the nurse practitioner asked me about my research. When I answered she got misty-eyed. She proceeded to tell me that her son is severely mentally ill and has had interactions with the criminal justice system due to his mental

illness. Thanking me for the work I'm doing, she said: "it's [the mental health system is] such a mess."

Mental health and illness are of national concern. As the detrimental results of an underfunded and overburdened system are receiving increasing attention, the United States is at a point where there is an understanding that mental health systems are overwhelmingly ineffective at best, and broken or in complete disrepair at worst. The majority of calls for change involve significant increases in spending and allocation of funds to mental health programs and systems. More money does have the potential to improve both the quality and quantity of mental health services. However, issues in patient care related to organizational structures and legislative barriers will continue unchanged until close inspection of mental health systems with consideration of these elements is performed. As the nation moves forward in its examination and possible overhaul of mental health systems, we need to consider the multi-level dimensions of mental health care. Until more effort is made to take a step back and thoroughly examine present systems of mental health, we will continue to perpetuate current ills to the detriment of mental health professionals, organizations, the general public, and, most importantly, the 25% of the U.S. population living with mental illness.

## BIBLIOGRAPHY

- Adair, Carol E., Gerald M. McDougall, Craig R. Mitton, Anthony S. Joyce, T. Cameron Wild, Alan Gordon, Norman Costigan, Laura Kowalsky, Gloria Pasmaeny, and Anora Beckie. 2005. "Continuity of Care and Health Outcomes among Persons with Severe Mental Illness." *Psychiatric Services*, 56(9):1061-9.
- Adler, Patricia A. 2011. *The Tender Cut: Inside the Hidden World of Self-injury*. New York University Press.
- American Academy of Child and Adolescent Psychiatry. 2009. "Systems-Based Practice: The Public Mental Health System." *American Academy of Child and Adolescent Psychiatry*. Retrieved October 1, 2014  
([http://www.aacap.org/App\\_Themes/AACAP/docs/resources\\_for\\_primary\\_care/training\\_toolkit\\_for\\_systems\\_based\\_practice/o%20-%20Systems%20Based%20Practice%20Module%20-%20Mental%20Health%20System%20For%20Web.pdf](http://www.aacap.org/App_Themes/AACAP/docs/resources_for_primary_care/training_toolkit_for_systems_based_practice/o%20-%20Systems%20Based%20Practice%20Module%20-%20Mental%20Health%20System%20For%20Web.pdf))
- American College of Emergency Physicians. 2009. *America's Emergency Care Environment: A State-by-State Report Card*. Washington, D.C: American College of Emergency Physicians.
- American College of Emergency Physicians. 2014. *America's Emergency Care Environment: A State-by-State Report Card*. Washington, D.C: American College of Emergency Physicians.
- American Hospital Association. 2007. *Behavioral Health Challenges in the General Hospital: Practical Help for Hospital Leaders*. Washington, D.C.
- American Psychiatric Association. 2013. *Diagnostic and Statistical Manual of Mental Disorders: DSM-5*. Washington, D.C: American Psychiatric Association.
- American Psychological Association. 2015. "Graduate Psychology Education (GPE) Program is Addressing Mental and Behavioral Health Needs of Underserved Populations." *American Psychological Association*. Retrieved February 3, 2015  
(<http://www.apa.org/about/gr/issues/gpe/populations.aspx>)
- Annas, George J. 2003. "HIPAA Regulations-A New Era of Medical-record Privacy?." *New England Journal of Medicine* 348(15):1486-1490.
- Armstrong, David, Eva Kline-Rogers, Sandeep M. Jani, Edward B. Goldman, Jianming Fang, Debabrata Mukherjee, Brahmajee K. Nallamothu, and Kim A. Eagle. 2005. "Potential Impact of the HIPAA Privacy Rule on Data Collection in a Registry of Patients with Acute Coronary Syndrome." *Archives of Internal Medicine*, 165(10):1125-1129.

- Armstrong, Elizabeth A., Laura Hamilton, Brian Sweeney. 2006. "Sexual Assault on Campus: A Multilevel, Integrative Approach to Party Rape." *Social Problems*, 53(4):483-499.
- Baraff, L., N. Janowicz, J. Asarnow. 2006. "Survey of California Emergency Departments about Practices for Management of Suicidal Patients and Resources Available for their Care." *Annals of Emergency Medicine*, 48:452-58.
- Baumer, David, Julia Brande Earp, and Fay Cobb Payton. 2000. "Privacy of Medical Records: IT Implications of HIPAA." *ACM SIGCAS Computers and Society*, 30(4):40-47.
- Bexar County Sheriff's Office. 2015. *Bexar County Sheriff's Office Adult Detention Center Facility*. Bexar County Sheriff's Office. Accessed March 16, 2015 ([http://home.bexar.org/sheriff/ADC\\_facility.html](http://home.bexar.org/sheriff/ADC_facility.html)).
- Biernacki, Patrick and Dan Waldorf. 1981. "Snowball sampling: Problems and techniques of chain referral sampling." *Sociological methods & research*, 10(2):141-163.
- Bhugra, Dinesh. 2014. "Alienated Alienists: A New Hope?" *The Lancet Psychiatry*, 1(4):257-259.
- Brekke, John S., Cathy Prindle, Sung Woo Bae, and Jeffery D. Long. 2001. "Risks for Individuals with Schizophrenia Who Are Living in the Community." *Psychiatric Services*, 52(10):1358-1366.
- Brown, Jennifer. 2014. "Breakdown: A Broken Mental Health System." *Denver Post Investigative Series*, November 21, 2014. Accessed March 15, 2015 (<http://extras.denverpost.com/mentalillness/#health>).
- Brown, Lawrence, Kimberley Isett and Michael Hogan. 2010. "Stewardship in Mental Health Policy: Inspiration, Influence, Institution?" *Journal of Health Politics, Policy and Law*, 35(3): 389-405.
- Brown, P. 1980. "Social Implications of Deinstitutionalization." *Journal of Community Psychology*, 8(4):314-322.
- Bureau of Labor Statistics. 2013. *Occupational Employment and Wages, May 2013*. United States Department of Labor.
- Cabana, Michael D. and Sandra H. Jee. 2004. "Does Continuity of Care Improve Patient Outcomes." *Journal of Family Practice*, 53(12):974-80
- Campbell, M. and Gregor, F. 2004. *Mapping Social Relations: A Primer in Doing Institutional Ethnography*. Lanham, MD: AltaMira Press.
- Canton, Carol L.M., Carol Wilkins and Jacquelyn Anderson. 2007. *People Who Experience Long-Term Homelessness: Characteristics and Interventions*. 2007 National Symposium

- on Homeless Research. Retrieved February 17, 2015  
(<http://aspe.hhs.gov/hsp/homelessness/symposium07/caton/report.pdf>).
- Case, Brian, Henry J. Steadman, Seth A. Dupuis and Laura S. Morris. 2009. "Who Succeeds in Jail Diversion Programs for Person with Mental Illness? A Multi-Site Study." *Behavioral Sciences and the Law*, 27:661-74.
- Castrejón, Isabel, Lauren McCollum, Mine Drusus Tarniover, and Theodore Pincus. 2012. "Importance of Patient History and Physical Examination in Rheumatoid Arthritis Compared to Other Chronic Diseases: Results of a Physician Survey." *Arthritis Care and Research* 64(8):1250-55.
- Center for Medicaid & CHIP Services. 2014. *State Medicaid and CHIP Income Eligibility Standards*. Centers for Medicare & Medicaid Services. Retrieved August 27, 2014 (<http://medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/Downloads/Medicaid-and-CHIP-Eligibility-Levels-Table.pdf>).
- Centers for Disease Control and Prevention. 2010. *National Hospital Discharge Survey, 2010*. Centers for Disease Control and Prevention National Center for Health Statistics.
- Charmaz, Kathy. 2001. "Grounded Theory." Pp. 335-52 in *Contemporary Field Research: Perspectives and Formulations* (2<sup>nd</sup> ed.). Edited by R. M. Emerson. Prospect Heights, IL: Waveland Press.
- Charmaz, Kathy. 2002. "Qualitative Interviewing and Grounded Theory Analysis." Pp. 675-94 in *Handbook of Interview Research: Context and Method*, edited by J. F. Gubrium and J. A. Holstein. Thousand Oaks, CA: Sage.
- Choo, Hae Yeon and Myra Max Ferree. 2010. Practicing Intersectionality in Sociological Research: A Critical Analysis of Inclusions, Interactions, and Institutions in the Study of Inequalities." *Sociological Theory*, 28(2):129-49.
- Conrad, Peter and Joseph W. Schneider. 1992. *Deviance and Medicalization: From Badness to Sickness*. Philadelphia, PA: Temple University Press.
- Colorado Department of Human Services. 2014. "Behavioral Health Organizations." *Colorado: The Official State Web Portal*. Retrieved September 22, 2014 (<http://www.colorado.gov/cs/Satellite/CDHS-BehavioralHealth/CBON/1251584326042>).
- Corrigan, Patrick W. and Petra Kleinlein. 2005. "The Impact of Mental Illness Stigma" Pp. 11-44 in *On the Stigma of Mental Illness: Practical Strategies for Research and Social Change*, edited by P. Corrigan. Washington, DC: American Psychological Association.
- Corrigan, Patrick W, F.E. Markowitz, and A.C. Watson. 2004. "Structural Levels of Mental Illness Stigma and Discrimination." *Schizophrenia Bulletin*, 30(3):481-91.

- Corrigan, Patrick W. 2007. "How Clinical Diagnosis might Exacerbate the Stigma of Mental Illness." *Social Work*, 52(1):31-9.
- Cooper, Amy E., Patrick W. Corrigan, and Amy Watson. 2003. "Mental Illness Stigma and Care Seeking." *Journal of Nervous and Mental Disease*, 191(5):339-41.
- Crenshaw, Kimberle. 1989. "Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics." *The University of Chicago Legal Forum*, 139:139-167.
- Crenshaw, Kimberle. 1993. "Mapping the Margins: Intersectionality. Identity Politics, and Violence Against Women of Color." *Stanford Law Review*, 43(7):1241-1299.
- Deane, Martha Williams, Henry J. Steadman, Randy Borum, Bonita M. Veysey and Joseph P. Morrissey. 1999. "Emerging Partnerships Between Mental Health and Law Enforcement." *Psychiatric Services*, 50(1):99-101.
- Denzin, Norman K. 1970. *The Research Act: A theoretical introduction to sociological methods*. Englewood Cliffs, NJ: Prentice-Hall, Inc.
- Detre, Thomas. 1987. "The Future of Psychiatry." *American Journal of Psychiatry*, 144(5):621-625.
- Earley, Pete. 2006. *Crazy: A father's search through America's mental health madness*. New York: Berkley Books.
- Eghigian, Greg. 2012. "Voices from the Past: An Asylum Superintendent on the Importance of Structures." *Psychiatric Times*, May 23, 2012. Retrieved February 5, 2015 (<http://www.psychiatrictimes.com/articles/voices-past-asylum-superintendent-importance-structures>).
- Epstein, Joan, Peggy Barker, Michael Vorburger, Christine Murtha. 2002. *Serious Mental Illness and its Co-occurrence with Substance Use Disorders*. Department of Health and Human Services Substance Abuse and Mental Health Services Administration Office of Applied Studies. Retrieved September 24, 2014 (<http://www.samhsa.gov/data/CoD/CoD.pdf>).
- Fink, P.J. and A. Tasman (Eds). 1992. *Stigma and Mental Illness*. Washington, DC: American Psychiatric Press, Inc.
- Frank, Richard G., and Sherry A. Glied. 2006. *Better but Not Well: Mental Health Policy in the United States Since 1950*. JHU Press.
- Foucault, Michel. 1965. *Madness and Civilization*. London: Tavistock.
- Foucault, Michel. 1975. *The Birth of the Clinic: An Archaeology of Medical Perception*.

- Foucault, Michel. 1977. *Discipline and Punish: The Birth of the Prison*. Trans. A. Sheridan. New York: Pantheon.
- Fox, Patrick K. Julie Reiskin, Michael Stafford, Alacey Berumen, Elizabeth McCann and Michael Lott-Manier. 2013. *Report of the Civil Commitment Statute Review Task Force*. State of Colorado.
- French, Laurence. 1987. "Victimization of the Mentally Ill: An Unintended Consequence of Deinstitutionalization." *Social Work*, 32(6):502-505.
- Gill, James, Arch Mainous, and Musa Nserko. 2000. "The Effect of Continuity of Care on Emergency Department Use." *Archives of Family Medicine*, 9:333-38.
- Glaser, Barney. 1978. *Theoretical Sensitivity*. Mill Valley, CA: Sociology Press.
- Glaser, Barney and Anselm Strauss. 1967. *The Discovery of Grounded Theory: Strategies of Qualitative Research*. London: Wiedenfeld and Nicholson.
- Glatter, Robert. 2014. "'Boarding' of Psychiatric Patients in Emergency Departments Unconstitutional in Washington State." *Forbes*, 8/16/2014. Retrieved September 22, 2014 (<http://www.forbes.com/sites/robertglatter/2014/08/16/boarding-of-psychiatric-patients-in-emergency-departments-unconstitutional-in-washington-state/>).
- Glisson, Charles. 2002. "The Organizational Context of Children's Mental Health Services." *Clinical Child and Family Psychology Review*, 5(4):233-53.
- Glisson, Charles, John Landsverk, Sonja Schoenwald, Kelly Kelleher, Kimberly Eaton Hoagwood, Stephen Mayberg, and Philip Green. 2008. "Assessing the Organizational Social Context (OSC) of Mental Health Services: Implications for Research and Practice." *Administration and Policy in Mental Health and Mental Health Services Research*, 35(1-2):98-113.
- Goffman, Erving. 1961. *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates*. Anchor Books.
- Goffman, Erving. 1963. *Stigma: Notes on the Management of a Spoiled Identity*. Touchstone.
- Goldman, D. 1995. *Emotional Intelligence*. New York: Bantam Books.
- Goldman, Howard H. 1982. "Integrating Health and Mental Health Services: Historical Obstacles and Opportunities." *American Journal of Psychiatry*, 139(5):616-620.
- Goleman, D. 1995. *Emotional Intelligence*. New York: Bantam Books.
- Gralnick, Alexander. 1985. "Build a Better State Hospital: Deinstitutionalization has Failed." *Psychiatric Services*, 36(7):738-741.



- Gulliford, Martin. 2006. "What is 'Continuity of Care'?" *Health Policy and Services*, 11(4):248-50.
- Gold, Jenny. 2014. "Wrestling With A Texas County's Mental Health System." *Kaiser Health New*, August 20, 2014. Retrieved February 18, 2015 (<http://kaiserhealthnews.org/news/san-antonio-model-mental-health-system/>).
- Greenhill, Maurice H. 1979. "Psychiatric Units in General Hospitals: 1979." *Hospital & Community Psychiatry*, 30(3):169-182.
- Gold, Jenny. 2014. "Wrestling with a Texas County's Mental Health System." *Kaiser Health News*. Accessed February 25, 2015 (<http://kaiserhealthnews.org/news/san-antonio-model-mental-health-system/>).
- Haggerty, Jeannie L., Robert J Reid, George K Freeman, Barbara H Starfield, Carol E Adair, and Rachael McKendry. 2003. "Continuity of Care: A Multidisciplinary Review". *British Medical Journal*, 327(7425):1219-21.
- Hampton, J.R., M.J. Harrison, J.R. Mitchell, J.S. Prichard, and C. Seymour. 1975. "Relative Contributions of History-Taking, Physical Examination, and Laboratory Investigation to Diagnosis and Management of Medical Outpatients. *British Medical Journal*, 2(5969):486-9.
- Hamblin, Allison, James Verdier, and Melanie Au. 2011. *State Options for Integrating Physical and Behavioral Health Care: Technical Assistance Brief*. Centers for Medicare and Medicaid Services, October 2011. Retrieved July 30, 2014 (<http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Downloads/BH-Briefing-document-1006.pdf>).
- Hampton, J.R., M.J. Harrison, J.R. Mitchell, J.S. Prichard, and C. Seymour. 1975. "Relative Contributions of History-Taking, Physical Examination, and Laboratory Investigation to Diagnosis and Management of Medical Outpatients. *British Medical Journal*, 2(5969):486-9.
- Hankivsky, Olena and Renee Cormier. 2010. "Intersectionality and Public Policy: Some Lessons from Existing Models." *Political Research Quarterly*, 64(1):217-229.
- Hawes, Jennifer Berry. 2013. "We Now Know that Many Disorders are Physiological, not Psychological." *The Post and Courier*. Retrieved May 28, 2014 (<http://www.postandcourier.com/article/20130414/PC16/130419587>).
- Hiday, V., M Swartz, J. Swanson, R. Borum, H. Wagner. 1999. "Criminal Victimization of Persons with Severe Mental Illness." *Psychiatric Services*, 50(1):62-68.

- Hindman, Jarrod and Shannon A. Breitzman. 2014. *Office of Suicide Annual Report Suicide Prevention in Colorado 2013-2014*. Denver, CO: Colorado Department of Public Health & Environment - Prevention Services Division.
- Holloway, Jennifer Daw. 2003. "More Protections for Patients and Psychologists Under HIPAA: HIPAA's Psychotherapy Notes Provision Safeguards Sensitive Patient Information." *Monitor on Psychology*, 34(2):22.
- Horvitz-Lennon, Marcela, Amy M. Kilbourne, and Harold Alan Pincus. 2006. "From Silos to Bridges: Meeting the General Health Care Needs of Adults with Severe Mental Illnesses." *Health Affairs*, 25(3):659-669.
- Imershein, Allen, Philip Rond, and Mary Mathis. 1992. "Restructuring Patterns of Elite Dominance and the Formation of State Policy in Health Care." *The American Journal of Sociology*, 97(4): 970-993.
- Institute for Children, Poverty & Homelessness. 2011. *A Tangled Web: Homeless Family Subpopulations and their Overlapping Needs*. A National Survey policy brief from ICPH. Retrieved February 3, 2015 ([http://www.icphusa.org/filelibrary/ICPH\\_brief\\_ATangledWeb\\_HomelessFamily%20SubpopulationsandTheirOverlappingNeeds.pdf](http://www.icphusa.org/filelibrary/ICPH_brief_ATangledWeb_HomelessFamily%20SubpopulationsandTheirOverlappingNeeds.pdf))
- Isaac, Rael Jean and Virginia C. Armat. 1990. *Madness in the Streets: How Psychiatry and the Law Abandoned the Mentally Ill*. Free Press.
- Jacobson, Peter D. "Medical Records and HIPAA: Is it Too Late to Protect Privacy." *Minnesota Law Review*, 86(6):1497-1514.
- James, Doris and Lauren Glaze. 2006. *Mental Health Problems of Prison and Jail Inmates*. Washington, D.C: U.S. Department of Justice, Bureau of Justice Statistics. Retrieved October 1, 2014 (<http://www.bjs.gov/content/pub/pdf/mhppji.pdf>)..
- Kelly, Bredan. 2006. "The Power Gap: Freedom, Power and Mental Illness." *Social Sciences and Medicine*, 63(8): 2118-2128.
- Kendell, R. E. 2001. "The Distinction Between Mental and Physical Illness." *The British Journal of Psychiatry*, 178:490-93.
- Kripalani, Sunil, Frank LeFevre, Christopher O. Phillips, Mark V. Williams, Preetha Basaviah, and David W. Baker. 2007. "Deficits in Community and Information Transfer Between Hospital-Based and Primary Care Physicians: Implications for Patient Safety and Continuity of Care." *JAMA*, 297(8):831-41.
- Kulynych, Jennifer, and David Korn. 2003. "The New HIPAA (Health Insurance Portability and Accountability Act of 1996) Medical Privacy Rule Help or Hindrance for Clinical Research?" *Circulation*, 108(8):912-914.

- Lamb, H. Richard, Linda E. Weinberger and Walter J. DeCuir. 2002. "The Police and Mental Health." *Psychiatric Services*, 53(10):1266- 71.
- Larkin, G., C. Claassen, J. Emond, A. Pelletier, C. Carmargo. 2005. "Trends in US Emergency Department Visits for Mental Health Conditions, 1992 to 2001." *Psychiatric Services*, 56:671-677.
- League of Women Voters of Colorado. 2014. *Behavioral Task Force Final Report: An Overview of Colorado's Behavioral Health System*. Denver, CO: League of Women Voters of Colorado - Behavioral Task Force.
- Levit, Katharine R., Tami L. Mark, Rosanna M. Coffey, Sasha Frankel, Patricia Santora, Rita Vandivort-Warren and Kevin Malone. 2013. "Federal Spending on Behavioral Health Accelerated During Recession as Individuals Lost Employer Insurance." *Health Affairs*, 32(5):952-62.
- Levy. Jenna. 2015. "In U.S., Uninsured Rate Sinks to 12.9%." *Gallup Well-Being*, January 7, 2015. Accessed March 17, 2015 (<http://www.gallup.com/poll/180425/uninsured-rate-sinks.aspx>).
- Link, Bruce G. 1987. "Understanding Labeling Effects in the Area of Mental Disorders: An Assessment of the Effects of Expectations of Rejection." *American Sociological Review*, 52(1):96-112.
- Link, Bruce G. and Jo C. Phelan. 1995. "Social Conditions as Fundamental Causes of Disease." *Journal of Health and Social Behavior*, extra issue:80-94.
- Livingston, James D., Teresa Milne, Mei Lan Fang, and Erica Amari. 2012. "The Effectiveness of Interventions for Reducing Stigma Related to Substance Use Disorders: A Systematic Review." *Addiction*, 107(1):39-50.
- Lofland, John, David Snow, Leon Anderson, Lyn Lofland. 2006. *Analyzing Social Settings: A Guide to Qualitative Observation and Analysis (4<sup>th</sup> Ed)*. Belmont, CA: Wadsworth.
- Lott-Manier, Michael, Lauren Gallagher and Andrea Smith. 2014. *2013 Legislative Report*. Denver, CO: Mental Health America of Colorado.
- Lutfe, Karen and Jeremy Freese. 2005. "Toward Some Fundamentals of Fundamental Causality: Socioeconomic Status and Health in the Routine Clinic Visit for Diabetes." *American Journal of Sociology*, 110(5):1326-72.
- Markowitz, F.E. 1998. "The Effects of Stigma on the Psychological Well-being and Life Satisfaction of Persons with Mental Illness." *Journal of Health and Social Behavior*, 39(4):335-47.

- Matthew, Dayna. 2014. "Overcoming Barriers to Collaboration Among Behavioral Health and Primary Care Providers." *PCPCC National Briefing/Webinar* March 27, 2014: University of Colorado Law School.
- Mayo Clinic. 2012. "Diseases and Conditions: Mental illness." *Mayo Clinic*. Retrieved April 20, 2014 (<http://www.mayoclinic.org/diseases-conditions/mental-illness/basics/definition/con-20033813>).
- Mechanic, David. 1987. "Correcting Misconceptions in Mental Health Policy: Strategies for Improved Care of the Seriously Mentally Ill." *The Milbank Quarterly* (1987):203-230.
- Mechanic, David and David A. Rochefort. 1990. "Deinstitutionalization: An Appraisal of Reform." *Annual Review of Sociology*, 16:301-327.
- Mendel, Peter, Lisa S. Meredith, Michael Schoenbaum, Cathy D. Sherbourne, and Kenneth B. Wells. 2008. "Interventions in Organizational and Community Context: A Framework for Building Evidence on Dissemination and Implementation in Health Services Research." *Administrative Policy of Mental Health*, 35:21-37.
- Mental Health America. 2015. *Parity or Disparity: The State of Mental Health in America 2015*. Mental Health America.
- Metzl, Jonathan M. 2011. "Why are the Mentally Ill Still Bearing Arms?" *The Lancet*, 377(9784):2172-2173.
- Miles, Matthew B. and A. Michael Huberman. 1994. *Qualitative Data Analysis: An Expanded Sourcebook* (2nd ed.). Thousand Oaks, CA: Sage.
- Moffatt, Ken. 1999. "Surveillance and Government of the Welfare Recipient." Pp. 219-246 in *Reading Foucault for Social Work* edited by A. S. Chambon, A. Irving, and L. Epstein. New York: Columbia University Press.
- Mojola, Sanyu. March 11, 2015. E-mail conversation.
- Moore, Maloy, Megan Garvey, Evan Wagstaff. 2014. "Deadliest U.S. Mass Shootings." *Los Angeles Times*, April 2, 2014. Retrieved October 1, 2014 (<http://timelines.latimes.com/deadliest-shooting-rampages/>).
- Morgan, Laura. 2014. "Update on Behavioral Health Carve-Outs from Medicaid: Executive Briefing." *Open Minds Market Intelligence*. Retrieved September 22, 2014 (<http://www.openminds.com/market-intelligence/executive-briefings/update-behavioral-health-carve-outs-medicaid-mcos.htm>).
- National Alliance on Mental Illness. 2011. *Workforce Development: Policy Brief*. Washington, D.C: National Alliance on Mental Illness.

- National Alliance on Mental Illness. 2014. *State Mental Health Legislation 2014: Trends, Themes & Effective Practices*. National Alliance on Mental Illness.
- National Association of State Mental Health Program Directors Research Institute. 2012. *FY 2010 State Mental Health Revenues and Expenditures*. Kaiser Health News. Retrieved March 16, 2015 ([https://kaiserhealthnews.files.wordpress.com/2014/08/186708\\_c6beb833346b45429322c4421d83aa1.pdf](https://kaiserhealthnews.files.wordpress.com/2014/08/186708_c6beb833346b45429322c4421d83aa1.pdf))
- National Scientific Council on the Developing Child. 2008. *Mental health Problems in Early Childhood Can Impair Learning and Behavior for Life*. Boston, MA: Center for the Developing Child at Harvard University.
- Ness, Roberta B., and Joint Policy Committee. 2007. "Influence of the HIPAA Privacy Rule on Health Research." *JAMA*, 298(18):2164-2170.
- Nicks, B. and D. Manthey. 2012. "The Impact of Psychiatric Patient Boarding in Emergency Departments." *Emergency Medicine International*, 2012:1-5.
- Nordt, Carlos, Wulf Rössler, and Christoph Lauber. 2006. "Attitudes of Mental Health Professionals Toward People with Schizophrenia and Major Depression." *Schizophrenia Bulletin*, 32(4):709-14.
- O'Connor v. Donaldson, 422 U.S. 563 (1975).
- Osher, Fred, David D'Amora, Martha Plotkin, Nicole Jarrett, and Alexa Eggleston. 2012. *Adults with Behavioral Health Needs Under Correctional Supervision: A Shared Framework for Reducing Recidivism and Promoting Recovery*. Council of State Governments Justice Center, Criminal Justice/Mental Health Consensus Project. New York: Council of State Governments Justice Center.
- Pandiani, J., S. Banks, B. Carroll, M. Schlueter. 2007. "Crime Victims and Criminal Offenders among Adults with Serious Mental Illness." *Psychiatric Services*, 58(11):1483-5.
- Parsons, Talcott. 1951. *The Social System*. New York: Free Press.
- Paulson, George. 2012. *Closing the Asylums: Cases and Consequences of the Deinstitutionalization Movement*. Jefferson, NC: McFarland.
- Pepinsky, Harold E. 1980. "A sociologist on police patrol." Pp. 223-34 in *Fieldwork Experience: Qualitative approaches to social research* edited by William B. Shaffir, Robert A. Stebbins and Allan Turowetz. New York, NY: St. Martin's Press.
- Pianin, Eric. 2013. "A New Push to Boost Spending on Mental Health. *The Fiscal Times*, September 9, 2013. Retrieved: September 30, 2014.

(<http://www.thefiscaltimes.com/Articles/2013/09/09/New-Push-Boost-Spending-Mental-Health>).

Pilgrim, David. 2008. "Recovery and Current Mental Health Policy." *Chronic Illness*, 4(4):295-304.

Proctor, Enola K., John Landsverk, Gregory Aarons, David Chambers, Charles Glisson, and Brian Mittman. 2009. "Implementation Research in Mental Health Services: An Emerging Science with Conceptual, Methodological, and Training Challenges." *Administration and Policy in Mental Health and Mental Health Services Research*, 36(1):24-34.

Provan, Keith G., and H. Brinton Milward. 1995. "A Preliminary Theory of Interorganizational Network Effectiveness: A Comparative Study of Four Community Mental Health Systems." *Administrative Science Quarterly*, (1995):1-33.

Prus, R. 1996. *Symbolic Interaction and Ethnographic Research: Intersubjectivity and the Study of Human Lived Experience*. Albany, NY: SUNY Press.

Quandagno, Jill. 2010. "Institutions, Interest Groups, and Ideology: An Agenda for the Sociology of Health Care Reform." *Journal of Health and Social Behavior*, 51(2):125-136.

Quintero, Maria and Sarah Flick. 2010. "Co-Occurring Mental Illness and Developmental Disabilities." *Social Work Today*, 10(5):6-7.

Rapley, Tim. 2007. "Distributed decision making: the anatomy of decisions-in-action." *Sociology of Health & Illness*, 30(3): 429-444.

Reed-Danahay, Deborah E. 2001. "Autobiography, Intimacy and Ethnography." Pp. 407-425 in *Handbook of Ethnography*, edited by Paul Atkinson, Amanda Coffey, Sara Delamont, John Loftland, and Lyn Loftland. Thousand Oaks, CA: Sage.

Rhoden, Nancy K. 1982. "The Limits of Liberty: Deinstitutionalization, Homelessness, and Libertarian Theory." *Emory Law Journal*, 31(2):375-440.

Ringeisen, Heather, Kelly Henderson, and Kimberly Hoagwood. 2003. "Context Matters: Schools and the "Research to Practice Gap" in Children's Mental Health." *School Psychology Review*, 32(2):153-68.

Rocheftort, David A. 1993. *From Poorhouses to Homelessness: Policy Analysis and Mental Health Care*. Auburn House/Greenwood Publishing Group.

Rodrik, Dani. 2000. "Institutions for High-Quality Growth: What They are and How to Acquire Them." *Studies in Comparative International Development*, 35(3):3-31.

- Rousseau, Denise. 1985. "Issues of Level in Organizational Research: Multi-level and Cross-level Perspectives." *Research in Organizational Behavior*, 7(1): 1-37.
- Ruggeri, Mirella, Morven Leese, Graham Thornicroft, Giulia Bisoffi, Michele Tansella. 2000. "Definition and Prevalence of Severe and Persistent Mental Illness." *The British Journal of Psychiatry*, 177:149-55.
- Sandler, G. 1980. "The Importance of the History in the Medical Clinic and the Cost of Unnecessary Tests." *American Heart Journal*, 100(6):928-31.
- Sartorius, Norman. 2007. "Physical Illness in People with Mental Disorders." *World Psychiatry*, 6(1):3-4.
- Sartorius, Norman. 2002. "Iatrogenic Stigma of Mental Illness: Begins with Behaviour and Attitudes of Medical Professionals, Especially Psychiatrists." *British Medical Journal*, 324(7352):1470-71.
- Saultz, John W. and Waleed Albedaiwi. 2004. "Interpersonal Continuity of Care and Patient Satisfaction: A Critical Review." *Annals of Family Medicine*, 2(5):445-51.
- Saultz, John W. and Jennifer Lochner. 2005. "Interpersonal Continuity of Care and Care Outcomes: A Critical Review." *The Annals of Family Medicine*, 3(2):159-66.
- Scott, Charity. 2000. "Is Too Much Privacy Bad for Your Health? An Introduction to the Law and Ethics of Medical Privacy." *Georgia State University Law Review*. 17(2):481-529.
- Seale, Clive. 2008. "Mapping the field of Medical Sociology: A Comparative Analysis of Journals." *Sociology of Health and Illness*, 30(5):667-95.
- Shadish, William R., Arthur J. Lurigio, and Dan A. Lewis. 1989. "After Deinstitutionalization: The Present and Future of Mental Health Long-Term Care Policy." *Journal of Social Issues*, 45(3):1-15.
- Sheth, Hitesh C. 2009. "Deinstitutionalization or Disowning Responsibility." *International Journal of Psychosocial Rehabilitation*. 13(2):11-20.
- Sjoberg, Gideon, Norma Williams, Ted R. Vaughan, and Andree F. Sjoberg (eds.). 1991. *A Case for the Case Study*. Chapel Hill, NC: The University of North Carolina Press.
- Smith, Dorothy E. 1987. *The everyday world as problematic: A feminist sociology*. Toronto, ON: University of Toronto Press.
- Smith, Dorothy. 2005. *Institutional Ethnography: A Sociology for People*. Lanham, MD: AltaMira Press.

- Snowden, Mark, Jagoda Pasic, Steven Mitchell, Jurgen Unutzer, Richard Veith. 2014. "Equitable Care of Psychiatric Emergency Room Patients: It Does Take a Village." *American Journal of Psychiatry*, 171(7):720-22.
- Spagnolo, Amy B., Ann A. Murphy, and Lue Ann Librera. 2008. "Reducing Stigma by Meeting and Learning from People with Mental Illness." *Psychiatric Rehabilitation Journal*, 31(3):186-93.
- Steadman, Henry J., Martha Williams Deane, Randy Borum and Joseph P. Morrissey. 2000. "Comparing Outcomes of Major Models of Police Responses to Mental Health Emergencies." *Psychiatric Services*, 51(5):645-649.
- Strauss, A. and J. Corbin. 1990. *Basics of Qualitative Research: Grounded Theory Procedures and Techniques*. Newbury Park, CA: Sage.
- Substance Abuse and Mental Health Services Administration. [2006] 2011. *After an Attempt: A Guide for Medical Providers in the Emergency Department Taking Care of Suicide Attempt Survivors*. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, United States Department of Health and Human Services.
- Surles, Richard C. and Martin C. McGurrin. 1987. "Increased Use of Psychiatric Emergency Services by Young Chronic Mentally Ill Patients." *Psychiatric Services* 38(4):401-405.
- Tang, N., J. Stein, R. Hsia, J. Maselli, R. Gonzales. 2010. "Trends and Characteristics of US Emergency Department Visits, 1997-2007." *JAMA*, 304(6):664-70.
- Torrey, Edwin Fuller. 1997. *Out of the Shadows: Confronting America's Mental Illness Crisis*. New York: John Wiley.
- Torrey, Edwin Fuller. 2008. *The Insanity Offense: How America's Failure to Treat the Seriously Mentally Ill Endangers Its Citizens*. New York: WW Norton & Company.
- Torrey, Fuller E., Doris A. Fuller, Jeffery Geller, Carla Jacobs, Kristina Ragosta. 2012. *No Room at the Inn: Trends and Consequences of Closing Public Psychiatric Hospitals, 2005-2010*. Treatment Advocacy Center. Retrieved August 27, 2014 (<http://tacreports.org/bed-study>).
- Treatment Advocacy Center Backgrounder. 2013. *The Anatomical Basis of Anosognosia (Lack of Awareness of Illness)*. Treatment Advocacy Center.
- The Center for Health Care Services. 2015. "Jail Diversion Program." *The Center for Health Care Services: Mental Health and Substance Abuse Solutions*. Retrieved February 18, 2015 (<http://www.chcsbc.org/innovation/jail-diversion-program/>).



- The United States Conference of Mayors. 2013. *Hunger and Homelessness Survey: A Status Report on Hunger and Homelessness in America's Cities*. The United States Conference of Mayors.
- United States Department of Health and Human Services. 2003. *Summary of the HIPAA Privacy Rule*. Office for Civil Rights Policy Brief.
- United States Department of Health and Human Services. 2014. *HIPAA Privacy Rule and Sharing Information Related to Mental Health*. Retrieved April 20, 2014 (<http://www.hhs.gov/ocr/privacy/hipaa/understanding/special/mhguidance.html>).
- United States Department of Justice. 2010. *National Study of Jail Suicide: 20 Years Later*. U.S. Department of Justice National Institute of Corrections. Retrieved September 24, 2014 (<http://static.nicic.gov/Library/024308.pdf>).
- Verdier, James, Allison Barret, and Sarah Davis. 2007. *Administration of Mental Health Services by Medicaid Agencies*. U.S. Department of Health and Human Services.
- Whitaker. Robert. 2010. *Anatomy of an Epidemic: Magic Bullets, Psychiatric Drugs and the Astonishing Rise of Mental Illness*. New York: Broadway Paperbacks.
- White, P, H. Rickards and A..J. Zeman. 2012. "Time to End the Distinction Between Mental and Neurological Illnesses." *British Medical Journal*, 344:e3454.
- Winker, Gabriele and Nina Degele. 2011. "Intersectionality as Multi-Level Analysis: Dealing with Social Inequality." *European Journal of Women's Studies*, 18(1):51-66.
- Wolcott, H. F. 1994. *Transforming Qualitative Data: Description, Analysis, and Interpretation*. Thousand Oaks, CA: Sage.
- Wolf, Michael S., and Charles L. Bennett. 2006. "Local Perspective of the Impact of the HIPAA Privacy Rule on Research." *Cancer*, 106(2):474-479.
- Yuval-Davis, Nira. 2006. "Intersectionality and Feminist Politics." *European Journal of Women's Studies*, 13:193-209.
- Zeller, Scott. 2013. "Psychiatric Boarding: Averting Long Waits in Emergency Rooms." *Psychiatric Times*, 09/16/2013. Retrieved September 22, 2014 (<http://www.psychiatrictimes.com/psychiatric-emergencies/psychiatric-boarding-averting-long-waits-emergency-rooms>).
- Zussman, Robert. 2004. "People in Places." *Qualitative Sociology*, 27(4):351-63.

APPENDIX A:  
Highly Publicized U.S Mass Shootings Committed by an Offender with a Previously Diagnosed  
Mental Illness, 2011-2013 (Source: Moore, Garvey and Wagstaff 2014)

Date	January 8, 2011	July 20, 2012	December 14, 2012	September 16, 2013
Location	Tucson, AZ	Aurora, CO	Newtown, CT	Washington Navy Yard Washington, D.C.
Offender	Jared Lee Loughner	James Holmes	Adam Lanza	Aaron Alexis
Crime Details	Opened fire in a grocery store during a meet-and-greet with Congresswoman Gabrielle Giffords. Giffords was among the injured, sustaining a shot to the head.	Entered through a movie theater exit door of a midnight premiere showing, set off gas canisters and opened fire on the audience. Prior to going to the theater Holmes had booby-trapped his apartment with explosives. Police recovered the devices without incident.	Forced entry into Sandy Hook Elementary School and opened fire on a first-grade classroom. Lanza killed himself on the scene. Prior to going to the school, Lanza had killed his mother in their home.	Entered the Naval base and opened fire in the headquarters of the Navy Seals Systems Command. Over the next 2-hours Alexis engaged in multiple fire exchanges with police and Navy security personnel. Alexis was shot and killed by officials on the scene.
Number Killed	6	12	27	14 (Includes offender)
Number Injured	11	58	1	3

APPENDIX B:  
POLICE OFFICER INTERVIEW GUIDE

Have you had any specific training for citizens with mental illness?

(Probes) Description of training: length, duration, refreshers, mandatory or optional?

How much of your work involves dealing with mentally ill citizens?

Approximately what percentage of calls?

What are the common types of calls?

Has this changed since you began working?

Some research suggests that police officers have become street-level psychiatrists. How accurate do you think that is in your experience in Boulder?

When calls come in involving mentally ill citizens, are they directed to certain officers? How is it decided who takes these calls?

What happens when you go on a call when mental health concerns are noted?

Can you walk me through the typical call?

Can you give me an example of a call you thought went especially well? Particularly poorly?

When you arrive at a call, how do you assess an individual's mental health? Do you assess their mental health?

How confident are you with your ability?

In your opinion what is the best possible outcome for mentally ill individuals who come into contact with police? Worst outcome?

What possible courses of action are available to you when you're dealing with a citizen who you feel is mentally ill?

What factors into your decision to do one over the others?

What makes you decide to take someone to the hospital?

What are your feelings on going to the hospital?

(Probes) worthwhile? Time it takes?

Is there any kind of department policy or protocol for taking someone to the hospital?

Do you know where they come from? Who developed them? Anything you disagree with?

What happens at the hospital?

What information do you give to the staff? Doctors?

Are you involved in the decision to admit the individual?

What happens if the individual is not admitted?

How do you feel doctors and other hospital staff perceive you and your judgment?

What is your reaction when you go to the hospital and the individual is not admitted?  
How frequently does this happen?

Does the department work with any community mental health providers?

If yes: Explain the partnership

Do you think it is helpful?

If no: Do you think it would change your interactions with mentally ill individuals?

When you bring a citizen you suspect is mentally ill to the jail, are there any special procedures for taking them in?

What information do you give to the jail?

What are your thoughts on incarcerating individuals with mental illness?

(Probes) Are they getting what you think they need? Is there a better alternative?

Based on what you've seen as an officer, how effective do you think mental health services are in Boulder? Is there anything they could be doing better?

If you were to redesign the mental health care system in Boulder County, what are the top three things you would change?

APPENDIX C:  
COMMUNITY MENTAL HEALTH PROVIDER INTERVIEW GUIDE

As I'm sure you're aware, the number of inpatient psychiatric beds in Colorado is very limited. Does this situation impact your work in the community? How?  
Has the situation changed since you began practicing?

When would you have a patient go to the hospital?  
How do you make sure he/she goes?

Can you walk me through a typical case?

When you refer patients to the hospital do you make any contact with the hospital?  
Are you aware of the bed availability before sending patients?

Have you ever experienced patients not admitted when you thought they should?  
Why do you think the discrepancy in judgment between yourself and the hospital exists?

When patients are admitted, do you have any contact with the hospital? During admission? After discharge?

Without giving any identifying information of the patient, can you give an example when things went really well with sending a patient to the hospital? Example when things went wrong?

Have you had patients who have had contact with police related to their mental health?  
In those cases, did you have any communication with the police and/or jail?

What is the typical case for police becoming involved? Can you give me an example when things went really well? When things went wrong?

What are your thoughts on the police and jail's ability to work with individuals with mental illness?

How well do you think the different aspects of the mental health system in Boulder work together? Is there continuity of care? Do you think this is important? To what extent is that the patients' responsibility?

If you were to redesign the mental health care system in Boulder, what are the top three things you would change?

APPENDIX D:  
JAIL EMPLOYEE INTERVIEW GUIDE

What percentage of inmates would you estimate are mentally ill?  
Has that changed at all since you began working at the jail?

How are offenders with mental illness identified?  
What kind of history do you get on offenders?  
(Probe) Medication, treatment history, current treatment, ect.?  
Where does this information come from?

Do you consider mentally ill offenders as substantially different from the rest of the jail population?  
In what ways?

Have you had any special training to work with inmates with mental illnesses?  
(Probes) Description of training: length, duration, refreshers, mandatory or optional?

Describe the typical mentally ill offender that you deal with?  
(Probes) Offense type, diagnosis, demeanor, appearance?

Are there any special considerations made when interacting with mentally ill inmates?  
(Probes) Do you approach these inmates any differently?  
How often are they separated from the general population?

Are there any policies or requirements for mentally ill offenders in the jail?  
(Probes) How are you informed of them? Who writes these? Do you agree with them? Is there anything you would change?

What treatment services are offered in the jail?  
Medications? Programming?  
How are people identified to receive these services?

Have you noticed any changes in the mentally ill population in the jail since you began working?

What are your thoughts on incarcerating severely mentally ill individuals?  
(Probes) Are they getting what you think they need? Is there a better alternative?

Are offenders ever referred out from jail to the hospital?  
What is the process? Who makes the decision?

Is there anything in place to have contact and communication between the jail and community mental health services?

In your opinion what is the best possible outcome for mentally ill offenders who come into the jail? Worst outcome?

Based on what you've seen in the jail, how effective do you think mental health services are in Boulder? Is there anything they could be doing better?

If you were to redesign the mental health care system in Boulder County, what are the top three things you would change?

APPENDIX E:  
HOSPITAL MENTAL HEALTH PROVIDER INTERVIEW GUIDE

What factors into a decision to admit a patient to a psychiatric ward?  
Who has a say in the decision?

Does the hospital have any prescribed procedures you have to follow when assessing a patient for admission?  
(Probes) How are you aware of them?  
Do you know who developed them?  
Do you think they are necessary? Is there anything you disagree with?

What is the procedure for admitting a patient? Can you walk me through the typical case?  
(Probes) Paperwork?  
Phone calls?

When making the decision to admit, are you aware of a patient's insurance status?  
If no: Who looks into this?  
If yes: Does it factor into your decision? How?

Are community mental health providers ever involved?  
Does this change the admission process at all?

When you decide against admitting a patient do you do any referrals to community mental health programs or providers?  
For patients who are currently connected with community services, is there any communication between the hospital and the community mental health providers?

What happens if there are no available beds on the unit?

How would you define a successful interaction and outcome with a patient in the ER?  
Without giving any names or identifying information, can you give an example?

How would you define an unsuccessful interaction and outcome with a patient in the ER?  
Without giving any names or identifying information, can you give an example?

Is there a different procedure for patients brought in by police?  
Are the police involved in the decision to admit?  
Do they ever voice a preference?  
How confident are you in the police's ability to assess people's mental health?  
Are you ever aware of what will happen to these patients if they are not admitted?  
Are there any additional factors considered for admission of these patients?

Can you walk me through a typical case involving the police bringing a patient to the ER?

As a mental health provider, what are your thoughts on the mentally ill in jails?



(Probes) are they given adequate treatment?  
Is there a better alternative?

How well do you think the different aspects of the mental health system in Boulder work together? Is there continuity of care? Do you think this is important? To what extent is that the patients' responsibility?

Has the psychiatric ward had any recent budget cuts or increases that you're aware of?  
If yes: Has that changed your approach to patients in any way?

If you were to redesign the mental health care system in Boulder, what are the top three things you would change?

APPENDIX F:  
Colorado Revised Statute 27-65-105 outlining procedure and requirements for an M-1, 72-hour mental health hold including the most recent, May 2013, revisions

*C.R.S. 27-65-105*

COLORADO REVISED STATUTES

\*\*\* This document reflects changes current through all laws passed at the First Regular Session of the Sixty-Ninth General Assembly of the State of Colorado (2013) \*\*\*

TITLE 27. BEHAVIORAL HEALTH  
MENTAL HEALTH  
ARTICLE 65.CARE AND TREATMENT OF PERSONS WITH MENTAL ILLNESS

C.R.S. 27-65-105 (2013)

27-65-105. Emergency procedure

(1) Emergency procedure may be invoked under either one of the following two conditions:

(a) (I) When any person appears to have a mental illness and, as a result of such mental illness, appears to be an imminent danger to others or to himself or herself or appears to be gravely disabled, then a person specified in subparagraph (II) of this paragraph (a), each of whom is referred to in this section as the "intervening professional", upon probable cause and with such assistance as may be required, may take the person into custody, or cause the person to be taken into custody, and placed in a facility designated or approved by the executive director for a seventy-two-hour treatment and evaluation.

(II) The following persons may effect a seventy-two-hour hold as provided in subparagraph (I) of this paragraph (a):

(A) A certified peace officer;

(B) A professional person;

(C) A registered professional nurse as defined in section 12-38-103 (11), C.R.S., who by reason of postgraduate education and additional nursing preparation has gained knowledge, judgment, and skill in psychiatric or mental health nursing;

(D) A licensed marriage and family therapist, licensed professional counselor, or addiction counselor licensed under part 5, 6, or 8 of article 43 of title 12, C.R.S., who by reason of postgraduate education and additional preparation has gained knowledge, judgment, and

skill in psychiatric or clinical mental health therapy, forensic psychotherapy, or the evaluation of mental disorders; or

(E) A licensed clinical social worker licensed under the provisions of part 4 of article 43 of title 12, C.R.S.

(b) Upon an affidavit sworn to or affirmed before a judge that relates sufficient facts to establish that a person appears to have a mental illness and, as a result of the mental illness, appears to be an imminent danger to others or to himself or herself or appears to be gravely disabled, the court may order the person described in the affidavit to be taken into custody and placed in a facility designated or approved by the executive director for a seventy-two-hour treatment and evaluation. Whenever in this article a facility is to be designated or approved by the executive director, hospitals, if available, shall be approved or designated in each county before other facilities are approved or designated. Whenever in this article a facility is to be designated or approved by the executive director as a facility for a stated purpose and the facility to be designated or approved is a private facility, the consent of the private facility to the enforcement of standards set by the executive director shall be a prerequisite to the designation or approval.

(2) (a) When a person is taken into custody pursuant to subsection (1) of this section, such person shall not be detained in a jail, lockup, or other place used for the confinement of persons charged with or convicted of penal offenses; except that such place may be used if no other suitable place of confinement for treatment and evaluation is readily available. In such situation the person shall be detained separately from those persons charged with or convicted of penal offenses and shall be held for a period not to exceed twenty-four hours, excluding Saturdays, Sundays, and holidays, after which time he or she shall be transferred to a facility designated or approved by the executive director for a seventy-two-hour treatment and evaluation. If the person being detained is a juvenile, as defined in section 19-1-103 (68), C.R.S., the juvenile shall be placed in a setting that is nonsecure and physically segregated by sight and sound from the adult offenders. When a person is taken into custody and confined pursuant to this subsection (2), such person shall be examined at least every twelve hours by a certified peace officer, nurse, or physician or by an appropriate staff professional of the nearest designated or approved mental health treatment facility to determine if the person is receiving appropriate care consistent with his or her mental condition.

(b) A sheriff or police chief who violates the provisions of paragraph (a) of this subsection (2), related to detaining juveniles may be subject to a civil fine of no more than one thousand dollars. The decision to fine shall be based on prior violations of the provisions of paragraph (a) of this subsection (2) by the sheriff or police chief and the willingness of the sheriff or police chief to address the violations in order to comply with paragraph (a) of this subsection (2).

(3) Such facility shall require an application in writing, stating the circumstances under which the person's condition was called to the attention of the intervening professional and further stating sufficient facts, obtained from the personal observations of the intervening

professional or obtained from others whom he or she reasonably believes to be reliable, to establish that the person has a mental illness and, as a result of the mental illness, is an imminent danger to others or to himself or herself or is gravely disabled. The application shall indicate when the person was taken into custody and who brought the person's condition to the attention of the intervening professional. A copy of the application shall be furnished to the person being evaluated, and the application shall be retained in accordance with the provisions of section 27-65-121 (4).

(4) If the seventy-two-hour treatment and evaluation facility admits the person, it may detain him or her for evaluation and treatment for a period not to exceed seventy-two hours, excluding Saturdays, Sundays, and holidays if evaluation and treatment services are not available on those days. For the purposes of this subsection (4), evaluation and treatment services are not deemed to be available merely because a professional person is on call during weekends or holidays. If, in the opinion of the professional person in charge of the evaluation, the person can be properly cared for without being detained, he or she shall be provided services on a voluntary basis.

(5) Each person admitted to a seventy-two-hour treatment and evaluation facility under the provisions of this article shall receive an evaluation as soon as possible after he or she is admitted and shall receive such treatment and care as his or her condition requires for the full period that he or she is held. The person shall be released before seventy-two hours have elapsed if, in the opinion of the professional person in charge of the evaluation, the person no longer requires evaluation or treatment. Persons who have been detained for seventy-two-hour evaluation and treatment shall be released, referred for further care and treatment on a voluntary basis, or certified for treatment pursuant to section 27-65-107.

**HISTORY:** Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 682, § 2, effective April 29. L. 2011: (1)(a)(II)(D) amended, (SB 11-187), ch. 285, p. 1329, § 75, effective July 1.

Editor's note: This section is similar to former § 27-10-105 as it existed prior to 2010.

#### RECENT ANNOTATIONS

Private hospital and privately employed doctor and nurse were not "state actors" who could be held liable for a constitutional violation under 42 U.S.C. § 1983. *Wittner v. Banner Health*, 720 F.3d 770 (10th Cir. 2013).

This sections grant of authority for a short-term involuntary hold in a private hospital does not pass the nexus/compulsion test for turning the private action of the hospital or the certifying doctor into state action. *Wittner v. Banner Health*, 720 F.3d 770 (10th Cir. 2013).

Involuntary commitment of the mentally ill is not a public function, that is, a traditional and exclusive function of the state, and thus state action. *Wittner v. Banner Health*, 720 F.3d

770 (10th Cir. 2013).

Private actor not transformed into a state actor under a joint action test. Allowing a hospital to hold a patient does not make the state responsible for a doctors decision to medicate the patient, depriving the patient of constitutional rights. *Wittner v. Banner Health*, 720 F.3d 770 (10th Cir. 2013).

States relationship with a private actor is no more than the mere private purchase of contract services. Public-private relationship did not transcend that of mere client and contractor because the private and public actors did not commingle their responsibilities. The state lacked the authority to unilaterally place patients at the hospital; it merely authorized the hospital to accept patients if it so chose. *Wittner v. Banner Health*, 720 F.3d 770 (10th Cir. 2013).

#### ANNOTATION

Law reviews. For article, "Commitment Procedures in Colorado", see 29 Dicta 273 (1952). For article, "One Year Review of Civil Procedure and Appeals", see 38 Dicta 133 (1961). For article, "One Year Review of Torts", see 38 Dicta 93 (1961). For article, "Patients' Rights vs. Patients' Needs: The Right of the Mentally Ill to Refuse Treatment in Colorado", see 58 Den. L.J. 567 (1981). For article, "New Legislation Concerning the Mentally Disabled", see 11 Colo. Law. 2131 (1982). For article, "The Clinton Mental Health Case -- A Civil Procedure Lesson", see 19 Colo. Law. 1809 (1990). For article, "Clinton Redux: A Mental Health and Technical Defense Follow-up", see 22 Colo. Law. 2389 (1993).

Annotator's note. Since § 27-65-105 is similar to § 27-10-105 as it existed prior to the 2010 amendments to this article, relevant cases construing that provision have been included in the annotations to this section.

For constitutional considerations, see *Barber v. People*, 127 Colo. 90, 254 P.2d 431 (1953).

Due process considerations do not require an in-person evaluation by an intervening professional prior to placement on an involuntary hold. *Tracz v. Centennial Peaks*, 9 P.3d 1168 (Colo. App. 2000).

Purpose of section. This section was designed to protect the mentally ill person from himself. *Kendall v. People*, 126 Colo. 573, 252 P.2d 91 (1952).

Article necessitates strict compliance. In situations involving involuntary confinement, strict compliance with this article is a necessity. *People in Interest of Henderson*, 44 Colo. App. 102, 610 P.2d 1350 (1980).

For requirement of strict compliance with statutory procedure, see *Okerberg v. People*, 119 Colo. 529, 205 P.2d 224 (1949); *Kendall v. People*, 126 Colo. 573, 252 P.2d 91 (1952); *Barber v. People*, 127 Colo. 90, 254 P.2d 431 (1953); *Rickey v. People*, 129 Colo. 174, 267 P.2d 1021 (1954).

A proceeding under this article is not a criminal action. *Kendall v. People*, 126 Colo. 573, 252 P.2d 91 (1952).

An adverse finding in mental illness may bear grave consequences in that the person may be denied his liberty and incapacitated to contract, and while it does not necessarily bring his name or reputation into disrepute, it is, nevertheless, a blot on his life and those he might have brought into being. *Kendall v. People*, 126 Colo. 573, 252 P.2d 91 (1952).

Procedure provisions of the C.R.C.P. are not applicable to mental illness proceedings. *Hultquist v. People*, 77 Colo. 310, 236 P. 995 (1925).

Use of this emergency procedure is not limited to patients who decline voluntary treatment. *People in Interest of Paiz*, 43 Colo. App. 352, 603 P.2d 976 (1979).

"Probable cause" should not be measured by yardstick of legal technicality, but by the factual and practical considerations upon which a reasonable physician acts. *People in Interest of Paiz*, 43 Colo. App. 352, 603 P.2d 976 (1979).

Reversible error occurred under subsection (1)(a) where jury instruction included neither the element of "probable cause" nor a definition of "gravely disabled" even though prosecution relied upon that provision as the basis for taking defendant into custody. *People v. Marquez-Lopez*, 952 P.2d 788 (Colo. App. 1997).

Emergency medical personnel has no duty to make an independent determination as to whether the intervening professional had probable cause to institute the hold-and-treat procedure. *Tracz v. Centennial Peaks*, 9 P.3d 1168 (Colo. App. 2000).

Subsection (1)(b) does not require prior judicial testing before one who has been a voluntarily committed outpatient can be taken into custody. *People in Interest of Henderson*, 610 P.2d 1350 (Colo. App. 1980).

Contrary to patient's claim, no court hearing or 24-hour notice is required to take mentally ill person into custody under this section. Nor does this section specify that the patient must designate or approve of the treatment facility to which he is committed. *Ketchum v. Cruz*, 775 F. Supp. 1399 (D. Colo. 1991).

Voluntary treatment program not terminated when patient taken into custody and then returned to hospital. Where voluntarily committed outpatient was off the hospital premises and was taken into custody by the police and then returned to the hospital, this did not, as a matter of law, terminate his voluntary treatment program. *People in Interest of Henderson*, 610 P.2d 1350 (Colo. App. 1980).

When a county court judge initiates a 72-hour hold, the result is a defect of process depriving the court of subject matter jurisdiction. *People In Interest of Lloyd-Pellman*, 844 P.2d 1309 (Colo. App. 1992).

A subsequent certification during the 72-hour hold period does not cure the defect. *People In Interest of Lloyd-Pellman*, 844 P.2d 1309 (Colo. App. 1992).

Violation of this section, while relevant to claim for malpractice, cannot, by definition, create a claim based on negligence per se. *Bauer v. Southwest Denver Mental Health Center*, 701 P.2d 114 (Colo. App. 1985).

Applied in *People v. Chavez*, 629 P.2d 1040 (Colo. 1981); *Brown v. Jensen*, 572 F. Supp. 193 (D. Colo. 1983); *People in Interest of Schmidt*, 720 P.2d 629 (Colo. App. 1986); *Asten v. City of Boulder*, 652 F. Supp. 2d 1188 (D. Colo. 2009)

APPENDIX G: ELKGATE GENERAL HOSPITAL'S MENTAL HEALTH  
ASSESSMENT

**COMPREHENSIVE ASSESSMENT TOOL**

IDENTIFICATION SECTION

**PATIENT NAME:** \_\_\_\_\_ **AGE:** \_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_\_  
**MARITAL STATUS:** \_\_\_\_\_ **LEGAL STATUS:** \_\_\_\_\_ **SEX:** \_\_\_\_\_ **DATE:** \_\_\_\_\_ **TIME: Start:** \_\_\_\_\_ **End:** \_\_\_\_\_  
**OCCUPATION/EDUCATION LEVEL:** \_\_\_\_\_ **LEGAL GUARDIAN:** \_\_\_\_\_  
**ACCOMPANIED BY:** \_\_\_\_\_ **REFERRAL SOURCE:** \_\_\_\_\_  
**WHY ARE YOU HERE TODAY?** \_\_\_\_\_  
**CHIEF COMPLAINT (In patient's own words)** \_\_\_\_\_

**PRECIPITATING EVENTS**

EVENTS THAT OCCURRED IN PREVIOUS 24-72 HOURS THAT PROMPTED ASSESSMENT (OR, IF SOCIAL SERVICES RTC PLACEMENT, EVENTS WHICH LED TO RECOMMENDATION FOR RTC LEVEL OF CARE):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SUPPORT SYSTEMS**

(Availability of Family/Friends to Participate in Treatment, Special Family Concerns)

**COLLATERAL DATA FROM FAMILY, HEALTH PROVIDER, ETC.:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**CURRENT LIVING ARRANGEMENTS AND LOCATION OF CLOSE FAMILY MEMBERS:**

**CURRENT SUPPORT SYSTEM (FAMILY, FRIENDS, SPONSOR, TREATMENT TEAM, ETC.):**

**CULTURAL BELIEFS AND/OR RELIGIOUS/SPIRITUAL BELIEFS AND IMPACT ON TREATMENT:**

**MARITAL HISTORY:**

**CHILDREN:**

**PRIMARY CARE PHYSICIAN:** \_\_\_\_\_ **RELEASE OBTAINED:** ☐Yes ☐No \_\_\_\_\_

**CURRENT PSYCHIATRIST:** \_\_\_\_\_ **RELEASE OBTAINED:** ☐Yes ☐No \_\_\_\_\_

**CURRENT THERAPIST:** \_\_\_\_\_ **RELEASE OBTAINED:** ☐Yes ☐No \_\_\_\_\_

DOB: \_\_\_\_\_  
ACCT NO: \_\_\_\_\_ **Place Label Here** > MR: /  
ATT DR: \_\_\_\_\_

Comprehensive Assessment Tool



**PRESENTING PROBLEMS/SOMATIC SYMPTOMS**

MAJOR LIFE AREAS	YES	NO	D.N.A.*	AS EVIDENCED BY
PROBLEMS AT WORK OR SCHOOL, OR DISABILITY WHICH PREVENTS PATIENT FROM WORKING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
DETERIORATION IN HYGIENE AND/OR GROOMING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
SOCIAL WITHDRAWAL OR DIFFICULTY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
PROBLEMS WITH ABILITY TO PARENT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

**PATIENT STRENGTHS:** \_\_\_\_\_

SLEEP	YES	NO	D.N.A.*	AS EVIDENCED BY
SLEEP DISTURBANCES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

**CHANGES IN EATING HABITS/APPETITE CONCERNS (Describe):**

\_\_\_\_\_

**WEIGHT: LOSS GAIN NUMBER OF POUNDS:** \_\_\_\_\_ **WITHIN:** \_\_\_\_\_ Days \_\_\_\_\_ Weeks \_\_\_\_\_ Months

**CLINICAL PRESENTATION/SYMPTOMS**

MOOD	YES	NO	D.N.A.*	AS EVIDENCED BY
SXS OF MANIA (Mood Swings, Racing Thoughts, Impulsivity, Euphoria, Irritability, Spending Sprees, Hypersexuality, Pressured Speech, Grandiosity, Distractibility, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
SXS OF DEPRESSION (Crying Spells, Difficulty Concentrating, Diminished Interest/Pleasure, Hopelessness, Worthlessness, Psychomotor Retardation/Agitation, Sad Mood etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
OTHER:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

ANXIETY	YES	NO	D.N.A.*	AS EVIDENCED BY
PANIC ATTACKS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
OBSESSIVE/COMPULSIVE THOUGHTS/BEHAVIORS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
GENERALIZED ANXIETY:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
OTHER:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

PSYCHOSIS	YES	NO	D.N.A.*	AS EVIDENCED BY
HALLUCINATIONS (describe)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
DELUSIONS/PARANOID IDEATIONS (describe)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
OTHER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

DOB: \_\_\_\_\_  
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 ACCT NO: \_\_\_\_\_  
 ATT DR: \_\_\_\_\_

Comprehensive Assessment Tool

MENTINTOX

**CLINICAL PRESENTATION/SYMPTOMS (cont)**

CHILD/ADOLESCENT BEHAVIORS	YES	NO	D.N.A.*	AS EVIDENCED BY
RUNNING AWAY RISK	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
DESTRUCTION OF PROPERTY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
CRUELTY TO ANIMALS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
STEALING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
REBELLIOUS/DEFIES FAMILY/AUTHORITY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
FIRE SETTING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
ASSAULTIVE BEHAVIOR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
USE OF WEAPONS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
OTHER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

**MENTAL STATUS**

**APPEARANCE:** ☐ NEAT ☐ APPROPRIATE ATTIRE ☐ POOR EYE CONTACT ☐ DISHEVELED ☐ UNCLEAN ☐ BIZARRE

☐ OTHER/COMMENTS \_\_\_\_\_

**SPEECH:** ☐ LOGICAL ☐ CONVERSATIONAL ☐ RAPID ☐ DRAMATIC ☐ UNDERTALKATIVE ☐ SLOW ☐ SOFT  
☐ PRESSURED ☐ ILLOGICAL ☐ RAMBLING ☐ NONSENSICAL ☐ MUMBLING ☐ CIRCUMSTANTIAL

☐ OTHER/COMMENTS \_\_\_\_\_

**MOOD:** ☐ EUTHYMIC ☐ DEPRESSED ☐ LABILE ☐ EXPANSIVE ☐ EUPHORIC ☐ IRRITABLE ☐ ANXIOUS

☐ ANGRY ☐ ELATED ☐ DYSPHORIC ☐ ELEVATED ☐ OTHER/COMMENTS \_\_\_\_\_

**AFFECT:** ☐ SAD ☐ FEARFUL ☐ JOYFUL ☐ ANGRY ☐ EUTHYMIC ☐ FLAT ☐ BLUNTED ☐ CONSTRICTED

☐ IRRITABLE ☐ LABILE ☐ INAPPROPRIATE ☐ OTHER/COMMENTS \_\_\_\_\_

**THOUGHT PROCESS:** ☐ ALERT ☐ ORIENTED ☐ CONFUSED ☐ TANGENTIAL ☐ DISORGANIZED ☐ RACING THOUGHTS

☐ PARANOID ☐ LOOSE ASSOCIATIONS ☐ DISORIENTED ☐ HALLUCINATIONS ☐ OTHER  
COMMENTS \_\_\_\_\_

**MEMORY:** ☐ INTACT ☐ IMPAIRED COMMENTS \_\_\_\_\_

**INSIGHT:** ☐ GOOD ☐ FAIR ☐ POOR COMMENTS \_\_\_\_\_

**JUDGMENT:** ☐ GOOD ☐ FAIR ☐ POOR COMMENTS \_\_\_\_\_

DOB: \_\_\_\_\_  
ACCT NO: \_\_\_\_\_ MR: \_\_\_\_\_  
ATT DR: \_\_\_\_\_

Comprehensive Assessment Tool

[REDACTED]

#### ALCOHOL/DRUG USE

- |                                   |  |  |  |
|-----------------------------------|--|--|--|
| <input type="checkbox"/> Alcohol  | <input type="checkbox"/> Marijuana     | <input type="checkbox"/> Stimulants    | <input type="checkbox"/> Barbiturates          |
| <input type="checkbox"/> Cocaine  | <input type="checkbox"/> Hallucinogens | <input type="checkbox"/> Methadone     | <input type="checkbox"/> Pain Meds             |
| <input type="checkbox"/> Tobacco  | <input type="checkbox"/> Opiates       | <input type="checkbox"/> Tranquilizers | <input type="checkbox"/> Over-the-Counter Meds |
| <input type="checkbox"/> Caffeine | <input type="checkbox"/> Inhalants     | <input type="checkbox"/> Sedatives     | <input type="checkbox"/> Other: _____          |

Substance Checked	Age of first use	Amount/Frequency	Duration of Problem Use	Last Use	Amount Used in Last 24 Hours

WHAT IS LONGEST PERIOD OF SOBRIETY? \_\_\_\_\_ WHEN? \_\_\_\_\_

AA/SUPPORT GROUP INVOLVEMENT: CURRENT: ☐ YES ☐ NO PAST: ☐ YES ☐ NO HAS SPONSOR?: ☐ YES ☐ NO

#### CURRENT AND PAST WITHDRAWAL SYMPTOMS/BEHAVIORS FROM ALCOHOL/DRUG USE:

- |   |                                   |                                      |   |                                       |                                    |                                   |
|---|-----------------------------------|--------------------------------------|---|---------------------------------------|------------------------------------|-----------------------------------|
| <input type="checkbox"/> Aggression/Assault | <input type="checkbox"/> Cramps   | <input type="checkbox"/> Agitation   | <input type="checkbox"/> Weakness               | <input type="checkbox"/> Diaphoresis  | <input type="checkbox"/> Seizures  | <input type="checkbox"/> Tremors  |
| <input type="checkbox"/> Irritability       | <input type="checkbox"/> Tingling | <input type="checkbox"/> Tachycardia | <input type="checkbox"/> Diarrhea               | <input type="checkbox"/> Fever/Chills | <input type="checkbox"/> Blackouts | <input type="checkbox"/> Anorexia |
| <input type="checkbox"/> Nausea/Vomiting    |                                   | <input type="checkbox"/> Delirium    | <input type="checkbox"/> Blood Pressure Changes |                                       |                                    |                                   |

PT REPORTS CURRENT WITHDRAWAL SXS AS: \_\_\_\_\_ MILD \_\_\_\_\_ MODERATE \_\_\_\_\_ SEVERE

BREATHALYZER: \_\_\_\_\_ VITAL SIGNS: B/P \_\_\_\_\_ PULSE \_\_\_\_\_ RESPIRATION \_\_\_\_\_

IF SUBSTANCE ABUSE TREATMENT IS INDICATED, PLEASE IDENTIFY THE CURRENT STAGE OF CHANGE:

- ☐ Precontemplation ☐ Contemplation ☐ Preparation ☐ Action ☐ Maintenance ☐ Relapse \_\_\_\_\_

Consequences of Use(i.e., legal, social, medical) \_\_\_\_\_

#### MEDICATIONS/HEALTH

Medication	Dosage	Frequency per day	Time of Day	Prescribed By	Duration of Use	Last Dose	Compliant Y/N
		<input type="checkbox"/> Once <input type="checkbox"/> Twice <input type="checkbox"/> Three times <input type="checkbox"/> PRN <input type="checkbox"/> Other: _____					
		<input type="checkbox"/> Once <input type="checkbox"/> Twice <input type="checkbox"/> Three times <input type="checkbox"/> PRN <input type="checkbox"/> Other: _____					
		<input type="checkbox"/> Once <input type="checkbox"/> Twice <input type="checkbox"/> Three times <input type="checkbox"/> PRN <input type="checkbox"/> Other: _____					
		<input type="checkbox"/> Once <input type="checkbox"/> Twice <input type="checkbox"/> Three times <input type="checkbox"/> PRN <input type="checkbox"/> Other: _____					
		<input type="checkbox"/> Once <input type="checkbox"/> Twice <input type="checkbox"/> Three times <input type="checkbox"/> PRN <input type="checkbox"/> Other: _____					
		<input type="checkbox"/> Once <input type="checkbox"/> Twice <input type="checkbox"/> Three times <input type="checkbox"/> PRN <input type="checkbox"/> Other: _____					

PAST MEDICATION HISTORY RESPONSE: \_\_\_\_\_

IF UNABLE TO OBTAIN MEDICATION INFORMATION PLEASE STATE REASON \_\_\_\_\_

Comprehensive Assessment Tool

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DOB: \_\_\_\_\_  
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Place Label Here > MR: \_\_\_\_\_  
ATT DR: \_\_\_\_\_

[REDACTED]



**MEDICATIONS/HEALTH (Cont)**

**CURRENT MEDICAL/PHYSICAL PROBLEMS AND COMPLAINTS OF PAIN (LIST):**

**ALLERGIES:**

**PSYCHOLOGICAL/SOCIAL HISTORY**

**INPATIENT TREATMENT HISTORY: Psychiatric/Substance Abuse**

Facility	Level of Care	Dates	DX if Known

**HX OF ECT** ☐ Yes ☐ No    **HX OF SECLUSION/RESTRAINT** ☐ Yes ☐ No    **HX OF EMERGENCY MEDS** ☐ Yes ☐ No

IF YES, PLEASE SPECIFY

**OUTPATIENT TREATMENT HISTORY:**

**FAMILY/PSYCHSOCIAL HISTORY:**

**ABUSE CONCERNS:**    ☐ NONE    ☐ CURRENT    ☐ PAST

DESCRIBE:

**SUBSTANCE ABUSE:** *Family*

**PSYCHIATRIC (INCLUDE ANY FAMILY HISTORY OF SUICIDE):**

**LEGAL HISTORY (CURRENT AND RELEVANT PAST HISTORY):** ☐ Yes ☐ No

DESCRIBE:

**MILITARY HISTORY:**

**LEISURE/RECREATIONAL ACTIVITIES:**

**EMPLOYMENT:**

**EDUCATION:**

Comprehensive Assessment Tool

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DOB: *[Redacted]*    **Place Label Here** > MR: *[Redacted]*  
ACCT NO: *[Redacted]*    ATT DR: *[Redacted]*

  
INITIAL PROBLEMS AND GOALS IDENTIFIED AND JUSTIFICATION FOR LEVEL OF CARE CHOSEN:

PATIENT/FAMILY EXPECTATIONS AND OBSTACLES TO TREATMENT FOR LEVEL OF CARE CHOSEN:

ADMISSION TO: ☐ Adult Psych ☐ Detox ☐ Rehab ☐ Senior ☐ Adol ☐ Child ☐ RTC  
☐ Subacute ☐ PHP ☐ CD IOP Facility name \_\_\_\_\_

REFERRED TO: ☐ PHP ☐ CD IOP ☐ Mental Health IOP ☐ Outpatient ☐ Other \_\_\_\_\_

PROVISIONAL DIAGNOSIS provided by physician/clinician:

AXIS I:

AXIS II:

AXIS III:

AXIS IV: Severity: \_\_\_\_\_ ☐ Primary Support Group ☐ Social Environment  
☐ Educational ☐ Occupational ☐ Housing ☐ Legal System  
☐ Economic ☐ Access to Health Care ☐ Other: \_\_\_\_\_

AXIS V:

Current

BDI \_\_\_\_\_ BSS \_\_\_\_\_

DISCHARGE CONCERNS/RECOMMENDATIONS:

ADDITIONAL INFORMATION/NOTES:

Comprehensive Assessment Tool

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DOB: \_\_\_\_\_  
ACCT NO: \_\_\_\_\_  
Place Label Here > MR: /  
ATT DR: \_\_\_\_\_

## INITIAL EVALUATION OF RISK TO SELF/OTHERS

(Please check all that apply)

Informant was ☐ Patient ☐ Family ☐ Friends ☐ Hospital ☐ Previous Records  
☐ Health Professional ☐ Other

### SECTION I – CURRENT RISK TO SELF/OTHERS

Does patient or do others report:

The patient having suicidal/self injuring ideation/behavior or making suicidal/self injuring threats? ☐ Yes ☐ No

The patient having aggression/assault ideation/behavior or making aggression/assault threats? ☐ Yes ☐ No

Does the patient exhibit complete inability to care for self/grave disability? ☐ Yes ☐ No

If answers to the above questions are NO, then go to Section II:

Otherwise, answer the following questions:

Is the ideation/behavior chronic? ☐ Yes ☐ No ☐ N/A

Does the patient have a specific plan? ☐ Yes ☐ No ☐ N/A

Does the patient have access to the plan? ☐ Yes ☐ No ☐ N/A

Does the ideation involve serious/lethal intent? ☐ Yes ☐ No ☐ N/A

Does the ideation have delusional or hallucinatory content? ☐ Yes ☐ No ☐ N/A

If the answers to any of above questions are YES, then describe the basis for such answer below.

Comments: (Describe the patient's plan, ideation, hallucination, etc.)

### SECTION II – HISTORY OF RISK TO SELF/OTHERS

Is there a history of suicidal/self-injuring ideation, behavior, or threats? ☐ Yes ☐ No

Is there a history of aggressive/assaultive ideation, behavior, or threats? ☐ Yes ☐ No

Is there a history of serious physical harm to self/others while in a treatment setting? ☐ Yes ☐ No

If answers to above questions are NO, go to Section III.

If the answer to any of the above questions is YES, then describe this history of suicidal/homicidal/assaultive - ideation/behavior

### SECTION III – ACCURACY OF REPORTS AND HISTORY OF RISK

Is there any evidence or concern that the patient or others may be concealing, denying or misrepresenting current or past suicidal, self-injuring, aggressive or assaultive ideations, behaviors or threats? ☐ Yes ☐ No

If the answer is YES, describe the evidence and concerns below:

This guideline is not intended to preclude any additional assessment tool, nor is it a substitute for clinical judgment.

Comprehensive Assessment Tool

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DO NOT place Label Here > MR: /  
ATT DR:

**INITIAL EVALUATION OF RISK TO SELF/OTHERS**

**SUICIDE & HOMICIDE/VIOLENCE RISK FACTORS ADDITIONAL TO SECTIONS I-III:**

The following risk factors are not completely exhaustive. Check all that apply:

**Suicide Risk Factors:**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> 19 years or younger or 45 and older     | <input type="checkbox"/> Major Depression                  | <input type="checkbox"/> Recent death of a loved one |
| <input type="checkbox"/> Single, widowed, divorced, or separated | <input type="checkbox"/> Schizophrenia or Bipolar Disorder | <input type="checkbox"/> Other _____                 |
| <input type="checkbox"/> Lack of social or religious support     | <input type="checkbox"/> Alcohol or heavy drug use         |  |
| <input type="checkbox"/> History of suicide in immediate family  | <input type="checkbox"/> Borderline personality disorder   |  |
| <input type="checkbox"/> Possession or access to gun             | <input type="checkbox"/> Organic brain syndrome            |  |
| <input type="checkbox"/> Lack or loss of employment              | <input type="checkbox"/> Severe anxiety                    |  |
| <input type="checkbox"/> Severe financial difficulties           | <input type="checkbox"/> Organized plan with lethal intent |  |
| <input type="checkbox"/> Severe problems with significant others | <input type="checkbox"/> Flat affect                       |  |
| <input type="checkbox"/> Severe school difficulties              | <input type="checkbox"/> Hopelessness                      |  |
| <input type="checkbox"/> Significant legal difficulties          | <input type="checkbox"/> Rapid mood shifts                 |  |
| <input type="checkbox"/> Low intelligence                        | <input type="checkbox"/> Command hallucinations            |  |
| <input type="checkbox"/> Calm after agitated depression          | <input type="checkbox"/> Serious health problems           |  |

**Homicide/Violence Risk Factors:**

- |  |  |
|--|--|
| <input type="checkbox"/> Violence/threats towards others | <input type="checkbox"/> Previous history of violence                  |
| <input type="checkbox"/> Possession of or access to gun  | <input type="checkbox"/> Violent social environment                    |
| <input type="checkbox"/> Paranoid ideation               | <input type="checkbox"/> Command hallucinations                        |
| <input type="checkbox"/> Organic brain syndrome          | <input type="checkbox"/> Borderline or antisocial personality disorder |
| <input type="checkbox"/> Heavy alcohol or drug use       | <input type="checkbox"/> Other _____                                   |

Comments: \_\_\_\_\_

Techniques/coping skills used by patient to help control dangerous behavior: \_\_\_\_\_

**SUMMARY EVALUATION OF RISK/SUICIDE/HOMICIDE/ASSAULTIVE BEHAVIOR:**

Rank below your conclusion regarding this patient's SUICIDAL risk and make any comments:

- ☐ Low      ☐ Moderate      ☐ Severe      ☐ Imminent

Rank below your conclusion regarding this patient's HOMICIDAL/ASSAULTIVE risk and make any comments:

- ☐ Low      ☐ Moderate      ☐ Severe      ☐ Imminent

Evaluation completed by \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Additional Assessor: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Reviewed with Physician: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Reviewing Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

This guideline is not intended to preclude any additional assessment tool, nor is it a substitute for clinical judgment.

Comprehensive Assessment Tool

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DOB: \_\_\_\_\_ Place Label Here > MR: /  
ACCT NO: \_\_\_\_\_  
ATT DR: \_\_\_\_\_

## APPENDIX G: MENTAL HEALTH CENTER'S MENTAL HEALTH ASSESSMENT

### History & Mental Status Worksheet

Date \_\_\_\_\_ Time \_\_\_\_\_ Name \_\_\_\_\_ M/F  
Address \_\_\_\_\_ Phone \_\_\_\_\_  
Ethnicity \_\_\_\_\_ Age \_\_\_\_\_ Birth date \_\_\_\_\_  
Marital Status \_\_\_\_\_ Children no./ages \_\_\_\_\_  
Referral Source \_\_\_\_\_ Legal Status \_\_\_\_\_  
Current Employer \_\_\_\_\_ Phone \_\_\_\_\_  
Insurance (Medicare/Medicaid/Private) #: \_\_\_\_\_  
Fee Amount \_\_\_\_\_  
P. E. (client's statement; client's tx Goals \_\_\_\_\_)

Goals:

M.S.

Dress (description)/ grooming \_\_\_\_\_

Physical (scars/self mutilation): \_\_\_\_\_

Weight/Age (remarks: \_\_\_\_\_

Posture: \_\_\_\_\_

Body Movements/Gait: \_\_\_\_\_

Speech: \_\_\_\_\_

Attitude/Eye contact \_\_\_\_\_

Mood/Affect \_\_\_\_\_

Vegetative signs:

Appetite G F P

Sleep G F P

Concentration G F P

Level of Consciousness \_\_\_\_\_ Cog. Level \_\_\_\_\_

"if you snooze....."

"A rolling stone....."

".....glass houses....."

Serial 7s (calculation, attention): \_\_\_\_\_

Orientation: person \_\_\_\_\_ place (city, state) \_\_\_\_\_ Time/date \_\_\_\_\_ Situation \_\_\_\_\_



Judgement (plans for today, future: social norms; impulse control; life decisions; knows safe/unsafe, right/wrong: Examples Lost in a forest? Smoke in a theater?)

Memory: Immediate recall (3objects)\_\_\_\_\_ delayed recall (10min)\_\_\_\_\_  
Recent memory (last Meal)\_\_\_\_\_ remote memory (presidents)\_\_\_\_\_

Insight G F P  
How do you account for your present situation?  
What causes these problems?

Perception: denies\_\_\_\_\_ no evidence of\_\_\_\_\_  
Hallucinations (type, & content)\_\_\_\_\_  
Illusions (type, content)\_\_\_\_\_

Psychotic thinking: denies-----No evidence of\_\_\_\_\_  
Phobias (content)\_\_\_\_\_  
Depersonalization/derealization\_\_\_\_\_  
Ideas of reference (example)\_\_\_\_\_  
Obsessions/compulsions (example)\_\_\_\_\_  
Delusions (content)\_\_\_\_\_  
How do people treat you?  
Does anyone control your thoughts?  
Is your body usually healthy?

Thought processes:  
Logical & coherent\_\_\_\_\_ vague & incoherent\_\_\_\_\_ Flight of ideas\_\_\_\_\_  
Loose associations\_\_\_\_\_ clang associations\_\_\_\_\_ tangential\_\_\_\_\_  
Circumstantial\_\_\_\_\_ thought flow\_\_\_\_\_

Examples:

Suicide/Homicide:  
Ideation  
Plan/means  
Prior attempts

Drug/ETOH  
Use/abuse  
Family hx

Significant History:  
Previous tx/current therapist  
(med/psych) symptoms/diagnosis/medications  
education/job hx  
social support/religion

Legal problems/military service

APPENDIX I:  
CREATION AND RECOMMENDATIONS OF THE COLORADO MENTAL HEALTH  
TASK FORCE

HOUSE BILL 13-1296

BY REPRESENTATIVE(S) McCann and Kraft-Tharp, Court, Fields, Hullinghorst, Labuda, Pabon, Primavera, Ryden, Young, Gardner, Gerou, Kagan, Peniston, Pettersen, Schafer, Singer;  
also SENATOR(S) Newell, Hudak, Jahn, Todd.

CONCERNING CIVIL COMMITMENT STATUTES, AND, IN CONNECTION THEREWITH, CREATING THE CIVIL COMMITMENT STATUTE REVIEW TASK FORCE, REDEFINING CERTAIN TERMS RELATED TO CIVIL COMMITMENT, AND MAKING AN APPROPRIATION.

*Be it enacted by the General Assembly of the State of Colorado:*

**SECTION 1.** In Colorado Revised Statutes, **add** 27-60-102 as follows:

**27-60-102. Civil commitment statute review task force - legislative declaration- creation - duties - repeal.** (1) THERE IS HEREBY CREATED THE CIVIL COMMITMENT STATUTE REVIEW TASK FORCE, REFERRED TO IN THIS SECTION AS THE "TASK FORCE", WHICH SHALL MEET DURING THE INTERIM AFTER THE FIRST REGULAR SESSION OF THE SIXTY-NINTH GENERAL ASSEMBLY.

(2) THE TASK FORCE SHALL STUDY AND PREPARE

*Capital letters indicate new material added to existing statutes; dashes through words indicate deletions from existing statutes and such material not part of act*

RECOMMENDATIONS CONCERNING THE IMPLEMENTATION OF THE CONSOLIDATION OF THE MENTAL HEALTH, ALCOHOL, AND SUBSTANCE USE DISORDER STATUTES RELATED TO CIVIL COMMITMENTS. AT A MINIMUM, THE TASK FORCE SHALL STUDY AND MAKE SPECIFIC RECOMMENDATIONS ON THE FOLLOWING ISSUES:

(a) THE METHOD BY WHICH THE MENTAL HEALTH, ALCOHOL, AND SUBSTANCE USE DISORDER STATUTES RELATED TO CIVIL COMMITMENT CAN BE CONSOLIDATED, INCLUDING POTENTIAL CHANGES TO STATUTORY LANGUAGE AND THE PROMULGATION OF RULES, IF NECESSARY;

(b) THE EFFECT ON DETOXIFICATION FACILITIES AND EMERGENCY HOLDS BY THE CONSOLIDATION OF THE MENTAL HEALTH, ALCOHOL, AND SUBSTANCE USE DISORDER STATUTES RELATED TO CIVIL COMMITMENT;

(c) INVOLUNTARY COMMITMENT FOR TREATMENT;

(d) ALIGNMENT OF THE CIVIL COMMITMENT STATUTES WITH THE STATEWIDE BEHAVIORAL HEALTH CRISIS SERVICES DELIVERY SYSTEM;

(e) THE NEED TO CLARIFY AND CODIFY DEFINITIONS IN THE BEHAVIORAL HEALTH STATUTES, INCLUDING BUT NOT LIMITED TO "ADVANCED DIRECTIVES FOR PERSONS WITH BEHAVIORAL HEALTH ILLNESSES", AND, AS THEY RELATE TO SUBSTANCE USE DISORDERS, THE TERMS "DANGER TO SELF OR OTHERS"; AND "GRAVELY DISABLED";

(f) THE LENGTH OF EMERGENCY AND LONG-TERM COMMITMENTS;

(g) PATIENT RIGHTS AND ADVOCACY RESOURCES; AND

(h) ANY OTHER ISSUES THE TASK FORCE DEEMS RELEVANT.

(3) THE TASK FORCE SHALL STUDY THE DEFINITION OF "DANGER TO SELF OR OTHERS" AS SET FORTH IN SECTION 27-65-102 (4.5) AND SHALL CONSIDER THE CIVIL LIBERTIES AND PUBLIC SAFETY CONCERNS OF THAT DEFINITION. UPON A MAJORITY OF THE TASK FORCE MEMBERS VOTING TO RATIFY THE DEFINITION SET FORTH IN SECTION 27-65-102 (4.5), THE TASK FORCE SHALL SUBMIT A LETTER STATING AS SUCH TO THE EXECUTIVE DIRECTOR AND THE REVISOR OF STATUTES NO LATER THAN NOVEMBER 1, 2013.

(4) (a) THE TASK FORCE WILL CONSIST OF THE FOLLOWING THIRTY MEMBERS, TO BE APPOINTED BY THE EXECUTIVE DIRECTOR OF THE DEPARTMENT OF HUMAN SERVICES OR HIS OR HER DESIGNEE, WITH THE EXCEPTION OF THE LEGISLATIVE APPOINTEES:

(I) ONE MEMBER WHO REPRESENTS A STATEWIDE ORGANIZATION OF SOCIAL WORKERS;

(II) ONE MEMBER WHO REPRESENTS A STATEWIDE ORGANIZATION OF LICENSED PSYCHIATRISTS;

(III) ONE MEMBER WHO REPRESENTS A STATEWIDE ORGANIZATION OF PHYSICIANS;

(IV) ONE MEMBER WHO REPRESENTS A STATEWIDE ORGANIZATION OF SUBSTANCE USE DISORDERS PROFESSIONALS;

(V) ONE MEMBER WHO REPRESENTS A STATEWIDE ASSOCIATION OF COMMUNITY BEHAVIORAL HEALTH PROVIDERS;

(VI) ONE MEMBER WHO REPRESENTS A STATEWIDE ORGANIZATION OF HOSPITALS;

(VII) ONE MEMBER WHO REPRESENTS A COMMUNITY SUBSTANCE USE DISORDER PROVIDER;

(VIII) ONE MEMBER WHO REPRESENTS A STATEWIDE ORGANIZATION OF PERSONS WHO PROVIDE LEGAL ADVICE TO AT-RISK ADULTS;

(IX) TWO MEMBERS WHO REPRESENT AN ASSOCIATION WITH EXPERIENCE IN CIVIL RIGHTS;

(X) TWO MEMBERS WHO REPRESENT STATEWIDE ORGANIZATIONS THAT ADVOCATE ON BEHALF OF PERSONS WITH BEHAVIORAL HEALTH DISORDERS;

(XI) ONE MEMBER WHO ADVOCATES ON BEHALF OF PERSONS WITH BEHAVIORAL HEALTH DISORDERS BUT DOES NOT REPRESENT A STATEWIDE ORGANIZATION;

(XII) ONE MEMBER WHO REPRESENTS AN ORGANIZATION THAT ADVOCATES ON BEHALF OF CHILDREN AND ADOLESCENTS;

(XIII) ONE MEMBER WHO REPRESENTS AN ORGANIZATION THAT ADVOCATES ON BEHALF OF OLDER ADULTS;

(XIV) ONE MEMBER WHO REPRESENTS AN ORGANIZATION THAT ADVOCATES ON BEHALF OF PERSONS WITH PHYSICAL DISABILITIES;

(XV) TWO MEMBERS WHO REPRESENT STATEWIDE ORGANIZATIONS OF LAW ENFORCEMENT OR PEACE OFFICERS, ONE MEMBER BEING A SHERIFF AND ONE MEMBER BEING A POLICE CHIEF;

(XVI) ONE MEMBER WHO REPRESENTS CITY OR COUNTY ATTORNEYS;

(XVII) ONE MEMBER WHO REPRESENTS AN ENTITY THAT PROVIDES MEDICAL MALPRACTICE INSURANCE;

(XVIII) ONE MEMBER WHO REPRESENTS A STATEWIDE ORGANIZATION OF COUNTIES;

(XIX) TWO MEMBERS WHO HAVE USED THE SYSTEM IN THE PAST TWO TO FIVE YEARS;

(XX) ONE MEMBER WHO REPRESENTS A STATEWIDE ORGANIZATION OF LICENSED PSYCHOLOGISTS;

(XXI) ONE MEMBER WHO IS AN ADVANCED PRACTICE NURSE WITH SIGNIFICANT EXPERIENCE IN THE CARE AND TREATMENT OF PERSONS WITH MENTAL HEALTH OR SUBSTANCE USE ISSUES;

(XXII) FOUR MEMBERS FROM THE GENERAL ASSEMBLY, TWO APPOINTED BY THE SPEAKER OF THE HOUSE OF REPRESENTATIVES AND TWO APPOINTED BY THE PRESIDENT OF THE SENATE; THE APPOINTEES FROM EACH CHAMBER MUST BE OF DIFFERENT POLITICAL PARTIES; AND

(XXIII) ONE MEMBER WHO IS A STAFF PERSON WITH THE DEPARTMENT OF HUMAN SERVICES.

(b) ALL APPOINTMENTS TO THE TASK FORCE MUST BE MADE ON OR

BEFORE JUNE 15, 2013.

(c) AT THE TIME OF APPOINTMENT, THE EXECUTIVE DIRECTOR OF THE DEPARTMENT OF HUMAN SERVICES, OR HIS OR HER DESIGNEE, SHALL DESIGNATE TWO MEMBERS OF THE TASK FORCE TO SERVE AS CO-CHAIRS OF THE TASK FORCE.

(d) THE LEGISLATIVE MEMBERS OF THE COMMITTEE SHALL BE COMPENSATED FOR ATTENDANCE AT MEETINGS OF THE COMMITTEE AND SHALL RECEIVE REIMBURSEMENT FOR ACTUAL AND NECESSARY EXPENSES INCURRED IN THE PERFORMANCE OF THEIR DUTIES AS MEMBERS OF THE COMMITTEE, AS PROVIDED IN SECTION 2-2-307, C.R.S. THE TOTAL AMOUNT AVAILABLE FOR REIMBURSEMENT AND COMPENSATION PURSUANT TO THIS PARAGRAPH (d) SHALL NOT EXCEED FIVE THOUSAND DOLLARS.

(5) THE TASK FORCE SHALL SUBMIT A WRITTEN REPORT OF ITS RECOMMENDATIONS TO THE EXECUTIVE DIRECTOR AND TO THE HEALTH AND HUMAN SERVICES COMMITTEE OF THE SENATE AND PUBLIC HEALTH CARE AND HUMAN SERVICES COMMITTEE OF THE HOUSE OF REPRESENTATIVES, OR ANY SUCCESSOR COMMITTEES, ON OR BEFORE NOVEMBER 1, 2013.

(6) (a) THE FIRST MEETING OF THE TASK FORCE MUST OCCUR NO LATER THAN JULY 15, 2013, AND THEREAFTER AS NECESSARY.

(b) MEETINGS OF THE TASK FORCE SHALL BE PUBLIC MEETINGS.

(7) THE TASK FORCE MAY SOLICIT AND ACCEPT REPORTS AND PUBLIC TESTIMONY AND MAY REQUEST OTHER SOURCES TO PROVIDE TESTIMONY, WRITTEN COMMENTS, AND OTHER RELEVANT DATA TO THE TASK FORCE.

(8) MEMBERS OF THE TASK FORCE SHALL SERVE WITHOUT COMPENSATION AND SHALL NOT BE ENTITLED TO REIMBURSEMENT FOR EXPENSES.

(9) THE LEGISLATIVE COUNCIL STAFF AND THE OFFICE OF LEGISLATIVE LEGAL SERVICES SHALL NOT PROVIDE STAFF SUPPORT TO THE TASK FORCE.

(10) THIS SECTION IS REPEALED, EFFECTIVE NOVEMBER 1, 2014.

**SECTION 2.** In Colorado Revised Statutes, 27-65-102, **amend** (9); and **add** (4.5) as follows:

**27-65-102. Definitions.** As used in this article, unless the context otherwise requires:

(4.5) "DANGER TO SELF OR OTHERS" MEANS:

(a) WITH RESPECT TO AN INDIVIDUAL, THAT THE INDIVIDUAL POSES A SUBSTANTIAL RISK OF PHYSICAL HARM TO HIMSELF OR HERSELF AS MANIFESTED BY EVIDENCE OF RECENT THREATS OF OR ATTEMPTS AT SUICIDE OR SERIOUS BODILY HARM TO HIMSELF OR HERSELF; OR

(b) WITH RESPECT TO OTHER PERSONS, THAT THE INDIVIDUAL POSES A SUBSTANTIAL RISK OF PHYSICAL HARM TO ANOTHER PERSON OR PERSONS, AS MANIFESTED BY EVIDENCE OF RECENT HOMICIDAL OR OTHER VIOLENT BEHAVIOR BY THE PERSON IN QUESTION, OR BY EVIDENCE THAT OTHERS ARE PLACED IN REASONABLE FEAR OF VIOLENT BEHAVIOR AND SERIOUS PHYSICAL HARM TO THEM, AS EVIDENCED BY A RECENT OVERT ACT, ATTEMPT, OR THREAT TO DO SERIOUS PHYSICAL HARM BY THE PERSON IN QUESTION.

(9) ~~(a)~~ "Gravely disabled" means a condition in which a person, as a result of a mental ~~illness~~; HEALTH DISORDER, IS INCAPABLE OF MAKING INFORMED DECISIONS ABOUT OR PROVIDING FOR HIS OR HER ESSENTIAL NEEDS WITHOUT SIGNIFICANT SUPERVISION AND ASSISTANCE FROM OTHER PEOPLE. AS A RESULT OF BEING INCAPABLE OF MAKING THESE INFORMED DECISIONS, A PERSON WHO IS GRAVELY DISABLED IS AT RISK OF SUBSTANTIAL BODILY HARM, DANGEROUS WORSENING OF ANY CONCOMITANT SERIOUS PHYSICAL ILLNESS, SIGNIFICANT PSYCHIATRIC DETERIORATION, OR MISMANAGEMENT OF HIS OR HER ESSENTIAL NEEDS THAT COULD RESULT IN SUBSTANTIAL BODILY HARM. A PERSON OF ANY AGE MAY BE "GRAVELY DISABLED", BUT SUCH TERM DOES NOT INCLUDE A PERSON WHOSE DECISION-MAKING CAPABILITIES ARE LIMITED SOLELY BY HIS OR HER DEVELOPMENTAL DISABILITY.

~~(I) Is in danger of serious physical harm due to his or her inability or failure to provide himself or herself with the essential human needs of food, clothing, shelter, and medical care; or~~

~~(II) Lacks judgment in the management of his or her resources and~~

~~in the conduct of his or her social relations to the extent that his or her health or safety is significantly endangered and lacks the capacity to understand that this is so.~~

~~(b) A person who, because of care provided by a family member or by an individual with a similar relationship to the person, is not in danger of serious physical harm or is not significantly endangered in accordance with paragraph (a) of this subsection (9) may be deemed "gravely disabled" if there is notice given that the support given by the family member or other individual who has a similar relationship to the person is to be terminated and the individual with a mental illness:~~

~~(I) Is diagnosed by a professional person as suffering from: Schizophrenia; a major affective disorder; a delusional disorder; or another mental disorder with psychotic features; and~~

~~(II) Has been certified, pursuant to this article, for treatment of the disorder or has been admitted as an inpatient to a treatment facility for treatment of the disorder at least twice during the last thirty-six months with a period of at least thirty days between certifications or admissions; and~~

~~(III) Is exhibiting a deteriorating course leading toward danger to self or others or toward the conditions described in paragraph (a) of this subsection (9) with symptoms and behavior that are substantially similar to those that preceded and were associated with his or her hospital admissions or certifications for treatment; and~~

~~(IV) Is not receiving treatment that is essential for his or her health or safety.~~

~~(c) A person of any age may be "gravely disabled", but such term shall not include a person who has a developmental disability by reason of the person's developmental disability alone.~~

~~(d) For purposes of paragraph (b) of this subsection (9), an individual with a relationship to a person that is similar to that of a family member shall not include an employee or agent of a boarding home or treatment facility.~~

**SECTION 3. Appropriation.** In addition to any other



appropriation, there is hereby appropriated to the legislative department, for the fiscal year beginning July 1, 2013, the sum of \$5,000, or so much thereof as may be necessary, for allocation to legislative council, for reimbursement and compensation of task force members related to the implementation of this act. Said sum is from reappropriated funds received from the department of human services' executive director's office.

**SECTION 4. Effective date.** (1) Except as provided in subsection (2) of this section, this act takes effect upon passage.

(2) Section 2 of this act takes effect July 1, 2014; except that section 27-65-102 (4.5), Colorado Revised Statutes, as added in section 2 of this act, shall only take effect upon the receipt of the letter to the Revisor of Statutes required by section 27-60-102 (3), Colorado Revised Statutes. If such letter is not received by November 1, 2013, section 27-65-102 (4.5) shall not take effect.

**SECTION 5. Safety clause.** The general assembly hereby finds,

determines, and declares that this act is necessary for the immediate preservation of the public peace, health, and safety.

Mark Ferrandino  
SPEAKER OF THE HOUSE  
REPRESENTATIVES

John P. Morse  
PRESIDENT OF OF  
THE SENATE

Marilyn Eddins  
CHIEF CLERK OF THE HOUSE  
REPRESENTATIVES

Cindi L. Markwell  
SECRETARY OF OF  
THE SENATE

APPROVED \_\_\_\_\_

John W. Hickenlooper  
GOVERNOR OF THE STATE OF COLORADO