

Mental Health Practitioner's Perspective

Daryl Handlin, LMSW, City of Wichita Mental Health Court (KS)

What is your background?

My name is Daryl Handlin, and I am a Licensed Master Social Worker working for COMCARE of Sedgwick County's Offender Assessment Program (SCOAP) and the City of Wichita Mental Health Court. In addition to my role with the court, I work part-time for COMCARE's Crisis Intervention Services. I have undergraduate degrees from Wichita State University and a master of arts from The University of Chicago's School of Social Service Administration, where I completed a clinical concentration. I am President of the Kansas National Association of Social Workers and served on the 2011 NASW National Delegate Assembly, including the Peace and Social Justice Panel. I also serve on the Executive Committee of Sedgwick County Crisis Intervention Team Council and am an instructor for associated trainings for first responders and law enforcement.

I am a firm believer that "many a false step is made by standing still." This proverb, adopted from a fortune cookie inscription, became my mantra as I went back to school to complete my graduate degree so that I could work more directly with people. After completing my degree, I came to SCOAP in June 2007. Going to graduate school and realigning personal and career goals was part of moving forward in my life. At SCOAP, I work with the Mental Health Court team to connect people to community and agency resources so they could have the same feeling of taking steps forward and improving their futures.

Why was the mental health program started?

The Mental Health Court was established as part of a collaborative partnership between the judicial system and mental health workers; it was initially funded by a grant from the Department of Justice to the City of Wichita Municipal Court. The court focuses on addressing the mental health issues of those entangled in the legal system and reducing the occurrence of offending behaviors. The City of Wichita Mental Health Court began on September 25, 2009, with one initial participant. The court was an additional piece of a problem-solving puzzle that complemented several local programs already in place. Among the other programs were city and county drug courts and a dedicated team of clinicians, including case managers, who work specifically with individuals with mental health problems and legal entanglement. The court grew rapidly as referrals flowed in from judges, probation officers, public defenders, prosecutors, attorneys, law enforcement, and clinicians to an average of approximately 80 participants at any given time. Through the Mental Health Court's partnerships, there have been positive changes to stop the revolving door effect, leading to minimized recidivism, and improved quality of life for court participants and the community as a whole.

What do you do in the program?

Working alongside a judge, prosecutor, public defender, and probation officer, I help participants confront barriers and seek change in their lives, reducing recidivism and creating a safer community. I equate high recidivism rates participants experienced prior to this program to "standing still" because it yields the same outcome time after time and is counterproductive. Along with the referrals mentioned in the above paragraph, I also use a database match to identify current and former consumers of community mental health services who have been booked in the local adult detention facility.

Whom does the court serve?

The court works specifically with those who have low-level misdemeanor crimes. These individuals have been found to spend a disproportionate amount of time in custody due to compliance issues, which are aggravated by a variety of biopsychosocial factors. Most within the court have been determined to meet the criteria for severe and persistent mental illness (SPMI); however, we have also utilized this court for others with less pervasive mental health problems and other accompanying factors, including functional impairment attributed to traumatic brain injury, developmental disabilities, and issues associated with aging. While most in our program receive care from the community mental health centers, our program also works with those involved in treatment with private providers and the Veterans Administration.

How do you work with a participant to determine his/her needs?

I utilize concurrent documentation (face-to-face with the participant), whenever possible, and discuss the intervention directly with the participant—noting responses, progress in treatment, and plans going forward. I find being honest, while still approaching delicate subjects carefully, is the best approach—even when just noting how the participant is doing with things like personal hygiene. I also try to be as transparent as possible about expectations. After initial assessment, as part of entry into our programs, I give the participants a copy of the letter I send to the court with the recommendations and expectations we the participant and I have mutually agreed upon. I meet with participants to reevaluate care needs and change recommendations during their term in the program as needed. I try to keep in mind that, despite my training and experience, the person I am meeting with is always the primary expert on his or her own needs and, therefore, possesses the greatest ability to solve problems utilizing personal strengths and natural support systems.

Please describe one aspect of working in the mental health court program that mental health practitioners, like you, would find particularly interesting.

One of the most interesting aspects of the job is working with a variety of systems in creative ways to achieve results. Communicating with multiple systems also creates challenges. In an effort to increase comprehensive communication, it is a regular practice for our staff to obtain participants' consents to release information. These releases assist our team in collaborating with partners in legal, medical, mental health, and social and community support systems. I consult my discipline's professional code of ethics, colleagues, and supervisory staff on ethical dilemmas. I work to protect each client's right to privacy and only share information necessary to collaborate with other providers and effectively communicate a participant's engagement and progress.

How do the members of the team communicate? What measures has your program put in place in order to effectively and legally share information about participants? Are there any issues you have encountered, especially around protecting participants' confidentiality?

The Mental Health Court team, comprised of a judge, prosecutor, public defender, probation officer, and mental health clinician, consults prior to court session. To inform the discussion, I complete simple written progress reports, noting satisfactory and unsatisfactory progress and add brief narrative derived from a review of electronic records and consultation with treatment providers. Then, while in court with participants, I discuss this report verbally, highlighting accomplishments and strengths first and

challenges and lapses in recovery next. There is also time for participants and treatment team members to give personal accounts and discuss what is working well along with areas for improvement. Our team encourages honesty in the courtroom, even when things are not going well. Our team is much less likely to recommend a sanction when a participant demonstrates ownership of problem behaviors and communicates these openly during a review. Occasionally this has given pause to public defenders and attorneys who are accustomed to cautioning those they represent from sharing self-deprecating information. What has helped to ease the discomfort with representatives and participants is that both have witnessed personally and by observing others that honesty builds trust in the relationship and generally does not lead to sanctions. At times, probation and prosecuting team members have voiced some frustration that there is a different standard for those in the program compared to others who have committed similar crimes but are not in this program—especially with regard to substance use. It is my firm belief, supported by my experiences, that if participants fear the bench because of lapses in recovery, they are more likely not to attend a court review. Sometimes we see participants seeking inpatient psychiatric treatment as a way to avoid court appearances when they are fearful. The avoidance of attending reviews may lead to expensive detention due to arrest on resulting bench warrants or expensive and unnecessary psychiatric treatment—both of which problem-solving courts seek to avoid.

Many practitioners are concerned about sharing participants' health-related information with other members of the team. What are your thoughts about this concern?

The sharing of medical information related to mental health in a public setting has to be done carefully. I will often meet with a participant during the proceedings in more private meeting areas when discussing delicate matters. For instance, in a group setting it is easier to discuss good attendance in treatment groups than it is to discuss someone going to their scheduled medication appointment and receiving an injection of psychotropic medications. At times it is necessary to coach other team members on the ethics of sharing medical or personal information as those within the court are not necessarily guided by the same ethical standards as mental health professionals. A simple example of a concern over sharing private information that the courtroom environment complicates is when a participant has a change in address or phone. On regular probation, this participant would report these changes to a probation officer in a private session. The communication of this change of information is still expected when a probationer is assigned to the court, but there are risks in communicating a participant's contact information where other participants can hear and collect the information. An alternative approach we utilize to mitigate this disclosure is to ask the participant to write down the information rather than communicating it verbally.

What is a major difference between the mental health court model and the drug court model relating to sharing information that mental health providers are likely to notice?

Drug courts tend to use a supportive group peer-recovery model. This also works for mental health courts; we often applaud or highlight accomplishments with the group. One difference from the drug court model is that the information discussed in Mental Health Court often relates to very personal and, at times, delicate information about personal medical thought disorders. At times there is discussion about medications and other treatment that may be very personal in nature. The other participants in mental health court are often within an earshot of the discussion at the bench, which makes this discussion all the more delicate. This may contrast with the drug court model in that there may be less stigma with discussing what is deemed to be more of a behavioral disorder than a medical disorder.

Do participants in the program have co-occurring disorders?

More than half of the program participants have co-occurring disorders or even tri-morbid disorders (mental health, substance abuse, medical). Integrated approaches that address multiple problems are the best approach. While we have comprehensive releases of information, ethical issues on what should be shared with the team in regards to things such as pregnancy and blood-borne pathogens, including HIV, have arisen—especially when high-risk behaviors and substance abuse were involved.

Some practitioners have expressed that the highly individualized approach of the mental health court model can make it difficult to maintain equity between participants in a mental health court program. How do you approach this issue as a mental health practitioner in your program?

Our court remains a voluntary program. I utilize motivational interviewing techniques to build motivation for treatment. The team also finds that incentives work better than sanctions. Incentives can be very simple, including things such as verbal praise; applause for basic milestones; and what we call the “rocket docket,” which simply means that those doing well get to go first on the docket. This is one of the most popular and desirable incentives. The judge also plays a pivotal role in this as well in making sure there is parity in this process.

Music is an avocation of mine. I believe creativity and my arts training help me to solve problems and come up with unique approaches. I have performed in the comic opera the Mikado by Gilbert and Sullivan a couple of times in the past. In the song, “A More Humane Mikado,” the lyrics speak of how those in power should “let the punishment fit the crime.” When discussing problem-solving courts with members of the community, there is often a perception that an alternative approach may go easier on participants who are not in specialized programs. In my experience, there is greater accountability expected from those who are in alternative programs. I believe, and our data suggests, that we achieve better results through increased accountability and oversight. It is important to evaluate whether increased oversight leads to different treatment from that someone without mental health problems would have if they had committed similar crimes.

Individualized approaches create some issues with equity for those who are in the program and those who are not but have similar charges. There can also be issues of equity with sanctions for those who are in the program. For instance, when discovering a participant is actively using substances and is also pregnant it has seemed that the team is more likely to impose a jail sanction in order to have an in-custody substance-abuse evaluation completed. Our team tries to make requirements and amends for charges similar to those who do not have mental health issues. For instance, a person with a domestic violence charge may be required to attend a 13-week domestic violence class. This class is a self-pay course in the community. When a participant in our program is homeless and without income, requiring that individual to complete the same requirement leads to failure. At the same time, when a crime has been committed and there is a victim involved, making amends and learning ways to change behaviors is important. In these cases I recommend alternative ways to learn anger-regulation skills and fulfill the court’s domestic violence requirements through treatment within the mental health system. This may include attending individual or group therapy within the mental health system.

Team members disagree on approaches to treatment. This seems to occur more often when utilizing sanctions and more restrictive environments. Consensus is always preferred, but I believe my job is to be an advocate for the participant. An example of this may be to recommend a participant for detox or inpatient substance-abuse treatment as opposed to jail. While a carefully placed jail sanction can be a

motivator to get a participant back on track, jail is not treatment. Participants are likely to experience lapses in medication management and increased symptoms within the detention environment.

Do you have example scenarios of outcomes, both good and bad, that participants have experienced while in the program?

Yes, here are two composite scenarios (any identifying information has been changed to protect confidentiality) based upon real situations illustrating successful (Scenario 1) and unsuccessful (Scenario 2) outcomes.

Scenario 1

Carlos is a Hispanic male in his early 20s with misdemeanor domestic violence charges involving a family member. Behaviors that led to arrest were aggravated by psychotic symptoms. Prior to the establishment of the court, upon conviction, he was required to complete a 13-week community-based self-pay course. Carlos is in the process of filing for disability benefits due to mental illness but he currently has no income or benefits. Unlike many with limited resources, he was fortunate in that his mother assisted with paying for the required course on standard probation. He was attending class as scheduled; however, the leader of the group noted that he often made unusual comments that were distracting to the group. On one occasion, he was observed talking to himself about spiders and snakes that others could not see in the room. The group leader attempted to redirect Carlos, but eventually he became frustrated and asked him to leave and not return. Despite paying his fee and attending regularly, this led to a violation of his probation and not completing this requirement could have resulted in additional jail time. Upon transfer to probation with the mental health court, he was referred for group therapy with other mental health consumers. He continued to struggle in group settings and his medication provider was consulted about ongoing symptoms. Because medication management led to reduced symptoms and more flexibility in meeting his requirements, he was able to complete the alternative course, and he graduated from the mental health court.

Scenario 2

John is a white male in his mid-30s who was homeless for eight years prior to his referral to the court. He is familiar to mental health providers and law enforcement personnel alike due to his limited engagement in treatment for schizophrenia and dozens of arrests for nuisance crimes, including trespassing, panhandling, and petty theft. After one arrest, he served more than six months at the detention facility for stealing a hairbrush (felony petty theft due to prior convictions). Upon assignment to the mental health court, he was able to gain disability benefits and housing. Problem behaviors persisted—often aggravated by alcohol use. Frequently he only made it to his mental health court reviews when he was brought from the detention facility after a new arrest or a detention resulting from bench warrants for failure to appear in court. Despite noting major accomplishments, such as his gaining disability benefits and housing after almost a decade of being unsuccessful in reducing problem behaviors, team members voiced frustration with repeated reinstatement following new charges and probation violations. Eventually his probation was revoked, and he was sanctioned with additional detention time. Since being released, he continues to be arrested for similar crimes.