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An Examination of Law Enforcement and Behavioral Health Collaborations in Multidisciplinary Teams (Forensic MDTs)

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AN EXAMINATION OF LAW ENFORCEMENT AND BEHAVIORAL HEALTH COLLABORATIONS IN MULTIDISCIPLINARY TEAMS (FORENSIC MDTS)

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Abstract

Purpose: The purpose of this qualitative case study research was to identify the advantages and disadvantages of collaborations among law enforcement and behavioral health providers on multidisciplinary teams when responding to behavioral health crises. The aims included 1) understand how communication between behavioral health professionals and law enforcement officers impacts their ability to collaborate; 2) uncover how information sharing between both disciplines influences outcomes; 3) describe the perceptions of members of both disciplines regarding levels of case engagement.

Background: Law enforcement is increasingly engaged in behavioral health crises. In addition, there is growing demand for clinical input regarding law enforcement matters. Complex cases appear to exceed the capabilities of an individualized response (law enforcement or behavioral health). As a result, there is a notable growth in the use of multidisciplinary teams, in an effort to engage multiple expertise.

Method: This study was guided by Yin's work on case study research. Purposive sampling was used, pulling from members of existing multidisciplinary teams. Inclusion criteria included the affiliation as either law enforcement personnel or behavioral health provider.

Results: The themes that emerged from this research are (1) *Systemic issues impact MDT success* (2) *Training and role on the team impacts member practice* (3) *Successful implementation of MDTs requires intentional work* (4) *Efficacy of MDTs increases when different expertise is engaged.*

Discussion/Conclusion: Through this case study, bounded in space and time, there is greater understanding about the perceptions of multidisciplinary team members regarding law enforcement and behavioral health collaborations when responding to behavioral health crises.

An overarching theme regarding a collaborative approach to “dividing and conquering the work” was noted in this study.

Keywords: forensic MDTs, deinstitutionalization, BHP’s, decriminalization, MDTs, diversion, CIT, Co-response, member, user.

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CHAPTER 1 – STATEMENT OF THE PROBLEM

The fields of criminal justice and behavioral health have been siloed for the past several decades, with information sharing limitations and differing perspectives in how to approach individual cases being a common occurrence (Alves & Meneses, 2018). Behavioral health professionals focus on clinical needs, historical information, and treatment planning, whereas law enforcement focuses on public safety and mitigation of risk (Harris & Lurigio, 2012). These differences have at times led to separate but parallel interventions involving the same individual. A growing need for cross-discipline or multidisciplinary collaborations between law enforcement and behavioral health has been noted in recent years, and most prominently since 2020 due to the impact of the COVID-19 pandemic (Altiraifi & Rapfogel, 2020). Increased complexity in clinical needs, including situational stressors and contextual factors, have contributed to this phenomenon. The movement of individuals who have been involved with the criminal justice and behavioral health systems away from secure facilities and into community settings was a significant shift starting in the 1960's (Guldimann et al., 2016). Multiple factors influenced this transition, including the deinstitutionalization movement, concerns about how individuals with mental health needs who encounter law enforcement were treated, community capacity to provide necessary care and treatment, and ongoing management of risk and clinical needs (Lamb & Bachrach, 2001). Chapter 2 will expand on these historical and social events to further illustrate the need for this research during what is currently a highly influential period in time.

Statement of the Problem

Beginning in the 1960's the transition of individuals with significant mental health needs from secure locations to community settings took place rapidly and with little preparation done to expand community capacity in order to address these new needs (Harris & Lurigio, 2012). In

particular, individuals with historical interactions involving law enforcement were moved back into the community with minimal discharge planning. The closure of psychiatric hospitals displaced a segment of the population, straining communities that lacked resources to accommodate the clinical needs of individuals with mental illnesses. Since several decades have passed, the longer-term impact of the deinstitutionalization movement continues to be experienced in several ways. The transition of individuals with significant clinical needs, who could potentially pose risks to self or others, to the community created a situation where the capacity of the behavioral health system and needs of the population did not align. This was particularly true in the absence of commensurate treatment options, including access to therapists, medications, and adequate treatment programs. Consequently, individuals who experienced untreated mental health concerns now potentially presented with behavioral challenges observable to the general public. As cases involving behavioral disturbances, that were previously addressed in institutions, impacted and disrupted communities, law enforcement services became increasingly involved in their management. Law enforcement lacked sufficient training and resources to address these types of calls, leading to an increased rate of arrest of individuals with behavioral disorders and the criminalization of mental illness (Bird & Shemilt, 2019).

Responding to higher rates of arrest for people with mental illness, advocacy work began drawing attention to the needs of incarcerated mentally ill individuals and calls for systemic changes grew (Al-Rousan et al., 2017). The need to provide law enforcement with specialized training and additional resources to manage individuals with mental illness created opportunities for cross-collaborations among law enforcement and behavioral health providers. This manifested in many ways, including behavioral health providers giving relevant trainings to law

enforcement, case consultations, expert court testimonies regarding clinical needs and risk, and recommended referrals to clinical resources. However, this changing landscape created new challenges around information sharing, awareness of procedures across disciplines, and overall management of case needs (U.S. Department of Health and Human Services, 2022). This proposed study examined these collaborations, as well as the context of the collaborative work of behavioral health providers and law enforcement personnel, known as forensic multidisciplinary teams (MDTs). While instances of conflict and progress in forensic MDT work have been noted in the literature, this area has not been fully examined or researched. Massachusetts is a good testing ground for new and novel approaches to the work discussed in this dissertation, given the progressive interventions in place already, to address behavioral health needs within the criminal justice system.

Conceptual Framework for the Study

This research was framed through the lens of two main theories, biopsychosocial theory and transformative justice theory, because of their applicability to this topic. Forensic MDT work follows a biopsychosocial model, with the amelioration of concerns and the betterment of life quality for the individual as the primary goals. The current state of collaboration between law enforcement and behavioral health providers aims to identify individual specifiers in a comprehensive way. Papadimitriou (2017) noted the need to understand individual needs as the result of multiple forces, both historical and current. In this case, both disciplines work to gain a more in-depth understanding of the complexities of case needs by examining and considering biological, psychological, and social factors. Forensic MDTs are increasingly recognizing the importance of a robust analysis of clinical needs and potential risk factors in order to decrease

the likelihood of the issues returning or the individual remaining engaged in the criminal justice system.

The other theory contributing to this conceptual framework, transformative justice, aims to acknowledge that factors preceding a crime also contributed to its occurrence (Coker, 2002). Individual qualities and factors of both the offender and victim are examined in an attempt to better impact all parties involved. The goal of this theory and its application is to examine its impact on interactions with law enforcement and its effect on crime outcomes and recidivism (Coker, 2002; Gready & Robins, 2014, Nocella, 2011). Since the work of forensic MDTs is transformative in nature and encompasses two disciplines (law enforcement and behavioral health), with the goal of making individual and systemic changes, this theory rounded out the conceptual framework for this study.

Purpose of the Study

This study aimed to examine collaborative partnerships between law enforcement and behavioral health providers through a qualitative case study review of MDT responses in Massachusetts. Forensic MDTs exist throughout many systems on a global scale, such as the courts and community settings, with little research on their efficacy and limitations. With a growing interest in this type of work, (from politicians, the media, legislators, and advocates), as well as societal expectations that complex case needs are addressed while risks to the individual and society are mitigated, forensic MDTs are increasing in presence (Dempsey et al., 2019). The ways that MDTs are created and put into practice have yet to be adequately studied. It is this researcher's assumption, based on relevant professional experience and a thorough review of the literature, that forensic MDT work yields varying degrees of positive collaborations, outcomes, and management of individual needs. These variations and what influences them is one area of

interest for this research. Beyond this, it is hypothesized that the experience of individual members from both professions are instrumental to the perceived efficacy of these teams. Key areas of focus in this research were the participants' understanding of their role, the other profession, the limitations and capabilities of the forensic MDT, procedural limitations and abilities, and their sense of the impact of their work.

As the acuity in cases and complexity of clinical needs have increased through the years (Greenhalgh & Papoutsi, 2018), forensic MDT work is increasingly called into question by community and legislative members and its contribution to the criminal justice and behavioral health systems requires further examination. A blueprint to assist with operationalizing such teams does not exist. In addition, member composition for each team varies, as do the individual experiences. There is a presumption that experiences impact team outcomes and overall satisfaction in the work of individual forensic MDT members (Koenraadt, 1992). This study strived to identify the key factors involved in forensic MDT outcomes and individual experiences, with the goal of contributing to the body of knowledge on forensic MDTs, their work, and outcomes.

Research Question and Aims

The research question framing this study was: What are the main advantages and disadvantages of collaborations among law enforcement and behavioral health providers on multidisciplinary teams when responding to behavioral health crises? This study took place in Massachusetts and aimed to 1) understand how communication between behavioral health professionals and law enforcement impacts their ability to collaborate; 2) uncover how information sharing between both disciplines influences outcomes; 3) describe the perceptions of members of both disciplines regarding levels of case engagement.

Definition of Terms

For the purposes of this research study, the following terms were used.

Forensic MDTs	Teams of professionals comprising of law enforcement and behavioral health providers who work on cases and assess risk factors, treatment needs, make connections to resources, etc.
Deinstitutionalization	Movement of individuals with significant mental health needs and potential risk factors away from secure settings and into the community. Also the movement which began in the 1960's.
BHPs	Behavioral health providers, for example LICSWs (licensed independent clinical social workers), LMHCs (licensed mental health counselors-for Massachusetts, known as LPCs in other states), PsyD (licensed psychologists), MDs (psychiatrists), PhD (doctorate level practitioners)
Decriminalization	Moving away from arresting mentally ill and moving towards engagement with treatment and care.

MDTs	Multi-disciplinary teams including law enforcement and behavioral health professionals.
Diversion (jail or ED)	Movement away from something, for example jail or emergency departments (ED). This done to avoid placing someone into the criminal justice system or ED unnecessarily. It also refers to the movement towards treatment and other rehabilitative options. Mechanisms for diversion include MDTs, cross-training, and collaborations.
Crisis Intervention Teams (CIT)	Law enforcement teams that are created following a 40-hour standardized training given to law enforcement to increase awareness of mental health diagnoses and needs, as well as expanding available resources, to ensure that what is learned translates into practice.
Member	A law enforcement or behavioral health provider on a forensic MDT.
User	Someone receiving services or assistance from a forensic MDT.

Procedures

Given the research question and goals of this study, an instrumental case study was the preferred approach because of its ability to examine and understand a particular phenomenon (Lucas et al., 2018). This study examined collaborations among law enforcement and behavioral health providers and served to better understand the particular features and qualities found in forensic MDTs. It was framed with an instrumental case study design, using individual team member experiences to examine forensic MDTs. Focus groups were one of the primary data sources, in addition to field notes and questionnaires. This type of data collection strategy has been demonstrated to be effective in this study design (Mohan et al., 2004; Nyumba et al., 2018). The use of this information gave the researcher the ability to substantively understand the experiences of team members' collaborative relationships within MDTs. After collecting the data, a thematic analysis process was used to unveil codes and common themes. A case study methodology guided the focus groups, in which members responded to specific questions, including information regarding their professional affiliation, experience doing individual assessments, experience working collaboratively, their impressions of advantages and disadvantages of working with the other discipline, their impressions of working on an MDT, and their ideas about team process.

Significance of the Study

Given the growing attention on law enforcement practices (Watson et al., 2008) and a need to address complex case needs (Kane et al., 2017), this study has the potential to contribute to the field of forensic clinical work by providing information related to how assessment of treatment needs and connection to appropriate resources occurs through collaborations. A rapidly changing landscape of social justice reform, legal changes (Bird & Shemilt, 2019) and an

increasing expectation of cross discipline collaborations have created the demand for forensic MDTs. However, a review of the literature shows that there is a lack of studies in this particular area. Given this disparity between demand and knowledge, the proposed study aimed to fill a gap in the available literature and inform future areas of focus on forensic MDTs. The ability to examine and study the experiences of law enforcement and behavioral health providers who are members on forensic MDTs is instrumental in better understanding what impacts outcomes positively and/or negatively. There are concerns regarding model fidelity in the implementation of forensic MDTs (Orovwuje, 2008), and several hypothesized areas of significant interest, such as information sharing or case accountability/ownership, require additional exploration. This study identified areas of need within MDTs and examined varied professional perspectives and approaches found on these teams. This information may potentially inform future expectations and performance of similar teams.

CHAPTER 2 LITERATURE REVIEW

Introduction

The fields of behavioral health and criminal justice have a multi-layered connection. Individuals who present with biobehavioral clinical needs and who also come in contact with law enforcement are subject to diversion (redirection away from the criminal justice system, towards…[clinical care/services]), charges and arrest, or receipt of a summons (Bird & Shemilt, 2019). Law enforcement personnel, trained in criminal justice and emergency first response, lack the expertise to appropriately address the needs of these individuals. As a result, in order to address this complex landscape, the need for a close partnership between behavioral health providers (BHPs) and law enforcement has become increasingly more pressing, and alternative collaborative models have been introduced (Widgery, 2020). Some of these include the co-response model, which embeds a clinician in a police department and the CIT (Crisis Intervention Team) model, which provides 40 hours of specialized behavioral health trainings to law enforcement and informs the subsequent creation of a specialized team. This interdisciplinary approach is also known as forensic multidisciplinary teams (MDTs) (Ferrara et al., 2019). As law enforcement's response to mental health needs has garnered public attention and policing processes have been questioned (Watson et al., 2008), research into this field has continued to expand (Bird & Shemilt, 2019; Dean et al., 2020; Dempsey et al., 2019). While focus has been given to treatment planning and prevalence rates of MDTs (Fuller & Cowan, 1999), there is a knowledge gap concerning factors that impact effectiveness (e.g., management of clinical needs, risk factors, resource allocation, etc.), which warrants further inquiry (Fuller & Cowan, 1999).

One article on co-response reflected a scoping review of eight studies on Canadian police and mental health co-response crisis teams, noting that further research was needed into these teams and correlations with reduced use of force and increased ability to meet client needs in the community (Ghelani et al., 2022). Findings included that compared to police-only responses, having a clinician on scene allowed for interagency collaboration and communication, improved de-escalation outcomes, and increased the care received by the individual (Munetz & Bonfine, 2022). Through a variety of collaborative models (training, case consultation, and treatment engagement), law enforcement and BHPs integrate and create forensic MDTs. While there is research focusing on certain aspects of MDTs that has been carried out, expanded work is necessary.

Chapter 2 explores and reviews the existing literature on law enforcement and human services collaborations, in order to further identify and describe the knowledge gap and provide appropriate background on what is known regarding these MDTs. Moreover, the review includes an examination of historical and social contexts of law enforcement and behavioral health, a highlighting of significant social changes impacting the care of mentally ill individuals who come in contact with law enforcement, MDTs, forensic MDTs, and a documentation of their experiences as a result. In this chapter, *members* are defined as professionals on the MDTs and *users* are defined as individuals receiving care from the MDT. Additionally, this chapter includes a discussion of the proposed theoretical framework for analyzing what works and doesn't work on forensic MDTs, and presents the literature supporting the empirical and methodological approaches that guided the study.

Relevant Background: Historical and Social Context

As a means to fully grasp how societal changes impact the broader healthcare and legal systems, it is pertinent to clearly define behavioral health. As definitions adjust, current use of *behavioral health* refers to both mental health and substance use disorders (Bao et al., 2013). Although its use has been debated, as it focuses on the behavioral aspects of an individual versus collective influences, it is argued that to use the term mental health is limiting, as it omits other possible factors such as substance use, environmental influences, and interpersonal dynamics (Levin & Hanson, 2020). In order to frame this research study and its relevance to today's work, an examination of the historical and social events which took place, and their impact, is also important.

In the United States, events such as the deinstitutionalization movement caused significant social changes and community shifts (Lamb & Bachrach, 2001). This movement, beginning in the 1960s, was marked by the closure of many state-funded psychiatric hospitals, redirecting care to the community (Lamb & Bachrach, 2001). The intent of this movement was the ability for individuals to live in the "least restrictive setting" possible. The goal being to allow for integration into society and re-socialization. As a result, law enforcement and behavioral health professionals faced numerous changes and challenges, including how to manage individuals' clinical needs and resulting behaviors that impacted their functioning within the larger society (Alves & Meneses, 2018). Whereas both professions traditionally operated in silos, independently working to achieve their own objectives without information flowing to or from other sources (Alves & Meneses, 2018), deinstitutionalization generated a need for law enforcement and behavioral health to work in integrated ways (Widgery, 2020). The shift in mental health resource allocation, from secure locations to community settings, created

disruptions in care, resulting in law enforcement often being involved in mental health cases in which certain behaviors raised concern within communities and caught the public's attention (Guldimann et al., 2016). For instance, in cases when an individual with mental health needs decompensates due to lack of access to care or treatment, in turn presenting with an altered mental status and/or concerning behaviors, law enforcement often becomes the first-line response and intervention (Harris & Lurigio, 2012).

In recent years, even in systems where both professions are present, there is still minimal overlap in approach and/or true cooperation between both disciplines (Wolff et al., 2011). An example of this dynamic is the court system, where an individual is criminally charged and may then be referred for an evaluation to the court clinician. Even though both professions exist within the same system, they work consecutively and not collaboratively (Wolff et al., 2011).

In addition to impacting the work of law enforcement and behavioral health professionals, a primary result of the deinstitutionalization movement was the inadvertent shift towards the criminalization of mental illness (Dempsey et al., 2019). The deinstitutionalization movement created a shift away from locked secure facilities towards community management of individuals with mental illness. This significant transition took the responsibility to meet behavioral health needs away from psychiatric hospitals and state systems dedicated to behavioral health services and placed it onto communities. Access to care became limited, as the process of shutting down secure psychiatric hospital locations outpaced the development of community resources (Yohanna, 2013).

Limitations in access to care are even more evident for those who have a serious mental illness or forensic concerns. At the community level, the management of this population suffers from the lack of specialized treatment approaches to manage behavioral health and clinical

needs, variations in consumer to provider capacity, limitations of legal language related to court ordered treatment plans, and the lack of overall capacity to manage significant mental illness outside of structured and staffed locations (Hachtel et al., 2019). In his historical account of psychiatric care in the United States, Yohanna (2013) highlighted how individual needs of those who struggled with mental illnesses were unable to be met in community settings, particularly as the community system faced a surge in demand for specialized behavioral health services. While deinstitutionalization came with several benefits including a more humane treatment of individuals, especially in instances when mental health concerns are mild or moderate, the infrastructure for the care of individuals who suffer from severe psychiatric conditions has been largely poorly conceived (Lamb & Bachrach, 2001). An increasing reliance on the court system to compensate for the shortcomings of community-based interventions, such as ordering involuntary medication and treatment compliance, is often less than ideal given the backlog of cases and limited ability to efficiently hear, monitor, and resolve these matters (Hachtel et al., 2019).

Arguments exist that without adequate community capacity (i.e.: capacity in acute psychiatric inpatient units and/or access to mental health providers), mentally ill individuals come into contact with law enforcement at higher rates when their clinical needs are poorly managed or not treated at all (Kane et al., 2017). In addition to the challenges previously described an examination of the inverse correlation between the number of psychiatric beds and inmate numbers, combined with recidivism of the mentally ill after release from legal custody, assists in framing the mental health burden that is also seen in the correctional systems (Al-Rousan et al., 2017). Currently, responsibility is placed on correctional systems to manage mental health needs previously left untreated by insufficient community resources. Individuals

requiring mental health care become more likely to encounter law enforcement when untreated; a result of behaviors and symptoms that elicit calls for service to the police. Lacking in alternatives, arrest occurs. Placed in correctional settings, these mental health needs create a significant burden on a system not designed for this level of care. Current prison reform advocacy work is seeking to shift individuals with mental illness away from the criminal justice system and back to community settings.

In addition, national policies such as the Crime Bill of 1994 caused an increase in inmate numbers across the United States. This bill provided additional federal funding to expand prisons and was responsible for creating tougher laws and punishment guidelines at the federal level (Eisen, 2019). Some examples of the more severe measures associated with the Bill of 1994 include the 3-strikes law (if convicted three times for the same type of offense, longer sentences were imposed) and more severe drug related charges (Eisen, 2019). Additionally, the Crime Bill of 1994 also provided federal approval for states to engage in increased tough-on-crime laws, which also allowed for the building of more prisons and encouraged the remittance of a person to police custody versus diversion or treatment at the state level (Ofer, 2019). According to Dempsey and colleagues (2019), in the last 30 years, the U.S. prison system has become the largest in the world to hold mentally ill people in their custody. Furthermore, racial minorities and those from a low socioeconomic status are among those who are the most impacted, being more likely to end up in custody and serve longer sentences (Jones & Sawyer, 2019). These unfair and biased experiences have highlighted the need for prison reform work, mental health advocacy efforts, and transformative approaches to the criminal justice system.

Legislation and social movements have impacted those who suffer from mental illnesses. It is significant to this research to review advocacy work that has been done to limit the negative

individual and systemic outcomes of these changes. The following section aims to examine deinstitutionalization and the decriminalization of mental illness through a critical lens, setting the historical context for the eventual formation of forensic MDTs to address treatment gaps, aid in the management of risk, and increase community capacity for treatment.

Deinstitutionalization and Decriminalization of Mental Illness

Starting in the 1960s in the United states, as advocates of patient rights argued that indefinite placement in secure settings for the treatment of mental illness was a violation of individual rights, societal expectations around care and treatment began to shift, giving rise to what became known as the deinstitutionalization movement (Dempsey et al., 2019). This movement resulted in the closure of many secure psychiatric facilities, generating the expectation that patients would be properly managed in the community (Dempsey et al., 2019). However, the capacity of the community to offer adequate mental health care and interventions failed to match the needs of patients who struggled with psychological and behavioral ailments (Green et al., 2016). Deficits are seen in a number of areas including a lack of access to specialized care, shortage of treatment programs and community beds, systemic deficiencies in managing medication compliance, a shortage of social workers and psychiatric nurses, etc. (Green et al., 2016). As a result of this discrepancy between need and capacity, the nation has witnessed a significant increase in the number of mentally ill individuals arrested on the basis of their behavior and placed into custody, with some statistics estimating the number of mentally ill individuals in custody at 1 in 7 (Fazel et al., 2016).

Other factors that likely impact this number include the absence of specific behavioral health trainings for law enforcement to help identify mental illness and connections to appropriate resources (Lantigua-Williams, 2016). Starting in the 1970s, the rate of incarceration

in the United States began to outpace other western countries, with an incarcerated population of 2.2 million individuals (Robertson, 2019). This leads to concerns that vulnerable populations, such as those who suffer from unmanaged mental health disorders, may be more likely to come in contact with law enforcement and be arrested for low level offenses, such as loitering or disorderly conduct (Jones & Sawyer, 2019). According to Jones and Sawyer (2019) those with a mental illness are three times more likely to be arrested. In fact, it has been demonstrated that in the United States, for every person with a severe mental illness occupying a psychiatric hospital bed, there are 10 individuals with a severe mental illness who are incarcerated (James & Glaze, 2006). An example of this over-reliance on the prison system to support people with mental illness is the Los Angeles County Jail, which has been identified as the largest de facto mental health institution in the country (Ume & Taylor, 2020). Subsequently a movement began among advocates and legal groups to decriminalize mental illness and bring attention to correlations between untreated mental illness and incarceration by tracking rates of individuals with mental illnesses in custody (Dean et al., 2020). In order to address these concerns, different initiatives have been proposed, such as diversion strategies and integration of behavioral health services into law enforcement systems. These strategies are based on integrated approaches that aim to address the needs of complex cases, striving to promote an individual's quality of life and stability in the community (Kane et al., 2017).

Moreover, decriminalization of mental illness is positively correlated with the presence of advocacy efforts made to train law enforcement in behavioral health. An increase in community capacity to address clinical needs and divert mentally ill individuals away from the criminal justice system, is also a desired outcome (Kane et al., 2017). Decriminalization of mental illness strives to reduce recidivism, disrupt excessive incarceration patterns, and improve quality of life,

while addressing individual needs and changing systems of oppression and injustice (Corneau & Stergiopoulos, 2012). An example of a strategy that strives to promote systemic change towards innovative approaches is *jail diversion*.

Jail Diversion and Diversion Work

Diversion, in its fundamental definition, refers to redirecting the course or shifting away from something (Kane et al., 2017). Efforts to divert individuals with mental health needs away from the criminal justice system and into systems of care is occurring in multiple settings. This type of work is found in courts (Wilson et al., 2018), police departments, District Attorney (DA) offices, and community programs. In these settings, the ultimate goal is to analyze each individual case and redirect individuals who come in contact with law enforcement to the most appropriate setting, which may range from psychiatric emergency services at a hospital and substance detoxification at an equipped center, to referrals to outpatient providers and follow up with community outreach services (Kane et al., 2017). Bird and Shemilt (2019) support the notion that diversion work is a product of the movement aiming to decriminalize mental illness. Previously, untreated mentally ill individuals exhibiting behaviors due to their mental health symptoms (e.g., psychotic episodes, presenting with manic tendencies, substance use, etc.) were criminally charged, and placed into law enforcement custody. Such outcomes were in part due to the lack of other treatment options (Bird & Shemilt, 2019). Diversion initiatives seek to offset the conflation between active mental illness and criminal behaviors against persons and society, while introducing relevant resources to those in need (Bird & Shemilt, 2019).

A critical examination of the impact of diversion work is imperative to partnerships involving law enforcement and behavioral health, as the outcomes of diversion affect ongoing collaborations and communities alike (Kane et al., 2017). If diversion is effective and serves the

needs of the public, the partnerships are reinforced. For instance, police departments see increased value in behavioral health providers, who advise on treatment options and assist in connecting individuals to resources (Widgery, 2020). Considering police are also tasked with community safety, having dependable partnerships is crucial, as effective diversion facilitates the delivery of adequate care and ensures individual and community safety (Widgery, 2020). In situations where these collaborations yield positive outcomes, there is increased incentive on both sides to promote and continue these partnerships (Orovwuje, 2008).

Crisis Intervention Teams (CIT) emerged as an approach to diversion in 1988, following the shooting death of Joseph Dewayne Robinson by Memphis Police. Mr. Robinson had a lengthy history of mental illness and was in the middle of a mental health crisis when law enforcement was called due to his behavior. He was observed holding a knife and engaging in self-injurious behavior. During this encounter with law enforcement, Robinson, a Black man, was shot and killed by eight White officers after refusing to surrender the knife (Ritter et al., 2010). A public outcry followed, demanding accountability from law enforcement and improved training. The absence of critical training for police in de-escalating mentally ill individuals created the need for specialized approaches such as Crisis Intervention Teams (Compton et al., 2008). CIT International guidelines note that approximately 20-25% of a department's officers should be trained in CIT (Compton et al., 2008). Contextualized as training that translates into team formulation, CIT goes beyond traditional training. The goal of CIT is the creation of teams of CIT trained officers within departments, who may then be accessed by their colleagues and collaborate on cases as needed. Under the oversight of a CIT coordinator, behavioral health calls are logged, necessary follow-ups are conducted, stakeholder meetings are scheduled, behavioral

health professionals are consulted, and community members are connected to resources (Watson et al., 2008).

Given the emergence of alternative forms of diversion, such as CIT and the broader forensic MDTs, it is important to examine the collaborations between team members and evaluate their effectiveness in addressing individual case needs and community expectations. Historical and present-day factors, paired with a current societal expectation of diversion away from the criminal justice system (Bird & Shemilt, 2019), have fundamentally shaped the work of forensic MDTs. Assimilation of diversion work into existing systems requires policy and legal changes. An examination of such factors and characteristics is provided in the following section.

Systemic Changes

In recent years, criminal justice reform language has focused on pertinent changes regarding juvenile offenders and interventions needed before custody is ordered (Bonnie et al., 2013). Focus has also been given to how the police arrest, detain and question young individuals (Galston, 2016). Some of these changes are the result of increased research on the adolescent brain. For instance, considering that the prefrontal cortex, the part of the brain involved in problem solving and impulse control, matures in early adulthood, reform efforts focusing on juvenile offenders have promoted changes regarding protocols for questioning by law enforcement, charging guidelines, and sentencing parameters (Bonnie et al., 2013). Consequently, legislative changes enacted in Massachusetts and across the nation have been developed to regulate law enforcement work, from hiring requirements and training mandates, to procedural regulations and disciplinary action. Massachusetts law (Commonwealth of Massachusetts, 2020, c.253) also includes language referencing law enforcement and behavioral health partnerships, training, and diversion efforts (Commonwealth of Massachusetts, 2020).

Hence, greater accountability of law enforcement creates a need for specialized training which is often facilitated by behavioral health providers.

It is pertinent to acknowledge the presence of police abolitionism in Black led movements first originating in the 1960s, such as efforts to address years of systemic racism and oppression (Bernier, 2021). Aiming to address bias and discriminatory police practices, these movements focused on equality and breaking the cycle of oppression (Bernier, 2021). Similarly, the 'defund the police' movement, which emerged after the death of George Floyd and the resulting national public outcry (Silverstein, 2021), calls for a portion of financial resources dedicated to police departments to be re-directed to social services. Major cities and small communities across the country have experienced this financial shift and outcomes from it are now being studied (Jilani, 2021). In particular, studies have focused on the re-distribution of funds and associated outcomes in addressing things such as poverty and education inequality.

Repercussions of racial disparities in policing go beyond the community. According to Smith (2002), minority communities are greatly over-represented in correctional facilities, with Black individuals six times more likely to get incarcerated than white individuals. Smith (2002) discussed this over-representation as a bias and representative of the need to mitigate oppression and inequality based on race. He also noted that absence of substantial social services in minority communities' left residents few options other than to call the police. This study analyzed the intersection between social and racial factors along with mental illness, exploring and inferring transformative change for the criminal justice and behavioral health systems (Smith, 2002). Attention on matters like White supremacy, anti-Black racism, and ableism, have all contributed to shifting away from the dominant narrative to an inclusive and empowering focus (Corneau & Stergiopoulos, 2012). Systemic change requires critical analysis of dominant systems that

traditionally favor White perspectives and beliefs. Both the systems of criminal justice and behavioral health have been viewed as oppressive and symbols of colonial dominance (Corneau & Stergiopoulos, 2012), highlighting the importance of challenging widespread structures.

In addition to these shifts within the criminal justice system, examining the impact of the COVID-19 pandemic is also critical in today's landscape. Amidst all its challenges, the pandemic has further exacerbated the crisis in the mental health system, contributing to the rising rates of mental health concerns, including rates of suicide (Javed et al., 2020). Tandon (2021) noted that suicide rates increased 3% from 2019 to 2020. Inequities that existed prior to COVID-19 became more prominent, with the gap between those able to access care and those unable to widening further (Altiraifi & Rapfogel, 2020). These inequalities are tracked along social and racial lines and became a prominent concern in the aftermath of COVID-19 (Altiraifi & Rapfogel, 2020). In addition to strains within the behavioral health system, the pandemic has also impacted the criminal justice system, which has experienced significant delays in the hearing of cases, longer custody placements for those who are the most vulnerable (minorities and those experiencing financial poverty), and greater difficulty in addressing previously identified issues of promoting systemic change (Dolan, 2021). Many of the present-day social justice movements have highlighted the need to address injustices brought to light by COVID-19. Given COVID-19's emergence in the United States in early 2020, research into this health crisis is still in its infancy, although overall rates of increased behavioral dysregulations in youth, higher rates of depression and anxiety in adults, increased rates of suicide, and a significant burden on the healthcare system have all been noted (Javed et al., 2020).

Current circumstances, including the impact of the COVID-19 pandemic and the sweeping effects from movements such as the deinstitutionalization movement, mass

incarceration, decriminalization of mental illness and criminal justice/mental health reform, are all felt at the individual and collective levels (Altiraifi & Rapfogel, 2020; Jakubec, 2004; Lamb & Bachrach, 2001). As a result, one must consider the impact of the individual on the system and the impact that the system has on the individual in return.

The criminal justice and behavioral health systems have traditionally focused on elements of social control, with a tendency to pathologize what does not align with mainstream beliefs (Lamb & Bachrach, 2001). In these traditional frameworks, individuals whose behaviors did not conform to the dominant narrative faced labeling, loss of civil liberties, social isolation, a lack of support, and forced conformity. This study aims to examine and address innovative approaches to combating systems of oppression and focusing on empowering the individual while addressing needs through a lens of equity and inclusion. To further examine this, forensic MDTs and the collaborations found between two different disciplines will be further reviewed.

Forensic MDTs

Forensic MDTs are at the core of this research. For the purposes of this study, forensic MDTs refer to teams made up of law enforcement and Behavioral Health Providers (BHPs) who work collaboratively within the law enforcement system to address complex case needs, manage risk, and provide pathways to appropriate care (Ferrara et al., 2019). Scher (2020) notes that law enforcement is trained to make quick assessments of situations, frequently in cases where information about an individual is limited. An example of this is an officer's reliance on information provided to police dispatch staff during a call for assistance. In addition, law enforcement historically trains to resolve matters efficiently and to clear calls quickly to be available for the next call for service (Scher, 2020). On the other hand, BHPs typically start off their assessment of an individual by completing an intake, including historical, current, and

collateral information. As these assessments are comprehensive, a clinical diagnosis may take time to fully formulate (Wallace, 2012). Consequently, each side of the forensic MDT views time differently – law enforcement relying on quick assessments and conclusions, and clinicians following a model that unfolds over time. Bridging the gap between these two approaches can be complex and time consuming. Each forensic MDT case has its own individual factors (specific clinical diagnosis, identified behavior that presents with risk, and substance use needs among others), which in turn requires a robust and comprehensive integration of treatment and care (Koenraadt, 1992). Identifying ways to link how law enforcement and behavioral health providers approach cases is critical.

The acuity and clinical complexity of cases today contributes to an increased need for integrated treatment interventions and more collaborative systems (Greenhalgh & Papoutsi, 2018). This is not always easy to facilitate, absent of issues, or seamless in its delivery. Dealing with a complex healthcare system, in addition to the challenges of insurance regulations and limited availability of providers, complicates the work of forensic MDTs. Additionally, these teams must consider the potential for legal and court involvement, as well as individualized needs, which may include housing, health insurance, and education. Other issues that arise are the potential for team members to view situations differently, shifting from a punitive lens to a therapeutic one, information sharing restrictions, disagreements over case needs, and struggles to effectively monitor user progress (Greenhalgh & Papoutsi, 2018; Haines et al., 2018). Aimed at helping their users address a variety of issues, forensic MDTs serve a dual role: to manage risk for the individual and community while also addressing specific treatment needs (Fuller & Cowan, 1999). Identifying factors that lead to MDTs operating well is a key component of this study.

In order to explore this collaborative work, a theoretical framework was necessary to inform this researcher of existing knowledge, areas of need, and to provide context for the research question. Noting that forensic MDT work is complex and multi-layered created a need for theories that are similarly framed. Included in this section are two theories noted to be the most applicable for this study: biopsychosocial theory and transformative justice theory. These theories were selected because of their focus on multiple information sources to examine phenomena. Providing depth to understanding an individual, situation, or event, these theories engage research in transformative ways.

Theoretical Framework

The study was framed with the biopsychosocial and transformative justice theories, which were used to inform the literature review and guide the study through a critical lens. Through these lenses, multiple factors, from historical and societal, to individual and systemic, contribute to the field of research in a comprehensive and thoughtful manner, highlighting systemic changes and their impact on existing collaborations between law enforcement and behavioral health providers. In order to carry out this research, it was important to also consider individual member and user experiences, institutional factors within the behavioral health and criminal justice systems, and structural elements inclusive of poverty, socioeconomic conditions, and political influences.

This study was underpinned by the biopsychosocial theory, which was developed by George Engel in the 1970s in response to the biomedical approach. Engel argued that the biomedical approach, in which individual mental health conditions were only viewed from a physical perspective, discounted other critical factors that could be impacting the individual's needs, such as potential psychological, personal, social, or environmental factors (Papadimitriou,

2017). According to Papadimitriou (2017) the biopsychosocial model allowed for a more empathetic and compassionate response to clinical needs, as it considered multiple factors that impact the individual as a whole. Engel asserted that psychosocial factors must be considered in addition to the biological in order for the model to be scientific (Smith, 2002). This theory also asserted that the individual's concerns, interests, ideas, and opinions must be weighed. Consideration of all these factors assisted in bridging the doctor-centered approach with the patient-centered approach (Smith, 2002).

de Ruigh et al. (2021) applied the biopsychosocial model to forensic work and conducted a study using the model to identify and compare the risks of re-offending between subgroups of detained juveniles. They concluded that the biopsychosocial model was useful in assigning individuals to appropriate groups and subsequently tailoring the intervention based on identified re-offending risks. In this instance and others, the biopsychosocial model has provided a comprehensive lens through which to analyze team member experiences and their ability to manage risk (de Ruigh et al., 2021). In the context of forensics, the biopsychosocial model may also help to explore the origins of crime, which has been debated for centuries. Criminal behavior has been characterized as free will, rooted in malice, as the result of biological pre-determinants in some contexts, and in others the result of social influences (Hunt, 2019). This variance in perspectives creates ambiguity and further emphasizes the lack of clarity in crime awareness in both the law enforcement and behavioral health systems. Given the historical lack of consensus regarding what causes crime, biopsychosocial theory provided valuable context to this study of forensic MDTs and their work.

Transformative justice theory emerged to examine factors that go beyond just the crime itself (Coker, 2002; Gready & Robins, 2014; Nocella, 2011). Transformative justice theory

highlights the need to look at what factors preceded the occurrence of a crime, as well as the individual qualities and conditions of the offender and the victim (Coker, 2002). The application of this theoretical approach has the goal of improving outcomes for all involved, including the offender, victim, and community (Nocella, 2011). Social and economic inequalities are also addressed within this theory, with the intention of improving long-term solutions and providing an ability to intervene where harm exists (Nocella, 2011). At its core, transformative justice theory strives to shift a negative situation into a positive one. Transformative justice theory focuses on the notion that change is greater than what takes place between two individuals and must include systemic changes as well. It is not about destroying and re-building systems but about engaging in collaborative work to shift harmful situations (Nocella, 2011). Coker (2002) noted that for change to occur, one needs to examine existing networks that support and reinforce problematic behavior. Transformative justice theory is used to assist in this process and to provide a framework for effecting change. Similarly, in order to effect change in the management of systems that perpetuate criminal justice involvement, this dissertation benefits from using a theory that examines these complexities through a critical lens. Its relevance is evident as it holds space for both individual and collective factors, while addressing systemic oppressions and the need to engage in transformative change at the community level.

Hence, the biopsychosocial and transformative justice theories provided a synthesized theoretical framework for this study. The biopsychosocial theory framed individual needs in a holistic way, examining the individual perspective through an integrated approach that includes predisposing, precipitating, perpetuating, and protecting biological, psychological, and social factors. Transformative justice theory then expanded upon the biopsychosocial focus to identify

collective and transformative ways that a system can address criminal justice, with the goal of maximizing positive outcomes for the individual and society.

Empirical Literature Review

Literature Review Process

In the literature review, an electronic search was performed on the following databases: Criminal Justice, Embase, PubMed and PsycINFO. Only peer reviewed articles published after 2000 were included in this review, given that a marked shift in community behavioral health needs occurred after the Crime Bill of 1994. Key words used in each search included *"behavioral health* AND *forensics," "law enforcement* AND *behavioral health," "forensic MDTs," and "MDT".* An ancestry search of the references from the identified articles uncovered additional pertinent sources that were included in the review. Articles were first screened by title and duplicate records were removed. Published studies containing the key words were further evaluated and selected based on the inclusion/exclusion criteria. Because of the limited research conducted on forensic MDTs, articles that include the presence of healthcare staff working in collaboration with law enforcement were also included. In addition, for expanded review and reference, MDTs in non-forensic settings were also included, as common themes may present. Referenced in this review is an examination of team member and user experiences, acuity of cases assigned to the team, treatment, and risk management. Media and non-scholarly articles were also included in this work given the recent attention in the news of law enforcement responses to behavioral health calls.

In this study and literature review, members are defined as professionals working on the MDTs and users are defined as individuals receiving care from the MDTs. Main discussion points outlined below include the experiences of forensic MDT members, experiences of users of

forensic MDT services, management of individual and community risk, comparison of traditional law enforcement interventions and new approaches, collaborations among disciplines.

Previous Research

Research into forensic MDTs has been limited, consequently leading to this researcher's examination of MDTs in other settings such as hospitals, where the research is more extensive. MDTs have operated for many years within hospital settings due to this model's similarity to medical care where multiple experts may be required. However, these MDTs still tend to focus on one discipline: in this case medical. Members from different fields on these teams (outside of healthcare) are very unlikely and therefore difficulties experienced by MDT members from vastly different professions may be absent from analyses of medical MDTs (Geach et al., 2019). As a result, it is difficult and not fully reasonable to apply all findings from research on MDTs to forensic MDTs. Given the specialization of forensic MDTs (law enforcement and behavioral health), studies examining their unique qualities are needed.

Expanding beyond this, the research that does exist on forensic MDTs tends to focus on structured and secure locations, for example state psychiatric hospitals (Haines et al., 2018). The environmental conditions make these studies also not entirely transferable to forensic MDT work found in the community. Research shows that environmental factors are important to consider, therefore creating an important distinction between examining forensic MDTs in secure locations and forensic MDTs in community settings (Geach et al., 2019). Teams located in structured locations typically fall under one administration, legal guidelines, policies, and information sharing protocols. These elements become far more complicated when integrating different administrations, professions, legal guidelines, policies, and information sharing protocols. Therefore, further research into forensic MDTs within community settings is an area of

significant need. This literature review indicates that the field of research has not kept up with the expansive growth of community forensic MDTs.

Looking at transformative change and its impact, Leese and Fraser (2019) examined how MDTs run team meetings in a forensic setting, finding that even small changes such as less-formal settings (for treatment engagement) and transparency in progress reports, produced better MDT outcomes. Transformative change was defined as change made that correlates to better outcomes for both members and users of MDTs. It was found that seemingly small changes from the treatment provider's perspective can impact outcomes for the user. Moving past this, an examination of the primary responsibility of forensic MDTs is critical. Fuller and Cowan (1999) evaluated the judgements of multidisciplinary teams and risk assessment capabilities, concluding that assessment of case needs is important because this impacts the planning of services and care. In addition to assessment, the ability to provide management and oversight of case needs is another critical factor in the creation of effective MDT interventions, and one often lacking in team capacity. Guldimann and colleagues (2016) examined the implementation of a forensic MDT in Switzerland, concluding that forensic experts support public officials in the assessment and management of individuals with concerning behavior via close cooperation. This is an example of a forensic MDT engaging in both assessment and management of case needs (Guldimann et al., 2016).

The examination of forensic MDTs includes a comparison of this model to traditional law enforcement approaches. Harris and Lurigio (2012) reviewed these traditional approaches to managing risk assessment, concluding that the outreach and collaborative elements of forensic MDTs are in fact critical components to preventing targeted violence. Finding that traditional approaches may miss opportunities for proactive engagement, Harris and Lurigio's work

highlights value of the non-traditional approach of forensic MDTs. Another part of the examination of forensic MDTs requires an evaluation of the referral systems in place for cases. Orovwuje (2008) reviewed the referral, assessment, and treatment interventions used by forensic MDTs to gauge their efficacy, recommending that a shared common philosophy among forensic MDT members assisted in tailoring care to the needs of the individual user. This in turn led to better management of referrals and cases.

Similarly, an important phenomenon to examine is the experience of forensic MDT members and its impact on team outcomes. Geach et al. (2019) recruited the assistance of clinical psychologists with experience in team formulation, concluding that addressing factors obstructing team formulation such as team distress, identified as a negative emotional state that can arise from the work and team dynamics, is critical to the outcomes of team formulation in practice. Short et al. (2019) conducted research into team formulation, concluding that increased understanding among members and space to reflect contributed to improved team collaborations and outcomes. Brown et al. (2017) tracked specific experiences impacting members such as stress and burnout rates, concluding that burnout rates may be higher among this population of professionals, compared to their non-forensic counterparts, by virtue of the content of the work. This collectively also highlights that positive ways to manage potentially harmful experiences is critical to team member satisfaction and effectiveness.

Moving into a critical analysis of existing interventions, Kane and colleagues (2017) examined the impact of several police related mental health interventions, comparing them to one another, concluding that these approaches demonstrate a positive outcome, defined as increased awareness of behavioral health needs, increased access to relevant resources, and higher rates of diversion away from the criminal justice system. With a long-term perspective in

mind, Bird and Shemilt (2019) focused their attention on the lasting impact of pre-arrest diversion. Their work critically aligned with the work of forensic MDTs who engage in diversion efforts. Short-term outcomes included a reduced risk of arrest compared to controls; however long-term outcomes did not show as strong of a correlation. Regarding mental health outcomes, diverted individuals were more likely to receive counseling and medications. They concluded that additional research and funding strategies are needed to systematically evaluate outcomes, since sustained efficacy over time is an important focus.

Mohan and colleagues (2004) explored the clinical characteristics of community forensic mental health services, concluding that integrated and parallel models of community forensic mental health teams differ in approaches and outcomes. These differences include management of the case, information sharing, treatment planning, and overall outcomes. As an example of an integrated model, forensic MDT outcomes can be compared to parallel models found in the community (a behavioral health provider who receives an individual sent to the hospital for an evaluation by the police). Along this line, seeking to apply MDTs to specialized crimes, Herbert, and Bromfield (2019) examined how MDTs responded to crimes against children, finding that they were more effective in improving criminal justice and mental health responses, compared to standard agency practices.

From the individual user's perspective, Shepherd et al. (2015) looked at personal recovery within forensic settings, concluding that forensic provider awareness of patient needs assisted in a positive transition between institution and community. As stability in the community and good life quality are goals of forensic MDTs, Shepherd and colleagues provide valuable context to this work. Haines et al. (2018) examined MDT functioning and decision making within forensic mental health, concluding that MDTs should give users increased

responsibility and input regarding their care. This echoes the work of Shepherd et al. and contributes to the theme of user engagement in their care.

Based on the body of current research, issues that emerge at the intersection of criminal justice and behavioral health build on historical and social movements discussed earlier. The first theme that emerged is one concerning MDTs, which can encompass a variety of disciplines, such as medical, educational, and behavioral health personnel. The purpose of such teams is to develop a shared understanding of the individual served in order to determine the appropriate interventions (Short et al, 2019). Considering forensic MDTs at a macro level, the systems of criminal justice and behavioral health are manifestations of years of historical and social contexts that impact collaborations. Impactful factors noted in the literature include: the deinstitutionalization movement, mass incarceration, decriminalization of mental illness, and a focus on diversion work.

At a micro level, this literature review yields themes that emerge related to MDT member experiences (Brown et al., 2017) and users' experiences (Shepherd et al., 2015). Although this study focuses on team member experiences, this literature review notes a correlation between users' experiences and team effectiveness, thus showing a reciprocal relationship (Bird & Shemilt, 2019; Compton et al., 2008). When users feel empowered and heard, their outcomes (social functioning, relationships, treatment compliance) improve (Haines et al., 2018; Marshall & Adams, 2018).

Although the previous studies identified that diversion work and integration of the disciplines of law enforcement and behavioral health contribute to some positive outcomes, no known studies have explored how systemic changes and current social events are impacting forensic MDTs, indicating that there is a knowledge gap that warrants further exploration. It is

the goal of this researcher to build on existing literature and contribute to the study of forensic MDTs in expansive and transformative ways.

Summary of Member and User Experiences

As the focus of this study was on forensic MDT member experiences, it is important to thread together the areas that emerge from existing research and their impact on team effectiveness which include: the need for accessibility to trainings (Brown et al., 2017), the presence of varied opinions among team members leading to altered relationships, the role of feelings and behaviors of team members (Short et al., 2019), an examination of factors that impact perceived effectiveness and improved team work (Short et al., 2019), the possession of a shared philosophy towards the population MDTs serve (Orovwuje, 2008), an awareness of overall cost savings through diversion (Bird & Shemilt, 2019), and the benefits of a specialist approach (Fuller & Cowan, 1999; Guldimann et al., 2016; Harris & Lurigio, 2012; Herbert & Bromfield, 2019; Kane et al., 2017; Mohan et al., 2004).

Overall member experiences also correlate with the team's ability to meet members' needs and to bring focus to areas of concern such as emotional exhaustion. Reviewing research done by Howard (2009), Brown et al., (2017) stated that "staff working in a forensic unit had slightly higher levels of emotional exhaustion than those who worked in the community" (p. 234). However, this study also noted a greater sense among staff of personal achievement and a lower fear of violence. Participants ascribed these outcomes to having supports in place for the staff and a perceived difference in personality characteristics of professionals in forensic contexts, including MDTs.

Existing research on users' experiences includes the expressed need for safety and security (Shepherd et al., 2015). Shepherd and colleagues (2015) identified that safety was a pre-

requisite for any patient during the recovery process. Without a sense of safety, recovery was hindered. Another critical area of focus was the importance of social approaches (Marshall & Adams, 2018). Social approaches are described as any engagement by staff with the individual which sets the tone for the intervention, treatment planning, and potential outcomes. Marshall and Adams (2018) noted that a social approach from staff towards the patient begins at the point of admission and intake and assists in facilitating a collaborative and engaging dynamic. An additional important finding is the impact of societal stigma on individual recovery and the user of forensic MDT services (Marshall & Adams, 2018). Stigma was found to have a negative impact on the progress of an individual. Due to the social, economic, and psychological impact of stigma, addressing stigma is critical in order to maximize recovery. Along these lines, aligning with empowerment of the patient's voice and decision making, which is inclusive of a social approach and efforts to de-stigmatize their experience, is critical. It was noted in the literature that improved communication with team members (Leese & Fraser, 2019), and increased responsibility about their own care and future (Haines et al., 2018), improved user recovery and minimized risk to self and others. Users' perspectives are typically marginalized (Leese & Fraser, 2019) and not considered in team discussions. However, increased input and contribution from people receiving MDT services has correlated to increased team success (Marshall & Adams, 2018). Team success is defined as increased user engagement in services, with decreased concerns reported.

With a growing understanding of the themes that contribute to MDT operationalization, it is important to consider how they are extrapolated and applied to this study's research purpose. Themes that emerge from both the member and user's perspectives are critical to establishing what research has uncovered thus far and what remains to be further analyzed. Given the

relatively limited research on this topic thus far, member and user themes provide insight into the interventions and approaches that are beneficial to team development and highlight areas that require expanded attention.

Forensic MDT Themes

The literature review revealed several themes specific to forensic MDTs. The need for specialized training (Brown et al., 2017) that encompasses psychosocial content and increased knowledge and understanding of mental health disturbances (Short et al., 2019) is critical to law enforcement and BHPs alike. Training is effective in helping to increase awareness across disciplines (Bureau of Justice Assistance, 2021). Given the differences in experience and professional backgrounds, training supplies key information needed to bridge existing gaps. In addition, Geach et al. (2019) noted the ability to manage team distress as a critical element to overall team functioning. Because of the higher risk, complexities, and associated stress found in forensic MDT cases, a closer examination of this theme is pertinent. Distress in teams can emerge at any point, particularly when disciplines with vastly different backgrounds come together to work in unison towards a shared goal. In such instances, stress may be more prominent, which then leads to distress (Geach et al., 2019). Teams able to manage this distress show better outcomes for members and users. In addition, perceived increase in team effectiveness leads to improved collaborative work (Short et al., 2019).

In forensic MDTs, the ability to handle stress is crucial for overall team success. It can also be more complex in forensic MDTs since law enforcement and BHPs are typically trained to view populations and behaviors differently. Collaborative work leads to good links between both fields and provides a specialist approach for the user (Fuller & Cowan, 1999; Guldimann et al.,

2016; Harris & Lurigio, 2012; Herbert & Bromfield, 2019; Kane et al., 2017; Mohan et al., 2004).

Regarding users' experiences, safety and security appear critical to their ability to engage productively with MDTs (Shepherd et al., 2015). This resonates within forensic MDTs as well, given the potential for criminal charges and court involvement. User faith in the forensic MDT's goal of helping to meet case needs is imperative for team effectiveness and success. The presence of supportive social networks is also critical to the well-being of users (Marshall & Adams, 2018; Shepherd et al., 2015). Applying this to forensic/mental health cases is significant, as certain users face a harder time finding supportive social networks, especially those with sexual offenses (Parton & Day, 2002). Along this line, the issue of stigma reduction is another reported area of focus. Marshall and Adams (2018) noted that individuals in forensic systems face dual stigma: that of mental illness and association with criminal activity.

Another theme to emerge was a review of two types of MDT work, the historic (parallel) and new (integrated) work. The parallel approach involves law enforcement and behavioral health working in silos on a case, with little if any interaction present whereas the integrated approach mirrors the collaborative approaches of MDTs. Taking the identified themes and applying them to the collaborations among law enforcement and BHPs is a critical component of this research. This dissertation examines the experiences of forensic MDT members who engage in integrated work and explores the advantages and disadvantages of such collaborations when responding to behavioral health crises. Some of the identified themes, for example safety and management, resonate with both team members and users. An ability to handle distress and to provide autonomy for users in decision-making are found to be consistent areas of focus in the literature. Determining these themes assisted in identifying relevant methodologies, which in

turn provided the framework for this dissertation work. The following section provides an outline of the methodological literature review that informed this study.

Methodological Literature Review

Among the most prominent methodological designs found in the review of literature on MDTs are the following: use of case study (Fuller & Cowan, 1999; Guldimann et al., 2016; Harris & Lurigio, 2012; Leese & Fraser, 2019; Orovwuje, 2008); surveys (Geach et al., 2019), focus groups (Mohan et al., 2004), and mixed methods (Haines et al., 2018). The literature has demonstrated a precedent and rationale for choosing a qualitative case study design type, including surveys and focus groups as data collection tools, when studying MDTs. Case study provides a multi-faceted and in-depth examination of a complex issue, and this aligns well with this study's research questions. Surveys are used to recruit participants, collect data, and provide multiple methods of instrumentation (Ponto, 2015). They can also be effectively used in both quantitative and qualitative studies, as well as mixed methods. Focus groups is another design used in qualitative research, comprised of a group of purposely selected individuals (rather than a statistical representation of a population), with the intention of understanding a social issue (Nyumba et al., 2018). For this study, a dynamic and interactive representation of MDT work was desired, and the dynamic found in focus groups was a critical piece.

In addition, common data collection methods used include interviews (Marshall & Adams, 2018), database searches (Brown et al., 2017; Short et al., 2019); and systematic literature reviews (Bird & Shemilt, 2019; Brown et al., 2017; Herbert & Bromfield, 2019; Kane et al., 2017; Shepherd et al., 2015). Given that the goal of this study was to examine the advantages and disadvantages of collaborations among law enforcement and behavioral health

providers on multidisciplinary teams when responding to behavioral crises, focus groups was the best-fit method of data collection.

Summary

This chapter described the historical and social contexts and events that positioned law enforcement and BHPs in forensic MDTs today. Working in silos, these two professions have traditionally adopted divergent philosophical perspectives and received varying preparation and training. One critical reason for the formation of forensic MDTs, and of bridging these gaps, is the increasing complexity of cases. Inclusive of both behavioral health needs and law enforcement involvement, the cases handled by forensic MDTs are often clinically complex with more risk concerns for both MDT members and users (Harris & Lurigio, 2012). In addition, social movements such as the deinstitutionalization movement, the concerns over rising incarceration rates in the 1970s, and the subsequent push to decriminalize mental illness, have paved the way to, and underscored the need for, collaborative partnerships between law enforcement and behavioral health (Guldimann et al., 2016).

In conclusion, this research is important as it seeks to understand the intersection of law enforcement and behavioral health. It is imperative to our communities that ability to meet complex needs, both from an individualist and collectivist perspective, exists. With a greater understanding of forensic MDTs, MDT work can be more effective which leads to better outcomes for the users. These improved outcomes lead to addressing behavioral health needs which in turn improve quality of life for MDT users and job satisfaction for MDT members. The ability to analyze complexities, troubleshoot systemic issues (such as long waitlists, insurance disruptions, etc.), and work collaboratively to offer the best of both law enforcement and behavioral health interventions is central to the work of forensic MDTs.

CHAPTER 3 METHODOLOGY

Introduction

Forensic multidisciplinary teams (MDTs) are teams comprising of both law enforcement and behavioral health providers. As discussed in chapter 2, multiple social and legal changes have shifted the focus of management of clinical needs and risk, either towards self or others, from secure settings (e.g., hospitals or jails) to community settings. The extensive scope of these cases, including management of risk, clinical needs, and other factors such as social, housing, and financial, necessitates multidisciplinary collaborations.

Generally, forensic MDTs get engaged with cases that have both criminal justice and behavioral health implications (Ferrara et al., 2019). Anecdotally, these teams can vary in capacity depending on years in existence, member composition, unique team factors, and overall work quality. The ability to monitor case progress, connect an individual to resources, assess treatment compliance, and manage risk, is dependent on the intricacies of forensic MDT collaborations related to team membership and types of cases. Chapter 3 outlines the methodology that was used in this study to examine the specific experiences of forensic MDT members. The data gathered in this study came from team members representative of the disciplines of law enforcement and behavioral health, by focusing on their perceptions of the collaborations found in forensic MDTs. Given the active and ongoing changes to the criminal justice and behavioral health systems, this research comes at a critical time when this kind of collaboration has yet to be thoroughly examined.

The research question framing this study was: What are the main advantages and disadvantages of collaborations among law enforcement and behavioral health providers on multidisciplinary teams when responding to behavioral health crises? Using a qualitative case

study approach, this study aimed to 1) understand how communication between behavioral health professionals and law enforcement can impact their ability to collaborate; 2) uncover how information sharing between both disciplines can influence outcomes; 3) describe the perceptions of members of both disciplines regarding levels of case engagement.

According to Yin (2013), in case study qualitative research, there are three categories of analysis: the single instrumental case study, the collective or multiple-case study, and the intrinsic case study. Ultimately, the main purpose of this design is to derive data from all levels of analysis. In a single instrumental case study, a specific issue is identified, and a single case study used to examine this issue. In a collective or multiple-case study, a specific issue is again identified. However, instead of focusing on a single case study to examine the matter of interest, multiple case studies are selected and analyzed in order to demonstrate different explanations for the particular phenomenon. Lastly, the intrinsic case study uses the case itself as the focus (Creswell, 2007) to examine a program or unique situation. This study was framed with an instrumental case study design, building from individual team member experiences to examine forensic MDTs.

To conduct a comprehensive examination of forensic MDTs, data was collected from multiple sources. Yin (2013) proposes six possible sources of data in case study research: documents, archival records, interviews, direct observations, participant observations, and physical artifacts. For the purposes of this research study, virtual focus group interviews were the primary data source. This decision was made considering that data obtained through this method can be rich and contextual, especially related to social science research (Smith, 2018). The use of this robust source of information gave the researcher the ability to substantively understand the experiences of team members regarding their collaborative relationships within MDTs. After

collecting the data through the focus group interviews, a data analysis process was used to unveil codes and possible common themes. A secondary data source were pre- and post-questionnaires. These questionnaires were added to bracket the study and provide multiple sources of data.

A semi-structured interview model guided the focus group process, in which each member responded to specific questions and prompts, including providing information regarding their professional affiliation, experience doing individual assessments, experience working collaboratively, their impressions of advantages and disadvantages of working with the other discipline, their impressions of working on an MDT, and their ideas about team process (see Appendix A for interview prompts). After each focus group was completed, the interview was transcribed and analyzed so initial codes could be attributed to each of the transcripts, identifying relevant themes. A thematic analysis between transcripts completed this process, tracking common themes, finding areas of strength and weakness of MDTs. Morse's guide (as cited in Houghton et al., 2015) for thematic analysis was used including broad coding (comprehending), pattern coding and memoing (synthesizing), distilling ordering, testing executive summary statements, and developing propositions. The overall case study analysis was then compared with existing knowledge described in the literature review with a goal of discovering similarities and differences.

Ethical Considerations

Issues of power differentials were considered throughout the study (Creswell & Poth, 2018). Participants were informed of all steps of the process, including how their data would be analyzed, who would have access to the data, and how the data would be used in the context of the study purpose. Protection of participants was fundamental, and this study was approved by the Lesley University Institutional Review Board (IRB). All elements of the study's procedures

were examined by the IRB, including the participant recruitment effort, informed consent, data collection protocols, data management, and plans for data analysis. Personal and health protected information was not discussed in these interviews, thus not engaging HIPAA standards or guidelines. Given the nature of the study, it was unlikely that the focus groups would be distressing. Though no requests for additional support were made, a list of resources from the Department of Mental Health's network was available to participants, in the event that anyone needed support following the group. Data was recorded on an Atto Digital Voice Recorder which was kept in a locked drawer in the researcher's locked office. The data obtained in interviews was transcribed using NVivo 12, a qualitative research software tool.

Given this researcher's familiarity with forensic MDTs, it was important to reflect on potential bias. Ponterotto (2005) referenced the significance of a researcher *bracketing* their biases and beliefs. Any potential biases and pre-existing beliefs are named in the methods chapter reflexivity section and discussed with validity measures as well. Mindful of researcher bias and impact, bracketing occurred throughout all phases of this research to minimize effect on the study outcomes. Seeking to examine how initial themes from this study's findings compared to other studies of forensic MDTs, this study acknowledged areas of potential conflict and engaged in mitigation efforts, such as ensuring the studied forensic MDTs were not ones on which this researcher was a member. Given the limited research available on forensic MDTs, this study has the potential to affect this research field in several ways. This study seeks to examine themes, analyze impact, and illustrate areas of conflict and growth.

Due to the increased attention on law enforcement in the United States, and debates regarding their role in mental health matters, this study occurred at a critically relevant time. Ensuring that all aspects of the study were grounded in sound epistemology, theory, and

methodology, increased the likelihood of applicability, and use of this study to support ongoing research of forensic MDTs. With these elements in mind, this study aimed to address a gap in current research.

Reflexivity

In this study, the researcher's own experiences were essential in identifying the research topic as one of interest. The researcher is a licensed mental health counselor in the state of Massachusetts with seventeen years of experience in both forensic and community settings. As the person responsible for the data collection and with personal experience working on forensic MDTs, the researcher was able to establish trust more easily in the researcher-participant dynamic due to her relevant experience and the mutual familiarity between herself and her prospective participants. In addition, the researcher's awareness of the capabilities and limitations of both professions (law enforcement and behavioral health), likely streamlined the focus group interview process and eliminated the need for clarifications around terminology used in the field and referenced protocols. Reflexivity was a critical aspect of this work and was considered within the data collection and analysis.

As a member of several forensic MDTs, the researcher has experience with teams that operate cohesively with outcomes reflective of user progress and benefit. Similarly, familiarity exists with teams that struggle in key areas, such as information sharing, common goals, positive working relationships, which in turn relate to poorer user outcomes. Given this experience, the researcher had a bias related to areas of focus for this research and assumptions regarding what assists teams in working effectively and what hinders their progress. Some of these assumptions related to effective implementation include familiarity with complex cases, a willingness to work across disciplines, and a proactive engagement in matters. Personal interests and areas of

aspiration lie in the ability to support assumptions with this study's findings. It was also this researcher's intention to consider power differentials between team members and users, while studying what factors promoted team outcomes and which factors did not.

Social Justice Implications

The topic of diversion exists at the intersection of the criminal justice and behavioral health systems. As such, the populations that forensic MDTs work with are intricately connected with social justice matters. Examining the dynamics between law enforcement and behavioral health professionals is likely to support the identification of the needs of a population that has historically been marginalized, and experienced discrimination in various forms (e.g. financial, social, racial, systemic). Efforts to correct this, while providing valuable resources and integrated care, are significantly underway and this research seeks to play a role. The lack of extensive literature and research related to forensic MDTs, paired with the historical importance of social justice movements today, presents an inherent timelessness for this study. In addition, the impact of this work on the disciplines represented in this study is expansive – including informing policy and protocol changes, as a result of the growing social justice momentum. Forensic MDTs prioritize connecting individuals to services while addressing common barriers. For that, they represent a step forward for social justice.

Pilot study

In preparation for the methodological approach described in this chapter, a small pilot study was conducted. The research inquiry focused on areas of benefit of MDT work and areas of growth. The pilot study was in-person and took place at the researcher's office and three participants were included. One participant was from law enforcement and two were behavioral health providers. A semi-structured interview was used to elicit information from the participants

that was reflective of their experiences, beliefs, and thoughts. Sensitive matters, including information sharing, potential conflicts within multidisciplinary teams, and liability concerns, were all accounted for in the design of the pilot. Considering the small sample size of the pilot, initial themes that emerged centered on the perceived value and impact of forensic MDTs, information sharing protocols, perceptions around liability and responsibility of each individual case and outcome, and systemic limitations in the management of individual case needs. Of note, both professional groups identified a sense that newer clinicians today are not sufficiently trained to manage crises and thus rely on the police for non-police related matters. This pilot study was helpful in modeling the initial recruiting efforts, outlining a description of the study purpose, honing the interview guide, practicing the actual interviewing process, and reviewing the participants' responses. This activity afforded a modified version of what the dissertation process would entail, thus enhancing preparation and readiness for the full study.

Study Setting

The dissertation study encompassed Department of Mental Health (DMH) supported projects, and included BHPs affiliated with Jail Diversion Program (JDP) contracts and police departments who were involved in programs using multidisciplinary teams in the state of Massachusetts. These projects were suitable given their membership composition of both law enforcement and behavioral health professionals. The expansive coverage of these teams throughout the Commonwealth of Massachusetts allowed for a variety of member experiences.

Population, Sampling, and Sample size

In this study, the main inclusion criterion was professional participation in a forensic MDT in Massachusetts. Participants included representatives of both the law enforcement and behavioral health fields who were able to communicate verbally in English. Purposive sampling

was used to recruit participants who had experience on a forensic MDT and met inclusion criteria (Creswell & Poth, 2018). Data from the focus groups was analyzed for richness of content and depth of responses given. The quality and depth of the data was the focus rather than the sample size, until saturation was reached (Dibley, 2011). Case study as a methodology, impacted the sample size, with 5-50 interviews generally considered adequate (Dworkin, 2012). The composition of the groups was one group of behavioral health providers and one group of law enforcement personnel.

Recruitment

Recruitment was facilitated by the researcher's pre-existing knowledge of current forensic MDTs, as well as reliance on known professionals who were involved in the field in her home state of Massachusetts. An email relating the purpose of this study was provided to existing forensic MDT members throughout the Department of Mental Health with the researcher's contact information included (Appendix B). Upon contacting the researcher, in response to the email, each participant was given an overview of the study's purpose and procedures, and they were given a Qualtrics survey with the consent form and demographic questionnaire (Appendix D) included. The informed consent form (Appendix C) was signed before participants engaged in the study. There was no financial compensation or incentives for doing the study. Each potential participant was screened by the researcher to ensure inclusion criteria were met.

Data collection, Management, Analysis

Virtual focus groups were facilitated after a sufficient number of participants had been recruited. Once this number was obtained (identified as 12-25), the researcher assessed participants' scheduling availability and worked to ensure focus groups were scheduled accordingly. A meeting link was then emailed to all focus group participants. All focus groups

occurred through the Zoom virtual meeting platform. Standard introductions took place, and each participant was afforded the opportunity to ask any clarifying questions in advance of the focus groups commencing. A case study design using standardized questions was used with all participants. The process of data collection and analysis was reviewed with the participants. In addition, redaction of identifiers in the transcript took place and although absolute anonymity could not be guaranteed, all foreseeable efforts were made to de-identify information provided. Identification numbers were assigned to each participant and used in lieu of names. Inclusion of identifiers, such as a name, did not take place in publication.

Permission to use an Atto Digital Voice Recorder or the selected platform (Zoom) to record the focus group interviews was gathered in writing by obtaining participants' electronic signatures on a PDF document. Focus groups followed a semi-structured guide, permitting expansion on answers that were reflective of unique experiences. The data analysis included use of the NVivo 12 software, so written transcriptions could be obtained. Codes were identified and logged using Microsoft Word. Codes were then used to identify overarching themes, which focused on the experiences of forensic MDT members, information sharing, and their engagement with cases.

Data analysis procedures included the framework developed from the four stages of analysis as outlined by Morse (1994, as cited in Houghton et al., 2015), which included comprehending, synthesizing, theorizing, and recontextualizing (Houghton et al., 2015). Strategies used by Miles and Huberman (1994) were used to actualize this framework. This process included content analysis, which focused on identifying prominent themes found in the data. Additionally, these strategies included broad coding (comprehending); pattern coding and memoing (synthesizing); distilling, ordering, and testing executive summary statements

(theorizing); and developing propositions (recontextualizing) (Houghton et al., 2015). Only participants were provided the zoom link (which also required a password for access), and they were prompted to be situated in private locations for the duration of the study. Data was stored and protected in locked cabinets located in the researcher's secure office. Electronic data was stored in a password protected computer to which only the researcher had access.

Rigor

In qualitative research, trustworthiness and applicability are the essential measures to evaluate the quality of the outcomes (Agius, 2013). Ways to assess for trustworthiness included the use of direct quotes from interviews, researcher field notes to provide consistency or clarity, and thick textual descriptions of the data collected (Agius, 2013). Additionally, trustworthiness was promoted by the researcher's credentials, triangulation of the data collection/analysis measures, and member check-in at each step in the process. The merit of qualitative research is based on the way it is conducted, the procedural decisions made by the researcher, and the specifics surrounding data generation, analysis, and management (Hammarberg et al., 2016). All documentation generated from this study was preserved, including focus group questions/answers, notes taken, researcher field notes, transcription records, coding of data. All generated materials were preserved in a designated locked cabinet in the researcher's office, with electronic data secured with a password only known to the researcher. Materials will be stored for 12 months following the completion of the study, at which time they will be destroyed through the use of a shredder and deletion from the electronic files stored on the computer (also eliminated from the computer's recycling bin).

Ongoing examination of the rigor of this study required consideration of other criteria relevant to qualitative studies. In quantitative studies for example, validity is an important

indicator. Lincoln and Guba (1985) note that a commensurate indicator in qualitative studies focuses on credibility. To achieve this they identify prolonged engagement, persistent observation, peer debriefing, negative case analysis, triangulation, and referential adequacy as measures researchers can take. Negative case analysis is important in qualitative thematic analysis because it allows this researcher to consider what is missing. Peer debriefings were accomplished with the support of the researcher's doctoral cohort and a peer. Triangulation occurred with the use of transcripts, field notes, questionnaires. The above were considered as multiple measures of credibility of this work. For the purposes of this study, prolonged engagement and persistent observation were not carried out, given the timeframe of the focus groups.

Close observation took place during the course of the experiential activity. This activity allowed the researcher to focus on the characteristics of a situation, in this case a police call involving a behavioral health issue, that was relevant to the study focus. Following exposure to this activity, participants were given prompts to discuss their analysis of the encounter. Additionally, they were asked to compare an MDT response to a similar situation.

Peer debriefing also took place in this study involving a colleague with expertise in qualitative research and the subject matter studied. Once the codes were identified, they were analyzed with the peer debriefer. Following this step, the thematic analysis was also discussed with the peer debriefer to ensure that all codes and subsequent themes were fully developed. Negative case analysis was engaged during the review of the transcript. One participant suggested that introducing behavioral health on a law enforcement call may result in a disagreement about what outcome is best. This participant noted that an MDT response may actually increase the risk of legal issues and liability. The presence of negative case analysis

allowed the researcher to consider what may have been missing from the study. Negative case analysis yielded that additional time to discuss points of disagreement was useful as well as an opportunity to debrief after the focus groups. Triangulation of the data was also a critical piece of this study's rigor. This was done with the use of the transcripts, field notes, questionnaires, and a peer debriefer. Transcripts were reviewed multiple times. The first time was for grammatical accuracy and proof-reading purposes. Subsequent reviews focused on the coding process and ensuring a comprehensive analysis took place. The researcher then began the thematic analysis of the transcripts. Both the coding process and thematic analysis were reviewed by the peer debriefer. Relevant points and questions were addressed in the follow up discussion between the researcher and the peer debriefer.

In addition, a comprehensive analysis of all available data was completed, including a review of the focus groups' recordings and post questionnaires. Researcher field notes rounded out the triangulation of the data. Ongoing examination of the rigor of this study requires consideration of other criteria relevant to qualitative studies. Three major stages characterize the constant comparison analysis. During the first stage (open coding), the data are chunked into small units. The researcher attaches a descriptor, or code, to each of the units. Then, during the second stage (axial coding), these codes are grouped into categories. Finally, in the third and final stage (selective coding), the researcher develops one or more themes that express the content of each of the groups (Strauss & Corbin, 1998, as cited in Onwuegbuzie et al., 2009).

In qualitative studies, rigor is also measured by trustworthiness and applicability (Agius, 2013). Trustworthiness is assessed with the use of direct quotes from interviews, field notes gathered, and thick textual descriptions of the data collected. The researcher's credentials and member check in at each step of the process also impact trustworthiness. For this study member

check in occurred with the peer debriefer and the researcher's doctoral study group. Synthesis of the data and theme development took place over a series of steps to ensure credibility. Repeated readings of the transcripts, discussions, and revisions of the themes took place. Themes were compared among participants and focus groups, this step also required reading, discussions, and revisions. These themes were connected to the themes identified previously in the literature review chapter. Finally, the researcher evaluated these themes and discussed them with the peer debriefer. A final interpretation of the findings was reported out (Shepherd et al., 2015).

Limitations

The advantages of case study as a qualitative design have been extensively studied. This method is commonly found in the social-sciences and practice-oriented fields, for example education and social work (Starman, 2013). There is a significant interpretative nature to qualitative research, which captures subjective experiences and aims to study these phenomena. These subjective views extend to the researcher, who is gathering, analyzing, and explaining the associated data. Simons (2009, as cited in Starman, 2013) noted that "case study is an in-depth exploration from multiple perspectives of the complexity and uniqueness of a particular project, policy, institution, program or system in a real life" (p. 32). As a result, the experiences of this study's participants are specific to their social and professional backgrounds and contexts and cannot be generalized. Applicability rather than generalizability is the desired outcome from this qualitative case study design.

Another limitation may have been the researcher's bias during the interpretative process. The researcher's personal experience and familiarity with forensic MDT's comes from participating in several of them throughout the state of Massachusetts. Given this awareness, potential bias was considered. Bracketing was used to decrease potential impact of the

researcher's preconceived notions to the study outcomes. Drew (2004, as cited in Tufford & Newman, 2010), defines bracketing as "the task of sorting out the qualities that belong to the researcher's experience of the phenomenon" (p. 83). Given this researcher's personal experience with several forensic MDTs, a way to control for this included selection of forensic MDTs for which the researcher was not a member. Other limitations included the unique experiences of selected participants and their teams. Teams can vary greatly based on individual membership, the area where the team operates (what are the available or absent resources there), and other factors such as the amount of time the team has operated. In addition, the limited amount of research on this topic presented as a limitation in this study given the absence of more extensive and in-depth reviews of this work by multiple researchers. Other limitations include, a small sample size, limited time with participants, a self-selection bias, potentially the use of a virtual platform vs. an in-person setting, participants specifically from Massachusetts, the use of only one researcher to plan the study, gather the data, and analyze the results.

CHAPTER 4 FINDINGS

Introduction

This study examined collaborations between law enforcement and behavioral health on multidisciplinary teams. In total 24 individuals participated in this study, which was guided by Yin's (2013) definition of a case study, described in Chapter 3. Case study was selected as it examines a case within a bounded system and the purpose of the case study is to be exploratory, explanatory, and descriptive – all of which were applicable here due to the relative lack of existing research on the topic. Multiple data sources were used to examine the collaborations of law enforcement and behavioral health, including pre-questionnaires, transcripts from focus groups, and post-questionnaires. This chapter describes the demographics of the participants of the focus groups, followed by descriptions of the themes that emerged when the coding of the data was completed.

Sample Recruitment

The researcher conducted purposive recruitment, using lists of behavioral health providers and law enforcement who work on forensic multidisciplinary teams in Massachusetts. These lists were accessible to the researcher as part of the professional work she does, and the network she built through the years. A recruitment email was sent out to individuals providing information about the study. As it was a purposive sample, individuals were selected from a master MDT list which represented departments that the researcher did not directly work with and who were located in varying parts of the Commonwealth of Massachusetts. In total 24 individuals responded. Given the chosen data collection method, the researcher capped each focus group at 12 participants, one group was comprised of behavioral health clinicians, and the other law enforcement officials. Groups were separated along professional lines to allow for

increased comfort for participants and to facilitate a streamlined data collection process. Anecdotally, behavioral health reported an ability to speak more candidly among peers, and the same held true for law enforcement. Inclusion criteria were checked, and informed consents obtained for all participants.

Data Source

Yin's (2013) conceptualization of case study was used as a guide, resulting in the collection of multiple sources of data, including the focus groups' digital audio files and their written transcripts, researcher field notes and self-administered questionnaires. Participants were included in the sample once they responded to the recruitment email, completed the pre-questionnaire and provided their informed consent. As this was a purposefully collected sample, none of the respondents were denied entry and all interested participants who completed the recruitment process were enrolled in the study. Both focus groups took place virtually on Zoom platforms. The virtual format was more conducive for participants based on scheduling needs and individual geographic locations spanning Massachusetts, allowing for a broad range of perspectives. Prior to the focus groups, individual demographic questionnaires (i.e. pre-questionnaires) were obtained. The questionnaires were electronically disseminated via Qualtrics. Each focus group lasted approximately 1.5 hours and was broken down into two sections. The first segment followed a semi-structured guide including the research questions along with specific prompts. The second part included an experiential exercise where a behavioral health scenario involving law enforcement was reviewed and discussed. This was achieved by observing body camera footage of this call and the corresponding law enforcement response. Participants in each group were asked to reflect on their impressions, what stood out to them, what they would have done the same way and what differently. They were also asked to

consider an MDT approach in this scenario and the differences this may have elicited in case engagement.

The identified research questions were asked, and prompts were given to stimulate engagement between participants. The researcher noted the weight of these topics and ensured that adequate time to process such was given. Following the first posed research question, which served as an opening prompt, the focus groups yielded a rich flow of conversation that lasted for the entirety of the study time. Prompts were then utilized to elicit responses from participants who may not have contributed yet or to connect identified areas of discussion. The researcher was able to directly observe participants and while field notes were being taken, the researcher was also attentive to non-verbal cues, calling on participants who appeared to want to contribute or weigh into the discussion. The focus groups were recorded and transcribed. At times, more sensitive topics came up from some participants, such as legal implications and liability, evoking a variety of responses in others.

Following the focus groups, a post-questionnaire (see Appendix E) was provided to each participant for completion. The post-questionnaire comprised of three areas inquiring about how experience working on a multidisciplinary team (MDT) impacted responses to the experiential activity, by providing five words that came to mind regarding the experiential activity, and comments/observations about the case study not previously shared. Field notes from the researcher were also collected and reviewed.

Process of Data Analysis

Once the focus groups were complete, the audio was transcribed via NVivo software. A legible transcript from each focus group was produced, ensuring that any participant identifying information was redacted. Transcripts were initially reviewed for the purpose of establishing

researcher familiarity with the content. Initial themes were identified during the second review, which were then used to create a code list. Each transcript was reviewed several times, so information was fully processed in an iterative manner and codes could be identified. A peer debriefer, an unbiased and independent doctorate level professional with relevant content and methodological expertise, engaged in the process along with the primary researcher to ensure that the coding was done in a rigorous manner. An inductive approach to the thematic analysis took place, as meanings and codes were derived from the actual data. Codes were then labeled and as patterns emerged, consistent codes were grouped together. Following this step, each transcript was again reviewed line-by-line to ensure that emerging themes presented consistently. At this stage, the definition and naming of each theme took place.

The theoretical frameworks of biopsychosocial theory and transformative justice theory were utilized in this process to create consistency in the coding and thematic analysis of the data. Considering the multi-dimensional nature of biopsychosocial theory, examining biological, psychological, and social factors assisted with understanding the complexity of the collaborations among behavioral health and law enforcement and the cases with which they collaborate. Each professional in this study's focus groups served as a member of an MDT, providing them with experience in assessing individual cases from multiple perspectives. Similarly, transformative justice theory was used to examine the factors leading up to a crime, as well as potential systemic changes that may be needed as a result. This was intentionally done in the discussion through the facilitation process. During the focus groups and subsequent analyses of the transcripts, antecedent factors (those leading up to an event) and systemic issues (such as access to care) presented consistently, emphasizing the appropriateness of these two theories as conceptual frameworks for the analysis of this data, both in the coding and thematic analysis

procedures. In the following sections of this chapter the codes, themes, and overall formulation of the collected data will be presented, including direct quotes and references to the transcripts, questionnaires, and field notes.

Findings

Participant Characteristics

The study participants consisted of 12 law enforcement and 12 behavioral health providers. All behavioral health providers, as well as two of the 12 law enforcement participants, were female. The remaining law enforcement participants (10) were male. Participant ages ranged from 27-63, with an average age of 36. In the sample, 18 of the 24 participants identified as White. One law enforcement identified as Black Cape Verdean, four as Hispanic/Latino, and one as multi-racial. Professional experience for law enforcement ranged from under 10 years to over 30 years. For behavioral health, the experience ranged from 2 to 15 years. Most participants had advanced education, primarily Masters' degrees, and all noted specialized training in the fields of behavioral health, crisis management, and forensic work. Participants represented 32 communities, spanning municipal and state law enforcement, and covering communities from the South Shore to the North Shore of the State. The range of highest education achieved for law enforcement included "some college courses", three with Associate's degrees, five with Master's degrees, two participants with two Master's degrees, and one participant with a Juris Doctorate. All behavioral health participants had Master's degrees.

Participants were also asked to identify specialized training they completed related to their work. The identified topics included: Certified Narcan trainer, Addiction and trauma related training, Forensic Interviewing, Suicide Assessment Training, CISM (Critical Incident Stress Management), MHFA (Mental Health First Aid), CIT (Crisis Intervention Team), FBI Crisis

Negotiation Training, CBT (Cognitive Behavioral Therapy), Restraint Training, ABLE (Active Bystandership in Law Enforcement), QPR (Question Persuade Refer), EMDR (Eye Movement Desensitization and Reprocessing), Domestic Violence Instructor, Fair and Impartial Policing Instructor, and Sexual Assault Investigator.

Contrast and Overlap Between Groups

As the focus groups took place, it became apparent that overlapping areas of interest and concern existed among participants. During the focus groups participants were asked to reflect on their own experiences within their professions as well as on multidisciplinary teams, their history of working with the other discipline, systemic changes that have occurred relevant to this work, as well as their observations of the experiential activity. The focus group questions focused on key areas such as information sharing; advantages and disadvantages of collaborations between law enforcement and behavioral health on multidisciplinary teams; management of cases; and communication across disciplines. In addition, practical limitations, including systemic issues, were reviewed, as the groups also discussed what they perceived to be the most meaningful part of multidisciplinary work.

The varied experience levels of participants, both professionally and specifically working on multidisciplinary teams, increased the diversity in the answers provided. Similarly, the level of existing knowledge of past siloed practices, and current practices encompassing multidisciplinary teams, also varied among participants. Participant responses to the initial research question created a flow of conversation and triggered reflections from others who then shared their perspectives. The responses initially given represented individualized perspectives, before steadily expanding into a more generalized review of systemic procedures and limitations, as well as community and policy guidelines. Opinions moved from general satisfaction with the

work and the progress made with multidisciplinary teams to frustration and concern with the need to spend time addressing significant barriers. Some of the identified barriers were trust, working relationships, level of knowledge, cross training across disciplines, the need to listen to the other perspective, and the struggle to co-exist on these teams, as well as the benefit that can come from them. As the focus groups continued, participants developed a sense of group cohesion, demonstrated by their sharing in more personal and direct ways with each other. For example, participants shared available resources and ways to overcome problems. At one point the researcher reminded participants to speak directly to each other, and not the researcher. This prompt appeared to shift the momentum, creating an increased level of comfort, less formality in responses, and language that appeared less structured or guarded. When participants were given permission to focus on each other rather than the researcher, the power dynamic shifted, and subsequent responses presented as less guarded.

Themes

The themes that emerged from analyzing the focus groups' materials (audio and visual, transcripts), field notes and pre-/post- questionnaires were (1) *Systemic issues impact MDT success* (2) *Training and role on the team impacts member practice* (3) *Successful implementation of MDTs requires intentional work* (4) *Efficacy of MDTs increases when different expertise is engaged.* These are examined below to illustrate what participants described as critical in their work on MDTs. The researcher focused on what the data demonstrated by examining each theme and presenting the findings.

Theme 1: Systemic issues impact MDT success

Systemic issues impact MDT success emerged as an initial theme from the analyzed data. During the focus groups, the context of the MDT within larger systems (such as healthcare,

justice, government) was discussed, as well as the corresponding implications. Some of the identified systemic issues include: the current process for involuntarily hospitalizing individuals, insurance protocols, rapid discharges from hospital settings, medication non-compliance, limited access to community systems of care, information sharing, poor resource utilization, inability to divert individuals to systems of care because of systemic issues (for example long wait lists and limited access to providers), limitations within each role, and legal limitations. Both behavioral health and law enforcement participants identified the above areas as indicative of systemic issues and barriers to their individual and MDT work. One of the most pressing systemic issues identified was the process of involuntarily remitting individuals to the hospital for care and subsequent discharges that may occur as quickly as the same day or the next, in spite of an expectation of a three-day minimum of care and observation.

Participant 14 from the law enforcement focus group noted: *The officers in the room, from everyone in the region that uses this hospital, were getting very frustrated because they were turning around, saying we section them and then they're back out two seconds later.* Participant 13 from the law enforcement focus group shared: *There are still a few officers that will send the Section 12 forward and say, well, why the heck wasn't he held the 72 hours?*

To manage these frustrations, participants from both groups identified that having each other to talk to helped diffuse the tension and stress. Without this outlet many shared that the work would become even more difficult and lead to more burnout. Limited access to community systems of care were also identified in both focus groups. The work of MDT members was described as filling a gap within the community and addressing critical needs.

Participant 15 from the law enforcement focus group reflected on this: *We kind of meet people where they're at. And that's kind of how we're dealing with people in crisis right now. So,*

if it's somebody that's high risk, we'll follow up with them. But people know now in the community that I'm doing this out of the station. So, if they call and see if I am available and I will go out and meet them.

Participant 14 from the law enforcement focus group continued:

And we found that a lot of people struggle to get therapists and they're kind of leaning towards the clinicians to become their therapists, and they're buying up, earning a lot of their time because they're constantly calling, venting to our clinicians. Because they can't find therapists in the community, so it's more of a community problem but that's something we end up having to address a lot of times.

In order for MDT work to take place, information sharing must occur. Similarly to what was identified above, safety concerns are often present along with a necessity to manage treatment needs jointly. Working across disciplines requires a level of collaboration and agreement. For example, information sharing is critical to address rapid hospital discharges and other treatment needs. Both law enforcement and behavioral health discussed the need to communicate with hospitals about the behaviors and symptoms they observe in individuals they send to the hospital, in order to gain appropriate care for the individual, but also in an attempt to avoid a rapid discharge.

Participant 20 from the law enforcement focus group noted:

Well, if you are very specific and not general, send it over and then take the time to make the follow up call to the hospital and speak to the clinician to give more information that gives us something to work with rather than a general section [12 order].

The need for a follow up piece, with both law enforcement and behavioral health, resonated in the focus groups as a way to combat systemic issues of siloed approaches. In

addition, the need to reserve hospital referrals for the most acute cases also emerged during the study. Poor resource utilization was brought up by participants related to an over-reliance on the hospital system to the exclusion of other treatment options.

Participant 17 from the law enforcement focus group stated:

Having the clinicians has kind of taught officers that not everything needs to result in a section [12 order]. Maybe there is something else going on and we can look into it further. But that's a big advantage, I think, and I think that'll be beneficial to the hospitals who are overrun right now, too.

Systemic limitations were also identified as impacting individual work. Although necessary, participants identified that a significant part of their work involves cross-training and educating of the opposite discipline about the capabilities and limitations of each professional role, as well as the ethical standards and practices that guide MDT work with behavioral health concerns. Overall progress was noted with consistently less internal resistance as MDTs become more established.

Participant 8 in the behavioral health focus group stated:

So, in the beginning, there were a lot of stops and starts…Now that we are pretty integrated with police officers, you know, 10 years ago wouldn't have been this way. I think police officers are warmly welcoming our intervention and our help when they're out in the field, because, from my conversations with them, you know, they were flying blind. They weren't trained in this, they weren't trained in how to de-escalate somebody who's delusional or paranoid, you know? So they're appreciating the new information because it's more tools for them to use.

Participant 4 in the behavioral health focus group reflected:

We run into situations where we send people to the hospital. And the next thing you know, they turn around and are sent right back out and they're back in the community and they (officers) get frustrated with the system. And one of the things that I've had to struggle with one of my departments, it seems to be getting better now, but it's taken some time to help them understand the way the infrastructure works and all the moving parts and when something doesn't turn out the way you think it should.

One more factor identified as contributing to systemic issues were Health Insurance Portability and Accountability Act (HIPAA) and Criminal Offender Record Information (CORI) or Criminal Justice Information Services (CJIS) statutes, which govern information sharing. Participant 5 from the behavioral health focus group noted that although MDTs have been functional for years, legal standards and rules have not adapted to be compatible with the work presently done. Although exceptions for law enforcement are outlined in HIPAA, and some guidelines for CORI/CJIS information sharing with non-law enforcement entities exists, varied interpretations of such exceptions, and overall resistance to work collaboratively, can still be found within the larger system. The post questionnaires also noted information sharing as a concern, especially in the context of de-escalating a situation. Law enforcement documented that behavioral health is often aware of information that is critical in a behavioral health crisis. Sharing that information is imperative and can lead to decreasing risk and increasing safety on these calls.

Theme 2: Training and role on the team impacts member practice

Training and role on the team impacts member practice emerged as a second theme in the data. Data collected during both the focus groups and the post-questionnaires indicated that MDT members complete specialized training and many times have also completed advanced

degrees in their respective fields. Participants discussed the specialized mental health training that law enforcement receives, predominantly aimed at increasing awareness of clinical diagnoses and presentations. Focus group data noted that in recent years the need for law enforcement to address a wider scope of behavioral health calls has increased. Improvement in this area has resulted in part from the specialized training received, as well as the expanded role of behavioral health providers in this field. In addition, academy training for new recruits and in-service (annual training) for law enforcement has included more mental health and substance use related topics. Similarly, behavioral health has participated in training aimed at increasing their awareness regarding law enforcement and the justice system. Both focus groups noted the expanded scope of respective training as an effort to bridge the gap between the two disciplines. Participant 3 from the behavioral health focus group reported: *In this day and age we are well-trained, I think these officers do have the clinicians, I think these officers, you know, in general know the signs and symptoms to look for.*

The presence of an MDT team comprised of members with specialized training was identified as a defining characteristic of the joint approaches taken with behavioral health calls. The overall way that treatment needs, and law enforcement encounters, are addressed was noted to have shifted as result of these factors. Participant 17 from the law enforcement focus group noted, "*I have officers that are probably stronger than or just as equals as any clinician we could put out there, if we can get some of those officers the training that they need. That's something I'm leaning towards."*

This theme also includes how an individual's role impacts their approach on the team. The role that each discipline assumes on these teams is impacted in great part by their training and background. Differing perspectives on how to approach calls for service, from what to pay

attention to, to what types of questions to ask and what disposition to consider, were all noted as impacted by the team member's role and training. In addition, the need to work collaboratively with team members was highlighted, particularly in situations where a clear solution may not be evident. Participants from both groups reflected on this and the differences between a collaborative environment and a siloed approach were brought up. Some noted that their personal background and experience comes from a collaborative place, thus making the transition to MDT work more seamless. Multi-disciplinary approaches were credited with addressing complex case needs in more efficient ways. Participants also noted how having an awareness of laws and professional responsibilities impacted their MDT work.

Participant 1 from the behavioral health focus group noted:

> *… but if someone's still denying, you know, all risk factors you can't infringe on their rights and section them anyway or infringe on their rights and arrest them, even as you know, like even if you know that they're probably doing something wrong, like there's rules that you have to follow. You can't just bypass it based on a gut feeling, unfortunately.*

Participants underscored the importance of sharing responsibilities, assuming differing roles, and being adaptive in their MDT work. Information regarding both the level of training and an individual's role prior to their MDT work, as well as how these were subsequently impacted by the MDT experience, were also mentioned.

Participant 9 from the behavioral health focus group noted:

[When previously speaking about information sharing] a bunch of us brought this up similarly that the clinicians have the ability to kind of like communicate better to hospital systems, other clinicians, things like that and about like understanding our role, and us

understanding their roles and their limitations. I think there's a huge benefit, too, especially if you've been lucky enough to have the same person working with you as a clinician when we're talking about like multidisciplinary approaches.

Knowledge as power also presented under this theme, along with shared liability and responsibility, knowing one's limitations and capabilities, dividing and conquering tasks based on training and roles, and tensions that can arise between team members. During the behavioral health focus group, the "imposter syndrome" was mentioned early on and echoed by several participants. It was noted that their training and role is often viewed as more educated and clinically informed than law enforcement, with a higher level of expertise. Participants in both groups indicated that by virtue of their background, law enforcement believed behavioral health providers to know more and assumed that they had expertise, even if the behavioral health provider did not feel that was the case. As an example, behavioral health reflected that when requested to review cases, they may be the least familiar MDT member with an individual but by virtue of their training and role, they are viewed by law enforcement and others involved in the case as an expert.

Participants from the behavioral health focus group described how being introduced into live behavioral crisis calls placed them in a unique position, in which they were immediately expected to be the expert on the scene when it comes to identifying or de-escalating underlying mental health issues. They talked about how officers quickly adapted to that dynamic, introducing the clinicians to the community as the mental health experts who would take the lead in several aspects of the crisis contact.

Theme 3: Successful implementation of MDTs requires intentional work

Successful implementation of MDTs requires intentional work was the third theme to emerge from the data. This theme emerged in both focus groups, as well as in the experiential activities and the post-questionnaires. It is characterized by the awareness of the need for intentional work (consistent and conscientious) in both the implementation phase and for the ongoing success of these teams. In the experiential activity it was noted that law enforcement often feels pressured to resolve calls in expedited time, with no access to resources at the scene. A call for service to law enforcement has a limited number of ways it can be addressed, often guided by legal statue and minimal alternative options (for example diversion, collateral information, or resource allocation). The MDTs fill a void and provide both on-scene and post-encounter components. The primary areas of focus and concern for law enforcement are adherence to the letter of the law, resolution of the matter, and safe outcomes. During the focus group, law enforcement reflected on the pressure from community constituents, media, and politicians to immediately and seamlessly integrate new and expanded behavioral health supports, and alternatives to policing options. With this, law enforcement reflected on tensions and immense pressure to subjugate their academy training and incorporate methods that previously were not known to them. This tension between academy training and behavioral health trainings was described as confusing at times. However, MDT work was described as assisting to decrease this confusion by increasing familiarity with behavioral health interventions. In the post-questionnaires participants were asked to reflect on their MDT work by writing down five words that came to mind. One participant noted “insightful, challenging, evolving, multidisciplinary, collaborative.”

Participants noted that an MDT cannot just be “thrown together”. Intentional work is required for it to first be implemented, and secondarily successful, due to team members’ different personalities, backgrounds, and trainings. Within the larger context, the creation of the MDT was described as often originating from an external source of pressure, such as the community or public figures demanding a new approach to behavioral health crises. Law enforcement participants described feeling this pressure and responding to it by reaching out to partners and “putting things together quickly”. After some time and experience doing this, issues and conflicts presented, and it was reflected that the implementation phase likely set the tone for subsequent outcomes.

During this phase selecting the right members was identified as critical. These members were described as key agencies in the community (for example schools, public health, elder services) and individuals who possessed skills such as the ability to work well on teams and those having necessary resources for cases. In addition, it was brought up that membership changes and broader factors (e.g., laws, initiatives, directives, policies, protocols) required ongoing and intentional work for the viability and relevance of an MDT at any given time. Participant 1 from the behavioral health focus group noted, ”*I do recognize that having been there for such an amount of time now assisted in building relationships with law enforcement officers, particularly patrol officers now.”* Participant 2 from the behavioral health focus group stated, “*So, I think that's the important piece for clinicians to work together with law enforcement. You know, so that we can train them and validate, you know, people's needs in the community.”*

Participant 3 from the behavioral focus group noted:

…in the beginning, there were a lot of stops and starts. There was a lot of, you know, who's going to do what, we would go out in the field and officers would just not really know what I did if I was with a patrol officer that I barely knew.

Participants described learning as they went, with the need to adapt critical. Engaging systems of support was also noted as an intentional step to maintaining the success of an MDT. Case work was described as isolating work, both for the behavioral health providers and law enforcement. MDT work and the formed relationships filled a void and brought a social component to the work done. Behavioral health working with law enforcement described feeling isolated from their professional peers, who often did not understand MDT work. Law enforcement noted that relationships with behavioral health could isolate them from their professional peers. Burnout with this work was also brought up as a concern, with safeguards identified as needed to protect against this and maximize the work of MDTs. Participant 5 from the behavioral health focus group reported, ”*So, I think there may be a shift to that model or that perspective. So, I think forming those peer groups might be beneficial, but that's my perspective.”*

Participant 6 from the behavioral health focus group noted:

One of the big things that you know, I can at least say for here is, you know, that you feel as a whole family. It's not we are the social workers and clinicians, and they are the officers, we really have been embraced as a whole in this department. And I, you know, pride us on learning from them too, because there are sometimes where that's a big, huge piece is understanding the legal side of it as well.

Participant 15 from the law enforcement group reflected:

We go to medical [calls], we go to overdoses, we go to domestic violence [calls], we go to mental health [calls]. So, at the end of the day, it is our job, but we're not professionals in it. We're just the Band-Aid. So, if we can have help in every one of those aspects that can kind of help us heal the wound and not just stick the Band-Aid on and go back sixteen times over the next month. That's where the clinicians are good because that crisis can be addressed.

Participant 14 from the law enforcement focus group noted:

So, I think that's where it's beneficial because for what REDACTED and I do, we follow up and we'll take the clinician out on the follow ups to offer more services because eventually they're going to be back in the community again. And the goal is to get rid of the hamster on the wheel, right? So having the clinician not only from a patrol aspect in the crisis moment, but we use it in the aftermath of it as well.

Proactive interventions were identified as both a necessary component of MDT work and a new approach to law enforcement work. Proactive outreach was noted as important in managing crises and avoiding escalations in symptoms and concerning behavior. Similarly, participants described during this case study that success of the MDT is also measured by the post-incident engagement, not just the on-scene component.

Participant 13 from the law enforcement group reported:

…[in non-MDT work] I'm seeing a lot of third person [Section 12 orders] that they're just handing out, seems like candy. People never even talked to the clients…and they're just signing off on the sections. So that's kind of where we're going. I'm more proactive, work with them in the community.

Theme 4: Efficacy of MDTs increases when different expertise is engaged

Efficacy of MDTs increases when different expertise is engaged was the fourth theme to emerge from the data. MDT work engages multiple professionals, with varying levels of expertise, to work together to address complex needs. Standing in contrast to siloed work, MDTs integrate perspectives and professionals to work together to maximize diversion efforts and address both treatment needs and criminogenic risk factors. In order to compare individualized intervention approaches to MDT work, it is important to examine the two. During this case study participants reflected on their experiences of working individually, working with others in their profession, and working on MDTs. Some participants discussed their work in past years which followed traditional siloed approaches, with limited information sharing between disciplines. During the focus groups and the experiential exercise, participants discussed areas of growth and improved access to care created by the development of MDTs. They also noted that the experiential activity allowed them to compare an MDT response to a single discipline response.

Participant 2 from the behavioral health focus group noted:

> *And I will tell you 10 years ago, you would never see mental health and law enforcement come together to kind of create that, you know, conflict resolution to come up with an alternative approach to, you know, the justice system or the emergency room.*

Participant 6 from the behavioral health focus group expanded on this by saying, ”*And then the communication piece with the officers, it's just, you know, fairly constant. I follow up with them after a call to let them know that this was the outcome.”*

The above comment occurred within a lively conversation about how the disciplines interact, the role each member plays, and the need for communication so that a case can be managed both in the short and long term. Behavioral health noted their work with MDTs

includes coordinating with an individual and their treatment provider, as well as consulting with law enforcement if legal concerns arise. Members of the law enforcement focus group described consulting with the behavioral health team members to determine if a behavior they are witnessing is something that should be pursued criminally or diverted into other systems.

Participants endorsed the importance of professional expertise in MDT work, indicating that the collaborative MDT process provides benefit across the spectrum of MDT case matters. As the acuity and complexity of cases MDTs encounter continue to increase due to a multitude of factors (COVID-19, social justice matters, socioeconomic inequities, juvenile issues, substance use, etc.), it was noted that enhanced expertise is needed. The limitations of any one profession to fully handle high-risk needs underscored the value of a multidisciplinary approach. In addition, the development of relationships was very important, and these were facilitated by MDTs.

Participant 3 from the behavioral health focus group noted:

> *building those community partnerships and understanding all the different stakeholders and providers who they are and creating, you know, a dialogue, putting names to faces, getting people to the table during high-risk meetings. Those kinds of things are critical to the situations where we're not sending them to the emergency room, where we're trying to help them stay stable in the community.*

The ongoing need to monitor risk and maintain community safety was discussed in both focus groups and reflected in the post-questionnaires. In part, the expertise of the MDT was noted to be a “leader in the work”. MDTs have become the team often utilized by hospitals and community members to address complex cases. Several participants reflected that expertise within the MDT was requested from community agencies and that the efficacy of MDT work on

one case led to requests for assistance with subsequent cases. The experiential activity highlighted a focus on individual and team strengths as well. Behavioral health noted that law enforcement had made significant progress in their understanding of behavioral health calls and that clinical expertise allowed for in-depth assessments to occur on scene. Law enforcement noted that cross discipline collaboration is invaluable on cases. The impact of varied expertise was also credited with assisting behavioral health calls even when a clinician is not on scene. Law enforcement that works collaboratively with behavioral health applies that knowledge on calls in every situation. During the experiential activity, both law enforcement and behavioral health focus groups reflected on the impact that a behavioral health professional has on scene. This was described as asking clinical questions, noticing details, calling collateral contacts, and consulting with other professionals about how to address the presenting needs.

Law enforcement noted that behaviors that were initially confusing to them, could be clarified by behavioral health via MDT work and cross-training. This was identified as having subsequent impact on the work done by law enforcement and serving to assist on calls where behavioral health may not be on scene. At the same time, the collaborative portion of this working relationship was highlighted. In the scenarios discussed by participants, one expertise was described as adding to the other and not duplicating, thus increasing effectiveness of the MDT.

> Participant 3 from the behavioral health focus group noted:
>
> *[law enforcement understood] a lot of the work that they may have been confused about because they weren't trained, could be clarified by the clinician who could assist them and be a support system for them versus taking over the whole call.*

Facilitated collaboration, proactive policing, addressing of community needs, and the development of relationships with MDT counterparts were also identified in the field notes and post-questionnaires as indicators of the significance of differing expertise in MDT work. Consensus across both groups and all collected data was found regarding the efficacy of MDTs increasing when different expertise is engaged. Another point that expanded on this was the comparison made between MDTs that operate well and demonstrate higher efficacy, and those that present with struggles or concerns. In the field notes it was underscored that efficacy is assessed by rates of diversion, positive relationships among MDT members, and connections to resources and community providers. Points of concern were identified as lower diversion rates, conflict among MDT members, and decreased effectiveness in meeting community needs. The post questionnaire also yielded feedback related to the ongoing use of the expertise of MDTs, their work on cases with better outcomes, evidenced by stable housing and employment for example, and community members' ongoing access of MDT services.

The working relationships between MDT members relies on trust and professionalism. Law enforcement described that initially there was suspicion around introducing another discipline into the department and into police culture. Participant 22 from the law enforcement focus group said the following of law enforcement responses when describing the behavioral health partners' early introduction and subsequent integration: *"They knew it wasn't a threat. It was actually there to help them. And they've learned how to use the calls and when it's not needed."*

After compiling the codes from the focus groups (including the experiential activity), the pre- and post-questionnaires, as well as the completed field notes, the identifying themes that emerged helped to answer the research question and aims. An overarching theme across all data

sources was a collaborative approach towards "*dividing and conquering the work*". At the foundation of MDT work is the ability to address systemic issues, provide critical training to members, intentionally construct teams for optimum success, and maximize team efficacy by engaging different expertise. MDTs, in this case study, were credited with helping to address complex behavioral health cases by sharing in the responsibility, treatment planning, and resource allocation.

Summary

This chapter presented the themes identified in this research regarding the collaborations between behavioral health and law enforcement. The case study, described as an event bounded by time and space, was examined. Law enforcement was brought together in time and space to answer research questions and complete an experiential activity together. Post-questionnaires were completed. Similarly, behavioral health was brought together in time and space to answer the same research questions and complete the experiential activity together. Post-questionnaires were also completed.

Participants described their professional experiences, interactions with the other discipline, perspectives of systemic issues, training needs, community gaps, and ideas regarding future steps. They talked about positive and negative experiences and conveyed both excitement and frustration with the work. Participants detailed the need to work collaboratively and compared conflicting demands, identified limitations in resources and time, and discussed logistical challenges and struggles. Set within the context of the larger community, MDT work was described as both necessary but also minimally understood. The need for support, supervision, and resources resonated throughout the participant pool. Four main themes emerged from this research and were identified as: (1) *Systemic issues impact MDT success* (2) *Training*

and role on the team impacts member practice (3) *Successful implementation of MDTs requires intentional work* (4) *Efficacy of MDTs happens when different expertise is engaged.* The overarching theme was recognized as *Dividing and Conquering the work,* to manage increasingly complex and high-risk cases.

Expanding on this, the following chapter includes key areas of consideration. Chapter 5 outlines a discussion of the findings connected to the literature review detailed in Chapter 2. The implications for future research, social justice advocacy, practice, and policy development are also included, along with this study's limitations.

CHAPTER 5 DISCUSSION AND CONCLUSIONS

Introduction

This study's purpose was to examine the collaboration among law enforcement and behavioral health providers in multidisciplinary teams (MDTs). Chapter 1 outlined the fields of behavioral health and law enforcement as historically siloed entities, rarely working collaboratively. Recent social and public health events were also discussed, leading to an increased use of collaborative approaches in law enforcement responses to mental health concerns. The statement of the problem was also reviewed, including the deinstitutionalization movement, the subsequent criminalization of mental illness, and the current efforts to de-criminalize mental illness. This study's research question and aims were also outlined. Chapter 2 covered the above-mentioned topics in more depth, drawing upon the literature to describe the impact of these events.

Diversion was also presented as a current response to addressing mental health needs and criminogenic risk factors. Some of this work included the use of MDTs. Chapter 3 outlined the methodology for this study. Yin's (2013) work on case study guided the process, which included focus groups along with questionnaires as data collection methods. Chapter 4 presented the study findings, including the analysis of the focus groups' transcripts and participants' questionnaires. The collected data was read and re-read, and the results were written and reviewed. A peer debriefer was consulted to enhance rigor, and field notes collected by the researcher were also reviewed to round out the study's analyses. The following research question guided this inquiry: What are the main advantages and disadvantages of collaborations between law enforcement and behavioral health providers on multidisciplinary teams when responding to behavioral health crises? Aims of this study included: 1) understand how communication between behavioral

health professionals and law enforcement impacts their ability to collaborate; 2) uncover how information sharing between both disciplines influences outcomes; 3) describe the perceptions of members of both disciplines regarding levels of case engagement.

The methodology for this study was selected as a best-fit option to examine an example of the collaborations between behavioral health providers and law enforcement, bounded in space and time. Participants were recruited based on their work on existing MDTs and their professional affiliation. The same questions were asked in each focus group, in a semi-structured format that allowed for follow-up, as needed. An experiential activity was also included in each focus group in order to assess the practical implications of MDT work. Through these activities, participants were able to describe their own experiences, their interpretation of the meaning of their work on MDTs, current issues, and future implications. Pre- and post- questionnaires, along with researcher-maintained field notes, rounded out the collected data.

This chapter reviews the identified themes and their connection to relevant existing research. In addition, the research question is answered via the analysis of these themes. Areas of existing knowledge in the work of MDTs are also discussed, and remaining questions are identified. The study findings are framed in relation to the literature review findings outlined in Chapter 2 and the researcher's perspective on this work. This section begins with a review of the aims: *(1) understand how communication between behavioral health professionals and law enforcement officers impacts their ability to collaborate; (2) uncover how information sharing between both disciplines influences outcomes; (3) describe the perceptions of members of both disciplines regarding levels of case engagement.* In addition, this chapter includes implications for future research, social justice advocacy, and policy development. The chapter concludes with a discussion of the study's limitations.

Discussion of Aims

Aim 1: Understand how communication between behavioral health professionals and law enforcement impacts their ability to collaborate

Participants in this study noted throughout the focus group and experiential activity, as well as in the post questionnaires, that communication among disciplines could be positive or add additional stress. Positive outcomes of the collaboration include improved engagement in a case, whereas the stress of delaying access to services and care, and hindering progress, were also noted. Cases involving multiple disciplines were described as requiring additional time and strategizing due to issues and limitations, including poor resource utilization and low staffing levels (found in community mental health and substance use treatment settings). Both law enforcement and behavioral health identified having to address these issues on a daily basis, which would either resolve more efficiently due to MDT involvement or require further engagement. The work of MDTs was noted to include extensive communication with other entities, including community behavioral health providers, court staff, educational personnel, legal staff, probation/parole, and others.

Additionally and related to communication, another area of concern was communication between behavioral health providers on MDTs and their supervisors. Behavioral health supervisors were described as often lacking awareness regarding the specialized nature of MDT work, as well as failing to prioritize support of MDT work. Reflecting on their work with law enforcement and on these MDTs, the behavioral health participants discussed at length the need for relevant and comprehensive supervision. During this study, the lack of seasoned supervisors and those with awareness of law enforcement work resonated with the behavioral health participants. Behavioral health providers described feeling isolated and lacking supervisory

support, which often left them experiencing feelings of vulnerability and frustration and seeking support from peers. This deficit of formalized supervisory and support systems has also been described in the literature, emphasizing peer support from other team members as a potential solution for the problem (Brown et al., 2017). However, unstructured supervision can be associated with negative outcomes, such as fragmentation of the program, stigmatization of the employee, and role ambiguity (Kutash et al., 2014). Hence, specific processes and supervisory agreements with qualified professionals that guide, nurture, and protect MDT team members are worthy of consideration.

An offshoot of the conversation about communication focused on the tension between roles and the differences in the way that each discipline approaches a case. The perspective of law enforcement emphasizes safety and legality, whereas behavioral health providers focus on clinical needs and resource allocation. Participants underscored the need for positive working relationships among team members to withstand this tension. This dynamic was also linked to the overall effectiveness of an MDT. Blanketed in both positive and negative descriptions (as either supporting or hindering the work), differing perspectives were described as an inseparable part of MDTs and these sentiments are reflected in the literature as well (Dempsey et al., 2019).

Playing to each other's strengths was noted in the post questionnaire as a difference between siloed work and MDT work. In particular, participants discussed the high-risk nature of calls related to domestic violence and attributed *playing to each other's strengths* as something that decreased the presence of complex dynamics and acute tensions in these situations. Law enforcement participants observed that laws have become stricter, citing the 1960's reinvestment in criminal justice reform and the women's movement of the 60s and 70s, along with the 1994 Violence against Women Act (Eisen, 2019) as evidence. More recently, community focus on

these calls and their behavioral health components has increased attention on the dispatching of BHPs in response. The experiential activity in this study also provided an example of a call for service that might involve a multidisciplinary response. In that context, ways to play on each other's strengths were brought up by participants. It was described that varied backgrounds provide different perspectives, and that by observing each other on calls gaps could be addressed, leading to a more holistic approach.

Whether separating parties during a call for service in order to independently confirm events, providing individualized attention to the victim, or determining next steps for the perpetrator, MDT members noted that each discipline contributed differently to the call. This benefit is maximized by relying on each team member's expertise and deferring to one another when appropriate. The elements of collaboration that participants described as most impacted by the individual professional's strengths included case consultation, planning, and connection to resources. These same elements have been demonstrated to facilitate the success of police-driven initiatives in collaborative partnerships when implementing strategies to address the commercial sexual exploitation of children (Farrell et al., 2020) and the opioid epidemic (White et al., 2021). While these particular issues are not the same as MDTs focusing on behavioral health crises, this research may be viewed as a precedent supporting the application of such principles in behavioral health responses.

A final element focused on communication among members was successful deployment and utilization of the team. Participants described that following COVID-19 restrictions, team use on cases had significantly increased. Attributing this to multiple factors, participants described that the impact of the COVID-19 pandemic and the strain on the existing health care system maximized the use of MDTs in their communities. Initial literature published on the

impact of the COVID-19 pandemic noted the extensive adverse effects and demands on healthcare professionals (Altiraifi & Rapfogel, 2020). Study participants described their own feelings of increasing demands and the high number of requests for assistance. In part, long wait lists for community resources and the absence of bridge services to cover needs on an interim basis contributed to increased MDT requests.

An MDT response may be requested in several ways, either by the individual themselves, the individual's family, dispatch staff, other systems such as schools, or by individual MDT members who wish to have a team perspective on a case. Because MDT work can include both intervention and postvention work, previously mentioned demands for proactive preventative work were also identified by participants as expanding the demands on MDTs. Given these increased demands, positive and consistent communication among members was described as imperative. The researcher's review of the transcript outlined participants' reflections regarding MDTs providing more services on scene as well as bridge services to those in need. These reflections included awareness of legal guidelines and behavioral health resources, to assist in facilitating the case process and outcome.

Individual qualities of each MDT member and the way that this impacts their work were also discussed. During the experiential activity this was prominent as participants' responses focused on each individual's training and role on scene at an MDT call for service. Individual perspectives were debated as participants conveyed their beliefs and processed feedback from others in the group. The experiential activity revealed strong feelings among participants that individual training and roles impacted how each member on scene approached a call for service. Participants' focus included specialized training for police, experience "on the job", whether behavioral health clinicians are experienced working with law enforcement or not, and the scope

of licensure in the field of behavioral health. The discussion on the behavioral health clinicians' background included topics such as overall qualifications, years of experience in the field, and current salary ranges for this work. Participants noted that work with law enforcement is often compensated at a lower amount than commensurate behavioral health providers in other jobs, consequently attracting less qualified and experienced candidates.

Law enforcement participants conveyed the need for highly trained clinicians on scene to assist with increasingly complicated behavioral health calls. The complication in these cases was described as the result of greater mental health needs and the prevalence of substance use, which was also cited in the literature (Bird & Shemilt, 2019). However, due to the lower salary range assigned to behavioral health work with law enforcement, mostly new graduates tended to respond to job postings. As a result, there was a mismatch in the skill set of applicants versus the skill set needed for this specific practice. This also impacted the quality of the communication among team members. In addition, new graduates lacked the hours of supervision needed for independent licensure. The absence of independent licensure limited the scope of practice and decreased the assistance these behavioral health providers could provide to law enforcement.

One example of this limitation is the inability of a non-independently licensed clinician to involuntarily hospitalize an individual under Massachusetts General Law chapter 123, section 12 (known colloquially as a "section 12"). Law enforcement participants elaborated on the advantage of a behavioral health provider who could legally recommend and petition involuntary hospitalization of someone who is presenting with acute safety concerns and meeting criteria for hospitalization. Although law enforcement is legally able to complete such a section, participants shared that typically a hospital weighed a section 12 order from a behavioral health provider more heavily than one from law enforcement. This was attributed to the clinical licensure,

expertise, and language used in the paperwork for the section 12 completed by a behavioral health provider. Communication with hospitals was also noted as a critical piece in the hospitalization process and the linkage to necessary treatment interventions.

In summation, examination of the various forms of communication among members and supervisors, tensions that can be experienced in the ways that each discipline views a case, individual team members' strengths, and accurate deployment of a MDT, can impact the level of collaboration on a case. These elements are important to examine as team efficacy and success are explored. Identifying these key areas can also serve as a template for future team development.

Aim 2: Uncover how information sharing between both disciplines influences outcomes

During the course of the study, the processes restricting information sharing consistently presented as a point of concern and a systemic issue leading to delays in addressing clinical needs during calls for service. Staff shortages were also connected to this as staff attrition in both disciplines and staff being overburdened were identified as contributing factors to compromised information sharing. The Health Insurance Portability and Accountability Act (HIPAA) was mentioned numerous times during the interviews and also recorded in the researcher's field notes as a key area of discussion under this aim. Similarly, the Family Educational Rights and Privacy Act (FERPA) was cited as restricting key information sharing on high-risk cases that MDTs handle in school-based settings. With respect to HIPAA, the law enforcement exceptions were discussed in the focus groups and the literature review indicated extensive exceptions to HIPAA permitting communication of health information to law enforcement under specific circumstances (U.S. Department of Health and Human Services, 2022).

Misinterpretations of HIPAA were also described as unnecessary and unhelpful to law enforcement work. The refusal to share pertinent information about a person in distress, when HIPAA allows for such sharing during emergency situations, was described by law enforcement participants as a daily point of frustration and an inhibitor to their work. Law enforcement participants noted cases where they were called for service, and subsequently hindered from performing their duties due to differing interpretations of HIPAA between the first responders and the agencies that placed the service call. Regarding HIPAA, law enforcement described making efforts to attend specialized trainings on this topic, only to find that many behavioral health and educational staff fail to understand the scope of coverage that law enforcement has under this federal law. Challenges associated with information sharing between law enforcement and clinicians has been demonstrated as an ongoing issue that can potentially be addressed and minimized in multidisciplinary teams (McKenna et al., 2015). This is achieved through improved interagency collaboration, which in turn leads to improved knowledge and information transfer. Moreover, there is indication that shared decision making can improve mental health outcomes in forensic contexts (Pope et al., 2022).

The overall focus of MDT efforts, to move an individual away from the criminal justice system and unnecessary hospitalizations, was described as diversion. The impact of diversions was mentioned as critical in both focus groups. Participants described that systemic issues, including limited access to treatment beds, the lack of appointment availability from providers, and conflict among systems, interfered with individual case progress and led to an inability to divert individuals on many occasions. Discussion around the existence of financial incentives to combat service restrictions and limitations, and their potential impact, occurred with participants in the law enforcement focus group describing these as state funds to help operationalize

additional programs. Participants highlighted the existence of stipends to encourage increased law enforcement responses with behavioral health providers, as well as bonuses to encourage behavioral health to partner with law enforcement; financial incentives were recognized as a reality of some MDT work. COVID-19 relief funds, known as ARPA funds, were also discussed in the focus groups and described in recent literature as a means to provide some amelioration to the systemic strain resulting from the pandemic (Javed et al., 2020).

These incentives were attached to the time law enforcement officers took to attend specialized training, to partner with a behavioral health provider on calls, and to attend stakeholder meetings. During this discussion, some law enforcement participants were supportive of financial incentives attached to this work. Others were resistant to this practice and cautioned against it. Their reasoning for this resistance was the need for buy-in to be internally driven and not the result of external motivators. Those who did not support financial incentives also explained that financial incentives can be time limited, whereas internal motivators present as having a longer-term effect on the culture of law enforcement work. Consistent with this idea, a previous study by Magaña and colleagues (2021) found that jail diversion programs in San Francisco experienced challenges when it came to police officers buying-in to alternative policing practices. However, a law enforcement assisted diversion program in Seattle found success in overcoming poor officer buy-in and tension between stakeholders through consistent work groups (Beckett, 2014), highlighting effective strategies that go beyond financial incentives when it comes to introducing novel policing and diversion practices into a system. In this researcher's anecdotal professional experience, the idea of incentivized/additional compensation for law enforcement continues to present in many discussions where efforts to collaborate are taking place. Union issues and change of working conditions (bargaining points in contract

negotiations) are often referenced when discussing financial compensation. For example, law enforcement participants described that the integration of a behavioral health partner into the cruiser, their work environment, alters the previously agreed upon working conditions. Beckett's study (2014) references the benefits of establishing sustainable relationships, meaningful commitment to the work, and shifting law enforcement interventions to behavioral health crises. Given some of the frustrations centered on information sharing, law enforcement participants described that incentives could provide a way around initial resistance to do this work.

Information sharing also expanded into the discussion of MDT formulation requiring intentional work and this was identified throughout all data sources: field notes, transcripts, and questionnaires. Participants reflected that prior to the start of their work they had little awareness about what elements were needed to optimize MDT success. Some noted that they had misconceptions, described as a belief that the identification of team members and the occurrence of team meetings were the only things needed for MDT effectiveness. Study participants discussed that after starting their MDT work, their perspectives changed and the complexity of factors that contribute to MDT effectiveness and success became more apparent. Given the historically siloed law enforcement work, several study participants discussed that the introduction of a behavioral health provider into law enforcement work was met with significant resistance.

The successful development of relationships between team members, along with trust, were also seen as key to information sharing. This appeared in the responses to the research questions, the discussions during the experiential activity, the post-questionnaires, and the researcher's field notes. While discussing how to implement an MDT, participants identified that recruiting team members and establishing regular team meetings were two starting points.

Subsequent MDT work was tied to the initial implementation steps, as study participants noted that if MDT membership, practices, and relationships are not thoughtfully implemented, and organically developed, MDT success is impacted. The significance of team member relationships was framed as instrumental to the success of an MDT given the amount of time spent working collaboratively on cases. Finding value in one's counterpart and validating each other's expertise were also noted as important. These relationships were identified in the field notes as buffers to the isolation that team members can feel in relation to their peers. Acknowledging that MDT involvement is viewed as specialized work, MDT members experienced isolation from their counterparts not familiar with MDT work. Protecting against this, MDT member relationships were noted to be critical support systems, safeguarding from burnout and providing necessary support (Geach et al., 2019).

Internal frustrations, both individual and within teams, also came to light in the post questionnaires. With increasingly complex cases and stressful circumstances, participants described that relationships among team members could either help manage these frustrations or fuel them. The development of team member relationships, via regular team meetings and collaborative work on cases, was also noted as useful to combat initial skepticism and increase trust in one another, which could also impact information sharing.

Adaptability around information sharing as well as an ability to understand when and how to share information were also noted as critical. During the focus group discussions, participants described believing that adaptability led to overcoming differences. Participants indicated that adding other professionals to case management could add insight and expertise, but also complicate things. They spent part of the experiential activity reflecting on how differences could be overcome. The on-scene engagement of law enforcement and behavioral

health became a central focus. Law enforcement discussed that they were trained to arrive on scene and resolve matters as efficiently as possible to become available for subsequent calls for service. They described that introducing a behavioral health provider on scene added time and potentially conflicting perspectives. The additional information available to either behavioral health or law enforcement required subsequent sharing of such in order for a case resolution to occur.

The need to overcome differences while maintaining efficiency was tied back to adaptability by study participants, which is a point that is reflected in the literature. The value of adaptability in assessments was outlined in the work done by Fuller and Cowan (1999). This work concluded that the adaptability demonstrated by multi-disciplinary teams allowed for sensitivity to local context, which was interpreted as providing more benefit than actuarial tools in risk assessment. Dean and colleagues (2020) discussed that those with severe mental illness had a greater likelihood of encountering the criminal justice system. According to Dean et al., efficiently assessing and addressing the underlying factors leading to this risk requires adaptability, information sharing, and enhanced expertise to intervene appropriately.

Understanding how information sharing between both disciplines influences MDT outcomes is also marked by the ability to understand each other's strengths and limitations. This ability was noted to have an impact on the implementation and success of MDT work. An awareness of each member's professional role is necessary in order to increase MDT effectiveness (Ferrara et al., 2019). This idea is interconnected with addressing barriers to collaborative work, a hallmark of successful MDT work. Participants described frustrations that often stemmed from a lack of awareness regarding a counterpart's role, including information sharing limitations. By addressing this gap, participants described that MDT success improved,

anecdotally measured by team member experiences and case outcomes. Relevant discussion in this study supported Gready & Robins' (2014) observation that knowing your individual counterpart's strengths and limitations was representative of a change in the way that transformative justice is engaged.

Awareness of federal and state laws, parameters of diversion and related programming, the presence of incentives, elements of team development, and team/member adaptability, were all identified as impacting information sharing across team members. Their relationship to case outcomes was also discussed, leading to ideas and suggestions for future steps. These elements were important study findings as they may inform subsequent teams and the work that they do.

Aim 3: Describe the perceptions of members of both disciplines regarding levels of case engagement

When discussing case engagement, participants identified tensions, community gaps, and information sharing as relevant factors. Both sets of focus group participants noted that responses to cases (case engagement) are often dictated by not only the presenting information and/or laws, but also area-specific resources and dynamics. Levels of case engagement and their correlation to tensions between other systems and MDTs emerged in this study. Described as applicable to both behavioral health and law enforcement, participants noted a multitude of tensions. Some examples included the behavioral health providers on MDTs experiencing tension with their colleagues who did not work with law enforcement (some describing this as jealousy and others as confusion about the role of behavioral health in law enforcement agencies). Other noted examples of tension were with community behavioral health providers and systems such as the schools and hospitals. Law enforcement described tensions with systems such as the courts and schools, as well as tensions among community partners who may be suspicious of law

enforcement and resistant to seeing them in any light other than adversarial. Tension was described within the context of peers, other disciplines, and systems governed by varied policies and protocols. It was brought up in discussion that local resources, such as the acute care system, may have positive or negative impressions of law enforcement, subsequently impacting their response to referrals from law enforcement and behavioral health providers who work with them.

Additionally, community gaps (leading to difficulties with case engagement) were identified by participants which included insurance barriers and restrictions, resource poverty in some areas, underutilization of supports, long wait lists, prescriber shortages, and transportation problems, among others. Participants indicated that MDTs may operate as data gatherers, pointing to service gaps in the community and potentially leading to changes in the deployment of resources. A connection between MDT work and service managers may lead to a more accurate allocation of needed services. Field notes collected by the researcher during the course of the focus groups highlighted that community gaps were described as prominent and expansive, often resulting in long delays in ability to access care, manage risk, and stabilize a case. These gaps added to the workload of MDTs, which is a point that is also reflected in the literature (Altiraifi & Rapfogel, 2020; Dempsey et al., 2019).

Study participants described encountering any number of the above issues on a daily basis in their work. One participant's perception of their effectiveness was noted in the field notes as "individuals call us long after an encounter to assist and because they cannot find someone else." Participants from both focus groups discussed that being contacted by community members reaching out for assistance was viewed as a sign of trust in MDT work from those served. Behavioral health providers on MDTs described getting calls from community members to support their clinical needs while they waited for community providers,

which they referred to as providing "bridge services." The literature also notes the use of MDTs to fill community needs and limitations, evidenced in the work done by Green and colleagues (2016), who highlight the role of police-linked teams in non-criminal scenarios, such as community-based, substance use care systems.

One more element related to case engagement identified by participants was how relevant legal statutes both facilitated and limited MDT work. Discussions about the scope of legal practice, Massachusetts general laws (particularly regarding involuntary commitment), civil rights, and criminal law were all documented in the researcher's field notes. During the course of the focus group discussions, several references to the "way things were and how they are now" were made. Participants elaborated, describing a time in the past of siloed work which had begun to transition towards increased collaborative work. However, because of factors such as the emergence of COVID-19 and the ensuing restrictions, along with social justice movements following the death of George Floyd and national protests against the police, participants described a regression in collaborative work. As a result of national anti-police sentiment, and the "defund the police" movement, many agencies and professionals became apprehensive of collaborations with law enforcement.

One major factor mentioned in the focus groups which also emerged in the literature was Massachusetts' Police Reform Law (Commonwealth of Massachusetts, 2020). This law covered many key areas including processes for certification and de-certification of police personnel, specific guidance and expectations on trainings for police related to behavioral health, the creation of the Police Officer Standards and Training (POST) Commission, and new regulations around information sharing (Commonwealth of Massachusetts, 2020). Of particular relevance, this law provided guidance on information sharing, thus changing law enforcement's ability to

obtain information related to certain types of criminal activity, juveniles, and certain communication from school and behavioral health personnel (Commonwealth of Massachusetts, 2020). Participants noted that guidelines like these impact levels of case engagement. The focus group discussions processed the impact of this law on a systemic level, as well as the impact it has on the individual working relationships among team members. One example of a systemic impact shared by participants involved the relationships between law enforcement agencies and school departments. Newly enacted legislation established updated guidelines for such partnerships. Individually, cases that were handled by teams of school and law enforcement staff shifted in part to siloed approaches. The impact of this law on MDT work needs to be studied and analyzed further.

Another factor impacting case engagement, which came to light early on in the behavioral health focus group, was the weight of being seen as the expert in a situation and the emergence of the imposter syndrome. The imposter syndrome was described as feeling fraudulent in the level of responsibility given in a case, fear of not being good enough to do what needs to be done, and the worry of disappointing others. This is not a unique phenomenon to MDTs and has been demonstrated among clinicians in various settings, impacting their performance and contributing to burnout (Bravata et al., 2020). Given the high stress of the setting and the inherent tension between behavioral health providers and law enforcement in MDTs, careful considerations should be given to the prevalence of imposter syndrome, so adequate steps to identify and ameliorate this concern can be taken (KH & Menon, 2022). Acknowledging these feelings, establishing coping skills, and relying on team members for support were identified as ways to address this.

The idea that “knowledge is power” was also relayed in the focus groups, with behavioral health participants referencing that their education and background in clinical work gets recognition from law enforcement. Participants noted that law enforcement may defer to them so much that they feel the collaborative part of the work gets negated. This discussion point linked with another: that of sharing liability and responsibility. In both focus groups and the experiential activity, participants reflected on the need for multidisciplinary approaches, the tension experienced by team members when engaging in this approach, and the eventual collaboration towards a shared outcome. Brown et al. (2017) acknowledged this tension, but they also demonstrated that the team dynamic provided some buffering to the ensuing tension due to reliance on a counterpart. This was also revealed in this study, as participants talked about feeling supported by their team members while conducting work that was described as specialized, acute, and complex.

Ability to assess risk was another pertinent concept in the discussion about case engagement. The significant increase of risk in cases handled by law enforcement was identified as a catalyst for MDT work. The types of behavioral health calls that law enforcement encountered contributed to the increase of need for MDTs and collaborations between law enforcement and behavioral health professionals. During the focus groups and experiential activity, participants described the need for behavioral health providers in case engagement, given their training and expertise in this work. Their approach to situations and crises was noted to be different from that of law enforcement. Professional training was described as instrumental to the work that behavioral health providers do, which is consistent with quality measures of mental health care delivery in varied fields (de Ruigh et al., 2021). Law enforcement participants described that MDT members make efforts to “stay in their own lane” and that MDT work

requires a level of "respecting this." This was expressed as a balance of collaborative work, recognition of training and expertise of each discipline, maintaining an awareness of the legal guidelines regarding scope of practice, keeping a balance of tensions, and honing an ability to recognize specific professional roles. The focus groups also noted the need for specialized risk assessments, for example when it came to juveniles and those experiencing neurocognitive disorders (e.g. dementia or intellectual disability). Participants concluded that based on the collaborations between law enforcement and behavioral health, it was noteworthy to look at group training opportunities. Given that both professions have the responsibility of completing risk assessments, ways to facilitate relevant joint trainings for MDT members from both backgrounds should be further explored.

The law enforcement post questionnaire proved to be an important data source regarding training and its impact on MDT members' approaches, as well as case engagement. A comparison of the training expectations for law enforcement in years past versus today noted a significant increase in the number of specialized trainings required today (Johnson, 2019). Law enforcement participants documented some of their completed trainings in the post questionnaire, noticeably including many topics that were historically uncharacteristic for law enforcement. Some of these included: Certified Narcan trainer, Addiction and trauma related training, Suicide Assessment Training, CISM (Critical Incident Stress Management), MHFA (Mental Health First Aid), CIT (Crisis Intervention Team), CBT (Cognitive Behavioral Therapy), and QPR (Question Persuade Refer). In the focus group law enforcement discussed both the need and the interest to sign up for these types of trainings in an effort to increase their competence and response to calls. Additionally, their work on MDTs and with behavioral health providers was described as a contributor to this. Working collaboratively on cases increased

interest in this work and subsequently led to completion of many of these trainings. Demonstrating both an awareness of, and an interest in, this work, law enforcement participants consistently discussed and reflected on the impact of training on their daily work. Trainings were also seen as contributing to increased buy-in and comfort with case engagement. Behavioral health professionals, depending on licensure, are required to periodically complete a set number of continuing education courses as well. Depending on licensing board guidelines, behavioral health continuing education topics are usually self-selected, with a few mandatory requirements, such as domestic violence, sexual assault, or opioid use disorder.

The most prominently discussed training in both focus groups was Critical Incident Team (CIT). Described as a training that went beyond classroom instruction, CIT outlines the creation of departmental teams to address community behavioral health needs. These teams are comprised of law enforcement with a special interest and skills in behavioral health cases, led by a coordinator, and guided by a specific policy. These policy guidelines include recommending intentional dispatching of CIT officers on relevant calls, holding regular team meetings, and prioritizing coordination with a behavioral health provider. CIT International, the chapter that created and provided this standardized training, advised that approximately 20-25% of police department personnel be trained in order to preserve it as a specialty (Compton et al., 2008). CIT proponents assert that the pairing of individual skills with this training optimizes the outcomes of responses to behavioral health calls for service.

Study participants noted that increasingly more law enforcement personnel are being trained across the state of Massachusetts in CIT. However, little research exists in the literature regarding CIT outcomes, and study participants discussed this, as well as the need to expand assessment of CIT statewide and nationally. Concerns about law enforcement interest and

willingness to transfer CIT knowledge into shift work were potentially ameliorated with an assessment before graduation from this training. The assessment was described as giving the training increased significance and going beyond simply recording attendance for training completion. This is part of a growing interest in standardizing the use of CIT training. A portion of CIT also reviews case engagement and connection to resources through collaborations with community partners.

It is noteworthy that the success of an MDT was defined by participants as the ability to follow up with a case, obtain collateral information, and navigate complex systems. Study participants mentioned in the focus groups and wrote in the post-questionnaire that "closing the loop" was a significant portion of MDT work. Law enforcement and behavioral health reflected on the need to engage all relevant parties in cases in order to optimize engagement, relay critical information, and ensure that appropriate resources are made available. Study participants discussed engaging cases for longer periods of time, providing bridge services to community members, connecting with other providers and family members, and navigating the complexity of the healthcare system in order to connect people with needed resources.

Intentional implementation was described as critical to the success of an MDT. In addition, utilizing integrated interventions and approaches towards engagement was identified as instrumental to this work. This was described as increasing access to appropriate resources, contributing to improved satisfaction in case outcomes, and amelioration of frustrations previously felt within each discipline.

Described as a "new approach" and going "beyond policing", participants noted MDT's focus on proactive engagement between law enforcement and behavioral health. Seeking to change the historically reactive approach to a situation, law enforcement described that their

communities and leaders expected a shift towards proactive work. This was identified as averting criminal activity while also decreasing arrests. The literature recommends updated approaches for forensic cases (i.e., those mental/behavioral health situations that have contact with the justice system), such as intervening early with needed resources and critically placing community-based programs to meet behavioral health needs (Dean et al., 2020; Dempsey et al., 2019). Addressing community needs was a prominent focus for this study's participants, as noted in both the focus group discussions and post-questionnaires. Participants shared that community needs have increased due to the closing of state hospitals (deinstitutionalization) and the subsequent expectation that law enforcement do more to manage behavioral health needs and criminogenic risk factors. Central to MDT work, according to participants, is the facilitation of collaborations across disciplines. In the post-questionnaire, law enforcement described that engagement with behavioral health providers required pushing past the silos, taking risks, and working towards a common goal of case assessment and management.

Engagement and validation across disciplines was a key concept, relative to the efficacy of MDTs. When one expertise validated the other, support and collaboration were promoted under the guise of teamwork. Validation from team members fostered mutual respect and a buffering from the stress of the work, while also increasing the likelihood of collaboration, shared responsibility, respect, and better case outcomes overall. According to participants, case outcomes improved when MDT members validated and collaborated with each other. Internal team disruption was defined as low on teams where validation was high. Study participants outlined in their post-questionnaires that a true team mentality made the work more sustainable and team members felt more connected to each other. The focus groups noted that validation across disciplines was important for effective case engagement. The significance of validation

also emerged in the research by Brown and colleagues (2017) who identified this as a buffer to burnout and fatigue.

The acknowledgment of individual strengths was an important recommendation for effective case engagement. Moving away from a siloed approach, MDT work aims to bring multiple individuals together to examine teamwork versus a singular approach (Geach et al., 2019). Participants reflected on siloed work as well as focusing on each team member's strengths, noting that each professional made different observations regarding a case. The behavioral health focus group discussion centered on the fact that behavioral health providers made observations, focused on clinical matters, beyond what was initially reported to dispatchers or law enforcement. Conversely law enforcement made their own observations beyond the initial report, and these tended to focus on safety. During the experiential activity and the examination of a behavioral health call, both focus groups discussed that combining individual strengths on-scene typically led to better outcomes. Many calls were described as complex, with the actual event vastly differing from the information initially conveyed to the dispatch operator. As a result, study participants discussed that case complexity and liability, along with intense public scrutiny, increased the need for multiple professional perspectives. The training received in academies, continuing education courses, and professional schooling were described as instrumental to the work MDTs do. Given the magnitude of the needs of forensic cases, study participants spent time reviewing their impressions about each profession's strengths. Behavioral health noted that law enforcement provided knowledge regarding criminal and civil matters, while law enforcement described the contribution of behavioral health to clinical matters. Collaborative approaches to case engagement were described as optimum to address complexities and increased risk.

It is important to mention that the literature also highlighted individual strengths in connection to MDT work (Alves & Meneses, 2018; Ferrara et al., 2019; Fuller & Cowan, 1999; Guldimann et al., 2016). The literature emphasized the influence of individual strengths on MDT work both in clinical and law enforcement matters. Complexity in cases mandated the use of multi-disciplinary approaches, which utilized the strengths of each member, and were necessary to conduct complete and thorough investigations. Additionally, Fuller and Cowan (1999) identified that team consensus could be predicted by analyzing pre-determined categories, including risks of self-harm, risks to the public at large, risks to mental health, and risks to staff. Individual strengths in these teams, paired with good working relationships, were key factors in team consensus. By focusing on key areas to identify team consensus, an assessment of the overall strengths of an MDT was achieved.

Team consensus matters, individual strengths are important, validation among members helps, and being proactive on cases improves outcomes. These are all elements of significance related to case engagement. Assessing the effectiveness of MDTs compared to individual approaches, is an important area of research focus and inquiry. Identifying members' perceptions of case engagement assists in informing future approaches related to complex cases.

Overarching Theme: Dividing and conquering

An overarching theme across all study data sources was the idea that MDTs collaboratively divide and conquer the workload of law enforcement and behavioral health. This was described as a process where decisions were made jointly and with the goal of achieving positive outcomes. Participants noted that the division of labor instilled a sense of conquering the challenges. Starting from a collaborative place of assessing individual needs, each case was then handed off to a team member who was identified as the lead to follow up on the next steps. This

process in turn led to a sense of shared case engagement and equitable division of labor. In addition, it illustrated that the underpinning of MDTs was the strategic and systematic use of each team member's skill set and expertise, thus leading to better outcomes for team members, the individual served, and the community. The aftereffects of the previously discussed deinstitutionalization movement were identified as a catalyst for changes to law enforcement work (Lamb & Bachrach, 2001). Citing increased demands for social work-related interventions during police calls for service, law enforcement partners described that MDTs helped to alleviate the burden and responsibility placed on them by providing expertise and needed resources. This point is reflected in the literature, such as in the work done by Compton and colleagues (2008).

Implications for Social Justice, Research and Policy

Implications for Social Justice

Law enforcement's primary mission is to serve and protect the public while upholding the law. From a social justice perspective this mission has become a central topic in recent years. Incidents of police brutality and use of force continue to occur (Silverstein, 2021). With widespread media coverage and 24/7 accessibility to the news, images of police violence have proliferated. The death of George Floyd in 2020 at the hands of law enforcement sparked months long protests across the country and led to sweeping police reform (Silverstein, 2021). Some of these changes focused on training received by police, including trainings on increased accountability for officers who stand by and allow violations to occur. The Active Bystandership for Law Enforcement (ABLE) Project is the most widely disseminated training regarding police bystander accountability. Focused on training officers about when to intervene if a colleague is demonstrating excessive force, ABLE has become integrated into many academies and departmental policies (ABLE Project, 2023). Originating from Ethical Policing is Courageous

(EPIC), ABLE has expanded nationally to over 41 states across the United States, training thousands of officers, and serving millions of community members. The core principles of ABLE are to a) prevent misconduct, b) avoid police mistakes, and c) promote officer health and wellness. ABLE serves as a national hub for training, technical assistance, and research aimed at creating a culture where police officers routinely intervene and accept interventions (ABLE Project, 2023).

Tracking of relevant demographic information related to arrest patterns has been in place for some time, however recent renewed calls for action have brought it to the forefront of the discussion [about the intersection of policing and social justice concerns]. This data is typically used in federal reporting on arrest patterns regarding marginalized populations and access to services. Collected data related to diversion from emergency departments also reflects a focus on race and ethnicity, seeking to identify disparities and address equity gaps. Relevant data from the Mental Health Association (MHA) notes that Black Americans experience mental health conditions at similar rates to White Americans, however, they also experience decreased access to services. This source also indicates that Blacks are more likely to be arrested for the same behavior that Whites are hospitalized for (Mental Health Association, 2023). Additionally, historical adversity has led to lower socioeconomic status for more Black Americans, which in turn translates to decreased mental health care (Mental Health Association, 2023). Regarding specific diagnoses, this data demonstrates that Black Americans are more likely to be diagnosed with psychotic spectrum disorders vs. White Americans who are more likely to be diagnosed with mood disorders for the same clinical presentation (Mental Health Association, 2023). This indicates a tendency to misdiagnose Black Americans with more serious and lifelong conditions. Black Americans with diagnosed psychotic disorders are more likely to be placed in custody than

other races. Additionally, the MHA data identifies that Black Americans are less likely to be offered medications and treatment than White Americans.

The professions of behavioral health and law enforcement have extensive racist histories, including the abuse and mistreatment of racial and ethnic minorities (Corneau & Stergiopoulos, 2012). This, in combination with the recent increased calls for action and equity in healthcare, has brought issues with police interventions to the forefront (Commonwealth of Massachusetts, 2020). The findings of this study in relation to MDT work can assist in guiding practices and continuing to support competency training for both behavioral health and law enforcement. Attention to data from both professions has illuminated gaps and areas of need which, paired with advanced police training and cultural competency awareness for both professions, can begin to maximize access to care. Underscoring the guiding principles of MDT work, participants in this study indicated that accuracy of assessment and access to care are critical aspects of rendering effective responses to calls for service. Layered in expertise, engagement, and supports, MDT-style interventions increase the likelihood of access to appropriate care while providing a means of tracking data and trends that can illuminate any ongoing areas of need and disparity (Farrell et al., 2020).

More recently, the Commonwealth of Massachusetts has prioritized equity and inclusion regarding healthcare (Behavioral Health Help Line, 2023). As a major funder of MDTs and diversion efforts, the state of Massachusetts hopes to maximize supports to marginalized populations and communities. The recent implementation of the Behavioral Health Help Line (BHHL) under the Department of Mental Health and the Community Behavioral Health Centers (CBHCs) as part of the state's Medicaid program, known as MassHealth, have re-designed the state healthcare system. The focus of these initiatives is "no wrong door" and access to

appropriate care. It is designed to be accessible to all individuals 24/7 while also being insurance and payer blind (Behavioral Health Help Line, 2023). Seeking to streamline access to care, eliminate insurance barriers, and engage 24/7 access to mental health and substance use care, Massachusetts has funded positions focused on equity and inclusion and increasing supports to marginalized communities (Behavioral Health Help Line, 2023).

Implications for Research

In the current body of literature, there is an absence of comprehensive studies evaluating the short and long-term impact of behavioral health training for law enforcement, as well as a gap in research examining the specific collaborations between law enforcement and behavioral health. One of the few examples of literature on this topic is the research into Crisis Intervention Team (CIT) training. Data collection related to law enforcement training began in the late 1980s, in turn giving us valuable information today (Compton et al., 2008). By comparison, there have only been a handful of studies conducted examining the impact of CIT. These studies concluded that CIT was held in positive regard by law enforcement. Overall, there was a finding that CIT training increased the officer's ability and confidence in addressing encounters of a behavioral health nature. Perceptions regarding behavioral health needs were also examined, and these were noted to improve in law enforcement after completion of CIT training (Ritter et al., 2010). In the state of Massachusetts, there is significant data regarding the numbers of law enforcement personnel trained in CIT (Commonwealth of Massachusetts, 2023a), however there is minimal data regarding team development. CIT team development is a significant component of CIT training, as highlighted by CIT International. The purpose of a team is to extend the impact of the training and translate that into a culture change for the police department (Compton et al., 2008).

Described as encompassing a coordinator, policy, dispatch protocol for calls, and regular meetings with behavioral health providers, CIT development is identified as the most critical piece of this work. Research into this part of CIT, the impact of a team on a police department, community, and the individuals served, was noted as limited currently. The ability to examine the impact of the training on the individual served, by comparing CIT trained officers to non-CIT trained officers, has begun to be an area of interest as renewed calls for law enforcement reform grow (Commonwealth of Massachusetts, 2023a). CIT is often described as a precursor for more extensive collaborations between law enforcement and behavioral health, including the joint on scene engagement of co-response models (Compton et al., 2008).

Aside from specialized training that brings law enforcement and behavioral health together, co-response and forensic MDTs are other areas requiring expanded examination. The research into co-response is more extensive with 26 studies conducted (Krider et al., 2020). Krider et al. describes that there are 19 different triage models, leading to multiple interpretations and operationalizations of co-response. The most commonly shared definition of co-response is the establishment of a specially trained team that includes one law enforcement and one behavioral health provider who respond to a behavioral health crisis together. The role of behavioral health in this model is to provide clinical support on scene, conduct assessments and screenings, navigate healthcare systems, and refer individuals to community resources. Advising law enforcement about appropriate responses is also part of the co-responder model (Ghelani et al., 2022). There is also a proactive follow-up element in this model, aimed at encouraging client treatment engagement. Focused on collaborations, the two disciplines are designed to complement each other and maximize support for the served individual. Although research into the co-responder model is more extensive than CIT, a review of the relevant literature

demonstrates that the variety of interpretations regarding the model can lead to confusion and mixed outcomes (Ghelani et al., 2022). Further research into the associated outcomes of each interpretation is needed. This study's research question and subsequent findings add to the understanding of law enforcement and behavioral health partnerships and collaborations. The data from this study may help to identify ways to maximize collaborations, manage interdisciplinary frustrations, navigate systemic issues, and optimize a multidisciplinary response to behavioral health crises. A possible implication from this study is the ability to address identified gaps in co-response work.

Implications for Policy

As outlined in chapter 4, there are federal laws that govern much of law enforcement and behavioral health work. The Health Insurance Portability and Accountability Act (HIPAA) regulates information sharing for behavioral health providers. The Criminal Offender Record Information (CORI), which is checked on the Criminal Justice Information Services (CJIS) platform regulates information sharing for law enforcement (CJIS, 2023). As a result, there is a need for professionals on forensic MDTs to adhere to their discipline's regulations while also providing critical and relevant care. This study aimed to explore the gaps in information sharing protocols, while adhering to federal laws and regulations. Seeking to guide the work of MDTs in new and informative ways, this study has implications for future policy development. Current initiatives are also underway, on a federal level, to amend law enforcement exceptions under HIPAA. Nationally this will have implications for the work MDTs do as well.

Recent legal changes, evidenced by the passing into law in 2020 of An Act Relative to Justice, Equity and Accountability in Law Enforcement in Massachusetts, have brought forth expectations regarding multidisciplinary collaborations (Commonwealth of Massachusetts,

2020). This law also demonstrates an increased desire for partnerships between behavioral health and law enforcement, as well as increased demands for clinical input on police matters. Signaling a shift in approaches, this state law requires expanded support from behavioral health on law enforcement matters, including training, de-escalation, case engagement, and resource connection. Forensic MDTs and this study's focus align with this shift, thus having implications for both informing current policy and guiding future policy. Standardization in policy development is a critical element to ensure consistency and fairness in approaches.

From a transformative justice theory perspective, policy development focuses on systemic change. Impacting both the offender and the victim, policy developed through a transformative justice lens has the ability to inform change on a macro level. Forensic MDTs approach cases through a biopsychosocial lens, examining the individual's needs through a multitude of perspectives. In turn, these approaches inform departmental policies aimed at addressing information flow and case engagement. Cross-trainings and regular meetings between law enforcement and behavioral health are impactful in building collaborative relationships and increased familiarity in the work. Policies are needed to inform practice and clearly identify limitations and capabilities, as well as the responsibilities of each team member.

This study has further implications related to the police academies statewide. The Municipal Police Training Committee (MPTC) operates multiple academies throughout Massachusetts and is tasked with developing and facilitating training for police recruits and officers (Commonwealth of Massachusetts, 2020). This study's findings can be translated into training modules related to integrated responses for behavioral health crises and other relevant topics. Informing training material would subsequently affect municipal and state law enforcement policy development, such as the guidelines developed by the MPTC (MPTC, 2023).

The MPTC's position as the statewide hub for police academy trainings is instrumental in guiding local policies. In addition, in partnership with the Peace Officer Standards and Training (POST), which regulates certification and de-certification for law enforcement in Massachusetts, the MPTC is considered the highest standard of practice for law enforcement (Commonwealth of Massachusetts, 2020). The findings from this study may have implications regarding policy development as a result. Policies regulating trainings are important in increasing fidelity across training modules and improving outcomes from trainings. This fidelity proves critical in establishing a benchmark for assessing training outcomes, performance standards for officers, and credibility of training instructors.

Expanding beyond the MPTC, the implications for policy development extend to the seven CIT-TTACs (CIT, Training and Technical Assistance Centers) and the two CR-TTACs (Co-Response, Training and Technical Assistance Centers) operated by the Massachusetts Department of Mental Health. Funded as hubs for specialized training and operationalizing support, these TTACs focus on CIT development and Co-Response support (Commonwealth of Massachusetts, 2023a). CIT development currently includes the creation of expanded curriculum focused on youth needs, dispatcher specific training, and refresher CIT courses (Commonwealth of Massachusetts, 2023a). Co-Response development focuses on creating infrastructure within law enforcement departments to support co-response and multi-disciplinary approaches to law enforcement calls. All TTACs are also tasked with informing policy development on these topics and integrated responses to police matters (Commonwealth of Massachusetts, 2023a). Participants in this study highlighted the need for policy to guide CIT practice and Co-Response implementation, and the findings of this study have important implications to the work of TTACs who regularly create and adapt important policy which sets a standard of practice in

Massachusetts. Implications include statewide fidelity across the development of teams and collaborative partnerships. With fidelity the ability to assess outcomes, both short and long term, improves. These policies are then shared throughout law enforcement agencies. They also inform how behavioral health agencies engage with law enforcement and the expectations about multidisciplinary collaborations.

Lastly, the implications of this study also intersect with the priorities of the recently developed Community Behavioral Health Centers (CBHCs). Expanded by Massachusetts to allow for more equity and inclusion regarding access to mental health and substance use treatment, these centers also house Drop Off Centers. These centers are available 24/7 and serve to accept individuals in crisis who do not meet hospital level of care. In addition, their mission is to provide immediate care while easing the burden on emergency departments, currently facing a boarding crisis (Behavioral Health Help Line, 2023). Subsequently, given the scope of CBHC work with law enforcement, the findings of this study are able to inform policy on multiple levels. These newly developed behavioral health centers require orientation and awareness of law enforcement trainings and interventions. This study's examination of the experiences of individuals from the behavioral health and law enforcement systems working collaboratively on behavioral health crises can be a resource to CBHC staff and managers.

Limitations

This study examined the perceptions of law enforcement and behavior health regarding their collaborations on MDTs. Codes and themes were unveiled following data collection and analysis. The collected data was subjective and representative of the participants' perspectives, thus not transferable. These perspectives were unique to the work of this particular study and not representative of all MDTs. Many of the individual perspectives are influenced by geographic

location, variations in MDT membership, area specific policies and protocols, as well as individual interpretations regarding laws and professional practice. Therefore, applying this study's findings without a close examination is cautioned against. In addition, the relatively small sample size, restricts the likelihood of causal relationships in findings. These findings may be seen as useful insights worth testing and elaborating on in future research. Identified limitations to this study align with what is found in qualitative studies, including recruitment, possible selection bias and researcher bias, along with data collection processes (Agius, 2013).

Starting with selection bias, it is important to refer to the work of Creswell and Poth (2018) who discussed the voluntary process of recruitment. Participants were recruited from a list of MDT members in the researcher's possession. Deliberate efforts were made to select participants from varied geographic locations and from communities with a variety of population sizes. Active engagement on MDTs was an inclusion criterion for all participants and ranges of MDT experience contributed to expanded and varied perspectives. Some participants had several years of MDT work experience. Others were relatively new to this work.

The study's sample contained some racial and ethnic diversity. Compared to the Massachusetts state census, there were some similarities and some disparities. The percentage of white participants was close to the 68% identified in Massachusetts data (Commonwealth of Massachusetts, 2023b). The percentage of Black participants, at approximately 10%, exceeded the state's rate (7%). Hispanic participants also exceeded the state data (13%) at approximately 25%. There were no Asian participants. Regarding gender, behavioral health participants identified as female (100%). While nationally male representation in this field is a smaller percentage than female, the absence of male-identified participants is noteworthy. Law enforcement had approximately 16% of participants (2) that identified as female, with the rest

(10) identifying as male. This also exceeded the national average of 12% female in law enforcement. Although there is opportunity for the research to be more diverse and representative of a more expansive population, the above referenced percentages demonstrate a conscientious effort to capture varied perspectives. This was achieved as part of the purposive sampling process.

Another limitation relates to effects of the COVID-19 pandemic at the time of data collection. Since 2020, familiarity with virtual platforms has significantly increased. For convenience and scheduling purposes, this study was held on virtual platforms. Pre-pandemic this would have been a study conducted in person. The nuances of in-person meetings and the dynamics that develop, such as a sense of comfort and ease of conversation flow, are not equally present on virtual platforms and may take longer to develop, compared to in-person experiences. Therefore, a possible limitation is the virtual platform and impact on allotted time. Conceivably in an in-person setting less time would have been spent "breaking the ice" and establishing a rhythm to the conversation (Woodyatt et al., 2016).

As the primary investigator for this study, the researcher plays a key role in all study elements. This researcher's professional role as intricately involved on MDTs and familiar with this work had to be bracketed to decrease bias. The researcher's bias carries potential for impacting the interpretation of the collected data, thus leading to another study limitation. Familiarity with the participant population and existing relationships also impact this study and are listed under potential limitations. The impact can occur both in the collection and interpretation of the data based on pre-existing ideas and beliefs. The methodology of the study, research questions, and purposive sampling can themselves lead to limitations as bias may be present at each point. Factors leading to decisions such as inclusion and exclusion criteria, also

contributed to study limitations. Additionally, another limitation could relate to the experiential exercise which was administered to each group (each group only representative of one discipline), thus lacking the multidisciplinary aspect of a real-world MDT response to such a scenario.

Particularly in case study research, a phenomenon is studied bounded in space and time (Nije & Asimiran, 2014). This methodology can limit study findings as it is representative of data collected for a specific moment in time and reflective of the perceptions of the study participants only. Interpretations and inferences are a part of the data collection and analysis portions, which can also contribute to study limitations (Nije & Asimiran, 2014). However, every effort for rigor was made by the researcher. This was facilitated by establishing multiple data sources, triangulating the data, peer debriefing of the coding and thematic analysis portions, conducting multiple reviews and iterations of data analysis, and maintaining a comprehensive study record for audit purposes.

Conclusion

The fields of law enforcement and behavioral health share many similarities and differences. Among the similarities is the responsibility to care for the population they serve. The job of meeting increasingly complex clinical needs while managing risk is a shared responsibility. Bringing these disciplines together to work collaboratively carries with it many challenges and rewards. Ways to minimize the challenges and increase the rewards were explored in this study through the perspective of MDT members. Behavioral health and law enforcement partners were brought together to identify and explore the main advantages and disadvantages evident to the members of multidisciplinary teams of law enforcement and behavioral health providers when responding to behavioral health crises. This study aimed to 1)

understand how communication between behavioral health professionals and law enforcement impacts their ability to collaborate; 2) uncover how information sharing between both disciplines influences outcomes; 3) describe the perceptions of members of both disciplines regarding levels of case engagement.

The study contributes to MDT knowledge and practice by focusing on the key areas integral to MDT development and success. Individuals served by forensic MDTs benefit from multiple areas of expertise and connection to resources. Risk is also managed through this collaborative work, which assists in diverting individuals away from the criminal justice system and emergency departments. Seeking to balance community and individual needs, MDTs must navigate complex laws, differing professional guidelines, multiple policies, unique geographic needs, and interpersonal dynamics. This study's results indicate that effective MDTs require intentional work, specialized training, varied expertise, and patience working on complex cases to overcome systemic and individual barriers faced by the teams.

Bounded in time and space, participants were asked to answer relevant research questions, participate in a shared experiential activity of a behavioral health call to law enforcement, and complete pre- and post-questionnaires related to their work. Researcher field notes were also collected for triangulation of the data. Transcripts were coded and re-coded over several iterations of review for rigor. Both thematic coding and thematic analysis were debriefed by a peer. The study's findings have potentially expansive implications in the field of social justice, research and policy development. Additionally, this work has highlighted future areas for expanding upon the research. One way to advance beyond this study includes focusing on a more diverse participant pool, representative of additional areas in Massachusetts.

At a time where clinical input into police matters is becoming a community expectation, this study's findings have potential implications that can contribute to shifting the role of MDTs across the State. Paired with Massachusetts' increasing support for MDTs, and the development of working groups for equity and inclusion, this study's findings indicate opportunities for bettering curriculum development and training for both behavioral health and law enforcement, information sharing practices, data collection and analysis, technical assistance, and expansion of behavioral health resources.

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Appendix A – Focus Group Guide

Questions:

1. Please describe your experience of working on a forensic multidisciplinary team. Consider issues such as self-perception and perception of others' roles within the team.

   Prompt:
   a. What is most meaningful to you about your work on this team?

2. Tell me about what it is like to communicate and work in an MDT with professionals who have different training/perspective than yours?

3. What are the main advantages and disadvantages of collaborations between behavioral health and law enforcement on multidisciplinary teams when responding to behavioral health crises?

   Prompt:
   a. Are there any themes/topics that are most prominent in your experience?

4. What are your perceptions of information sharing within the team? Consider your own profession's regulations and the regulations of the other profession.

   Prompts:

   a. Have practical aspects of professional regulations impacted the collaborative nature of your multidisciplinary teamwork?

   b. What has that been like for you?

Appendix B – Recruitment Email

Email sent out to 30 potential participants identified by my colleagues as fitting the criteria of either law enforcement or behavioral health provider participating on a forensic MDT.

For privacy purposes the content of the email is cut and pasted here

"Your participation in a PhD dissertation study is kindly requested. You have been identified by virtue of your role on a forensic multidisciplinary team. Your participation is completely voluntary and non-compensated. Everything will be confidential and used solely for the purposes of educational advancement and course requirement completion. A focus group will be conducted lasting 60-90 minutes. During this time semi-structured interview questions will be asked, and a fictional behavioral health crisis call reviewed as a group. At the conclusion of the study, a written post-study questionnaire will be distributed to be completed at that time. This will conclude the elements of the study."

If you are interested, please kindly respond to this email for further specifics to be discussed and conveyed.

Joanne Barros, LMHC, PhD Candidate

Appendix C – Informed Consent

29 Everett St., Cambridge, MA 02138

Informed Consent

You are invited to participate in the research project titled "An examination of law enforcement and behavioral health collaborations in multidisciplinary teams (forensic MDTs)". The intent of this research study is to "1) understand how communication between behavioral health professionals and law enforcement impacts their ability to collaborate; 2) uncover how information sharing between both disciplines influences outcomes; 3) describe the perceptions of members of both disciplines regarding levels of case engagement."

Your participation will entail "Participants will meet for 1-2 hours for a focus group of peers, behavioral health providers and law enforcement personnel."

In addition

- You are free to choose not to participate in the research and to discontinue your participation in the research at any time without facing negative consequences.
- Identifying details will be kept confidential by the researcher. Data collected will be coded with a pseudonym, the participant's identity will never be revealed by the researcher, and only the researcher will have access to the data collected.
- Any and all of your questions will be answered at any time and you are free to consult with anyone (i.e., friend, family) about your decision to participate in the research and/or to discontinue your participation.
- Participation in this research poses "minimal to no harm, if any is reported appropriate supports will be provided."

• If any problem in connection to the research arises, you can contact the researcher "Joanne Barros at 617-480-9398, jbarros3@lesley.edu" or Lesley University sponsoring faculty "Joseph Mageary, PhD."

• The researcher may present the outcomes of this study for academic purposes (i.e., articles, teaching, conference presentations, supervision etc.) I am 18 years of age or older. My consent to participate has been given of my own free will and that I understand all that is stated above. I will receive a copy of this consent form.

_____ _____ _____ _____

Participant's signature Date Researcher's signature Date

There is a Standing Committee for Human Subjects in Research at Lesley University to which complaints or problems concerning any research project may, and should, be reported if they arise. Contact the Committee Chairperson at irb@lesley.edu

Appendix D – Demographic Information

Demographic questionnaire:

- What is your age?
- What is your race and ethnic background?
- What is your gender?
- What is the highest level of education you have completed?
- What is your professional title?
- How long have you been in this role?
- Do you have any MDT specialized training?

Appendix E – Post-questionnaire

-Please describe how your experience on a forensic MDT impacted your responses during the experiential case example.

-Please list five words that come to mind when thinking about this experiential exercise.

-Are there any other comments or observations about the experience that you think would be useful for the researcher to know?