LOS ANGELES POLICE DEPARTMENT
CONSENT DECREE MENTAL ILLNESS PROJECT

Final Report

Appendices

CITY OF LOS ANGELES
(LOS ANGELES POLICE DEPARTMENT)

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APPENDIX A: LITERATURE REVIEW

Purpose

It is commonly known throughout law enforcement that police officers often have contacts with persons who are suspected or known to have a mental illness. There is also some suggestion, although no empirical data, that the number of such contacts has increased in recent years due to several major policy changes in the mental health field.[1] These policy changes include the closing of large state and county hospitals resulting in a decreased number of psychiatric beds, restrictions on involuntary commitment criteria, and decreased funding of community mental health programs.[2&3]

Many law enforcement agencies have responded to this national situation by developing specialized programs and approaches for dealing with the specific problems that arise in encounters with persons who may have a mental illness. This appendix summarizes the available published research on innovative and best practices in this area.

Methodology

Lodestar reviewed pertinent professional literature in both the mental health and criminal justice fields to collect information on best practices used by police departments to de-escalate potentially violent encounters and provide more appropriate disposition for persons who may have a mental illness.

Relevant information was reviewed and compiled from: electronic databases; professional literature; media reports; and law enforcement trade publications. These sources were complemented with secondary analyses of national research surveys. To enhance the practical value of this review, selected information is also incorporated from Lodestar's recent site visit contacts with scholars, practitioners and leaders of existing specialized response programs.

Findings

Frequency of Contact

People with severe mental illness frequently have contact with police because of disruptive behavior or minor infractions that may be a consequence of their experiencing psychiatric symptoms or social disruptions related to their disability. Most of these encounters are resolved

[1] Engel, R. S. & Silver, E. (2001). Policing mentally disordered suspects: A reexamination of the criminalization hypothesis, *Criminology 39*, pp. 225-252.
[2] *Ibid.*
[3] Teplin, L. A. (2000). Keeping the peace: Police discretion and mentally ill persons, *National Institute of Justice Journal, July*, pp. 9-15.

informally, although a substantial number do result in arrest. Disposition of these cases through arrest results in large numbers of misdemeanants with mental illness being held in jails and processed through the court system. In fact, most studies show that the prevalence of severe mental illness in jails and prisons is about three to five times higher than in the community.[4]

People with severe mental illness come into contact with the criminal justice system through police encounters so often that it is essentially the norm, rather than the exception. Police officers report frequent contacts with persons who are mentally ill, who in turn similarly report frequent contacts with police.

- Major police departments across the country estimate that seven percent of all their police contacts involve people with mental illness in crisis.[5]

- In a survey of over 450 police officers in three U.S. cities, officers reported responding to an average of six calls involving people with mental illness in crisis within the past month.[6]

People with a mental illness also report frequent contacts with police.

- In a survey of over 350 involuntarily committed people with severe mental illness, approximately 20 percent reported that they had been picked up or arrested for crime in the four months preceding their hospital admission.[7]

- More than half of the members surveyed from a state chapter of the National Alliance for the Mentally Ill (a major advocacy organization composed primarily of family members of people with mental illness) reported that their relatives with mental illness had been arrested at least once. The average number of arrests was more than three.[8]

- In a sample of 360 psychiatric patients seen at an urban outpatient mental health clinical, almost half (48.6 percent) had a history of arrest. Those patients with a criminal history (mean age of 43) had accumulated an average of 6.8 arrests.[9]

The result of using arrest to dispose of minor offense cases is that approximately 685,000 people with severe mental illness are admitted to U.S. jails every year. Numerous studies from around the country show that between six and 15 percent of all jail inmates have a severe

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[4] Lamb, H. R. & Weinberger, L. E. (1998). Persons with severe mental illness in jails and prisons: A review, *Psychiatric Services, 49*, pp. 483-492.
[5] Deane, M. W., Steadman, H. J., Borum, R., Veysey, B. M., & Morrissey, J..P. (1999). Emerging partnerships between mental health and law enforcement, *Psychiatric Services, 50*, pp. 99-101.
[6] Borum, R., Deane, M. W., Steadman, H. J., & Morrissey, J. (1998). Police perspectives on responding to mentally ill people in crisis: Perceptions of program effectiveness, *Behavioral Sciences and the Law, 16,* pp.393-405.
[7] Borum, R., Swanson, J., Swartz, M., & Hiday, V. (1997). Substance abuse, violent behavior and police encounters among persons with severe mental disorder. *Journal of Contemporary Criminal Justice, 13*, pp. 236-250.
[8] McFarland, B., Faulkner, L., Bloom, J., Hallaux, R., et al. (1989). Chronic mental illness and the criminal justice system. *Hospital and Community Psychiatry, 40,* pp. 718-723.
[9] Frankle, W.G., Shera, D., Berger-Hershkowitz, H., Evins, A.E., Connolly, C., Goff, D., & Henderson, D. (2001). Clozapine-associated reduction in arrest rates of psychotic patients with criminal histories. *American Journal of Psychiatry, 158,* pp. 270-274.

mental illness.[10] This means that nationally there are currently more people with severe mental illness in U.S. jails than in state psychiatric hospitals.[11] According to the National Alliance of the Mentally Ill (NAMI), there are over 200,000 persons with a severe mental illness incarcerated in federal and state jails and prisons on any given day.[12] In Los Angeles, the County jail has been referred to as the largest psychiatric institution in America, because on an average day the jail houses more than 1,500 inmates with severe mental illness.[13]

Although some people with mental illness do commit offenses for which incarceration is the most appropriate disposition, many are confined as a result of arrests for minor infractions. In these cases, confinement does not alleviate, and may exacerbate, the original problem – that is, an individual with mental illness is experiencing a crisis episode that has led to inappropriate behavior. If the goal is to reduce the likelihood of future encounters with law enforcement, then mental health treatment is more likely than routine criminal adjudication to facilitate that goal. Policy makers have long recognized the need to reduce the prevalence of severe mental illness in jail by diverting minor offenders into the mental health system. This was a major recommendation of the National Coalition for Jail Reform as early as the 1970s.

National Perspective

Over the past decade, law enforcement agencies have been increasingly active in developing specialized approaches to manage field encounters involving people with mental illness. The objective of these efforts typically is twofold: (1) to reduce aggression or use of force in the encounters, and (2) to divert cases involving persons who may have a mental illness from the criminal justice system where appropriate to improve outcomes. While many of the first generation efforts met with limited success, the second generation of specialized approaches is more focused and sophisticated and show substantial promise.

First Generation Approaches

Some of the earliest efforts to improve response to persons with mentally illness focused exclusively on training. It was initially believed that officers' difficulty in responding to people with mental disabilities was caused primarily by negative attitudes and biases arising from erroneous assumptions and lack of information about mental illness.[14&15] These first generation training efforts did appear to improve officers' knowledge of mental health issues[16] and their ability to apply this knowledge in identifying and communicating about mental illness,[17]

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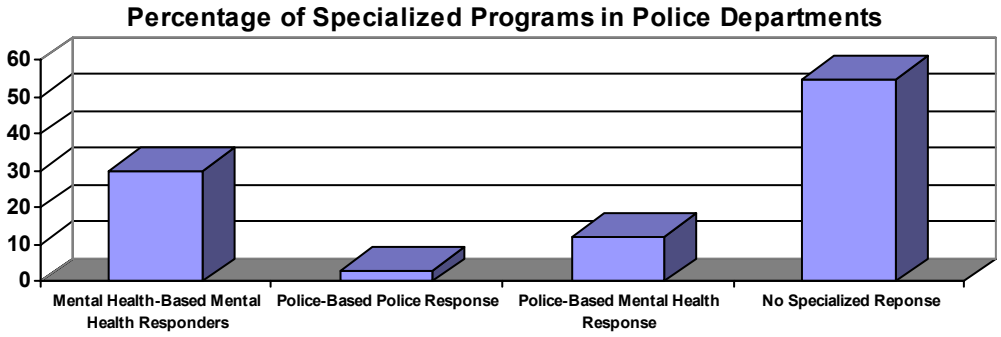
[10] Lamb, H. R. & Weinberger, L. E. (1998). Persons with severe mental illness in jails and prisons: A review, *Psychiatric Services, 49*, pp. 483-492.
[11] Torrey, E.F., Stieber, J., Ezekiel, J., Wolfe, S.M., Sharfstein, J., Nobel, J.H., & Flynn, L.M. (1992). Criminalizing the seriously mentally ill: The abuse of jails as mental hospitals, *National Alliance for the Mentally Ill*.
[12] http://www.nami.org/update/omirasec11.html (9/6/2001). Section 11. Reduction in the Criminalization of Persons with Severe Mental Illnesses.
[13] CAPT *Outreach* Magazine (2000). Prisons: The nation's new mental institutions, *Author, February.*
[14] Nunnally, J. C., Jr. (1961). *Popular conceptions of mental health: Their development and change.* New York: Holt.
[15] Lester, D. & Pickett, C. (1978). Attitudes toward mental illness in police officers. *Psychological Reports, 42,* pp. 888.
[16] Godschalx, S. M. (1984). Effect of a mental health educational program upon police officers, *Research in Nursing and Health, 7*, pp. 111-117.
[17] Janus, S.Ss, Bess, B.E., Cadden, J.J., & Greenwald, H. (1980). Training police officers to distinguish mental illness. *American Journal of Psychiatry, 137*, pp. 228-229.

but attitudes and performance were more resistant to change. Early efforts to train officers in crisis intervention also produced indeterminate results. Many departments have implemented crisis training programs in varying forms, however, the empirical data on their efficacy is equivocal.[18]

Second Generation Approaches

The second generation of programs shifted strategies. Instead of providing brief training for all officers, they use specialized responders for calls involving persons who are mentally ill.[19 & 20] A national survey of major police departments found that there are various models used to provide a specialized response to persons who are mentally ill in crisis. The chart below shows the percentage of departments that report having a specialized program. One of the key distinctions among these programs, however, is whether the specialized responders are law enforcement personnel or mental health professionals. A discussion of the three major second generation approaches is presented below.



Source: Deane, et al., 1999

Mental Health-Based Mental Health Responders. In this more traditional model, a partnership or cooperative agreement is developed between the police department and the local community mental health system. Through this agreement, a mobile mental health crisis team provides assistance to police when responding to persons who may have a mental illness. Mobile mental health crisis teams typically exist as part of the local community mental health services system and operate independently of the police department.

The mobile crisis team (MCT) emerged as a key emergency intervention during the 1960s-1970s. During this period, psychiatric emergency services experienced tremendous growth as it moved toward treating people with mental disability in the community, rather than in institutions.

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[18] Mulvey, E.P. & Repucci, N.D. (1981). Police crisis intervention training: An empirical investigation. *American Journal of Community Psychology, 9,* pp. 527-546.
[19] Borum, R., Deane, M. W., Steadman, H. J., & Morrissey, J. (1998). Police perspectives on responding to mentally ill people in crisis: Perceptions of program effectiveness, *Behavioral Sciences and the Law, 16,* pp.393-405.
[20] Steadman, H. J., Deane, M. W., Borum, R., & Morrissey, J. P. (2000). Comparing outcomes of major models of police response to mental health emergencies, *Psychiatric Services, 51,* pp. 645-649.

Mobile crisis programs still appear to be quite popular today. Geller, Fisher and McDermeit[21] surveyed departments of mental health in all 50 states and found that 37 (72.5 percent) of them had some mobile crisis response capacity. Ninety-five percent believed that mobile response capacity had a significantly positive impact on the functioning of their state's crisis services.

Despite a proliferation of MCT programs and their descriptions in the professional literature over the years[22], there are very few data to evaluate their claims of effectiveness.

- Only eight of the MCT programs in the Geller study routinely collected any data that would allow for an assessment of effectiveness. Nor were any data provided in the study to assess the degree of cooperation between the mobile crisis teams and other emergency services in the community, most notably law enforcement agencies.

- In one of the few early studies, Fisher and colleagues evaluated the claim that mobile crisis services reduce hospitalization rates by resolving crises in the community.[23] Investigators compared the admission rates in Massachusetts catchment areas with and without mobile crisis response, controlling for differences in community resources and demand for hospitalization. They found no effect for mobile crisis response on hospital admission rates.

A study by Bengelsdorf did show some positive impact of MCT on cost effectiveness.[24] The study involved following 50 adult psychiatric patients for six months after their index intervention. The study found that while mobile crisis intervention was fairly expensive, it still produced substantial cost savings. This was particularly true for cases where admission was diverted, but also for cases where the admission was only forestalled.

Perhaps one of the most significant barriers to greater satisfaction with, and utilization of, mobile crisis teams is that sometimes – of necessity – the response times are too lengthy for patrol officers in field encounters.[25 & 26]

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[21] Geller, J.L., Fisher, W.H., & McDermeit, M., (1995). A national survey of mobile crisis services and their evaluation. *Psychiatric Services, 46*, 893-897.
[22] *Ibid*.
[23] Fisher, W.H., Geller, J.L., & Wirth-Cauchon, J. (1990). Empirically assessing the impact of mobile crisis capacity on state hospital admissions. *Community Mental Health Journal, 26,* 245-253.
[24] Bengelsdorf, H., Church, J.O., Kaye, R.A., Orlowski, A., & Alden, D.C. (1993). The cost effectiveness of crisis intervention: Admission diversion savings can offset the high cost of service. *Journal of Nervous and Mental Disease, 181*, 757-762.
[25] Borum, R., Deane, M. W., Steadman, H. J., & Morrissey, J. (1998). Police perspectives on responding to mentally ill people in crisis: Perceptions of program effectiveness, *Behavioral Sciences and the Law, 16,* pp.393-405.
[26] Stroul, B.A. (1993). *Psychiatric crisis response systems: A descriptive study.* Rockville, MD: National Institute of Mental Health.

- In a study of police programs, the Knoxville, TN police department continues to use MCTs to provide mental health crisis services for the police. Ratings by patrol officers regarding the effectiveness of MCTs on reducing the amount of time they spend on mental disturbance calls are significantly lower when compared to ratings of other specialized police response programs.[27]

If mobile crisis response were more rapid, there is reason to believe that the MCT would be well received by law enforcement personnel.[28] In an article entitled: "What do police officers really want from the mental health system?" Gillig and colleagues report that the officers in their study "repeatedly stressed the importance to them of having rapid on-site assistance from mental health professionals when faced with difficult or complex situations involving mentally ill persons" (p.665). [29]

Some law enforcement agencies have developed an alternative approach to address the MCT response time problem. This approach relies on the use of a team of police officers who are specially trained in mental health issues.

Law Enforcement-Based Specialized Law Enforcement Responders. The dominant model for the use of specialized law enforcement responders is the Crisis Intervention Team (CIT) pioneered by the Memphis Police Department. The CIT is a police-based program staffed by police officers with special training in mental health issues. The team operates on a generalist-specialist model, so that CIT officers provide a specialized response to "mental disturbance" crisis calls in addition to their regularly assigned patrol duties. For general patrol, the officers are assigned to a specific area, however CIT officers have city-wide jurisdiction for these specialized calls. Patrol officers volunteer for the program, and are carefully screened and selected to receive an initial 40-hours of specialized training about mental illness, substance abuse, psychotropic medication, treatment modalities, patient rights, civil commitment law, and techniques for intervening in a crisis. Professionals, advocates, and consumers in the community provide this training at no charge to the police department.[30&31]

CIT selects volunteer officers with the greatest interest, most amenable attitudes and best interpersonal skills, then provides them with intensive training and deploys them specifically as a first line response to these specialized calls. Although the Memphis mental health system has a mobile crisis team in the city, they are rarely called or used by CIT officers. Since the CIT program began operation more than 12 years ago, it has gained national recognition, from mental health advocates (NAMI) and the criminal justice community[32]. Currently, there are

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[27] Borum, R., Deane, M. W., Steadman, H. J., & Morrissey, J. (1998). Police perspectives on responding to mentally ill people in crisis: Perceptions of program effectiveness, *Behavioral Sciences and the Law, 16*, pp.393-405.
[28] Olivero, J.M., & Hansen, R. (1994). Linkage agreements between mental health and law enforcement agencies: Managing suicidal persons. *Administration and Policy in Mental Health, 24*, 217-225.
[29] Gillig, P.M., Dumaine, M., Stammer, J.W., Hillard, J.R., & Grubb, P. (1990). What do police officers really want from the mental health system. *Hospital and Community Psychiatry, 41*, 663-665.
[30] Cochran, S., Deane, M., & Borum, R. (2000). Improving police response to mentally ill people in crisis: Crisis Intervention Teams. *Psychiatric Services, 51*, pp. 1315 – 1316.
[31] DuPont, R. & Cochran, S. (2000). Police response to mental health emergencies – barriers to change. *Journal of the American Academy of Psychiatry and Law, 28*, pp. 338 344.
[32] Steadman, H.J., Stainbrook, K.A., Griffin, P., Draine, J., Dupont, R., & Horey, C.H. (2001). A specialized crisis response site as a core element of police-based diversion programs, *Psychiatric Services, 52,* pp. 219-222.

more than 18 jurisdictions that have implemented or are implementing the CIT model including: Athens, GA; San Jose, CA; Jacksonville, FL; Independence, MO; Albuquerque, NM.[33]

A recent National Institute of Justice (NIJ) study found that the Memphis CIT program resulted in: a low arrest rate for mental disturbance calls, approximately three percent; a high rate of utilization by patrol officers; a rapid response time, and frequent referrals to treatment.[34] More recently, an evaluation of the Albuquerque CIT program found that since CIT began in the city, the number of police shootings involving individuals in crisis declined, despite the seven percent increase in population since 1996. Albuquerque attributes this to the CIT program and their commitment to less than lethal force tactics.[35]

Although CIT has many proponents, some have raised concerns that the model uses law enforcement officers as the sole and primary responders to mental health crises, when it would be more appropriate to have a mental health professional on-scene.[36] Other law enforcement agencies have developed another approach for dealing with mental health crises that encourages a rapid response and provides appropriate dispositions for these encounters. This approach involves mental health professionals that ride along with officers to provide consultation and perform evaluations of subjects in crisis.

Law Enforcement-Based Mental Health Responders Some law enforcement agencies have experimented with approaches that allow both a sworn officer and a mental health professional to serve as first responders to mental health crisis calls. There have been numerous innovative programs following this model. The Birmingham Police Department instituted a Community Service Officer program (CSO). They developed a team of civilian social workers who would be employed by the police department and provide on-site assistance for mental health crises and related emergencies. The program has been in existence for over 20 years.

The CSOs are civilian police employees with professional training in social work and related fields. As civilians, they do not carry weapons or have the authority to effect an arrest. They are also non-uniformed in their attire, and drive unmarked police vehicles but do carry police radios. The CSOs are on duty between 8:00 am and 10:00 p.m. during the week and are "on call" during overnight and weekend hours.

When a police officer responds to a scene involving a person with mental illness in crisis, he/she may contact a CSO who will respond directly and provide on-scene crisis intervention, referral, transportation, or disposition as necessary. Recent research suggests that a CSO may be particularly skilled at on-scene intervention.[37] A survey of Birmingham Police Officers revealed that more than a third thought the CSO program was effective for meeting the needs of people

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[33] DuPont, R. & Cochran, S. (2000). Police response to mental health emergencies – barriers to change. *Journal of the American Academy of Psychiatry and Law, 28,* pp. 338 344.
[34] Steadman, H. J., Deane, M. W., Borum, R., & Morrissey, J. P. (2000). Comparing outcomes of major models of police response to mental health emergencies, *Psychiatric Services, 51*, pp. 645-649.
[35] Bower, D. L. & Pettit, W. G. (2001). The Albuquerque Police Department's crisis intervention team: A report card, *FBI Law Enforcement Bulletin, 70,* pp. 1-6.
[36] Eslinger, D.F. (2001, December 6). Police officers aren't mental health professionals. *Orlando Sentinel.*
[37] Steadman, H. J., Deane, M. W., Borum, R., & Morrissey, J. P. (2000). Comparing outcomes of major models of police response to mental health emergencies, *Psychiatric Services, 51*, pp. 645-649.

with mental illness in crisis, and about half thought it helped to keep people with mental illness out of jail and helped maintain community safety.[38]

In June 1996, building on a foundation established by the Los Angeles County Sheriff's Office (MET program), the San Diego Police Department – in collaboration with the County Department of Mental Health and the Sheriff's Office – began a pilot test for the Psychiatric Emergency Response Team (PERT). Each PERT team is composed of a sworn, uniformed patrol officer with specialized training and a civilian mental health clinician who respond jointly to calls involving persons with a mental illness. The two primary goals of the program are: (1) to divert Persons who are mentally ill who commit only minor offenses away from jail and (2) to reduce the amount of time that officers are required to spend managing these calls.

In the first year of operation, the PERT team handled 1,200 cases with only 7 of them resulting in arrest. Most cases resulted in transportation to a medical/psychiatric facility or in referral to outpatient mental health services. A preliminary evaluation also found that officers spent an average of only 22 minutes on each of these calls – a significant reduction from the time required before the implementation of PERT. Following the success of the pilot program, PERT was expanded to all divisions of the police department throughout San Diego County.

Similar programs exist in the Los Angeles Police Department (LAPD), Pasadena, and Long Beach. A more detailed description of San Diego's program is presented in the Site Visit section of this report. A previous study examining LAPD's program (SMART) found that few arrests were made by SMART teams and a majority of persons encountered by the team were transported to the hospital.[39]

Review of Approaches

There are proponents of each of the specialized approaches who assert the advantages of their program over the others.

- Agencies taking the traditional approach of partnering with Mobile Crisis Teams emphasize the sensibility of defining proper roles for mental health professionals and for law enforcement officers. Using this approach, the mental health clinician has the initial contact with the persons with mental illness. Because the clinician is connected to the local mental health system, it is suggested that the persons with mental illness are more likely to receive an appropriate mental-health related disposition and less likely to be arrested for only minor offenses. Moreover, this gives the mental health system greater responsibility for managing mental health problems and crises in the community.

- Crisis Intervention Team (CIT) programs emphasize the importance of having a rapid response to the call and of having a specialist as the initial and primary responder. They also suggest that their program is relatively inexpensive to implement and does not require hiring any new personnel.

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[38] Borum, R., Deane, M. W., Steadman, H. J., & Morrissey, J. (1998). Police perspectives on responding to mentally ill people in crisis: Perceptions of program effectiveness, *Behavioral Sciences and the Law, 16*, pp.393-405.

[39] Lamb, H. R., Shaner, R., Elliott, D. M., DeCuir, W. J., & Foltz, J. T. (1995). Outcome for psychiatric emergency patients seen by an outreach police-mental health team, *Psychiatric Services, 46(12)*, pp. 1267-1271.

- Law enforcement agencies that use combined response teams of officers and clinicians claim to have the advantages of rapid (and initial) response to calls involving persons with mental illness and of having a mental health professional on-scene to assess and manage the subject's symptomatic behavior and to facilitate appropriate mental health-related dispositions. Although this approach arguably requires additional personnel, the clinicians often are paid by the mental health authority, and having a multi-agency response can enhance community partnerships. Moreover, some administrators believe that reductions in patrol time spent on these calls produces substantial operational savings for the department over time.

One study compared all three programs in three different cities on arrest rates, response time, and law enforcement satisfaction.[40] Lower rates of arrests and response time with higher levels of satisfaction were found for the Police-Based responses when compared to the Mental Health-Based response. Though there is some empirical evidence to support the claims that one type of program has specific advantages over another, it is not clear whether some programmatic advantages may be related to the particular contextual features of the jurisdiction, such as a strong emergency mental health infrastructure.

A recent review of three specialized responses in Montgomery County, PA; Memphis, TN; and Multnomah County, OR suggest that there are five major elements of successful specialized responses.[41] These elements include: (1) a central and single point of entry into the mental health system; (2) policies and procedures at the receiving psychiatric facility that allow for a quick disposition; (3) laws that support diversion from arrest and jail towards psychiatric treatment; (4) cross-disciplinary training that includes both law enforcement and mental health professionals; and (5) linkages to community services so that officers can link individuals to the appropriate care. All three programs are considered innovative and exemplary by consumer advocates and other law enforcement agencies; however, even "effective" programs may not perform equally well in every community. Yet, without strong empirical evidence of their local viability, law enforcement administrators are asked to decide whether to implement a specialized response program, and if so, which one to choose.

Policies and Guidelines

In addition to police department development of specialized responses, other organizations have developed specialized policies for law enforcement to engage in when dealing with persons who are mentally ill in crisis.

The National Alliance for the Mentally Ill has created guidelines for state and local police training and response to offenders with mental illnesses.[42] These guidelines include a minimum of 30 hours of training for new police recruits that include information about symptoms and characteristics of severe mental illnesses, appropriate responses to persons who are mentally ill who are in crisis, alternatives to arrest or incarceration for minor offenses, and community

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[40] Deane, M.W., Steadman, H.J., Borum, R., Veysey, B.M., & Morrissey, J.P. (1999). Emerging partnerships between mental health and law enforcement, *Psychiatric Services, 50,* pp. 99-101.
[41] Steadman, H.J., Stainbrook, K.A., Griffin, P., Draine, J., Dupont, R., & Horey, C.H. (2001). A specialized crisis response site as a core element of police-based diversion programs, *Psychiatric Services, 52*, pp. 219-222.
[42] http://www.nami.org/update/omirasec11.html (9/6/2001). Section 11. Reduction in the Criminalization of Persons with Severe Mental Illnesses.

resources to provide appropriate referrals. NAMI also suggests that for all other officers a 20-hour training be provided that include the same components as the 30-hour training. NAMI also recognizes the need to have access to a professional with specialized training in dealing with persons who are mentally ill that is in crisis on a 24 hour, seven day a week basis. This specialist does not have to be a mental health professional, but could also be a specially training police officer.

In 1984, the American Bar Association adopted the criminal justice mental health standards (Standard 7-2.1 to 7-2.9) proposed by its Standing Committee on Association Standards for Criminal Justice. These standards call for law enforcement agencies to:

- provide specialized training to assist officers in their response to persons who may be mentally ill;
- use qualified professionals to provide such training for recruit and in-service programs;
- create written policies that document the appropriate procedures for crisis encounters with mentally ill persons; and
- collaborate with mental health agencies on developing appropriate policies and procedures for police contacts with persons who are mentally ill.[43]

[43] American Bar Association. (1984). *Criminal justice mental health standards.* Chicago, IL: Author.

APPENDIX B: Methods and Findings from the Evaluation of Best Practices in Other Law Enforcement Agencies

METHODS

Lodestar employed two complementary approaches to discover successful practices of other police agencies regarding contacts with persons who may be mentally ill. The first was a thorough review of the relevant literature in this area. Based on that review and additional information, five carefully selected model programs throughout the United States were assessed using site visits and other research procedures.

Literature Review

Lodestar reviewed the professional literature in mental health and in criminal justice to search for innovative and best practice approaches used by police departments to de-escalate potentially violent encounters with persons with a mental illness and to provide more efficient disposition. Electronic databases were searched for relevant articles along with a review of professional literature, media reports, law enforcement trade publications, and supplemented with secondary analyses of national research surveys, personal contacts with scholars, practitioners and leaders of existing specialized response programs. Appendix A contains a detailed summary of the findings of the literature search. A brief summary of the findings are presented below.

Over the past decade, law enforcement agencies have been increasingly active in developing specialized approaches to managing field encounters with people who may be mentally ill. The objective of these efforts typically is twofold: (1) to reduce aggression or use of force in the encounter, and (2) to divert cases involving such persons from the criminal justice system, when appropriate, in order to improve outcomes for the consumer. While many of the first generation efforts to accomplish these ends met with limited success, the second generation of specialized approaches is more focused and sophisticated and shows substantial promise.

Some of the earliest efforts to improve response to persons who have a mental illness focused almost exclusively on training. It was initially believed that officers' difficulty in responding to people with mental disabilities was primarily due to their negative attitudes and biases arising from erroneous assumptions and lack of information about mental illness.[1&2] Although these early training efforts did appear to improve officers' knowledge of mental health issues[3] and their ability to apply this knowledge in identifying and communicating about mental illness,[4] changes in attitudes and performance were more resistant to change. Similarly, early efforts to train officers in crisis

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[1] Nunnally, J. C., Jr. (1961). *Popular conceptions of mental health: Their development and change.* New York: Holt.
[2] Lester, D. & Pickett, C. (1978). Attitudes toward mental illness in police officers. *Psychological Reports, 42*, pp. 888.
[3] Godschalx, S. M. (1984). Effect of a mental health educational program upon police officers, *Research in Nursing and Health, 7*, pp. 111-117.
[4] Janus, S.S., Bess, B.E., Cadden, J.J., & Greenwald, H. (1980). Training police officers to distinguish mental illness. *American Journal of Psychiatry, 137*, pp. 228-229.

intervention produced indeterminate results. Although many departments have implemented crisis training programs in varying forms, the empirical data on their efficacy has been fairly equivocal.[5]

The second generation of programs shifted strategies. The review of the literature found that there are various models used to create a specialized response to persons with mental illness in crisis. Instead of providing brief training for all officers, these new models use specialized responders for calls involving such persons.[6 & 7] One of the key distinctions among these programs, however, is whether the specialized responders are law enforcement personnel or mental health professionals. The following is a brief description of the three prominent second generation approaches:

- ***Mental Health-Based Mental Health Responders***
  In this more traditional model, partnerships or cooperative agreements are developed between police and local community mental health providers. A mobile mental health crisis team exists as part of the mental health system and operates independently of the police department.

- ***Law Enforcement-Based Specialized Law Enforcement Responders***
  The dominant model for the use of specialized law enforcement responders is the Crisis Intervention Team (CIT) pioneered by the Memphis Police Department. The CIT is a police department-based program staffed by police officers with special training in mental health issues. The team operates on a generalist-specialist model, so that CIT officers provide a specialized response to "mental disturbance" crisis calls in addition to their regularly assigned patrol duties.

- ***Law Enforcement-Based Mental Health Responders***
  Some law enforcement agencies have experimented with approaches that allow both a sworn officer and a mental health professional to serve as first responders to mental health crisis calls. There have been numerous innovative programs following this model.

One study compared all three programs in three different cities on arrest rates, response time, and law enforcement satisfaction.[8] Lower rates of arrests and response time with higher levels of satisfaction were found for the law enforcement-based responses when compared to the Mental Health-Based response. Though there is some empirical evidence to support the claims that one type of program has specific advantages over another, it is not clear whether some programmatic advantages may be related to the particular contextual features of the jurisdiction, such as a strong emergency mental health infrastructure.

A recent review of three specialized responses in Montgomery County, PA; Memphis, TN; and Multnomah County, OR suggest that there are five major elements of successful specialized

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[5] Mulvey, E.P. & Repucci, N.D. (1981). Police crisis intervention training: An empirical investigation. *American Journal of Community Psychology, 9,* pp. 527-546.
[6] Borum, R., Deane, M. W., Steadman, H. J., & Morrissey, J. (1998). Police perspectives on responding to mentally ill people in crisis: Perceptions of program effectiveness, *Behavioral Sciences and the Law, 16,* pp.393-405.
[7] Steadman, H. J., Deane, M. W., Borum, R., & Morrissey, J. P. (2000). Comparing outcomes of major models of police response to mental health emergencies, *Psychiatric Services, 51*, pp. 645-649.
[8] Deane, M.W., Steadman, H.J., Borum, R., Veysey, B.M., & Morrissey, J.P. (1999). Emerging partnerships between mental health and law enforcement, *Psychiatric Services, 50*, pp. 99-101.

responses[9]. These elements include: (1) a central and single point of entry into the mental health system; (2) policies and procedures at the receiving psychiatric facility that allow for a quick disposition; (3) laws that support diversion from arrest and jail towards psychiatric treatment; (4) cross-disciplinary training that includes both law enforcement and mental health professionals; and (5) linkages to community services so that officers can link individuals to the appropriate care. All three programs are considered innovative and exemplary by consumer advocates and other law enforcement agencies; however, even "effective" programs may not perform equally well in every community. Yet, without strong empirical evidence of their local viability, law enforcement administrators are asked to decide whether to implement a specialized response program, and if so, which one to choose.

Four of the five cities studies by Lodestar represent two of the law enforcement responses. The fifth city, New York City, is distinct in that a specialized unit for high risk incidents is used to respond to persons who may be mentally ill when patrol assesses that the situation may be dangerous. There is no research literature on the New York City model.

Site Visits

During the development of the work plan for this evaluation, Lodestar and LAPD discussed the process for selecting a diversity of model programs nationwide that address police contacts with persons who may have a mental illness. A survey conducted in 1996 of all major US police departments serving populations of 100,000 or more provided a guide. The survey asked about the agency's response to calls. Forty-five percent (78) of the responding agencies provided some program of specialized response to encounters involving people with mental illness. These programs were found to fall into three major categories: (1) Law Enforcement-Based, Specialized Police Response; (2) Law Enforcement-Based, Mental Health Response; and (3) Mental Health-Based, Mental Health Response.[10]

Based largely on this research, it was decided that sites selected for review should include examples of each of the two law enforcement-based approaches. On that basis, five cities were selected for study:

- **Memphis,**
- **New York City,**
- **Portland,**
- **San Diego, and**
- **Seattle.**

These cities actually represent three different models: the first two are specialized responses by law enforcement that are documented in the literature (law enforcement-based specialized law enforcement response (Memphis, Portland, and Seattle) and mental health-based response (San Diego). The third model (a tactical approach – New York City) is not a unit dedicated to responding to persons with a mental illness, but provides support to patrol officers in high risk encounters with persons who appear to have a mental illness.

[9] Steadman, H.J., Stainbrook, K.A., Griffin, P., Draine, J., Dupont, R., & Horey, C.H. (2001). A specialized crisis response site as a core element of police-based diversion programs, *Psychiatric Services, 52,* pp. 219-222.
[10] Deane, M. W., Steadman, H. J., Borum, R., Veysey, B. M., & Morrissey, J..P. (1999). Emerging partnerships between mental health and law enforcement, *Psychiatric Services, 50*, pp. 99-101.

Each site except Portland was visited by two Lodestar team members, accompanied by an LAPD representative. A Portland visit was unnecessary because Lodestar's Lead Consultant, who attended two of the site visits, had recently evaluated Portland's program on two separate occasions. Initially, the consultant was part of a team that studied the history and development of the Portland program, detailing the mental health infrastructure in place at the time of implementation and the training that followed the adoption of the specialized response procedure. The early researchers also identified problems with implementation and the transferability of the "Memphis model" to Portland's Police Bureau. Later, the Portland program was included as a research site in a national multi-site study, also including the consultant, and monitored subsequent progress and developments. For this LAPD study, the consultant, now on the Lodestar team, again contacted the Portland program to update targeted information.

Data Collection at the Sites

Lodestar collected program data from multiple sources for each of the sites visited: document review, direct observation (e.g., ride-alongs wherever possible), and semi-structured key informant interviews with program coordinators, police administrators, community mental health staff and other key community partners. Interview protocols used in a previous study of police responses to persons with mental illness were modified for the purposes of this study and used as a guide for observations, interviews, and document review. Protocols were semi-structured to accommodate differing features of each site's program.

Because each police department was affording Lodestar valuable time and resources, data were collected in a responsive and efficient manner in order to ensure that quality information was obtained with the least possible intrusion. Site visits were scheduled at the agency's earliest convenience. Each visit consisted of discussions with the program's Coordinator and key personnel of the program over a two-day period. Lodestar participated in ride-alongs at two locations (Memphis and Seattle).

Updated information on Portland Police Bureau was obtained through conversations with the program Coordinator. A LAPD representative participated in all site visits and in a phone discussion with Portland's Coordinator.

FINDINGS FROM THE REVIEW OF OTHER CITIES' PRACTICES

The five cities selected for intensive study fall roughly into three groupings, as follows:

- **Law enforcement-based specialized police response: Memphis, Portland and Seattle**
- **Law enforcement-based mental health-based response: San Diego**
- **A tactical approach: New York**

The defining feature of the three cities that illustrate forms of Law enforcement specialized police response, Memphis, Portland and Seattle, is the use of specially trained law enforcement officers. San Diego's program differs in that it uses a combination of a law enforcement officer and a mental health professional to respond to persons with a mental illness in crisis. New York City, which falls outside the first two models, deploys a tactical team when there is a high risk encounter. This section contains a more detailed discussion of the essential features of each of the five programs.

Law Enforcement-Based Specialized Police Response

MEMPHIS

"The Memphis Police Department's Crisis Intervention Team is providing national leadership in dealing with the mentally ill."
- The Memphis Flyer, January 2002

Program Background/Description

In 1987, after a police shooting of a mentally ill person occurred, the local Alliance of the Mentally Ill (AMI) expressed concern that officers of the Memphis Police Department (MPD) were not appropriately trained to handle crisis incidents with mental health consumers. The Crisis Intervention Team (CIT) program was developed in response to community concerns and focused on advanced training and specialization with police officers. The program emphasizes consumer and officer safety, along with specific knowledge about mental health issues and how to handle crisis situations.

Currently, the Memphis Police Department CIT unit is composed of approximately 182 patrol officers out of a force with 1,800 sworn personnel, with the 24-hour coverage in each precinct. On average, there are 30 CIT officers available on each of the four shifts. CIT officers respond to approximately 9,000 specialized calls per year.

Memphis Police Department
Memphis, Tennessee

Geographic Size: 296.03 sq. miles
Population: 650,100

Number of Sworn Officers: 1,843
Number of Patrol Officers: 950

Approximate Number of 911 Calls per Year: 872,000
Approximate Number of Mental Disturbance Calls per Year: 9200

Program: **Crisis Intervention Team**
Number of CIT Officers: 215

Program Description

"Trying to get somebody help will solve the problem – taking them to jail is only a temporary solution."
- CIT Officer, Memphis Police Department

The CIT is a police-based program staffed by police officers with special training in mental health issues. The team operates on a generalist-specialist model, so that CIT officers provide a specialized response to "mental disturbance" crisis calls in addition to their regularly assigned patrol duties. For general patrol, the officers are assigned to a specific area. However, CIT officers have city-wide jurisdiction for these specialized calls. The officer may resolve the situation at the scene through de-escalation, negotiation or verbal crisis intervention. Alternately, the officer may contact an individual's case manager or treatment provider, provide a referral to treatment services, or transport the individual directly to the psychiatric emergency center for further evaluation.

In the years since the precipitating incident, the program has gained national recognition, from mental health advocates (NAMI) and the criminal justice community (National Institute of Justice). CIT programs based on the "Memphis model," have been adopted in other communities such as: Waterloo, IA, Portland, OR, Albuquerque, NM, Seattle, WA, and most recently San Jose, CA, Houston, TX, and Athens, GA. Numerous other departments are in the early planning phases of considering or implementing a CIT. Results from a recent National Institute of Justice study suggest that the Memphis CIT program has a low arrest rate for mental disturbance calls, a high rate of utilization by patrol officers, a rapid response time and results in frequent referrals to treatment.

The key addition to training is a unified philosophy of – and commitment to – diverting people with mental illness from the criminal justice system when their offense is comprised solely of disruptive behavior or relatively minor infractions that appear to be obvious manifestations of the illness. Serious offenders are still subject to criminal sanctions. The philosophy is not "soft on crime" but – consistent with the tenets of community policing – takes a problem-solving approach to responding.

Specialized training is a necessary component of CIT, but it is not sufficient to comprise a CIT program. An effective CIT program requires more than a collection of officers who have attended a special school for a week. The core tenets of the program are as follows:

- The CIT program operates on a "generalist-specialist" model, so a department does not lose any officers to special assignment. CIT officers are assigned to regular squads, have regular patrol duties in regularly assigned sectors, but they may cross patrol sectors to respond to a mental health crisis call.

- The "team" concept implies that these officers have volunteered and have been screened (including specialized interviews and psychological testing) and selected for this special assignment. It is not composed of individuals sent to training because they have deficiencies that need remediation, nor is it a training designed for all patrol officers.

- The key addition to training is a unified philosophy of – and commitment to – diverting people with mental illness from the criminal justice system when their offense is comprised solely of disruptive behavior or relatively minor infractions that appear to be obvious manifestations of the illness. Serious offenders are still subject to criminal sanctions. The philosophy is not "soft on crime" but – consistent with the tenets of community policing – takes a problem-solving approach to responding.

Community Partnerships and Working Relationships

"CIT is an infrastructure of partnership among police, mental health providers, consumers, and NAMI (advocacy groups)."
- CIT Coordinator, Memphis Police Department

Community partnerships are essential for a CIT to function effectively. According to the CIT representatives and advocates in Memphis, relationships need to be developed with the mental health system, community service providers, and with key family and consumer advocacy groups. These stakeholders play a critical role in training and in improving response during emergencies. The partnership between the Memphis Police Department and the University of

Tennessee - Memphis Medical Center's Psychiatric Emergency Center is a key element in the program's effectiveness. The procedures and facilities for the psychiatric emergency department (MED) were developed in collaboration with the police. CIT officers and MED staff work closely to facilitate a smooth transfer of custody and to ensure continuity of communication about the patient. The MED immediately accepts all referrals by the police, eliminating any conflicts about patient selection and minimizing officers' waiting time. Average wait times range from 5 to 10 minutes. The CIT program also has a strong partnership with the Memphis chapter of NAMI assists with officer training, and sponsors an annual award and banquet to honor CIT officers. CIT officers also attend NAMI meetings throughout the year.

The existence of a psychiatric "drop off center" in the jurisdiction is a critical element in the effectiveness of the CIT, as it minimizes officer down time and indirectly may affect other positive outcomes. In a national survey of police departments, those who had access to a "drop off center," were nearly twice as likely to perceive their response to these calls as being effective, compared with those who did not have access to such a resource.

The CIT Program has other relationships with the community including one with the Mobile Crisis Team (MCT), a team of mental health professionals who respond to persons in mental health crisis. They can place persons on involuntary psychiatric holds but may need assistance from CIT officers if the person is violent or potentially violent. Memphis also has community courts that provide pre-trial diversion after arrest. The CIT Coordinator emphasized that community and mental health courts must work in conjunction with other systems and programs to be truly effective.

Program Implementation and Maintenance

Program Administration

"You must have a high level of buy in – Chiefs and city government have to be on board."
- Director, MED

Leadership

The CIT Coordinator credits the relationships between the MPD and the community for the success of the program. The Coordinator reports that support for the program and its diversion objectives needs to originate at the highest levels within the law enforcement agency. The philosophy of the CIT program cannot operate effectively in opposition to current departmental directives or procedures. NAMI representatives echo the need for a strong leader when describing characteristics necessary for a CIT program to be successful in any jurisdiction. The leader must be diplomatic and have a desire to cooperate and collaborate with outside agencies.

Administrative support/Engagement of departmental personnel

There is strong support from both the administration and other officers. Both lower and upper rank officers reported the need and presence of a strong leader and foundation that has helped the CIT become effective.

Departmental incentives

CIT officers are provided with incentive pay. They also wear a CIT pin and are given an annual award and banquet, sponsored by the local NAMI chapter.

Recruitment and Retention of Personnel

There were no reported difficulties with recruitment or retention of CIT officers. CIT officers interviewed were extremely supportive and proud of the program. As mentioned earlier, officers are encouraged to volunteer for CIT training, but must undergo an assessment and interview along with personnel file review before becoming a CIT officer. Retention does not appear to be a problem even though, in the fall, the number of CIT officers typically decreases due to promotions and officers leaving patrol.

CIT officers in Memphis receive only a token salary incentive of $50 per month. The CIT Coordinator would like to do more, and the officers would, of course, like to receive a higher incentive. Currently, the intrinsic rewards seem to far out-weigh the financial considerations. These include annual recognition events, identification by recognized uniform pin, extra training, acknowledgement and respect by fellow officers, and possible faster track for promotion to S.W.A.T. and Hostage Negotiation Teams.

Estimated Program Costs

Training costs are limited to cost of taking patrol officers out of the field for 40 hours of CIT training. Because mental health professionals provide the training free of charge, and the MED has no cost to the MPD, there is little economic impact. There is no administrative staff except for one CIT Coordinator.

Program Policies

Training Programs and Practices

The CIT selects volunteer officers with the greatest interest, most amenable attitudes and best interpersonal skills, then provides them with intensive training and deploys them specifically as a first line response to these specialized calls. Intensive training consists of an initial 40-hours of specialized training with mental health providers, family advocates and mental health consumer groups providing information about mental illness, substance abuse, psychotropic medication, treatment modalities, patient rights, civil commitment law and techniques for intervening in a crisis. The training is provided by professionals, advocates and consumers in the community at no charge to the police department. However, advocates of CIT are quick to point out that “CIT is more than training.” This concept is meant to impart to its participants a program philosophy of “responsibility and accountability to the community, family members and consumers of mental health services.”

CIT training emphasizes good human relations. During the 40-hour training officers hear from family members of individuals with mental illnesses. They visit drop-in centers and residential programs and have the opportunity to discuss with consumers their experiences with police, what it is like to hear voices, why they do not like to take medication, or life when homeless. Triage decision-making is included with a focus on dispositions of the encounter

other than arrest or hospitalization. To better prepare the CIT officer, how to access community resources is also a major training topic.

Officers are trained to use skills to de-escalate high-risk encounters and to avoid use of force. With an emphasis on both consumer and officer safety, verbal de-escalation skills are cultivated in training as well as in the field.

Another component of training is the use of less than lethal weapons, such as pepper foam and the SL-6, a device that fires a plastic projectile with the intent of controlling the subject without a lethal injury. Within MPD, these weapons are carried only by CIT officers. Anecdotally, officers report that because the SL-6 is so large, it intimidates subjects and often the subject will cooperate on sight of the weapon. Thus far, officers have only used the SL-6 twice, each time without fatal injury.

Field Operations/Procedures

The Communications Division uses technology that allows officers who are CIT trained to be assigned a special code so that when a mental disturbance calls is identified by the Communications Operator, a CIT officer can be dispatched directly by the operator. Once CIT arrives on the scene, the CIT officer is considered the officer in charge of that scene.

The CIT officer evaluates the scene by taking reports from family members and neighbors, if feasible, in addition to assessing the subject. If hospitalization is required, the officer can take the subject directly to the MED.

Incident Documentation and Tracking

CIT officers complete a special report, called a “Stat Sheet,” for each CIT call they complete. The Stat Sheet is used by the CIT Coordinator and Director of MED to evaluate the success of the CIT program. It also allows the Coordinator to read incidents and provide any follow-up if necessary.

The Stat Sheet includes basic information about the incident (i.e., date, location, time), equipment and technique that may be used (e.g., handcuffs, verbalization, rip hobble), disposition of the incident, and who transported the subject to the hospital if applicable. The back of the Stat Sheet allows the officer to complete a narrative describing the incident and outcome. Generally, officers complete one to two pages (see Appendix C).

Perceived Effectiveness

As mentioned earlier, a study of the CIT program found low arrest rates, more appropriate referrals to treatment and high utilization of CIT officers within the department. Within the department, contact with both CIT and non-CIT officers found praise for the program. Non-CIT officers often report relief to have the CIT officer available to take the lead with the encounter. It was observed that the CIT officer was often respected and allowed to take the lead on such interventions.

The NAMI chapter in Memphis is extremely supportive of the CIT program. Not only do they sponsor the annual award ceremony and banquet for CIT officers, but collaborate with the MPD on a regular basis and participate in the training of officers.

The police department and the psychiatric emergency center (MED) are politically joined as a system. The MED is principally local government funded and operates out of the university. The state funded mental health system is quite separate. Midtown Mental Health Center, which is the primary community mental health center in Memphis, operates a Mobile Crisis Team (MCT). They claim that the MCT is frequently the first responder to high-risk crisis calls and uses the police department for safety backup. These two systems are separate but do complement each other. Midtown and other local community mental health centers provide case management services to consumers referred to them by both the CIT officer and the staff at the MED. Although there appears to be a healthy respect for each other, there appears to be a difference of perspective.

PORTLAND

"CIT Officers are more confident and value themselves as assistants to the community and the department."
- CIT Coordinator, Portland Police Bureau

Program Background/Description

The impetus for adopting a specialized police response in Portland's Police Bureau (PPB) came after an incident in 1992 in which a child was held at knife point by a man with a history of mental illness. The subject allegedly began to cut the boy's throat and both the subject and the child were killed by the police. Though the PPB expected a lawsuit would ensue, the parents of the child were more interested in having the department examine their procedures for police handling of persons who have a mental illness.

Subsequently, the department began a national search for specialized programs and found the CIT program in Memphis. They also examined the LA Sheriff's MET program but decided that they wanted a program of police first responders available through initial dispatch. In October 1994, they sent a team to the CIT training in Memphis and brought back recommendations to the Chief to adopt the program in Portland.

Portland Police Bureau
Portland, OR

Geographic Size: 146.57 sq. miles
Population: 529,121

Number of Sworn Officers: **1,044**
Number of Patrol Officers: **375**

Approximate Number of 911 Calls per Year: 420,000
Approximate Number of Mental Disturbance Calls per Year: 1300

Program: **Crisis Intervention Team**
Number of CIT Officers: **115**

Program Description

CIT officers are distributed roughly equally among the five precincts in Portland. CIT officers have regular patrol responsibilities and precinct boundaries, but they have city-wide jurisdiction for CIT-related calls. When a CIT officer arrives on the scene of a crisis incident, they are – by general orders – in charge of that scene, regardless of the rank and seniority of other personnel. Patrol officers that are CIT-trained include traffic, school police, mounted patrol and gang.

There are a total of 115 trained CIT officers, with between 90 and 95 percent designated as active CIT officers. An active officer is defined as an officer in a unit that receives radio calls and has access to a vehicle. Generally, all Sergeants are CIT trained, as are Detectives. Training is voluntary and available to any officer who is interested, without any specialized assessment or selection procedures. All Hostage Negotiators are CIT trained.

CIT trainings are conducted twice a year for approximately 20 officers each session.

Community Partnerships and Working Relationships

"It is night and day how much advocacy and input law enforcement can have in the mental health system and how much information law enforcement can get from the mental health system since the start of CIT."
- CIT Coordinator, Portland Police Bureau

As in Memphis, the PPB CIT program in Portland has strong ties to the local NAMI chapter, which also sponsors an annual award banquet to honor the CIT officers. In contrast to Memphis, these banquets hold little interest to the officers. The CIT Coordinator explained that the CIT officers view their specialized response as necessary and part of their job, rather than a special piece of their duties. The officers generally feel uncomfortable about being singled out. Recently, the PPB and NAMI have decided to no longer give a CIT officer of the year award, which has resulted in increased attendance to the yearly banquet.

One of the roles of the CIT Coordinator is serving as a liaison with community mental health groups. The Coordinator sits on a variety of committees including an advisory committee to County Mental Health and service providers. The CIT program also assisted in the development of the mental health court four years ago. Portland also has a community court that is sensitive to the needs of misdemeanants with mental health needs and often provides appropriate mental health care services to prevent further offenses.

When the CIT program began, there was no drop off center for psychiatric emergencies and no systematic after hours crisis response in the mental health system. Psychiatric crises had to be routed through the local hospital emergency departments and the process was time consuming for officers.

In January of 1997, the Crisis Triage Center (CTC) opened. The CTC drastically streamlined the process for police referrals of psychiatric crises. The CTC operated as a drop off center for the police, much like the MED in Memphis. In fact, the CTC program was developed in consultation with the Director of the MED. CTC served all of Multnomah County and accommodated approximately 35 patients per day. In a 6 month period, it was reported that CTC conducted over 5000 evaluations.

At the same time CTC opened, a Mobile Crisis Team (MCT) was implemented. The MCT works in teams of two, including a psychiatric nurse and a mental health therapist. The MCT is a second responder on some police calls and assists the CIT officers by providing consultation when needed. Consultation may include information about previous psychiatric history and related information, but only in times when serious danger to self or others is evident.

Unfortunately, the CTC closed in July, 2001 due to lack of funding. As a result, CIT officers now take persons who need to be hospitalized to the ER and must wait until the person is evaluated by hospital personnel. The Coordinator reports that officers spend more time waiting for the evaluation overall although, in some ERs, areas are secured and the officer can leave.

Although the Coordinator did not report a huge impact at this time, he did report that he and emergency room department managers have been in numerous discussions about the impact of the CTC closing and have begun developing solutions. For example, the PPB would like to see a County-run secure evaluation unit that would have beds available for persons that police bring on a voluntary and involuntary basis.

Program Implementation and Maintenance

Program Administration

Leadership

In August, 1995, under the coordination of a Sergeant, PPB conducted their first training. Now, a line patrol officer serves as the CIT Coordinator.

The CIT Coordinator's responsibilities include recruitment, training, ongoing maintenance and update of the training program, completion of an annual report, and serving as the PPB's mental health liaison with the community which includes advocacy groups, consumers and mental health professionals. Similar to Memphis, the CIT Coordinator also reviews all mental health related incidents. All patrol officers route any incidents that involve a person who is known or suspected of having a mental illness. Last year, the Coordinator reviewed 2,062 incidents forward by officers of which 49 percent were handled by CIT officers.

Administrative support/Engagement of departmental personnel

The current Coordinator suggested that there is some difficulty having the role of CIT Coordinator and supervisor of CIT officers, but not having a higher rank than those officers for whom he is in charge. The Coordinator also reported that it has been difficult to maintain the program and recruit in addition to his other responsibilities.

Departmental incentives

Unlike Memphis, there are no monetary incentives for CIT officers. The officers do receive and wear a CIT pin that was recently re-designed, though they are not required to wear the pin and not all officers do so.

Recruitment and Retention of Personnel

Recently, PPB has experienced few problems with the retention of CIT officers. One of the initial problems with the program was CIT officer burnout. The program began before a full cadre of officers was in place, and the existing CIT officers were given all psychiatric crisis and related calls. These cases were time consuming and difficult because of the nature of the mental health system structure at the time and CIT officers were spending almost all of their time on CIT calls.

After the CTC was opened and an increased number of officers were CIT trained and available for mental health related calls, burnout decreased; however, with the closing of the CTC and lack of any existing system to replace it, similar problems may again appear.

Estimated Program Costs

In general terms, associated costs are restricted to that of the initial 40-hour training, and any cost for time spent on continuing education activities. The CIT Coordinator is full-time and has no administrative support staff. There is some cost associated with extended periods of waiting by police officers at psychiatric facilities, but this cost was not identified as significant by PPB personnel.

Program Policies

Training Programs and Practices

In order to develop the CIT program, a community panel of mental health professionals and the PPB convened and planned the basic curriculum on 10 to 15 occasions. They adopted the basic training curriculum from Memphis (which includes topics on disorders and symptoms). The basic course (described earlier in this report) is 40 hours in length and instruction is provided free of charge by local mental health professionals, NAMI family members and some consumers. PPB has intensified the role playing components and added modules on developmental disabilities.

Training includes childhood mental disorders and special issues related to children and response to calls from schools. There is a minimum of 6 hours of role playing and recently a cultural competency component was added to the training curriculum. A panel of mental health professionals presents information about how different aspects of culture might affect the manifestation of mental illness. The Coordinator reported that the component was well received by officers.

More recently, new components were added to the continuing education for CIT officers. The continuing education component offers a variety of opportunities including sending officers to specialized trainings aimed at County mental health professionals and, when the CTC was open, “sit-alongs” with triage staff. Last year they instituted shift walks with mobile crisis teams to provide continuing education. Every six months the CIT program conducts a 30-minute video and presentation, typically at roll call, to keep officers up-to-date on various issues related to mental illness. A CIT newsletter is distributed every two months which includes educational pieces as well.

Training division has implemented a variety of tactics that are considered less than lethal (e.g., bean bag guns, pepper spray) but an analysis of use of force by CIT officers with persons who may be mentally ill has not been conducted at this time.

Currently, CIT trainings are conducted twice a year for approximately 20 officers each session. Initially, there was much enthusiasm within the department. Interest has been consistent but not as high as when the program was in the initial stages.

Field Operations

Calls that come into the Communications Division that appear to involve a person who is known or suspected of having a mental illness are coded as such by the operator and the dispatcher locates and dispatches the nearest CIT officer on duty, even if that officer is outside of the

precinct in which the call originated. Once a CIT officer arrives on the scene, he or she is considered the officer in charge of that scene.

The CIT officer will assess the situation to determine if the subject needs to be hospitalized in addition to assessing whether a crime has been committed. If the officer determines that hospitalization is necessary, he or she will place the subject on an involuntary hold, or persuade the subject to go to the hospital voluntarily. In both cases, the CIT officer will transport the subject to the nearest emergency room.

Incident Documentation and Tracking

There are no special CIT logs or tracking forms completed by officers. CIT officers will route relevant incidents to the CIT Coordinator for review. Persons in Records also route relevant incidents to the Coordinator. CIT incidents are tracked by review of routed incidents and analysis of "Mental Complaint" (mental disturbance) calls received through their dispatch system.

Perceived Effectiveness

As mentioned earlier, the CIT Coordinator is responsible for an annual report of CIT responses. The Coordinator uses data from the CIT database to calculate the total number of reports for all police type holds and assists that involved CIT, and to obtain information about mental disturbance ("mental complaint") calls. Information is disseminated internally, and the Coordinator shares on a monthly basis information about voluntary transports of persons who have a mental illness with interested community members and organizations. This continual sharing of information maintains the communication, collaboration and good relationship between the PPB's CIT program and community members.

Seattle

"Public safety is the goal. We're trying to make any encounter safer for police, family, and the consumer."
- CIT Coordinator, Seattle Police Department

Program Background/Description

In March 1997, it became clear that hostage negotiators in the Seattle Police Department (SPD) needed more training in handling incidents that involve persons who may be mentally ill. A man, holding a sword in a public place for 11 hours, did not move or respond to police requests to place his sword down. Eventually, the police used a fire hose to pin the man against the wall. It became clear to the SPD that they had a limited number of options to use when dealing with potentially violent encounters with mentally ill persons.

In response, the SPD asked Portland, Oregon and Albuquerque, New Mexico departments for assistance in developing a CIT program to address the gap in officers' skills. Their first CIT class started in February 1998 and, according to the SPD, the training has been successful.

Seattle Police Department
Seattle, WA

Geographic Size: 84 sq. miles
Population: 563,374

Number of Sworn Officers: **1,261**
Number of Patrol Officers: **640**

Approximate Number of 911 Calls per Year: 849,000
Approximate Number of Mental Disturbance Calls per Year: N/A

Program: **Crisis Intervention Team**
Number of CIT Officers: **250**

Program Description

Approximately 200 of the 250 trained CIT officers are in patrol. Like other CIT programs, SPD officers have general patrol responsibilities. They are assigned to a precinct but are allowed to leave their area if a CIT officer is needed elsewhere. The primary response officer will generally relinquish the lead position upon arrival of the CIT officer.

CIT training is provided twice a year for approximately 20 officers each session. Reducing training to once a year is under consideration at this time. In the initial stages of CIT, the Coordinator reported that CIT officers were "ambassadors to the program" that raised interest in the department. Now, interest is steady.

Community Partnerships and Working Relationships

As in other CIT programs, the SPD linked with a local NAMI chapter and King County Mental Health to develop their CIT program. The NAMI chapter sponsors a banquet and award ceremony, as do Portland and Memphis, and the SPD often meets with County Mental Health personnel to maintain communication between the two agencies.

The CIT officers have a central drop off location for subjects that need hospitalization, the Crisis Triage Unit (CTU). The CTU is a joint venture between the County and Harborview Hospital. The unit was developed with the intention of being the single point of entry into multiple treatment systems prior to the development of CIT. The CTU has 10 psychiatric inpatient beds available for the entire County. CTU representatives report that since the development of the CIT program, encounters with SPD officers have improved.

Approximately 35 percent of referrals come from SPD and other local law enforcement agencies. Washington State law allows peace officers to detain persons who are suspected of meeting criteria for an involuntary hold, but cannot place a person on a hold. Only County Designated Mental Health Professionals (CDMHP) have the authority to place an individual on a psychiatric hold. Police officers can take subjects they suspect meet the appropriate criteria (mentally ill and imminent danger to self or others) to the CTU, and a CDMHP will evaluate the subject's mental status at this locked facility if the subject does not choose to stay voluntarily. In order to place a hold, the CDMHP must collect all witness information, placing a large responsibility on the officer to provide complete, accurate, and clear information about the encounter that led the officer to believe the person needed hospitalization.

The County also runs a Mobile Crisis Team (MCT). According to SPD reports, the MCTs rarely assist officers in the community due to long wait periods for the CDMHPs to arrive on-scene. Despite this, the relationship between the County and the SPD is good. When a CDMHP is concerned that a person they need to assess may be violent, the CDMHP can call on CIT officers to assist with the visit to ensure the safety of the CDMHP as well as the subject.

Another important partnership for the CIT program in Seattle is with the Crisis Clinic, a 24-hour hotline service that serves as a central crisis line for the entire County. The Crisis Clinic not only receives calls from officers to ask for assistance, but is often asked to respond to suicidal calls that have been traced due to high-risk.

Program Implementation and Maintenance

Program Administration

Leadership

The current CIT Coordinator, a Sergeant, is not the original officer that developed the program, but is still able to maintain and improve relationships with the County, AMI, CTU and other agencies.

Administrative Support/Engagement of departmental personnel

In Seattle, it is clear that the CIT program is backed by the agency's command staff. The command's confidence in the CIT program is seen in the allocation of funds for certain educational experiences, as well as the designation of an assistant to provide follow-up for CIT-related cases. As mentioned before, veteran officers tend to be skeptical of the program; newer officers are very supportive.

Departmental incentives

No monetary incentives are provided directly to CIT officers. Instead, the CIT Coordinator will send outstanding CIT officers to relevant conferences and trainings as a reward. The CIT program also has a pin, similar to the Memphis pin as in other CIT sites. Officers are not required to wear them.

Recruitment and Retention of Personnel

CIT officers volunteer for training. Initial recruitment was difficult, and the first class consisted of hostage negotiators rather than patrol officers. Currently, younger officers are reported to be more interested in the program, whereas some veteran officers do not see a need for specialized training or responders. There are no reported problems with retention of personnel beyond the yearly loss of CIT officers in patrol as a result of promotions.

Estimated Program Costs

Unlike Memphis and Portland, where trainers are County personnel, service providers and program advocates who have assumed the cost of training, in Seattle many of the CIT trainers are paid by service agreements. However, the CIT Coordinator suggested that instruction for 20 officers at a time is not a major cost for the department. The CIT Coordinator is full time and has a full time assistant.

Program Policies

Training Programs and Practices

"Having information makes all the difference in the world – to help prepare for the scene. It's all about knowing your resources."
- CIT officer, Seattle Police Department

"Before CIT, I didn't feel like I was serving these persons very well."
- CIT officer, Seattle Police Department

The Seattle training program was modeled after the Memphis training. It consists of 40 hours and includes topics such as:

- mental disorders
- symptomatology
- psychotropic medication
- geriatric disorders
- civil commitment
- NAMI presentations
- alcohol and substance abuse
- crisis intervention
- role playing
- child's crisis intervention
- verbal de-escalation skills

Trainers are provided by a variety of agencies, including the County (CDMHPs), Children's Crisis Response Team, Geriatric Crisis Response Team, and local clinics and hospitals. Personnel from the CTU provide training on how to use the CTU and provide the appropriate written referral necessary for CDMHP to complete an affidavit for involuntary hospitalization.

The SPD also recently acquired a virtual reality program that simulates the symptoms of schizophrenia that will be used in CIT training. In addition, this year the SPD's CIT will begin to condense the 40-hour CIT training into 8 hours to provide updated training for both CIT and non-CIT officers.

Field Operations

The dispatcher can identify CIT officers on duty through their computerized dispatch system. When mental disturbance calls are received by Communications, the operator typically dispatches a CIT officer to respond. As a more recent development, CIT officers are now mandated to go to all high risk calls that involve a person who may have a mental illness. CIT officers may cross precinct boundaries to respond to such calls. CIT officers are not scheduled to provide 24-hour coverage so there may be occasions in which there are no CIT officers available.

Once officers arrive on the scene, they evaluate the situation to determine if the subject needs hospitalization. If the officer believes that the subject meets the criteria, an ambulance will be called to transport. The average waiting time for the ambulance, which is paid for and provided by the County, is 10 to 15 minutes.

Incident Documentation and Tracking

There is no formal document completed by CIT officers, except when the individual is sent to the hospital under the protective custody provision. However, all incident reports that involve persons who have a mental illness are labeled as "CIT" or "mental." Non-CIT officers also designate calls in this way. The records division then forwards all reports with "CIT" or "mental" labels to the CIT Coordinator for review. Records personnel also forward incidents that may not be so labeled but that appear to involve persons who may have a mental illness. The Coordinator has created a database that contains information about the number of incidents that resulted in arrest, CTU hospitalization or use of force, and whether the subject made a suicide threat or attempt.

The Coordinator also uses the review of incidents to identify any cases in which follow-up may be warranted. The Coordinator consults with the Crisis Clinic, CDMHPs and the hospital to determine the best course of action. For example, a person was sent to the CTU because of concern that he might hurt himself. He owned several guns which were readily available in his home. Based on past history, the Coordinator thought it was best to hold the consumer's guns temporarily, and had to send officers back to the residence to retrieve the weapons. The CIT Coordinator's assistant helps in the process of incident reviews and follow-up.

The State of Washington, unlike most states, does not allow the law enforcement officer to certify an individual for mental health evaluation. The officer must present the probable cause information on a report that accompanies the individual to the CTU. At the CTU or other hospital, the Designated County Mental Health Professional must certify the admission. The

Communications Division also identifies mental disturbance calls. The Coordinator estimated that SPD receives 2,400 mental disturbance calls last year.

Perceived Effectiveness

Most notable in judging the perceived effectiveness of the Seattle CIT is the support that it receives from the law enforcement leadership and the judicial system. Reported reductions in death and injury to officers and consumers have made the program an overwhelming success.

The perception of other non-CIT officers is mixed. However, it was observed that CIT-trained officers welcome CIT responders when a person who may have a mental illness is encountered. Strength and recognition of the program can also be attributed to effective leadership by the CIT Coordinator and Assistant.

The establishment of the psychiatric emergency service (CTU) allows the immediate closure of calls requiring protective custody. Improved linkage and written reports have eliminated an old "drop and run" complaint. CIT officers are also knowledgeable about and have good relationships with a wide range of social services including drop-in centers, homeless shelters and soup kitchens.

Law enforcement-based Mental Health-Based Response

SAN DIEGO

Program Background/Description

The San Diego Police Department (SDPD) wanted to create an outreach team to manage encounters with persons with mental illness and ensure the provision of follow-up services that could create continuous care to prevent future encounters with the police. The SDPD recognized that the mental health system could not, on its own, address the needs of such persons, particularly those that have frequent contacts with the police.

San Diego Police Department
San Diego, CA

Geographic Size: 420 sq. miles
Population: 1,110,549

Number of Sworn Officers: **2,100**
Number of Patrol Officers: **1,500**

Approximate Number of 911 Calls per Year: 400,000
Approximate Number of Mental Disturbance Calls per Year: 4400

Program: **Psychiatric Emergency Response Team**
Number of PERT Officers: **70**

The department reviewed specialized practices used by other police departments throughout the country. They found a model developed out of the Los Angeles County Sheriffs Department (the MET program) and decided to adapt it to San Diego. In June 1996, the SDPD launched the Psychiatric Emergency Response Team (PERT) as a pilot program in one of its divisions. It was considered such a success that the Sheriffs Department has adopted the model in San Diego County. As a result, the Community Resource Foundation chose to create a body that would provide some funding for the program, as well as monitor the program's success.

The Foundation is the parent company for PERT Incorporated, a 501(c)3, not-for-profit organization. The PERT Inc. board reserves three seats for the local chapter of NAMI and another four seats for other members. Other members include the Police Chief in charge of PERT and the Director of County Mental Health. The annual budget is in excess of one million dollars and provides some clinicians with a salary, while other clinicians are paid directly by the County of San Diego.

Program Description

Each PERT team is composed of a sworn, uniformed patrol officer with specialized training and a civilian mental health clinician who respond jointly to calls involving people with mental illness in crisis. The primary goals of the program are to divert people with mental illness away from jail, reduce the amount of time that officers were required to spend managing these calls, and provide persons in crisis with the appropriate referrals and follow-up care to prevent crisis in the future, resulting in fewer contacts with the police department.

PERT officers are not solely dedicated to responding to mental disturbance calls. Officers assist in other patrol duties while the clinician remains in the vehicle. According to PERT officers, this is an important advantage to the PERT program. The officer is not taken away from other patrol duties and, typically, would encounter persons with mental illness during their regular course of duty. The availability of a licensed clinician on-scene helps to facilitate "5150" (involuntary hold) assessments at the receiving facility, thereby allowing the responding officer to return to the field more quickly.

Developers also recognized the need to have a receiving facility that is secure so that persons on a psychiatric hold could be kept safe until a psychiatric evaluation could be completed. A secure facility would allow the officer to return to patrol faster. The County created a central intake facility with a locked unit so that officers can drop off consumers in need of an evaluation or those on a voluntary commitment, without having to wait for the evaluation to be completed. In addition, because there is a clinician who can manage the case and determine if the subject has public or private insurance, oftentimes a drop off can occur at other hospitals quickly and without a long wait time.

There are now 15 to 17 PERT teams in San Diego. There are 70 officers that have received the full training for PERT, and another 350 officers that received a truncated course. Clinicians do not have consistent partners, but are assigned to different PERT-trained officers. However, clinicians remain in the same station.

Community Partnerships and Working Relationships

The development of PERT required a great deal of support from the County of San Diego as well as the community. In the initial stages of program development, the SDPD and County Mental Health built a relationship and included the mental health community in the process. Family advocates and consumers were involved in the process as well. The Chief became the "Liaison to the mental health community." This required an open dialogue about police procedures and encounters with persons with a mental illness, which continues today. For example, recently a police shooting of a person who has a mental illness occurred. In response, the Chief called a meeting with NAMI and consumers at a local drop-in facility to discuss the shooting and answer any questions.

The PERT board is an illustration of the partnerships that are necessary to make this program work in San Diego. The board determines the coverage necessary to provide consistent and appropriate coverage of all the communities in the city. They do so by examining the need in each community simultaneously, considering available resources to provide an adequate response.

There are no mobile crisis teams or specialty courts in San Diego.

Program Implementation and Maintenance

Program Administration

Leadership

The PERT program in the SPD is supervised by the Assistant Chief of Police. The Chief participates on the PERT, Inc. board of directors and provides agency support necessary to create the policies, procedures and training to ensure the program's effectiveness.

Administrative support/Engagement of departmental personnel

Every division has a sworn officer that is the PERT Coordinator. The Coordinator maintains the schedule of teams each week.

Departmental incentives

There is no incentive pay provided to PERT officers.

Recruitment and Retention of Personnel

PERT officers are well received by other officers in the department. PERT officers volunteer for the 40-hour training or "Menu" training, which is an elected in-service training.

Estimated Program Costs

The law enforcement agency reports incurring only soft costs, meaning the SDPD provides office supplies and office space at stations for PERT clinicians, but does not provide PERT clinicians' salary or benefits, or any incentive pay for PERT officers. Training is provided free of charge by PERT, Inc. There were initial start-up costs that included mobile phones, pagers and radios for teams. SDPD also reports that the cost of a patrol officer to be involved in the team, but because duties are distributed between regular patrol duties and PERT responsibilities, the cost of those salaries may be less than one full-time salary. The cost of the clinicians is considerable – probably over one million dollars a year – but this is paid by PERT, Inc. and the County, not by SDPD.

Program Policies

Training Programs and Practices

Training provided to officers consists of 40 hours and covers topics which include:

- Advanced communication skills training
- De-escalation techniques in crisis situations
- Mental health referrals and resources
- Special safety concerns
- Scenario training

A shorter training is provided for officers that elect to be trained through in-service instruction, or "menu training." The duration of the class is three to eight hours hours, depending on reporting source.

Field Operations

When a mental disturbance call is identified by the Communications Operator, regular patrol is dispatched and if a PERT unit is on duty and available, the operator will notify the PERT unit. Regular patrol officers typically respond first and ensure the scene is safe. The safety of the clinician is important to the SDPD and, according to PERT officers, they prefer that clinicians are brought onto the scene only when the scene is considered safe for both the clinician and subject. Consequently, PERT clinicians are not involved in high-risk calls or calls where there is concern that the subject may be violent. PERT officers can go outside of their designated jurisdiction if assistance is needed. PERT officers notify the appropriate supervisor before their departure.

PERT clinicians may provide some historical information for officers in crisis situations that are deemed unsafe, but are not allowed to interact with the subject or be near the perimeter of the incident. As mentioned previously, PERT clinicians do not have permanent partners, but float through the department and are paired typically with PERT trained officers. At times the officer may not have any specialized training. Because of minimum staffing for patrol, there may be shifts in which no PERT officers are available in a station. PERT is not available on a 24-hour/7 day a week basis, but attempts to provide coverage Sunday through Friday on 10 hour shifts in the morning and evening.

Incident Documentation and Tracking

There is little tracking that the SDPD completes for PERT activities. This may be a result of PERT, Inc. collecting information and conducting analyses. Communications does not identify calls as PERT calls and PERT officers do not have a special code used for dispatch purposes.

Perceived Effectiveness

According to the Chief, there has been a dramatic reduction in out-of-service time for officers. Officers appear to have improved their handling of calls and can now provide assistance to family members because of their specialized training. Roughly 60 to 70 percent of mental disturbance calls are covered by PERT.

A Tactical Approach

NEW YORK CITY

"The Emergency Services Unit is a tool."
- ESU Trainer, New York Police Department

Program Background/Description

In the late 1970s, the New York Police Department (NYPD) received a call about an elderly woman with boiling lye in her kitchen. When the officer arrived, he found her holding a knife and eventually shot her. This incident motivated the NYPD to look critically at its protocols for dealing with persons with mental illness. As a result, they developed a special training program for its Emergency Services Unit (ESU), a tactical unit that handles high risk incidents.

New York Police Department
New York, NY

Geographic Size: 321.8 sq. miles
Population: 8,008,278

Number of Sworn Officers: **38,000**
Number of Patrol Officers: **18,000 – 20,000**

Approximate Number of 911 Calls per Year: N/A
Approximate Number of Mental Disturbance Calls per Year: N/A

Program: **Emergency Services Unit**
Number of ESU Officers: **340**

Program Description

Although the ESU is characterized as a Law enforcement, Specialized Police Response program, it is in many ways quite different than other programs in this category. The approach combines advanced communication and advanced tactical skills to resolve high-risk incidents without lethal force. The ESU provides support to all units in the NYPD. Officers are trained to use a variety of specialized equipment and weapons to provide assistance on tasks ranging from persons in crisis to vehicular accidents to barricaded suspects. There are ten ESU stations or "trucks" placed around the city. Each unit consists of a truck that remains stationary due to its large size. There are a variety of other specialized trucks that are under the supervision of ESU. There are smaller trucks that patrol designated areas, Radio Emergency Patrol Vehicles (REP). These trucks are considered the "workhorses" of the ESU. Typically, REPs arrive on-scene first and are stocked with rescue equipment, non-lethal weapons, and a variety of other tools. (See Appendix C for more detailed description.) There are numerous specialized vehicles that are also part of the ESU, but are not used to respond to mental disturbance calls.

There are a total of 340 ESU officers. Units are located across New York City. Three are located in Brooklyn, two each in the Bronx, Queens and Manhattan, and one on Staten Island. ESU is available 24 hours a day, 7 days a week. Patrol officers can request ESU assistance or the trucks may be dispatched directly.

The ESU's general objective in responding to high-risk calls is to isolate and contain the subject or situation and remove all non-involved persons from the scene. The strategic and persistent

use of tactics and equipment results in the ESU avoiding lethal uses of force against violent persons who may be mentally ill. Officers described numerous incidents in which the subject wielded a knife or other weapon, yet ESU officers chose to deploy less-than-lethal weapons or tactical procedures – sometimes including tactical retreat and regrouping – and developed creative ways of handling such situations.

The ESU is particularly adept at using less-than-lethal devices for control and intervention. For example, the unit routinely uses a special mesh containment – somewhat like a bag – to transport persons who are extremely combative from the point of containment to the vehicle. This prevents the subject from harming him/herself, officers or others. They have also created some devices specifically to reduce the potential for injury in controlling subjects who are assaultive or highly agitated. One of these is the "Y-Bar" – a Y-shaped steel bar used to pin a subject against a wall or backdrop so that they can be controlled and taken into custody.

Community Partnerships and Working Relationships

Unlike the other programs that were visited, the ESU has no ties with community advocacy groups or consumers. Specialized training is provided by a mental health professional and faculty member at John Jay College of Criminal Justice, but no other partnerships have been established. There are no special relationships between the ESU and any of the psychiatric hospitals or emergency departments within the city.

Program Implementation and Maintenance

Program Administration

Leadership

The ESU has its own training facility where officers receive specialized tactical training for a variety of responsibilities. There is a Commanding Officer of the ESU and many trainers who conduct specialized instruction over the course of the training program. No one officer is specifically responsible for coordinating calls involving persons who may be mentally ill.

Administrative support/Engagement of departmental personnel

Evidence of administrative support is seen through the continued funding of ESU units at very high levels and expressions of support from ESU command staff for the unit's creative approaches to problem solving. ESU officers reported a sense of support by the administration and other personnel who listen to their ideas about how to improve their tactics.

Departmental incentives

Assignment to ESU allows an officer to receive special public safety and emergency medical training. Despite having extensive specialty training, ESU officers do not receive any special duty pay or incentives. ESU is considered to be an elite and well-respected unit within the NYPD, and officers view their affiliation with pride.

Recruitment and Retention of Personnel

There were no reported problems with recruitment or retention of ESU officers. In fact, those who were interviewed appeared to enjoy their jobs and responsibilities, and carried a sense of pride when describing incidents in which a shooting was avoided because of their philosophy and tactics.

Estimated Program Costs

The ESU is an expensive unit. Each of the 10 stations has well over one million dollars worth of equipment. Because the ESU program is not solely a specialized police response to persons with mental illness, however, it is difficult to gauge the costs that are exclusively associated with that function. Training for officer handling of persons who may be mentally ill is three weeks, and there are a variety of non-lethal weapons and equipment that are relevant to these incidents, but may not be solely used for these incidents. There is some cost associated with extended periods of waiting by police officers at psychiatric facilities, but this cost was not identified as significant by NYPD personnel.

Program Policies

Training Programs and Practices

ESU training is six months and covers a myriad of topics including:

- Emergency Medical Technician (EMT) certification
- Public Safety Diver (Scuba) Certification
- Bridge climbing
- Ropes training
- Heavy weaponry
- Emergency Psychological Technician
  (Special tactics for persons who may be mentally ill)
- Hazard Materials training
- Animal control
- Helicopter use
- Elevator rescue
- Building collapse
- Trench rescue
- FEMA support

Though this is not an exhaustive list, it covers the major training areas. The ESU training focuses on handling mental disturbance calls over a three week period. Two weeks (80 hours) are dedicated to training on tactics such as less than lethal weapons and verbal de-escalation. The third week is a 40-hour course provided at John Jay College. The instructor is a mental health professional who teaches officers about mental illness and medications, and provides the background knowledge necessary to handle persons in crisis more effectively. The course also includes extensive role playing and scenario-based training. Officers receive college credit for the course, and receive a certificate of completion. This course certifies the officers as "Emergency Psychological Technicians."

Field Operations

Patrol officers are dispatched by Communications when a mental disturbance call is received. If, based on the call, the situation is high-risk, ESU will be sent concurrently with patrol. Otherwise, patrol responds to the call without any assistance. If the situation becomes potentially violent, violent, or the person refuses to be taken into custody for the purposes of hospitalization or any other reason, the ESU is contacted along with a patrol supervisor.

Patrol supervisors have ultimate authority and responsibility on the scene; however, anecdotally, ESU officers report that often the ESU will make tactical decisions in collaboration with the patrol supervisor.

ESU officers rarely take persons to the hospital. Usually, patrol officers will take the person, or an ambulance (operated by FDNY) might be called if medical attention is necessary. Wait times at the hospital vary from 15 minutes to 2 hours.

Incident Documentation and Tracking

An incident form is completed for every ESU response. The log identifies what kind of response occurred and what tactics were used. Data are then entered and used to create a monthly report of ESU activity.

Perceived Effectiveness

According to the ESU Commanding Officer, ESU receives approximately 100,000 requests each year for assistance on calls involved a person suspected of having a mental illness. ESU does not respond to all of these calls. In 2001, ESU responded to 38,083 calls; 39,151 in 2000. In 2001, ESU responded to 101,283 incidents, showing that 38 percent of their response volume is for persons with a mental illness. In 2001, force was used in only seven percent of the responses to persons who may be mentally ill, suggesting that the training, tactics and equipment provide the necessary skills to de-escalate potentially violent encounters. According to Fyfe[11], police shootings of such persons have decreased since the instigating incident.

[11] Fyfe, J.J. (2000). Policing the emotionally disturbed. Journal of the American Academy of Psychiatry and Law, 28, pp. 345-347.

SUCCESSFUL PRACTICES IN THREE MODEL UNITS

Three types of core organizational units were found in programs that deal directly with police responses to persons who may be mentally ill: Crisis Intervention Teams, Psychiatric Emergency Response Teams, and Emergency Services Units. The adoption by LAPD of successful practices found in any of these units in other police departments is not always straightforward. In many instances – due to significant differences between jurisdictions – a transfer of a program's philosophy, policies or procedures may be infeasible or undesirable. This section identifies elements of successful practice that are integral to making these types of units effective in their own jurisdictions.

Crisis Intervention Team (Memphis, Portland, Seattle)

- **Strong mental health infrastructure**
  A successful Crisis Intervention Team (CIT) requires that a strong and supportive mental health system be in place. A critical piece that makes this unit so effective is the ability of police officers to take a person into protective custody and quickly transport him/her to a psychiatric facility that will immediately respond. This results in a reduction of out of service time for the officer. The CIT may fail to have good results if the mental health system does not agree on a central point of intake.

- **Financial and system assistance from local mental health agency**
  An adequately funded central receiving facility, or at least one that has a staffed and locked unit for those persons in protective custody under a psychiatric hold, is essential. The mental health authority typically funds the psychiatric receiving facilities in cities that adopt the CIT program.

- **Agency support**
  An agency's highest authority must actively support any major change, particularly changes that affect operations across departmental units. Clear policies and procedures, and their effective implementation, are needed regarding departmental interface with CIT, including those with Communications, SWAT and HNT.

- **Officer supervision and buy-in**
  In the CIT programs reviewed, Coordinators and supporters emphasized that a new CIT program must have support by officers as well as supervisors. The success of CIT is contingent on the CIT officer being made available for calls involving persons who may be mentally ill and the understanding by shift supervisor of the officer's role.

- **Community stakeholder support**
  An essential element in creating and maintaining a CIT program is the involvement of various community stakeholders including consumer advocates, family members, and behavioral healthcare providers. Representatives of local government, court systems, and community and business leaders are also involved in successful CITs.

Psychiatric Emergency Response Team (San Diego County)

- **Strong relationship with the community**
  On-going support by the local NAMI chapter is found to be an important component of San Diego's reported success with their PERT program. The police department has made a commitment to communicate actively with the community about PERT functions and incidents as necessary.

- **Financial and system assistance from local mental health authority**
  The County mental health agency provides the financial support for clinicians as well as access to County mental health records in a lap top computer for clinicians. This facilitates the evaluation of the subject by the police officer and clinician. In addition, the central receiving facility provided by the County allows the officer to provide quick referral to mental health services for those persons in need.

- **Leadership**
  The PERT program was started and continues to be strongly led by someone within the police department who provides support to the PERT officers. PERT officers are also dedicated to the program and are proud of their work with persons with mental illness in crisis.

- **Agency Support**
  SPD provides PERT with the administrative support necessary to run the program effectively. This support is in the form of established policies and procedures that enable communications across jurisdictions to interface with PERT when needed.

- **Development of an administrative body**
  The establishment of PERT, Inc. provides the police department with a board of directors that integrates community members, advocates, law enforcement and mental health representatives. This natural stakeholders group provides guidance and structure to the program not only in the city by County-wide.

Emergency Services Unit (New York City)

- **Extensive tactical training**
  The strength of the Emergency Services Unit (ESU) lies in the large number of tactics available to it. This allows an ESU to plan and be patient in its approach. The extensive tactical training specific to dealing with persons who may be mentally ill results in adept and highly skilled officers prepared to handle high risk encounters.

- **Continued financial support from the police department**
  The ESU is an expensive program. Commitment to providing training and equipment has meant a financial commitment that extends beyond initial start-up to ongoing maintenance and the acquisition of more advanced equipment as it is available.

- **Inter-departmental support**
  The pride of ESU officers and trainers speaks to their dedication to handle any high-risk encounter. Their willingness to develop new and innovative ideas for equipment and tactics reflects the support of their program internally.

COMMON ELEMENTS OF SUCCESSFUL PRACTICES

The literature review and targeted study of the five cities point to four general practices that are considered to be essential to the success of specialized programs: strong community partnership; specialized training; program accountability; and leadership.

- **Community Partnerships**
  Partnerships created between community agencies and police departments promote a problem-solving rather than adversarial approach. Successful programs have active, ongoing collaboration with agencies such as NAMI and the local mental health authority to ensure that the community's concerns are addressed and to create a forum for the exchange of information. This requires regular meetings, good working relationships, ready disclosure of information, the personal involvement of police command staff and high-level personnel of other agencies, and a joint commitment to maintaining preventive systems. Contact between partners cannot be limited to crises.

- **Specialized Training**
  Programs report that there has been a reduction in the use of force and police injuries as a result of specialized training. This ultimately improves public perceptions and reduces the police department's liability risk. Specialized training includes increased attention to the topic of mental illness for basic recruits, elaboration and reiteration at roll calls, and annual updates (in-service) for all officers. Additional training is required for special response personnel that includes techniques for verbal de-escalation, better knowledge of community resources, and understanding of the consumer and family perspective.

- **Increased Accountability**
  Departments that institute successful specialized programs are continually assessing their value. In most programs, examinations are conducted not only of program operations but of program effectiveness as well. The information derived from these evaluations, in turn, helps to refine policies, training and other systems to improve program effectiveness.

- **Proactive Leadership**
  Successful police departments have taken leadership roles to address the needs of persons with mental illness in crisis, as well as officer safety. That is, they have actively reached out to the community to help them develop innovative programs. This proactive approach requires a critical internal self-analysis of the department's training, policies and procedures, an aggressive search for resources to do so, and a strong commitment to improve current systems.

APPENDIX C: Sample Interview Protocols for Other Law Enforcement Agencies

LAPD Consent Decree Mental Illness Project

Memphis AMI Representative Interview

Date __/__/__ Form ID# Memphis City Code

Background Information

For our records, who is your employer?_____

What is your official position or job title:_____

How long have you been with your current agency: _____yrs. _____mos.

How long have you been in your current position: _____yrs. _____mos.

What is your involvement in the CIT program?

Interview

1. We are here to understand how the Memphis Police Department's CIT program works and how it might useful to other places in the U.S. We would like to ask you some questions about AMI's role with the CIT program and to gain some understanding of how AMI thinks the program works.

   Please describe AMI's role in the CIT program.

   Is there anything else we should we know?

2. What kind of a relationship would you say that AMI has with the Memphis Police Department?

1	2	3	4
Not at all good	Somewhat good	Moderately good	Very good

3. Are there any specific training needs for police officers that you feel would improve the department's response to people with severe mental illness?

4. Overall how well prepared are the CIT officers are in handling emotionally disturbed persons in crisis?

1	2	3	4
Not at all prepared	Somewhat prepared	Moderately prepared	Very well prepared

5. Overall how well prepared are the "non-CIT" patrol officers in handling emotionally disturbed persons in crisis?

1	2	3	4
Not at all prepared	Somewhat prepared	Moderately prepared	Very well prepared

6. Can you recall any serious incidents regarding a person with mental illness and a CIT officer? (If yes, examples)

7. Has anyone complained to AMI about police handling of situations in the past year? (If yes, how many, what type, and has AMI filed any complaints with the police department?)

8. Does AMI feel that the police arrest a substantial number of people who should be diverted to the Mental Health system?

   Yes _____ No_____

9. Do you believe that community policing/CIT efforts have changed the police response to emotionally disturbed persons in Memphis?

10. What do you feel are the key elements to effective police response to emotionally disturbed persons in your community? (i.e., what do the police need to do their job well?)

11. How effective do you believe the Memphis CIT Program is for handling "emotionally disturbed persons in crisis" in accomplishing the following objectives: (circle one for each answer)

Allowing police officers to do what their job should be?

1	2	3	4
Not at all Effective	Somewhat Effective	Moderately Effective	Highly Effective

Meeting the needs of emotionally disturbed persons in crisis?

1	2	3	4
Not at all Effective	Somewhat Effective	Moderately Effective	Highly Effective

Keeping emotionally disturbed persons out of jail?

1	2	3	4
Not at all Effective	Somewhat Effective	Moderately Effective	Highly Effective

Reducing the amount of time the officers spend on these types of calls?

1	2	3	4
Not At All Effective	Somewhat Effective	Moderately Effective	Highly Effective

12. How well do you think the mobile mental health crisis team responds to persons with mental illnesses in your community?

1	2	3	4
Not at all well	Somewhat well	Moderately well	Very well

13. How strong do you think the relationship is between the police and the mental health system?

1	2	3	4
Not at all strong	Somewhat strong	Moderately strong	Very strong

14. In your opinion, what could be done to improve the CIT response to persons with mental illness in crisis?

15. Do you believe that the CIT program would work well as a "model" of crisis response to emotionally disturbed persons for other police departments? (Why or why not?)

Yes ___ No___

16. In setting up/operating an appropriate crisis response program, who are the key players in the community?

LAPD Consent Decree Mental Illness Project

Memphis Psychiatric Emergency Room Staff Interview

Date __/__/__ Form ID# Memphis City Code

Background Information

For our records, who is your employer? _____

What is your official position or job title:_____

How long have you been with your current agency: _____yrs. _____mos.

How long have you been in your current position: _____yrs. _____mos.

What is your involvement in the CIT program?

Interview

We are here to understand how the Memphis Police Department's CIT program works and how it might be useful to other places in the U.S. We would also like to understand how they interface with the mental health system and use the psychiatric emergency room for crisis situations. We would like to ask you some questions about the ER and your experience with the Memphis Police Department and the CIT officers in particular.

1. Please describe your professional responsibilities

2. Could you describe for us the way in which police referrals are handled at the ER?

3. How helpful is the ER in providing assistance to the CIT officers when handling emotionally disturbed persons?

1	2	3	4
Not at all helpful	Somewhat helpful	Moderately helpful	Very helpful

4. How does the ER staff handle persons who are referred with dual diagnosis?

5. Overall, how well prepared are the CIT officers when handing emotionally disturbed persons in crisis?

1	2	3	4
Not at all prepared	Somewhat prepared	Moderately prepared	Very well prepared

6. Overall, how well prepared are the "non-CIT" patrol officers to handle EDP's in crisis?

1	2	3	4
Not at all prepared	Somewhat prepared	Moderately prepared	Very well prepared

7. Relative to other police department problems, in your opinion, how big of a problem are emotionally disturbed persons (EDP's) for the Memphis Police Department?

8. Can you put a number on that for us?

1	2	3	4
Not at all	Somewhat	Moderate	Significant

9. What do you feel are the key elements to effective police response to EDP's (ie., what would they need to do their job well?)

10. How effective do you believe the Memphis CIT Program is for handling "emotionally disturbed persons in crisis" in accomplishing the following objectives: (circle one for each answer)

Allowing police officers to do what their job should be?

1	2	3	4
Not at all Effective	Somewhat Effective	Moderately Effective	Highly Effective

Meeting the needs of emotionally disturbed persons in crisis?

1	2	3	4
Not at all Effective	Somewhat Effective	Moderately Effective	Highly Effective

Keeping emotionally disturbed persons out of jail?

1	2	3	4
Not at all Effective	Somewhat Effective	Moderately Effective	Highly Effective

Reducing the amount of time the officers spend on these types of calls?

1	2	3	4
Not at all Effective	Somewhat Effective	Moderately Effective	Highly Effective

11. How do you think the mobile mental health crisis team responds to persons with mental illnesses in your community?

12. In your opinion, what could be done to improve the CIT response to persons with mental illness in crisis?

13. Do you believe that the CIT program would work well as a "model" of crisis response to emotionally disturbed persons for other police departments? (Why or why not?)

Yes ___ No___

14. What would be the most difficult part of the program to transfer to other jurisdictions?

15. In setting up/operating an appropriate crisis response program, who are the key players in the community?

16. How easy is it to get an emotionally disturbed person admitted to a hospital when it is necessary?

1	2	3	4
Not at all easy	Somewhat easy	Moderately easy	Very easy

LAPD Consent Decree Mental Illness Project

Memphis Mobile Mental Health Crisis Team Director Interview

Date __/__ /__ Form ID# Memphis City Code

Background Information

For our records, who is your employer?_____

What is your official position or job title:_____
How long have you been with your current agency: _____yrs. _____mos.
How long have you been in your current position: _____yrs. _____mos.

What is your involvement in the CIT program?

Interview

We are here to examine the Memphis Police Department's CIT program. We would also like to understand how they interface with the mental health system. We would like to ask you some questions about your program and also find out about your experience with the CIT program.

1. Please describe your professional responsibilities:

2. So that we can understand how your program works, could you please describe for us how you operate, what types of calls you receive and how you might respond?

Probes:
Does Mobile Crisis go to the jail for calls?
Respite?
How are they funded?
Where do your referrals come from?

3. About how many crisis calls for emotionally disturbed persons have you had in the last month: (can estimate)_____

4. Do you ever receive calls for assistance from the Memphis Police Department's CIT's?
Yes___ No___

5. Overall how well prepared are the CIT officers when handling emotionally disturbed persons in crisis?

1	2	3	4
Not at all prepared	Somewhat prepared	Moderately prepared	Very well prepared

6. Overall, how well prepared are "non-CIT" patrol officers to handle EDP's in crisis?

1	2	3	4
Not at all prepared	Somewhat prepared	Moderately prepared	Very well prepared

7. Overall, how well prepared is the Mobile Crisis Unit to handle EDP's who may be charged with an offense?

1	2	3	4
Not at all prepared	Somewhat prepared	Moderately prepared	Very well prepared

8. How effective do you believe the Memphis CIT Program is for handling "emotionally disturbed persons in crisis" in accomplishing the following objectives:
(circle one for each answer)

Allowing police officers to do what their job should be?

1	2	3	4
Not at all Effective	Somewhat Effective	Moderately Effective	Highly Effective

Meeting the needs of emotionally disturbed persons in crisis?

1	2	3	4
Not at all Effective	Somewhat Effective	Moderately Effective	Highly Effective

Keeping emotionally disturbed persons out of jail?

1	2	3	4
Not at all Effective	Somewhat Effective	Moderately Effective	Highly Effective

Reducing the amount of time the officers spend on these types of calls?

1	2	3	4
Not at all Effective	Somewhat Effective	Moderately Effective	Highly Effective

9. Do you ever request CIT assistance? (If not, skip next question)

1	2	3	4
Never	Rarely	Sometimes	Often

10. How often would you estimate that you request CIT assistance per month? (#_____)

11. How helpful is the law enforcement system in providing assistance to mobile crisis when handling emotionally disturbed persons in crisis?

1	2	3	4
Not at all helpful	Somewhat helpful	Moderately helpful	Very helpful

12. How satisfied are you with their response time?

1	2	3	4
Not at all satisfied	Somewhat satisfied	Moderately satisfied	Very satisfied

13. How helpful is the ER in providing assistance when handling emotionally disturbed persons?

1	2	3	4
Not at all helpful	Somewhat helpful	Moderately helpful	Very helpful

14. How easy is it to get an emotionally disturbed person admitted to a hospital when it is necessary?

1	2	3	4
Not at all easy	Somewhat easy	Moderately easy	Very easy

Please answer the following questions to the best of your ability:

15. When the Mobile Crisis team encounters a person who currently appears to be showing signs of serious mental illness, but who has done something for which s/he could be legally charged with a crime, generally, how does mobile crisis respond?

16. What do you feel are the key elements for effective police response to EDP's (i.e., what do you need to do your job well?)

17. What could the mental health system do to be more responsive to the needs of the CIT officers?

18. Do you believe that the CIT program would work well as a model of crisis response to emotionally disturbed persons for other police departments?

    Yes_____ No_____

19. What would be the most difficult component of the program to transfer to other jurisdictions?

20. In setting up/operating an appropriate police/mental health response program, who are the key players in the community?

21. How do you believe the CIT program fits into the mental health system?

22. How is the relationship between the CIT officers and the mental health system?

1	2	3	4
Not at all good	Somewhat good	Moderately good	Very good

LAPD Consent Decree Mental Illness Project

Memphis Police Chief Interview

Date __/__/__ Form ID# Memphis City Code

Background Information

For our records, who is your employer?_____

What is your official position or job title:_____

How long have you been with your current agency: _____yrs. _____mos.

How long have you been in your current position: _____yrs. _____mos.

What is your involvement in the CIT program?

Interview

The CIT program has established national recognition as a unique police response to persons with mental illness. We would like to ask you a few specific questions about the situation here in Memphis.

1a. Relative to other problems that a police department might experience, how big of a problem would you say emotionally disturbed persons (EDP's) are for the Memphis Police Department?

1b. Can you put a number on that for us?

1	2	3	4
Not at all	Somewhat	Moderate	Significant

2. What do you feel are the key elements for effective police response to EDP's (i.e., what do you need to do you job well?)

3. Overall, how well prepared are the "non-CIT" patrol officers to handle EDP's in crisis?

1	2	3	4
Not at all prepared	Somewhat prepared	Moderately prepared	Very well prepared

4. Overall, how well prepared are the CIT officers to handle EDP's in crisis?

1	2	3	4
Not at all prepared	Somewhat prepared	Moderately prepared	Very well prepared

5. **How effective do you believe the Memphis CIT Program is for handling "emotionally disturbed persons in crisis" in accomplishing the following objectives:**
(circle one for each answer)

Allowing police officers to do what their job should be?

1	2	3	4
Not at all Effective	Somewhat Effective	Moderately Effective	Highly Effective

Meeting the needs of emotionally disturbed persons in crisis?

1	2	3	4
Not at all Effective	Somewhat Effective	Moderately Effective	Highly Effective

Keeping emotionally disturbed persons out of jail?

1	2	3	4
Not at all Effective	Somewhat Effective	Moderately Effective	Highly Effective

Reducing the amount of time the officers spend on these types of calls?

6. How helpful is the mental health system in providing assistance to your officers when they are handling emotionally disturbed persons?

1	2	3	4
Not at all helpful	Somewhat helpful	Moderately helpful	Very helpful

7. What could the mental health system do to be more responsive to your needs as a police department?

8. What do you think the "non-CIT" patrol officer's attitudes are toward the CIT officers?

9. Do you believe that the CIT program would work well as a "model" of crisis response to emotionally disturbed persons for other police departments? (Why or why not?)
   Yes__ No__

10. What was the most difficult part of applying the CIT program in Memphis?

11. What would be the most difficult part of the program to transfer to other jurisdictions?

12. What advice would you have for other departments who are thinking of implementing a CIT program?

13. In what ways do you think the CIT program in Memphis is different than in other cities like Portland or Albuquerque?

14. What do you think could be done in Memphis to make police response to emotionally disturbed persons better?

LAPD Consent Decree Mental Illness Project

Memphis Police Manager/ CIT Coordinator Interview

Date __/__/__ Form ID# Memphis City Code

Background Information

For our records, who is your employer? _____

What is your official position or job title: _____

How long have you been with your current agency: _____yrs _____mos.

How long have you been in your current position: _____yrs. _____mos.

What is your involvement in the CIT program?

Interview

The CIT program in Memphis is an innovative and unique police response to persons with mental illness. Could you please describe the program philosophy and structure.

Some Probes:

Step by Step way the system works:

When might a CIT call the mobile crisis unit? Do non-CIT patrol officers call Mobile Crisis directly? When might a patrol officer call Mobile Crisis directly? How big of a problem were EDP's prior to the CIT program? How were EDP's handled prior to the CIT program?

1. Please describe your professional responsibilities:

2. Relative to other police department problems, how big of a problem are EDP's for the Memphis Police Department?

1	2	3	4
Not at all	Somewhat	Moderate	Significant

3. About how many police calls for Emotionally Disturbed Persons have you had in the last month: (estimate) _____

4. About how many hours of training do CIT officers receive for handling emotionally disturbed persons? _____

5. About how many hours of continuing education do CIT officers receive for handling emotionally disturbed persons? _____

6. Can you describe some of the training procedures to us?

7. Overall, how well prepared are the CIT officers when handling emotionally disturbed persons in crisis?

1	2	3	4
Not at all prepared	Somewhat prepared	Moderately prepared	Very well prepared

8. Overall, how well prepared are the "non-CIT" patrol officers to handle EDP's in crisis?

1	2	3	4
Not at all prepared	Somewhat prepared	Moderately prepared	Very well prepared

9. Overall, how well prepared is the Mobile Crisis Team to handle EDP's who may be charged with an offense?

1	2	3	4
Not at all prepared	Somewhat prepared	Moderately prepared	Very well prepared

10. How effective do you believe the Memphis CIT Program is for handling "emotionally disturbed persons in crisis" in accomplishing the following objectives: (circle one for each answer)

Allowing police officers to do what their job should be?

1	2	3	4
Not at all Effective	Somewhat Effective	Moderately Effective	Highly Effective

Meeting the needs of emotionally disturbed persons in crisis?

1	2	3	4
Not at all Effective	Somewhat Effective	Moderately Effective	Highly Effective

Keeping emotionally disturbed persons out of jail?

1	2	3	4
Not at all Effective	Somewhat Effective	Moderately Effective	Highly Effective

Reducing the amount of time the officers spend on these types of calls?

1	2	3	4
Not at all Effective	Somewhat Effective	Moderately Effective	Highly Effective

11. How helpful is the mental health system in providing assistance to you when handling emotionally disturbed persons?

1	2	3	4
Not at all helpful	Somewhat helpful	Moderately helpful	Very Helpful

12. Do you have access to specialized on-site assistance from mobile mental health crisis for emotionally disturbed person cases?

Yes__ No__

13. How satisfied are you with their response time?

1	2	3	4
Not at all satisfied	Somewhat satisfied	Moderately satisfied	Very Satisfied

14. How helpful is the ER in providing assistance to you when handling emotionally disturbed persons?

1	2	3	4
Not at all helpful	Somewhat helpful	Moderately helpful	Very helpful

15. How easy is it to get an EDP admitted to a hospital when it is necessary?

1	2	3	4
Not at all easy	Somewhat easy	Moderately easy	Very easy

Please answer the following questions to the best of your ability:

16. When a CIT officer encounters a person who currently appears to be showing signs of serious mental illness, but who has done something for which s/he could be charged with a crime, generally, how do the CIT officers decide whether to arrest that person or to provide some other disposition?

17. What do you feel are the key elements to appropriate police response to EDP's (i.e., What do you need to do your job well).

18. What could be done to improve your departments' response to persons with mental illnesses in crisis?

19. What could the mental health system do to be more responsive to the needs of the CIT officers?

20. Do you believe that the CIT program would work well as "model" of crisis response to emotionally disturbed persons for other police departments? (why or why not?)
Yes___ No___

21. What was the most difficult part of applying the CIT program in Memphis?

22. What would be the most difficult part of the program to transfer to other jurisdictions?

23. What advice would you have for other departments who are thinking of implementing a CIT program?

24. In what ways do you think the CIT program in Memphis is different than that in other cities like Portland or Albuquerque?

25. In setting up/operating an appropriate program, who are the key players in the community?

LAPD Consent Decree Mental Illness Project

Memphis Psychiatric Emergency Room Director Interview

Date __/__/__ Form ID# Memphis City Code

Background Information

For our records, who is your employer? _____

What is your official position or job title: _____

How long have you been with your current agency: _____yrs. _____mos.

How long have you been in your current position: _____yrs. _____mos.

What is your involvement in the CIT program?

Interview

We are here to understand how the Memphis Police Department's CIT program works and how it might be useful to other places in the U.S. We would also like to understand how they interface with the mental health system and use the psychiatric emergency room for crisis situations. We would like to ask you some questions about the ER and about your experience with the Memphis Police Department and the CIT officers in particular.

1. Could you describe for us your professional responsibilities?

2. Could you describe for us the way in which police referrals are handled in the Psychiatric ER?

3. How helpful is the ER in providing assistance to the CIT officers when handling emotionally disturbed persons?

1	2	3	4
Not at all helpful	Somewhat helpful	Moderately helpful	Very helpful

4. Is there any specific funding for police cases?

Yes___ No___

5. How does your staff handle persons who are referred with dual diagnosis?

6. Overall, how well prepared are CIT officers when handing emotionally disturbed persons in crisis?

1	2	3	4
Not at all prepared	Somewhat prepared	Moderately prepared	Very well prepared

7. Overall, how well prepared are the "non-CIT" patrol officers to handle EDP's in crisis?

1	2	3	4
Not all prepared	Somewhat prepared	Moderately prepared	Very well prepared

8. Relative to other police department problems, how big of a problem are emotionally disturbed persons (EDP's) for the Memphis Police Department?

9. Can you put a number on that for us?

1	2	3	4
Not at all	Somewhat	Moderate	Significant

10. What do you feel are the key elements to effective police response to EDP's (i.e., what would they need to do their job well?)

11. How effective do you believe the Memphis CIT Program is for handling "emotionally disturbed persons in crisis" in accomplishing the following objectives: (circle one for each answer)

Allowing police officers to do what their job should be?

1	2	3	4
Not at all Effective	Somewhat Effective	Moderately Effective	Highly Effective

Meeting the needs of emotionally disturbed persons in crisis?

1	2	3	4
Not at all Effective	Somewhat Effective	Moderately Effective	Highly Effective

Keeping emotionally disturbed persons out of jail?

1	2	3	4
Not at all Effective	Somewhat Effective	Moderately Effective	Highly Effective

Reducing the amount of time the officers spend on these types of calls?

1	2	3	4
Not at all Effective	Somewhat Effective	Moderately Effective	Highly Effective

12. How do you think the mobile mental health crisis team responds to persons with mental illnesses in your community?

13. In your opinion, what could be done to improve the CIT response to persons with mental illness in crisis?

14. Do you believe that the CIT program would work well as a "model" of crisis response to emotionally disturbed persons for other police departments? (Why or why not?)

Yes___ No___

15. What would be the most difficult part of the program to transfer to other jurisdictions?

16. In setting up/operating an appropriate crisis response program, who are the key players in the community?

17. How easy is it to get an emotionally disturbed person admitted to a hospital when it is necessary?

1	2	3	4
Not at all easy	Somewhat easy	Moderately easy	Very easy

LAPD Consent Decree Mental Illness Project

Memphis Mental Health Center Director Interview

Date __/__/__ Form ID# Memphis City Code

For our records, who is your employer?_____

What is your official position or job title:_____

How long have you been with your current agency: ____yrs. ____mos.

How long have you been in your current position: ____yrs. ____mos.

What is your involvement in the CIT program?

Background Information

Interview

We are here to examine the Memphis Police Department's CIT program. We would also like to understand how they interface with the mental health system. We would like to ask you some questions about the mental health system in Memphis and also find out about your experience with the CIT program.

1. Please describe your professional responsibilities:

2. How do you believe the CIT program fits into the mental health system?

3. Overall, how well prepared are the CIT officers when handling emotionally disturbed persons in crisis?

1	2	3	4
Not at all prepared	Somewhat prepared	Moderately prepared	Very well prepared

4. Overall, how well prepared are the "non-CIT" patrol officers to handle EDP's in crisis?

1	2	3	4
Not at all prepared	Somewhat prepared	Moderately prepared	Very well prepared

5. Overall, how well prepared is the Mobile Crisis Unit to handle EDP's who may be charged with an offense?

1	2	3	4
Not at all prepared	Somewhat prepared	Moderately prepared	Very well prepared

6. **How effective do you believe the Memphis CIT Program is for handling "emotionally disturbed persons in crisis" in accomplishing the following objectives**: (circle one for each answer)

Allowing police officers to do what their job should be?

1	2	3	4
Not at all Effective	Somewhat Effective	Moderately Effective	Highly Effective

Meeting the needs of emotionally disturbed persons in crisis?

1	2	3	4
Not at all Effective	Somewhat Effective	Moderately Effective	Highly Effective

Keeping emotionally disturbed persons out of jail?

1	2	3	4
Not at all Effective	Somewhat Effective	Moderately Effective	Highly Effective

Reducing the amount of time the officers spend on these types of calls?

1	2	3	4
Not at all Effective	Somewhat Effective	Moderately Effective	Highly Effective

7. How helpful is the ER in providing assistance to the CIT officers when handling emotionally disturbed persons?

1	2	3	4
Not at all helpful	Somewhat helpful	Moderately helpful	Very helpful

8. How easy is it to get an emotionally disturbed person admitted to a hospital when it is necessary?

1	2	3	4
Not at all easy	Somewhat easy	Moderately easy	Very easy

Please answer the following questions to the best of your ability:

9. What do you feel are the key elements to effective Police/Mental Health response to EDP's (i.e., what would help the police department and mental health professionals do their job well?)

10. What could the mental health system do to be more responsive to the needs of the CIT officers?

11. What could the CIT officers do to be more responsive to the needs of those in the Mental Health system?

12. Do you believe that the CIT program would work well as a "model" of crisis response to emotionally disturbed persons for other police departments?

Yes _____ No _____

13. What would be the most difficult part of the program to transfer to other jurisdictions?

14. In setting up/operating an appropriate Police/Mental Health response program, who are the key players in the community?

APPENDIX D: List of Training Documents Reviewed

Curricula Review Documents

Recruit Officer's Hourly Distribution Schedule (Learning Domain (LD) # 37)
Managing Contacts with Developmentally Disabled or Mentally Ill
LD # 3 Community Police Problem Solving
LD # 3 Tactical Communications
LD # 3 News Media Relations
LD # 3 Community Police Problems
LD # 4 Crisis Intervention/Victim Assistance
LD # 12 Narcotics
LD # 25 Domestic Violence
LD # 27 Missing Persons
LD # 30 Primary Investigation Child Abuse
LD # 30 Rape
LD # 31 Custody
LD # 32 Stress Management
LD # 37 Persons with Disabilities with Instructor Unit Guide
LD # 42 Cultural Diversity
LD # 42 Hate Crimes
LD # 42 Sexual Harassment
FATS Scenario Report
POST Basic Course Instructor Guide
Basic Course Workbook Series
Police Contacts with Mentally Disabled Persons - Update 5/2/01
Scenario 2, 415 Man, Possible 5150 (Tactics Training Unit)

Roll Call Lesson Plans

Persons With Developmental Disabilities (Deployment Period # 6-01)
Law Enforcement Response to Mental Illness (Deployment Period # 4-01)
Mental Illness - 5150 Detention (Deployment Period 11-98)

Suicide by Cop (Note: used for SWAT but unclear how many patrol officers received this training).

Police Contacts with Mentally Disabled Persons - Update
CEDP information - miscellaneous

Bulletins

2001 Index of Valid Training Bulletins
Effective Encounters with Mentally Ill Persons
Verbal Tactics
Handling Disabled Persons in Arrest Situations

Overcoming Language Barriers
Weapons Other Than Firearms
Phencyclidine
In-Custody Deaths
Use of Force - Restraining Procedures and Devices
Use of Force - The "Team Take-Down"
Use of Force - Taser Model TE-93
Use of Force - Chemical Agent Control Devices "Oleoresin Capsicum"
Arrest and Control Part I – Introduction
Arrest and Control Part II - Joint Locks
Arrest and Control Part III - Distraction Strikes, Evading and Blocking Techniques
Arrest and Control Part IV - Takedowns
Arrest and Control Part V - Ground Control and Weapon Retention
Personal Searches Part III - "High-Risk Prone Search"
Printed articles, internal communications

Field Training Manual
CEDP Module 1, Field Officer Update

Jail Operations Manual
Department Manual - Section 4/260
Detention Officer Core Course
Occupational Health and Safety Division - Developmentally/mentally disabled arrestees
Jail Division Roll Call Training Calendar
Course Outline - Unit 14

Communication Center
Mentally Disabled Evaluation of a Caller - Fact Sheet
Roll Call Training - Lesson Plan - Section 5/130.1

CIT
CIT Training Curriculum and related documents
CIT Training Curriculum - revised 12/14/01

SMART Materials
SMART Training Curricula and miscellaneous documents

Special Topics-Firearm Training
Various curricula related to firearms, not-lethal and less-than-lethal weapons.
FATS Scenario Report by Type of Training
Special Topics-Crisis Response Team Program
CRTP information on the web

Review of Departmental Policies and Procedures Related to Training
Report submitted to Commissioners (120 day work plan) 5/2/01
Fact Sheet (8/23/99) to coordinate with LASD
Department Review of Training and Procedures (4/24/2001)
- *120-Day Work Plan Update*
- *Data Collections - Researching Police Programs*
- *Review of Telecourse*
- *Miscellaneous internal memos*

Timeline for Training and Policy Review
Motions of the Board of Police Commissioners
Miscellaneous reports regarding Margaret Mitchell Officer Involved Shooting
Meeting with National Alliance for the Mentally Ill
Field Problems and Firearms Training Simulator - Tactical Communications
Tactics with Weapons
Executive Summary

APPENDIX E: List of Other Documents Reviewed

CIT Materials
Crisis Intervention Team Pilot Program Evaluation

SMART Materials
SMART Guidelines
SMART Operations Manual
SMART Guidelines for Field Units

MEU Materials
Duties and Responsibilities of the MEU
MEU Unit Reports
MEU Dispatch and Daily Logs
Expansion of Duties of the Mental Evaluation Unit and Establishment of Psychiatric Emergency Coordinating Committee

General Policies Related to Persons with Mental Illnesses
Manual of the Los Angeles Police Department (attention to Sections 217 - 217.50, 258.17 - 262.90, 275.40 - 279, 640, 647, 840.50)
Welfare and Institution Code (attention to Section 510 - 5157)
Special Order # 27 "Investigating and Adjudicating Non-Categorical Use of Force Incidents"
Apprehension and Transportation Order
LAPD Arrestee Medical Screening Form
Application for 72-Hour Detention
Implementation of the Los Angeles Police Department/Los Angeles Unified School District Mental Health Referral Program
Communication Division Manual Section 5/130.1 Re: Mentally Disabled
Use of Force Handbook (August, 1995)

APPENDIX F: Recruit Training Observation Coding Form

PROTOCOLS FOR LOS ANGELES POLICE DEPARTMENT TRAINING EVALUATION

DATA SOURCES

Current identified data sources are listed below. Other sources may be identified by L.A.P.D. or identified and requested by evaluators.

Curricula	Other Documents	Interviews/Observations
Basic recruit curriculum	Department policies	Trainers
Course workbook	Training schedules	Officer's who have completed training
Training handouts	Internal memos related to training	Consumers/families/advocates
Training bulletins	Planning committee minutes	Administrative staff
	Participant evaluations	Direct observation of training
	Internal training event evaluation	
	Ordinances and agreements	

TRAINING FORMAT

Check the type of training being reviewed:

_____ Basic Recruit
_____ In-services (4 to 8 hrs.)
_____ Roll Call
_____ Special (8 to 40 hrs)
_____ Reviews, Updates, Recertifications

EVALUATION PROTOCOLS

The reviewer/interviewer/observer will use the following questions to evaluate the training program. A three (3)-point format is used with space for comments to more objectively state the reason for the rating. All questions may not be relevant for all aspects of the training program nor for all sources of data.

OUTLINE OF PROTOCOLS

I Curriculum content
- A Recognizing mental illnesses
- B Risk potential for self-harm or violence to others
- C Medical conditions and psychiatric medications
- D Substance abuse
- E Mental health related laws and client rights
- F Intervention strategies
- G Community resources
- H Consumer, advocate, and family involvement and awareness

II Training methods

III Planning, development, and evaluation

I CURRICULUM CONTENT (Documents review)

A Recognizing Mental Illness

Does the training program,

Extensive_____ **Moderate**_____ **Not At All**_____

1. provide basic terminology and definitions for defining mental illnesses?

_____

_____

Extensive_____ **Moderate**_____ **Not At All**_____

2. teach the officer how to recognize symptoms of mental illnesses?

_____

_____

Extensive_____ **Moderate**_____ **Not At All**_____

3. review situational stressors which may contribute to someone experiencing a mental Illness or creating a crisis?

_____

_____

Extensive_____ **Moderate**_____ **Not At All**_____

4. provide information on the various categories of major mental illnesses?

_____

_____

Extensive_____ **Moderate**_____ **Not At All**_____

5. provide information on mental retardation and developmentally disabled?

_____

_____

Extensive_____ **Moderate**_____ **Not At All**_____

6. prepare the officer to complete a "mini" mental status assessment including orientation to person, place, and time?

_____

_____

Extensive_____ **Moderate**_____ **Not At All**_____

7. identify and discuss diagnostic terms that are used by the behavioral healthcare community?

_____

_____

B Risk potential for self-harm or violence to others

Does the training program,

Extensive_____ **Moderate**_____ **Not At All**_____

1. discuss risk potential, violence and mental illness?

_____

_____

Extensive_____ **Moderate**_____ **Not At All**_____

2. define which symptoms of mental illnesses are most concerning?

_____

_____

Extensive_____ **Moderate**_____ **Not At All**_____

3. define and discuss the issue of “suicide by cop"?

_____

_____

Extensive_____ 4. discuss assessment of suicide potential?
Moderate_____ _____
Not At All_____ _____

Extensive_____ 5. describe demographic and clinical factors of suicide?
Moderate_____ _____
Not At All_____ _____

Extensive_____ 6. teach a method to assess the degree of lethality of suicidal behavior?
Moderate_____ _____
Not At All_____ _____

Extensive_____ 7. review general strategies for suicide crisis intervention?
Moderate_____ _____
Not At All_____ _____

C Medical conditions and psychiatric medications

Does the training program,

Extensive_____ 1. include medical conditions that mimic or mask symptoms of a mental illness?
Moderate_____ _____
Not At All_____ _____

Extensive_____ 2. give examples of medical conditions that are medical emergencies?
Moderate_____ _____
Not At All_____ _____

3. provide information on physicial symptoms that can be clues to a medical emergency?
Extensive_____
Moderate_____ _____
Not At All_____ _____

Extensive_____ 4. define psychiatric medications?
Moderate_____ _____
Not At All_____ _____

Extensive_____ 5. present a listing of updated psychiatric medications?
Moderate_____ _____
Not At All_____ _____

Extensive_____ 6. define and describe the categories of psychiatric medications
Moderate_____ _____
Not At All_____ _____

Extensive_____ 7. define and describe the side effects of medications?
Moderate_____ _____
Not At All_____ _____

Extensive_____ 8. discuss the therapeutic effects of psychiatric medications?
Moderate_____ _____
Not At All_____ _____

Extensive_____ 9. include examples of medications from each category?
Moderate_____ _____
Not At All_____ _____

Extensive_____
Moderate_____
Not At All_____

10. utilize a professional such as psychiatric nurse or psychiatrist to present information on medications and medical conditions?

_____
_____

D Substance Abuse

Does the training program,

Extensive_____
Moderate_____
Not At All_____

1. describe the possible effects of alcohol and other drugs on a person experiencing symptoms of a mental illness?

_____
_____

Extensive_____
Moderate_____
Not At All_____

2. describe the effects of various drugs and alcohol on the body?

_____
_____

Extensive_____
Moderate_____
Not At All_____

3. discuss the current problem drugs in the community?

_____
_____

Extensive_____
Moderate_____
Not At All_____

4. define and discuss persons who have been dually diagnosed?

_____
_____

Extensive_____
Moderate_____
Not At All_____

5. describe symptoms of mental illness resulting from drug intoxication or withdrawal?

_____
_____

Extensive_____
Moderate_____
Not At All_____

6. describe symptoms of alcohol or drug intoxification which are similar to symptoms of various mental illnesses?

_____
_____

E Mental health related laws and client rights

Does the training program,

Extensive_____
Moderate_____
Not At All_____

1. discuss the laws pertaining to mental health treatment in the state, including involuntary commitment laws and protective custody procedures?

_____
_____

Extensive_____
Moderate_____
Not At All_____

2. review police duties under the Americans with Disabilities Act and other civil rights laws?

_____
_____

Extensive_____
Moderate_____
Not At All_____

3. provide information regarding a mental health court system and the officer's role?

_____
_____

Extensive_____ 4. discuss police responsibilities for voluntary emergency commitment?
Moderate_____ _____
Not At All_____ _____

Extensive_____ 5. discuss police responsibilities for involuntary emergency commitment?
Moderate_____ _____
Not At All_____ _____

6. review criteria for taking a person into custody that has a mental illness, is in crisis, and has committed a crime?
Extensive_____
Moderate_____ _____
Not At All_____ _____

7. discuss interviewing suspects who may have a mental illness with active symptoms?
Extensive_____
Moderate_____ _____
Not At All_____ _____

Extensive_____ 8. review non-custodial police options?
Moderate_____ _____
Not At All_____ _____

Extensive_____ 9. review protective custody options?
Moderate_____ _____
Not At All_____ _____

10. discuss police responsibility and discretion regarding persons with a mental illness who have committed a misdemeanor?
Extensive_____
Moderate_____ _____
Not At All_____ _____

11. review police procedures/responsibilities on serving court orders for involuntary examinations/treatment?
Extensive_____
Moderate_____ _____
Not At All_____ _____

Extensive_____ 12. review police responsibilities for elopements from treatment facilities?
Moderate_____ _____
Not At All_____ _____

F Intervention strategies

Does the training program,

Extensive_____ 1. provide an operational strategy for officers interacting with persons in crisis who have symptoms of a mental illness?
Moderate_____
Not At All_____ _____
_____

Extensive_____
Moderate_____ 2. offer examples of verbal indicators of the major mental illnesses?
Not At All_____ _____
_____

Extensive_____ 3. offer examples of non-verbal indicators of the major mental illnesses?
Moderate_____ _____
Not At All_____ _____

Extensive_____ 4. review de-escalation guidelines and interventions?
Moderate_____ _____
Not At All_____ _____

Extensive_____ 5. include techniques such as "verbal judo" for effective verbal interventions?
Moderate_____ _____
Not At All_____ _____

Extensive_____ 6. emphasize officer safety?
Moderate_____ _____
Not At All_____ _____

Extensive_____ 7. discussion the positive and negative responses of a person with mental illness when uniformed officers arrive?
Moderate_____ _____
Not At All_____ _____

Extensive_____ 8. review community policing resources including mobile crisis teams, specialized police units, and medical transport for a person with a possible mental illness?
Moderate_____ _____
Not At All_____ _____

G Community resources

Does the training program,

Extensive_____ 1. provide information on community resources?
Moderate_____ _____
Not At All_____ _____

Extensive_____ 2. discuss how to access community resources?
Moderate_____ _____
Not At All_____ _____

Extensive_____ 3. discuss how the continuum of services relates to each other? (institutional-community care, criminal justice, education, and health care)
Moderate_____ _____
Not At All_____ _____

Extensive_____ 4. provide information on how law enforcement accesses mental health service providers for emergency situations?
Moderate_____ _____
Not At All_____ _____

Extensive_____ 5. distribute a recently updated listing of community resources?
Moderate_____ _____
Not At All_____ _____

H Consumer, advocate, and family involvement and awareness

Does the training program,

Extensive_____
Moderate_____
Not At All_____

1. address misconceptions people may have regarding a mental illness?

_____
_____

Extensive_____
Moderate_____
Not At All_____

2. address socioeconomic status and mental illness?

_____
_____

Extensive_____
Moderate_____
Not At All_____

3. address gender and mental illness?

_____
_____

Extensive_____
Moderate_____
Not At All_____

4. include interactions with consumers?

_____
_____

Extensive_____
Moderate_____
Not At All_____

5. have officers visit treatment centers, drop-in centers, and/or various treatment programs as part of their training?

_____
_____

Extensive_____
Moderate_____
Not At All_____

6. discuss the stigma of mental illness and the stigmatization of persons diagnosed with a mental illness?

_____
_____

Extensive_____
Moderate_____
Not At All_____

7. include the family's perspective?

_____
_____

Extensive_____
Moderate_____
Not At All_____

8. discuss cultural and racial diversities?

_____
_____

II TRAINING METHODS (Interview & Observations)

1. How many hours of training are required for officers interacting with persons in crisis or experiencing a mental illness?

   less than 4 hrs___ between 4 and 8 hrs___
   between 8 and 24 hours___ more than 24 hours___

_____
_____

Extensive_____
Moderate_____
Not At All_____

2. Does the training environment allow for questions and discussion?

_____
_____

Extensive_____
Moderate_____
Not At All_____

3. Is training review time set aside during roll call?

_____
_____

Extensive_____
Moderate_____
Not At All_____

4. Are dramatizations or role-plays utilized to highlight and practice intervention strategies?

_____
_____

Extensive_____
Moderate_____
Not At All_____

5. Are audio-visuals used in the presentation of information?

_____
_____

Extensive_____
Moderate_____
Not At All_____

6. Are both mental health professionals and law enforcement officers used for presenting information?

_____
_____

Extensive_____
Moderate_____
Not At All_____

7. Does the department have a training manual to structure all training?

_____
_____

Extensive_____
Moderate_____
Not At All_____

8. Was the training curriculum developed collaboratively between law enforcement and local mental health professionals?

_____
_____

Extensive_____
Moderate_____
Not At All_____

9. Are consumers included in the presentation of information?

_____
_____

Extensive_____
Moderate_____
Not At All_____

10. Does the training program teach skills to triage (i.e. prioritizes critical actions) the situation for medical, criminal, substance abuse or other relevant factors?

_____
_____

Extensive_____
Moderate_____
Not At All_____

11. Does the training program provide needed skills to determine the possible presence of a mental illness and determine level of intervention required?

_____
_____

III PLANNING, DEVELOPMENT AND EVALUATION (Documents review & interviews)

Extensive_____
Moderate_____
Not At All_____

1. Is there consumer input into the development of the curriculum?

_____
_____

Extensive_____
Moderate_____
Not At All_____

2. Are consumers utilized in the review of content and language?

_____
_____

Extensive_____
Moderate_____
Not At All_____

3. Is the curriculum developed jointly, or with input from all stakeholders?

_____
_____

Extensive_____
Moderate_____
Not At All_____

4. Is the curriculum consistent with Departmental policies and procedures?

_____
_____

Extensive_____
Moderate_____
Not At All_____

5. Is feedback from participants included in evaluating and revising the curriculum?

_____
_____

Extensive_____
Moderate_____
Not At All_____

6. Is there a scheduled review of the material presented in the training program?

_____
_____

Extensive_____
Moderate_____
Not At All_____

7. Is there a mechanism to follow-up the training and determine its impact on practices?

_____
_____

Extensive_____
Moderate_____
Not At All_____

8. Is there a clearly stated agenda of the information to be presented in the training?

_____
_____

Extensive_____
Moderate_____
Not At All_____

9. Are the learning objectives clearly defined?

_____
_____

Extensive_____
Moderate_____
Not At All_____

10. Is the training program structured to facilitate adult learning?

_____
_____

Extensive_____
Moderate_____
Not At All_____

11. Are steps taken to prepare the presentation for the target audience?

_____
_____

Extensive_____
Moderate_____
Not At All_____

12. Do participants voluntarily attend this training?

_____
_____

Extensive_____
Moderate_____
Not At All_____

13. Does the training impact written policies and procedures?

_____
_____

Extensive_____
Moderate_____
Not At All_____

14. What learning outcomes are used in measuring the effectiveness of training?
Learning concepts___ Memorizing facts___ Applying knowledge___
Solving problems___ Improving job performance___ Changing attitudes___

_____
_____

APPENDIX G: Patrol Survey

G1: Patrol Survey Instrument

G2: Patrol Survey Findings

APPENDIX G1: Patrol Survey Instrument

Los Angeles Police Department Patrol Officer Survey

March 2002

The LAPD is interested in your field experiences in working with individuals who may suffer from mental illness. **Your responses will be confidential. This form will be seen only by researchers external to LAPD**. Information from this survey will help improve training for patrol officers as well as services to the mentally ill.

Please indicate to what extent you agree with each of the statements listed below.
(Please circle your responses.)

4 = Strongly Agree **3 = Agree** **2 = Disagree** **1 = Strongly Disagree**

		Strongly Agree	Agree	Disagree	Strongly Disagree
1.	I feel that LAPD basic recruit training provides adequate specialized training for responding to people with mental illness in crisis.	4	3	2	1
2.	I feel that LAPD provides adequate in-service training for responding to calls involving people with mental illness in crisis.	4	3	2	1
3.	I am confident in knowing when to contact the Mental Evaluation Unit (MEU) when encountering situations in the field.	4	3	2	1
4.	Overall, I feel well prepared to handle situations involving mentally ill persons who may be in crisis.	4	3	2	1
5.	Overall, I feel other patrol officers (non–SMART) in the LAPD are well prepared to handle situations involving mentally ill persons who may be in crisis.	4	3	2	1
6.	Relative to other problems facing patrol officers, responding to individuals with mental illness is not a significant LAPD concern.	4	3	2	1
7.	Verbal de-escalation techniques are effective with subjects who have a mental illness.	4	3	2	1
8.	I believe that MEU has been helpful in working with patrol officers and individuals who are mentally ill and in crisis.	4	3	2	1
9.	I believe that SMART units have been helpful in working with patrol officers and individuals who are mentally ill and in crisis.	4	3	2	1
10.	I have the less-than-lethal equipment necessary to resolve calls involving persons with mental illness without using deadly force.	4	3	2	1
11.	I feel LAPD officers do a good job responding to those with mental illness.	4	3	2	1

Overall, I feel that the LAPD response to handling people with mental illness in crisis is …	**Strongly Agree**	**Agree**	**Disagree**	**Strongly Disagree**
1. … meeting the needs of people with mental illness.	**4**	**3**	**2**	**1**
2. … keeping people with mental illness out of jail.	**4**	**3**	**2**	**1**
3. … helping steer people with mental illness toward needed medical care and social services.	**4**	**3**	**2**	**1**
4. … minimizing the amount of time officers spend on these types of calls.	**4**	**3**	**2**	**1**
5. … decreasing the potential to have an encounter escalate into a use of force incident.	**4**	**3**	**2**	**1**
6. … maintaining community safety.	**4**	**3**	**2**	**1**

18. Specifically, what methods or behaviors have you found effective in interacting with people who may be mentally ill and in crisis?

_____

_____

_____

_____

_____

19. What recommendations do you have to improving the LAPD's response to handling people with mental illness who are in crisis?

_____

_____

_____

_____

_____

_____

Overall, how difficult do you find the following tasks when handling calls involving people with mental illness in crisis	**Very difficult**	**Difficult**	**Somewhat difficult**	**Not difficult at all**
20. … communicating with them in a field encounter	**4**	**3**	**2**	**1**
21. … managing their potential for violence	**4**	**3**	**2**	**1**
22. … identifying and securing an appropriate disposition	**4**	**3**	**2**	**1**
23. … efficiently processing a 5150 (involuntary hold)	**4**	**3**	**2**	**1**

24. In your experience, to what extent are verbal de-escalation techniques as effective with subjects who have mental illness as with subjects who do not? *(Please check one.)*

____ Very effective ____ Effective ____ Somewhat effective ____Not effective

25. Which one of the following would be the most effective in helping you respond to calls involving persons who may be mentally ill? *(Please check one.)*

____ Field access to telephone consultations with a mental health clinician

____ On-scene response from a mental health clinician

____ On-scene response from an officer with specialized training in managing people who may be mentally ill

____ No outside is assistance is necessary in responding to these calls

26. Have you ever contacted the Mental Evaluation Unit (MEU)? _____yes _____no

27. Have you ever had contact with SMART units? _____yes _____no

28. Do you believe LAPD should provide additional training in verbal de-escalation techniques with subjects who have a mental illness? _____yes _____no

29. How many encounters with mentally ill persons in crisis have you had in the past month? _____

30. Have you ever used force on a subject who you believed was mentally ill?

_____ Yes

If yes: _____ Non-categorical use of force

_____ Categorical use of force

_____ No

31. Have you ever used chemical spray on a subject who you believed was mentally ill?

_____ Yes

If yes, was its effect in comparison to a subject who was mentally ill:

_____ more effective

_____ equally effective

_____ less effective

_____ No

31. Have you ever used a taser or electronic force device on a subject who you believed was mentally ill?

_____ Yes

If yes, was its effect in comparison to a subject who was mentally ill:

_____ more effective

_____ equally effective

_____ less effective

_____ No

Please provide the following information about yourself:

30. Your gender: _____ male _____ female

31. Your age: _____

32. Number of years as a police officer: _____

Thank you for participating in this study.

APPENDIX G2: Patrol Survey Findings

Lodestar developed a written survey for patrol officers to assess their experience and attitudes about working with those who may have a mental illness. (See **Appendix G1** for a copy of the survey.) The purpose of the study was to:

- Determine patrol officers' perceptions of the frequency and significance of handling mental disturbance calls;
- Assess the officers' self-reported level of preparation and training in dealing with individuals who may be mentally ill;
- Identify officers' familiarity with the mission, operations and effectiveness of current LAPD efforts to assist with the mentally ill; and
- Identify barriers and recommendations for improving the police response to people who may be mentally ill.

A total of 222 surveys were completed by patrol officers at 12 roll calls in six divisions from March 11-19, 2002. The divisions (Devonshire, Hollenbeck, Newton, and Pacific, Southeast and West Los Angeles) were selected because of their geographic diversity and the differences in the number of Welfare Institution Code (WIC) 5150/attempted suicide cases handled on an annual basis. The surveys were conducted during roll calls of day, A.M. and P.M. watches. No officers refused to complete the survey.

The completed surveys were analyzed using SPSS 11.0, a statistical software package widely used in social science research. Quantitative data were examined using frequencies and cross-tabulations. Qualitative data were coded and analyzed for content. Information is summarized in table and chart formats, as well as with written descriptions. Direct quotations from officers' surveys are included throughout the body of this report.

Officers Completing the Survey

Survey participants included officers of all ranks. Most officers were male (83.1%), and the age of officers ranged from 18 to 57 years, with an average age of 33.6 years. Officers' experience in the field varied from less than one year to 31 years of experience. The average experience of officers surveyed is 8.4 years.

Officers report having on average, 3.4 contacts with mentally ill persons per month. Nearly half of officers surveyed reported having ever used force (either categorical (49%) or non-categorical (55%)) on a subject whom they believed to be mentally ill. Of those officers 26% had used chemical spray, and 11% had used a taser or electronic force device.

Perceptions About LAPD Response

Officers responded to several questions about their perceptions of LAPD response to handling people with mental illness in crisis. Over a third (36%) of responding officers agreed that relative to other problems facing patrol officers, responding to individuals with mental illness is not a significant LAPD concern.

Most officers (88%) agree (or strongly agree) that the LAPD maintains community safety. Many officers also agree that LAPD meets the needs of people with mental illness (82%) and decreases the potential to have an encounter escalate into a use of force incident (81%). Respondents agree that LAPD is helping steer people with mental illness toward needed medical care and social services (79%), and that LAPD is keeping people with mental illness out of jail (74%). There was less agreement among officers regarding whether or not the LAPD is minimizing the amount of time officers spend on mental illness calls. Half of responding officers agree that LAPD is working toward reducing the time spent on mental illness.

MEU

Most officers (99%) have had some contact with the Mental Evaluation Unit, and most officers (95%) agree that they are confident in knowing when to contact the Mental Evaluation Unit when encountering situations in the field. Three quarters (75%) of responding officers agree that MEU has been helpful in working with patrol officers and individuals who are mentally ill and in crisis.

SMART

Most officers (91%) have had contact with SMART units. Many officers (73%) agree that SMART units have been helpful in working with patrol officers and individuals who are mentally ill and in crisis.

Perceptions About Training

- Nearly half of the officers surveyed believe that LAPD should provide additional training in verbal de-escalation techniques with subjects who have a mental illness.
- Many responding officers (70%) agree that LAPD basic recruit training provides adequate specialized training for responding to people with mental illness in crisis.
- Two thirds of responding officers (66%) agree that LAPD provides adequate in-service training for responding to calls involving people with mental illness in crisis.

Responding to the Mentally Ill

When asked about officers' experience with handling calls involving people with mental illness in crisis, 59% report no difficulty when processing a 5150 involuntary hold. Many officers (81%) report little difficulty (somewhat difficult or not at all difficult) in identifying and securing an appropriate disposition for encounters with mentally ill persons. Officers reported more difficulty (somewhat difficult or difficult) with their experience in managing the potential for violence (69%), and with communicating with these people in a field encounter (71%).

When asked about techniques and equipment that officers use, 75% responded that verbal de-escalation techniques are effective with subjects who have a mental illness. Most officers (91%) agreed that they have the less-than-lethal equipment necessary to resolve calls involving persons with mental illness without using deadly force. Additional methods or behaviors officers have found effective include the following:

- Verbal de-escalation tactics (e.g., speaking slowly and calmly)
- Remaining calm
- Providing sympathy and empathy

- Listening to the subject
- Calling for SMART response
- Finding out background information
- Obtaining information through interviews with family and friends of the subject
- Building trust with the subject
- Developing a rapport with the subject

Overall, most officers (92%) agree that they feel well prepared to handle situations involving mentally ill persons who may be in crisis, and 82% agree that other patrol officers are well prepared. Most officers (91%) also agree that LAPD officers do a good job responding to those with mental illness.

Improving Police Response to Persons with a Mental Illness

Some recommendations officers had for improving LAPD's response to handling people with mental illness who are in crisis included the following:

- Increase the number of SMART teams that are available for all hours and all divisions
- Expand MEU staff so that staff members are available all hours
- Provide more and better training, including the use of professionals
- Regularly provide updated information to patrol officers
- Have more hospitals that are contracted with LAPD and are available for 5150 holds

Finally, officers were asked what would be most effective in helping them respond to calls involving persons who may be mentally ill. The most frequently selected item was on-scene response from an officer with specialized training in managing people who may be mentally ill (44%). On-scene response from a mental health clinician was selected by a quarter of respondents (26%). Field access to telephone consultations with a mental health clinician was selected by 14% of the respondents, and 15% of the respondents believed that no outside assistance is necessary in responding to these calls.

APPENDIX H: Communications Findings

Dialing 911 is a nearly universal emergency response system. First implemented in the United States in 1968, the adoption of the 911 system was rather slow throughout the United States, and the City of Los Angeles did not begin using it until 1984. The purpose of adopting the system was to address the need to provide quick and efficient help in response to emergencies.

The Los Angeles 911 system receives approximately 3.5 million calls a year, which are sent to the Communications Division of LAPD. However, over 85 percent of these calls are not regarded by LAPD as true emergencies. The 911 system is intended to be limited to emergencies, meaning a: life-threatening situation; crime in progress; or serious crime that just occurred. The emergency board operators code, prioritize, and relay data from 911 calls to appropriate responders.

Methodology

Lodestar conducted Key Informant Interviews with personnel from the Communications Division of the LAPD to elicit data regarding the tracking and routing of all 911 calls. In addition, Lodestar requested aggregated data for all 911 calls coded as 918 or 918V ("mental" calls and "violent mental" calls) for each reporting division. Data were also aggregated by final disposition code for each of the 18 LAPD divisions.

In addition, 22 incident reports from 911 were examined to understand the process that each call goes through from inception to termination. Reports were randomly selected by Communications personnel from 1999, (N=9 incidents), 2000 (N=5), and 2001 (N=8). Lodestar received assistance from Communications Division personnel in understanding the codes and acronyms used in these reports so that a more accurate description could be obtained.

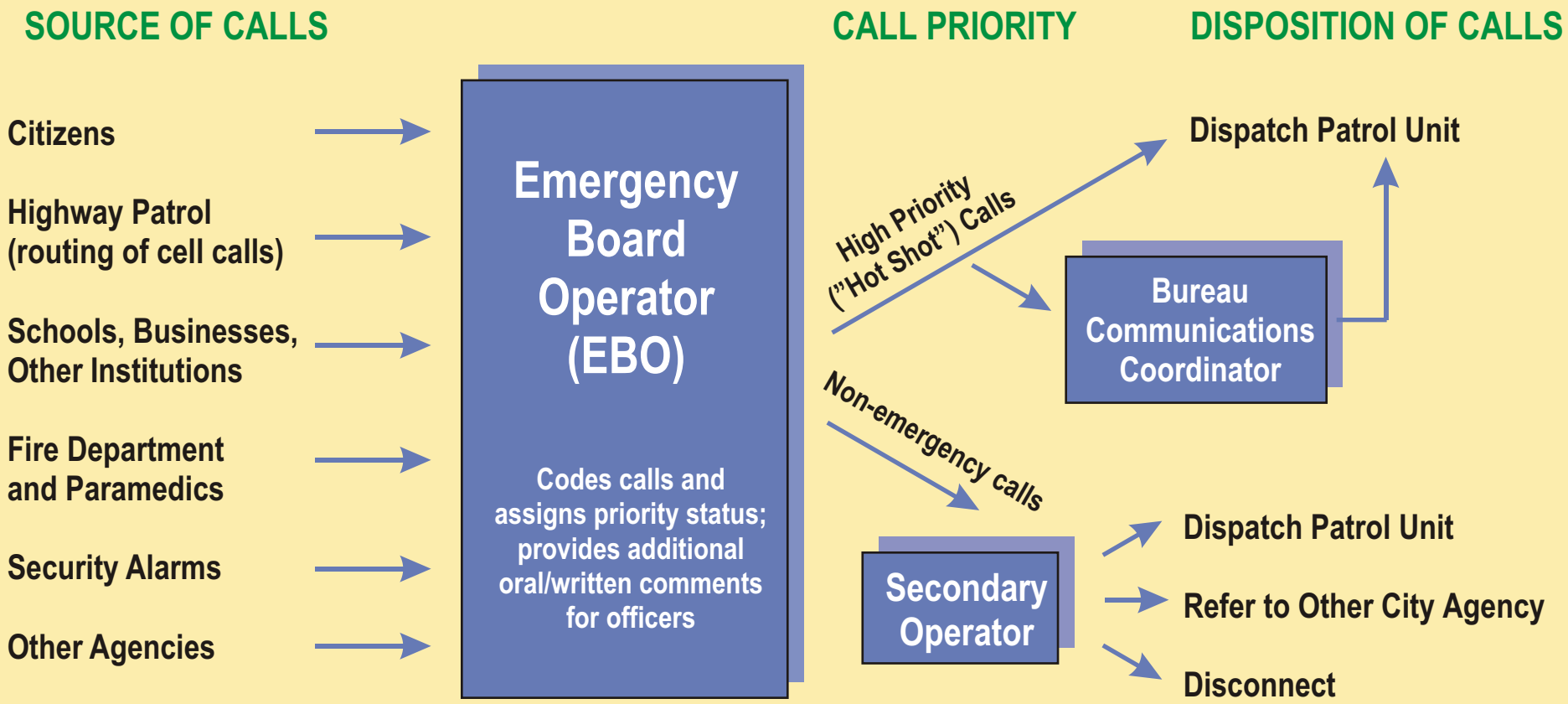
Finally, two site visits were conducted by Lodestar staff. These visits allowed Lodestar to gain a better understanding of how the 911 reporting system works by observing the operators in action, conducting interviews, and collecting data.

911 System

All calls coming into the 911 system are routed by the Communications Division of the LAPD. (See flowchart, **Figure 1**.) In order to determine the nature of the call, Emergency Board Operators (EBOs) interview all callers to assess the urgency of each situation. In addition, the preliminary responsibility for determining the mental state of all callers is also placed on the EBO. EBOs question the caller to obtain as much relevant information as possible to ascertain the priority level of each call, the pertinent details, and the main actors to provide an accurate report to the dispatched officers. This evaluation of the caller is important for the safety of the caller, the public and the responding police officers. The following describes the process of 911 calls from the initial contact with the EBO to the final disposition of the call by the responding police officer.

Figure 1

Routing of 911 Calls



All 911 calls begin in one of several sources, including:

- Citizens
- California Highway Patrol (cell phone calls)
- Schools, businesses, and other organizations/institutions
- Fire Department and paramedics
- Security alarms
- Other community agencies

Emergency calls from surrounding incorporated cities such as Culver City or Beverly Hills, have their own communications department and calls are routed through these channels.

Once the call has been placed to 911, the next available operator answers the call in the order that it was received. The time of the call is noted for each incident and each incident then receives a unique incident number. The EBO obtains all preliminary information including the address and/or location of the incident and the name of the person reporting the incident. The EBO then takes note of the information concerning the incident and questions the caller for clarification or additional information.

At this point, the evaluation of the call begins, as the operator must obtain enough information to alert the responding officers to any potential dangers or other circumstances. The role of Communications is to help screen and identify calls before officers are dispatched.

This involves being able to screen about whether the subject has a known mental illness and any other relevant information necessary for the patrol officer to respond to the call. Each call is coded according to the nature of the incident, for example a robbery or alarm call. One option the operators have is to code the call as a 918 or “mental” call. A call is coded as a 918 if the person in need is reported or suspected of having a mental illness.

Evaluating a caller who is suspected of having a mental illness requires an active line of questioning. Operators may inquire about behaviors, treatment history, and prescribed medication; however, there is no standard set of questions used by operators.

Once a call is labeled as a 918, the operator should determine whether or not the person is in possession of any weapons. If there is any indication that the caller is violent or has the immediate potential or ability of endangering him/herself or others, the call is placed as a “hotshot” or high priority call and a unit is immediately dispatched to the location. In addition, the operator may attach a “V” to the numeric code (918V) to indicate a potentially violent encounter or suspect. All calls are coded for priority, with 2H the highest priority, followed by 2, 1 and none. All calls 2 and higher are considered “hotshots” and are handled immediately.

For all high priority calls, the dispatching of a unit can be done by one of two people, the EBO who took the initial call or the Bureau Communications Coordinator (BCC). Ordinarily, a “hotshot” call will be dispatched by the EBO. If for any reason there is no unit immediately responding to the call, the EBO will ask the BCC to dispatch the call so the EBO is not monopolized by one call for a lengthy period of time. A particular unit will be dispatched to the call depending upon the needs of the call (i.e. does a two-person unit need to respond or any patrol unit that is the closest to the location); however, dispatchers do not dispatch a special unit (SMART) or contact MEU if a call is identified as 918. The policy is to dispatch a regular patrol unit. Once the call is dispatched, the call is monitored by the person designated for that division who manages the officer’s status by entering updated information per officer report.

If the call is determined to **not** be a high priority or "hotshot", the EBO will transfer the caller to a secondary line for non-emergency calls. Additionally, if a reason for police service is not given or cannot be discerned by the EBO, the caller will be transferred to this secondary operator where more time can be spent ascertaining the nature of the call. This may result in a long wait for the caller and as an employee in the Communications Department pointed out, an emergency situation may develop while this call is on hold on the secondary line. A new option on the secondary line is the Integrated Voice Response (IVR) System which is a computer generated voice that asks the caller questions rather than a live operator. This secondary operator attempts to ascertain the nature of the call and will then determine if a police officer is necessary to handle the situation. If the nature of the call can still not be determined, the secondary operator may then transfer the call to a supervisor or disconnect the call. The IVR system is currently in place but does not answer a call unless an operator is not available.

When dispatching a unit, all cars tuned to the proper radio frequency can hear the incident, and a car may respond to the call if they feel they are needed or are closer to the location. The unit(s) responding to the call are then in communication with the Radio Telephone Officer (RTO) of the appropriate division. The RTO completes the incident report for each 911 call once the officer gives his/her final disposition code to the incident.

911 Call Data

From 1999-2001, there were 29,343 calls into the 911 system coded as either 918 or 918V ("mental" and "violent mental", respectively). LAPD's Communication Division receives 3.5 million calls a year; however, 85 percent of these calls are not regarded by LAPD as true emergencies. Of those true emergency calls, an average of 11,938 calls each year, or 2.3% were considered "mental disturbance" calls (918 or 918V). **Table 1** presents data indicating the number of violent and non-violent mental illness calls that were received per area.

Table 1

Number of Mental (918) 911 Calls by Reporting Area and Violent/Non-Violent

Division	1999		2000		2001	
	918V Calls	918 Calls	918V Calls	918 Calls	918V Calls	918 Calls
Central	84	376	93	495	112	483
Rampart	185	460	181	481	186	509
Southwest	197	416	177	418	231	492
Hollenbeck	108	191	124	250	111	240
Harbor	135	267	145	280	96	343
Hollywood	167	510	155	577	186	637
Wilshire	216	533	205	537	172	590
West LA	97	374	105	394	89	446
Van Nuys	184	421	169	423	123	400
West Valley	156	380	181	403	186	424
Northeast	126	293	142	370	132	405
77th Street	238	399	222	437	231	467
Newton	89	220	94	253	116	281
Pacific	108	336	114	382	120	425
No. Hollywood	134	370	139	367	146	411
Foothill	179	335	159	344	175	390
Devonshire	176	334	156	356	151	416
Southeast	151	255	155	291	158	289
Total	**2730**	**6470**	**2716**	**7058**	**2721**	**7648**

Source: Communications Division, LAPD

To conduct an analysis of the outcome of 918 and 918V calls, data were aggregated to indicate the total final disposition codes for each area. Disposition codes are used by the responding officers to close each dispatched call and report the closing status. The following disposition codes appeared during the past three years for all mental calls:

- ADV Advised
- ARR Arrest
- BOC Bad Order Call
- CMP Complete
- CCB Canceled by Call-back
- CIT Citation
- CLO Closed
- CPR Cancelled by Person Reporting
- CTR Call Transferred (to other agency)
- FAL False Alarm
- GOA Gone on Arrival
- IFU Investigation Follow-up
- INF Informed
- OCC Officer Completed Call
- QNR Questioned and Released
- RPT Report
- WRN Warning

These codes can be classified as either (1) final dispositions that are unclear about the final outcome or (2) dispositions that describe the action taken by the officer or clearly describe the outcome of the call. Data are presented in two tables, one that presents disposition codes with less detail about outcome and another includes codes in which some clear action was taken. According to Communications personnel, disposition codes were developed for the use of daily activity logs for field officers and not for the purpose of outcome analysis.

Table 2 shows the number of cases for those codes indicating that the call was completed with little information about the outcome. While advised, completed, informed and closed dispositions all imply that the call was closed and no further action was taken, by far officer completed call (OCC) was the most common code (10,882) across all divisions. Advised (ADV) was the second most common code among this group (7,184). Another common final disposition was gone on arrival (GOA), indicating that the subject was no longer at the scene when the officers arrived.

Table 2
Final Disposition Codes with Unclear Outcome
for 911 Mental Calls (918 and 918V) by Code and Division, 1999-2001

Division	ADV	CMP	CLO	FAL	GOA	INF	OCC	QNR	WRN
Central	279	62	12	4	415	0	663	30	36
Rampart	421	40	6	3	419	1	797	48	16
Southwest	542	30	5	1	346	0	756	30	13
Hollenbeck	335	27	4	0	177	3	417	20	3
Harbor	215	20	4	0	247	5	446	30	16
Hollywood	524	37	7	3	577	1	734	58	30
Wilshire	553	36	10	6	474	3	852	45	30
West LA	368	19	0	3	440	1	468	45	21
Van Nuys	379	20	9	1	352	3	563	59	17
West Valley	372	17	4	2	349	3	598	51	18
Northeast	470	28	5	1	342	1	673	48	14
77th Street	500	32	6	0	371	2	794	36	9
Newton	291	11	1	1	209	1	389	13	10
Pacific	314	66	5	2	368	0	501	37	26
No. Hollywood	460	17	4	2	337	1	554	44	17
Foothill	390	19	5	1	290	0	601	37	10
Devonshire	423	16	2	3	322	3	583	24	14
Southeast	348	12	2	1	228	0	493	14	10
TOTAL	**7184**	**509**	**43**	**10**	**6263**	**28**	**10882**	**669**	**310**

Source: Communications Division, LAPD

Table 3 presents the total number of cases for those calls in which the code indicates a clear action was taken (e.g. arrest or citation) or the call was cancelled or transferred to another agency before the call was closed by responding patrol. The most common disposition code among this group was arrest (ARR; 2016) followed by completed report (RPT; 1283).

However, as previously discussed, this information cannot be used to infer much about a given emergency call as there is an extensive amount of overlap in codes used and a lack of codes for many actions that can be taken, in particular with subjects who may have a mental illness.

Table 3
Final Disposition Codes with Clear Outcome
for 911 Mental Calls (918 and 918V) by Code and Division, 1999-2001

DIVISION	ARR	BOC	CCB	CIT	CPR	CTR	IFU	RPT
Central	94	12	9	2	3	14	2	66
Rampart	145	12	7	4	7	8	0	62
Southwest	109	6	10	3	1	8	1	70
Hollenbeck	83	6	7	2	2	3	1	42
Harbor	83	5	10	2	6	9	1	64
Hollywood	154	10	9	4	2	3	4	75
Wilshire	125	12	8	5	3	15	0	74
West LA	56	7	6	7	0	4	0	60
Van Nuys	260	2	10	1	2	7	0	96
West Valley	107	6	13	7	5	7	1	93
Northeast	96	8	11	3	4	5	4	96
77th Street	126	11	7	6	3	5	0	84
Newton	78	6	2	0	1	2	1	36
Pacific	82	11	6	6	2	5	2	52
No. Hollywood	96	7	8	4	4	9	2	60
Foothill	116	3	5	1	4	9	0	92
Devonshire	112	13	9	3	6	6	2	88
Southeast	94	9	4	1	1	6	3	73
TOTAL	**2016**	**146**	**141**	**61**	**56**	**125**	**24**	**1283**

Source: Communications Division, LAPD

There are some drawbacks to examining disposition codes in this system because there are no set criteria for each code and there is considerable overlap for codes as well. For example, no clear distinction could be supplied for the advised (ADV), informed (INF), questioned and released (QNR), and warning (WRN) codes. Likewise, there seems to be no systematic way to indicate that the call was completed without any action on the part of the officer, as completed

codes (CMP and OCC) and closed all indicate that the call was completed or closed but does not mean no action was taken. It seems that the use of these codes is up to the discretion of the officer and some areas appear to use some codes more frequently than others.

In addition to these limitations, each officer at the scene provides a disposition code. Therefore, each incident may have more than one disposition code, because each unit must provide a disposition to the dispatcher. Because some officers use some dispatch codes more frequently than others, this makes it nearly impossible to determine what the outcome is using aggregated data.

Another limitation is that there is no final dispatch code to indicate that the subject was taken to one of the county hospitals and processed as a 5150 WIC. While this information may be supplied in the full 911 report, information regarding treatment specific to mentally ill subjects cannot be extrapolated from the final codes supplied by the responding police officers. This finding suggests that the tracking system for 911 is limited in its ability to report on specific outcomes for 918 calls.

To better understand the process of how persons who may have a mental illness are handled through the emergency reporting system, the Communications Division provided us with 22 incidents to review. Nine incidents occurred in 1999, 5 in 2000, and 8 in 2001. Of these 22 incidents, 13 were classified as violent and the remaining 9 were non-violent. This is not reflective of the breakdown between violent and non-violent calls, as only 23 percent of the total 911 calls classified as mental calls were coded as violent (918V).

"Hotshot" Calls

As previously mentioned, once the 911 call is released by the Communications Division to the dispatched unit and area, all communication between the officer and the area is via the Radio Telephone Operator (RTO). This information is included in the incident report, mainly in the form of internal codes and acronyms. The following is a brief description of how a typical 918 (V) emergency or "hotshot" 911 call is handled once a patrol unit is dispatched to the location of the incident.

- Location and phone number are noted in addition to the name of the person reporting (if possible).
- The code indicating the call involves a possibly mentally ill person is applied.
- Priority for the call is indicated.
- Comments including a physical description of the subject and as much information as possible concerning the incident are supplied.
- The requested unit responds that it is either en route to the location or cancels the dispatch because they are unable to answer the call.
- Once the unit reaches the location, the officer informs the RTO that he/she is at the scene.
- If at any point while en route to the location the unit is interrupted by another call or incident, the unit informs the RTO of the interruption and typically the RTO will then dispatch another unit.

- If other units are necessary or more than one answered the call, all communications are completed through the RTO.
- If the person is judged to be mentally ill and meets the requirements for a 5150 and a crime has been committed, the police officers will either contact MEU to dispatch a SMART team or will transfer the subject him/herself to one of the 4 available hospitals.
- If the person is **not** judged to be mentally ill, and no crime has been committed, the officers will make note that the subject was advised or questioned and the call will be closed.
- Oftentimes, especially if the call is placed on a lower priority, the response time is longer and the subject is no longer at the location, such an incident is coded as gone on arrival (GOA).

Review of Incidents

Results of the 22 reviewed incidents' final dispatch codes are as follows:

- Almost a quarter (23 percent) of the 911 incident reports examined ended with a final dispatch code of gone on arrival; an additional 14 percent of the incidents were coded as officer completed the call (OCC) and another 14 percent were coded as advised (ADV) with no additional comments; one call was coded as completed (CMP) and another as informed (INF); one additional call was coded as CPR;
- From the 22 reports examined, 5 (23 percent) were handled by the SMART team, taken to detox (1) or taken to a mental health facility (3). An additional case was actually arrested and taken to the division jail, but all of this information came from the more extensive comments throughout the report.

These data are more or less representative of the total sample of 911 calls where 22 percent were coded as gone on arrival (GOA) and 37 percent as completed (OCC). Like these 22 incidents, final dispatch codes of completed (CMP), informed (INF), and cancelled by person reporting (CPR) are not very frequently used in the total sample.

As mentioned above, there is no disposition code specific to 918 calls. For those incidents where the subject was transported to a mental health facility, the final code was arrest (ARR) or officer completed call (OCC). One can infer from the information and the additional comments included by the officer in the report that the subject was not actually arrested (in fact, one case was confirmed by referencing the arrest report with the division and no arrest was recorded) but rather was likely processed as a 5150 at the mental health facility. Only one of the 22 incidents indicated that there was any communication with the MEU during the incident. As it is standard operating procedure to contact the MEU prior to transporting any subject to a mental health facility or anywhere else, it is likely that it is **not** standard procedure to make note of this in the incident report.

APPENDIX I: LAPD Best Practices (MEU/SMART/CIT Pilot)

I1: Training Evaluation

I2: Operations and Calls

I3: Best Practices

I1: Training Evaluation

Crisis Intervention Team

Review Process

Documents

Crisis Intervention Team Pilot Program Evaluation
CIT Training Curriculum and related documents
CIT Training Curriculum - revised 12/14/01

Identified Strengths

The revised *CIT Training Curriculum* was reviewed and compared to similar programs throughout the country. The quality is outstanding and makes improvement on the training offered in other model CIT programs.

Outstanding Curricula Development in Pilot Project

The revisions address many of the deficits found in the first round of training. For example, the revised training included increased attention and involvement of community agencies in the training (# 1 in Identified Areas for Improvement), increased attention to medical and substance use impact (# 2 in Identified Areas for Improvement), and increased attention to verbal de-escalation and tactical strategies.

Recognizing Mental Illness

The curriculum extensively identifies categories, definitions, and examples of the major mental illnesses. Included is information on teaching officers on the recognition of symptoms and terminology used by the behavioral healthcare community.

Risk Potential for Self-harm or Violence to Others

The curriculum addresses risk potential for violence, and the issue of violence and mental illness. The curriculum extensively addresses the issue of “Suicide by Cop,” gives information on assessing suicide potential, clinical factors of suicide, and presents strategies for suicide crisis intervention.

Medical Conditions and Psychiatric Medication

The curriculum has information on conditions that are medical emergencies, and clues to medical emergencies. There is clear and extensive information on psychiatric medications, including updated information, therapeutic/side effects of medication, and examples of medications from each category. The training also used a physician to co-train with an officer.

Substance Abuse

The information presented in the CIT curriculum is extensive. Various categories of substances and their effects on the body are presented (CNS depressants, inhalants, cannabis, PCP, CNS

stimulants, narcotic analgesics, etc.). The curriculum also reviews current problem drugs in the community (Ecstasy, LSD, "cocktailing").

Mental Health Related Laws and Client Rights

There is a strong emphasis on the rights of persons confronted by officers in crisis situations. The curriculum reviews pertinent state and local laws on protective custody, and non-custody options. There is clear information presented on the disposition of persons who are taken into protective custody and have committed a crime (misdemeanor/felony).

Intervention Strategies

The CIT training presents extensive information on use of force tactics/policies and crisis intervention strategies. The curriculum reviews less-lethal tactics (verbalization, Taser, swarm techniques, takedowns, beanbag, 37 mm) to the use of deadly force (use of force spectrum). The crisis communication training section reviews goals of crisis intervention, defines the stages of a crisis, and recommends strategies of intervention for each crisis stage. Active listening skills and being "fluid" and "adapting" to the situation are reviewed. Officer safety is extensively emphasized.

Community Resources

Persons from the community present information on community resources in a panel format with agency representatives from the community.

Areas to Consider for Improvement

Community Resources

Additional and updated listing of social service or community support agencies could be enhanced. According to the CIT coordinator, it is difficult to identify the agency that might meet the needs of the subject. Agencies in the Central Area often restrict access to services making many referrals useless for the officer and the subject. Field trips to agencies may be valuable.

Consumer, Advocate, and Family Involvement

Although there were representatives from Los Angeles Men's Place (LAMP) and the Midnight Mission to relate experiences of homelessness to officers, the training experience would be enhanced with the perspectives of persons with a mental illness.

Systemwide Mental Assessment Response Team (SMART)

Review Process

Documents

SMART Guidelines
SMART Operations Manual
SMART Training Curricula and miscellaneous documents
SMART Guidelines for Field Units

Identified Strengths

Recognizing Mental Illness

The SMART curriculum extensively provides definitions of mental illnesses, symptoms, and categories. The program provides training and information on making "mini" mental status examinations (person, place, time, naming 3 objects, memory recall). There is information on conditions that mimic or mask symptoms of a mental illness (psychiatric/psychological masquerade). The information in the curriculum is in depth and extensive. The curriculum also provides extensive information on elderly persons who may have a mental illness and conditions related to the geriatric population.

Risk Potential for Self-harm or Violence to Others

There is an extensive amount of information on suicide dynamics and assessment, as well as assessment information for potential violence. There is detailed information on strategies for suicide crisis intervention. There is a module and extensive information presented on school violence (signs, assessment, types).

Medical Conditions and Psychiatric Medications

The curriculum provides detailed information on medications, categories, side effects and therapeutic effects. A listing of current medications is also provided. A psychiatric medication module was instructed by a mental health professional.

Substance Abuse

The curriculum provides extensive information on current street drugs and problem drugs in the community. It also presents information on a dual diagnosis model. The curriculum provides detailed information on various categories of drugs, examples of each category, and general indicators of use for each category.

Mental Health Related Laws and Client Rights

There is a module in the training presenting information on the Mental Health Court program, and how the program works (diversion/collaboration between mental health professionals and defense attorneys). Non-custodial and protective custody options are reviewed, as well as a module on legal implications.

Intervention Strategies

The SMART training provides extensive information on intervention strategies, use of force policy review, and establishing rapport with persons in crisis. There is information presented on de-escalation guidelines and verbal intervention strategies. There is a review of resources available to the SMART team, including hospitals, transport information, etc.

Community Resources

The training provides information on hospitals and bed space in the Los Angeles area.

Areas to Consider for Improvement

Community Resources

The curriculum does not provide information on social service agencies in the community. Additional training in available resources and how to access them may be useful.

Consumer, Advocate, and Family Involvement

There are no segments in the training with views and perspectives from families of persons with a mental illness, community advocates, or consumers. There is no mention of officers visiting drop-in centers or treatment centers.

Mental Evaluation Unit (MEU)

Review Process

Documents

Duties and Responsibilities of the MEU
MEU Unit Reports
MEU Dispatch and Daily Logs
Expansion of Duties of the Mental Evaluation Unit and Establishment of Psychiatric Emergency Coordinating Committee

Comments

Review of these documents in combination with Los Angeles Police Department Policy Manual, SMART Operations, etc. provided the reviewer with a fair idea as to the operation of the MEU Unit. No documents were reviewed that indicated that the detectives in that unit received any mental health training.

I2: OPERATIONS & CALLS

Mental Evaluation Unit (MEU) Description

LAPD's Mental Evaluation Unit (MEU) conducts preliminary screenings of persons, adults and juveniles, who come to the attention of the police and are suspected of having a mental illness. Specifically, this includes those who may be suspected of being:

- Mentally disordered;
- A victim of amnesia;
- Senile;
- Post-alcoholic;
- An Alzheimer patient;
- Infected with AIDS and may be dangerous to themselves or others;
- Developmentally disabled; and
- Any other person who officers have probable cause to believe requires psychiatric evaluation.

MEU also handles any Tarasoff notifications. Tarasoff notifications are reports from mental health professionals in which there is reasonable cause to believe their client poses harm to another. Based on a preliminary investigation, MEU determines the appropriate LAPD response, which may include deploying a SMART unit, providing advice to patrol officers, recommending a possible 72-hour involuntary hold, or offering a referral to community services.

Methods - MEU

A site visit to the MEU headquarters was conducted by Lodestar staff to conduct Key Informant Interviews and observe how the system operates. Lodestar observed several incoming phone calls into the MEU and the protocols used in handling them. During this site visit, Lodestar was informed that MEU completes an incident report for each call where action was taken (e.g., 5150 WIC, Tarasoff, or SMART dispatch). Total numbers of incoming calls to the MEU were provided for years 1999-2001.

The Consent Decree required a review of 15 incidents from the MEU. Because incident reports were so terse, Lodestar reviewed 60 MEU incident reports, 20 from each year (1999-2001), that were randomly selected by MEU personnel in order to better understand the process of each MEU call. MEU also provided copies of their MEU call tracking logs, SMART dispatch logs, and a sample application for a 72-hour detention for evaluation and treatment (5150 WIC).

Systemwide Mental Assessment Response Team (SMART) Description

SMART is a LAPD Unit designed to provide a cooperative, compassionate mental health/law enforcement response to assist citizens in accessing mental health services. Deploying one LAPD police officer and one LA County Department of Mental Health (DMH) clinician, SMART teams assist field police officers when requested. The intent is to provide quick resolutions without unnecessary incarceration or hospitalization. This is done by effective intervention, referral or placement for a person with a mental illness. The use of SMART units is intended to

respond effectively to the needs of the mentally ill while allowing patrol officers to return to field duties once SMART has arrived on the scene.

LAPD patrol officers contact MEU for advice prior to taking any apparently mentally ill person into custody. The MEU officer determines whether a SMART team is to be deployed. If dispatched, the SMART team responds as promptly as feasible and determines the most appropriate type of intervention needed. There are currently eleven SMART officers in the LAPD.

Methods - SMART

A site visit to the SMART headquarters along with Key Informant Interviews with DMH and LAPD personnel involved in SMART were conducted in order to gain an understanding of SMART protocols and operations. During the site visit, Lodestar was informed that SMART records all calls in which a SMART unit responded. Aggregated data of SMART logs were requested and received from DMH. Data presented are in categories used by SMART to describe the process of calls and incidents.

Though a review of SMART incidents was not required by the Consent Decree, the Lodestar team believed that a cursory review would be helpful in understanding the process the SMART unit uses during an encounter or incident with a person who may have a mental illness. Lodestar received permission from DMH to review 15 incident reports. Unfortunately, incidents were reported as a clinical encounter and were descriptions of mental status, symptomatology, and other related clinical information completed by the clinician. No information in incidents contained specific reference to the SMART officer's role or actions except that the SMART officer co-signed all involuntary psychiatric holds (5150 WIC).

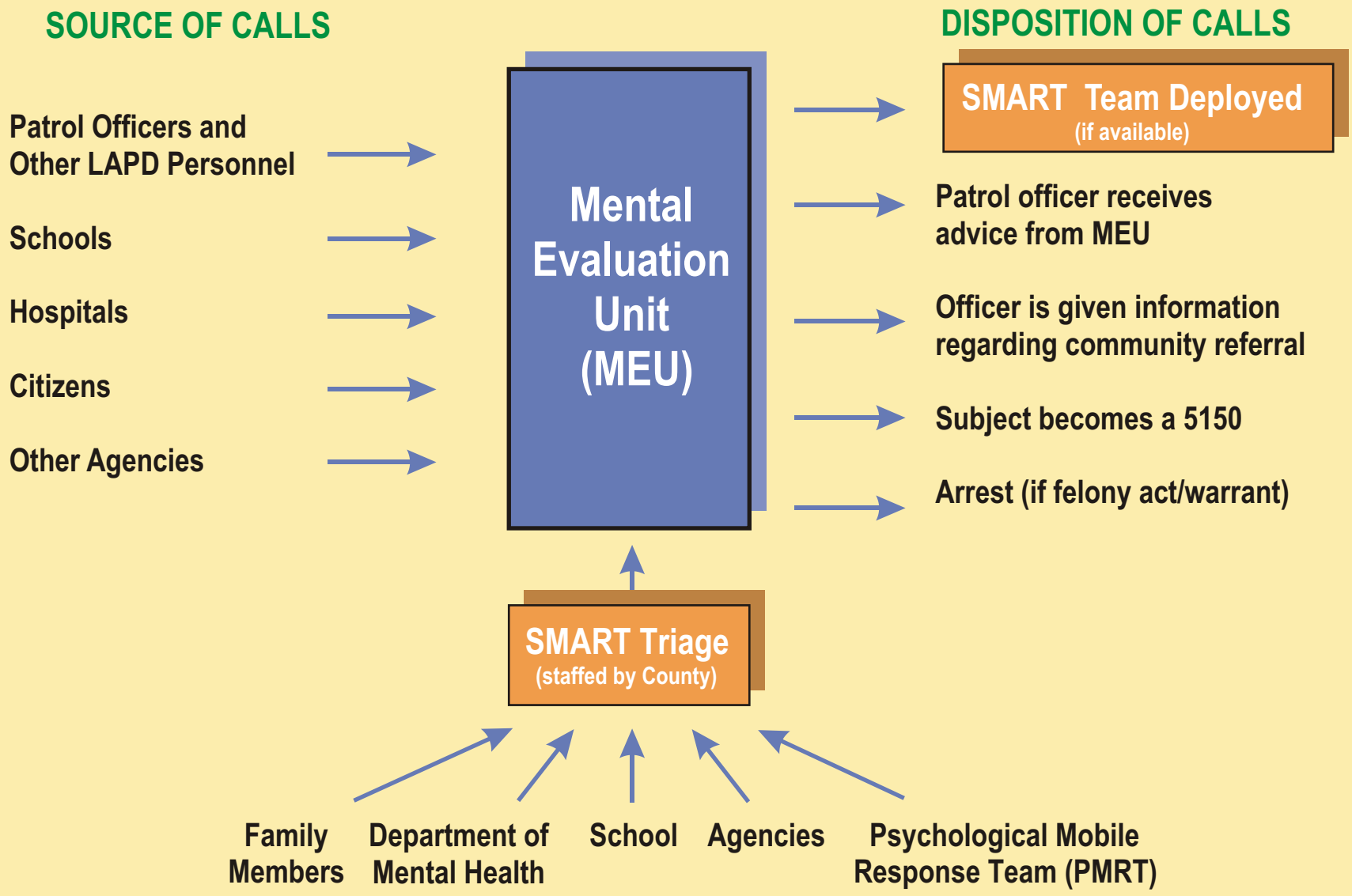
Mental Evaluation Unit (MEU) and SMART Operations

MEU personnel assess each situation as calls come into the unit and dispatch a SMART unit or advise the calling patrol officer. (See flowchart, **Figure 1**.) MEU's main purpose is to provide consultation for patrol officers and other sources when they encounter situations that involve persons who may be mentally ill. Like the 911 emergency reporting system, calls come from many sources.

The vast majority of calls come from patrol officers who are instructed to call the MEU when dealing with a person who may be mentally ill. While citizens may call the MEU directly, Communications Division will normally dispatch a patrol officer to the location of the incident before any other action is taken to evaluate and ensure the public and officer's safety.

Figure 2

Routing of Calls to Mental Evaluation Unit (MEU) and Systemwide Mental Assessment Response Team (SMART)



Other people and agencies may call MEU for assistance, including:

- Hospitals
- Schools
- Other city or county agencies
- Citizens
- Other LAPD personnel

If a hospital calls the MEU directly as in the case of a hospital escapee, they may choose to dispatch a SMART unit immediately to the hospital rather than sending a patrol car first. MEU can also dispatch a SMART unit directly to a school to complete an evaluation for a child or adolescent if needed. However, this is only in certain circumstances and depending on each individual situation, a patrol car may be sent to handle the situation if MEU assesses that is a more appropriate action. While the SMART units are on patrol 24 hours a day, the DMH operates a Psychiatric Mobile Response Team (PMRT) which is equipped with two clinicians available for mental status evaluations. This team does not work on a 24 hour schedule, so the MEU handles calls from the DMH when the PMRT is not on duty.

Another major source of calls is the SMART triage counselor, a DMH employee. SMART triage is not a division to which calls are typically routed, but calls are received by the SMART triage counselor. In other words, calls received by triage are not necessarily persons looking for a patrol officer, but want a specialized response to a mental health crisis. Subsequently, MEU must be consulted by SMART triage prior to any action by a SMART unit. SMART triage is available in two shifts between 10am and 2am

As described earlier, SMART is a pairing of a LAPD officer and DMH Clinician that is used by the LAPD to evaluate persons with a mental illness to provide the most appropriate referral. Calls to SMART come from a variety of places including the community, DMH, schools, other agencies, and the Psychiatric Mobile Response Team (PMRT) (see Figure 2). These calls are taken by the SMART triage counselor. The triage counselor is a mental health employee who can check the DMH's computerized database to determine if the person in need has a mental health history with the DMH. If triage believes the call requires SMART, MEU is contacted and a request is made. In other words, if a call is received by SMART triage and not police, the call is routed to MEU. If the call originated from patrol, MEU is contacted directly. MEU determines if a SMART unit is to be dispatched.

SMART units are in the field often listening to radio calls. If a "mental" call is heard (918), the SMART officer will consult with MEU officers to determine if a SMART unit at the site of the call is needed. However, because there are times when there is only one unit available, that unit can only be tuned into one police division and will only hear calls originating from that division. For example, if a SMART unit is patrolling in the Devonshire division and a call comes in and is dispatched to the Hollywood division, that unit must be called by MEU because they will not hear the radio call.

Once calls enter the MEU from any of these sources, the MEU officer assesses whether or not a SMART unit is needed at the scene. A SMART unit is the preferred manner for dealing with a suspect who may have a mental illness if the screening suggests the subject meets the criteria to be processed as a 5150 Welfare Institution Code (WIC). These criteria are met if the subject is:

- A danger to himself or herself
- A danger to others
- A gravely disabled adult or minor

If the subject meets any of these criteria, then he or she can be classified as a 5150 WIC and placed in a mental health facility for up to 72 hours. There are four county hospitals that will accept persons placed on a 72 hour hold. These hospitals are:

- Olive View Hospital
- USCMS Hospital
- Harbor UCLA Hospital
- Augustus Hospital

LAPD officers and SMART normally use the most convenient location in order to expedite the process. Even if the subject has insurance and can be placed at another hospital or a private facility, it is not the responsibility of the LAPD officers to determine this. Their responsibility is to deliver the subject to one of these hospitals and any further hospitalization needs are the responsibility of the hospital's administration.

MEU officers keep a daily log of the SMART units on duty throughout the day. There should normally be eleven teams in the LAPD but currently they are understaffed and have only nine in rotation. MEU officers contact the SMART unit(s) on duty once a call comes in that meets the criteria for a SMART unit. As there may be only one team on duty, it is often the case that the SMART unit may be unavailable to handle the call, and the MEU officers provide consultation to determine the best response to the call. If the MEU suggests the person be placed on a hold, the patrol officer completes the paperwork necessary for the 5150 WIC and delivers the subject to the most conveniently located hospital. If the subject is extremely combative, the patrol officers will not transport the subject to the hospital. In this case, either the patrol officer or the MEU will dispatch a Rescue Ambulance (RA) to transport the combative subject.

If the subject is not a threat to anyone and is capable of taking care of him or herself, the MEU will advise and instruct the patrol officers on how to proceed with the case. For example, if the subject committed a felony, the subject will be arrested even if the patrol officer and SMART unit assess that he or she suffers from a mental illness. Once the subject is in custody, a mental evaluation can be completed by appropriate persons in the jail.

MEU recently relocated (December 2001) from Parker Center to the same facility that SMART is located. When they were housed at the Parker Center, it was often the case that patrol officers would bring subjects directly into the MEU for assessment or further action. In the new facility, MEU has experienced space constraints and poor location so that it is no longer feasible to assess persons at MEU. All cases are handled in the field by officers at this time. In addition, MEU officers at the new location are available from 7am to 3pm. The new location closes after 3pm; however, the MEU operation then moves to a location at Parker Center where all calls are forwarded and the MEU continues to operate at that location until the following morning.

MEU Tracking System

Currently the MEU uses a paper and pencil method of tracking their calls from incoming sources. A daily log is used in the department and passed from desk to desk as personnel respond to calls. This system is susceptible to error as many calls are not recorded because the log may not be conveniently available to them during a call.

The MEU intends to track information about the calls received. Key variables include: the source of the call (officer, citizen, DMH, etc), the outcome of the call (5150, SMART unit was dispatched, Tarasoff notification), the total number of arrested/booked individuals, whether the person served was transient/homeless, developmentally disabled, demented with AIDS, or an arrest/transportation order was received for a hospital escapee. All calls are tracked by reporting division. Certain variables are reported monthly by MEU and are defined below:

- **Hospital Escapee** - persons who left the hospital before the hold was completed
- **Booked** - persons who meet criteria but were arrested rather than placed on a 5150 WIC due to a felony charge
- **Tarasoff** - notification by a health professional as possible danger to other party
- **Reject** - an event in which a call was received but the person served did not meet criteria for a 5150 WIC
- **SMART** - if the SMART unit was sent to assist patrol
- **5150 WIC** - the patrol officer placed the person on a hold
- **Attempted Suicide** - the person attempted to kill him/herself and was placed on a hold
- **Secret Service** - requests consultation from MEU during screenings to gather any relevant history on a suspect; and
- **Miscellaneous** - inquires and questions as well as LAPD supervisor calls regarding past encounters with individuals.

MEU is required to track and keep records of the variables listed above.

Table 1 indicates the total number of each type of call and the total number of 5150 WIC cases processed between 1999 and 2001 by the MEU. Nearly three-quarters (74 percent) of MEU calls in 2001 involved SMART referrals, 5150s, or attempted suicides. These three were the most frequent types of calls in 1999 and 2000 as well.

Table 1 Mental Evaluation Unit (MEU) -- Summary of Calls, 1999, 2000 and 2001			
Type of Calls	**1999**	**2000**	**2001**
Hospital escapees	78	66	29
Booked	32	22	23
Tarasoff	63	37	29
Reject	33	9	18
SMART Referral	1,838	2,049	1,763
5150 Welfare and Institution Code	2,286	2,301	2,018
Attempted Suicide	1,442	1,679	1,432
Secret Service Requests	48	49	15
Miscellaneous	483	1,142	1,685
TOTAL	**6,303**	**7,354**	**7,012**

Source: MEU Unit, Detective Headquarters Division, LAPD

The paper and pencil system for tracking all MEU calls seems to have its largest discrepancy in the number of calls tracked by type. As indicated in the table above, there were a total of 6,303 categorized calls in 1999. However, there were a total of almost 25,000 incoming MEU calls in 1999, leaving over 18,000 calls unaccounted. There is a similar discrepancy in 2000 and 2001. MEU officers appear to track the division from which the call originates more than they track the circumstances or end result. One reason given for this discrepancy is that all reported missing persons are reported to the MEU and there are approximately 15,000 missing persons in Los Angeles each year. Also, MEU is contacted to rule out hospitalization as an explanation for a missing person. However, these missing person calls are not accounted for in the tracking form at this time.

MEU also tracks calls by completing incident reports. An incident report is a document completed by the MEU officer after a call or documentation for a 5150 is received. Officers are instructed to send all 5150 documents to MEU. MEU keeps the records of all 5150s, including the creation of an incident report. Most 5150s by patrol will occur after consultation with MEU, so an incident report exists before paperwork is received. If documents are received by an officer, and no incident report has been created by MEU, MEU officers will gather information pertinent to the 5150 by the patrol officer and make an incident report.

Incident reports include the following information:

- Date report was taken
- Type of Report
- Name and contact information of person served
- Demographic information of person served
- Division
- Reporting person
- Conditional release information
- Narrative

The type of report contains six categories: Tarasoff notification; Reject; SMART; 5150 WIC; Injury; or Other. All categories are defined similarly to the pencil and paper log described earlier. There is an additional category, Injury, which is unique to incident reports. If there is any injury to the person served (e.g., overdose of Tylenol or cuts on the body after a suicide attempt) then the report is coded as injury despite the possibility that a 5150 was invoked.

The narrative contains information about the call and any information about the person relevant to a mental evaluation. Information contained can include history of mental illness, medications prescribed and general information about mental status. Often, if SMART is deployed, the narrative will include who from the SMART team was on-scene. The length of narratives are rather short, typically 3 to 4 lines. MEU is able to calculate some statistics from the incident reports. **Table 2** below describes the type of reports taken by MEU in 1999, 2000, and 2001.

Table 2
Mental Evaluation Unit (MEU) – Incident Report Statistics, 1999, 2000 and 2001

Category of Call	1999	2000	2001
Tarasoff	52	38	30
Reject	35	10	10
SMART	1,765	2,182	2,317
5150	2,378	2,533	2,912
Injury	1,504	1,780	1,940
Other (includes info on individuals who do not meet criteria of 5150, but should be tracked)	294	644	490
TOTAL	**6,028**	**7,187**	**6,699**

Source: MEU Unit, Detective Headquarters Division, LAPD

There are discrepancies when comparing data from the pencil and paper method to the incident report system. For example, the number of 5150 holds according to incidents is much higher (2,912) than the pencil and paper method (2,018) for 2001, but in previous years the discrepancy is less. This may be due to different inputs into the system. For example, an incident report can be created if a 5150 document is sent to MEU, but no call is received prior to the hold. MEU would not be able to track that incident using the pencil and paper method.

According to incident reports, SMART is called out more often than would be expected if using the pencil and paper data, particularly in 2001 (2,317 compared to 1,763, respectively). Discrepancies such as this are typical when comparing different data systems that were not meant to be compared or collected in the same manner. This can be problematic for program planning purposes and evaluation of program effectiveness. It is impossible to determine which system is the most accurate and will provide the most sensible data that supervisors need in order to staff and evaluate this program.

SMART Tracking System

SMART units are a collaborative effort between the DMH and LAPD. During the research process, it was discovered that SMART officers do not complete incident reports like MEU officers. Instead, records are completed by DMH SMART clinicians on all calls seen by SMART. Information about the encounters are kept in a log and entered into a database managed by DMH. Data contained in logs include numerous variables relevant to each case seen. Specific variables were requested by Lodestar and are presented below.

Call Location

As indicated in **Table 3,** most SMART teams are dispatched to a station within LAPD or to a residence, with a plurality of responses at residences. This is expected given SMART teams provide support and assistance to patrol officers in the field.

Table 3
Systemwide Mental Assessment Response Team (SMART) Statistics: Call Locations, 1999, 2000 and 2001

Call Location	1999		2000		2001	
LAPD Mental Evaluation Unit (MEU)	304	14.2%	185	6.8%	84	3.1%
LAPD Station	618	28.9%	768	28.2%	921	33.6%
Home	730	34.2%	1140	41.9%	1121	40.9%
Street	210	9.8%	269	9.9%	219	8.0%
Jail	41	1.9%	53	1.9%	53	1.9%
School	71	3.3%	75	2.8%	108	3.9%
Group Home (child/adolescent)	16	0.7%	22	0.8%	6	0.2%
Board and Care Home	37	1.7%	49	1.8%	59	2.2%
Business	99	4.6%	60	2.2%	53	1.9%
Clinic/Hospital	5	0.2%	59	2.2%	81	3.0%
Church	1	0.04%	2	0.1%	2	0.1%
Court	1	0.04%	2	0.1%	5	0.2%
Community Agency	2	0.1%	7	0.3%	1	.03%
Motel/Hotel	0	0.0%	20	0.7%	4	0.1%
Shelter	0	0.0%	11	0.4%	15	0.5%
Train/Bus Station	0	0.0%	0	0.0%	10	0.4%
TOTAL	**2135**	**100%**	**2722**	**100%**	**2742**	**100%**

Source: LAPD-LA County Department of Mental Health SMART Program

Hold Status

A majority of holds is completed due to dangerousness to self. **Table 4** describes other reasons persons are placed on a hold by SMART.

Table 4
Systemwide Mental Assessment Response Team (SMART) Statistics: Hold Status, 1999, 2000 and 2001

Hold Status	1999		2000		2001	
DTS (Danger to Self)	618	59.9%	697	37.2%	841	40.1%
DTO (Danger to Others)	220	21.3%	292	15.6%	305	14.5%
GD (Gravely Disabled)	194	18.8%	169	9.0%	210	10.0%
DTS/DTO (Danger to Self/Danger to Others)	0	0.0%	248	13.2%	236	11.2%
DTS/GD (Danger to Self/Gravely Disabled)	0	0.0%	210	11.2%	220	10.5%
DTO/GD (Danger to Others/Gravely Disabled)	0	0.0%	186	9.9%	174	8.3%
DTS/DTO/GD (Danger to Self/Danger to Others/Gravely Disabled)	0	0.0%	73	3.9%	112	5.3%
TOTAL	**1032**	**100%**	**1875**	**100%**	**2098**	**100%**

Source: LAPD – LA County Department of Mental Health SMART Program

Welfare Institution Code Type

When holds are used, almost all are for adults as evidenced in **Table 5**. According to DMH employees interviewed, a children's crisis team is available for families or agencies that suspect a child or adolescent needs a mental evaluation (which may explain the lower numbers).

Table 5
Systemwide Mental Assessment Response Team (SMART) Statistics: WIC Type, 1999, 2000 and 2001

WIC Type	1999		2000		2001	
5150 (Adult—72 hour involuntary hold)	1313	86.3%	1780	85.3%	1811	85.3%
5585 (Child under 18—72 hour involuntary hold)	160	10.5%	246	11.8%	278	13.1%
6000 (Voluntary admission; no hold)	48	3.2%	58	2.8%	31	1.5%
Conservatee	0	0.0%	3	0.1%	2	0.1%
TOTAL	**1521**	**100%**	**2087**	**100%**	**2122**	**100%**

Source: LAPD – LA County Department of Mental Health SMART Program

Call Source

Table 6 indicates sources of the calls for service. Most calls come from community members, family, friends, neighbors and landlords of persons with a mental health need (average of 69% over the last three years). Between 12 and 16 percent of calls come from consumers themselves suggesting that some consumers call the police department directly when in crisis.

Table 6
Systemwide Mental Assessment Response Team (SMART) Statistics: Call Source, 1999, 2000 and 2001

Call Source	1999		2000		2001	
Department of Mental Health clinic/ specialized programs	70	3.3%	85	3.1%	58	2.3%
Community/Neighbor/Landlord	647	30.3%	825	30.5%	1032	41.3%
Family/Friend	736	34.5%	968	35.8%	853	34.1%
Self	333	15.6%	426	15.7%	309	12.4%
Detective	50	2.3%	34	1.3%	11	0.4%
Jail	41	1.9%	37	1.4%	25	1.0%
School	76	3.6%	102	3.8%	71	2.8%
Fire Department/Paramedics	5	0.2%	9	0.3%	6	0.2%
APS/DCFS	16	0.7%	9	0.3%	12	0.5%
Threat Management Unit	3	0.1%	4	0.1%	5	0.2%
Group Home/Board & Care Home	64	3.0%	55	2.0%	46	1.8%
Other Law Enforcements	8	0.4%	23	0.9%	12	0.5%
Government Agency	1	0.0%	7	0.3%	2	0.1%
Social Service Agency	8	0.4%	4	0.1%	0	0.0%
Court	4	0.2%	1	0.0%	0	0.0%
Therapist	56	2.6%	70	2.6%	19	0.8%
Hospital/Clinic	9	0.4%	29	1.1%	20	0.8%
SWAT/CNT	5	0.2%	2	0.1%	9	0.4%
Work Place	2	0.1%	0	0.0%	0	0.0%
MTA/TRANSIT	0	0.0%	8	0.3%	8	0.3%
Medical Doctor	0	0.0%	7	0.3%	0	0.0%
TOTAL	**2134**	**100%**	**2705**	**100%**	**2498**	**100%**

Source: LAPD – LA County Department of Mental Health SMART Program

Prior Contact with SMART

Table 7 indicates the number of persons with prior contacts with SMART. SMART statistics show that the number of persons who have had prior contacts with SMART has increased over the past three years. On average, 16 percent of persons having contact with SMART have had a prior contact of some kind over the last three years.

Table 7
Systemwide Mental Assessment Response Team (SMART) Statistics: Prior Contact with SMART, 1999, 2000 and 2001

	1999	2000	2001
Number of Prior Contacts	291	412	508
Total Number Encountered	2010	2620	2688
Percentage of Prior Contacts	14.5%	15.7%	18.9%

Source: LAPD – LA County Department of Mental Health SMART Program

Source of Dispatch

As shown in **Table 8**, almost all calls are dispatched by the MEU (between 71 and 84 percent). According to County records, 80 calls in 2001 were dispatched by the SMART triage counselor but MEU personnel report that a SMART unit can only be dispatched by MEU. This finding may be a direct result of the triage counselor communicating directly with the MEU officer in the building and both collaboratively determining that a SMART unit should be dispatched, and so the triage counselor may inform the unit to respond to the call. Access was recently added to the log. Access is a 24 hour information line sponsored by DMH to provide mental health referrals to the community and may respond to community requests for psychiatric emergencies.

Table 8
Systemwide Mental Assessment Response Team (SMART) Statistics: Source of Dispatch, 1999, 2000 and 2001

Source of Dispatch Type	1999		2000		2001	
Mental Evaluation Unit (MEU)	1786	83.7%	2204	71.4%	2130	79.2%
Radio Call	286	13.4%	297	11.4%	453	16.8%
SMART Triage	0	0.0%	0	0.0%	80	3.0%
Others	62	2.9%	0	0.0%	0	0.0%
Access (from Department of Mental Health)*	N/A	N/A	N/A	N/A	27	1.0%
TOTAL	2134	100%	2501	100%	2690	100%

Source: LAPD – LA County Department of Mental Health SMART Program
* New category created in 2001

In sum, most calls for SMART units originate from family, friends and neighbors requesting assistance with an individual who may have a mental illness. More often, the call is for someone who may be a danger to him/herself, and SMART serves adults most of the time. MEU is the major source of SMART dispatch and most teams provide services in the person's home or on a street location. About 16 percent of persons involved in a SMART call have had some prior contact with SMART, suggesting that SMART provides a service that may be especially important for some persons with ongoing needs that result in more contacts with the police.

An Evolving System

The different systems used by LAPD to track calls and incidents include several that record information about police encounters with persons who may have a mental illness. This reflects the importance to LAPD of having systematic information about these encounters.

As discussed earlier, data collection and tracking within LAPD is complex, with separate components having been developed independently over many years for many purposes. For example, LAPD systems that route calls do not necessarily have features designed to track outcomes. As might be expected, different departmental units record and use data for their own planning and management purposes. The separate systems they have created are necessary and relevant to their own needs, but are not necessarily designed to integrate with another department's system. The current set of mini-systems has evolved to satisfy many needs but without the coherency to address sufficiently the current over-arching needs of the LAPD for information regarding encounters with persons who may be mentally ill.

Current challenges for data collection and reporting include:

- **SYSTEM INTEGRATION.** The methods of recording and storing data range from the systemwide local area network to paper-and-pencil tallies. Data storage is neither uniform nor uniformly accessible. For example, currently MEU data are maintained in an Access database in one computer workstation. No MEU activity is documented on the LAPD-wide local area network.

- **CONTINUITY OF INSTITUTIONAL KNOWLEDGE**. Many data collection forms and procedures have been passed down within divisions and have not been coordinated with other divisions. Individuals and much of the "institutional knowledge" about the methods and rationale for the existing system have long since transferred to other divisions. Members of divisions inherit forms that they use without a complete understanding of the documents' origins and final disposition.

- **RELIANCE ON PERSONAL MEMORY**. In some situations, the memories of department personnel are the prime means for recalling data. As is obvious, this system is subject to memory lapses, varying degrees of individual interpretation, and, as already noted, personnel turnover.

- **INADEQUATE DESIGN**. The Department's computerized data collection procedures frequently limit the number of choices (e.g., the system accepts one keystroke) and the choices are not mutually exclusive or independent categories.

Thus, MEU incident reports require those completing the form to select between "Tarasoff" and "Injury" and "5150" (among others)—when, in fact, all three may apply to the situation. Likewise, 911 calls are limited to one code, so a mentally ill person who is armed can only be classified as armed. Conversely, some systems provide multiple outcomes, making it impossible to determine which the true outcome is.

- **DIFFERING DEFINITIONS.** Each department may have developed independent definitions. For example, one department may use "attempted suicide" while another department may use "injury." Since injuries can be self-inflicted, caused by others, or accidental, the category provides little information about the source or the extent of the injury. As a result, different definitions create confusion when reviewing and reporting the data that has been collected by different departments or divisions.

- **DIFFERING CATEGORIZATIONS**. The categorizing of data is not always standardized within the Department. For example, were the LAPD to receive a request from the mayor, chief, media, Commission, etc. regarding the number of involuntary 72-hour holds of mentally ill persons during the past three years, the categorization of information would vary depending upon who within LAPD provided the statistics. For example, there is currently no commonly accepted standard for reporting data relevant to encounters with persons who may have a mental illness. For instance, Crime/Arrest records collapse 5150 WIC holds and suicide attempts while MEU reports them separately.

- **DIFFERING NUMERIC REPORTS**. The actual numeric reports also show variability within the Department. Again using the above 5150 data, the reported number of total encounters varies. Even when 5150s and attempted suicides, as reported both by MEU and Crime and Arrest, are combined, the numbers do not match. This variability is presented in **Table 9**.

Table 9
Variability of 5150 and Attempted Suicide Data Reported within LAPD 1999, 2000 and 2001

LAPD Source of Information	1999	2000	2001
Crime and Arrest	3,590	3,995	4,756
MEU Calls - Mental Evaluation Unit, Detective Headquarters Division	3,728	3,980	3,450
MEU Incidents - Mental Evaluation Unit, Detective Headquarters Division	3,882	4,313	4,852

- **DATA REPORTING AND REVIEW**. Given the fact that data are collected in various divisions, the knowledge of and access to the data is problematic. Lodestar did not identify any consistent review of tracked information that informs the LAPD about police encounters with persons who may have a mental illness.

Despite these challenges, data systems track a large number of variables useful to understanding encounters with persons with a mental illness such as:

- 5150 WIC holds;
- Attempted suicides;
- Types of calls and incidents; and
- Source of referrals.

In addition, different divisions have used these data to develop tracking reports and internal analyses of collected data, suggesting that these systems are useful and informative for specific internal purposes.

All of these challenges are to be expected where independent tracking approaches have evolved over decades of police work. As is the case with many other large organizations, tracking systems developed for internal record keeping and analysis were not created for the purpose of external research or analysis. Thus, system developers never anticipated the variety of uses for which data would be requested and used.

While the data systems reviewed have a good foundation, the LAPD has the opportunity to improve not only its systems of tracking police encounters with persons with a mental illness but related factors outside of tracking systems.

I3: Best Practices

Review Process

- Reviewed pilot projects in specific precincts as well as systemwide practices.

SYSTEMWIDE PRACTICES

MEU/SMART

> ***"You have to change your attitude from dealing with criminals to dealing with someone who may have a mental illness."***
>
> *-SMART Officer*

Program Background

LAPD uses two specialized responses in dealing with encounters with persons who may have a mental illness. These responses do not respond to every encounter, nor are these specialized programs consulted for each encounter. These two responses are systems that have been used to assist patrol officers to expedite and provide appropriate dispositions to encounters with persons who are suspected of having a mental illness.

The Mental Evaluation Unit is the older of the two systems. In the late 1970's, Detective Headquarters Division had hospital detail, where detectives had ongoing communication with hospital staff. As a result of a police shooting of a person with a mental illness, LAPD decided that they needed a tracking system to monitor police encounters with persons with a mental illness. This system would include a central place where officers could call and get information about the mental and behavioral history of subjects that had a prior contact with police and receive advice on how to appropriately handle encounters with persons who are suspected of having a mental illness. This system developed into the Mental Evaluation Unit (MEU) in the early 1980's.

Los Angeles Police Department
Los Angeles, CA

Geographic Size: 466 sq. miles
Population: 3,694,820

Number of Sworn Officers: 8,856
Number of Patrol Officers: 2,779

Program: **Mental Evaluation Unit**

Number of MEU Officers: 4

Program: **Systemwide Mental Assessment Response Team**

Number of SMART Officers: 11

Years later, a secondary system developed as a result of recommendations of the Incarcerated Mentally Ill Task Force, a group created by the Los Angeles County Board of Supervisors in 1991. The task force, comprised of governmental and private agencies, was asked to address public concerns about the increasing number of forced hospitalizations and incarcerations of persons who have a mental illness. The task force concluded that the needs of persons with a mental illness in the county were not being adequately addressed and met.

As a result, one of the recommendations of the task force was the creation of the Systemwide Mental Assessment Response Team (SMART) in 1993. Originally, it was a pilot program and eventually became a permanent program at the LAPD. SMART is a team that consists of a trained mental health professional provided by the County of Los Angeles Department of Mental Health (DMH) and a law enforcement officer from the LAPD. The team is mobile and based on the premise that the team would be able to provide a more appropriate resolution to encounters with persons who may have a mental illness, with the ultimate goal of reducing unnecessary hospitalizations or incarcerations.

Program Description

Both MEU and SMART provide a specialized service for patrol officers when they encounter persons who are suspected of having a mental illness. The difference between the two is that SMART can respond to a scene with a LAPD officer and DMH mental health professional while MEU provides advice and consultation to field officers.

In the past, officers brought subjects into MEU offices for evaluation by MEU officers, but cannot at this time due to constraints in their current office space. As such, this discussion of MEU will describe the program as it operates today.

LAPD's Mental Evaluation Unit (MEU) conducts preliminary screenings of persons, adults and juveniles, who come to the attention of the police and are suspected of having a mental illness. Specifically, this includes those who may be suspected of being:

- Mentally disordered;
- A victim of amnesia;
- Senile;
- Post-alcoholic;
- An Alzheimer patient;
- Infected with AIDS and may be dangerous to themselves or others;
- Developmentally disabled; and
- Any other person who officers have probable cause to believe requires psychiatric evaluation.

MEU also handles any Tarasoff notifications. Tarasoff notifications are reports from mental health professionals in which there is reasonable cause to believe their client poses harm to another. Based on a preliminary investigation, MEU determines the appropriate LAPD response, which may include deploying a SMART unit, providing advice to patrol officers, recommending a possible 72-hour involuntary hold, or offering a referral to community services.

SMART assists field police officers in encounters with persons who are suspected of having a mental illness by responding in-person. The team can provide solutions and resolve encounters that may avoid unnecessary hospitalization or incarceration. Because a mental health

professional is on the team, referrals, intervention, of placement of a person in crisis can be handled more efficiently so that the field officer can return to other duties. According to the SMART manual, there is capacity for 13 teams (one team would be supervisory), but at this time there are only 10 teams and one supervisory team due to staffing shortages of mental health professionals. SMART officers are in plain clothes and use unmarked vehicles. The role of the SMART officer is to:

- Provide and maintain safety for the subject and mental health professional
- Notify Communications Division of the status of the call
- Notify MEU when responding to a call and upon disposition
- Provide consultation to LAPD field officers on scene
- Complete property receipt of subject, if necessary
- Complete SMART activity log (which includes time of assignment, time of arrival and completion, call location)
- Transport persons on psychiatric holds to an appropriate facility

According to SMART, it is important to have a field officer evaluate the scene before a SMART unit arrives. Ideally, both the field officer and SMART unit would arrive simultaneously and allow the officer to assess the scene for dangerousness. Once the scene is stabilized or determined to be safe, the SMART unit will begin to assess the mental status and needs of the subject and determine an appropriate response. Subsequently, the field officer can leave the scene and return to duty. According to SMART units interviewed, the usual response time is between 5 minutes to 40 minutes. Responding to radio calls rather than waiting to be dispatched by MEU generally lessens the response time. SMART units report that this more proactive approach provides a more effective response because the unit can arrive simultaneously with the patrol unit and attend to the needs of the subject faster.

SWAT and Crisis Negotiations Team (CNT) will request consultation from SMART and MEU if a subject is suspected of having a mental illness. MEU can provide information about whether the subject has been placed on an involuntary hold by LAPD officers in the past. Because information from the DMH's Management Information System is available to the SMART mental health professional, units can share psychiatric history and information about past encounters with the subject that may be pertinent to the encounter. SMART units report that ideally, they would provide consultation as to how to de-escalate an encounter and at times, SMART clinicians have stood behind officers to try to engage the subject in an effort to de-escalate the situation.

Community Partnerships and Working Relationships

MEU does not partner with any other agencies except for DMH. The MEU office is located in the same space as the SMART staff. This allows MEU officers to consult with DMH staff if necessary.

SMART is a partnership between DMH and LAPD. Through this collaboration, both agencies have sponsored conferences and training events for SMART units. There are informal relationships between the SMART supervisor and local hospitals and emergency rooms developed for the purpose of communication and active problem-solving when units encounter difficulties at

hospitals. SMART also communicates with local NAMI chapters via conferences and training events. In the past, advocates have provided training and education for SMART units.

Program Implementation and Maintenance

Program Administration

Leadership

MEU and SMART officers are supervised by two detectives, one for each program. There is a DMH supervisor for the SMART mental health professionals.

Administrative Support/Engagement of Departmental Personnel

Currently, during the day shift, there are two detectives working as supervisors (one D3 and one D2), and one patrol officer (P2). A second patrol officer position is authorized, but currently no one in that position is assigned to the field. MEU also has resources that allow for three additional detectives and two police officers, but these positions have not yet been filled. There are a total of 10 SMART officers and one supervisor.

Departmental Incentives

There is no incentive pay for SMART or MEU personnel. Often, officers that are interested in working with persons who may have a mental illness apply to work at MEU. If a P3 position is available at MEU, people will apply to promote to that level (they often will apply to multiple P3 areas). Officers may apply to work at MEU with the possibility of a future placement at Detective Headquarters Division, a division in which there are more opportunities to work in specialized areas. The specialized unit aspect of MEU and SMART is appealing to many officers.

Recruitment and Retention of Personnel

If a position is available, MEU typically advertises the opening. In the past, MEU has encouraged officers to apply through roll call announcements; however, recently there have not been staff available to do so.

SMART officers are recruited from field police officers. Officers with three to five years experience are targeted but there is no minimum requirement for number of years with LAPD. There were no reported problems with recruiting or retaining SMART.

Estimated Program Costs

Most program costs for MEU and SMART appear to be associated with personnel. There are a total of two detectives and two patrol officers that are MEU detail. For SMART, there are 10 officers and one supervisor (detective). Additionally, there is a cost of sending officers to a local 40 hour conference several times a year.

Program Policies

Training Programs and Practices

There is no formal training for MEU. MEU officers learn by reviewing the policies and procedures manual, on the job by observing others and receiving supervision.

SMART officers do not receive formal training before working on a SMART unit. Officers learn on the job and will attend training events and mental health conferences sponsored by DMH, LAPD, or Los Angeles Sheriffs Department (LASD) during the year. The number of conferences range from three to four a year. Conferences and training events include DMH training for mental health professionals on placing persons in danger on an involuntary psychiatric hold. Other examples include issues related to: use of force, mental health courts, psychopharmacology, and suicide assessment. A manual of handouts from these conference proceedings and a recently revised policies and procedures manual is available to units for review. Workshops are provided by subject matter experts from DMH and other local agencies.

Operations

MEU is housed in an office next to SMART headquarters in downtown Los Angeles. Regular MEU hours are from 7am to 3pm. At 3pm calls are forwarded to Detective Headquarters Division, for response to MEU calls in the evenings. There is one officer (P2) and one detective (D2) on duty in the evening shift, and one officer (P2) on duty in the morning shift. These officers take calls for MEU, but continue to have other duties. They are capable of sending out the SMART team, but not all of the officers have training in how to handle MEU calls. Currently MEU staff is putting together an information packet to give to officers at Detective Headquarters Division regarding how to handle MEU calls, and in the future may also have a verbal training with these officers.

The officers at Detective Headquarters Division take handwritten reports of calls received by MEU which are entered into a database. Each day, MEU faxes a list of names in their reports to Detective Headquarters Division, so that if someone calls regarding a missing person, the officers can give out information about persons they know to have been transported to a hospital or other care facility.

SMART units arrive on a scene in several different ways. As it was originally conceived, when field police officers encountered a person who was suspected of having a mental illness, the MEU was notified. After a brief assessment with the officer, if MEU believed that a SMART unit was necessary to respond, the MEU would locate an available SMART unit and dispatch the unit to the scene. Originally, SMART units and vehicles were housed in a location downtown, and would wait there to be dispatched. Due to the geographic size of Los Angeles, SMART decided to cover different geographic areas and patrol those areas until a call was received. According to SMART units interviewed, once units were stationed in these areas responding times decreased. In addition, SMART officers monitor the radio frequency for the area in which they are stationed. If a relevant call is heard, SMART units begin traveling to the scene while notifying MEU of their destination. If MEU receives a call that was more pressing and in need of the SMART unit, MEU would dispatch the unit to the MEU call. This rarely happens according to interviewed SMART members.

SMART has five shifts with at least one team deployed in every watch. Each team is stationed in one of the four major geographic areas of the city. There are five shifts each day and are staffed as follows:

Shift	Number of SMART units
07:00 am – 15:30 pm	3
10:00 am – 6:30 pm	1
1:00 pm – 9:30 pm	1
3:00 pm – 11:30 pm	2
6:00 pm – 2:30 am	1
11:00 pm – 7:30am	2

Currently, there are only 9 clinicians available so there are only 10 teams with one clinician working an extra shift allowing for almost 24 hour coverage. The program was originally designed to provide coverage every day of the week. Due to limited staffing and the need to provide vacation and adjust for periods of illness, teams have traditionally not been available on a 24-hour basis every day of the week.

Incident Documentation and Tracking

Currently the MEU uses a paper and pencil method of tracking their calls from incoming sources. A daily log is used in the department and passed from desk to desk as personnel respond to calls. This system is susceptible to error as many calls are not recorded because the log may not be conveniently available to them during a call.

The MEU intends to track information about the calls received. Key variables include: the source of the call (officer, citizen, DMH, etc), the outcome of the call (5150, SMART unit was dispatched, Tarasoff notification), the total number of arrested/booked individuals, whether the person served was transient/homeless, developmentally disabled, demented with AIDS, or an arrest/transportation order was received for a hospital escapee. All calls are tracked by reporting division. Certain variables are reported monthly by MEU and are defined below:

- **Hospital Escapee** - persons who left the hospital before the hold was completed.
- **Booked** - persons who meet criteria but were arrested rather than placed on a 5150 WIC due to a felony charge
- **Tarasoff** - notification by a health professional as possible danger to other party
- **Reject** - an event in which a call was received but the person served did not meet criteria for a 5150 WIC
- **SMART** - if the SMART unit was sent to assist patrol
- **5150 WIC** - the patrol officer placed the person on a hold.

- **Attempted Suicide** - the person attempted to kill him/herself and was placed on a hold
- **Secret Service** - requests consultation from MEU during screenings to gather any relevant history on a suspect; and
- **Miscellaneous** - inquires and questions as well as LAPD supervisor calls regarding past encounters with individuals.

MEU is required to track and keep records of the variables listed above.

MEU also tracks calls by completing incident reports. An incident report is a document completed by the MEU officer after a call or if documentation for a 5150 is received. Officers are instructed to send all 5150 documents to MEU. MEU keeps the records of all 5150s, including the creation of an incident report. Most 5150s by patrol will occur after consultation with MEU, so an incident report exists before paperwork is received. If documents are received by an officer, and no incident report has been created by MEU, MEU officers will gather information pertinent to the 5150 by the patrol officer and make an incident report.

Incident reports include the following information:

- Date report was taken
- Type of Report
- Name and contact information of person served
- Demographic information of person served
- Division
- Reporting person
- Conditional release information
- Narrative

The type of report contains six categories: Tarasoff notification; reject; SMART, 5150 WIC, Injury, or Other. All categories are defined similarly to the pencil and paper log described earlier. There is an additional category, Injury, which is unique to incident reports. If there is any injury to the person served (e.g., overdose of Tylenol or cuts on the body after a suicide attempt) then the report is coded as injury despite the possibility that a 5150 was invoked.

The narrative contains information about the call and any information about the person relevant to a mental evaluation. Information contained can include history of mental illness, medications prescribed and general information about mental status. Often, if SMART is deployed, the narrative will include who from the SMART team was on-scene. The length of narratives is rather short, typically 3 to 4 lines and focus on the subject's behavior.

In the initial stages of development of SMART, DMH and LAPD agreed that SMART encounters were clinical encounters, so that any documentation of the event would fall under confidentiality restrictions of DMH. It was agreed that SMART officers would not document the encounter and the mental health professional would note the encounter and create a case file or place the note in a current case file if the subject was a consumer of DMH services. LAPD has no computerized system of SMART contacts; however, DMH keeps a computerized database of these encounters. The SMART unit completes a tracking log which is then entered into a database located in the SMART office. SMART tracks a number of variables including call location, type of hold, and to which hospital the subject was transported.

Perceived Effectiveness

Lodestar conducted a survey of patrol officers to explore perceptions about training and procedures about encounters with persons who may have a mental illness (a detailed description of the survey and a full analysis will be included in the Draft Final Report). Lodestar attended a total of 12 roll calls in 6 divisions. Two hundred twenty-two officers were surveyed. A large majority of officers report using MEU or SMART in the past (98.6 percent and 90.7 percent, respectively). Three quarters of the officers agree that MEU or SMART were helpful when working with persons with a mental illness in crisis (77.5 percent and 75.5 percent, respectively).

PILOT PROGRAMS

CIT

Program Background

In response to a police shooting of a homeless person with a mental illness, the LAPD determined that a specialized response different than MEU or SMART was necessary to address encounters with persons who have a mental illness. Central Area was selected as a region in which a pilot program could be implemented as a result of internal support with the area and the population that resides in the area. The homeless community, located in Central Area, contains a large number of homeless persons with an estimated third to half suffering from a mental illness according to local service providers.[1] Central Area provided a good environment to test the effectiveness of a pilot program that targeted the improvement of police encounters with persons who may have a mental illness. Based on a review of best practices in other police departments across the nation, the LAPD decided to implement a Crisis Intervention Team (CIT), a model originally developed by Memphis Police Department in Tennessee and now adapted for cities such as Albuquerque, Portland, Seattle, Jacksonville, and San Jose. The CIT pilot began in Spring of 2001 and an internal evaluation of the program was conducted by LAPD and distributed early in January 2002.

Los Angeles Police Department
Los Angeles, CA
Central Area

Geographic Size: 4.89 sq. miles

Population: 42,054

Number of Patrol Officers: 78

Program: **Crisis Intervention Team**

Number of CIT Officers: **32**

Program Description

CIT is a first responding unit of field officers with special training in mental health issues. The program in based on the Memphis Model, a generalist-specialist model that provides a

[1] LAPD. (2002). Crisis Intervention Team Pilot Program Evaluation.

specialized response to "mental disturbance" crisis calls by officers who also have regularly assigned patrol duties. The CIT officer typically resolves situations at the scene through de-escalation, negotiation or verbal crisis intervention. LAPD consulted with Albuquerque Police Department in the development of the pilot CIT training and operations.

Community Partnerships and Working Relationships

The CIT Coordinator collaborates with outside agencies such as DMH, LAMP, and the Homeless Task Force for technical assistance in developing the training and operations. Unlike other CIT programs, LAPD did not consult with advocacy groups in the development and implementation of the training and program operations. The CIT Coordinator reports that the pilot was implemented quickly without an adequate period of time to establish partnerships with the advocacy community but that currently, efforts are being made to do so.

Program Implementation and Maintenance

Program Administration

Leadership

The pilot program was led in large part by a lieutenant in Central Area with the assistance of a sergeant, senior lead officer, and senior police service representative. All were assigned to the CIT program in Day Watch. Leaders were expected to maintain regular patrol and administrative duties while they developed and implemented CIT.

Administrative Support/Engagement of Departmental Personnel

Training was developed through collaborative efforts with Albuquerque's CIT Coordinator and local agencies in Los Angeles outside of the LAPD. Once completed, LAPD experts reviewed the curriculum for content and appropriateness.

Departmental Incentives

There are no incentives provided for CIT lead or patrol officers. The LAPD holds a banquet for employee recognition, and the CIT coordinator and others involved in the planning and development of the program were honored for the first CIT cohort in March 2002.

Recruitment and Retention of Personnel

Officers in the pilot were assigned to the program rather than asked to volunteer. According to the evaluation report, some officers were not interested in the assignment. Thirty-two officers were trained in May 2001 and another 30 will be trained in May 2002. Because officers transferred to other shifts during the pilot, only 48 percent of those trained remained in Day Watch where the CIT Coordinator could monitor the training and implementation of CIT.

Estimated Program Costs

Because patrol officers and leadership maintained regularly assigned duties, the cost of program were mostly associated with the development and implementation of the 40-hour training.

Program Policies

Training Programs and Practices

The training curriculum is modeled after Albuquerque's CIT program which uses the Memphis Model of program implementation and training. A more extensive review of the CIT training is described earlier in this report.

Operations

CIT officers respond to mental disturbance radio calls in their assigned area. After a response, CIT officers were required to complete an assessment form so that their contacts could be tracked. During the pilot period (May to October) CIT officers documented 60 encounters. CIT officers called on SMART at times to evaluate subjects further and if necessary, transport to a psychiatric facility.

Incident Documentation and Tracking

CIT officers track incidents with the Crisis Assessment and Intervention Report developed by CIT leadership. The form includes information about contact location, medical status, physical symptoms, reasons for involuntary hold, and disposition of the incident. Eventually, these data are to be incorporated into MEU's database.

Perceived Effectiveness

Because this was a pilot program, CIT leadership examined training by reviewing scores on exams given after training. Officers' scores ranged from 85 to 100 percent and many officers reported the training was valuable for use in the field.

Use of force was examined across the 60 encounters with CIT. Of those, there were 13 incidents in which the subject was violent or aggressive and in only one was use of force necessary. The program is highly regarded with some concern that there are still a third of CIT officers that have not responded to a mental disturbance call and some CIT officers remain disinterested in the program.

Van Nuys Community Court Pilot

- A Community Court addresses offenders who may have a mental illness
- Law Enforcement and Community Volunteers work together to address homelessness, illiteracy, alcohol and drug addiction, mental and emotional problems and unemployment "recognizing unbroken cycle".

- Incorporates the judicial system, social service providers and the community-at-large when dealing with mental health issues
- Court requires offenders (who qualify) to immediately begin to address problems that may cause them to offend, i.e. mandatory drug and alcohol programs
- Reports 90 percent success rate for those defendants who elect to take advantage of the Community Court system
- Decreasing repeat offender percentage
- Bike Patrol officers utilized for community policing
- Good use of volunteers

It is unclear as to the extent and content of training of the officers or volunteers to work with individuals who may have a mental illness. Although mental illness is listed as a major focus, it is unclear that persons with a mental illness are handled differently.

This program has several positive elements that can be built on as well as introduced to other communities. The collaboration of various community groups is noteworthy. The community court results in more individuals accessing services.

Hollywood: Fact Sheet Contacts with the Mentally Ill (Project No. 01-244)

The Hollywood Community Police Station has been involved in a Homeless Outreach Project that addresses problems for persons who may have a mental illness. The Homeless Outreach Project has been developed to address the needs of the Hollywood Division's unique demographics. The division's involvement has been ongoing since March of 2000.

- Community partners assist officers with homeless/mental health intervention
- Program strength is its mobilizing the private sector and community resources
- A special Homeless Outreach subcommittee has been established adjunct to the Community Police Advisory Board with representatives from agencies who serve homeless persons and those who may have a mental illness
- The SMART teams are frequently utilized by officers
- During each deployment period, social service agencies provide a central phone number that can be accessed for advisement or respond to officers' location when they encounter a person who may have mental illness
- Officers has access to addresses and phone numbers of behavioral healthcare providers
- An Operations Plan was developed to include "the mentally ill homeless" as target group. Each Basic Car Area has a copy of action plans and resource lists.
- Roll call training is scheduled.

This project may be well received and result in improved quality of life for the homeless. However, it is obvious from the goals of the program is in reducing the visible numbers of

homeless/transients and to reduce crime and needed interventions. Although this program is established to deal with persons with a mental illness who are homeless, the majority of officers rely on SMART to deal with persons who may have a mental illness. The officers are given a myriad of social service agencies, addresses and phone numbers that may be contacted for assistance or referral. The Operations Plan is impressive with purpose, mission and situation statements however the plan does not mention how the program may affect the individual who may have a mental illness. There is no mention of specific police training on how to interact with persons who may have a mental illness (homeless or not).

In general, this program does well to open dialogue among police, the business community, and the service providers. It may be much more successful by refocusing the effort on improved human relations and the linking of persons with service than its stated goals of decreasing the community's homeless problem. Training relevant to mental illness and homelessness may need to be increased.

APPENDIX J: Categorical Use of Force

J1: Categorical Use of Force Coding Instrument

J2: Categorical Use of Force Findings

APPENDIX J1: Categorical Use of Force Coding Instrument

LAPD Consent Decree Mental Illness Project

Use of Force Incident Coding Form

Date Coded __ __/__ __/__ __ Case ID# 1 __ __ __ Coder: __ __

Type of Incident: ❑ Cat. Use of Force ❑ Non-Cat. Use of Force

SUBJECT DEMOGRAPHICS

1. Age __ __
(Code 99 for Don't Know)

2. Sex: ☐Male (1) ☐Female (2) ☐Don't Know (9)

3. Height (in inches) __ __ __

4. Weight (in lbs.) __ __ __

5. Race: ☐African American (1) ☐Asian (2) ☐Hispanic (3) ☐White (4) ☐Other (7) :_____ ☐Don't know (9)

INCIDENT CHARACTERISTICS

6. Time of Incident:__ __:__ __
(military time)

7. SMART called by Patrol Officer:
☐No (0)
☐Yes (1) Time called:__ __:__ __ (military time)
Time arrived: __ __:__ __ (military time)

8. Precipitant of Encounter-(Nature of the Call That Brought the Police) ***(check one)***

1. ☐ Disorderly/disruptive behavior
2. ☐ Neglect of self – care
3. ☐ Public intoxication
4. ☐ 415 / Disturbance call
5. ☐ Family dispute
6. ☐ Neighbor dispute
7. ☐ Business dispute
8. ☐ Trespassing
9. ☐ Nuisance (loitering, panhandling)
10. ☐ Destruction of property
11. ☐ Theft/other property crime
12. ☐ Alcohol or drug offense
13. ☐ Suicide threat or attempt
14. ☐ Threat of violence to others
15. ☐ Battery/violence toward another person
16. ☐ Batter/violence toward officer
17. ☐ Other (Please specify: _____)
18. ☐ No information

9. Location of Incident Where Force Occurred ***(check one)***

1. ☐ Subject's home
2. ☐ Other home
3. ☐ Club/Bar
4. ☐ Restaurant
5. ☐ Retail Store
6. ☐ Street
7. ☐ Parking Lot
8. ☐ Subject's Yard
9. ☐ Other Yard
10. ☐ Other Location (Please specify:_____)
11. ☐ No information

10. Complainant Relationship ***(check one)***

1. ☐ Partner/Spouse
2. ☐ Boyfriend/girlfriend
3. ☐ Parent
4. ☐ Sibling
5. ☐ Friend/acquaintance
6. ☐ Business owner
7. ☐ Other family member
8. ☐ Police observation

77 ☐ Other stranger
99 ☐ Don't Know

11. Symptoms Evident at Time of Incident ***(check all that apply)***

1. ☐ Disorientation/confusion

2. ☐ Delusions (specify if known:_____)

3. ☐ Hallucinations (specify if known:_____)

4. ☐ Disorganized speech (freq. derailment, incoherence)

5. ☐ Disorganized or bizarre behavior

6. ☐ Manic (elevated/expansive mood, inflated self-esteem, pressured speech, flight of ideas, distractible)

7. ☐ Depressed (sadness, loss of interest in activities, loss of energy, feelings of worthlessness)

8. ☐ Unusually scared or frightened

9. ☐ Belligerent or hostile (angry, uncooperative)

10. ☐ No information

12. Did the subject's behavior at the scene reasonably suggest that s/he might have a severe mental illness?

1 ☐ Yes 0 ☐ No 9 ☐ Don't Know

13. Which of the following facts contained in the report or narrative suggest the subject had a severe mental illness? *(check all that apply)*:

1. ☐ Subject self reported
2. ☐ Collateral reported (3rd party informed)
3. ☐ Behavioral inference, no history
4. ☐ Report that medication prescribed
5. ☐ Report that med non-adherent
6. ☐ Post incident testing suggested a drug was prescribed for mental illness: _____

14. Did the subject's behavior or circumstances precipitating the encounter appear to be a likely result of subject's mental illness?

1 ☐ Yes 0 ☐ No 9 ☐ Don't Know

15. Did the officer know/suspect the subject had a severe mental illness either before or immediately after arriving on scene (as opposed to only learning of the subject's history after the fact)?

1 ☐ Yes 0 ☐ No 9 ☐ Don't Know

16. Regardless of demeanor, did the subject maintain a reality-based interaction with the officer (not catatonic, unresponsive, or responding to hallucinations or delusions)?

1 ☐ Yes 0 ☐ No 9 ☐ Don't Know

17. Medication Adherence ***(check one)***

1 ☐ Subject (or Other) reports that subject has not been prescribed psychotropic meds

2 ☐ Subject (or Other) reports that subject has been taking prescribed psychotropic medication as prescribed [Please specify medication: _____)]

3 ☐ Subject (or Other) reports recent nonadherence with prescribed psychotropic medication:[_____)]

4 ☐ Subject (or Other) reports subject has been prescribed psychotropic medication but no information about medication adherence

5 ☐ No information concerning prescribed psychotropic medication

18. Prior Contacts ***(check all that apply)***

a) Known person (from prior police contacts)
1 ☐ Yes 0 ☐ No 9 ☐ Don't Know

b) Repeat call (w/in 24 hrs.)
1 ☐ Yes 0 ☐ No 9 ☐ Don't Know

19. Drug/Alcohol Involvement
Evidence that subject under influence of alcohol or drugs (observed and actual evidence)
1 ☐ Yes 0 ☐ No 9 ☐ Don't Know

If YES:
1 ☐ Alcohol
2 ☐ Other drug (specify:_____)
9 ☐ Don't Know

20. Global Category of Force: (*check one)*
1 ☐ Slight force: Officer used strong directive language and/or minimal physical force to encourage the suspect to cooperate and follow directions.

2 ☐ Forcibly subdued suspect with hands: Officer used an arm/wrist lock, takedown, block, punch, kick, and/or struck or wrestled the suspect.

3 ☐ Forcibly subdued suspect using methods other than hands: Officer used chemical agent, baton, gun, or other special tactics or weapons.

21. Types of Force Applied (*check all that apply)*:

21.1 Physical 1 ☐ Yes 0 ☐ No
If yes, check all that apply:
a) ☐ Grabbing/holding (firm grip, "C" grip)
b) ☐ Twist or Wrist Lock/ Pain Compliance
c) ☐ Takedown/Wrestling/Ground Control
d) ☐ Punch/Strike
e) ☐ Kick
f) ☐ Carotid hold
g) ☐ Threatened suspect with weapon

21.2 Electronic (Taser) 1 ☐ Yes 0 ☐ No
a) No. of cassettes fired_____
b) Distance from Subject__ __ __ (in inches)
c) Penetrate skin? 1 ☐ Yes 0 ☐ No
d) Waiting time for Taser__ __ __ (in minutes)
e) Was it effective? 1 ☐ Yes 0 ☐ No
f) Why not? _____

21.3 Lethal 1 ☐ Yes 0 ☐ No
a) Firearm Used? 1 ☐ Yes 0 ☐ No
b) No. of shots fired __ __ __
c) No. of shots hit subject __ __ __

21.4 Non-Lethal/Tactile Weapon (bean bag, rubber bullets) 1 ☐ Yes 0 ☐ No
a) No. of shots fired __ __ __
d) No. of shots hit subject __ __ __

21.5 Chemical Spray 1 ☐ Yes 0 ☐ No
a) No. of times sprayed_____
b) Type used_____
c) Distance from Subject__ __ __ (in inches)
d) Duration of spray__ __ __ (in seconds)
e) Was it effective? 1 ☐ Yes 0 ☐ No
f) Why not? _____

21.6 Impact (Baton) 1 ☐ Yes 0 ☐ No
If yes, check all that apply:
a) ☐ Strike
b) ☐ Block
c) ☐ Control

22. Before using force, did the Officer engage or attempt to engage the subject verbally?

1 ☐ Yes 0 ☐ No 9 ☐ Don't Know

If yes:
1 ☐ Officer only issued verbal commands/directives
2 ☐ Officer attempted to calm or negotiate with subject

23. How did Subject respond to Officer's verbalization?

1 ☐ Positively (became more calm, less hostile or agitated)
2 ☐ Neutrally (no significant change in demeanor or behavior in response to Officer)
3 ☐ Negatively (became more hostile, belligerent, agitated or angry)

24. At the time the officer used force, was s/he attempting to affect an arrest?

1 ☐ Yes 0 ☐ No 9 ☐ Don't Know

25. Which of the following reflect the subject's behavior toward the officer(s) during the incident? (*check all that apply)*:

1. ☐ Immediate compliance w/ officer requests
2. ☐ Disrespectful or obscene gesture
3. ☐ Threatening stance
4. ☐ Passive resistance (go limp)
5. ☐ Evade, hide or flee
6. ☐ Impede Officer's Movements
7. ☐ Resist cuffing
8. ☐ Resist placement in police vehicle
9. ☐ Assaultive toward police
10. ☐ Used or tried to use deadly force

26. If the subject physically resisted or attempted to use force against an officer, when did that occur:

1 ☐ Before the officer laid hands on the subject

2 ☐ Immediately after the officer laid hands on the subject for routine control (e.g., cuffing after subject voluntarily complies with request to place hands behind back)

3 ☐ Immediately after the officer laid hands on the subject for forcible control

4 ☐ After the officer laid hands on the subject, but later in the incident.

27. Which one was the last use of force that finally controlled the subject (check one):

1. ☐ Physical/ Non-striking
2. ☐ Physical/ Striking
3. ☐ Electronic (Taser)
4. ☐ Chemical
5. ☐ Impact:
Specify_____
6. ☐ Lethal
7. ☐ Non-Lethal (e.g. bean bag, rubber bullets)

28. What was the effect on the subject when force was used? *(check all that apply)*:

1. ☐ None apparent
2. ☐ Eye closure
3. ☐ Choking
4. ☐ Coughing
5. ☐ Fell to Ground
6. ☐ Attacked Officer
7. ☐ Cont. some resistance
8. ☐ Increased resistance
9. ☐ Stopped resistance
10. ☐ Other _____

30.1 How many Officers were involved in the entire incident/situation (on scene)? __ __
30.2 How many Officers were involved in the use of force incident? __ __

a) Officer 1 –

Sex:
1 ☐ Male
0 ☐ Female
9 ☐ Don't Know

Race:
1 ☐African American
2 ☐Asian
3 ☐Hispanic
4 ☐White
7 ☐Other: _____
9 ☐Don't Know

b) Officer 2 –

Sex:
1 ☐ Male
0 ☐ Female
9 ☐ Don't Know

Race:
1 ☐African American
2 ☐Asian
3 ☐Hispanic
4 ☐White
7 ☐Other:_____
9 ☐Don't Know

31. Did the subject threaten any person other than him/herself?

1 ☐ Yes 0 ☐ No 9 ☐ Don't Know

If so, who:
1. ☐ Relationship Partner
2. ☐ Family Member
3. ☐ Friend / Acquaintance
4. ☐ Police Officer
5. ☐ Stranger
6. ☐ Other: _____

29. a) Was suspect incapacitated?

1 ☐ Yes 0 ☐ No 9 ☐ Don't Know

b) Time (in seconds) to incapacitate Subject:

____ ____ ____

32. Did the subject engage in physical aggression against any person other than him/herself?

1 ☐ Yes 0 ☐ No 9 ☐ Don't Know

If so, who:
1. ☐ Relationship Partner
2. ☐ Family Member
3. ☐ Friend / Acquaintance
4. ☐ Police Officer
5. ☐ Stranger
6. ☐ Other: _____

33. Did the subject threaten suicide?

1 ☐ Yes 0 ☐ No 9 ☐ Don't Know

34. Did it appear that the subject was attempting to precipitate deadly force by the officer (e.g. 'suicide by cop')?

1 ☐ Yes 0 ☐ No 9 ☐ Don't Know

35. <u>Weapons Involvement</u>
Did subject use/brandish a weapon?
1 ☐ Yes 0 ☐ No 9 ☐ Don't Know

If YES:
Type of weapon ***(check all that apply)***
1. ☐ Knife/Edged
2. ☐ Rifle
3. ☐ Gun
4. ☐ Stick/ Blunt object
5. ☐ Other (specify_____)

36. *(If the officer had an injury)* Did the subject appear intentionally to cause injury to an officer?

1 ☐ Yes 0 ☐ No 9 ☐ Don't Know

37. What was the nature of the injury sustained by Officer(s)? *(skip if no injury)*

1. ☐ Complaint of pain/Strained muscle, etc
2. ☐ Temporary chemical irritation;
3. ☐ Bruise/abrasion/scratch/burn
4. ☐ Puncture/cut
5. ☐ Knife wound
6. ☐ Gunshot wound
7. ☐ Internal injuries
8. ☐ Concussion / Loss of Consciousness
9. ☐ Broken bones or teeth

38. Was the subject injured during the use of force incident?

1 ☐ Yes 0 ☐ No 9 ☐ Don't Know

39. What was the nature of the injury sustained by subject? *(skip if no injury)*

1. ☐ Complaint of pain/Strained muscle, etc
2. ☐ Temporary chemical irritation;
3. ☐ Bruise/abrasion/scratch/burn
4. ☐ Puncture/cut
5. ☐ Knife wound
6. ☐ Gunshot wound
7. ☐ Internal injuries
8. ☐ Concussion / Loss of Consciousness
9. ☐ Broken bones or teeth

40. <u>Incident Description</u>: (Please give us a brief synopsis of the incident (who did what to whom). Include information that helps to give a better understanding of the incident (i.e., relevant quotes).

APPENDIX J2: Categorical Use of Force Findings

As part of this study, the Lodestar team examined incidents involving individuals who may have a mental illness and who were involved in a categorical use of force. The definition of categorical use of force is specified by the Los Angeles Police Department as follows:

- All incidents involving the use of deadly force by an LAPD officer;
- All uses of an upper-body-control hold by an LAPD officer (and can include the use of a modified carotid, full carotid, or locked carotid);
- All uses of force by an LAPD officer resulting in an injury requiring hospitalization;
- All head strikes with an impact weapon;
- All other uses of force by an LAPD officer resulting in a death; and
- All deaths while the arrestee or detainee is in the custodial care of the LAPD.

Under current LAPD policy, a canine bite is not a use of force. However, for purposes of this study, a categorical use of force "shall include all incidents where a member of the public is bitten by a canine assigned to the LAPD and where hospitalization is required." (*Request for Proposal No. 01-200-008*, City of Los Angeles Police Department.)

Method

Lodestar obtained 31 Categorical Use of Force incidents from LAPD involving persons who may be mentally ill. Incidents between January 1, 1999 and December 31, 2001 were requested. Lodestar staff developed a coding form for reviewing the incidents. (See **Appendix J1** for a copy of the incident coding form.) This form contains options for categorizing:

- Type of call that brought the police;
- Behaviors exhibited by the subject;
- Types of force used to control the incident, and
- Results of each type of force.

Section VI, Paragraph 111 of the Consent Decree requires a "detailed review of at least 10 incidents since January 1, 1999 in which a person who appeared to be mentally ill was the subject of a Categorical Use of Force…" The LAPD's current system for documenting and tracking Categorical Use of Force (CF) incidents does not include an entry for identifying whether or not the subject appeared to have a mental illness. Accordingly, to identify cases meeting the specifications in the Consent Decree, investigators in the Critical Incident Investigation Division had to rely on their memory of cases that had occurred during or after 1999 in which the subject of a CF was believed or known to be mentally ill.

The incidents were thoroughly read and examined independently by two Lodestar staff members. In addition, a written summary of each incident was developed. Summary information was also calculated for the Chief of Police's findings on whether the officers' actions were in accordance with policy. Descriptive analyses were run to examine the frequency of the types of force used and behaviors exhibited by the subject. Aggregate analyses combined with the qualitative summary information about each incident contributed to the written report.

Findings

In addition to the responsibility of the police to deal effectively with persons who may have a mental illness, many communities have experienced a high-profile incident in which an officer used force - often deadly force- against a subject who was actively experiencing symptoms of mental illness. Two large existing datasets on law enforcement use of force suggest that officers may use force more frequently with subjects who have a mental illness than with those who do not. Data from the Police Services Study (PSS) conducted in the mid 1970s showed that officers used force in 3 percent of cases where the subject did not have a mental illness, but in 13 percent of cases involving a person with a mental illness. An analysis of this trend in the more recent Project on Policing Neighborhoods (POPN) showed that force was used in 7.8 percent of cases where the subject did not have a mental illness, but in 10.8 percent of cases involving a person with a mental illness[1]. These analyses also revealed, however, that although persons with a mental illness tend to be involved in less serious offenses, they were significantly more likely (than non-disordered subjects) to have a weapon at the scene [2].

Official systems for monitoring justifiable homicides by law enforcement do not currently record whether the subject is known or believed to have a mental illness; therefore we do not have an accurate gauge of the prevalence or relative risk of fatal police shootings involving persons with mental illness. In the absence of reliable information, some advocacy organizations have extrapolated national statistics to suggest that people with severe mental illness are killed by law enforcement about three times more frequently than the general population. [3,&4] Similarly, in a state of the art review of "what we know about police use of force," Professor Kenneth Adams suggests that the professional literature has established with moderate confidence that "use of force is more likely to occur when police are dealing with person under the influence of alcohol or drugs or with mentally ill individuals." [5]

Regardless of the precise figures, it is clear that use of force encounters carry a high potential for liability - both in financial costs incurred from lawsuits and social cost incurred from damage to public perceptions of police and to community partnerships. There are also costs to the persons against whom the force is used (physical, mental, financial) and costs to the officer who uses the force. Thus, investing resources to avoid escalation of these encounters and to reduce use of force seems to be prudent strategy.

LAPD Incidents

LAPD personnel selected relevant CF incidents that potentially contained a person with a mental illness based on memory of the incidents' existence. This method of case finding used by LAPD to gather categorical use of force (CF) incidents is unsystematic and significantly limits the utility and confidence of using derived information to inform policy or operational decisions, but anecdotally the case material may have some value. The limiting factor, of course, is that one cannot know how many relevant incidents actually occurred during any specified period. There may or may not have been more CF cases since January 1, 1999 involving subjects who had a mental illness. Thus, because of limits in how the cases were identified, one cannot know

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[1] Engel, R. & Silver, E. (2001). Policing mentally disordered suspects: A reexamination of the criminalization hypothesis. *Criminology, 39*, 225-252.
[2] Ibid.
[3] Eslinger, D. (2001, December 6). Police officers aren't mental health professionals. *Orlando Sentinel.*
[4] Zdanowicz, M. (May/June, 2001). We should know how many people with mental illnesses are killed by police. *Catalyst, 3*.
[5] Adams, K. (1999). Use of force by police: Overview of national and local data. *Bureau of Justice Statistics*. Washington, DC: US Department of Justice.

whether those selected fairly represent the "typical" incident of this type in LAPD or whether those cases that were easily remembered were different in some particular way (e.g., one may be more likely to recall unusual cases or those in which unusual tactics or devices were employed).

Incident Description

Thirty-one cases of CF involving a subject who appeared to have a mental illness were recalled as having occurred since January 1, 1999. All 31 incidents occurred in 1999 and 2000. Incidents that occurred in 2001 were not yet available for review at the time of this study. There were no incidents where a member of the public was bitten by a canine assigned to the LAPD.

The subjects in these incidents were most often male (87 percent), but their race or ethnicity was not reported. Most incidents occurred either in the daytime (0800-1759, 15 incidents) or evening (1800-2359, 12 incidents). Most police encounters (58 percent) in these incidents came from a radio call or the officers had monitored a communications division broadcast (15 percent). About 18 percent of the police response to these incidents came from a street encounter, such as officers observing strange behaviors or a crime in progress. Some encounters (6 percent) also came from a routine traffic stop or from an ambulance response for medical help (3 percent).

In approximately half of the cases (45 percent) the CF occurred on the street, another third (32 percent) happened at the subject's residence. The “precipitating event” for police response varied but most often involved either battery/violence toward another person (32 percent) or some form of theft or property crime (19 percent). Regardless of the precipitant, the subject’s behaviors affecting the event that initiated police response usually (71 percent) appeared to be a result of the subject’s mental illness – rather than being a criminal event where the subject happened to have a mental illness, but where that fact was irrelevant to the encounter.

Subject Behavior

Although there was evidence in all cases that the subject had a mental illness, this fact was not always discernible from the subject’s behavior at the scene. In fact, symptoms suggesting mental illness were present in about two out of three (68 percent) cases. In other cases the subject's illness was only known after the fact. In addition to the mental illness, there was evidence to suggest that in at least half (51 percent) of the incidents, the subject was also under the influence of alcohol and/or illicit drugs at the time of the encounter. At least 16 percent of the subjects were known to police from prior law enforcement contacts, but since this factor is not systematically recorded, the exact proportion is unknown.

Although the subjects did have mental illnesses, regardless of their demeanor, in almost all circumstances (94 percent) they did appear to maintain a reality-based interaction with the on-scene officer. Given the select nature of CF incidents, it is perhaps not surprising that a substantial proportion of the subjects threatened (84 percent) or tried to use deadly force (48 percent) toward other people. Most subjects engaged in threatening (71 percent) or physical aggression (65 percent) specifically toward police officers. Subjects used or brandished a weapon in more than two thirds of the incidents (68 percent), with knives (26 percent) and handguns (23 percent) being the most common. The subject actually used or attempted to use lethal force on the officer in nearly half (48 percent) of the incidents.

An officer was injured in just over a quarter of the cases (29 percent), although the injuries were usually non-serious. In contrast, 84 percent of the subjects sustained injury during the incident – often (45 percent) from a gunshot wound.

In addition to using or threatening violence toward others, about 20 percent of the subjects explicitly threatened suicide and at least one in four (26 percent), overall, appeared intentionally to precipitate deadly force by the officer – a phenomenon that has been referred to as "suicide by cop."

Officer Behavior

Multiple officers were usually on the scene when the CF occurred (7 or more officers were present in more than half of the encounters), but the actual use of force usually involved 2 officers (42 percent), with most (58 percent) involving three or less. By definition, officers applied force in all of these encounters; however, before using force, the officer engaged or attempted to engage the subject verbally in almost every case (94 percent). About half of those verbal actions involved the officer attempting to calm or negotiate with the subject (48 percent), and the others only involved the officer issuing commands or directives (45 percent). In most circumstances, the subject did not show any marked behavioral response to the officers communications (58 percent), but in some circumstances they responded negatively (36 percent) by becoming more hostile or agitated.

Most of the incidents identified involved an application of force that required more than the use of hands to subdue the subject (84 percent) – this is likely a reflection of selecting specifically for CF classified cases. Officers applied some type of physical force in most (74 percent) cases, and an officer displayed a weapon to the subject in nearly two thirds (61 percent) of them.

Less than lethal tactical devices were used with varying degrees of success. Electronic (Taser-type) devices were employed in 4 incidents (13 percent), with uniformly ineffective results. Chemical spray (usually OC) was used in 6 cases (19 percent) and was considered ineffective two-thirds of the time (67 percent). Batons were also used in 6 cases (19 percent) although in only 1 case was it the final force than controlled the subject. Officers deployed less-than-lethal tactical weapons (e.g., bean bag guns) in about a third (36 percent) of the incidents and those devices controlled the subject about 68 percent of the time.

Officers applied lethal force (usually firearm) in about half (55 percent) of the identified cases – usually firing 5 or more shots and usually (53 percent) striking the subject no more than once. Lethal force was the final factor that controlled the subject (allowed them to be taken into custody) in a substantial proportion (82 percent or 14 of 17) of the cases in which it was applied.

Incident Outcomes

Some key factors that influenced the use of force in these incidents include whether the subject brandished a weapon, whether that weapon was pointed at an officer or other civilian, whether the subject advanced towards or attacked an officer (with or without a weapon), and whether the subject attempted to harm him/herself. In some cases, the situation appeared to be an attempted 'suicide by cop', where the subject sought the use of lethal force.[6]

Thirteen (13) subjects died during the CF incident, although not all deaths resulted from police force. In three of the 13 deaths, the subject either killed him/herself or died from another cause

[6] The index of suspicion for 'suicide by cop' was determined using cues such as statements by the subject regarding a desire to have the officer shoot him/her or that he/she wanted to die, notes from the subject found after the incident, a third party informant of suicidal behaviors, or explicit behavioral attempts to encourage an officer to shoot the subject.

(e.g., drug overdose). One death resulted from a bean bag injury and the other deaths resulted from an officer shooting. Four of the 10 incidents where the officer caused the death of the subject, a 'suicide by cop' attempt was suspected. In all cases where an officer shot the subject, the precipitating action that affected the shooting was when the subject had advanced towards an officer, civilian, or him/herself, with or without a weapon.

Limits of the Review

The results of this review should be viewed with caution and – standing alone – may have very few direct implications for policy, training, or operations. The information is illustrative and descriptive, but not necessarily predictive. In accordance with program evaluation protocol, Lodestar will defer on deriving operational implications or making any specific recommendations until the entire evaluation is complete. In the final report, that includes recommendations to LAPD, Lodestar will likely draw upon lessons learned from these CF incidents to develop specific suggestions for procedure (e.g., documentation of CF incidents) and operations.

Categorical Use of Force cases in LAPD – by definition – are unusual incidents. While useful facts or relevant information may be culled from these cases, there are also many other encounters with subjects who may have a mental illness in which lesser levels of force are employed (Non-Categorical Use of Force Cases). In many ways, these cases are more "typical," and the documentation for them is much more systematic, particularly with regard to designation of a subject's potential mental illness. While LAPD could only recall 31 CF incidents involving the target population since January 1, 1999, there are approximately 500 non-CF incidents involving subjects who may experience a mental illness. Having more cases, and a more systematic way of identifying them would likely allow for a more reliable and informative foundation for recommendations. Unfortunately, the review, coding and analysis of these Non-Categorical Use of Force cases is beyond the scope of this present study and project resources. However, a review of these cases would prove an important source of information and LAPD should consider their possible value as they make changes to comply with the Consent Decree.

APPENDIX K: Community Stakeholders Findings

Lodestar added a community research component to the study design that supplements the requirements of the RFP and contributes significantly to the overall objectives of the study. Community research was used in order to gather insight from stakeholders about police contacts with persons with a mental illness. Stakeholders identified were service providers, advocates for the mentally ill, and consumers (individuals and families). The input from these individuals and groups served to inform this study about community perceptions about police encounters with persons in crisis who may have a mental illness, and to elicit constructive suggestions that might inform training, policies and procedures.

Method

Lodestar interviewed 60 key stakeholders, which include community mental health consumers, advocates, and service providers. Interviewees were recommended by a number of sources including mental health professionals and LAPD staff, and a comprehensive list of these stakeholders was developed. This sampling procedure ensured a broad variety of constituents and experiences, but was not intended to represent any particular group or groups. Open-ended questions were used to ask interviewees' about their experience and insight into LAPD's procedures, training, policies, and the recording and tracking of police encounters with persons with a mental illness.

In addition, Lodestar gathered information regarding interviewees' experience with or knowledge of other police departments' programs and practices and first hand experience with LAPD police encounters. Interviewees provided thoughts on what types of services or referrals LAPD could provide and other recommendations for improving interactions between LAPD officers and those who may be mentally ill.

Findings

The following discussion presents themes identified through a review of responses to these key informant interviews.

Training

A majority of respondents report that an increase in training for patrol officers would be important in improving police response to persons with a mental illness. More specifically, many interviewees state that officers need more training in the identification, evaluation, and assessment of mental illness. Some respondents suggest that the involvement of service providers and mental health professionals would improve training. A few respondents recommend the involvement of consumers in basic recruit training in order to provide first-hand knowledge of the consumer's perspective when encountering police in the field.

Some respondents identified the CIT trained officers in the Central Area as an improvement and model of police behavior during encounters with persons who have a mental illness. Specific reference to leadership in the Central Area was identified as an important feature of the change seen in patrol.

Collaboration with Community

Not surprisingly, over a third of interviewees identified the desire to see the LAPD collaborate more with community agencies and stakeholders. Though many knew of the partnership between LAPD and DMH, some persons interviewed still recommended that more collaboration is needed. More specifically, they felt that partnerships with consumer advocacy groups and specialized mental health agencies across the City of Los Angeles are necessary.

Incident Tracking

Though most respondents were not aware of how the LAPD tracks encounters or how LAPD might track encounters, a quarter strongly endorsed the value of police tracking incidents with persons with a mental illness. Some identified important variables to track including: name, psychiatric history, medications, outcome, and whether a use of force was necessary. Some suggested that incident records be entered into a computer database that was available in laptops for officers. The purpose of such tracking was viewed as assisting officers in future encounters with the same individual, to help the officer to determine a more appropriate disposition. A few respondents expressed concern that records may be used inappropriately or that records should not be kept due to privacy considerations.

Expansion of SMART

A number of programs were identified as providing the appropriate response to persons with a mental illness. These programs included LAPD's SMART units and similar programs in surrounding areas including Pasadena, Long Beach, and Los Angeles County (LASD's Mental Evaluation Team). Most respondents who were familiar with SMART recommend that the program should be expanded to provide more coverage and faster response to calls. Those who identified SMART as a model program did not always identify it as a LAPD program.

APPENDIX L: Review of Training Materials

Methods

A variety of research and analytical methods was used for this Interim Report. Document reviews, interviews, observations and surveys were conducted. All documents received by Lodestar from the various divisions of LAPD were reviewed for content related to its trainings, policies and procedures relevant to persons with a mental illness.

Curricula and Evaluation Reviews

Curricula reviewed included Systemwide Mental Assessment Response Team, Basic Recruit, and the Crisis Intervention Team. Other lesson plans and written training documents for roll call trainings and continuing education purposes were reviewed. The evaluations of participants in the Basic Recruit training were analyzed.

Key Informant Interviews

Interviews were conducted with Commander Gascon of the Training Division, Lieutenant Margolis regarding the CIT Program, SMART units, MEU staff, various trainers and other training personnel. A session of the training coordinating committee was attended along with several visits to MEU and SMART offices.

Observation of Training

Three observations of Basic Recruit classes relevant to this project were made within one training cohort. Two observers attended the presentation of the training materials on the developmental disabilities section (7 hours split into two days). Using a coding form, the observers documented what was presented during this portion of the training. (See **Appendix F** for a copy of the Protocols for Los Angeles Police Department Training Evaluation). Finally, the testing portion of the role plays for recruits was evaluated by one observer. The role plays observed included a 5150 scenario, a domestic violence scenario, and a sexual assault scenario. The 5150 scenario was observed by the evaluator, four times with different recruits.

Survey of Patrol Officers

Lodestar developed a written survey for patrol officers to assess their experience and attitudes about working with those who may have a mental illness. (See **Appendix G** for a copy of the Patrol Officer Survey.

Lodestar staff administered the surveys, which contained both quantitative and qualitative questions. A total of 236 surveys were completed by patrol officers at 12 roll calls in six divisions from March 11-19, 2002. The divisions (Devonshire, Hollenbeck, Newton, Pacific, Southeast and West Los Angeles) were selected because of their geographic diversity and the differences in the number of Welfare Institution Code (WIC) 5150/attempted suicide cases handled on an annual basis. The surveys were conducted during roll calls of day, A.M. and P.M. watches.

The completed surveys were analyzed using SPSS 11.0, a statistical software package widely used in social science research. Quantitative data were examined using frequencies and cross-tabulations. Qualitative data were coded and analyzed for content.

Review Process

Documents reviewed are listed in each section. The review process included:

- Internal memos and planning documents
- Interviews of key personnel
- Analysis of curricula
- Observation, when possible
- Evaluations and comments of participants

Review of Training Efficacy

Three key elements differentiate this section:

- ***Presentation style.*** *Rather than a narration of training materials, policies and procedures, this section presents succinct, distilled findings across a wide range of documents and research activities. A significant number of documents, including curricula, reports, workbooks, evaluations, training guides, manuals, policies, bulletins, etc. were reviewed. Searching through the large volume of materials was a sifting process to identify those elements that related to encounters with individuals who may be mentally ill. While each document reviewed is identified by title, the documentation of the reviews are frequently aggregated and presented as concise findings.*

- ***Focus of expertise.*** *As stated in Lodestar's initial proposal and workplan, this report draws heavily upon the expertise and professional experience of a key team consultant. Given the specific content requirements of training related to individuals who may be mentally ill, a substantial portion of the analyses and evaluations in this report have been contributed by a team member who is a nationally renowned expert in this area and who is a training practitioner as well as an academician.*

This section of the report is a review of training documentation and courses related to police encounters with persons with a mental illness.

BASIC RECRUIT TRAINING

Basic Recruit training consists of 102 hours of human relations training. This includes 7 hours of tactical communications, 6 hours on persons with disabilities, 9 hours of scenario training and 8 hours of scenario testing. Revision of the LAPD Basic Recruit training may be hampered by the mandates and oversight of the State of California. In the past, the state has delayed reviews of revised curricula.

Review Process

Observation (Module # 37 - *Persons with Disabilities* and Scenario training)

Interviews

Review of participant evaluations (26 sets of evaluations)

Curricula reviews

Documents

Recruit Officer's Hourly Distribution Schedule (Learning Domain (LD) # 37)
Managing Contacts with Developmentally Disabled or Mentally Ill
LD # 3 Community Police Problem Solving
LD # 3 Tactical Communications
LD # 3 News Media Relations
LD # 3 Community Police Problems
LD # 4 Crisis Intervention/Victim Assistance
LD # 12 Narcotics
LD # 25 Domestic Violence
LD # 27 Missing Persons
LD # 30 Primary Investigation Child Abuse
LD # 30 Rape
LD # 31 Custody
LD # 32 Stress Management
LD # 34 First Aid & CPR
LD # 37 Persons with Disabilities with Instructor Unit Guide
LD # 42 Cultural Diversity
LD # 42 Hate Crimes
LD # 42 Sexual Harassment
FATS Scenario Report
POST Basic Course Instructor Guide
Basic Course Workbook Series
Police Contacts with Mentally Disabled Persons - Update 5/2/01
Scenario 2, 415 Man, Possible 5150 (Tactics Training Unit) - 11/17/00

Identified Strengths

Recognizing Mental Illness

The training curriculum provided definitions of mental disorder, thought disorder, and mood disorder. The curriculum highlighted behavioral cues for each defined category. Situational stressors were reviewed, but the focus was on post partum psychosis, with an example given. Clear definitions and behavioral indicators were given for 3 major categories of mental illness (schizophrenia, major depression, and bipolar disorder).

Risk Potential

The curriculum provided information on risk potential, violence, and mental illness. The course also provided information on symptoms of various mental illnesses that are most concerning, but did not link symptoms with specific illness (i.e., "suicide should always be taken seriously.") The training provides examples of persons presenting a danger to themselves, to others, and persons who are "gravely disabled."

Mental Health Related Laws and Client Rights

The curriculum provided information on Lanterman-Petris-Short Act, Welfare and Institutions Code 5150, and police duties under the Americans with Disabilities Act. It reviews extensively the rights and entitlements of developmentally disabled and persons with a mental illness. There is brief mention of police protective custody options. It provides a listing of designated facilities for 5150 code action, and defines developmentally disabled, mental retardation, and mental illness according to California law.

Intervention Strategies

The curriculum presents information on field contacts with persons with a mental disorder, focusing on verbal and nonverbal intervention strategies. Main points of intervention include: request backup, calm the situation, move slowly, communicate, make no threats, and be truthful. There is mention of evaluating for medical attention, detainment for mental evaluation and treatment, and referral and arrest options. Officer safety is emphasized extensively. It also provides in-depth information on various psychoactive drugs of abuse.

Scenario Training

The scenario training includes vignettes of persons with a mental illness and suicidal individuals. Several new vignettes have been developed in the past two years. There are two specific scenarios focusing on encounters with persons with mental illnesses. These are incorporated in the basic recruit training during tactical application portions of the curricula.

Areas to Consider for Improvement

The above listing of strengths respects the inclusion of mental illness related issues in the curriculum. However, it is noted that the total amount of training that gives attention to mental illness is only a small portion of the 6-hour training related to persons with disabilities. The 6-hours include and focuses heavily on Developmental Disabilities, Cerebral Palsy, Epilepsy, Deafness, Visual-Impairment, etc.

The majority of training is didactic and does not use principles of adult learning. In the didactic portion of the basic recruit training; there is both a lack of detail and lack of step-by-step strategies. For example, the definitions for mental illness diagnoses are not paired with the assessment/investigative process.

Recognizing Mental Illness

The curriculum did not include information on conducting a "mini" mental status examination including orientation to person, place and time. The information presented mostly focused on developmentally disabled, mental retardation, and hearing impaired.

Risk Potential

There is little in the lesson plans on assessment or the demographic and clinical factors of suicide and violence risk. Also, there was no identified area in the curriculum discussing the issue of "Suicide by Cop." Although there was moderate mention of assessing the degree of lethality of suicidal behavior, there was no mention on what to ask and what to observe to adequately assess risk potential or skills for suicide crisis intervention.

Medical Conditions and Psychiatric Medications

One example was given in the curriculum on medical conditions that mimic or mask symptoms of a mental illness in the Developmental Disabilities module. No information on physical symptoms that may indicate a medical emergency or examples of conditions considered medical emergencies. Categories of updated psychiatric medications were not provided. There is some information presented in the First Aid/CPR module, but according to Basic Recruit personnel, it is minimally covered.

Substance Abuse

While there was moderate mention of symptoms describing alcohol or drug intoxication, which are similar to symptoms of a mental illness, there was no mention of the effect of drugs and alcohol on symptoms of mental illness. There was no information presented on current problem drugs in the community. No information presented on dually diagnosed persons (persons with a mental illness and a substance abuse problem). According to Training personnel, a handout on substance abuse is being developed at this time.

Mental Health Related Laws and Client Rights

While the training did provide ADA guidelines, involuntary commitment laws/protective custody procedures for officers, there was no information on mental health court system, or the officer's role in such a system. In Module #37, there was no information presented on interviewing suspects taken into custody who may have symptoms of a mental illness or on police responsibilities for persons who may have a mental illness, are taken into protective custody, and have committed a crime (misdemeanor versus felony). These topics are covered minimally in a separate module (POST LD #30 Interrogation) as reported by Basic Recruit staff. These principles should be integrated into Basic Recruit Training in Module #37 to reinforce specific procedures relevant to persons with a mental illness.

Intervention Strategies

In tactics training *Scenario 2 415 Man, Possible 5150* (Developed: November 17, 2000) an intervention strategy is discussed without any consideration of officer safety. In the Tactical Considerations the "drawing their weapons" is emphasized. In the Department Policies section, the statement indicates "Department policy mandates officers make an arrest for 243E". This

would be questionable with this scenario. Additionally, the specific language of the training material raises additional concern:

> "Department policy mandates that officers make an arrest for 243E, Battery, when it occurred in a domestic violence incident and…….blah blah blah."

The meaning of "blah blah blah" is open to interpretation (at best), and, at worse, misinterpretation. Because the meaning is unknown, there exists the potential for a highly negative interpretation. Scenario training of this quality is a major problem that needs to be addressed with the training program.

There was no information presented on community policing resources, use of specialized police units, or medical transport procedures.

Community Resources

Although there was a listing of receiving facilities in the area, there was no information presented on other support services in the community, how to access and refer persons to those services, or how those services relate to law enforcement.

Consumer, Advocate, Family Involvement and Awareness

There is limited active involvement of family, consumer, or advocates in basic recruit training. A video shown during basic recruit training involved personal accounts of parents' encounters of police with their mentally ill children. Information about stigma and mental illness was limited to the video.

Observation of Basic Recruit Training

The instructors encouraged participation of the recruits by asking them to give personal experiences. Instructors moved very quickly through the lesson plan and hit only every other bullet point. Much of the material was read, and few details or examples were given. Instructors were knowledgeable of the material but do not have an in-depth understanding of the material as evidenced by their inability to answer more complex recruit questions. Major topics were related to persons with developmental disabilities with only a few to mental illnesses.

Three very good videos were utilized in Part II. These included definitions and experiences of persons with mental illnesses. A handout was used to introduce tactics including 5150 and the Lanterman-Petris-Short Act. Policies were discussed including use of MEU and SMART. Again, many of the procedures were read to the audience. Postpartum Psychosis received the most extensive written attention. A handout titled "Tactical Considerations when Dealing with Persons with Mental Disorders" covers many good points but is judged to be far from adequate to direct officers through the process of rapport building, communication, assessment, and disposition.

Observation of Scenario Training

Observers intended to observe scenario training for Module #37, but the class did not have enough time. Observers were instructed to return at a later date when more observations could be made. This later date was the day scheduled for testing rather than training scenarios. These three testing scenario evaluation activities that were directly or somewhat related to the topic of mental illness were observed by Lodestar staff. The scenarios were 5150, Domestic Violence, and Sexual Assault. The patrol officers observed performed acquired well with communications and tactics. It appeared that the recruit officers had skills in these areas.

Review of Participant Evaluations

The evaluations from 26 presentations on the topic of Persons with Disabilities were reviewed and analyzed. Presentations were part of a larger training done with LAPD recruit classes. The 26 sets of evaluations are taken from recruit classes beginning in Jan. 1999 through July 2001. Each evaluation set included evaluations written by 19 - 40 training participants.

Out of the 13 sets of evaluations completed in 1999, nine received an overall above average rating and 4 received an overall excellent rating. Comments primarily focused on the participants' opinions of the instructors, their teaching styles, knowledge of the topic, and delivery of necessary procedural information. These comments included both negative and positive perspectives.

Out of the 9 sets of evaluations during classes held in 2000, 6 received an overall rating of excellent with only 3 sets receiving an overall rating of above average. The focus of the comments included not only opinions of the instructors, but also comments that reflected a more in-depth understanding of the topic and how it will impact their experience in the field. An example of such a comment was, "Instructors were very clear and helped me understand how important it is to be able to communicate with someone with a disability because you may not understand why someone is not following your commands”. It was also evident the some of the classes included guest speakers with disabilities and these evaluations reflected very positive responses to these guest speakers.

Out of the 4 sets of evaluations completed during classes held in 2001, all 4 received an overall rating of excellent. Initial evaluations reflected presentations that did not present material in an informative or useful way. Currently participants felt that presentations were highly informative and useful, and included a variety of methods for delivering information such as the use of, role playing, and direct instruction on how to follow procedures. One set of evaluations included positive responses to guest speakers. Basic Recruit personnel clarified that guest speakers are not used in training, and the guest speakers perceived by recruits were auditors from ADA, BSS, and MEU. What is not clearly reflected in evaluations is the actual information delivered. It is difficult to determine the focus of presentations being evaluated but appeared more related to Developmental Disabilities than Mental Illnesses.

ROLL CALL TRAINING

Review Process

Documents

Topic Schedule

Roll Call Lesson Plans

- *Persons With Developmental Disabilities (Deployment Period # 6-01)*
- *Law Enforcement Response to Mental Illness (Deployment Period # 4-01)*
- *Mental Illness - 5150 Detention (Deployment Period #11-98)*

Identified Strengths

The Roll Call Lesson Plans are reflective of the identified topics and subjects. The plans give descriptions of persons with developmental disabilities and persons with mental illness. In addition, the lesson plans describe the symptoms of both developmental disabilities and mental illness thoroughly. In one of the lesson plans reviewed the officers are introduced to the Welfare and Institutions Code (WIC) 5150 regarding the detainment of a person who is displaying symptoms of mental illness for transportation to a mental health facility for 72 hours for evaluation. The lesson plans were excellent in regards to the psychiatric resource centers available.

The Training Bulletin # 9 "Effective Encounters with Mentally Ill Persons" (which may be used for some roll call trainings) is an excellent training document. This training includes information on mental illness, on-scene assessment, protecting civil rights, and disposition.

The Lesson Plan for Standardized Roll Call Training Program - *Persons with Developmental Disabilities* provides good guidelines for "What Should the Officers Do" and "What Actions Should the Officers Consider". This plan only refers to developmental disabilities but has relevance to mental illness.

Several new scenario training lesson plans have been developed for roll call training. These include “415 man with a knife”, suicide by cop (2), non lethal force (2), and “5-step hard style”. These modules are far superior to previously reviewed training documents.

Areas to Consider for Improvement

The Standardized Roll Call Training Program lesson plans touch on a wide range of topics. There have been three topics that deal directly with persons with mental illness, and three that deal with persons with developmental disabilities. Additional lesson plans that introduce the officers to more mental illness diagnoses such as Substance-Induced Psychotic Disorder and Personality Disorder that can be discussed with the major mental illness diagnoses would be helpful for officers.

Data from Los Angeles Police Human Relations Training Unit show a considerable amount of inconsistencies of the scheduling of training that deal with developmental disabilities, and

mental illness. The lesson plan *Law Enforcement Response to Mental Illness* was offered for the first and only time, in year 2001. *Mental Illness and 5150 WIC Holds (Detention)* has not been offered for at least three years.

Regretfully, roll call training such as *Law Enforcement Response to Mental Illness* has little training value, since it only provides information without application. Second, the presentation of concepts is very difficult during roll call. The officer in charge of roll call usually provides roll call training. He/she reads the training handout to officers, or runs the video. The need for a critical review of roll call training was called for in the Board of Inquiry Final Report. Roll call may be better utilized for modules on topics like WIC 5150.

Lesson plans for new scenario training demonstrates attention to past training deficits. The scenarios however need review from outside experts as to how they may be applied to persons with a mental illness. For example, the "5-step hard style" may not be the best tactics with persons with a mental illness.

CONTINUING EDUCATION/ IN-SERVICES/ REVIEWS, UPDATES, RECERTIFICATION

Little information was received on any continuing education related to mental illness. Most continuing education seems to be allocated to roll call training. In the past five years the following topics were listed that have some relevance:

- 5150 WIC
- Alzheimer's
- Interacting with Disabled
- Seizures and Epilepsy
- Suicide by Cop
- Police Contacts with Mentally Disabled Persons - Update

Much of the following review is based on a historical review of training. It is understood that the curricula and policies for continuing education have been revised, i.e. Continuing Education Delivery Plan (CEDP). The plan called for a mandatory training for lieutenants and below. This training is to be offered every two years, which includes five 8-hour modules. Twenty-four hours of the training is focused on "perishable skills" mandated by POST. Topics include arrest and control, force options, driving skills and tactical communications. The CEDP Module 1 Field Officer Update, provided in Spring 2001, was reviewed as an example of this new initiative.

Review Process

Documents

Suicide by Cop

(Note: used for SWAT but unclear how many patrol officers received this training).

Police Contacts with Mentally Disabled Persons – Update

CEDP Module 1, Field Officer Update

CEDP information - miscellaneous

Identified Strengths

Internal communication of May 2, 2001, *Police Contacts with Mentally Disabled Persons – Update*, indicated a number of training videotapes, manuals, and handouts that have been/were being developed for use in on-going continuing education training regarding bulletin subject.

"Suicide by Cop" training material (3 presentations)

- Subject matter handouts related to teleconferences of July 22 and August 26, 1999. Handout material was thorough and specific to subject matter of "suicide by cop".

- Subject material handout/overhead presentation "thumbnail sketches" of FBI Suicide and Law Enforcement Conference of September 21 – 23, 1999. Thorough, though somewhat clinically oriented material.

CEDP Module 1, Field Officer Update

New curriculum is problem-based in format rather than didactic. Probationary patrol officers must be able to demonstrate competency in each of 36 topics with field-testing on seven major categories. One category emphasizes encounters with persons with a mental illness.

Mental Health Related Laws and Client Rights

There is an extensive review of federal, state laws (4th amendment, 5150 WIC). The curriculum asks participants to understand the intent of the laws, and when these laws come into effect (5150). It reviews procedures for persons who meet criteria for 5150 and have committed crimes, and focuses on violation of 4th amendment rights by officers responding to persons confronted by officers.

Recognizing Mental Illness

A brief scenario/video summary presents a person presenting symptoms of a mental illness in a situation with other citizens involved. The officer is asked to investigate, interact, identify possible symptoms, and bring closure to the situation. Review of 5150 criteria, 4th amendment considerations, and crimes committed.

Training Methods

There is extensive use of teaching skills/tools to facilitate adult learning. Video clips of scenarios, interactive exercises, debriefing, quizzes, and game type activities were incorporated into training (Pursuit policy/Jeopardy game). The method for evaluating the retention of information was included in each.

Intervention Strategies

The curriculum identified information presenting options for the officer: SMART team, 5150 options, verbal de-escalation, and disposition options.

Areas to Consider for Improvement

It is important to establish and maintain files for each scheduled continuing education training, containing agendas, study guides, handouts, videotapes and student evaluations.

Consumers and family members of persons with a mental illness are not represented in planning.

According to personnel from Continuing Education, all material is reviewed each year; however, documents reviewed suggest there is an absence of annual updates. Material such as, "Police Contacts with Mentally Disabled" should be mandatory for all personnel annually. Notes indicate that "Generally, divisional training days have been discontinued for the foreseeable future" (internal Training Evaluation, 4/24/2001). Though there were no documents stating such, staff within Continuing Education state that divisional training will still be provided based on need, but that none have been scheduled at this time.

A module dedicated to addressing persons with a mental illness (e.g., Module 1) has not been offered for two years and may not again for several years. Considering the turnover of officers, the adequacy of this plan should be addressed.

CEDP Module 1, Field Officer Update

Risk Potential

No information was presented on assessing risk potential for self-harm or violence to others. This could be reviewed during the probationary period and practiced through the use of dramatizations, role-play, or video scenarios. (Note: BSS has provided documentation of a two-hour training in sergeant's school on risk awareness and prevention. The material is very well developed and can be used in various divisions).

Psychiatric Medications/Medical Conditions

There was no information on psychiatric medications, side effects, therapeutic effects, or categories of medication.

Community Resources

There was no information presented on community resources for persons with mental illness. An experienced Field Officer with knowledge of community resources would be ideal for mentoring basic recruits in the field.

Consumer/Advocate Involvement

There is no identified involvement of consumers or advocates. The family perspective is not included in the training. During the probationary period, the perspectives of the family, consumers, and advocates would be valuable in assisting the recruit in understanding how the public views their duties and responsibilities.

TRAINING BULLETINS OR OTHER WRITTEN COMMUNIQUÉS

Review Process

Documents

Bulletins

2001 Index of Valid Training Bulletins
Effective Encounters with Mentally Ill Persons
Verbal Tactics
Handling Disabled Persons in Arrest Situations
Overcoming Language Barriers
Weapons Other Than Firearms
Phencyclidine
In-Custody Deaths
Use of Force - Restraining Procedures and Devices
Use of Force - The "Team Take-Down"
Use of Force - Taser Model TE-93
Use of Force - Chemical Agent Control Devices "Oleoresin Capsicum"
Arrest and Control Part I - Introduction
Arrest and Control Part II - Joint Locks
Arrest and Control Part III - Distraction Strikes, Evading and Blocking Techniques
Arrest and Control Part IV - Takedowns
Arrest and Control Part V - Ground Control and Weapon Retention
Personal Searches Part III - "High-Risk Prone Search"
Printed articles, internal communications

Bulletins are provided to all personnel with documentation of receipt on Form 1.42.0. The employee is responsible to know the content.

Identified Strengths

Bulletins are disseminated to officers as an educational tool and are sometimes used in conjunction with roll call.

The department has addressed the need to change context of wording in training titles when advertising officers' interactions with persons that may have a mental illness i.e. "Handling the Mentally Ill" to "Effective Encounters with Mentally Ill Persons".

Communiqués discourage language describing persons as "psycho," "mental," "schizo" and other negative terminology.

More recently published Bulletins, for example *Effective Encounters with Mentally Ill Persons* (December, 2000), is well written with both information and points to remember. *Weapons Other Than Firearms (*January, 2002) does an excellent job of incorporating issues of mental illness in a more generally applicable training topic.

The involvement of the Police Chief in the approval of training is evident.

The BEAT newsletter is a good communication tool.

Areas to Consider for Improvement

Unfortunately, *Bulletins* only reflect one article discussing mental illness in the period from 1977 to 2001. As Bulletins are reissued, inclusion of material on mental illness could be included in general training topics as it has been in *Weapons Other Than Firearms.*

Use of Force Handbook indicates verbal de-escalation as the first intervention step. Additional attention to this important first step is essential.

FIELD TRAINING OFFICERS

The Manual and training curricula is focused on the preparation and field-testing of the probationary officer. There is no mention as to how the Field Training Officers (FTO) receive their training. One reference was found indicating a 4-hour block on Human Relations Field Applications for Supervisors (sergeants).

Review Process

Documents

Field Training Manual

Sufficient material was not available to draw conclusions about the curricula or process used to train field officers.

SPECIFIC DIVISION OR PROJECT TRAININGS

Jail/Correctional Officers

Review Process

Documents

Jail Operations Manual
Department Manual - Section 4/260
Detention Officer Core Course
Occupational Health and Safety Division - Developmentally/mentally disabled arrestees
Jail Division Roll Call Training Calendar
Course Outline - Unit 14

Identified Strengths

The Jail Operations Manual Policies 205.03 and 205.6 give a brief description of what the responsibility of the Jail Supervisor is when a person with a mental illness is detained for a criminal offense. The manual continues with policies that address special confinement, safety in the cell and the removal of articles and clothing.

The Occupational Health and Safety Division of Los Angeles Procedures Manual contains detail about evaluation and monitoring people with developmental disabilities. The manual also provides the criteria for identifying people with a developmental disability, having a physician or nurse available to evaluate the arrestees, making sure the person understands the implication of his/her arrest, and having a legal guardian present to ensure the proper legal procedures are followed.

Lesson Plan for Unit 14 of the Standards and Training for Corrections provides training on risk factors, report writing, substance use assessment, legal issues, mental health issues, and medical issues.

Information provided by BSS indicates they provide an annual class on suicide prevention for the jail division.

It is understood that Jail Division training is provided by the Sheriff's Office. At least one training day per year is for new employees with a focus on mental illness.

Areas to Consider for Improvement

Both the Jail Operation Manual and the Occupational Health and Safety Division Manual address the procedures and criteria for the detainment of persons with developmental disabilities; there should be additional resources that address people with Mental Illness.

The lesson plan addresses common symptoms and diagnoses of mental illness; however, the curriculum could be strengthened with more information about how to assess or intervene. For example, topics that may need expansion include: medical problems that mimic mental illness, side effects of medications, self-damaging behaviors, determination of transfer need and special housing.

Communication Center

Review Process

Documents

Mentally Disabled Evaluation of a Caller - Fact Sheet
Roll Call Training - Lesson Plan - Section 5/130.1

Identified Strengths

The Communications Division is commended for their revision of the policy manual and roll call training relevant to calls from persons with a possible mental illness.

Intervention Strategies

The roll call training provides a strategy for obtaining information important for officers responding to a call. It also reviews how to determine if a call should be transferred to a non-emergency operator where more time can be spent ascertaining the nature of the call.

Risk Potential for Self-harm or Violence

The curriculum includes a definition of a person with a mental illness that meets the criteria for an involuntary psychiatric hold under Section 5150 of the Welfare and Institutions Code. This definition clearly states that 5150 criteria include: the suspect is a danger to others, has harmed, attacked, or threatened others, is a danger to self, has threatened to inflict harm to self or gravely disabled. It also gives the definition of gravely disabled.

Mental Health Related Laws and Client Rights

The training defines WIC 5150, and the duties of the police service representative (PSR).

Medical Conditions

The training prompts trainers to remind PSR that physical disabilities, illnesses, or emotional distress may cause a person to sound as if they are mentally disabled or under the influence of alcohol or narcotics.

Areas to Consider for Improvement

Intervention Strategies

The training does not include verbal de-escalation techniques to assist PSR with agitated mentally disabled/gravely-disabled caller. Includes prompts for information that might indicate the person may have a mental illness such as medication or service utilization.

Risk Assessment

Information submitted by BSS shows 2-hour mandatory training on suicide intervention.

Crisis Intervention Team

Review Process

Documents

Crisis Intervention Team Pilot Program Evaluation
CIT Training Curriculum and related documents
CIT Training Curriculum - revised 12/14/01

Identified Strengths

The revised *CIT Training Curriculum* was reviewed and compared to similar programs throughout the country. The quality is outstanding and makes improvement on the training offered in other model CIT programs.

Outstanding Curricula Development in Pilot Project

The revisions address many of the deficits found in the first round of training. For example, the revised training included increased attention and involvement of community agencies in the training (# 1 in Identified Areas for Improvement), increased attention to medical and substance use impact (# 2 in Identified Areas for Improvement), and increased attention to verbal de-escalation and tactical strategies.

Recognizing Mental Illness

The curriculum extensively identifies categories, definitions, and examples of the major mental illnesses. Included is information on teaching officers on the recognition of symptoms and terminology used by the behavioral healthcare community.

Risk Potential for Self-harm or Violence to Others

The curriculum addresses risk potential for violence, and the issue of violence and mental illness. The curriculum extensively addresses the issue of "Suicide by Cop," gives information on assessing suicide potential, clinical factors of suicide, and presents strategies for suicide crisis intervention.

Medical Conditions and Psychiatric Medication

The curriculum has information on conditions that are medical emergencies, and clues to medical emergencies. There is clear and extensive information on psychiatric medications, including updated information, therapeutic/side effects of medication, and examples of medications from each category. The training also used a physician to co-train with an officer.

Substance Abuse

The information presented in the CIT curriculum is extensive. Various categories of substances and their effects on the body are presented (CNS depressants, inhalants, cannabis, PCP, CNS stimulants, narcotic analgesics, etc.). The curriculum also reviews current problem drugs in the community (Ecstasy, LSD, "cocktailing").

Mental Health Related Laws and Client Rights

There is a strong emphasis on the rights of persons confronted by officers in crisis situations. The curriculum reviews pertinent state and local laws on protective custody, and non-custody options. There is clear information presented on the disposition of persons who are taken into protective custody and have committed a crime (misdemeanor/felony).

Intervention Strategies

The CIT training presents extensive information on use of force tactics/policies and crisis intervention strategies. The curriculum reviews less-lethal tactics (verbalization, Taser, swarm techniques, takedowns, beanbag, 37 mm) to the use of deadly force (use of force spectrum). The crisis communication training section reviews goals of crisis intervention, defines the stages of a crisis, and recommended strategies of intervention for each crisis stage. Active listening

skills and being "fluid" and "adapting" to the situation is reviewed. Officer safety is extensively emphasized.

Community Resources

Additional and updated listing of social service or community support agencies could be enhanced. According to the CIT coordinator, it is difficult to identify the agency that might meet the needs of the subject. Agencies in the Central Area often restrict access to services making many referrals useless for the officer and the subject. Field trips to agencies may be valuable.

Areas to Consider for Improvement

Community Resources

Additional and updated listing of social service or community support agencies could be enhanced. Field trips to agencies may be valuable.

Consumer, Advocate, and Family Involvement

Although there were representatives from Los Angeles Men's Place (LAMP) and the Midnight Mission to relate experiences of homelessness to officers, the training experience would be enhanced with the perspectives of persons with a mental illness who have had contact with law enforcement during crisis situations.

Systemwide Mental Assessment Response Team (SMART)

Review Process

Documents

SMART Guidelines
SMART Operations Manual
SMART Training Curricula and miscellaneous documents
SMART Guidelines for Field Units

Identified Strengths

Recognizing Mental Illness

The SMART curriculum extensively provides definitions of mental illnesses, symptoms, and categories. The program provides training and information on making "mini" mental status examinations (person, place, time, naming 3 objects, memory recall). There is information on conditions that mimic or mask symptoms of a mental illness (psychiatric/psychological masquerade). The information in the curriculum is in-depth and extensive. The curriculum also provides extensive information on elderly persons who may have a mental illness and conditions related to the geriatric population.

Risk Potential for Self-harm or Violence to Others

There is an extensive amount of information on suicide dynamics and assessment, as well as assessment information for potential violence. There is detailed information on strategies for suicide crisis intervention. There is a module and extensive information presented on school violence (signs, assessment, types).

Medical Conditions and Psychiatric Medications

The curriculum provides detailed information on medications, categories, side effects and therapeutic effects. A listing of current medications is also provided. A psychiatric medication module was instructed by a mental health professional.

Substance Abuse

The curriculum provides extensive information on current street drugs and problem drugs in the community. It also presents information on a dual diagnosis model. The curriculum provides detailed information on various categories of drugs, examples of each category, and general indicators of use for each category.

Mental Health Related Laws and Client Rights

There is a module in the training presenting information on the Mental Health Court program, and how the program works (diversion/collaboration between mental health professionals and defense attorneys). Non-custodial and protective custody options are reviewed, as well as a module on legal implications.

Intervention Strategies

The SMART training provides extensive information on intervention strategies, use of force policy review, and establishing rapport with persons in crisis. There is information presented on de-escalation guidelines and verbal intervention strategies. There is a review of resources available to the SMART team, including hospitals, and transport information.

Community Resources

The training provides information on hospitals and bed space in the Los Angeles area.

Areas to Consider for Improvement

Community Resources

The curriculum does not provide information on social service agencies in the community. Additional training in available resources and how to access them may be useful.

Consumer, Advocate, and Family Involvement

There are no segments in the training with views and perspectives from families of persons with a mental illness, community advocates, or consumers. There is no mention of officers visiting drop-in centers or treatment centers.

Mental Evaluation Unit (MEU)

Review Process

Documents

Duties and Responsibilities of the MEU
MEU Unit Reports
MEU Dispatch and Daily Logs
Expansion of Duties of the Mental Evaluation Unit and Establishment of Psychiatric Emergency Coordinating Committee

Comments

Review of these documents in combination with Los Angeles Police Department Policy Manual, SMART Operations provided information about the operation of the MEU Unit, but no documents were reviewed that indicated that the detectives in that unit received any mental health training.

SPECIAL TOPICS

FIREARM TRAINING – Non-lethal and Less-than-lethal Weapons

Review Process

Documents

Various curricula related to firearms, not-lethal and less-than-lethal weapons.
FATS Scenario Report by Type of Training

Identified Strengths

Various references are made to firearms training in the use of Bean Bag Shotguns, Oleoresin Capsicum Sprays, Tasers, Collapsible Batons, and 37 MM Munitions. Several of these are clearly included in Basic Recruit and recertification trainings but others are listed as available through video training or curricula offered through DOJ, CSTI, and POST.

Areas to Consider for Improvement

It is unclear as to extent of the initial and recertification training requirements in the use of these weapons. The importance of training in the use of these products is essential if available to the officers in the discharge of their duties. However, it is some concern when reviewing

recommendations following Use of Force Incidents, or more general recommendations for enhanced training, that weapons training is presented as the first, and sometimes only, option.

Only 5 of 125 scenarios are WIC 5150 or suicide related scenarios.

CRISIS RESPONSE TEAM PROGRAM (CRTP)

Review Process

Document

CRTP information on the web

Comments

There is insufficient information to review and the CRTP program is not central to this report. It is noted however that this volunteer unit responds to emotional and mental health crises. The training information that was reviewed appeared appropriate.

Review of the Planning and Evaluating Process for Training

Review Process

Analysis of available internal documents and planning committee reports of the Professional Advisory Committee (PAC).

Identified Strengths

Recent efforts of Department-wide planning have resulted in a better understanding of the systems issues. There is recognition that training has often been sporadic in scheduling and consistency among divisions and bureaus are often limited. The PAC also recognizes the operational impact of one division on the overall performance of the Department. For example, if Communications staff is not trained, the patrol officer may not have the information needed prior to arriving on the scene.

There is also evidence of the need to revise training to be more problem-based and to evaluate the officer's ability to respond appropriately.

Areas to Consider for Improvement

There is little input from the community in the planning and evaluating process for training. Community agencies, consumers, and family members should be involved in all aspects of the revamping of training. This does not mean the development of curricula, but advice on how training can be enhanced. Stakeholder perspective is important for revising the curriculum as well as valuable for public relations and communication.

There is a lack of support for new training efforts across programs, as evidenced by the comments in the CIT pilot report. Units such as the Behavioral Science Section should have an important role in at least the planning if not the delivery of training. The Training Division as a whole seems isolated from training activities in many divisions and units (e.g., SMART and MEU).

Limited cross training occurs. MEU, Field Training Officers, SMART, and CIT need to coordinate and share training responsibilities.

Minimal databases and MIS systems are in place. A database on community resources needs expansion and updating. A database of all MEU, SMART, and CIT responses need to be maintained and available to each of these groups.

Review of the Departmental Policies and Procedures Related to Training

Review Process

Analysis of the State of California and Department codes, policies and procedures regarding training.

Analysis of Department policies and procedures to determine if training content is consistent.

Documents

- *Report submitted to Commissioners (120 day work plan) 5/2/01*
- *Fact Sheet (8/23/99) to coordinate with LASD*
- *Department Review of Training and Procedures (4/24/2001)*
  - *120-Day Work Plan Update*
  - *Data Collections - Researching Police Programs*
  - *Review of Telecourse*
  - *Miscellaneous internal memos*
  - *Timeline for Training and Policy Review*
  - *Motions of the Board of Police Commissioners*
  - *Miscellaneous reports regarding Margaret Mitchell Officer Involved Shooting*
  - *Meeting with National Alliance for the Mentally Ill*
  - *Field Problems and Firearms Training Simulator - Tactical Communications*
  - *Tactics with Weapons*
  - *Executive Summary*

Training Policies Related to Persons with Mental Illnesses

Recruit Officer's Training Schedule (although not policies and procedures, this training schedule addresses some of the issues about basic recruit training).

Six hours of training is provided relevant to persons with mental illness. This includes a very broad area of topics including legal issues, didactic training on behavioral health disorders, and tactical considerations. Other disabilities including Hearing and Visually Impairment are covered in this limited time frame.

> **Comments**
> Little detail is provided in this schedule as to what is covered in the training curriculum or the training methodology. Included in this training is state POST mandated modules.

Commission on Peace Officer Standards and Training: Minimum Standards for Mental Illness and Developmental Disabilities (November, 2001).

Regulatory minimum standards for training on developmental disabilities and mental illness.

> **Comments**
> State requirements for basic recruit training in mental illnesses are considered weak, at best. Content is broad and often seems perfunctory by using didactic methods solely to teach basic terminology.

Department Review of Training and Procedures (including numerous supporting documents). Internal process of review in 2001.

> **Comments**
> Documents indicate an excellent "first step" in the revision of curricula, training approaches, and training importance for the Department. Description of tasks in that internal study is consistent with many of our findings. In the Update of May 2, 2001, nearly all of the 23 tasks were completed (with 3 eliminated).
>
> The findings to-date of this review however does not see major impact of these recommendations on the actual culture or training practices of the Department. The pilot CIT program in Central Bureau not only is bringing about positive changes in the Central Bureau but also is beginning to see generalization beyond its own boundaries.
>
> Other strategies for the revision of curricula, preparation of vignettes, and coordinated planning have yet to make significant impact. The revisions are valuable.

General Policies Related to Persons with Mental Illnesses

Review Process

Documents

Manual of the Los Angeles Police Department (attention to Sections 217 - 217.50, 258.17 - 262.90, 275.40 - 279, 640, 647, 840.50)

Welfare and Institution Code (attention to Section 510 - 5157)
Special Order # 27 "Investigating and Adjudicating Non-Categorical Use of Force Incidents"
Apprehension and Transportation Order
LAPD Arrestee Medical Screening Form
Application for 72-Hour Detention
Implementation of the Los Angeles Police Department/Los Angeles Unified School District Mental Health Referral Program
Communication Division Manual Section 5/130.1 Re: Mentally Disabled
Use of Force Handbook (August, 1995)

Manual of the Los Angeles Police Department

Major provisions address:

Role and duties of Detective Services Group including Mental Evaluation, System-wide Mental Assessment Response Team, Los Angeles County – USC Medical Center Services, Field Investigations, Logs and Files, Special Liaison, Mentally Ill Persons, Mental Evaluation Reporting Procedures, Firearms in Possession of Mentally Disordered Persons, and Transportation.

Highlighted structure and functions established: Detective Headquarters Division is responsible for conducting preliminary investigations of persons suspected of having a mental illness or other behavioral health condition. Additionally they are responsible to serve as liaison to the mental health system, and advise patrol officers. The policy also outlines duties to maintain data, review cases, and follow-up.

Detective Headquarters Division assists in field officer response to persons in crises who may have a mental illness. They provide intervention, referral, or placement allowing field offers to quickly return to other field duties.

The LAPD manual specifies duties and responsibilities of the Mental Evaluation Unit of the Detective Headquarters Division including the dispatch of the SMART personnel. The MEU is to be contacted prior to taking an apparently mentally ill person into custody.

Transportation policies indicate that a person may be transported by the officer or the officer may call for an ambulance transport when individual is violent and requires restraint or is injured or physically ill and is in need of immediate medical attention. Ambulance requests are made through the MEU.

The MEU is responsible to handle all transportation orders of the State Department of Mental Hygiene.

Comments

The manual establishes duties and responsibilities for Detective Division including the MEU and SMART operations. No criteria or guidelines are provided as to how the tasks are to be performed. The manual appears to not address officer's discretion regarding use of Institutional and Welfare codes, the handling of minor misdemeanors when the individual is in need of treatment, or policies and procedures related to interactions with persons with a mental illness.

These sections do not address training of officers regarding ADA, mental illness or other behavioral healthcare issues.

It is understood that department policy manuals establish the framework with operational manuals providing more details. However, the Manual seems to leave too many gaps that are factual only by the history of the Department's structure and operation.

Welfare and Institutions Code Section 5150-5157

This California Administrative Code provides criteria and procedure for a peace officer's action of placing an individual in protective custody for evaluation. The officer is provided some guidance on probable cause to take the individual into custody. Section 5150 specifies the information required on an emergency order for custody by a peace officer.

Comments

California law criteria for protective custody follows a widely accepted definition of 1) danger to self, 2) danger to others, or 3) gravely disabled due to a mental disorder. It allows designated authorities including police officers to take an individual into protective custody and deliver that person to a designated evaluation facility upon probable cause. Code states information that must be provided to the individual orally.

Duties and Responsibilities of the Mental Evaluation Unit

Duties identified in the MEU manual cover four major areas: 1) record keeping, 2) roles of MEU in preliminary intervention, 3) monitoring of persons with a mental illness on parole, Conditional Release Program, and elopements, and 4) providing liaison with both internal and external agencies.

Policies relevant to MEU procedures are described in the manual. Policies include:

- Lanterman-Petris-Short Act – Guidelines for "probable cause to believe a person qualifies under one or more of the following categories for WIC: danger to others, danger to self, and gravely disabled."

- Use of Mental Status Evaluation Questions (Assessment)
- Mentally disordered persons who are usually not eligible for 5150 WIC
- Custody of Mentally Disordered Persons
- Mentally Disordered Persons in Hospitals
- Persons with a mental illness in Private Residences or Board and Care Facilities
- Apprehension and Transportation Order
- Procedures for Taking a MDP Juvenile Into Custody
- Section 8102 WIC
- Attempt Suicide Investigation
- Sexual Assault Investigation
- Officers Assisting the Los Angeles Fire Department, RA Units with Patient Transportation

Comments
This manual provides expanded details as to practices and procedures as outlined in the Los Angeles Police Department Manual. Topics are well explained and clearly understood.

SMART Operations Handbook (May, 1997) and Operations Manual (no date)

This handbook provides a general framework and organization for the SMART program. The same material in greater detail and additional information is found in the SMART Operations Manual. Policies and procedures are included to guide the work of the SMART team members and also a segment of the MEU procedures as they interface with SMART.

Comments
This manual helps the reader to understand the organization and functioning of SMART but provides little in terms of practices and procedures.

Communication Division Manual Section 5/130.1 Re: Mentally Disabled

The Communication Division is in process of revising their manual. This section's focus is on the evaluation process, team approach to phone assessment, and use of secondary operators.

Comments
The minutes of training planning meetings indicate significant efforts of the Communication Division to enhance their services to persons who may have a mental illness.

Use of Force Handbook (August, 1995)

This handbook provides basic guidelines for interventions prior to, and leading to possible use of force.

Comments

There is an excellent priority placed on verbalization procedures as an option. This includes recommendations on how to address individuals, simple communication and commands.

APPENDIX M: Crisis Intervention Team Log

APPENDIX N: Recommendations' Computations

Appendix N

Recommendations' Detailed Computations

Recommendation 1
Can be absorbed within existing resources

Recommendation 2
Can be absorbed within existing resources

Recommendation 3
Can be absorbed within existing resources

Recommendation 4
Can be absorbed within existing resources

Recommendation 5
Can be absorbed within existing resources

Recommendation 6

Salary - Lieutenant II	$108,379
Car (plain sedan)	$26,537
Computer	$2,030
	$136,946

Salary increase for 2003/04	20002/03 salary	$108,379
	5 % increase	1.05
	Total	**$113,798**

Recommendation 7
Can be absorbed within existing resources

Recommendation 8
Option 1: Can be absorbed within existing resources
Option 2: TBD by LAPD under Recommendation 1 activities

Recommendation 9
Can be absorbed within existing resources

Recommendation 10
Can be absorbed within existing resources

Recommendation 11
Can be absorbed within existing resources

Recommendation 12
Can be absorbed within existing resources

Recommendation 13
Can be absorbed within existing resources

Recommendation 14		Salary	No. of Staff	Total
13 officers				
	P2s	67,132	10	$671,320
	P3s	76,039	3	$228,117
1 D2		87,405	1	$87,405
1 clerical/typist		35,015	1	$35,015
				$1,021,857

	Cost per unit	No. of Units	Total
Cars (plain sedan)	$26,537	9	$238,833
Vans (1 per 2 Bureaus)*	$24,957	2	$49,914
Equipment - handheld Astro Radios**	$2,500	21	$52,500
3 standard PCs with software	$2,030	3	$6,090
			$1,369,194

* Vans will allow for transporting homeless individuals with property as well as wheechair-bound and obese persons
** Supplements existing equipment. Will provide 2 radios per car and allow all CART teams to monitor two frequencies

Salary increases for 2003/04	20002/03 salaries	$1,021,857
	5 % increase	1.05
	Total	**$1,072,950**

Recommendation 15
Can be absorbed within existing resources

Recommendation 16
Can be absorbed within existing resources

Recommendation 17
Can be absorbed within existing resources

Recommendation 18
Can be absorbed within existing resources

Recommendation 19
Can be absorbed within existing resources

Recommendation 20
Can be absorbed within existing resources

Year One	**Year Two**	**Year Three**
1 FTE = 1,984 hours	FTE=3.6 7,200/1,984	FTE=7.2 14,400/1,984
Printing-<$1,250	Printing-<$2,500	Printing-<$2,500

Recommendation 21
Can be absorbed within existing resources

Recommendation 22
Can be absorbed within existing resources

Recommendation 23
Can be absorbed within existing resources

Recommendation 24
Can be absorbed within existing resources

Year One	On-going
Printing-<$10,000	Printing-<$10,000

Recommendation 25
Time of internal staff can be absorbed within existing resources

Time of external subject matter expert

	Hours	Rate	Total
Low	120	$90	$10,800
High	160	$110	$17,600

Recommendation 26
Can be absorbed within existing resources

Recommendation 27
Can be absorbed within existing resources

Recommendation 28
Can be absorbed within existing resources

Recommendation 29
Can be absorbed within existing resources

APPENDIX O: 8-Hour Continuing Education Training Content

Outlined below is a proposed 8-hour curriculum for field officer training to be conducted under the direction of LAPD's Continuing Education..

8-Hour Training Content Recommendations

Understanding mental illness **1.5 hours**

Definition, causes, and manifestation of psychiatric disorders
Differential diagnosis of substance use and personality disorders
Medical aspects and common medications used in psychiatry

Communication skills and verbal de-escalation **2.0 hours**

Officer's verbal/non-verbal behaviors, demeanor
Supportive and calming communications
De-escalation tactics

Assessment and investigation **1.5 hours**

Assessing evidence that person is experiencing mental illness
Obtaining collateral information
What questions to ask?
Triage decision-making

Coordination of services with special assigned personnel, i.e. CAIT – DMV, CAIT, etc. **.5 hour**

Policies and protocols related to special services
How and when to contact

Client rights and protective custody **.5 hour**

ADA and mental health client rights
5150 protective custody
Officer discretion on misdemeanors

Consumer and community relations **1.0 hour**

Officer should have live or video contact with persons experiencing mental illness and family members. (Note: face-to-face training is most appropriate if it is a part of a 4 to 8 hour block. If not, a video may be better utilized).

Community resources **1.0 hour**

Non-custodial referrals when neither 5150 custody nor arrest is initiated
Knowledge of community agencies and methods for potential referrals