

BEATING MENTAL ILLNESS: CRISIS INTERVENTION TEAM TRAINING AND LAW ENFORCEMENT RESPONSE TRENDS

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I. AN OVERVIEW OF FIELD RESPONSES

The management of a mental health crisis begins in the field and can either escalate or de-escalate based on the management of the crisis by first responders, which is influenced by the training those first responders received. Law enforcement has known for a long time that there has been a paradigm shift in which law enforcement has become the first responders and the gatekeepers to mental health services. This shift is exemplified by the below excerpt from the Los Angeles Police Department (“LAPD”) Manual:

CONTACT WITH PERSONS SUFFERING FROM A MENTAL ILLNESS

In police contacts with persons suffering from a mental illness, the goal of the Department is to provide a humane, cooperative, compassionate and effective law enforcement response to persons within our community who are afflicted with mental illness. The Department seeks to reduce the potential for violence during police contacts involving people suffering from mental illness while simultaneously assessing the mental health services available to assist. This requires a commitment to problem solving, partnership, and supporting a coordinated effort from law enforcement, mental health services and the greater community of Los Angeles.¹

This is not a new challenge for law enforcement, one only needs to look at historical documents, such as the following Los Angeles Police Training Bulletin from 1948, which states, “An alert policeman anticipates the unpredictable thoughts and actions of a mentally ill person. He treats the patient with understanding and consideration, remembering, however, that the use of protective restraint is often necessary.”²

The advent of de-institutionalization was codified in California by the Lanterman-Petris-Short Act in 1967, and by subsequent legislation across the nation. We, as a society, can no longer simply lock a chronically mentally ill

¹ LOS ANGELES POLICE DEP’T, 1 MANUAL OF THE LOS ANGELES POLICE DEP’T 240.30, http://www.lapdonline.org/lapd_manual/volume_1.htm#210_EMPLOYEE_CONDUCT (last visited Oct. 11, 2016).

² W.H. PARKER, DAILY TRAINING BULLETIN OF THE LOS ANGELES POLICE DEPARTMENT 229, 231 (1954).

person away in a mental health facility or sanitarium, because in doing so, we consequently violate their constitutional right to due process.³ The concept of a community-based treatment model, in the least restrictive environment, has created a revolving door at most Psychiatric Emergency Departments and Medical Emergency Rooms across the county, in which first responders have become the primary mechanism through which persons in crisis are contacted, de-escalated, detained, and transported for treatment.

This shift in the role and breadth in which first responders became involved in managing service calls involving a person suffering from a mental health crisis ultimately led to several tragedies in which a person with a mental illness died because of the actions of the involved law enforcement officers. These tragedies led to the birth of two law enforcement-based response strategies (known as “Specialized Policing Responses” (“SPR”)).

The first is the Crisis Intervention Team (“CIT”) model, more commonly known as the “Memphis Model.” This is a first responder, law enforcement based model. This model was developed in 1988 in Memphis, Tennessee, and it utilizes three basic core elements: 1) ongoing elements; 2) operational elements; and 3) sustaining elements.

Ongoing Elements	Operational Elements	Sustaining Elements
Partnerships: Law Enforcement, Advocacy, & Mental Health	CIT: Officer, Dispatch, & Coordinator	Evaluation and Research In-Service Training
Community Ownership: Planning, Implementation, & Networking	Curriculum: CIT Training	Recognition and Honors
Policies and Procedures	Mental Health Receiving Facility: Emergency Services	Outreach: Developing CIT in Other Communities

By incorporating these three core elements you will achieve the two primary goals: 1)improve officer and consumer safety; and 2)redirect individuals with mental illness from the judicial system to the health care system.⁴The “Memphis Model,” or some form of it, has been adopted by communities and jurisdictions across more than forty states, and in some states, including Maine, Connecticut, Ohio, Georgia, Florida, Utah, Kentucky, Texas and California, it has been adopted as a statewide initiative.

³ CAL. WELF & INST. CODE, §§ 5000 et seq. (West 2016).

⁴ RANDOLPH DUPONT ET AL., UNIV. OF MEMPHIS, CRISIS INTERVENTION TEAM CORE ELEMENTS 3 (2007).

CIT is also being utilized in many jurisdictions around the world, including Australia, Canada, and the United Kingdom.

In Texas, Senate Bill 1473, *The Bob Meadours Act*, mandated sixteen hours of crisis intervention or de-escalation training for all Texas Peace Officers.⁵ In California, Governor Brown recently signed into law Senate Bills 11 and 29, which increase academy training to fifteen hours for behavioral health related topics and requiring additional training for all Field Training Officers ranging from eight to forty hours in order to qualify for these advanced positions.⁶ In New Mexico, after some tragedies, the legislature mandated that “[forty] hours of crisis management—including crisis intervention, confrontation de-escalation practicum, and proper interaction with persons with mental impairments training—shall be included in the curriculum of each basic law enforcement training class.”⁷ These types of training have become a national trend to address the growing challenge of providing crisis intervention/de-escalation/behavioral health training for first responders.

While the CIT construct was groundbreaking and the foundation of where we are today, it is no longer 1988, and we need to shift the culture in law enforcement away from the SPR model to a mindset of de-escalation and proper call management for *all crisis calls for service*. This was recognized as early as 2002 in an article published in *Psychiatric Services* that stated, “[t]his mental health training is needed for *all police officers*, not just for those who are a part of the specialized mobile crisis teams.”⁸ In Los Angeles, Houston, and many other jurisdictions, this has proven to be good public policy and the community supports it. Los Angeles and Houston are two of six cities that are members of the Law Enforcement/Mental Health Learning Site program supported by the Justice Center, the Council of State Governments, and the Bureau of Justice Assistance.⁹

In Los Angeles, after completing one year in the field, all probationary police officers are required to attend a two-week Police Science Leadership course and, as a component of that course, attend the Department’s forty-hour Mental Health Intervention Training (“MHIT”). In addition, California Senate Bills 11 and 29 have required that the LAPD’s academy instruction be increased from approximately eleven hours to fifteen hours of Crisis Intervention/Behavioral Health training, and all Field Training Officers are required to attend the Department’s forty-hour MHIT course in order to maintain their California Peace Officer Standards and Training certification. LAPD has recently added four hours of Crisis Intervention/Behavioral Health training to its new Field Training Officer update course, which is required every two years. Finally, at the end of 2015, all sworn members of

5 The Bob Meadours Act, TEX. EDUC. CODE ANN. § 96.641 (West 2005).

6 S.B. 11, 2015-2016 Leg., Reg. Sess. (Cal. 2015); S.B. 29, 2015-2016 Leg., Reg. Sess. (Cal. 2015).

7 N.M. STAT. ANN. § 29-7-7.5 (2016).

8 H. Richard Lamb et. al., *The Police and Mental Health*, 53 PSYCHIATRIC SERVS. 1266, 1269 (2002) (emphasis added).

9 *Law Enforcement Mental Health Learning Sites*, THE COUNCIL OF ST. GOV’TS, <https://csgjusticecenter.org/law-enforcement/projects/mental-health-learning-sites/> (last visited Oct. 11, 2016).

the LAPD completed the two-hour California Peace Officer and Standards Training–Mental Health Update Course and a one-hour block of instruction on Crisis Communication and de-escalation training as a component of the five-hour Public Trust training. As of July 2016, over 700 LAPD officers and 140 personnel from other agencies have attended the MHIT course. At the end of the course, trainees provided “final takeaways” to the facilitators and the panel from the National Alliance on Mental Illness (“NAMI”), which clustered along the common themes of empathy, compassion, and the ability to provide resources to the families in crisis.

It is not the officer who would volunteer for the course who I wish to change, for they would most likely handle the crisis call correctly anyway. Rather, it is the officer who initially did not see the value in the training who I want to convince and win over, for in the end they will become the greatest advocate for change.

The second law enforcement response strategy is known as the Co-Responder Team (“CRT”). This is a secondary response model, where a specially trained officer and a mental health clinician respond to the person in crisis, after being contacted by uniformed field officers. Typically, these teams are dispatched and ride together in a police vehicle. This strategy was first employed by the Los Angeles County Sheriff’s Department in 1992, known as Mental Evaluation Team (“MET”), and in 1993 by the LAPD, when it began deploying the Systemwide Mental Assessment Response Teams (“SMART”).

The goals of the CRT model are to: 1) prevent unnecessary incarceration and/or hospitalization of mentally-ill individuals; 2) provide alternate care in the least restrictive environment through a coordinated and comprehensive systems approach; 3) prevent the duplication of mental health services; and 4) allow patrol officers to return to field duties as soon as possible.

Today, the CRT model is used by hundreds of jurisdictions across the United States, Canada, England, and Australia, including San Diego County (“PERT”), Los Angeles County (“MET” and “SMART”), Baltimore County (“MCT”), Seattle Police Department (“CIT”), Vancouver Police Department (“AOT”), Leicestershire Police (“Triage-Car”), and Queensland Police Service (“MHIP”).¹⁰ The CRT response model is now the predominant model adopted by a majority of large urban areas in Canada. In Los Angeles County, the Department of Mental Health has partnered with twenty-three

¹⁰ *Behavioral Health Services*, CTY. OF SAN DIEGO MENTAL HEALTH SERVS., http://sandiego.networkofcare.org/mh/services/agency.aspx?pid=PsychiatricEmergencyResponseTeamPERT_61_2_0 (last visited Oct. 11, 2016); *Eob-Field Response Operations*, L.A. CTY. DEP’T OF MENTAL HEALTH, http://dmh.lacounty.gov/wps/portal/dmh/our_services/countywide?1dmy&page=dept.lac.dmh.home.services.countywide.detail.hidden&urile=wcm%3Apath%3A/dmh+content/dmh+site/home/our+services/our+services+detail/eob-field+response+operations (last visited Oct. 11, 2016); *Behavioral Assessment Team*, BALTIMORE CTY., http://www.baltimorecountymd.gov/Agencies/police/workplace_violence/wvmobilecrisisteam.html (last visited Oct. 11, 2016); Kathleen O’Toole, *Crisis Intervention*, SEATTLE POLICE DEP’T, <http://www.seattle.gov/police/work/cit.htm> (last visited Oct. 11, 2016).

¹⁰ Kathleen O’Toole, *Crisis Intervention*, SEATTLE POLICE DEP’T, <http://www.seattle.gov/police/work/cit.htm> (last visited Oct. 11, 2016);

law enforcement agencies in the county, establishing the County as the largest supporter of the CRT model in the world.

The CIT and CRT models are not mutually exclusive; many of the CRT programs utilize CIT as a base concept and have added the CRT as an additional layer of response and call management. In addition, several jurisdictions have added another layer of response, utilizing the CRT as an intensive case management team. In jurisdictions such as Los Angeles and Houston, they employ all three of these response strategies: training front line officers (CIT), utilizing a Co-Responder Team (CRT), and establishing an intensive case management team. These teams of officers are co-deployed with mental health professionals and work closely with the criminal justice and behavioral health systems to manage high-risk individuals. Jurisdictions which have initiated these specialized CRT follow up teams include the Houston Police Department–Chronic Consumer Stabilization Initiative (“CCSP”) and the Los Angeles Police Department–Case Assessment Management Program (“CAMP”). These CRT follow up teams focus on individuals who are high utilizers of emergency service and at risk for violent encounters with first responders.

Examples of high risk behavior include: 1) subjects who are assaultive and/or involved in “use of force” incidents with police; 2) subjects that attempt “suicide by cop”; 3) high utilizers of emergency services by abuse of the 911 system; 4) subjects that initiate the response of SWAT and/or high profile tactical operations; 5) returning veterans subject to a crisis response who are suffering from Post-Traumatic Stress Disorder or other mental illnesses who are the subject of an crisis response; 6) subjects involved in acts of targeted school violence; and 7) the seizure of prohibited firearms from mentally ill possessors. The CRT follow up teams identify at-risk individuals and develop detailed intervention plans in an effort to divert the individual from utilization of emergency services by employing a more prevention-minded management model to stabilize the individual before a crisis ensues.

The LAPD’s SPR collaborative with the Los Angeles County Department of Mental Health, CAMP, is a decade old. Since its inception in 2005, many tragedies have been averted and countless lives have been saved. CAMP has two primary goals: 1) preventing a violent confrontation between emergency service personnel and individuals suffering from mental illness; and 2) developing innovative prevention-minded strategies, engaging these individuals, and linking them to mental health services.

It began with a review of the LAPD’s Mental Evaluation Unit incident database in 2004, which identified sixty-seven individuals as persons who repeatedly came into police contact as a result of their mental illness. Since this strategy was new and there were no previous models to draw from, CAMP adopted a simple three-step strategy: identify, mitigate, and manage the risk. Several additional initiatives, which have proven to be successful

case management strategies, were then added.¹¹ In 2008, CAMP developed the Returning Veterans Initiative and the School Threat Assessment Response Team (“START”), extended its collaboration with the Department’s Threat Management Unit (“TMU”)—which addressed stalking suspects, and expanded the Mentally Ill Prohibited Persons Firearms strategy. In 2012, a full-time position was dedicated to the management of firearms seized from mentally ill individuals, which followed the California Department of Justice’s Armed Prohibited Persons System (“APPS”) initiation and funding. In 2012, the Los Angeles Threat Assessment Response Partners (“LA-TARP”), a collaboration with Los Angeles Unified School District, was established. In 2014, CAMP had over 700 referrals for service, which was a twenty percent increase over the prior years.

On average, CAMP teams carry approximately thirty to forty active cases.¹² The length a case stays “active” depends on the complexity of the case and the willingness of the person suffering from a mental illness to engage in addressing their mental illness and other potential issues, including substance abuse. Since CAMP was first launched in 2005, approximately *sixty-five percent* of case referrals have resulted in some form of successful linkage to mental health services between the affected individual and the appropriate mental health service. CAMP also engages in predictive and preventative measures to divert individuals away from a path towards violence by utilizing strategies that focus on the prevention aspect of risk-threat management, which have resulted in several cases of Targeted School Violence¹³ being prevented.

II. CALL INTAKE AND TRIAGE

Systems vary across the nation as to how a mental health crisis call for service is triaged and managed. Depending on the jurisdiction, there can be a separate police department dispatches and fire department dispatches. Sometimes these systems are combined, and other times, these systems may be managed by another agency entirely. The service call can create a police response, a fire or Emergency Medical Services (“EMS”) response, or a combined response to the person suffering from a mental health crisis. Dispatch protocols vary; however, many jurisdictions have begun to differentiate mental health related calls from other crisis calls in an effort to track them. For example, to identify the call as being mental health related, the Chicago Police Department uses a “Z” code, and the LAPD uses a “918” code. These protocols enhance each agency’s ability to track service calls and demonstrate if the agency has an established mental health crisis response protocol to properly respond to these calls. Some agencies, such as the Portland Police Bureau, transfer a suicidal individual to one of the crisis

¹¹ Stephanie O’Neill, *Police and the mentally ill: LAPD unit praised as model for nation*, 89.3 KPCC – So. CAL. PUB. RADIO (March 9, 2015), <http://www.scpr.org/news/2015/03/09/50245/police-and-the-mentally-ill-lapd-unit-praised-as-m/>.

¹² Cases carry the status of “Active” or “In-active” because for those individuals struggling with a chronic persistent mental illness there are no absolutes.

¹³ An act of targeted violence involves a learning institution in which the individual perpetrating the act is associated with the learning institution.

hotlines for management and do not dispatch a police unit, unless the crisis hotline returns the call for police/fire dispatch. Similarly, the Houston Police Department, utilizing a Bureau of Justice Assistance grant, has a 911 crisis diversion program in which a crisis counselor works in the 911 dispatch center and manages 911 crisis calls for service in an attempt to de-escalate the call and provide referral or linkage to behavioral health services.

In order to properly triage and manage a service call, the dispatcher must ask the right questions. If the agency or jurisdiction has an established SPR, dispatcher training is important. Many agencies have CIT training for dispatchers, which can range from eight to sixteen hours long, providing dispatchers with an overview of mental illness, crisis de-escalation skills, and the understanding of what the appropriate emergency response should be.

Hand in hand with training police and fire personnel, community outreach and training are imperative. There are many important questions to discuss with your community and family members. When do you call 911? If you call 911, what do you tell the operator? What should you expect when the police/fire department respond? If your family member is an adult, what information can they share with me? In Los Angeles, approximately eighty-two percent of the service calls involving someone suffering from a mental health crisis involve a person in a caregiving environment. That means the dispatcher will be speaking to a family member, caregiver, or community member; so, training the public is imperative for proper de-escalation and call management.

NAMI has a training program titled, “Family-to-Family.”¹⁴ This is a great platform to engage family members and inform them of what first responders need to know in order to properly engage, de-escalate, and treat their loved one. In addition to engaging the families, it is important to give the community an opportunity to participate in the process. NAMI-Dallas, the Houston Police Department, and the LAPD have created 911 checklists for family members to use in a time of crisis.¹⁵ The checklists provide family members a quick overview of what information is needed and what to expect when first responders arrive.

One of the Core Elements of CIT is Community Ownership: Planning, Implementation & Networking. Allowing the community to have a voice in the process adds a sense of ownership and cooperation. This is practiced in many communities that have adopted one or both of the SPR models. In Los Angeles, a Mental Health Crisis Response Program Advisory Board convenes every quarter in different locations within the city to brief the community on the Department’s “Mental Health Crisis Response Program,”

14 *NAMI Family-To-Family*, NAT’L ALL. ON MENTAL ILLNESS, <https://www.nami.org/Find-Support/NAMI-Programs/NAMI-Family-to-Family> (last visited Oct. 11, 2016).

15 *Guidelines For Effective Communication With 911 Dispatch*, NAT’L ALL. ON MENTAL ILLNESS GLENDALE, <http://namiglendale.org/dealing-with-911/> (last visited Oct. 11, 2016); *Emergency Guide*, HOUS. POLICE DEP’T - MENTAL HEALTH DIVISION, <http://www.houstoncit.org/emergency-guide/> (last visited Oct. 11, 2016); *911 Checklist*, NAT’L ALLIANCE ON MENTAL ILLNESS DALL. (2015), http://www.namidallas.org/uploads/2/2/4/3/22433150/911_checklist_2015.pdf (last visited Oct. 11, 2016).

and allow for engagement and input from the community. This community involvement not only adds credibility to the efforts of the SPR, but also begins to move this important social issue away from the criminal justice system and back into public health system where it belongs.

III. ON SCENE DE-ESCALATION, EVALUATION, AND CALL MANAGEMENT

Once a service call has been generated for a call involving a mentally ill person, officers are generally provided a brief description over the radio and are provided with a priority code as to the type of response required. In general, this involves the officer activating their patrol vehicle's lights and sirens to expedite the response to the call location. While en-route to the caller's location, officers will receive additional information via mobile digital computers, which are located in their vehicle. This information can be very detailed, including previous call history and a detailed account of what is going on and who the reporting party is. Ideally, the responding officer for a mental crisis service call has received additional training, such as CIT, MHIT, or one of the many other programs. However, most officers have received some training in their basic academy, such as in the California Peace Officer Standards and Training, Learning Domain 37, which covers persons with disabilities and provides foundational training on the recognition, appropriate response, and importance of referrals when handling incidents involving people with mental illness and disabilities. Specifically, Learning Domain 37 is designed to: 1) introduce laws to protect people with disabilities; 2) enhance the recognition of behaviors that are indicative of disability or mental illness; 3) provide de-escalation skills; 4) teach situation-appropriate responses and referrals to the individual and community; and 5) reduce the stigma associated with mental illness and disabilities.

In addition to Learning Domain 37, sixteen other Learning Domains review aspects of handling people with disabilities.¹⁶ If a CIT or MHIT officer is not available, one may be dispatched in a back-up car. Once on scene, the officers must quickly assess the situation and determine if it is a crime in progress, if their safety or public safety is in jeopardy, and decide how they will respond to the person in crisis. For many years, law enforcement has functioned from a forced-compliance perspective: "ask for compliance, order compliance, then make them comply." However, this does not always work, especially when dealing with a mentally ill person or someone who is having a mental health crisis. The chart below details various fundamental crisis communication techniques and training models:

¹⁶ *Mental Health Training in the Regular Basic Course*, COMMISSION ON POST, <https://www.post.ca.gov/mental-health-training-in-the-regular-basic-course.aspx> (last visited Oct. 4, 2016).

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Time	<p>Time is on your side,</p> <p>There is no need to rush. . .<u>slow down.</u></p> <p><u>It may take time to resolve the situation peacefully; be patient</u></p>
Space	<p>Give the subject <u>space</u>, yet maintain control</p> <p>Let the subject know that you will respect their <u>space</u></p> <p>Remove distractions: limit number of officers, turn down radios, and clear people from the scene</p>
Background Information (Medications, Diagnosis, Family/Friends, Issues, etc.)	<p><u>Obtain information from the subject, neighbors, relatives, and witnesses</u></p> <p><u>Establish one point of contact for the subject (someone to whom he/she responds)</u></p> <p><u>Introduce yourself by your first name</u></p> <p><u>Ask only one question at a time: “Why are you here?”, “Do you want to kill yourself?”, “I believe that you feel you are hearing voices, tell me what they are saying to you?”</u></p> <p><u>Identify Hooks and Triggers: Focus on those things to which the subject responds, avoid those things that aggravate the subject</u></p> <p><u>Repeat yourself as necessary to build rapport and influence the subject</u></p> <p><u>Display patience and sincerity when speaking to the subject</u></p> <p><u>Limit emotionality</u></p> <p><u>Don’t make promises you can’t keep. Keep the promises you make</u></p>

Officers are reminded that if one tactic does not work, be flexible and willing to adjust their approach. An acronym that can be helpful is LEAP:

Listen—practice active listening skills; Empathize—see the situation through their eyes, how serious this is; Ask—why are we here, test reality and decision making; and Paraphrase—use reflective speech, demonstrating you are hearing what they are saying. Common roadblocks to effective crisis communication are: 1) interrupting; 2) interjecting your own views; 3) expecting a response and not getting it; 4) ignoring/missing non-verbal clues/expressions; and/or 5) avoiding the subject's concerns, such as food or a can of soda, etc.

First responders who are CIT or MHIT trained are also taught the **ABCs** of suicide and a crisis. The Antecedents are event triggers that create **Beliefs** in the person. The beliefs are the interpretation of the event which can be corrupted by substances that skew perceptions, such as alcohol or drugs. Some beliefs can cause him or her to behave in a manner that provokes a police response. It is important to understand these beliefs because they are the bridge to successfully communicating with this person in crisis. The Consequences are the behaviors and emotions exhibited by the person in crisis.¹⁷ The ability to understand the “why” *may* ultimately provide the hooks necessary to bring about a peaceful resolution to the crisis.

Crisis communication/de-escalation techniques and training can also be found in clinical settings for healthcare professionals. Some of these include Nonviolent Crisis Intervention[®] Training and Management of Actual or Potential Aggression (“MAPA[®]”).¹⁸

Once the situation has become static and safe, an assessment of the mental condition of the person you are speaking to needs to be conducted; this is generally performed by a law enforcement officer or a mental health clinician as a part of the CRT or an independent mental health response model such as Los Angeles County's Department of Mental Health Psychiatric Mobile Response Team (“PMRT”).¹⁹ Also, depending on the state, other persons or entities, such as family members, concerned citizens, or judges can cause a person to be involuntarily detained and transported to a facility for a psychiatric evaluation.²⁰ In most cases, you must establish probable cause to believe that a person is: 1) a danger to themselves; 2) a danger to others; and/or 3) gravely disabled and unable to care for themselves. Most states require that some form of a written application be completed and turned into the receiving facility, establishing that there was sufficient probable cause to detain, transport, and present the person to a

17 See also Ruth Malkinson, *Cognitive-Behavioral Grief Therapy: The ABC Model of Rational-Emotion Behavior Therapy*, 19 PSYCHOL. TOPICS 289 (2010); David Bonham-Carter, *Cognitive Behavioural Therapy & the ABC Model*, CBT TECHNIQUES & SELF COACHING TIPS, <http://www.davidbonham-carter.com/abcmodelcibt.html> (last visited Oct. 4, 2016); Saul McLeod, *Cognitive Behavioral Therapy*, SIMPLY PSYCHOLOGY (2008), <http://www.simplypsychology.org/cognitive-therapy.html>.

18 *Nonviolent Crisis Intervention Training*, CRISIS PREVENTION INST., <http://www.crisisprevention.com/Specialties/Nonviolent-Crisis-Intervention> (last visited Oct. 17, 2016).

19 *Eob-Field Response Operations*, L.A. CTY. DEP'T OF MENTAL HEALTH, http://dmh.lacounty.gov/wps/portal/dmh/our_services/countywide?1dmy&page=dept.lac.dmh.home.services.countywide.detail.hidden&urile=wcm%3Apath%3A/dmh+content/dmh+site/home/our+services/our+services+detail/eob-field+response+operations (last visited Oct. 11, 2016).

20 TREATMENT ADVOCACY CENTER, EMERGENCY HOSPITALIZATION FOR EVALUATION: ASSISTED PSYCHIATRIC TREATMENT STANDARDS BY STATE (June 2011).

treating facility. In California and other states, this probable cause detention comes with certain rights to due process under the 14th Amendment and the ability to challenge their detention in court. For example, in California, this is called a “Riese” hearing.²¹ These cases are handled in Los Angeles at the Mental Health Court of the Los Angeles Superior Court. Los Angeles County is the only county in California using a centralized court for cases involving mental disorders and mental health legal issues.²²

A complicating factor to this process is when the person transported is also using controlled substances. When dealing with co-occurring disorders, it is not always clear whether the behaviors being observed are a result of the mental illness or the substance that has been ingested. The first responder must assess the totality of the observed facts and behaviors in order to make appropriate decisions.

Depending on the jurisdiction, the use of physical restraints, either by law enforcement or a transporting ambulance, depends on specific policies and procedures. Many law enforcement agencies leave it to the discretion of the officer, however the vast majority of officers will handcuff the person due to the volatile nature of the contacts. The LAPD Manual states:

HANDCUFFING PERSONS WITH A MENTAL ILLNESS. Officers *shall* handcuff a person with mental illness taken into custody when the person is not restrained by means of a straitjacket or restraining straps When handcuffing a person with a mental illness, officers must use only official handcuffs and ensure that the handcuffs are double locked. . . .²³

Recent statistics have shown that the use of physical restraints as soon as practical during mental health crisis contacts minimizes the use of force and injuries to both the officer and the person in the crisis. In 2014, out of approximately 14,000 crisis service calls in Los Angeles, approximately 380 resulted in an application of force by officers, in order to control the person in crisis. Compared to the Los Angeles County Sheriff’s Department (“LASD”), which reported that forty percent of their reported uses of force involve the mentally ill.²⁴ The LASD is rapidly moving to address many of these issues. The LASD increased training to the deputies both in custody services and in patrol functions, and is in the process of establishing a Mental Evaluation Bureau.²⁵ The use of force by officers involving persons suffering

21 James B. Page, *Informed Consent and Substituted Judgment*, 1 STAN. MED. REV. 8, 10 (1999).

22 *Mental Health*, THE SUPERIOR CT. OF CAL. COUNTY OF LOS ANGELES, <http://www.lacourt.org/division/mentalhealth/mentalhealth.aspx> (last visited Oct. 17, 2016). See *What is Mental Health Court?*, THE SUPERIOR CT. OF CAL. COUNTY OF LOS ANGELES, <http://www.lacourt.org/division/mentalhealth/MH0011.aspx> (last visited Oct. 17, 2016). See also *How is Mental Health Court Organized?*, THE SUPERIOR CT. OF CAL. COUNTY OF LOS ANGELES, <http://www.lacourt.org/division/mentalhealth/MH0014.aspx> (last visited Oct. 17, 2016).

23 L.A. CAL., POLICE DEP’T LINE PROCEDURES VOL. 4, SERIES 217.36, http://www.lapdonline.org/lapd_manual/volume_4.htm#217 (detailing “Guidelines for Handcuffing Persons with mental Illnesses”).

24 O’Neill, *supra* note 15. The LASD does not have a policy on handcuffing or restraining mentally ill persons in crisis.

25 Stephanie O’Neill, *LA Sheriff’s Department Plans Dramatic Expansion of Mental Health Policing*, 89.3 KPCC – SO. CAL. PUB. RADIO (July 23, 2015), <http://www.scpd.org/news/2015/07/23/53312/la-sheriff-s-department-plans-dramatic-expansion-o/>.

from a mental illness has garnered national and international attention. Officers in the field are taught to use only that amount of force that is reasonable and necessary to overcome resistance, prevent injury, and/or escape.²⁶ In some states, such as California, this has been codified into state law, as evidenced by California Penal Code § 835a, which states:

Any peace officer who has reasonable cause to believe that the person to be arrested has committed a public offense may use reasonable force to affect the arrest, to prevent escape or to overcome resistance. A peace officer who makes or attempts to make an arrest need not retreat or desist from his efforts by reason of the resistance or threatened resistance of the person being arrested; nor shall such officer be deemed an aggressor or lose his right to self-defense by the use of reasonable force to effect the arrest or to prevent escape or to overcome resistance.²⁷

Not all contacts result in a detention for and examination of a person's mental condition. This means that the person did not present as a "danger to self or others," and has a safety plan and a supportive environment that he or she can be left in. This is where advocacy groups, such as NAMI, become so very important—they offer support, guidance, and advocacy for persons who are mentally ill and in need of services.²⁸ In addition, many counties and non-governmental agencies offer support and treatment options. In the CIT and CRT models, first responders are encouraged to have this information readily available and distribute it to those in crisis and their family members.

IV. ARREST VS. HOSPITALIZATION/DIVERSION

Another consideration is when a person suffering from a mental health crisis has committed a crime, and it is deemed appropriate to divert them from an arrest and the criminal justice system to mental health services. Some agencies have invested in diversion, keeping those individuals with a serious mental illness out of the criminal justice system.²⁹ On August 5, 2015, the Los Angeles County District Attorney, Jackie Lacey presented to the Los Angeles County Board of Supervisors her "Mental Health Advisory Board Report."³⁰ This report establishes a roadmap and a collaborative framework to divert the mentally ill from the criminal justice system and into mental health and substance abuse treatment. In addition, it utilizes the Substance Abuse and Mental Health Services Administration ("SAMSHA") Sequential Intercept Model. This model identifies five key points for "intercepting"

26 *Graham v. Connor*, 490 US 386, 396–97 (1989).

27 CAL. PENAL CODE § 835a (Deering 1957).

28 See also NAT'L ALLIANCE ON MENTAL ILLNESS, <https://www.nami.org> (last visited Oct. 17, 2016); See also *Mission*, NAT'L ALLIANCE ON MENTAL ILLNESS CAL., <http://namica.org/about-us/nami-california-mission/> (last visited Oct. 17, 2016).

29 See *Criminal Mental Health Project*, ELEVENTH JUD. CIR. OF FL., <http://www.jud11.flcourts.org/Criminal-Mental-Health-Project> (last visited Oct. 17, 2016).

30 See JACKIE LACEY, MENTAL HEALTH ADVISORY BOARD REPORT: A BLUEPRINT FOR CHANGE (2015).

individuals with behavioral health issues, linking them to services, and preventing further penetration into the criminal justice system.³¹

Through her Criminal Justice Institute, the District Attorney has developed and is now delivering a new sixteen-hour course, “Crisis Intervention Tactics for First Responders,” in an effort to provide additional training for law enforcement and to assist in diverting persons with a mental illness from the criminal justice system. Additionally, with the large number of returning combat veterans who are suffering from a mental illness, Veteran’s Treatment Courts have been established to address this specific population.³² Nationally, the Justice Center Council of State Governments, with the assistance of the Bureau of Justice Assistance, has established the Mental Health Court Learning Site program to help address this important need.³³

Many law enforcement agencies have specific policies and procedures on diversion, but in most cases officers are given a great deal of discretion.³⁴ An example of a law enforcement policy is cited below in an excerpt from the LAPD Manual:

TAKING PERSONS WITH A MENTAL ILLNESS INTO CUSTODY.

When a person is taken into custody for a criminal offense and the person is suspected of having a mental illness, the Mental Evaluation Unit shall be contacted prior to the person being booked. When a subject is a suspect in a felony or high-grade misdemeanor crime, or the subject has any warrants, the criminal matters shall take precedence. If the subject is under arrest for a low-grade misdemeanor, misdemeanor warrant, or infraction, and meets the criteria for an Application for 72-hour Detention for Evaluation and Treatment, booking is at the discretion of the Area watch commander.³⁵

The LAPD engages in the diversion of the mentally ill, when appropriate, and tracks these pre-booking/post-booking diversions from the criminal justice system into mental health services, in their Mental Evaluation Incident Tracking System. The LAPD/LACDMH CAMP model also interacts with the criminal courts and mental health courts to develop interventions, linkages, and strategies to decrease recidivism, preventing the individual with mental illness from re-entering the criminal justice system.

31 *SAMHSA’s Efforts on Criminal and Juvenile Justice Issues*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., <http://www.samhsa.gov/criminal-juvenile-justice/samhsas-efforts> (last visited Oct. 17, 2016). These five key points are: 1) community and law enforcement; 2) arrest and initial detention/court hearings; 3) jails and specialty courts; 4) reentry from jails and prisons to the community; and 5) community corrections.

32 *California Counties with Veterans Treatment Courts*, CAL. VETERANS LEGAL TASK FORCE, <http://www.cvlrf.org/ca-counties-with-veterans-treatment-courts.html> (last visited Oct. 11, 2016).

33 *Criminal Justice/Mental Health Learning Sites*, THE COUNCIL OF St. Gov’ts, <https://csgjusticecenter.org/mental-health/learning-sites/> (last visited Oct. 17, 2016).

34 See generally Linda A. Teplin, *Keeping the Peace: Police Discretion and Mentally Ill Persons*, NAT’L INST. OF JUST. J., July 2001, at 8.

V. TRANSPORTATION

When there is no criminal offense, and a mental health intervention and involuntary detention is determined to be necessary, the next question is: how is the person in crisis going to be transported to the treating facility? In most agencies, the person in crisis is transported in a police vehicle, behind a cage. The Cincinnati Police Department has specific transportation guidelines for the transportation of a person to a mental health detention center.³⁶ The Memphis Police Department has also delineated policies and procedures for transporting the mentally ill person by police in a police vehicle.³⁷ In Oakland, Alameda County, contract ambulances are used, decreasing the stigma and criminalization of those in crisis while also decreasing the drain on fire and police services.³⁸ In some jurisdictions, the closest facility can be several hours away from location of the initial detention. This is especially challenging in many rural communities, but can and does exist in some metropolitan locations, such as Madison, Wisconsin. The Treatment Advocacy Center, a non-profit organization dedicated to treating those with mental illnesses, has generated a model law on transportation for legislators;

Transportation to emergency facility. Prototyping individuals may only be transported by either law enforcement officers with the power of arrest or others who have been designated to perform this function by the state, county or department of mental health.³⁹

In many jurisdictions, the use of drop-off or urgent care centers has greatly reduced the strain on psychiatric and medical emergency rooms.⁴⁰ In Los Angeles, when transported by law enforcement to a traditional psychiatric emergency department, wait times can vary from two hours to as long as ten hours, with the average wait time being approximately two and a half hours. Using an urgent care center greatly reduces wait times, allowing patrol officers to return to their duties in fewer than thirty minutes. In addition, these urgent care centers have a host of services, providing linkages, and decreasing involuntary hospitalizations. However, if a person requires additional involuntary services, they may be transferred to long-term care facilities as needed.

VI. HOSPITALIZATION

Once the person in crisis has been transported to a treatment facility, a report must be provided to the facility staff delineating the reason for the

³⁶ CITY OF CINCINNATI, POLICE DEPARTMENT PROCEDURE MANUAL 12.600 (2013)

³⁷ MEMPHIS POLICE DEPARTMENT, MEMPHIS POLICE DEPARTMENT POLICY AND PROCEDURES ch. IX 5–11 (2010).

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³⁹ TREATMENT ADVOCACY CENTER, MODEL LAW FOR ASSISTED OUTPATIENT TREATMENT § 4.3 (2000).

⁴⁰ Peter Korn, *Cinching Up The Safety Net*, PORTLAND TRIB., Nov. 27, 2014, <http://portlandtribune.com/pt/9-news/241809-107661-cinching-up-the-safety-net>; *Calif. Mental Health Clinics Aim To Offset Psychiatric Bed Shortage*, CAL. HEALTHLINE, August 28, 2014, <http://www.californiahealthline.org/articles/2014/8/28/calif-mental-health-clinics-aim-to-offset-psychiatric-bed-shortage>.

involuntary detention. These required forms vary by state but the Treatment Advocacy Center has a comprehensive list, which includes the applicable laws in each state. The benefit of adopting the training associated with many of the SPRs is that the training teaches the detaining officers what is required by their specific state's laws and for the treating staff at the medical facility. First responders are not expected to be diagnosticians, but should be able to describe the behaviors observed and statements made that caused them to believe the person detained qualifies for an involuntary detention. During this training, law enforcement officers are reminded that the report they are completing is a legal document, no different than an arrest report they would complete for a criminal complaint. They are taught the behaviors to look for that would be indicative of a mental illness and that they must use clear and concise language, absent of acronyms and terms that officers would commonly use in a police report. They are also taught the importance of gathering witness and family statements to establish the probable cause needed to make the detention. In California, officers *must* consider available relevant information from any mental health provider or other credible person, including family members or witnesses.⁴¹ This will assist the treating staff in assessing and developing an appropriate treatment plan for the person in crisis. A poorly written report can lead to poor outcomes and missed opportunities for a strong linkage to mental health services.

It is at this juncture, in the management of the person in crisis, that information be accurately documented and shared in order to ~~is critical to properly~~ develop a comprehensive team approach. It is also here that the federal privacy laws, based on interpretation, may block this flow of information. It is important to understand that in most cases, limited information can be shared between the healthcare provider and law enforcement.⁴² This is when having a CRT mental health clinician on the response team can be beneficial, as they are able to communicate with the treating staff at the medical facility. At minimum, law enforcement should be satisfied with one-way communication between themselves and the treating/receiving staff at the medical facility, ensuring that the reporting is as complete and accurate as possible to best enable the treating facility to provide the appropriate intervention for the person in crisis.

VII. DISCHARGE PLAN: COLLABORATION AND SAFETY PLAN

This is where law enforcement, treatment providers, and community stakeholders must work together to ensure that the person who was in crisis is properly linked to mental health services, ensuring not only their safety but also the safety of the community at large. There are many factors which go into discharge planning, but safety is the key to a successful outcome. In

41 CAL. WELF. & INST. CODE, § 5150.05 (West 2016).

42 See *When Does the Privacy Rule Allow Covered Entities to Disclose Protected Health Information to Law Enforcement Officials?*, U.S. DEP'T OF HEALTH & HUM. SERVS. (July 23, 2004), http://www.hhs.gov/ocr/privacy/hipaa/faq/disclosures_for_law_enforcement_purposes/505.html; see generally JOHN PETRILA & HALLIE FADER-TOWE, INFORMATION SHARING IN CRIMINAL JUSTICE-MENTAL HEALTH COLLABORATIONS (Bureau of Justice Assistance 2010).

Los Angeles, at least sixty percent of crisis calls involve individuals who are one-time users of emergency services and will not be seen in an emergency setting again. However, there are some persons who become mentally well enough to be discharged by law, but still may pose a significant risk to their safety and to society. This is where laws such as *Tarasoff v. Regents* and its subsequent extensions and adaptations across the country present challenges.⁴³ Treatment providers, depending on their jurisdictions, must understand the “duty to warn” as it applies to their professional license and their state laws. This “duty to warn” has now be extended to a “duty to protect” and this is where a beneficial relationship with law enforcement can assist a therapist or treating physician in complying with these sometimes confusing and complicated laws.⁴⁴ This is where it is important to review the confidentiality exceptions to the Healthcare Information Portability and Accountability Act (“HIPPA”), and understand that communications are permissible for reasons of public safety or to report or assist officers in identifying and making an arrest of a person who is wanted for a crime. This must be looked at from a public safety perspective and it must be understood that the vast majority of these cases are not criminally prosecuted, but by intervening, the person is diverted from from potentially violent acts, that put those individuals and the public at risk. This is when having SPRs in your community can be beneficial to the discharge and management of potentially high-risk, mentally ill individuals.

Another topic of national, and to a lesser extent international, concern is the accessibility of firearms to persons in crisis or suffering from a mental illness. In some states, mental health professionals have added duties. For example, in California, when a person has been the subject of an involuntary detention, “the facility shall immediately, on the date of admission, submit a report to the Department of Justice, on a form prescribed by the Department of Justice, containing information that includes, but is not limited to, the identity of the person and the legal grounds upon which the person was admitted to the facility.”⁴⁵ Similarly, according to the New York SAFE Act, a “mental health professional” must report a person who “is likely to engage in conduct that would result in serious harm to self or others” to the County Director of Community Services or designee as soon as practicable.⁴⁶ Depending on the jurisdiction, this can be challenging, but the stronger the relationship is between law enforcement, treatment providers, and community stakeholders, the easier it is to navigate these legal challenges. The responsibility of patient care does not end with the discharge of the person suffering from a mental illness from the facility and a referral for treatment to a community provider. It is necessary to provide a true bridge to a successful linkage and then follow up to ensure it is strong. This can include

43 Charles Patrick Ewing, *Tarasoff Reconsidered*, MONITOR ON PSYCHOL., July/Aug. 2005, at 112.

44 Stephen E. Berger & Michael A. Berger, *Tarasoff “Duty to Warn” Clarified*, THE NAT’L PSYCHOLOGIST, March 1, 2009, <http://nationalpsychologist.com/2009/03/tarasoff-%E2%80%9Cduty-to-warn%E2%80%9D-clarified/101056.html>.

45 CAL. WELF. & INST. CODE, §§ 8100–8108 (West 2016).

46 New York Secure Ammunition and Firearms Enforcement Act, N.Y. MENTAL HYG. LAW § 9.46 (McKinney 2016).

engagement by a full service provider, who can provide wrap around services, such as supportive housing, mental health treatment, health services, medication.

VIII. CONCLUSION

At first glance, there appears to be a lot of work being done nationally and internationally to address the growing tension between mentally ill persons and law enforcement. However, many communities and jurisdictions have yet to become engaged in the discussion about responding to and managing high-risk mental health crisis calls. In many cases, a tragedy must occur before action is taken to address this public health crisis, which generally falls on law enforcement. The first responder role in agitation/crisis management is very important and sets the tone for all of the subsequent contacts the person suffering from a mental health crisis will have on their journey through a very complicated, regulated, and fragmented system of care. It is only through a thorough analysis of the system, its key stakeholders, and a willingness to work cooperatively in order to provide the best intervention possible, that there can be successful outcomes. We cannot hide behind fabricated or misperceived barriers that prevent this collaborative approach from being successful. We must train all facets of the system, so that there is an intimate knowledge of each other's capabilities and legal limitations. This includes the consumer, for to see the world through their eyes, failure is not an option, and lives are at stake.

There are many well-intentioned individuals working diligently in their own silos, not realizing that working together may make the task at hand achievable. Begin the process in your community and if one is in place, join it and make it stronger.⁴⁷

⁴⁷ Author's note: I was asked by the University of Southern California Gould School of Law to participate in a panel on this very important topic. Not knowing exactly what the make-up of the audience, or what the background of the co-presenters were, I did some research. It was a very interesting mix of consumers, advocates, educators, plaintiff attorneys in civil rights cases, and others. I did not attend the night before when the founder of the "Black Lives Matters" movement was there, but I understand it was very contentious. I wish I had been there to witness and perhaps find balance.

Knowing the participants is key to the message you wish to impart, but at most I had an opportunity to listen and hopefully educate. What I found were some very impassioned individuals seeking justice. I did my best to put a human face on law enforcement and the challenges we face when dealing with persons who are in crisis and the lack of knowledge and community supports that create the crisis to begin with. I had dinner with a disability rights attorney who argued the *Sheehan v. City of San Francisco* case before SCOTUS. This is the first time I have ever spoken to a plaintiff's attorney outside of an active case. While we did not agree on everything, there are things we can certainly learn from.

In the end, I believe I was successful in humanizing police officers and providing perspective. We can always single out one event, but many of the advocates who complain of stereotyping and profiling by law enforcement are just as guilty because they stereotype and profile those of us in uniform. What I found disappointing is that several other law enforcement professionals were invited but declined to come. We should welcome the opportunity to engage in a dialogue, learn, and provide perspective. Otherwise, we will be represented solely by the media and possibly not as who we truly are as a profession.

