

**Final Report of the Sheriff Civilian Oversight Commission
Regarding the Mental Evaluation Team Program of the
Los Angeles County Sheriff Department**



February 15, 2018

TABLE OF CONTENTS

EXECUTIVE SUMMARY	3-14
FULL REPORT - BOARD OF SUPERVISORS' MOTION	15
SHERIFF CIVILIAN OVERSIGHT COMMISSION ACTIONS	15
MET ISSUES.....	16
OTHER LASD CO-RESPONSE TEAMS	24
SIMILAR CO-RESPONSE TEAM MODELS OUTSIDE OF LASD	25
PUBLIC INPUT	27
ANALYSIS	29
SPECIFIC RECOMMENDATIONS.....	31
CONCLUSION	35

**FINAL REPORT OF THE SHERIFF CIVILIAN OVERSIGHT COMMISSION
REGARDING THE MENTAL EVALUATION TEAM PROGRAM OF THE
LOS ANGELES COUNTY SHERIFF DEPARTMENT**

EXECUTIVE SUMMARY

The Los Angeles Board of Supervisors asked the Los Angeles County Sheriff Civilian Oversight Commission (COC) to make recommendations about how to improve Mental Evaluation Teams (MET), a specialized unit of Los Angeles County Sheriff's Department (LASD) that responds to calls from patrol deputies who are interacting with people with mental illness, developmental disabilities, mental health issues, drug-related episodes, or anyone who may be a danger to himself or others. The COC constituted an ad hoc committee on MET comprised of commissioners with relevant professional experiences: a violence preventionist, a retired LASD lieutenant, and a public defender. The COC ad hoc committee studied MET and other co-response team deployment models from different jurisdictions, attended LASD de-escalation trainings with a mental health focus, and consulted with LASD, Los Angeles Police Department (LAPD), Department of Mental Health (DMH), Office of Diversion and Reentry (ODR), the American Civil Liberties Union (ACLU) of Southern California and the National Alliance on Mental Illness (NAMI).

The COC ad hoc committee has concluded that more systemic support for de-escalating confrontations between patrol deputies and people with mental illness will reduce police shootings and other uses of force, as well as build trust with disaffected communities. To that end, we make the following four strategic recommendations:

COC Strategic Recommendations for MET

- I. Increase the number of MET teams from 23 to 60
- II. Prioritize department-wide de-escalation training with a mental health focus
- III. Promote inter-agency collaboration with other mental health partners and stakeholders
- IV. Treat MET and department-wide de-escalation training with a mental health focus as equally important, complementary strategies for reducing uses of force and promoting constitutional policing

Each recommendation is equally important and is discussed more fully in the following.

I. INCREASE THE NUMBER OF MET TEAMS FROM 23 TO 60

MET are co-response team deployments consisting of a specially-trained LASD deputy and a DMH clinician who assist patrol deputies interacting with people with mental illness. Ideally, MET would respond to the scene quickly enough to help a patrol deputy de-escalate a tense encounter with a mentally ill person, who according to one recent study is sixteen times more likely to be fatally shot by police. According to LASD Use of Force data for 2016, 82% of total use of force incidents that exclude shooting incidents involved persons having a mental health history, WIC 5150¹ holds, being under the influence, or both being under the influence and WIC 5150. As for shootings, data from the Los Angeles County's Open Data Portal as of January 11, 2018 show that 10% of LASD shooting incidents involved persons with mental health concerns. It should be noted that the Inspector General recently reported on the deficiencies in LASD's data collection and reporting methodologies² as well as inaccuracies in their statistics³.

¹ Welfare and Institutions Code (WIC) 5150 is the involuntary treatment of a mentally disordered person who may pose a danger to self or others or is gravely disabled.

² Office of Inspector General (2017). Reform and Oversight Efforts: Los Angeles County Sheriff's Department. Retrieved from: <https://oig.lacounty.gov/Portals/OIG/Reports/Reform%20and%20Oversights%20Efforts%20July%202017.pdf?ver=2017-08-09-144106-333>.

³ Office of Inspector General (2017). A Review of the Jail Violence Tracking and Reporting Procedures of the Los Angeles County Sheriff's Department. Retrieved from: <https://oig.lacounty.gov/Portals/OIG/Reports/A%20Review%20of%20the%20Jail%20Violence%20Tracking%20and%20Reporting%20Procedures%20of%20the%20Los%20Angeles%20County%20Sheriff's%20Department.pdf?ver=2017-08-09-144105-990>.

Hence, the data provided by LASD on shooting incidents may be imprecise, given that most studies indicate rates of least 25% and as high as 50% of all fatal law enforcement shootings that involve mental illness as a factor⁴. MET's expertise in mental health-informed de-escalation techniques should reduce the number of shootings and uses of force against people with mental illness.

Unfortunately, MET is too understaffed to achieve this level of de-escalation. When the COC ad hoc committee began its evaluation, MET had only ten teams to cover vast distances within the most traffic-clogged, populous county in the United States.

Currently, there are 16 field MET teams with eight-nine teams on duty each day. With so few teams, MET simply could not timely respond to all calls in which a patrol deputy was confronting a mentally ill person who didn't respond to commands. For example, on March 8, 2017, LASD patrol deputies fatally shot Dennis "Todd" Rogers, a 41-year-old African American man suffering from bipolar disorder who was acting erratically and wielding an electric hair clipper in the parking lot of a 24 Hour Fitness gym in Ladera Heights. The deputies responding to the 5150 hold call had requested MET assistance to de-escalate the situation, but the only two MET teams covering Los Angeles County were unavailable because they were already occupied with other calls.

Our study revealed that by the time the MET arrives at the scene, the tense encounter has usually already ended and the only remaining issue is whether a mentally ill person in need of treatment should be taken to a hospital instead of being arrested and jailed. While diverting people from jail to treatment is laudable, with proper staffing MET can and should do so much more to assist patrol deputies in dealing with mentally ill people who fail to heed their commands. MET is most effective when the co-response teams arrive in time to actually affect the outcome of the situation.

The reasons for the longstanding understaffing of MET elude us. In 1991, LASD became the first law enforcement organization in the United States to implement co-response team deployments to more effectively interact with people with mental illness in crisis. LAPD followed suit two years later, when in 1993 it established System-wide

⁴ Treatment Advocacy Center (2015). Overlooked in the Undercounted - The Role of Mental Illness in Fatal Law Enforcement Encounters. Retrieved from: <http://www.treatmentadvocacycenter.org/storage/documents/overlooked-in-the-undercounted.pdf>.

Mental Assessment Response Teams (SMART) that were designed to perform the same specialized services as MET. Despite being a pioneer, LASD has fallen well behind LAPD, which currently has 17 teams on duty per day providing “24/7” coverage for the entire city of Los Angeles. By all accounts, SMART has positively impacted how LAPD officers interact with people with mental illness and it is widely viewed as a model for co-response team deployments by law enforcement agencies throughout the nation.

This low number of MET teams has been the greatest impediment to MET realizing its full potential. The Board of Supervisors recently accepted a blue ribbon commission’s recommendation to increase the number of MET teams from 10 to 23, and LASD now has 17 MET teams. But 23 MET teams are not enough. LASD officials estimate that it would take up to 40 teams for MET to make a meaningful impact on de-escalation; DMH officials estimate that 60 to 80 MET teams are needed. Given the vast distances and large population of Los Angeles County, 60 teams seem conservative. We recommend increasing the number of MET teams from the current 23 to 60.

Increasing the number of MET teams to 60 would allow LASD to disperse MET across the entire County so that areas within LASD jurisdiction could be better covered. LASD currently limits MET service to days and shifts that, in its view, are likely to be most busy, and it provides substantially more coverage to northern Los Angeles County than to the southern areas. Mental health crises don’t occur only on certain days or during certain hours, and they certainly aren’t limited to a particular neighborhood or zip code. Consequently, it is critical that LASD devise a plan to deliver continuous, timely MET assistance to patrol officers interacting with people suffering from mental health problems during all hours throughout all areas. Strategically creating MET “hubs” based in different stations throughout the County would allow LASD to achieve continuous full coverage.

LASD and DMH officials expressed concerns that it would take substantial time and effort to recruit, hire and train so many new MET team members. The recommended increase in MET teams need not occur in one fell swoop. But LASD and DMH should work together to devise a joint strategic plan for incrementally hiring and training new

team members and make implementation of that strategic plan a high priority until the target of 60 MET teams has been achieved.

II. PRIORITIZE DEPARTMENT-WIDE DE-ESCALATION TRAINING WITH A MENTAL HEALTH FOCUS

LASD generally uses “one-deputy units,” which means that most patrol deputies ride alone, and seek backup assistance from other patrol deputies as the situation should dictate. The likelihood of MET ever being a true first responder is mathematically unlikely. Due to this fact, patrol deputies will frequently find themselves initially interacting with a mentally ill person without any specialized assistance. A tense encounter under such circumstances is fraught with the potential for misunderstandings, problems and unintended consequences. The risk of rapid escalation is compounded by the fact that many people who suffer from mental illness will misinterpret or ignore assertive commands.

Numerous recent studies and research show that police officers are primed to use force options instead of de-escalation techniques since force is overemphasized during training. This is why comprehensive de-escalation training with a mental health focus for all patrol deputies is absolutely critical. Conduct that a patrol deputy views as irrational or defiant may be a manifestation of mental illness or developmental disability. Helping deputies to recognize common “red flags” of mental illness and more effectively interact with people with mental illness will de-escalate tense encounters and obviate the perceived need to use force to ensure compliance and safety. Thus, every dollar spent on training will reduce uses of force and the large monetary settlements and judgments related to lawsuits.

LASD offers some high-quality mental health de-escalation trainings, such as Crisis Intervention Training (CIT) and Multiple Interactive Learning Objectives (MILO) simulator training. The 32-hour CIT training teaches patrol deputies to identify common symptoms of mental illnesses and developmental disabilities and how to more effectively interact with mentally ill people who are decompensating. The MILO simulator training sends armed patrol deputies into different virtual reality scenarios that

focus on effectively interacting with people in crisis. The MILO simulator either escalates or de-escalates the interaction depending on the trainee-deputy's performance. If the trainee-deputy empathizes and positively interacts with the person in crisis, the encounter de-escalates, resulting in a non-violent resolution. If the trainee-deputy acts aggressively and fails to establish a rapport with the person in crisis, the encounter rapidly escalates and ends in a use of force. After the simulation ends, the trainers—sergeants with significant mental health training—score the trainee-deputies' interactions and debrief each trainee-deputy about LASD use-of-force policy compliance and performance issues. Both trainings are effective, particularly the interactive MILO simulator training.

Unfortunately, both critical training programs are severely understaffed and underfunded. Four CIT instructors must train over 2,800 patrol deputies. The current LASD budget does not allow for any additional instructors or support staff, making it impossible for all patrol deputies to complete the training in a timely manner.

Nor are there enough MILO simulators to ensure the consistent, regular, scenario-based practical skills training necessary to acclimate deputies to effective de-escalation techniques. LASD has only two MILO simulators for patrol use (Industry and Palmdale stations) and one similar VirTra simulator (Training Bureau) compared with LAPD, which has over twenty simulators. A large organization such as LASD needs more simulators to effectively train officers in de-escalation techniques.

Increasing training personnel who specialize in mental health would facilitate LASD offering more basic, advanced and refresher de-escalation trainings with a mental health focus; acquiring more simulators would allow LASD to offer more opportunities for deputies to participate in practical, interactive, scenario-based trainings that will better hone their de-escalation technique skills. De-escalation requires a complex skill-set that cannot be gleaned in a single training; rather, continuous, regular training and practice is the best way to achieve proficiency in de-escalation techniques. Just as deputies are required to participate in weapons qualifications several times per year, they should be required to participate in de-escalation trainings with a mental health focus with at least the same frequency, if not more.

The need for regular, continuous de-escalation training with a mental health focus is not limited to patrol deputies; sergeants, watch commanders, unit commanders and higher-level executives who create and implement LASD use-of-force policies should be required to participate in some level of the trainings. Exposing every level of management to de-escalation training will produce more insight about patrol deputies' concerns and challenges with reconciling existing use-of-force training and policies with a more effective, holistic approach to interacting with mentally ill people in crisis. A deeper understanding of mental illness gleaned from the trainings will facilitate better leadership, better policy-making and culture change.

Many police chiefs and sheriffs often remark that “training is policy.” Consequently, implementation of department-wide de-escalation training with a mental health focus should be a high priority. LASD estimates that, given current staffing, it will take approximately six years for all patrol deputies to complete basic de-escalation training. This is too slow. We recommend that LASD identify the number of trainers and simulators it would take to provide timely de-escalation trainings with a mental health focus to all patrol deputies. LASD should create and implement a plan for providing advanced and refresher training to all deputies to ensure proficiency with de-escalation techniques.

III. PROMOTE INTER-AGENCY COLLABORATION WITH OTHER MENTAL HEALTH PARTNERS AND STAKEHOLDERS

Active, consistent collaboration between LASD and DMH is necessary to make a co-response team deployment model such as MET work. MET is unique because each team draws from integrated law enforcement and mental health expertise to de-escalate tense situations without resorting to traditional police tactics, such as “command presence” and the use of force. Because of this integrated approach, MET has experienced and will continue to experience unique problems that can only be solved by both agencies coming together to identify and implement solutions.

For example, when we first looked into the matter, three of the ten MET teams lacked a clinician and were referred to as “deputy only” teams. By definition, MET must have

both a deputy and a clinician to form a co-response team. To have almost one third of all the then-existing teams be “deputy only” defeated the core purpose and mission of MET. Despite this, LASD lacked a clear plan to rectify this serious shortcoming. DMH officials confirmed their difficulty recruiting clinicians to join MET due to inconvenient sheriff shifts, uncertainty about MET locations and assignments, and inadequate compensation. Some clinicians reported unaddressed safety concerns. Despite this, DMH also lacked a clear plan to rectify the situation.

While some progress restoring lost clinicians has been made, MET still has deputy-only teams—presumably because the difficulty recruiting clinicians persists. If LASD and DMH worked together more collaboratively to solve thorny problems such as this, their joint effort would likely net solutions that each agency can’t deliver on its own. The two agencies should identify ways to incentivize clinicians to join MET to ensure that all MET teams are fully staffed. A Memorandum of Understanding (MOU) needs to be developed to set clear expectations for each department.

DMH has made general reference to “union rules” as possibly prohibiting giving some incentives to clinicians to join MET, but incentivized schedules and payments have long been used in other unionized industries and professions. Perhaps it is worth consulting a public-sector labor lawyer to evaluate options.

The effectiveness of integrated collaboration is borne out by the LAPD SMART team experience. Like MET, every SMART team is comprised of a police officer and a clinician. Because they use the same co-response team deployment model and recruit clinicians from the same agency, LAPD must confront all the same issues and challenges recruiting and integrating clinicians into a police culture as LASD. Moreover, the same union rules cited by DMH as prohibiting incentivizing clinicians to join MET apply to SMART. Yet, all 32 SMART teams are staffed by both an officer and a clinician. The LASD and DMH need to explore all options available to them to solve this clearly solvable problem.

IV. TREAT MET AND DEPARTMENT-WIDE DE-ESCALATION TRAINING WITH A MENTAL HEALTH FOCUS AS EQUALLY IMPORTANT, COMPLEMENTARY STRATEGIES FOR REDUCING USES OF FORCE AND PROMOTING CONSTITUTIONAL POLICING

More resources are needed to avoid pitting the expansion of MET against providing sufficient de-escalation training with a mental health focus for supervisors and patrol deputies. In the course of our study, some framed the solution in zero-sum terms, arguing that the LASD budget can only support either increasing the number of MET teams or expanding training opportunities, but not both. We reject this either/or approach.

Los Angeles County pays huge settlements every year in civil-rights actions arising from LASD deputy shootings and other uses of excessive force. These aggregate settlement costs have been steadily rising each year. In 2016, the County paid a record high of \$51 million in settlements for such cases--many of which involved victims who suffered from mental health problems or developmental disabilities⁵. Given rising settlement costs, refusing to invest in both MET and de-escalation training with a mental health focus would be penny wise and pound foolish. Simultaneously expanding both MET and de-escalation training has potential to reduce the number of police uses of force and shootings, which in turn will reduce the inevitable lawsuits, litigation costs, and settlements that attach to such incidents.

Much more than money is at stake. COC regularly hears public comment from heartbroken family members or caregivers who called 911 for help with a mentally ill person who was decompensating, only to witness the reporting deputies fatally shoot the person under their care. For example, on January 4, 2012, LASD patrol deputies reported to a mental health treatment facility in Rosemead and fatally shot Jazmyne Ha Eng, a 40-year-old woman suffering from schizophrenia, because she was acting erratically and ignored commands to drop the hammer in her hand. The caregivers who had placed the 911 call for 5150 hold assistance were devastated because they never

⁵ Estabrook, S. H. (2017). Los Angeles County Office of the County Counsel "Overview of Sheriff's Department Law Enforcement Paid Judgments and Settlements FY 2011-12 through FY 2015-16," Presentation at Sheriff Civilian Oversight Commission Meeting on March 23, 2017.

expected that the deputies would shoot Ms. Eng, who had been sitting calmly in the lobby holding the hammer for hours but became agitated after law enforcement arrived.

NAMI representatives—some of whom personally experienced such a tragedy—were steadfast in their belief that both MET and de-escalation training with a mental health focus must be expanded in order to have any hope of achieving positive systemic change.

Many knowledgeable stakeholders noted the unconscionable dearth of mental health treatment options in Los Angeles County and forcefully advocated that public funds would be better spent on increasing the number of community-based treatment providers than on expanding MET and de-escalation training. While more resources for community-based mental health treatment providers are certainly needed, underfunding MET and de-escalation training would do nothing to solve that intractable problem and would likely exacerbate the plight of many people with mental illness who inevitably end up interacting with the police.

Right or wrong, in our society law enforcement are almost always the first-responders to people in crisis, especially people with mental illness in crisis. The unnecessary use of force against mentally ill citizens is often caused by ignorance of the symptoms of and the behaviors driven by mental illness. Because MET and mental-health informed de-escalation training provide first-responders with the tools to understand and effectively deal with mental illness, both are likely to reduce the improper use of force against people with mental illness and intellectually disabled people in crisis. In this respect, MET and de-escalation training facilitate “constitutional policing” by providing the foundation for ethical, legal practices that seek to protect mentally ill people’s civil rights.

CONCLUSION

The COC ad hoc committee on MET urges LASD to implement its four strategic recommendations as expeditiously as possible. Our recommendations are consistent with and build on the more incremental reforms already being implemented by Chief Stephen Johnson and MET Unit Commander Lieutenant John Gannon, whose assistance to the COC ad hoc committee has been invaluable to the completion of this

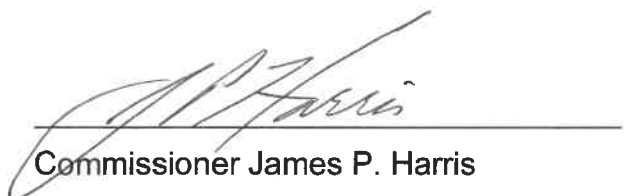
report. These incremental reforms are already reducing uses of force. Last month, MET handled 506 new cases. Of those, eight (2%) required MET to act as “code 3” co-responders to crises still in progress and sixteen (4%) were handled by MET as high-priority response to help first responders on scene, also still trying to de-escalate patients. MET also referred 111 of the cases (22%) to either the triage desk or PMRT as the most appropriate responders. MET handled four other tense incidents to conclusion, thereby obviating the need to activate a costly Crisis Negotiation Team during off-hours, and intervened in nine jail incidents to gain inmates’ cooperation and compliance in lieu of initiating a forced cell extraction. Finally MET handled 62 cases (12%) where patrol personnel on scene advised that use of force appeared imminent until the MET unit arrived and gained the patient’s compliance without using force. Based on this progress, we are confident that implementing the four strategic recommendations will further reduce uses of force.

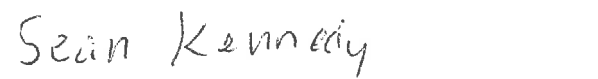
The committee requests that both LASD and DMH report to the COC regularly on the progress of the MET program and the status of the recommendations that may be adopted by the LASD.

Implementing the recommendations will solve problems far beyond MET. Uses of force affect all citizens, not just people struggling with mental illness. Police shootings generate enormous controversy throughout Los Angeles County and create a ripple effect that includes trauma to witnesses and survivors, serious long term damage to already struggling families and the erosion of community trust and support for LASD. Creating a culture of de-escalation throughout LASD will reduce police shootings, thereby also reducing the negative effects on communities caused by the shootings. Law enforcement personnel equipped with the skills and the specialized assistance also benefit from the reduced risk of injury to themselves. Deputies who are trained to affirmatively alleviate the suffering of mentally ill people by connecting them with treatment and services instead of incarcerating them will come to interact with all members of the community in a more empathetic manner. As such, implementing the recommendations will accelerate culture change throughout the entire department and

help achieve the dual goals of “constitutional policing” and “community policing” that are the foundation for healthy police-community relations.


Commissioner Patti Giggans (Lead)
Executive Director/CEO, Peace Over Violence


Commissioner James P. Harris
LASD Lieutenant (Ret.)


Commissioner Sean Kennedy
Executive Director and Professor, Center for Juvenile Law and Policy, Loyola Law School

FINAL REPORT OF THE SHERIFF CIVILIAN OVERSIGHT COMMISSION REGARDING THE MENTAL EVALUATION TEAM PROGRAM OF THE LOS ANGELES COUNTY SHERIFF DEPARTMENT

BOARD OF SUPERVISORS' MOTION

On January 10, 2017, the Board of Supervisors (BOS) requested the COC, in consultation with the DMH, the Inspector General (IG) and Sheriff, to identify potential improvements to the current co-response team deployment models that might more successfully achieve the program's mission of de-escalating violent confrontations between law enforcement and persons with mental illness.

SHERIFF CIVILIAN OVERSIGHT COMMISSION ACTIONS

After receiving the Board's request, the COC and its staff took the following actions:

1. Established an ad hoc committee consisting of three commissioners to work with the COC staff to study the MET Program and report back to the full commission. The members of the COC ad hoc committee are Commissioner Patti Giggans, Commissioner Sean Kennedy and Commissioner James P. Harris, staffed by Christine Aque, Analyst;
2. Participated in MET trainings such as the "In-Service" training using the MILO Training Simulators and mental health refresher trainings for deputies dealing with people with various mental conditions;
3. Participated in MET ride-alongs;
4. Participated in CIT trainings;
5. Had discussions with the IG;
6. Held several meetings with LASD (Lt. John Gannon, Lt. Sergio Murillo, Chief Stephen Johnson) and Miriam Brown, Acting Deputy Director of DMH, to discuss the MET model, expansion phase, de-escalation training, challenges and current status;
7. Held meetings with key informants which included Nancy Eng, Patricia Russell and Mark Gale of NAMI, Judy Cooperberg of the Los Angeles County Mental Health

Commission and Mental Health America, Donovan Muschett from Mental Health America, Nick Hyde from Disability Rights California, and Esther Lim of ACLU of Southern California;

8. Met with management from LAPD SMART, a local co-response team deployment model, located in the Police Administration Building in downtown Los Angeles;
9. Participated in LAPD SMART trainings;
10. Held a meeting with Judge Peter Espinoza of ODR to look at existing diversion efforts by the County; and
11. Researched similar co-response teams across the country to gather evidence on effectiveness and best practices.

MET ISSUES

Discussions with the IG took place on May 3 and August 8, 2017, with LASD on May 17, July 26 and November 27, 2017, with DMH on May 17, July 18 and November 2 of 2017, and during ride-alongs with the MET team on April 24, May 30 and June 17, 2017. A meeting with the LAPD SMART was held on August 3, 2017. A number of key takeaways arose from these meetings:

Interdepartmental Coordination

One initial challenge is the coordination between two departments with dissimilar cultures, systems and processes. LASD deputies are expected to be more flexible in their assignments in terms of locations and hours. Most clinicians/social workers are used to taking jobs that have regular predictable daytime shifts and stable locations. The adjustable scheduling needs of LASD did not always coincide well with DMH's processes, which include strict requirements on staffing notification per union rules. Initially these problems occurred when MET teams were reassigned to different shifts or locations. Recently, these issues appear to have been resolved between the departments. However, currently there is no MOU between DMH and LASD which may have contributed to these challenges. Best practice literature underscores the

need for a MOU to address how each agency will commit resources and address other issues.⁶

In addition, the MET expansion's newly created triage desk will need to develop clear policies and procedures on identifying whether calls need to be referred to the Psychiatric Mobile Response Team (PMRT), which is staffed by DMH clinicians that are dispatched to help individuals in mental health crisis, or MET, which may require a deputy's assistance. This will greatly alleviate the need to involve law enforcement in situations that may only require a clinician's assistance, although PMRT reports a daily backlog to handle the calls and occasionally asks the LASD MET to help with that workload. In fact, the 911 hotline dispatchers at stations may have to be part of a systemwide effort requiring training to properly triage and refer clients to the appropriate resources without needlessly having to involve law enforcement.

The need for coordination also extends to the ODR which provides funding for MET and CIT. ODR works with LASD in the jails and has diverted hundreds of inmates into their intervention programs since its inception. However, though ODR had expressed the need for assistance in their housing sites when a client is experiencing severe mental crisis, LASD MET's jurisdiction does not serve most of their sites. ODR needs to reach out to the jurisdiction within which their housing locations exist (typically LAPD but not exclusively) and seek their guidance as to how assistance can best be provided.

Geography

Due to the small number of MET teams covering the vast Los Angeles County service area of 4,084 square miles, MET is currently severely limited in its ability to respond to mental health situations in a timely fashion. Patrol deputies, being the first responders, are often faced with crises when the potential for tension and violence is greatest and when specialized mental health expertise is most needed. Since MET are not first responders, they arrive after the deputy is called to the scene. Due to the time delay, there is great pressure on the deputy to de-escalate the situation while calming and ensuring the individual's safety who may be experiencing a mental health issue while

⁶ Bureau of Justice Assistance (2008). Improving Responses to People with Mental Illness. Retrieved from: https://www.bja.gov/publications/le_essential_elements.pdf.

waiting for the arrival of the MET. It is clear that patrol needs to be able to handle these situations with increased training and skills for de-escalation. Arrival time to the scene is a critical problem with a county this large. Although the current expansion plan's proposed 23 teams⁷ may be a start, significantly more, i.e., 40 to 80, may be ideal and even necessary in the future to ensure effective coverage of Los Angeles County AND to be adequate for use in continued de-escalation efforts and the diversion of mental health patients to non-criminal justice resources and facilities. According to LASD, based on an analysis of their 2017 Third Quarter data, when MET completes its expansion at 23 teams, MET will be able to respond to 52-58% of mental health crises countywide. Currently about 16 field teams exist with eight-nine teams on duty each day. When the current expansion is completed with the full 23 teams, about 11-12 will be available each day inclusive of all three shifts. The calculations to determine the appropriate number of teams must take into account a relief factor for regular days off and vacations. Hence, one needs more than three teams to effectively cover three eight-hour shifts per day. Sheriff McDonnell, in his statement to the House Committee on the Judiciary Subcommittee on Crime, Terrorism, Homeland Security, and Investigations stated that "in Los Angeles County alone in areas policed by the sheriff's department, 911 calls involving people with mental illness have grown 55% since 2010."⁸ As the MET program continues to grow and evolve, and as mental health crisis calls continue to climb, the need for countywide 24-hour coverage by MET will become more evident.

Staffing

Adequate staffing is an issue. During the initial part of 2017, out of the ten MET co-response teams then available, three were deputy-only teams. This was inconsistent with the concept of a multi-disciplinary/co-response deployment team. DMH is experiencing difficulty in recruiting clinicians, possibly due to factors already mentioned

⁷ Chief Executive Officer's letter to the Board of Supervisors dated May 16, 2017. Retrieved from: <http://file.lacounty.gov/SDSInter/bos/supdocs/110734.pdf>.

⁸ Statement of James P. McDonnell, Sheriff of Los Angeles County on behalf of the Major County Sheriffs of America & the National Sheriff's Association Before the House Committee on the Judiciary Subcommittee on Crime, Terrorism, Homeland Security, and Investigations. Retrieved from: <http://docs.house.gov/meetings/JU/JU08/20170517/105964/HHRG-115-JU08-Wstate-McDonnellJ-20170517.pdf>.

such as less-than-desirable work shifts, but may also be due to the perception of the level of risk working alongside deputies. This is a specialized mobile clinical position that requires a certain willingness to be out in the field and meet extemporaneous crises, a qualification which may not always be readily found in potential candidates. Clearly the screening of both deputies and clinicians is vital to the success of this co-deployment team. San Diego's Psychiatric Emergency Response Team (PERT) which is San Diego's MET counterpart, experienced similar staffing issues owing to the perceived working conditions of the positions not being commensurate with the salaries.⁹ The idea of providing shift differential incentives to entice candidates for these shifts was considered during the meetings, but DMH sees challenges relating to the unions. Yet, this does not seem to be such a significant issue for the DMH clinicians deployed with the LAPD.

Another situation that arose during this current phase of the MET expansion is that the triage desk will have a DMH clinician only during the daytime hours (e.g., 10 a.m. - 8 p.m.) and a DMH supervisor on call for telephone consultation only outside of those hours, leaving a MET deputy to manage the triage desk. Unfortunately, due to the approved expansion plan not including funds for DMH staffing, this was the option left for DMH.

Training

To meet the departmental expectation and goal of de-escalation, training for all patrol deputies and station desk staff (911 "call takers") is paramount. Since the patrol station takes the 911 calls and patrol deputies are the first responders, it is incumbent upon them to properly assess and de-escalate these situations safely as they wait for MET to arrive. In our inquiry, the theme of all patrol deputies being trained in CIT has come up repeatedly. However, the CIT program was underfunded for the 2017-18 fiscal year with the approved budget not allowing for additional instructors or support staff. With approximately 2,826 patrol deputy positions (not factoring professional staff at station desks) and only four CIT instructors, LASD is unable to project a definitive timeline for

⁹ Letter to Honorable Judge Jeffrey Barton by Mark Marvin, Director of PERT, dated August 15, 2016, retrieved from: http://www.sandiegocounty.gov/content/dam/sdc/grandjury/reports/2015-2016/PERTReport_response2.pdf.

which all personnel will complete the training at the current level of funding and staffing (LASD Training Bureau, personal communication, July 5, 2017).

In addition, unlike the original “Memphis model” training curriculum, which is a 40 hour model, the current 32-hour LASD CIT curriculum does not consistently provide all its participants to engage in role-playing scenarios and practice de-escalation tactics as in the Memphis model. Two usable MILO scenario simulators are located at the LASD Industry and Palmdale Stations, and an additional “VirTra” simulator, which has more features, is offered at the LASD Training Bureau. These force option simulators provide realistic, incident based “stress-induced scenarios” that have been described by some as the best training tools¹⁰, although they are not yet incorporated into the LASD CIT training curriculum. Currently, a one-day LASD MET training, now endorsed by the Regional Community Policing Institute (RCPI), offered at the Industry Station teaches de-escalation tactics using the MILO system, in which pairs of deputies are evaluated in their ability to demonstrate de-escalation tactics in crises rather than resorting to use of force, or less force, whenever possible. MET leadership believes that this is a best practice that should be replicated within the LASD CIT program, as it is for the custody deputies undergoing the De-Escalation and Verbal Resolution Training (DeVRT) course. The number of force option simulators, compared with LAPD having one in every patrol division, is woefully inadequate to provide the benefits of the scenario-based practical skill training requirements envisioned in the CIT model. Ongoing training is also critical, as these are perishable skills and require repetition to develop optimal “muscle memory.” The training opportunities provided by such simulators may also benefit some of the personnel who have been in the department a long time who require a gradual cultural shift in the way of thinking about roles and of learned tactics, which usually tend towards force, rather than non-force, use.

Another important issue to consider in training is having measurable performance outcomes. This is critical as several hundred deputies have already completed the LASD CIT classes, yet there is no evaluation process to verify improvement in their

¹⁰ Police Executive Research Forum (2012) An Integrated Approach to De-escalation and Minimizing Use of Force. Retrieved from: http://www.policeforum.org/assets/docs/Critical_Issues_Series/an%20integrated%20approach%20to%20de-escalation%20and%20minimizing%20use%20of%20force%202012.pdf

skills in de-escalating situations. The lack of verifiable skill enhancement is a huge concern that may lead to the false assumption that the deputies are capable at de-escalation techniques when there was no opportunity to demonstrate these abilities in a supervised, controlled environment which allows for practice and remediation.

Additional suggestions raised during the COC ad hoc committee meetings include requiring training officers and sergeants to conduct ride-alongs with MET deputies, as well as having watch commanders and other higher level positions participate in the CIT and other MET trainings to become well acquainted with actual situations that deputies often face during crisis calls. Training should also be more closely coordinated between LASD and DMH to enable both the clinician and deputy to go to all the same trainings and to “be on the same page” when handling crisis situations together. Currently both departments each have their own separate trainings but are slowly moving toward cross-training.

One major challenge brought up by LASD regarding trainings is the need to maintain service levels; for example, contract cities have service level requirements that need to be met, which pose a difficulty both in backfilling and also paying for overtime in order for staff to participate in the trainings.

Mental Health Resources

Systemic drawbacks include the lack of facilities that are LPS-(Lanterman-Petris-Short Act)-designated, which are emergency psychiatric care centers providing beds for short term acute care, for individuals that are being placed on a 5150 hold. Unless the individual has private insurance, more often than not, individuals that are taken to County hospitals encounter long wait times to secure a bed. Wait time is always an issue when deputies are forced to accompany the individual until the handover takes place. Another concern is with “high utilizers” or “chronic consumers” of law enforcement resources. Deputies often are called to deal with the same individuals during calls who are repeatedly in and out of hospitals without any long term plans for stabilization. Follow-up care and case management obviously is a critical issue to be considered as part of MET. There is an unfortunate lack of access to beds statewide,

although the County is looking to increase the number of public treatment facilities. This is a worthwhile endeavor given a recent cost study showing that public mental health spending is associated with a return on investment by reducing the number of inmates in the jails.¹¹ Of particular note is also the need to address the lack of sobering treatment centers along with this lack of urgent care center (UCC) drop off locations as most UCCs will not take someone under the influence. This dearth of resources is especially significant for the Antelope Valley area.

Transportation

The availability of transportation units for transporting patients to facilities is also another significant concern. County and private ambulances are called in for patients that meet certain criteria which do not allow for MET units to provide transportation. Such circumstances include patients who are non-ambulatory, pregnant, have certain medical conditions, or are frail. It could take up to three to seven hours for an ambulance to arrive, which could also impact MET team availability for other situations as they have to accompany the individual until the arrival of the ambulance. Currently there are 37 ambulance companies serving the entire County¹². More research is needed as to how other systems work out their transportation needs. Additionally, the lack of cars for MET teams is also a continuing challenge. Although there is the consideration for the necessity to balance the optimal use of cars with their actual availability, transportation for MET staff should be prioritized in order for them to actually be available for service.

Case Management/Follow-Up

One of the primary areas that will be addressed more deeply during the future expansion phases of MET is the Risk Assessment and Monitoring Program (RAMP). RAMP is currently a pilot program which selects a few cases, e.g., "chronic consumer" clients for follow-up to ensure linkages to services. Completed 5150 hold applications from patrol deputies who were not assisted by MET on calls will be reviewed in the

¹¹ Treatment Advocacy Center Research Weekly (2017). Psychiatric beds spending linked to jail population reduction. Retrieved from: <http://www.treatmentadvocacycenter.org/fixing-the-system/features-and-news/3755-research-weekly-psychiatric-beds-spending-linked-to-jail-population-reductions>.

¹² Telephone call to Los Angeles County Emergency Medical Services Agency, August 23, 21017

future to see which individuals need MET follow-up. MET staff will conduct in-person visits to the individual and/or caretaker to determine if linkages can be made to community health service providers. This case management model is loosely based on the structure of the LAPD Case Assessment Management Program (CAMP) which comprise a detective and clinician team that follow up on repeat contact or high-risk individuals. However, the LASD RAMP lacks sufficient personnel to provide adequate countywide follow-up on most WIC 5150 patients encountered by the department. This is an area currently being explored in depth by LASD which is looking to expand the program beyond the addition of just one sergeant to oversee all RAMP cases countywide in this current fiscal year. All aspects of the MET program need to be evaluated, including whether the LASD is the most appropriate agency for tasking with this critical mental health follow-up.

Strategic Direction and Vision for the MET Program

The COC ad hoc committee requested a longer term strategic plan from LASD to identify plans for the future expansion and development of MET. It is vital to think in terms of vision and goals for improving services to the mentally ill and developmentally disabled and responses to a variety of mental health issues, which includes both the expansion and effectiveness of MET. The LASD is drafting a multi-phase expansion model for MET under the leadership of Unit Commander Lieutenant John Gannon, which will address, at a minimum, some of the elements already described above, including an expanded triage desk which is patrol-centric and will be able to dispatch, improved technology, the creation of public-private partnerships, and the possible use of “Tele-Mental Health” technology to assist patrol deputies in accessing a clinician directly to assist in encounters. The strategic plan will engage the formation of five to six regional centers. The size of the county warrants a regional approach with clusters that are decentralized so as to impact response times. The MET program is part of LASD’s vision to create a command structure that oversees all the mental health initiatives, including MET, CIT, triage desk and a community outreach program. The plan is still currently in development although most of the points discussed during meetings with

LASD are examined in this report. The COC ad hoc committee endorses the strategies as discussed in the meetings which are part of the longer term vision for MET.

OTHER LASD CO-RESPONSE TEAMS

LASD also has two other co-response deployment team models: the Higher Education Assessment Teams (HEAT) and the Crisis Response Units (CRU) which self-identify as Transit MET teams (TMET). Both are comprised of a sworn deputy and a clinician, although some of the TMET units are staffed by a deputy only.

There are two HEAT Teams that provide threat assessment services for the nine community colleges that are part of the Los Angeles Community College District (Los Angeles City College, East Los Angeles College, West Los Angeles College, Los Angeles Trade Tech College, Los Angeles Southwest College, Los Angeles Harbor College, Los Angeles Valley College, Los Angeles Pierce College, and Los Angeles Mission College). HEAT Teams are not dispatched to actual calls for service, but respond to campus requests due to complaints about students or faculty of concern. From January through September 2017, HEAT teams have responded to 106 referrals (interviews) and opened cases and/or conducted full threats assessments on 7 individuals. The goal is to intervene with troubled students/staff before they reach that breaking point that can lead to violence. The HEAT Teams have intervened with several individuals who were in possession of deadly weapons and believed to possibly use them if intervention had not taken place. Deputies generally participate in trainings provided to the DMH clinicians such as Mental Health and Autism Training, Terrorist/Radicalization Training provided by USC, CIT, Increased Challenges in Working with Middle Eastern Communities, Association of Threat Assessment Professionals, Racial Profiling Training and Mental Health Awareness and De-escalation Training.

CRU/TMET consists of six one-man units with two DMH clinicians assigned to two of the deputies. They provide services to the Metro clients on the Los Angeles Metro Rail and bus system (e.g., Blue Line, Green Line, Gold Line, Silver Line and the Bus Zones under contract). From January through September 2017, TMET had a total of 4,003

contacts, of which 6% were successfully transported to mental health services under 5150 holds, whereas an additional 14% were transported to medical or other homeless outreach services. TMET staff go through several mental health-related conferences and training courses, including CIT and CNT.

There was discussion of an integrated collaboration between the TMET and MET programs by having all calls dispatched via the new triage desk to increase the capacity to serve the large county service area. This is still under debate, but may be a feasible alternative to further augment the overall number of MET teams while simultaneously offering Metro potentially shorter response times for the nearest team to respond more quickly to calls impacting the transit system.

SIMILAR CO-RESPONSE TEAM MODELS OUTSIDE OF LASD

While the LASD was the first agency to have MET in 1991, the LAPD started in 1993 and has evolved into a model for other departments in the country. It has a co-responder team called the SMART which is the largest in the country and also partners with DMH. The LAPD has a Mental Evaluation Unit (MEU) which has five components: 1) mental health/crisis intervention training for all patrol officers, 2) triage desk, 3) crisis response team known as SMART which is similar to MET, 4) CAMP, and 5) community engagement which aims to establish linkages with mental health providers. Much of this LAPD model is replicable. The LAPD SMART team has the advantage of having a centralized location which lends itself to building a more cohesive, collaborative culture. The SMART officers wear civilian clothing with the SMART emblem embroidered on their shirts. Their tactical equipment, vests, etc. are always with them in their cars ready if needed. This presents a non-threatening appearance on the scene, similar to the LASD MET and consistent with the requirements of WIC 5154.

The MEU's community engagement component attempts to bridge the gap between the community and patrol officers by conducting outreach quarterly in different areas of the city, educating the public about their activities, and using the relations established to build a network that may help support individuals from "falling through the cracks."

They have staff assigned to that unit full time, and are finding it a critical part of their success. The LASD MET lacks this important component due to lack of staffing.

LAPD is developing an online training curriculum in conjunction with NAMI that consists of video online training that will explain what NAMI is, what resources are available, and which will be a required course. One key recommendation they made about de-escalation and crisis intervention is to not be insular and to attend as many conferences as possible to learn what other agencies are doing and incorporate best practices into your own program.

The Long Beach Mental Evaluation Team (LBMET), which is also staffed by DMH as well as the Long Beach Police Department (LBPd), had been in operation since 1996. Although unable to share any program data, the LBMET supervisor made an observation about the enhanced skills set acquired by patrol officers as a result of interactions with MET. Now LBPd is rather sophisticated in dealing with the mentally challenged people they encounter.¹³

San Diego's PERT is also a similar model, although their clinicians are from a nonprofit agency that deploys them to various law enforcement agencies. These teams can cross into other jurisdictions if needed as per a regional agreement. In the last year, they had about 8,000 crisis calls of which 53% were detained under a 5150 hold.¹⁴

These co-response teams are loosely based on the Crisis Intervention Team “Memphis model” which is considered a best practices model nationwide consisting of a 40-hour specialized training.¹⁵ Research suggests positive outcomes of the Memphis model, including lower rates of arrests among the mentally ill, decreased use of SWAT teams, reduced risk of injury both to officers and individuals with mental illness, less use of force and cost savings.^{16,17,18}

¹³ Interview with Frank Mullnix, Supervisor of Long Beach MET on September 19, 2017.

¹⁴ Interview with Marla Kincaid, Law Enforcement Liaison of San Diego PERT on October 6, 2017.

¹⁵ L.E.A. Walker et al. (2016). Best Practices for the Mentally Ill in the Criminal Justice System. Retrieved from http://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=3&cad=rja&uact=8&ved=0ahUKEwjelfXytfWAhWkqVQKHVaCC54QFgg1MAI&url=http%3A%2F%2Fwww.springer.com%2Fcd%2Fcontent%2Fdocument%2Fcd_downloadaddocument%2F9783319216553-c2.pdf%3FSGWID%3D0-0-45-1522181-p177567014&usq=AQvVaw3zIfAvoRIDVQEqgiHZssb.

Watson & Fulmabarker (2012). The Crisis Intervention Team Model of Police Response to Mental Health Crises: A Primer for Mental Health Practitioners. Retrieved from: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3769782/pdf/nihms500811.pdf>.

A study on the Houston Crisis Intervention Response Team program showed a lower likelihood of using deadly force as well as a higher likelihood of using verbal commands as a de-escalation tactic.¹⁹ The Burbank Police Department has a Mental Health Evaluation Team which conducted an evaluation of its program. While there were no marked differences between rates of overall uses of force within the department and uses of force during mental health service calls, rates of arrests decreased within a two year period since its inception.²⁰

PUBLIC INPUT

Key informants from the public were invited by the COC on June 19, 2017 and September 18, 2017 to express their input regarding the LASD's MET program. Community members in the meeting touched on several themes regarding the mentally ill and made the following suggestions:

1. There is not enough access to acute psychiatric care which is a problem across the board. Lack of community resources such as beds is a challenge.
(Currently there are about 1,900 public and private beds in Los Angeles County, some of which may not be available for the 5150 holds²¹.)
2. CIT has been known to help decrease litigation costs. Priority should be given to this mental health training for all the LASD patrol deputies who are the first responders. *(The LASD CIT training includes some of the core elements of the CIT "Memphis model" but is adapted to the needs of the LASD deputies specifically emphasizing de-escalation, de-criminalization of mental illness, and diversion from the criminal justice system through linkages to appropriate community resources and supports. Currently there are no actual metrics to verify enhanced skills gained from the training.)*

¹⁷ Canada, Angell & Watson (2010). Crisis intervention teams in Chicago: Successes on the ground. Retrieved from: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2990632/pdf/nihms205753.pdf>

¹⁸ Dawson, S. (n.d.) Written Testimony In Support of SSB 5311, Crisis Intervention Training. Retrieved from: <http://www.namitm.org/wp-content/uploads/2016/02/NAMI-Crisis-Intervention-Trainings-Positive-Fiscal-Impacts.pdf>.

¹⁹ Colucci, McCleary & Ng (2014). Mathematical methods in the social sciences Houston Texas Police Department Project on officer-involved shooting. Retrieved from: http://www.houstontx.gov/police/departments_reports/ois/HPDThesis.pdf

²⁰ Iacobono, M. (2015). Burbank Police Department Mental Health Evaluation Team (MHET) Evaluation. Retrieved from: <https://pqdtopen.proquest.com/doc/1674331742.html?FMT=AI>.

²¹ Hunt, J. (2017). LASD Crisis Intervention Training Course, April 10-13, 2017

3. Field training officers (FTOs) should be prioritized for LASD CIT training. *(FTOs were trained first in state mandated eight-hour mental health awareness training.)*
4. Deputies should have regular refresher trainings for CIT. *(The one-day RCPI Training on Mental Health and the one-day In-Service Mental Health training courses offered occasionally by LASD are both worthy to consider as continuing education mandates after completion of the 32-hour LASD CIT course).*
5. Reducing the length of the mental health training curriculum in order to be able to train more officers was also proposed, as having every deputy on active duty equipped with some knowledge of mental illness is better than none.
6. Cross training should occur for both the deputy and clinician in order to understand each other's perspectives and language and clarify responses during a crisis.
7. The proposed triage desk is a good idea as it allows the deputy to get consultation while on the scene, especially while waiting for a MET team or if none is available. *(The new LASD/DMH Triage Desk had a "soft launch" on December 7, 2017, where it has remained open 24/7 ever since.)*
8. Lived experience is critical to the mental health training; both mental health community advocates and deputies should share their experiences in order to problem-solve issues and to reinforce learning. *(NAMI has been consulted in the development of the LASD CIT training which include a session with NAMI representatives. The "Autism Interaction Solutions" has been providing a 2-hour training on developmental disabilities, including an interactive hour-long experience among patients and deputies, with the MET 8-hour "In-Service" training offered through RCPI.)*
9. Statistics should be tracked on use of force, particularly comparing CIT-trained officers and non-CIT-trained officers.
10. There is a breakdown in communication between service providers and first responders which results in critical information such as contextual factors of a situation involving mentally ill patients being overlooked. Proper procedures need to be in place in order to ensure that that critical information is passed on and understood by first responder officers. *(This lack of communication was also*

pointed out by ODR which has experienced similar challenges with law enforcement, in general, in knowing what their roles are in the transport of 5150 hold clients. This again recalls the need for training for first responders.)

11. DMH should reinforce accountability measures for service providers that are charged with the safety and well-being of their mentally ill patients.

The community members were unanimous in their agreement that the following items are critical to achieving the program mission:

- Prompt completion of Crisis Intervention Training for all patrol deputies; and
- Increasing the number of MET teams.

ANALYSIS

In his testimony to US House, Sheriff McDonnell's observed the "need to reexamine how first responders approach and deal with people having a mental health crisis."²² He described some approaches for law enforcement in addressing mental health issues. Among them, CIT needs to be provided to all first responders such as law enforcement. Also access to co-response deployment teams and mental health treatment centers need to be expanded. Diversion efforts should include better training of district, city and defense attorneys as well as having mental health courts that provide treatment options for those with mental illness rather than send them to jail or prison. Also jails and prison facilities need to be revamped in order to provide the most appropriate conditions to facilitate treatment. These approaches reflect the lessons learned from the research undertaken by the COC ad hoc committee.

MET has the potential to de-escalate encounters between deputies and mentally ill people, thereby reducing both the number of police shootings and the large monetary settlements that follow improper shootings. However, based on the information gathered, MET has very little ability to do "de-escalation" in the conventional sense.

²² Statement of James P. McDonnell, Sheriff of Los Angeles County on behalf of the Major County Sheriffs of America & the National Sheriffs Association Before the House Committee on the Judiciary Subcommittee on Crime, Terrorism, Homeland Security, and Investigations. Retrieved from: <http://docs.house.gov/meetings/JU/JU08/20170517/105964/HHRG-115-JU08-Wstate-McDonnellJ-20170517.pdf>.

Since there are not enough units for MET to act as first co-responders, they usually arrive after the initial encounter between the patrol deputy and the mentally ill person is already over. Recent research shows that calls involving individuals experiencing acute mental health crises are “by definition, already escalated and ripe for the use of force as a means to secure the scene as officers are trained to do.”²³ As such, MET often isn’t on the scene when the potential for tension and violence is greatest and when specialized mental health expertise is most needed. During the early part of 2017, MET often took 1 – 1.5 hours to respond to some calls due to limited availability, making it impractical for the patrol deputy to rely on MET assistance for de-escalation. The low number of MET units results in long delays and makes it hard for them to meet their mission, whether that is de-escalation or diverting mentally ill people to hospitals.

While the LAPD’s SMART program deploys at least 17 units daily to cover the city of Los Angeles, MET in comparison is severely understaffed. MET simply cannot meet its mission with so few units, with leadership in both departments suggesting the ideal number being at least 43-80 units. Increased funding for more MET units may allow them to decentralize and cover more parts of the county, thereby reducing the time it takes MET to arrive on the scene to assist patrol deputies.

Institutional factors may also inhibit MET from achieving de-escalation. As evidenced by the existence of MET units staffed only by a deputy sheriff in some cases, there may be some difficulty recruiting DMH clinicians. DMH acknowledged the difficulty in recruiting clinicians to cover some shifts, which require working during nights, weekends, and holidays. While 24-hour, 7-days-per-week coverage is deeply ingrained in LASD culture, most DMH clinicians are accustomed to working in clinics that treat people during regular business hours, Monday through Friday. DMH may need to consider offering bonuses or flexible work schedules to clinicians to incentivize them to work unpopular MET shifts. However, DMH expressed concerns that this may have implications for union rules. Union rules, however, are subject to negotiation and this option needs to be explored.

²³ Pifer, N. A. “Policing the Mentally Ill in Los Angeles on the Frontlines of Transinstitutionalization.” Under review for *The Challenges of Policing in America: Security, Dignity, Democracy*, Tamara Rice and Eric Miller, eds. Cambridge University.

DMH clinicians may also be reluctant to directly participate in first-response or other high tension encounters with mentally ill people because, unlike sheriff deputies, they aren't trained or equipped for self-protection if an encounter turns violent. Clinicians don't have firearms, Tasers, mace, bullet-proof vests or keys to the car they travel in. Some feel like they are "sitting ducks" and may have fears about what will happen if their deputy partner becomes incapacitated. Further dialogue between DMH and LASD is needed to address clinicians' safety concerns.

With regards to training, the MILO simulator training was also highly effective in creating an impact on the trainee deputies. The benefits of such trainings are clear: they help patrol deputies more effectively interact with mentally ill people and reduce the potential for excessive use of force, including shootings. The training could even be made more effective had a DMH clinician been present to provide additional feedback. It would be worthwhile for LASD to offer this type of high-quality, interactive training to all deputies on a faster schedule than currently being contemplated.

SPECIFIC RECOMMENDATIONS

Based upon the COC ad hoc committee's intensive review, four strategic recommendations are made, each of which include more specific recommendations that may be considered by LASD:

I. INCREASE THE NUMBER OF MET TEAMS FROM 23 TO 60

1. The recently Board-approved number of 23 MET teams should be expanded to 60.
2. Since all MET teams are not always on call at the same time, LASD and DMH need to determine shift scheduling such that the maximum number of teams is always available.
3. Develop hubs within certain divisions, and have a lieutenant serve as the mental health liaison. Hubs will maintain the close collaborative nature as in LAPD's SMART, which is centralized.

4. Funding should be intensified for LASD and DMH to be able to develop a joint strategic plan for incrementally hiring and training staff to reach the targeted number of 60 MET teams.
5. Prospective social workers need to be supported in their concerns about the perceived risks of the position.

II. PRIORITIZE DEPARTMENT-WIDE DE-ESCALATION TRAINING WITH A MENTAL HEALTH FOCUS

1. Comprehensive de-escalation training with a mental health focus such as the CIT should be made a priority at LASD so that all patrol deputies will be trained much earlier than the six-year projected completion timeframe (as of February 2017)²⁴.
2. Increase the current number of training personnel to address the above.
3. The MILO Simulator component should be incorporated into the CIT training.
4. Having a training simulator in every station is essential to afford every deputy the opportunity to practice de-escalation skills. Collateral benefits will accrue from this approach.
5. Clinicians should be available to do the debriefing after every MILO training session to provide the clinician perspective.
6. MET personnel should have a primary role in conducting the CIT and other de-escalation training sessions with a mental health focus due to their valuable first-hand knowledge and experience.
7. Develop and implement a plan for refresher CIT and other de-escalation training sessions with a mental health focus to be offered at regular intervals and incorporate current best practices. These refresher training sessions should be a requirement implemented with the same frequency as weapons qualifications.
8. CIT training is currently only for patrol deputies and sergeants, but not for watch commanders, unit commanders or higher level executives. CIT and other de-

²⁴ Presentations by Chief Stephen Johnson on Los Angeles County Sheriff's Department Investment in Mental Health Initiatives and Miriam Brown, LCSW, Acting Deputy Director, County of Los Angeles Department of Mental Health. Sheriff Civilian Oversight Commission Meeting, February 23, 2017, slide 16. Retrieved from: http://file.lacounty.gov/SDSInter/bos/supdocs/1018407_AttachmentIII-5LASD-MentalHealthPowerpoint.pdf

escalation training, even if abbreviated, may be beneficial in order for them to provide better direction in crisis situations and formulate good policies.

9. Train patrol officers on how to better complete 5150 hold applications, so that the LPS-designated facility or urgent care center does not release the individual early due to insufficient hold criteria being met, and so that the individual actually obtains needed treatment.
10. Consider promoting training on deputy self-care and mindfulness training, to include trauma-informed practices on addressing PTSD and vicarious trauma.
11. Require training officers, including Master Field Training Officers, and sergeants to conduct ride-alongs with MET personnel to increase their understanding of mental health crisis situations.
12. Develop and implement measurable performance outcomes for CIT and other de-escalation training sessions to ensure that trainee deputies have acquired the necessary knowledge and skills that are taught.
13. Consider more cross-training between LASD's deputies and DMH's clinicians so that both team partners obtain the same knowledge and skills and "be on the same page" when responding to situations.

III. PROMOTE INTER-AGENCY COLLABORATION WITH OTHER MENTAL HEALTH PARTNERS AND STAKEHOLDERS

1. The Sheriff and DMH should reinforce the collaborative process between the two departments to ensure that MET teams are always fully staffed. An MOU needs to be developed to set clear expectations for each department.
2. Both LASD and DMH need to agree on scheduling with a one-year commitment from LASD on the locations and shifts in order to address clinician concerns around scheduling stability.
3. Both LASD and DMH needs to develop a plan for incentivizing clinicians, particularly for hard-to-fill shifts. A public sector labor lawyer may be consulted to evaluate options to address relevant union issues.

4. A steady management structure is needed for LASD in order to ensure continued championing of MET efforts. In the past, the continuing change in LASD leadership over the MET program may have contributed to the delay in the progression of MET since it first started in 1991.
5. Identify the characteristics and elements needed to form a more cohesive team culture between the two departments (team building).
6. The proposed Telemental health program by DMH may be a worthwhile consideration to increase patrol deputies' access to clinicians and obtain guidance and support in dealing with individuals in crisis. However, this should not supplant the need for additional MET units.
7. Reduce the paperwork demands on clinicians in order to increase their availability to the teams.
8. The newly created triage desk needs to include a DMH clinician on site at least 20 hours per day during a.m. and p.m. shifts to serve its optimal purpose of providing consultation to every call if necessary.
9. Expand RAMP in order to better identify chronic consumer cases and link them to services to reduce the recurrences of calls. Currently 12% of all patients handled by the MET units need RAMP services and follow-up to ensure linkage.
10. Just like LAPD SMART's community engagement piece, with additional staff, the LASD could also regularly engage communities to educate them about the MET program and expand their network of potential resources. This will indeed be helpful particularly for referring individuals they encounter that do not necessarily meet 5150 hold criteria.
11. Transportation via ambulance needs to be looked into further in order to ensure rapid transport to facilities for those meeting 5150 hold criteria. There may be other opportunities to explore such as wheelchair van service.
12. Proper procedures in the dispatching of mental health crisis calls should be reinforced to ensure that all critical information is passed on and understood by first responders.

IV. TREAT MET AND DEPARTMENT-WIDE DE-ESCALATION TRAINING WITH A MENTAL HEALTH FOCUS AS EQUALLY IMPORTANT, COMPLEMENTARY STRATEGIES FOR REDUCING USES OF FORCE AND PROMOTING CONSTITUTIONAL POLICING

1. Increase budgets for both MET and department-wide de-escalation training with a mental health focus to ensure that neither strategy for reducing uses of force is underfunded.
2. The LASD and DMH should jointly develop a strategic plan for a longer term vision in addressing mental illness in the community. For this reason, both the MET teams and de-escalation training programs with a mental health focus such as the CIT should be regarded as equally vital as the LASD's Special Weapons and Tactics (SWAT) program, another program with specialized expertise in handling high risk situations.
3. Support the creation of more urgent care and other psychiatric care facilities to ensure that individuals with mental health concerns get the appropriate care and treatment needed.

CONCLUSION

The COC ad hoc committee strongly recommends the consideration of these recommendations in order to promote the co-response program mission of de-escalating violent confrontations between law enforcement and persons with mental illness, as well as provide a rapid and compassionate response at the time and place the crisis is occurring. These recommendations will facilitate a culture of de-escalation throughout LASD that will impact rates of uses of force on the mentally ill and the subsequent lawsuits and settlements.

Because of the continuing interest that the public holds in this issue, the committee requests that both LASD and DMH report to the COC regularly on the progress of the MET program and the status of the recommendations that may be adopted by the LASD.



Commissioner Patti Giggans (Lead)

Executive Director/CEO, Peace Over Violence



Commissioner James P. Harris

LASD Lieutenant (Ret.)



Commissioner Sean Kennedy

Executive Director and Professor, Center for Juvenile Law and Policy, Loyola Law School