

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



August 24, 2017

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## **EXECUTIVE SUMMARY**

By motion of January 10, 2017, the Board of Supervisors (Board) requested that the Sheriff Civilian Oversight Commission (COC) recommend 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 deputies and persons with mental illness. The COC ad hoc committee studying the issue held meetings with the Los Angeles Sheriff Department (LASD) and Department of Mental Health (DMH) management staff overseeing the Mental Evaluation Team (MET) Program, had a meeting with the Los Angeles Police Department (LAPD) System-wide Mental Assessment Response Team (SMART), had discussions with the Inspector General (IG), took public comment, conducted ride-alongs with MET and participated in the LASD MET training. The ad hoc committee requested for LASD to develop a longer term strategic plan with a five to seven year timeline for MET to improve services to the mentally ill, developmentally disabled or other mental conditions and people in crisis. This is currently in development and will be included in the final report. Our research is corroborating the belief that MET is a promising and best practice that will greatly enhance the well-being and safety of the people of Los Angeles County. We are encouraged that this approach is one of intelligence and forward-thinking. The ad hoc committee has been thoughtfully and mindfully researching the issue and plans to release the final report on its recommendations in time for the COC Meeting on October 26, 2017.

## **BOARD OF SUPERVISORS' MOTION**

On January 10, 2017, the Board of Supervisors (BOS) requested the COC, in consultation with the DMH, the 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 RESPONSE**

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 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 Multiple Interactive Learning Objectives (MILO) Training Simulators and mental health refresher trainings for deputies dealing with people with various mental conditions;
3. Participated in MET ride-alongs;
4. Held discussions with the Office of Inspector General (OIG);
5. Held a total of four meetings with management from the LASD (Lt. John Gannon and Lt. Sergio Murillo) and Miriam Brown, Acting Deputy Director of DMH, to discuss the MET model, de-escalation training, challenges and current status;
6. Held a special meeting of the ad hoc committee with key informants which included members from the National Alliance for Mental Illness (NAMI), Mental Health America, Disability Rights California, American Civil Liberties Union (ACLU), and the Los Angeles County Mental Health Commission; and
7. Met with management from LAPD SMART a local co-response team deployment model, located in the Police Administration Building in downtown Los Angeles.

## **MET ISSUES**

Discussions with the OIG took place on May 3, 2017 and August 8, 2017, with LASD on May 17, 2017 and July 26, 2017, with DMH on May 17, 2017 and July 18, 2017, and during a ride-along with the MET team on June 17, 2017. A meeting with the LAPD SMART was held on August 3, 2017. A number of key takeaways arose:

### **Departmental Coordination**

One major 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. DMH clinicians; however, are assigned more stable shifts and locations. DMH is currently experiencing difficulty in recruiting clinicians due to less-than-desirable shifts, e.g., 3pm-1am or Wednesday through Sunday. The vast geographic locations of MET are a considerable factor also. Most clinicians/social workers are used to taking jobs that have regular predictable daytime shifts. The adjustable scheduling needs of LASD do not always coincide well with DMH's processes, which include strict requirements on staffing notification per union rules.

### **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 functioning as a diversion tactic to take individuals to facilities for mental health assessments rather than for de-escalation. 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 pacify the situation and calm and secure the individual's safety who may be experiencing a mental health issue while waiting for arrival of the MET. Therefore, it is becoming 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 teams<sup>1</sup> 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 as a de-escalation tactic and diversion to resources accompanying first responders.

## **Staffing**

Adequate staffing is an issue. Out of the ten MET co-response teams, three are deputy-only teams. This is 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 such as the less-than-desirable 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.

## **Training**

To meet the departmental expectation and goal of de-escalation, training for all patrol deputies is paramount. Since the patrol deputies are the first responders, the opportunity for de-escalation is usually on them in general, and in particular in crisis situations as they wait for MET to arrive. In our inquiry, the theme of all patrol deputies being Crisis Intervention Team (CIT)-trained has come up repeatedly. However, the CIT program was underfunded for the current fiscal year with the approved budget not allowing for additional instructors or support staff. With approximately 2,826 patrol deputy positions and only four CIT instructors, LASD is unable to project a definitive timeline for which all personnel will complete the training at the current level of funding and staffing.

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<sup>1</sup> 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>.

In addition, unlike the original “Memphis model” training curriculum, current LASD CIT courses do not include every participant to engage in mandated role-playing and extensively practice de-escalation tactics, despite having the means to do so. Two usable MILO scenario simulators are located at the Industry and Palmdale Stations as well as a “VirTra” simulator at the LASD Training Bureau which has yet to be incorporated into the LASD CIT training curriculum. By comparison, the one-day LASD MET training offered in partnership with the Industry Station teaches de-escalation tactics, in which pairs of deputies must provably demonstrate their ability to de-escalate crises rather than resorting to use of force, or less force, whenever possible. This is a best practice that should be replicated, as it is for the custody deputies undergoing the De-Escalation and Verbal Resolution Training (DeVRT) course. This is vitally important as several hundred deputies have already completed the LASD CIT classes, yet there is no evaluation process to verify improvement in their 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.

In addition to the CIT, the Crisis Negotiations Training (CNT) was also considered effective and has been recommended as a source for additional training. However, this is a 40-hour course that should not be prioritized over the LASD CIT training, with the added simulator enhancements. Additional suggestions include requiring training officers and sergeants to conduct ride-alongs with MET deputies, as well as having refresher training for patrol deputies to keep skills fresh. 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.

### **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 Welfare and Institutions Code (WIC) 5150 hold. The 5150 hold is the involuntary treatment of a mentally disordered person who may pose a danger to self or others or is gravely disabled. 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 “revolving door patients.” 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.

### **Transportation**

The availability of transportation units for transporting patients to facilities is also another 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 23 ambulance companies serving the entire County. More research is needed as to how other systems work out their transportation needs.

### **Local Law Enforcement Model**

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 co-supported by DMH as a co-deployment model. 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) the Case Management Assessment Program (CAMP) which comprise a detective and a clinician that follow up on repeat contact or high-risk individuals, and 5)

community engagement which aims to establish linkages with mental health providers. The community engagement component also attempts to bridge the gap between the community and patrol officers by conducting outreach, 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.” 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 LASD will have to work toward making this happen in a more regionalized system. 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.

### **Case Management/Follow-Up**

One of the primary areas that will be addressed more deeply during the expansion phase is the Risk Assessment and Monitoring Program (RAMP). RAMP is currently a pilot program which selects a few cases, e.g., “revolving door” clients for follow-up to ensure linkages to services. Completed 5150 forms from patrol deputies who were unable to get MET on calls will be reviewed in the future to see which individuals need critical follow-up. MET staff will conduct in-person visits to the individual 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 CAMP. 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; further recommendations will be made for program expansion beyond the addition of just one sergeant to oversee all RAMP cases Countywide in this current fiscal year.

### **Strategic Direction**

The 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 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, creating public-private partnerships, and the possible use of “Telemental 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 the estimated time of arrival (ETA). One of the questions to be explored is where MET fits within the department. The plan is being developed and will be included in the final report by the ad hoc committee.

## **PUBLIC INPUT**

Key informants from the public were invited by the COC on June 19, 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 WIC 5150/LPS/Involuntary holds.)*
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.)*
3. Field training officers (FTOs) should be prioritized for LASD CIT training. *(FTOs were trained first in state mandated 8-hour mental health awareness training.)*

4. Deputies should have regular refresher trainings for CIT. *(The current one-day Regional Community Policing Institute Training on Mental Health and the one-day In-Service Mental Health training courses offered occasionally at the Industry Station 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.
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.)*
9. Statistics should be tracked on use of force, particularly comparing CIT-trained officers and non-CIT-trained officers.

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.**

## **NEXT STEPS**

MET has the potential to de-escalate encounters between deputies and people with mental health issues/conditions in crisis, as well as divert mentally ill persons away from the criminal justice system whenever possible. This will reduce the number of police shootings, use of force, prevent injury and death, and also potentially reduce the large monetary settlements that arise from lawsuits. MET will increase its capacity to triage and help with case management so that persons with mental conditions can be referred for care and follow-up. This model is a promising practice and has the potential to become a best practice.

The ad hoc committee's next steps are to continue our research and inquiry, include more public input, review the completed plan from LASD on the longer term vision for improving services to the mentally ill and developmentally disabled, and make recommendations for expansion and improvement of MET. The ad hoc committee plans to release the final report on its recommendations in time for the COC Meeting on October 26, 2017.