A DESCRIPTIVE STUDY OF LAPD'S CO-RESPONSE MODEL FOR INDIVIDUALS WITH MENTAL ILLNESS

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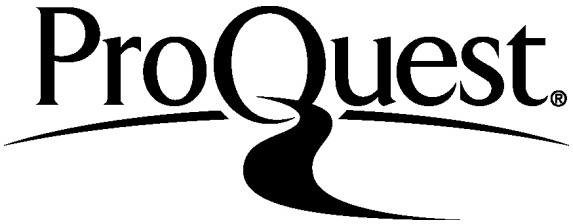

ABSTRACT

A DESCRIPTIVE STUDY OF LAPD'S CO-RESPONSE MODEL FOR INDIVIDUALS WITH MENTAL ILLNESS

By

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Police strategies have transformed over the years. The prior approach of criminalizing mental illness by incarcerating those in mental health crisis in jails was exposed to be ineffective. The development of partnerships between police officers and mental health professionals was the next evolution in the law enforcement response to mental illness. This collaboration works in partnership to provide positive outcomes for those struggling with a mental health crisis. This quantitative study evaluated the effectiveness of the co-response model by completing a secondary data analysis of pre-existing 2014-2015 data extracted from the Los Angeles Police Department (LAPD) Mental Evaluation Unit database documenting law enforcement encounters with consumers of mental health services. Descriptive and inferential analyses were conducted on 15,454 records. Significant findings indicate that this new partnership has provided a positive impact in deterring the criminalization of persons with mental illness by directly connecting those persons to more appropriate treatment facilities to help them manage their symptoms and conditions.

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CHAPTER 1

INTRODUCTION

Since the beginning of the deinstitutionalization process of those with a mental illness in the 1950s, there have been problems with the strategies for treating mental health service consumers, especially those who encounter the police on the street. When the deinstitutionalization program began, what was not considered was the dramatic adjustment in the delivery of services that would be required with the next generation of mental health service consumers (Lamb & Bachrach, 2001). Persons with severe mental illness warrant safety and protection. However, as a result of deinstitutionalization, many traded institutional confinement for a different form of institutional care through nursing homes, intermediate care facilities, jails and prisons, and by becoming homeless (Yohanna, 2013). This has created a situation in which law enforcement officers have become the primary gatekeepers to mental health services when a person with a mental illness is in crisis or in need of services (Lurigio & Watson, 2010). The Crisis Intervention Team (CIT) model for law enforcement, developed in 1988, was envisioned to improve the response of law enforcement to calls for service involving persons with a severe mental illness (Watson & Fulambarker, 2012), but over the years there have been few advancements in this model.

Law Enforcement Response to Mental Illness

Individuals living with a severe mental illness often do not have positive interactions with police officers responding to calls for service (Lord, Bjerregaard, Blevins, & Whisman, 2011). The first-generation approach to improving police responses to mental illness focused on providing brief behavioral training only to police officers, but this training was not effective in changing attitudes and knowledge regarding the identification of symptoms and best practices in

communication involving a person with a severe mental illness (Lodestar, 2002). The second-generation approach to handling law enforcement interactions with the mentally ill was to have officers with special training respond to and handle calls involving persons with the symptoms of a mental illness (Lodestar, 2002). The CIT model was developed to help promote positive interactions between individuals with mental illness and law enforcement (Cochran, Deane, & Borum, 2000). Prior to the CIT model, most first responding patrol officers were unable to recognize the signs and symptoms of mental illness in relation to the actions of the individual that warranted a police interaction. Officers often perceive mental health related calls as being unpredictable and dangerous (Sellers, Sullivan, Veysey, & Shane, 2005). Without adequate training in de-escalation, officers can inadvertently approach in a manner that then escalates the situation (Krameddine & Silverstone, 2015). However, as a result of CIT training, officers can now better assess, de-escalate the behavior, and then provide an appropriate level of care to the individual when they are able to distinguish between behaviors related to mental illness versus those of criminal offenders (Tucker, Van Hasselt, & Russell, 2008). The officer can, as needed, make referrals to the mental health system, instead of enforcing an arrest. In the past, police contacts often resulted in the incarceration of a mentally ill individual (Reuland, 2004; Ritter, Teller, Munetz, & Bonfire, 2010; Watson et al., 2010). The CIT model of intervention is designed to give police officers the skills to de-escalate potentially volatile interactions with offenders, recognize the signs of a possible mental illness, and when required, resume their law enforcement duties (Watson et al., 2010).

Since its launch in 1988 in Memphis, Tennessee, CIT was immediately recognized to be an effective approach to diverting individuals who required mental health intervention instead of criminal incarceration (Steadman, Deane, Borum, & Morrissey, 2000). Current estimates suggest

that there are over 1,000 CIT programs worldwide that are now implemented (CIT International, 2011). As the number of calls for service requiring officers to address the needs of an individual with a mental illness increases, the collaboration of police officers and mental health service providers becomes critical for appropriately meeting the needs of the mentally ill (Teller, Munetz, Gil, & Ritter, 2006). The CIT model aims to appropriately address the needs of the person with a mental illness by providing linkage to resources available in the community, and diversion from the criminal justice system. For many years, this model was considered to be the best practice for law enforcement's increased number of calls involving a person with mental illness (Watson & Fulambarker, 2012).

Although there are many successes and positive aspects associated with the CIT model, a major limitation is the CIT officer's lack of mental health clinical training, and the absence of a skilled mental health professional present with the officers at the scene of a call (Gur, 2010). In one study CIT officers failed to recognize signs of a mental illness in 50% of the presented scenarios. Clinically trained graduate students were able to recognize mental illness in 30 cases, whereas CIT officers stated mental illness was a factor in only 15 scenarios (Gur, 2010). This creates a challenging situation for both law enforcement officers and those with active mental health symptoms, potentially endangering themselves and/or others. Law enforcement officers trained in the CIT model are not mental health professionals with clinical backgrounds; thus they are not equipped to assess mental health symptoms and behaviors in order to provide appropriate treatment to an individual with a mental illness (Gur, 2010). Furthermore, the response time needed for a qualified mental health clinician to help the responding officer with assessment and treatment is often excessive given the geographic territory of large cities and the number of calls

requiring assistance (Lodestar, 2002). These limitations provide the impetus for an evolution in the law enforcement response to help both the responding officers and the mentally ill patient.

The New Co-Response Model

In January 1993, a newer intervention model had evolved which grew from the successes of the CIT model, but also addressed some if its limitations. Within the Los Angeles Police Department (LAPD), these new teams are part of the Mental Evaluation Unit (MEU) and are known in the community and within the LAPD as the Systemwide Mental Assessment Response Teams (SMART). Their goal is to build on the successes of the CIT program by partnering CIT trained LAPD officers with mental health clinicians from the Los Angeles County Department of Mental Health (LACDMH), who have expertise in the assessment and treatment of the mental health challenges experienced by those who have contact with law enforcement (O'Neill, 2015a). These new law enforcement partnerships with mental health service providers have given police officers the necessary resources to offer a more appropriate and effective intervention, along with discharge planning tools to help those who are mentally ill and engaging in disruptive behaviors within the community (Watson & Fulambarker, 2012). Essentially, this program diverts the individual from the law enforcement booking and incarceration system by helping those with a serious and persistent mental illness find appropriate mental health services and programs in the community to meet their needs (O'Neill, 2015b). The LAPD has the largest operation and is among the oldest mental health policing programs in the nation. Its SMART co-response model has been recognized as an evolution in the response by law enforcement when encountering a person in a possible mental health crisis (O'Neill, 2015a). The LAPD model has been designated by the Council of State Governments Justice Center as one of six national training sites for specialized mental health policing (O'Neill, 2015a).

Purpose of the Study

The purpose of this study was to gain a better understanding regarding the outcomes of the LAPD's SMART co-response model connecting law enforcement and mental health service providers. Therefore, this study focused on the following research questions:

1. What was the demographic profile of the persons with mental illness who have had contact with police officers in the city of Los Angeles?
2. What type of treatment the LAPD co-response model, SMART, provided for the consumers of mental health services after a law enforcement contact was initiated?
3. Was there a difference in the disposition between SMART units and Patrol units?

Social Work Relevance

The struggle for professionals to maintain a balance between autonomy and requests by the public for accountability has propelled the development of a code of ethics. These codes serve to offer a foundation and guide for professionals seeking direction during ambiguous situations (Frankel, 1989). Police departments instill a set of core values into police officers, incorporating service to the communities they serve, respect for people, and quality through continuous improvement (LAPD, 2015a). Internationally, social workers across several countries have adopted a single, formal code of ethics. In some countries, including the United States, independent ethical codes have been developed in order to reflect the ideals and values of social work for that region (Idit & Penelope, 2008). In the United States, social workers have embraced the National Association of Social Workers (NASW) Code of Ethics, which includes such ethical values as service, dignity and worth of the person, and competence (2006). Thus law enforcement and social work have embraced similar core ethical values (LAPD, 2015a; NASW, 2006). Social workers provide services to individuals who are at times overwhelmed by a

multitude of difficult circumstances and have exhausted all known coping mechanisms (Hepworth, Rooney, Rooney, Strom-Gottfried, & Larsen, 2009). The present analysis will allow social workers to better understand the complexities of the relationship between law enforcement and mental illness that have grown and only shows signs of a continued growth. Social workers may also be able to identify with law enforcement personnel in their desire to improve the current dichotomy in professions and provide a more appropriate level of care to those individuals encountered by police officers on the streets. The field of social work will benefit from a better understanding of the limitations of police officers, and the manner in which they are currently attempting to improve their encounters with community members who are experiencing a mental health crisis or are in need of mental health interventions and resources available in the community.

Multicultural Relevance

Studies have shown that internalized stigma regarding mental illness is cross-cultural; consequently one must be aware of this stigma when interacting with an individual with a mental illness and understand it as an obstacle to the recovery of the person with a mental illness (Oliveira, Esteves, Pereira, Carvalho, & Boyd, 2015). The city of Los Angeles has a population of 3.8 million people living in a 469-mile area; Los Angeles has the most ethnically and racially diverse population in the country with minorities from all regions of the world (Pisano & Callahan, 2014). The LAPD personnel share a rich and diverse ethic diversity allowing its officers to connect with the various diverse communities within its borders (LAPD, 2015b).

Conceptual Definitions

For the purpose of this study, the following terms were defined.

CIT: The Crisis Intervention Team model is the most well-known police response to individuals with mental illness with the primary goal of diverting individuals from the criminal justice system to mental health services available within the community. Officers received specialized training regarding recognizing the signs and symptoms of mental illness, more effectively communicating with the individual, and then linking the individual to the most appropriate resource available (Watson et al., 2010).

Mental disorder: A mental disorder is a condition characterized by a clinically significant disruption in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes fundamental to mental functioning (American Psychiatric Association, 2013).

MEU: The Mental Evaluation Unit is the LAPD's specialized unit comprised of police officers and clinicians from the LACDMH who respond to patrol officers' requests for a mental evaluation and also advise officers regarding their radio call involving a person with a possible mental illness (O'Neill, 2015a).

SMART: Systemwide Mental Assessment Response Teams are known by the acronym SMART. These teams partner a LAPD police officer with specialized mental health intervention training and either a psychologist, psychiatric nurse, or licensed clinical psychiatric social worker from the LACDMH (O'Neill, 2015a).

CHAPTER 2

REVIEW OF THE LITERATURE

This chapter will discuss the impact of mental illness and police strategies during police contacts with individuals with a mental illness. There has been an evolution of police strategies developed over the years to address the needs of the mentally ill population. Understanding the complexity of mental illness enables police officers to appropriately provide an intervention leading to an effective interaction. This study evaluated the effectiveness of the co-response model within the Los Angeles Police Department (LAPD), partnering police officers with clinicians from the Los Angeles County Department of Mental Heath (LACDMH). Additionally, the ability of this partnership to provide an individual with a mental illness an effective and appropriate interaction and treatment plan was assessed in this study.

Mental Illness

The National Alliance on Mental Illness; NAMI (2015) describes mental illness as a condition that can impact a person's thinking, feelings, mood, and his or her ability to relate to others. A mental condition is not the result of one event, but instead has multiple interlinking causes including genetics, environmental factors, and lifestyle choices (National Alliance on Mental Illness, 2015). NAMI (2015) reports that 1 in 5 adults experience a mental health condition every year, and 1 in 20 live with a serious mental illness such as schizophrenia or bipolar disorder. Major mental illness such as schizophrenia and bipolar disorder rarely appear suddenly and without any warning signs. Often, family, friends, teachers, or individuals themselves recognize that something is not right about the individual's thinking, feelings, or behaviors before a severe mental illness manifests itself (American Psychiatric Association, 2015). With proper treatment most people with a mental illness can realize their potential and

live substantial and fulfilling lives in the community, while also being able to cope with the stressors of life and working productively to make meaningful contributions to the world (National Alliance on Mental Illness, 2015).

Los Angeles County (2010) encompasses an area of 4,084 square miles with a recorded population of 10,409,039, positioning it ahead of most state populations, with only seven states recording a higher population. The strategic plan regarding mental health in Los Angeles County (2010) is to improve health, mental health outcomes, and efficient use of scarce resources by promoting proven service models and prevention principles that are population-based, client-centered, and family focused. The LACDMH is the largest county mental health department in the United States, providing mental health services including screenings and assessments, case management, crisis intervention, medication support, peer support, and other recovery services (Los Angeles County, 2010). In the United States 1.1% of the population live with schizophrenia, 2.6% are diagnosed with bipolar disorder, 6.9% experience major depressive disorder, and 18.1% have had symptoms of an anxiety disorder such as posttraumatic stress disorder, obsessive-compulsive disorder and specific disorders. Among the 20.7 million adults in the United States who experience a substance use disorder, 40.7% or 8.4 million adults have reported a co-occurring mental illness (National Alliance on Mental Illness, 2015).

Historical Impact of Deinstitutionalization

Deinstitutionalization originated in the United States as early as 1955 with the slow diversion of persons with a severe mental illness being released from state managed care to community outpatient mental health clinics (Jimenez, 2010). In the 1960s, states continued with the expansion of community based mental health programs; subsequently, policy makers began investigating cost saving measures to divert mental health care away from large expensive

institutional care systems managed by the state (Jimenez, 2010). Motivated by his own family experience with a developmental disability, President John F. Kennedy introduced a federal plan to divert the care of individuals with mental illness to community based mental health clinics (Jimenez, 2010). With the passage of the federal Mental Retardation Facilities and Community Mental Health Centers Construction Act in 1963, the movement for deinstitutionalization was rapidly deployed at the state level (Jimenez, 2010). In 1968, there were approximately 399,000 patients in state managed mental hospitals and 168,000 inmates in state prisons; in a decade the number of individuals with a severe mental illness in asylums dropped 64%, to 147,000, while the number of inmates climbed by 65%, to 277,000 (Steadman, Monahan, Duffee, & Hartstone, 1984).

In the 1950s, state mental hospitals initiated the release of many individuals with severe mental illness into community-based facilities (Scheid & Brown, 2009). These community mental health facilities were envisioned to provide subsequent care and follow-up services (Primeau, Bowers, Harrison, & Xu, 2013). The concept of deinstitutionalization consisted of three developments: the release of persons with severe mental illness housed in psychiatric hospitals to community based mental health centers, the diversion of new admissions of severely mentally ill persons to alternative facilities, and the expansion of services for the care of individuals who had been institutionalized but were now in the local communities seeking outpatient services (Primeau et al., 2013). This fundamental change in mental health policy shifted the focus of care for persons with severe mental illness from the psychiatric hospitals to local community mental health centers (Kunitoh, 2013). Deinstitutionalization succeeded in its goal of reducing the use of state hospitals; however, it never accomplished its goal of providing adequate and appropriate outpatient treatment for persons with severe mental illness (Kunitoh,

2013). Although the first two developments of deinstitutionalization progressed rapidly, the third process of establishing community mental health facilities struggled with providing appropriate and adequate services for the number of severely mentally ill individuals seeking services in the their respective communities (Talbott & Bachrach, 2000).

Since the deinstitutionalization movement, researchers have suggested that psychiatric patients transitioned from one form of institution to another with the jail system. These findings underscore the need to provide funding and research toward more community mental health services for the severely mentally ill to avoid negative outcomes such as incarceration, involuntary hospitalization, or inefficient state spending (Primeau et al., 2013).

Stigma of Mental Illness

Policies and interventions that reduce the stigmatization of mental illness may assist increase police effectiveness and diminish some of the barriers faced by individuals with mental illness seeking treatment (Morabito & Socia, 2015). Realizing that the stigmatization of mental illness exists across cultures may assist law enforcement in the development of policies, strategies and trainings to provide more successful outcomes with members of this population.

In the United States there continues to be a widespread public stigma against mental illness among children and adults (Parcesepe & Cabassa, 2012). In a study examining how mental illness affected the trustworthiness of an individual, researchers demonstrated that individuals described as having a mental illness were evaluated as being less trustworthy than a person described as having no mental illness (Rice, Richardson, & Kraemer, 2014). The researchers realized that although the research was preliminary, it does identify distrust as an important component of the stigma correlated with mental illness (Rice et al., 2014).

Stigma and discrimination continue to be prominent features in the life of a person coping with a mental illness, which adds to the stressors of the illness and causes a lowered self-esteem and quality of life, and affecting the possibilities of adequate housing and work (Hansson & Markstrom, 2014). Researchers concluded that those working in community mental health care must ensure people with a mental illness feel a sense of belonging in the community, and then aid them in developing a support network in order to achieve social integration in the community (Granerud & Severinsson, 2006).

A major driving force behind the stigma that a person with a mental illness is violent has been created by a belief held by the general public that has been growing in recent years (Reavley & Jorm, 2012). One researcher focusing on perspectives from the United States addressed several factors regarding stigmatization of mental illness. This research demonstrated several important findings, including stigmatization toward a person with a mental illness has increased over the past half century, violent acts committed by a person with a mental illness have increased over the past half century, the perception of violent behavior by a person with a mental illness is an important cause of the stigma, most episodes of violence committed by a person with a mental illness are often due to a lack of treatment compliance, persons with a severe mental illness who receive treatment show significant decreases in episodes of violence, and reducing violent behavior among a those suffering from a severe mental illness will in turn reduce the stigma (Fuller, 2011). This research helped shed light on the current state of stigma and mental illness while also identifying some of the motives for the formation of this stigma over the years.

Researchers reviewed newspapers reporting on the subject of mental illness in the United States and discovered that 39% of the published articles reported stories concerning the

dangerous and violent nature of individuals suffering from a mental illness; this perpetuates the stigma and shows how media in the United States are facilitating the continuance of a stigma against mental illness (Corrigan, Watson, & Gracia, 2005). A study of German high school children randomly assigned them to either read an article linking mental illness with violence or provided them with factual events of violence involving individuals with a severe mental illness such as schizophrenia; the researchers exposed how reading the article led to increased beliefs in dangerousness as opposed to the factual events (Dietrich, Heider, Matschinger, & Angermeyer, 2006). Another study discovered a revealing aspect of attitudes toward mental illness, which was found to be unique to the United States. Surveys were carried out in a range of countries to assess the views of persons with a mental illness and a linkage to dangerous behaviors; the researchers reported that developed countries (Australia, Canada, Germany, and Japan) generally had a lower occurrence of negative beliefs regarding consumers of mental health services than developing countries; Brazil, India, and Turkey (Jorm, Reavley, & Ross, 2012). The researchers theorized that this finding was due to better mental health services in more developed countries; however, the Unites States was the only exception with rates similar to those of developing countries (Jorm et al., 2012). Some scholars have attributed this disparity to the fact that the United States has the highest homicide rate and the highest rate of civilian firearm ownership among developed countries (Hoskin, 2001). The notion that the United States is exporting a belief associating mental illness and violence becomes more of a social issue because numerous reports of multiple homicides by persons with mental illness in the Unites States have unfortunately captured the worldwide interest (Jorm & Reavley, 2014). An anti-stigma intervention for mental illness was studied with 120 recruit officers in Sweden, and results indicated the intervention was effective in changing attitudes, mental health literacy, and

intentional behavior observed at a 6-month follow-up (Hansson & Markstrom, 2014). This study points to the possibility of reducing the stigma against mental illness by developing interventions employing education and training to offset the amount of erroneous information being disseminated by other sources.

Criminalization of Mental Illness

An unforeseen effect of deinstitutionalization has been the criminalization of consumers of mental health services (Perez, Leifman, & Estrada, 2003). There is no indication that in the near future there will be a sudden shift in ideology prompting more mental health institutes to be built. As a result correctional facilities continue to be overwhelmed with persons with a mental illness (L.E. Martinez, 2010). In 1972 Marc Abramson coined the term the "criminalization of mental illness" (Perez et al., 2003). This criminalization draws attention to a significant number of individuals with a severe mental illness who became involved in minor criminal offenses and are then consequently arrested and prosecuted in the county jail system (Lamb & Weinberger, 2001). This is further evidenced by the observation of the population of inmates with a mental illness inside county jails being predominantly those individuals who have not received adequate mental health treatment (Lamb & Weinberger, 2001). Consumers who require mental health services are instead being labeled criminals and being arrested, only to be released into the streets, where they are left with few mental health services and limited options other than to return to the jail system (Lamb & Weinberger, 2001).

Lamb and Weinberger (2001) believe that criminalization of mental illness has occurred for many reasons, some of which include the unavailability of long-term hospitalization in state hospitals, more rigid criteria for civil commitments, difficulty in accessing mental health services within communities, and the belief by the law enforcement community that mental illness can be

more effectively dealt within the criminal justice system than the mental health service system. An alarming fact concerning mental illness is that the nation's three largest mental health facilities are Los Angeles County Jail, Riker's Island, and Cook County Jail (Barker, 2013).

To address the increasing number of mentally ill offenders in the criminal justice system, many counties across the country have established mental health courts to address the complex issue of seeking criminal punishment or seeking mental health services for a mentally ill criminal offender (Watson, Hanrahan, Luchins, & Lurigio, 2001). Mental health courts are a promising innovation on the continuum of interventions for individuals who suffer from a mental illness, where the nexus for the offense was directly related to their symptoms of their mental illness (Watson et al., 2001).

Resistance to Mental Health Services

A failure to follow recommended treatment plans established by mental health professionals can have overwhelmingly alarming consequences for those individuals who are seriously and persistently mentally ill (Vuckovich, 2010). An important social issue is non-compliance to mental health treatment, defined as a failure to accept a recommended treatment plan prescribed by a mental health professional (Vuckovich, 2010). These occurrences have had significant negative consequences for the individual suffering from severe and persistent mental illness (Vuckovich, 2010). Non-compliance to prescribed psychotropic medications is a major predictor to future involuntary psychiatric hospitalization (Coombs, Deane, Lambert, & Griffiths, 2003). It is estimated that 75% of hospitalized psychiatric individuals would do not adhere to a recommended psychotropic medication plan will relapse and become involuntarily hospitalized within 2 years (Vuckovich, 2010). As a result of the inability or refusal to adhere to a recommended treatment plan prescribed by a mental health professional, there is an increased

risk for assault and dangerous behavior and a reduction in the quality of life for the consumer who is not receiving mental health services (Roe & Swarbrick, 2007). In a 14-nation survey, active psychosis has been recognized as the third leading cause of disability, and there is a massive cost associated with managing individuals dealing with severe and persistent mental illness (Vuckovich, 2010). In the United States, the estimated cost linked to schizophrenia and bipolar disorder is over $100 billion annually. A concerning fact is the link between the failure to abide by a prescribed psychotropic medication treatment plan being a significant predictor of future suicide (Vuckovich, 2010).

Psychotropic medications are routinely prescribed to consumers of mental health services seeking emergency interventions. Yet this practice did not increase compliance to outpatient follow up treatment after 2 months (Calfat, Pan, Shiozawa, & Chaves, 2012). In a study with a sample of 121 patients, researchers identified several factors influencing non-adherence to a prescribed treatment including side effects, lacking insight, and having no recognition of the need for the continued treatment (Cardoso & Xavier, 2015). Research has suggested that the occurrence of violence in schizophrenia is associated with several socio-demographic variables including age, gender, economic and social living status. Similar to the general population, violence in schizophrenia is principally perpetrated by young, male individuals of disadvantaged socio-economic status (Bo, Abu-Akel, Kongerslev, Haahr, & Simonsen, 2011). Schizophrenia is not a direct predictor of violence for individuals dealing with the symptoms of a mental illness; other co-occurring factors similar to the factors influencing violence among the general public have a greater influence in predicting future violence (Bo et al., 2011).

To address the non-adherence to the prescribed mental health treatment plans, several practitioners have attempted to use other methods to describe the disparity of persons with

mental illness completing the treatment plan once they leave the hospital setting. Motivational Interviewing has been effective in addressing the ambivalence of bipolar patients and has supported improved adherence to the psychotropic medication treatment plan (Laakso, 2012). Using a patient centered approach has been illustrated to be effective with enhancing insight and attitudes regarding treatment for a person with a mental illness (Laakso, 2012). Patient non-adherence to psychotropic medication treatment plans may be due to the negative side effects of the medication, but also to some inadvertent factors such as forgetfulness, cognitive impairments, limited access to health care, financial issues, and poor relationships with health care providers (Drymalski & Campbell, 2009).

Law Enforcement Contacts with Mental Illness

Police officers are entrusted to not only protect the community they serve, but are increasingly are being asked to provide social services to the community (Lurigio & Watson, 2010). Law enforcement roles in the community are shifting and now requiring a knowledge of and sensitivity to the social problems affecting a community in order to address the evolution in the type of calls for service (Lurigio & Watson, 2010). Appropriate training, including scenario-based training for police officers, has been recognized as a critical component essential to improved interactions between police officers and persons with mental illness (Krameddine & Silverstone, 2015). In 2010, research was completed comparing 56 CIT trained versus 56 non-CIT trained police officers within the Chicago Police Department. There was a significant correlation between training and the ability to provide a more appropriate disposition to the calls for service involving a person with mental illness (Watson et al., 2010). The researchers theorized that this correlation was due in part to their knowledge of available local mental health services and community programs (Watson et al., 2010).

This increased training within the law enforcement community has better enabled officers to recognize the signs and symptoms of a person in crisis due to a mental illness, while also equipping police officers with the de-escalation techniques necessary to provide a more positive interaction with individuals having a mental illness (Watson, Morabito, Draine, & Ottati, 2008). Police officers receive training in tactics when dealing with a potentially violent situation, but these traditional tactics are often not effective when dealing with a person with a mental illness (Engel, Sobol, & Worden, 2000). Acting as gatekeepers to the mental health system, many officers are finding themselves becoming involved in community roles that require sensitivity to the social issues of the community that officers are not equipped to handle after traditional police training (Lurigio & Watson, 2010). As more law enforcement agencies embrace the philosophy of community policing, the role of police officers has evolved to become more compatible with community-based social services (Lurigio & Watson, 2010).

Research has shown that a police officer's risk for a violent encounter with an individual dealing with a severe mental illness is relatively low when consumers follow a mental health treatment program (Manzoni & Eisner, 2006; Naples & Steadman, 2003; Swanson et al., 2006). However, many individuals who have a severe mental illness live on the streets and do not receive regular mental health treatment (Glick & Applbaum, 2010). This occurrence has led to increasingly poor decision making by individuals with severe mental illness, consequently resulting in potentially violent encounters with law enforcement (Caceda, Nemeroff, & Harvey, 2014). The deinstitutionalization of individuals with mental illness and the lack of community resources have left this population vulnerable and led to many becoming a part of the criminal justice system (Chaimowitz, 2012).

Many incarcerated individuals have a history of mental illness, or have received mental health referrals while incarcerated (Matwjkowski, Lee, & Han, 2014). Local jails have the highest percentage of inmates with mental problems, with nearly two thirds (64.2%) reporting a current or recent mental health problem (National Institute of Mental Health, n.d.). State prisons reported a slightly lower percentage (56.2 %), while federal prisons reported the lowest (44.8%) in comparison to the other institutions (National Institute of Mental Health, n.d.). Due to the increased rates of criminal activity and incarceration among individuals with a severe mental illness, law enforcement has adapted its policing strategies to address the growing number of contacts involving this population. Law enforcement agencies across the United States have transformed their policies regarding responses to a person with a mental illness and established partnerships with mental health agencies (Rueland, 2010).

Serious mental illness and substance abuse are co-occurring events that result in youth becoming homeless at greater rates than the general population; consequently, this population becomes vulnerable to longer durations of homelessness continuing into adulthood (Childress et al., 2015). The participants of a study examining youth with severe mental illness experiencing homelessness reported three fourths faced major depression, over half reported experiencing bipolar disorder, and over one third reported schizophrenia or schizoaffective disorder, which is significant because many youth with severe mental illness tend to have symptoms emerge before the age of 25 (Childress et al., 2015). In a study examining the perceptions and experiences of 60 individuals with mental illness from Vancouver, Canada, researchers discovered that almost three quarters (72%) of the participants were generally satisfied with the manner in which law enforcement handled their most recent contact. Specifically, 51% rated their previous contact with police as a positive experience, while 32% viewed their last contact with police offices as a

negative experience in their life (Livingson et al., 2014). Police officers have made advances in improving relationships with the mentally ill population; however, more police training is needed to address the increased dependence on law enforcement to oversee mental health incidents within the community.

Severe Mental Illness and Violence

Individuals suffering from a severe mental illness such as schizophrenia often have 3 to 5 times a higher risk of being involved in violent crime and behavior in the community than the general population (Swanson et al., 2006). Research has identified a modest relationship between severe mental illness and a tendency for violence. More importantly, researchers have discovered a significantly stronger relationship between severe mental illness and comorbid substance use leading to a higher inclination toward violence (Van Dorn, Volavka, & Johnson, 2012). Comorbid severe mental illness with illicit drug use can result in a higher prevalence of violent encounters within the community and with law enforcement (Edlinger et al., 2014). One study found evidence supporting a link between severe mental illness and increased resistance during police interactions (Mulvey & White, 2014). In a study examining 60 consumers with mental illness in Canada, 37% of the participants reported feeling the amount of force used by police officers during their previous contact was excessive (Livingson et al., 2014).

Individuals suffering from schizophrenia are often viewed by the general public as being dangerous; however, the majority of patients admitted to locked psychiatric units due to a risk of harm to others have presented with comorbid psychoactive substance abuse (Edlinger et al., 2014). In a study designed to investigate factors associated with homicide after discharge from a locked psychiatric hospital, researchers identified 47 cases where the individual committed homicide within 6 months after discharge and 105 cases where there were no violent offenses

after discharge (Fazel, Buxrud, Ruchkin, & Grann, 2010). Although one cannot assume a direct correlation between schizophrenia and homicide, the researchers discovered an enhanced inclination for violence conceivably leading up to homicide in those individuals with a severe mental illness such as schizophrenia when psychoactive substance abuse and/or lack of treatment compliance were comorbid with the mental illness (Fazel et al., 2010). Alcohol and drug use does occur among people who are not violent; however, these substances usually play a role as a catalyst in the victims, offenders or both of violent events (Boles & Miotto, 2003).

In order to learn more about public views of severe mental illness and violence being interrelated; one research team explored the influence of an educational intervention directly dealing with the prejudices concerning schizophrenia. Researchers separated two 3-hour lessons with a week in between each lesson plan, and assessed the participant views of schizophrenia at baseline versus post intervention using matched questionnaires (Magliano et al., 2014). At the end of the intervention, more participants firmly believed that recovery from schizophrenia was possible, and the person was not as dangerous or unpredictable as previously viewed in their baseline assessment; hence, the researchers validated the view that education regarding severe mental illness to the general public could be used to modify their views and address their preconceived notions regarding mental illness (Magliano et al., 2014). De-escalation techniques are crucial to a law enforcement officer in order to effectively handle a radio call involving a person with a severe mental illness by utilizing techniques to reduce police liability and injury to both the officer and mental health consumer (Oliva, Morgan, & Compton, 2010).

Shift in Law Enforcement to the Gatekeepers of Mental Health Services

There is scarce research examining the motivations for a person choosing a career in law enforcement; moreover, there is not much research studying the original motivation and current

job satisfaction (White, Cooper, Saunders, & Raganella, 2010). One study targeting a sample population of 1,463 New York City police officers who graduated the police academy in June 2002 discovered that recruit officers with high motivations at the beginning of their careers had a higher job satisfaction than their cohort who presented with low motivation during an initial assessment by researchers (White et al., 2010). A sample of patrol officers from 11 law enforcement agencies in the southwestern region of the United States completed surveys as part of a study measuring factors affecting job satisfaction (Johnson, 2012). This research suggested that an officer's job task characteristics and to a lesser extent the organizational characteristics of his/her agency were the main sources of job satisfaction (Johnson, 2012). Law enforcement has begun to realize that a higher than normal level of stress is endured by police officers during the course of their career (Patterson, Chung, & Swan, 2012). Stress among police officers has been linked to police misconduct and may have negative effects on the law enforcement organization (Patterson et al., 2012).

Most officers will not report that they pursued a career in law enforcement in order to provide mental health services to individuals with severe mental illness; however, the number of contacts with community members suffering from a mental illness has been increasing (Tucker, Van Hasselt, & Russell, 2008). Police officers are now often the initial contact for both the criminal justice and mental health systems, but unfortunately there is a great disconnect between law enforcement and mental illness treatment, primarily due to lack of proper training, resources, and collaborative community support (Tucker et al., 2008). Police officers are not able to solve the social issues relating to mental illness on their own. Community mental health centers that provide 24-hour services are essential to address the needs of consumers of mental health services (L.E. Martinez, 2010). These mental health facilities should have a relationship with the

criminal justice system in order to alleviate the practice of housing the mentally ill in jails (L.E Martinez, 2010). The current system in place is overwhelmed by the number of services required in the community; consequently, this has led to an increased burden on police officers to respond to psychiatric emergencies in the community that could have been resolved with more adequate psychiatric care rather than incarceration (Barker, 2013).

A study in 2010 highlighted that police perceptions of the increases in the number of police contacts with individuals requiring emergency mental health services were in part due to failures in the overall mental health system (McLean & Marshall, 2010). A historical lack of cooperation among agencies has often meant police officers have waited for hours with individuals in need of emergency mental health intervention in emergency departments (McLean & Marshall, 2010). The majority of police contacts involving mental illness are with consumers who are out of contact with mental health services; police play an essential role in linking these individuals to services (Van den Brink et al., 2012). There is a need for police officer training in recognizing mental illness, and subsequently being able to employ effective and appropriate strategies when dealing with a person in a mental health crisis who may be disengaged with mental health services (Van den Brink et al., 2012).

In previous studies researchers have discovered a correlation between criminal history and higher rates of care from specialty mental health providers (Matwjkowski et al., 2014). Criminal justice diversion programs tend to partner with community mental health resources; this relationship has served as a significant referral source for community mental health service providers (Matwjkowski et al., 2014). One of the primarily challenges police often encounter are the limitations in their ability to resolve a situation where an individual is in need of emergency

mental health services due to a lack of support from mental health service providers (Ogloff et al., 2013).

The CIT Model

The number of consumers of mental health services who had been a part of the criminal justice system has caught the attention of academics, advocates, policy makers, and practitioners (Fisher, Silver, & Wolff, 2006). Police officers are often the first responders to incidents involving consumers of mental health services who may be in crisis (Lurigio & Watson, 2010). Many law enforcement officers consider consumers of mental illness as posing a threat due to their rapidly cycling shifts in moods, creating a greater danger to officers, the consumer, and the community (Reuland, Schwarzfeld, & Draper, 2009). One study determined that police officers in general apprehended and transported one person every 2 hours to a facility for mental health services (Ogloff et al., 2013).

To address the growing need for a more appropriate response to mental illness after several negative interactions between consumers of mental health services and local law enforcement officers, the CIT model was widely adopted in an attempt to divert individuals with mental illness from the criminal justice system to more appropriate mental health services (Lord et al., 2011). CIT officers become ambassadors for the mental health community and advocates for more appropriate outcomes, including referrals for mental health services in the community and diversion from the criminal justice system when appropriate (Watson et al., 2008). Research has suggested that officers feel substantially better prepared to handle contacts with those affected with mental illness after CIT training; 97% stated they felt at least moderately prepared in contrast to those who had not taken the CIT training who revealed they felt prepared only 26% of the time (Ritter, Teller, Munetz, & Bonfire, 2010). In a study with 28 police officers employed

by three of Miami-Dade County's police agencies, the CIT model was proven to be statistically significant as an innovative community health program that benefits law enforcement, consumers, mental health professionals, and stakeholders (Ellis, 2014). Officers' knowledge, perceptions and attitude scores toward persons with a severe mental illness showed statistically significant changes at the end of a weeklong CIT training (Ellis, 2014). In one study the CIT model was effective in diverting an individual from possible arrest to mental health services 19% of the time (Franz & Borum, 2011). The CIT model was also shown to be effective in reducing the arrest rate of individuals with a mental illness and over time can be an important tool in reducing discretionary arrests among persons with a mental illness (Franz & Borum, 2011).

Canada, Angell, and Watson, (2010) completed a study analyzing the responses of 216 officers to examine how CIT was used in four Chicago police districts. Results indicated that police, regardless of whether they received CIT training, perceived many positive attributes of CIT that relate directly to their ability to effectively perform their duties (Canada et al., 2010). One study reported a reduction in the inappropriate use of jails within the United States to house persons with active symptoms of mental illness when the criminal justice system, the mental health system, and advocacy groups within the community work together (Franz & Borum, 2011). Although there are several successes, there is a need for an evolution of the CIT model because many police officers lack sufficient mental health training and knowledge of mental illness to recognize and manage the risk associated with a person in need of an emergency mental health intervention (Clayfield, Fletcher, & Grudinskas, 2011).

The LAPD SMART Model

Partnerships between the police and mental health clinicians can improve collaboration, efficiency, and the treatment of those community members dealing with a mental illness (Kisely

et al., 2010). The law enforcement co-partnership model is the next evolution of CIT, resulting in providing a more appropriate level of treatment for consumers of mental health services who are in crisis and necessitate a police response. Specially trained officers from the LAPD and clinicians from the LACDMH seek to help those with mental illness by investigating what has caused them to cycle in and out of the psychiatric county hospital and criminal justice systems (O'Neill, 2015). This model is highly regarded by law enforcement, mental health, and civil rights advocates (O'Neill, 2015). LAPD is not the only law enforcement agency to deploy mental health clinicians with law enforcement officers, but it is the largest and most robust program in the United States, and has been designated as a national training site in 2010 (Swan, 2015). About 12% of the nation's 18,000 law enforcement agencies utilize crisis intervention training to assist first responding officers to employ empathy when they respond to calls for service involving an individual in mental distress. A single layered approach involving a police officer response only has not been significant in improving the long-term treatment of a person in mental distress (Swan, 2015). Individuals with mental illness in contact with a mobile collaborative response teams presented greater engagement with a treatment plan as measured by outpatient contacts (Kisely et al., 2010). As the number of law enforcement agencies adopting a model utilizing officers and clinicians to respond as a team to handle crisis calls for service increases, it becomes evident there is a need to investigate the effectiveness of this new model. One research study examined the impact of an integrated mobile crisis team formed by the partnership between mental health services, plain-clothes police officers from a municipal police agency, and emergency services exposed increased use by individuals in mental health crisis, families, and service partners (Kisely et al., 2010).

Police officers and mental health professionals working together is only a component of the larger scale of transformation that is required to effect greater change. Private and public agencies must collaborate to provide individuals with mental illness the care and compassion required to alleviate the social issue (L.E Martinez, 2010). Teaming mental health clinicians with police officers to work collaboratively as a crisis response team is a more cost-effective system to divert mental illness from the criminal justice system and instead funnel these individuals to appropriate treatment within the community (Barker, 2013). Equipping officers with systems to more appropriately handle calls involving a person with a mental illness has been rated as being an asset to police officers and perceived to impact officers, individuals, and community safety by improving accessibility to mental health services, enhancing officer's skills, techniques, and knowledge; and improving an officer's confidence in his/her abilities and preparedness in responding to calls involving persons experiencing a mental health crisis (Bonfine, Ritter, & Munetz, 2014). Psychiatric emergency teams consisting of a police officers and a mental health clinician are able to better deal with psychiatric emergencies in the field. This partnership enables both entities to handle calls characterized by acute and chronic mental illness, a high potential for violence, a high incidence of serious substance abuse, and long histories with both the criminal justice and the mental health systems (Lamb & Weinberger, 2001).

Law enforcement agencies across the nation are becoming aware of the need for a mental health professional to be readily available to respond to the contacts being made by police officers with a person in a mental health crisis. Recently the Downey Police Department collaborated with LACDMH and six other police departments in the southeast region of Los Angeles County to pair mental health professionals and patrol officers ("Press - Telegram," 2015). Mental health concerns have become a usual occurrence in newspaper articles and are

viewed on newscasts during the nightly news more frequently. As more information about mental illness is being disseminated, the LAPD co-partnership model has been singled out as a possible model for other law enforcement, including other large agencies such as the Los Angeles County Sheriff's Office (A. Martinez & Margolis, 2015).

The LAPD co-response model is based on strategies from the CIT model; however, it also established procedures and policies for what officers should do when they encounter a person going through a mental health crisis (CSG Justice Center, 2015). The Mental Evaluation Unit triage desk is staffed with officers with extensive training in mental illness and crisis situations, and a clinician from LACDMH who provides expertise in the area of mental health crisis intervention (CSG Justice Center, 2015). This unit handled and/or provided advice in more than 14,000 calls in 2014, having to apply force to overcome resistance in only 2.8% of the contacts, a number that is low compared to others law enforcement agencies where the use of force numbers can be as high 50% (CSG Justice Center, 2015). This co-partnership model responded to more than 4,700 calls in 2014, including high profile intervention, such as assisting LAPD SWAT teams with dangerous standoffs or a suicidal person who might be contemplating jumping off the ledge of a tall building (O'Neill, 2015). About 12% of the nation's 18,000 law enforcement agencies use the CIT model of training to assist its officers to respond compassionately to persons with a mental illness crisis; however, officers are ultimately left with two choices, arrest and transport to jail or send them to the emergency room (Swan, 2015). Working with LACDMH clinicians provides more follow up interventions and assistance in locating available community resources and providing an appropriate type of intervention.

There has been a long history of interactions between law enforcement and mental illness. The complexity of the issue has led to years of misunderstanding and frustration, which

has contributed to the continuation of the stigmatization and criminalization of mental illness over the years. As a result of these social issues, many individuals with a mental illness have been subjected to arrest by law enforcement instead of receiving the needed mental health treatment. Understanding the nature of mental illness and addressing its social issues have led to advances in police strategies regarding policing the mentally ill. The idea that incarceration may not be the best solution is gaining widespread acceptance across several law enforcement agencies. Law enforcement agencies around the world have adopted a model partnering with mental health professionals. This study examined the descriptive outcomes of the LAPD SMART model and its ability to properly identify and provide mental health crisis interventions when interacting with consumers of mental health services in the city of Los Angeles.

CHAPTER 3

METHODOLOGY

Research Design

This study utilized a secondary analysis of existing data extracted from the Incident Reporting Control System v. 2.58 of the LAPD Mental Evaluation Unit (MEU). The MEU is a specialized unit within LAPD's Detective Support and Vice Division. LAPD patrol officers are required per LAPD policy to contact MEU for advice and dispatch of a SMART unit when contact is made with a person who may have a mental illness. This unit maintains a database cataloging all contacts with an individual who may have a mental illness and is accessed only by officers assigned to the MEU. Officers in this unit receive extensive training in regards to dealing with individuals exhibiting symptoms of mental illness. This research design was selected because the data are comprehensive and unique; no other law enforcement agency in the southern California area maintains such a database. Additionally, there was virtually no opportunity for researcher bias in determining a demographic of the contacts with law enforcement or outcomes. A limitation of the design was that officers in the MEU entered the data into the Incident Reporting Control System; hence, the researcher had no control over the accuracy or quality of the assessments and data collected.

Sample

The sample in this study consisted of all 15,454 available telephonic reports recorded in the Incident Reporting Control System for the MEU made by police officers and entered into the database system by officers assigned to the MEU. The data collected included a majority of the LAPD radio call interactions with a person with a mental illness, because of department policy that officers must notify the MEU for guidance and support when confronting a consumer of

mental health services (LAPD, 2015a). This study analyzed the extracted data for the time period of July 1, 2014 to June 30, 2015. Approval for access to the data for this thesis was obtained by the commanding officer of the Detective Support and Vice Division, the commanding officer of the Crisis Response Support Section: MEU, the program head of the LACDMH/SMART Program, and the officer of charge of the MEU Administration and Training Section of the LAPD unit maintaining this database (Appendices A and B).

Instrumentation and Data Collection

The officer in charge of the MEU Administration and Training Section, omitting any information that could be utilized to identify the person who had an interaction with law enforcement officers, supervised the extraction of all data variables into an Excel database. The following variables were extracted in an Excel format after ensuring all personal history information was removed prior to its dissemination for this thesis project. The researcher in an Excel data entry sheet numerically recorded the data. The variables were: (1) gender, (2) ethnicity, (3) age, (4) incident date, (5) incidents in which the specialized co-response SMART model had contact with the consumer of mental health services, (6) incidents where patrol officers completed an application for an involuntary mental evaluation, (7) type of report taken, (8) disposition of contact, and (9) geographical area handling the incident. A unique identification number was created for each case to replace the original 7-digit case identification numbering system.

All information was then uploaded to the Statistical Package for the Social Sciences v.23 (SPSS) software for data analysis. All data records were destroyed after entering the information into SPSS, and no identifying identification numbers or names were recorded. SPSS records

were retained on a data disk during the data analysis; they will be retained for 3 years upon completion of the project, and then destroyed.

Data Analysis Plan

Descriptive and inferential data analyses were conducted on the variables examined in this study. Descriptive statistical analyses were conducted in order to provide a demographic profile of the sample. Inferential data analyses were conducted comparing the disposition of the incident (dependent variable) to whether the contact was handled by patrol officers or a specialized SMART unit (independent variables). Chi-square tests were utilized. These comparisons were conducted in order to investigate the effect of the LAPD co-partnership model on the disposition of the call for service.

Limitations

One limitation of the data was that the sample consisted of the outcomes from one municipal law enforcement agency. The LAPD is the largest law enforcement agency in California; however, the dataset examined a large metropolitan city and may not be applicable to smaller, rural cities. Additionally, data were limited to officers who contacted the MEU; there was a possible group of contacts not documented due to the lack of notification by patrol officers to the MEU.

CHAPTER 4

RESULTS

Descriptive Characteristics of the Sample

The purpose of this quantitative study was to examine the use of the collaboration between LAPD officers and clinicians who are employed with the LACDMH in their SMART program. These two entities work in partnership when responding to calls involving individuals requiring acute mental health services. These trained law enforcement and mental health professionals provide intervention and/or placement in appropriate mental health facilities. SMART services replace the prior practice of apprehension and incarceration of mentally ill individuals who have reported negative interactions with law enforcement.

The study sample was comprised of 15,454 reports recorded by LAPD's MEU between the dates of July 1, 2014 and June 30, 2015. The demographic characteristics of the sample (N = 15,454) are represented in Table 1. The majority of participants were male (n = 9,490, 61.4%). The ethnicity of the majority of contacts with law enforcement in Los Angeles was generally evenly distributed among Caucasian (n = 5,218, 33.8%), Hispanic (n = 4,678, 30.3%), and African-American (n = 4,358, 28.2%), followed by Asian (n = 528, 3.4%) and other groups (n = 672, 4.3%). The participant ages ranged from 4 to 99 with a mean of 35.7 years of age (SD = 15.4).

Descriptive Geographical Information of Sample

The LAPD provides citywide enforcement to the citizens of Los Angeles by placing officers in 21 geographical police divisions located within four bureaus (see Appendix C). Table 2 provides the number of police contacts with mental illness by geographical division. The Valley Bureau led the city in regards to contacts with individuals with a mental illness (n =

5,196, 33.6%); this bureau includes the community police stations of Van Nuys (*n* = 962, 6.2%), Mission (*n* = 805, 5.2%), Topanga (*n* = 774, 5.0%), West Valley (*n* = 726, 4.7%), North Hollywood (*n* = 714, 4.6%), Devonshire (*n* = 663, 4.3%), and Foothill (*n* = 552, 3.6%). The Central Bureau followed (*n* = 3,618, 22.2%), including the community police stations of Central (*n* = 1,433, 9.3%), Rampart (*n* = 629, 4.1%), Northeast (*n* = 585, 3.8%), Newton (*n* = 535, 3.5%), and Hollenbeck (*n* = 436, 2.8%). The West Bureau was next (*n* = 3,435, 22.2%), including the community police stations of Hollywood (*n* = 776, 5.0%), Pacific (*n* = 749, 4.8%), Olympic (*n* = 654, 4.2%), West Los Angeles (*n* = 646, 4.2%), and Wilshire (*n* = 610, 3.9%).

TABLE 1. Demographic Characteristics of Sample

	n	**%**
Gender		
Male	9,490	61.4
Female	5,964	38.6
Ethnicity		
Caucasian	5,218	33.8
Hispanic	4,678	30.3
African-American	4,358	28.2
Other	672	4.3
Asian	528	3.4
Age Categories		
4-18	1,854	12.0
19-25	2,821	18.3
26-35	3,865	25.1
36-45	2,681	17.4
46-55	2,397	15.5
56-65	1,304	8.5
66-75	319	2.1
76-85	134	0.9
Over 85	45	0.3

The South Bureau (*n* = 3,116, 20.2%), which had the least number of reported contacts with mental illness, includes the community police stations of Southwest (*n* = 1,084, 7.0%), 77th

Street (*n* = 863, 5.6%), Harbor (*n* = 595, 3.9%, and Southeast (*n* = 574, 3.7%). Some contacts (*n* = 89, 0.6%) did not have a geographical area identified.

Table 2 shows the number and percent of police interactions with individuals reported with a mental illness by each of the geographical divisions within the city of Los Angeles. Clearly the Central Area had the greatest number of interactions (*n* = 1,433, 9.3%), followed by the Southwest Area (*n* = 1,084, 7.0%), Van Nuys Area (*n* = 962, 6.2%), 77th Street Area (*n* = 863, 5.6%), and Mission Area (*n* = 805, 5.2%). These five geographical divisions handled a

TABLE 2. Police Contacts with Mental Illness by Geographical Area

Geographical Area	*n*	%
Valley Bureau	**5,196**	**33.6**
Van Nuys Area	962	6.2
Mission Area	805	5.2
Topanga Area	774	5.0
West Valley Area	726	4.7
North Hollywood Area	714	4.6
Devonshire Area	663	4.3
Foothill Area	552	3.6
Central Bureau	**3,618**	**22.2**
Central Area	1,433	9.3
Rampart Area	629	4.1
Northeast Area	585	3.8
Newton Area	535	3.5
Hollenbeck Area	436	2.8
West Bureau	**3,435**	**22.2**
Hollywood Area	776	5.0
Pacific Area	749	4.8
Olympic Area	654	4.2
West Los Angeles Area	646	4.2
Wilshire Area	610	3.9
South Bureau	**3,116**	**20.2**
Southwest Area	1,084	7.0
77th Street Area	863	5.6
Harbor Area	595	3.9
Southeast Area	574	3.7

higher number of radio calls involving a perceived mental illness than any other parts of the city. These five divisions (n = 5,147, 33.5%) handled over a third of all LAPD contacts with mental illness within the city of Los Angeles during the 1-year time period covered in this study.

Police Contacts and Dispositions

Table 3 illustrates the volume of contacts handled by both regular patrol officers and those of the SMART unit partnerships. Of the reported contacts with an individual with mental illness, uniformed patrol officers handled the majority of the contacts (n = 9,980, 64.6%), with SMART units handling about half that number (n = 4,861, 31.5%). Data indicated that detectives, citizens, and other specialized units had the fewest stops (n = 613, 4.0%).

Table 3 also demonstrated the disposition of police contacts with individuals with mental illness was equally distributed among hospitalization in a county hospital (n = 5,411, 35.0%) and hospitalization in a private hospital (n = 5,380, 34.8%), followed by arrest (n = 1,500, 9.7%), referral only (n = 1,105, 7.2%), no police action taken (n = 1,037, 6.7%), and hospitalization in a mental health urgent care (n = 474, 3.1%). Some reports (n = 547, 3.5%) did not have a disposition for the recorded police contact documented in the report.

TABLE 3. Outcomes of All Police Contacts with Mental Illness

	n	**%**
Incident Handled By		
Patrol Officers	9,980	64.6
SMART Unit	4,861	31.5
Other	613	4.0
Disposition		
County Hospital	5,411	35.0
Private Hospital	5,380	34.8
Arrest	1,500	9.7
Referral	1,105	7.2
No Action	1,037	6.7
Urgent Care	474	3.1

Patrol and SMART Dispositions in All Recorded Police Contacts

As shown in Table 4, patrol (*n* = 9,980, 64.6%) handled twice as many contacts with a person with a mental illness than SMART (*n* = 4,861, 31.4%). A contact with patrol officers usually resulted in either hospitalization in a county hospital (*n* = 3,688, 37.0%) or hospitalization in a private hospital (*n* = 3,225, 32.3%), followed by arrest (*n* = 1,324, 13.3%), no action taken (*n* = 853, 8.5%), referral (*n* = 469, 4.7%), other (*n* = 293, 2.9%), and hospitalization in a mental health urgent care (*n* = 128, 1.3%). SMART being requested to respond to a police contact with a person with mental illness resulted in a higher number of hospitalizations in a private hospital (*n* = 2,091, 43.0%). This was followed by hospitalizations in a county hospital (*n* = 1,660, 34.1%), referral (*n* = 500, 10.3%), hospitalization in an urgent care (*n* = 343, 7.1%), other (*n* = 104, 2.1%), no action taken (*n* = 94, 1.9%), and arrest (*n* = 69, 1.4%).

TABLE 4. Patrol and SMART Dispositions in All Recorded Police Contacts

	n	**%**
Mental Illness Contacts with Patrol Officers Only		
County Hospital	3,688	37.0
Private Hospital	3,225	32.3
Arrest	1,324	13.3
No Action	853	8.5
Referral	469	4.7
Other	293	2.9
Urgent Care	128	1.3
Mental Illness Contacts with SMART Unit		
Private Hospital	2,091	43.0
County Hospital	1,660	34.1
Referral	500	10.3
Urgent Care	343	7.1
Other	104	2.1
No Action	94	1.9
Arrest	69	1.4

Disposition of Involuntary Hospitalizations: Patrol Versus SMART

As shown on Table 5, an assessment of the involuntary hospitalizations due to a mental illness comparing patrol officers and SMART revealed SMART units (*n* = 3,976, 51.9%) handled a slightly larger number of calls for service requiring involuntary hospitalization than uniformed patrol officers (*n* = 3,627, 47.3%). SMART units completed an application for a mental evaluation to a private facility the majority of the time (*n* = 1,873, 47.1%), followed by an application to a county facility (*n* = 1,565, 39.4%) and an application to a mental health urgent care (*n* = 339, 8.5%). Uniformed patrol officers completed an application for a mental evaluation to a county facility the majority of the time (*n* = 3,172, 87.5%), followed by a private facility (*n* = 270, 7.4%) and a mental health urgent care (*n* = 117, 3.2%).

TABLE 5. Disposition of Involuntary Hospitalizations: Patrol Versus SMART

	n	**%**
Contact Handled By		
SMART Handled	3,976	51.9
Patrol Handled	3,627	47.3
SMART Dispositions		
Private Hospital	1,873	47.1
County Hospital	1,565	39.4
Urgent Care	339	8.5
Patrol Dispositions		
County Hospital	3,172	87.5
Private Hospital	270	7.4
Urgent Care	117	3.2

Bivariate Analysis Results

Analysis of Involuntary Hospitalization and Gender/Ethnicity

Table 6 illustrates the police encounters (n = 7,603) resulting in the submission of an application for an involuntary mental evaluation by either patrol officers or SMART in relation to gender and ethnicity. Patrol officers hospitalized more males (n = 2,466, 62.0%) than females (n = 1,510, 38.0%). Similarly, SMART Units hospitalized more males (n = 2,279, 62.8%) than females (n = 1,348, 37.2%). The result of the chi-square analysis (x^2=0.53, d.f.=1, p=.46) was not statistically significant at the .05 level. This suggests that there was no relationship between whether patrol officers or a SMART Unit handled a contact and the gender of the individual.

The majority of individuals hospitalized by patrol officers were African-American (n = 1,145, 31.6%), followed by Hispanics (n = 1,108, 30.5%), Caucasians (n = 1,098, 30.3%), Other or unidentified ethnicity (n = 143, 3.9%), and Asian (n = 133, 3.7%). SMART Units submitted an application for an involuntary hospitalization to individuals who were identified as Hispanic

TABLE 6. Analysis of Involuntary Hospitalization and Gender/Ethnicity

Characteristic	Patrol	%	SMART	%	x^2	p
Gender						
Male	2,279	62.8	2,466	62.0	.53	.46
Female	1,348	37.2	1.510	38.0		
Ethnicity						
African- American	1,145	31.6	1,268	31.9		
Hispanic	1,108	30.5	1,270	31.9		
Caucasian	1,098	30.3	1,150	28.9	2.82	.59
Other/Unidentified	143	3.9	146	3.7		
Asian	133	3.7	142	3.6		

(n = 1,270, 31.9%), followed by African-American (n = 1,268, 31.9%), Caucasian (n = 1,150, 28.9%), Other or unidentified ethnicity (n = 146, 3.7%), and Asian (n = 142, 3.6%). The result of

the chi-square analysis (x^2=2.82, d.f.=4, p=.59) was not statistically significant at the .05 level. This suggests that there is a no relationship between whether patrol officers or a SMART Unit handled a contact and the ethnicity of the individual.

Analysis of Disposition of Involuntary Hospitalization and Ethnicity

Table 7 shows there was a similar distribution of involuntary hospitalizations for a mental evaluation across the ethnicities of African American (*n* = 1,562, 31.70%), Hispanic (*n* = 2,150, 31.1%), and Caucasian (*n* = 2,066, 29.9%). Asian and unidentified groups had fewer law enforcement contacts (*n* = 509, 7.3%).

The ethnicity of the community members requiring the response of LAPD officers and involuntary hospitalization in a county facility for mental health treatment were largest among African Americans (*n* = 1,562, 32.8%), and Hispanics (*n* = 1,452, 30.5%), followed by Caucasian (*n* = 1,409, 29.6%), Other unidentified group (*n* = 180, 3.8%), and Asian (*n* = 159, 3.3%). Those individuals being transported to a private facility for mental health treatment were most often Hispanic (*n* = 698, 32.4%), followed by Caucasian (*n* = 657, 30.5%), African-American (*n* = 632, 29.3%), Asian (*n* = 86, 4.0%), and Other/Unidentified (*n* = 84, 3.9%). The results of the chi-square analysis (x^2=9.60, d.f.=4, p=.05) was statistically significant at the .05 level. This suggests that there is a significant relationship between the disposition of an involuntary hospitalization due to a mental illness and ethnicity in this study.

TABLE 7. Analysis of Disposition of Involuntary Hospitalization and Ethnicity

Ethnicity	County	%	Private	%	x^2	*p*
African- American	1,562	32.8	632	29.3		
Hispanic	1,452	30.5	698	32.4		
Caucasian	1,409	29.6	657	30.5	9.60	.05
Other/Unidentified	180	3.8	84	3.9		
Asian	159	3.3	86	4.0		

Analysis of Unit Handling Involuntary Mental Evaluation Hold and Type of Disposition

As shown in Table 8, police encounters (n = 7,660) resulting in the submission of an application of a mental evaluation hold were analyzed comparing SMART and patrol officers against the type of hospitalization they offered to a consumer of mental health services. SMART units hospitalized individuals requiring mental health interventions the majority of the time in a private hospital (n = 1,873, 49.6%), followed by county hospital (n = 1,565, 41.4%) and a mental health urgent care (n = 339, 9.0%). Patrol officers hospitalized individuals requiring mental health interventions the majority of the time at a public county facility (n = 3,172, 89.1%), followed by a private hospital (n = 270, 7.6%) and a mental health urgent care (n = 117, 3.3%). Some contacts (n = 324, 4.2%) did not have an identified unit handling designated and were excluded from the analysis. The result of the chi-square analysis (x^2=1,847.47, d.f.=2, p=.001) was statistically significant at the .05 level. This suggests that there is a strong significant relationship in the difference of the type of hospitalization and whether patrol officers or a SMART Unit handled the interaction with the individual with a mental illness.

TABLE 8. Analysis of Unit Handling Involuntary Mental Evaluation Hold and Disposition

	SMART	**%**	**Patrol**	**%**	x^2	p
County Hospital	1,565	41.4	3,172	89.1		
Private Hospital	1,873	49.6	270	7.6	1,847.47	.001
Urgent Care	339	9.0	117	3.3		

Analysis of Adult/Juvenile Involuntary Holds by SMART/Patrol and Type of Disposition

As shown in Table 9, police encounters (n = 7,660) resulting in the submission of an application of a mental evaluation hold for an adult (5150 WIC) and juvenile (5585 WIC) by SMART or patrol were analyzed comparing the type of hospitalization offered to the consumer of mental health services. Adult consumers of mental health services were hospitalized by

SMART in a private hospital (*n* = 1,502, 46.7%), followed by county hospital (*n* = 1,435, 44.6%) and a mental health urgent care (*n* = 282, 8.8%). Patrol hospitalized adult individuals requiring mental health interventions mainly in a county hospital (*n* = 2,925, 89.2%), followed by a private hospital (*n* = 243, 7.4%) and a mental health urgent care (*n* = 110, 3.4%). Juvenile consumers of mental health services were hospitalized by SMART in a private hospital (*n* = 371, 66.5%), followed by county hospital (*n* = 130, 23.3%) and a mental health urgent care (*n* = 57, 10.2%). Patrol hospitalized juvenile individuals requiring mental health interventions mainly in a county hospital (*n* = 247, 87.9%), followed by a private hospital (*n* = 27, 9.6%) and a mental health urgent care (*n* = 7, 2.5%). Some data (*n* = 324, 4.2%) did not have a unit handling designated and were excluded from the analysis. As shown in Table 9 the result of the chi-square analysis (x^2=2.28, d.f.=2, p=.32) was not statistically significant at the .05 level. This suggests that there is a no significant relationship between whether patrol handled the contact and the disposition of the encounter. The result of the chi-square analysis (x^2=90.80, d.f.=2, p=.001) was statistically significant at the .001 level. This suggests that there is a strong significant relationship in regards

TABLE 9. Analysis of Adult/Juvenile Involuntary Holds by SMART/Patrol and Disposition

	5150 WIC	%	5585 WIC	%	x^2	*p*
SMART						
County Hospital	1,435	44.6	130	23.3		
Private Hospital	1,502	46.7	371	66.5	90.80	.001
Urgent Care	282	8.8	57	10.2		
Patrol						
County Hospital	2,925	89.2	247	87.9		
Private Hospital	243	7.4	27	9.6	2.28	.32
Urgent Care	110	3.4	7	2.5		

to the type of intervention offered to consumers of mental health services when they have a SMART unit respond and take over the call from patrol officers.

Analysis of Geographical Areas and Ethnicity of Mental Evaluation Holds

Table 10 gives the breakdown of the geographical area divisions and the location of involuntary hospitalization related to ethnicity of the individual who met criteria for the submission of an application for an involuntary mental evaluation. Some data (n = 741, 9.7%) was entered incorrectly and could not be included in the analysis. Seventeen of the 21 divisions did not show a significant statistical relationship after a chi-square analysis comparing the geographical division to whether an individual's ethnicity had a determining factor on transportation to a county or private psychiatric facility. The results of the chi-square analysis for Harbor Division (x^2=13.80, d.f.=4, p=.01), Newton Division (x^2=13.48, d.f.=4, p=.01), Olympic Division (x^2=12.78, d.f.=4, p=.01), and Wilshire Division (x^2=11.42, d.f.=4, p=.02) were all statistically significant at the .05 level. These results suggest there is a significant relationship between these four geographical divisions and the individual's ethnicity being a determining factor when transporting to a county or private psychiatric facility.

TABLE 10. Analysis of Geographical Area and Ethnicity of Mental Evaluation Holds

	County	%	Private	%	x^2	p
Van Nuys Area						
Caucasian	96	43.8	45	42.9		
Hispanic	69	31.5	34	32.4		
African American	35	16.0	16	15.2	1.01	.91
Other/Unidentified	12	5.5	8	7.6		
Asian	7	3.2	2	1.9		
Mission Area						
Hispanic	132	55.9	42	60.0		
Caucasian	59	25.0	13	18.6		
African American	32	13.6	10	14.3	1.53	.82
Other/Unidentified	9	3.8	3	4.3		
Asian	4	1.7	2	2.9		

TABLE 10. Continued

	County	%	Private	%	x^2	*p*
Topanga Area						
Caucasian	105	56.8	42	53.8		
Hispanic	35	18.9	20	25.6		
African American	21	11.4	10	12.8	2.84	.59
Other/Unidentified	18	9.7	4	5.1		
Asian	6	3.2	2	2.6		
West Valley Area						
Caucasian	75	44.6	34	39.1		
Hispanic	46	27.4	27	31.0		
African American	26	15.5	9	10.3	3.69	.45
Other/Unidentified	15	8.9	12	13.8		
Asian	6	3.6	5	5.7		
North Hollywood Area						
Caucasian	79	40.7	45	47.4		
Hispanic	68	35.1	34	35.8		
African American	33	17.0	10	10.5	2.84	.58
Other/Unidentified	10	5.2	5	5.3		
Asian	4	2.1	1	1.1		
Devonshire Area						
Caucasian	85	44.7	27	39.1		
Hispanic	59	31.1	21	30.4		
African American	19	10.0	11	15.9	1.92	.75
Other/Unidentified	19	10.0	7	10.1		
Asian	8	4.2	3	4.3		
Foothill Area						
Hispanic	88	49.2	31	55.4		
Caucasian	51	28.5	14	25.0		
African American	26	14.5	6	10.7	2.60	.63
Other/Unidentified	12	6.7	3	5.4		
Asian	2	1.1	2	3.6		
Central Area						
African American	327	48.4	82	46.3		
Caucasian	187	27.7	53	29.9		
Hispanic	130	19.3	33	18.6	0.50	.97
Asian	20	3.0	6	3.4		
Other/Unidentified	11	1.6	3	1.7		

TABLE 10. Continued

	County	%	Private	%	x^2	*p*
Rampart Area						
Hispanic	79	40.1	40	38.5		
Caucasian	47	23.9	37	35.6		
African American	54	27.4	20	19.2	5.74	.22
Other/Unidentified	9	4.6	3	2.9		
Asian	8	4.1	4	3.8		
Northeast Area						
Hispanic	65	39.2	34	37.0		
Caucasian	55	33.1	36	39.1		
African American	27	16.3	12	13.0	1.13	.89
Asian	12	7.2	6	6.5		
Other/Unidentified	7	4.2	4	4.3		
Newton Area						
Hispanic	97	49.0	43	46.2		
African American	66	33.3	38	40.9		
Caucasian	33	16.7	8	8.6	13.50	.01*
Asian	0	0.0	4	4.3		
Other/Unidentified	2	1.0	0	0.0		
Hollenbeck Area						
Hispanic	100	73.5	49	66.2		
African American	18	13.2	8	10.8		
Caucasian	11	8.1	9	12.2	3.87	.42
Asian	6	4.4	6	8.1		
Other/Unidentified	1	0.7	2	2.7		
Hollywood Area						
Caucasian	116	43.4	70	52.6		
African American	78	29.2	29	21.8		
Hispanic	54	20.2	28	21.1	4.44	.35
Other/Unidentified	10	3.7	3	2.3		
Asian	9	3.4	3	2.3		
Pacific Area						
Caucasian	82	54.3	63	63.6		
African American	37	24.5	17	17.2		
Hispanic	19	12.6	13	13.1	2.95	.57
Other/Unidentified	8	5.3	4	4.0		
Asian	5	3.3	2	2.0		

TABLE 10. Continued

	County	%	Private	%	x^2	*p*
Olympic Area						
Hispanic	64	28.7	47	41.6		
Caucasian	63	28.3	31	27.4		
African American	45	20.2	17	15.0	12.78	.01*
Asian	43	19.3	15	13.3		
Other/Unidentified	8	3.6	3	2.7		
West Los Angeles Area						
Caucasian	65	50.8	53	57.6		
African American	29	22.7	18	19.6		
Hispanic	19	14.8	11	12.0	2.24	.69
Other/Unidentified	12	9.4	6	6.5		
Asian	3	2.3	4	4.3		
Wilshire Area						
African American	82	43.9	31	27.4		
Caucasian	59	31.6	36	31.9		
Hispanic	34	18.2	32	28.3	11.42	.02*
Other/Unidentified	7	3.7	7	6.2		
Asian	5	2.7	7	6.2		
Southwest Area						
African American	206	59.5	120	67.8		
Hispanic	94	27.2	41	23.2		
Caucasian	39	11.3	12	6.8	6.75	.15
Other/Unidentified	5	1.4	1	0.6		
Asian	2	0.6	3	1.7		
77th Street Area						
African American	201	68.8	83	61.0		
Hispanic	73	25.0	37	27.2		
Caucasian	15	5.1	10	7.4	7.09	.13
Other/Unidentified	2	0.7	3	2.2		
Asian	1	0.3	3	2.2		
Harbor Area						
Hispanic	64	34.4	42	46.7		
Caucasian	74	39.8	29	32.2		
African American	44	23.7	12	13.3	13.79	.01*
Asian	4	2.2	4	4.4		
Other/Unidentified	0	0.0	3	3.3		

TABLE 10. Continued

	County	%	Private	%	x^2	*p*
Southeast Area						
African American	152	67.3	55	56.1		
Hispanic	61	27.0	38	38.8		
Caucasian	8	3.5	4	4.1	5.41	.25
Asian	3	1.3	1	1.0		
Other/Unidentified	2	0.9	0	0.0		

Significant at .05 Level

CHAPTER 5

DISCUSSION

There is a great need in law enforcement for more effective means of providing services to those dealing with the effects of a mental illness. The use of the criminal justice system has not only served to criminalize the mentally ill, but it has also led to jails becoming some of the largest mental health facilities in the nation (Barker, 2013). This obvious flaw in the manner mentally ill individuals have been dealt with in the past by the law enforcement community has given rise to new and innovative programs addressing the needs of this community. The continued evolution of the CIT model and constant modification of the co-response model have led to many improvements in an officer's ability recognize mental illness and effectively provide the most appropriate level of care needed in each particular contact. Given the current need for a focus on improved mental illness interventions by law enforcement, this study examined the recent utility of the co-partnership SMART unit model between officers from the Los Angeles Police Department patrolling with clinicians from the Los Angeles County Department of Mental Health (LACDMH). This study included 15,454 officer contacts over a 1-year period from July 1, 2014 to June 30, 2015 in which mental illness was a component for the call for service.

This study initially asked the following research questions: (1) What is the demographic profile of the persons with mental illness who have had contact with police officers in the city of Los Angeles? (2) What type of treatment did the Los Angeles Police Department co-partnership model, SMART, provide for the consumers of mental health services after a law enforcement contact was initiated? (3) Is there a difference in the disposition between SMART units and Patrol units?

Research Question No. 1

The demographic profile of the persons with mental illness who have had contact with law enforcement officers in the city of Los Angeles exposed that the majority of individuals having contact with law enforcement during a police radio call involving mental illness are 19-35 year old males who are Caucasian, Hispanic, or African American. The Valley Bureau of Los Angeles had the highest number of contacts with law enforcement; however, the Central Division located in downtown Los Angeles, including the area known as Skid Row, had the highest number of contacts among all divisions within the LAPD. As of July 1, 2014 the city of Los Angeles had an estimated population of 3,928,864 with an ethnic demographic breakdown of 49.8% Caucasian, 48.5% Hispanic, 9.6% African-American, and 11.3% Asian (U.S. Census Bureau, 2010). This study revealed that the ethnic composition of the individuals being encountered by police officers during a mental health encounter was mostly Caucasian at 33.8%, followed by Hispanic at 30.3%, and then African American at 28.2%. Although African Americans in Los Angeles only make up 9.6% of the total population, they represent 28.2% of the police contacts with a person with mental illness. This could be the result of lack of available resources in the community that would require police intervention in order to provide assistance. More research to address this phenomenon is needed to explore other factors that may be influencing this finding.

Research Question No. 2

Regarding the question about the type of treatment the LAPD SMART unit provided for the consumers of mental health services after a law enforcement contact, the results were compelling. When examining the disposition of the interactions by the LAPD SMART units as compared to traditional patrol officers, the differences showed statistical significance. The ability

to discharge individuals needing a mental health intervention to mental health facilities and hospitals that are not available to other patrol officers can be advantageous to the citizen with mental illness. The existence of a co-partnership model can present county hospitals with not being burdened with law enforcement initiated psychiatric holds, which can detract vital hospital services for other patients. Having contact with SMART enables individuals with a mental illness to experience greater treatment options such as private hospitals and urgent care facilities following their interactions with LAPD. The Los Angeles Police Department has divided the city into 21 geographical areas served by a community police station. These stations are further divided into small neighborhood units known as Basic Cars. There are approximately eight to ten Basic Cars areas per Community Police Station, and each Basic Car has one patrol unit permanently assigned to provide service to the respective area. During any given shift there are approximately 168-210 patrol units in the city of Los Angeles. (Los Angeles Police Department, 2015). Currently, there are four SMART cars deployed in the city, one assigned to each respective bureau of the city during a regular shift.

The current deployment of only one SMART unit in each geographical bureau has been insufficient to address the increased need for mental heath police intervention in the community, which has led to the current expansion to provide a SMART interaction with more members of the community (Lacey, 2015). The MEU plans to double its deployment early in 2016 to address the increasing number of mental health related radio call in the city. The current plan is to deploy a minimum of 8-10 SMART units in the city during a given shift, essentially, doubling the ability of the specialized unit to assist patrol officers in the field.

An interesting finding was revealed when analyzing police contacts requiring a 5150 California Welfare and Institutions Code (WIC) involuntary hospitalization of an individual with

a mental illness. When patrol officers submitted an application for a 5150 WIC hold, they transported the individual to a Los Angeles County mental health facility just under 90% of the time. With such a large number of patrol officers transporting mental health patients to one of the three county hospitals in Los Angeles County, it is easy to see how staffing resources at county hospitals could quickly become exhausted (Sewell, 2015).

The ability to partner with LACDMH clinicians who can help with accessing private hospitals throughout Los Angeles County is an important and valuable aspect of the SMART unit, along with their clinical expertise in mental health interventions. The ability of the SMART unit to provide better placement for mental health treatment is an important function of this collaboration. When a SMART unit's assessment has determined an application for an involuntary mental health hold is warranted, they are able to coordinate the transfer of the care to a private hospital or mental health urgent care over 55% of the time. The capability of the SMART unit to help transport individuals with mental illness to specialized facilities to treat their conditions not only potentially decreases the volume of clients seeking services at county hospitals, but also allows LAPD patrol officers to attend to other police calls placed by members of the community instead of waiting at a county hospital for medical staff to assess and admit a mentally ill consumer who was apprehended by the LAPD.

Research Question No. 3

Mental health resources obtainable in the community have been a topic of concern for individuals with a mental illness pursuing options since deinstitutionalization was enacted in the mid-1950s (Lamb & Bachrach, 2001). Results from this study indicated the number of SMART units currently deployed can barely address the mental health calls throughout the community. During the 1-year time period from July 1, 2014 to June 30, 2015, patrol officers (not SMART

units) still handled 64.6% of the calls for service involving an individual with a mental illness. More importantly, chi-squared results on Table 9 showed significant differences in the type of disposition received when a community members was contacted by a SMART unit. The SMART unit was able to distribute hospitalized community members in variety of resources including county hospitals (*n*= 1,565, 41.4%), private hospitals (*n*= 1,873, 49.6%), and mental health urgent care centers (*n*= 339, 9.0%), where as patrol officers were largely limited to the county hospital system (*n*= 3,172, 89.1%). Ideally the SMART units would handle the majority of the law enforcement contacts, since they are able to more appropriately address the psychiatric needs of the community member while also addressing the linkage and referrals needs to more appropriate resources within the community. With the expansion of the MEU there is an expectation that SMART units will be able to handle the majority of the contacts within the city.

An interesting finding of the study indicated SMART units were limited in their ability to hospitalize community members in the private hospitals systems when those facilities reached capacity and could no longer able accept clients referred from the SMART units. As private hospitalization resources have become increasingly limited, SMART units needed to hospitalize individuals requiring emergency mental health treatment in a county hospital 1,565, or 39.4% of the time during the time of this study. This is an indication of the potential shortage of mental health care facilities available for SMART units use in the greater Los Angeles area. There has recently been a planned expansion of community mental health urgent care centers programs for up to seven additional Urgent Care facilities throughout Los Angeles County in order to address the shortage of available community resources. These plans will take time to implement and currently the expansion will not be immediate (Lacey, 2015).

Limitations

The results of this research were derived from the secondary analysis of data extracted from the LAPD database of mental health encounters with individuals from July 1, 2014 to June 30, 2015. There are several factors that are identified limitations of this study. Although LAPD has a strict policy requiring officers to report all encounters to the MEU regarding their contacts with a person with a mental illness, one cannot guarantee that all field contacts encountered by patrol officers were communicated by officers to the MEU triage desk. Another limitation is that MEU officers assigned to triage calls from patrol offices are then tasked to enter the data into the LAPD database, but this there was no control over the accuracy of the data entered into the database. An additional limitation is that this study was conducted from data collected in Los Angeles, California and may not be representative of police encounters in other geographic areas around the country.

Although these limitations do exist, this study still provides valuable information regarding the utilization and effectiveness of the SMART unit program in Los Angeles County and how this law enforcement program can best help those citizens experiencing a mental health crisis. Limitations notwithstanding, it was expected this study has provided valuable information to law enforcement regarding its contacts with mentally ill individuals. As a result of learning about the relationship between law enforcement and mental illness, social workers in mental health can better assess risks and strategies for appropriate interventions regarding contacts with law enforcement. This information allows social workers to provide improved preventative services and safety planning.

Implications for Future Research

Future research should consider a closer examination of the SMART partnership model examining outcome data over a longer period of time, which could then examine trends of law enforcement interactions with those who are mentally ill to modify services accordingly.
In addition, future researchers should examine ethnic differences in police interactions involving mental health emergencies regarding culturally competent responses by LAPD. For instance, examining utilization of mental health treatment programs by the African American and Latino communities could help address the disparity in mental health care within the community in Los Angeles.

Further research is also advised regarding the changing responsibilities of law enforcement officers to evaluate their acceptance of this new responsibility, as the gatekeepers to the mental health system. As times have continued to change, the LAPD has also been changing to address the needs of its officers. For example, police officers today are asked to provide better service to the community, address the stigma of mental illness, and encourage empathy; in response the LAPD has evolved in its approach to address the needs of the community members in need of mental health interventions (LAPD, 2015a). The LAPD has been providing mental illness training to its officers for several years, but in the past year it has developed a new training to address the stigma of mental illness, promote compassion and empathy among its officers, educate officers about available community resources, and facilitate a discussion with family members of mentally ill community members in partnership with the National Alliance on Mental Illness (LAPD, 2015a). An example is the Mental Health Intervention Training (MHIT) is a 40-hour, 4-day course approved by the commission of California Peace Officers Standards and Training (POST). This training is designed to provide first responding police

officers with the tools necessary to correctly intervene to a crisis call for service involving persons experiencing a mental health crisis. MHIT addresses historical and current legal aspects of mental health laws, addresses mental health firearm laws, and promotes a discussion of the stigma of mental illness while promoting more understanding and knowledge regarding the subject of mental illness. Another example is a program in development that will be in collaboration with the LACDMH, Autism Society of Los Angeles, and National Alliance on Mental Illness.

Conclusion

This study focused on the evolution of policing strategies for individuals with mental illness with the current co-partnership model. By focusing on the model utilized by the Los Angeles Police Department, one is able to observe a practical application of the model in a large municipality. The realization a modification needed to take place and the subsequent implementation of change is slowly gaining consideration by agencies in Los Angeles County and around the world. A report submitted by Los Angeles District Attorney Jackie Lacey on the social issue of mental illness called for many recommendations over the next couple of years, including the expansion of law enforcement mental illness training and the expansion of partnerships with LACDMH and law enforcements agencies across Los Angeles County (Lacey, 2015). The LAPD realized there was a need, and sought all available resources in order to address a growing concern in the community. The evolution of the CIT model of policing the mentally ill is a well-established model and has been replicated around the world. With changing times the LAPD must adapt and improve on a model in order to address the changing needs of the community. The co-partnership SMART unit model embraced by LAPD and many other agencies in Los Angeles Country can be an effective tool in its ability to stop the criminalization

of the mentally ill, but also provides an appropriate level of treatment using the combined resources of the LAPD and the LACDMH.

By combining the largest mental health agency in the nation and the largest police force in California, a model has been established that can be replicated across the world for the appropriate treatment of a population that has not been afforded the level of understanding and compassion one would give any other group with a medical diagnosis. This study was important in providing data that can help substantiate this SMART unit partnership model as a viable and successful strategy to provide appropriate treatment of those in a mental health crisis.

APPENDICES

APPENDIX A

APPROVAL LETTER FROM THE LOS ANGELES POLICE DEPARTMENT OIC OF UNIT

A note from:
LIEUTENANT II BRIAN BIXLER
OFFICER-IN-CHARGE
Crisis Response Support Section
Detective Support and Vice Division

July 27, 2015

The request by Hector Lopez to extract data from the Incident Reporting Control System for the Los Angeles Police Department Mental Evaluation Unit has been approved. Captain II Kelly Mulldorfer, Commanding Officer of Detective Support and Vice Division, Detective III Charles Dempsey, Officer-In-Charge of Admin and Training Section, Charles Lennon, Mental Health Clinical Program Head for the County of Los Angeles – Department of Mental Health, Law Enforcement Programs – LAPD MEU – SMART & CAMP, and I have reviewed Hector's request for a California State University, Long Beach thesis project entitled "A Descriptive Study of LAPD's Co-Partnership Model For Helping Mentally Ill Offenders" and we have approved his request to extract the below listed data.

Hector was advised we would have to review the project prior to submission, which he did not have an issue complying with.

Below are the requested variables approved to be extracted from the MEU Incident Reporting Control System. The time frame of data requested is July 1, 2014 to June 30, 2015:

- Gender
- Descent
- Age
- Incident Date
- SMART Handled Incidents Only
- Type of Report Taken (5150 WIC, 5585 WIC, 5150 AMB/INJ, 5585 AMB/INJ)
- Disposition (ie. County Hospital, Private Hospital, Urgent Care, Arrest, Referral, No Action Taken)
- Area Handling the Incident (ie. 77th, Central, Mission, Pacific, etc.)

Lieutenant II Brian Bixler
Officer-In-Charge
Los Angeles Police Department
Detective Support and Vice Division
Crisis Response Support Section
Mental Evaluation Unit

APPENDIX B

APPROVAL LETTER FROM THE LOS ANGELES POLICE DEPARTMENT OIC ADMIN/TRAINING SECTION OIC LACDMH

A note from.....

DETECTIVE III CHARLES DEMPSEY

OFFICER-IN-CHARGE
Mental Evaluation Unit
Case Assessment Management Program (CAMP)
100 West First Street, Room 630 *Telephone: (213) 996-1300*
Los Angeles, Ca 90012 *Fax: (213) 996-1320*

July 21, 2015

Lieutenant Bixler,

I support Hector in this endeavor and do not see any conflicts in regards to him using this information. I also advised him that we would have to review prior to submission, which he did not have an issue complying with.

Thank you,

Charles

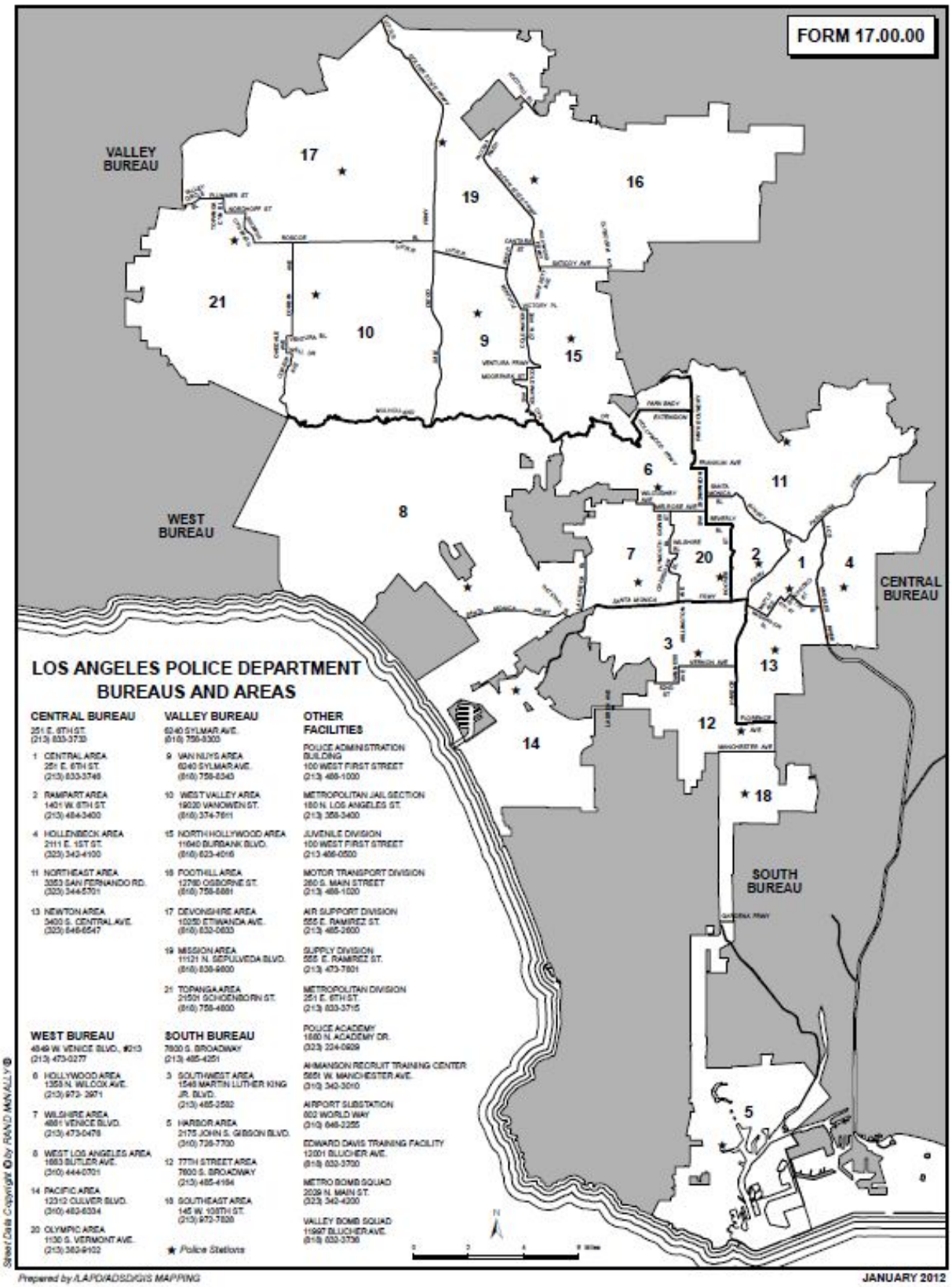
Charles Lennon, DMH

As this is information available to media under the Freedom of information act, I support this request.

Approved. 7/22/15

APPENDIX C

LOS ANGELES POLICE DEPARTMENT GEOGRAPHICAL DIVISION MAP


FORM 17.00.00
VALLEY BUREAU
WEST BUREAU
CENTRAL BUREAU
SOUTH BUREAU
17
19
16
21
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9
15
6
11
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7
20
2
1
4
3
13
12
14
18
5
LOS ANGELES POLICE DEPARTMENT
BUREAUS AND AREAS
CENTRAL BUREAU
251 E. 6TH ST.
(213) 833-3730
1 CENTRAL AREA
251 E. 6TH ST.
(213) 833-3746
2 RAMPART AREA
1401 W. 6TH ST.
(213) 484-3400
4 HOLLENBECK AREA
2111 E. 1ST ST.
(323) 342-4100
11 NORTHEAST AREA
3353 SAN FERNANDO RD.
(323) 344-5701
13 NEWTON AREA
3400 S. CENTRAL AVE.
(323) 846-6547
VALLEY BUREAU
6240 SYLMAR AVE.
(818) 756-8303
9 VAN NUYS AREA
6240 SYLMAR AVE.
(818) 756-8345
10 WEST VALLEY AREA
19020 VANOWEN ST.
(818) 374-7611
15 NORTH HOLLYWOOD AREA
11640 BURBANK BLVD.
(818) 623-4016
16 FOOTHILL AREA
12760 OSBORNE ST.
(818) 756-8881
17 DEVONSHIRE AREA
10250 ETIWANDA AVE.
(818) 832-0603
19 MISSION AREA
11121 N. SEPULVEDA BLVD.
(818) 838-9800
21 TOPANGA AREA
21501 SCHOENBORN ST.
(818) 756-4800
WEST BUREAU
4849 W. VENICE BLVD., #213
(213) 473-0277
6 HOLLYWOOD AREA
1358 N. WILCOX AVE.
(213) 972- 2971
7 WILSHIRE AREA
4861 VENICE BLVD.
(213) 473-0476
8 WEST LOS ANGELES AREA
1663 BUTLER AVE.
(310) 444-0701
14 PACIFIC AREA
12312 CULVER BLVD.
(310) 482-6334
20 OLYMPIC AREA
1130 S. VERMONT AVE.
(213) 382-9102
SOUTH BUREAU
7600 S. BROADWAY
(213) 485-4251
3 SOUTHWEST AREA
1546 MARTIN LUTHER KING JR. BLVD.
(213) 485-2582
5 HARBOR AREA
2175 JOHN S. GIBSON BLVD.
(310) 726-7700
12 77TH STREET AREA
7600 S. BROADWAY
(213) 485-4184
18 SOUTHEAST AREA
145 W. 108TH ST.
(213) 972-7920
★ Police Stations
OTHER FACILITIES
POLICE ADMINISTRATION BUILDING
100 WEST FIRST STREET
(213) 486-1000
METROPOLITAN JAIL SECTION
180 N. LOS ANGELES ST.
(213) 358-3400
JUVENILE DIVISION
100 WEST FIRST STREET
(213 486-0500
MOTOR TRANSPORT DIVISION
260 S. MAIN STREET
(213) 486-1020
AIR SUPPORT DIVISION
555 E. RAMIREZ ST.
(213) 485-2600
SUPPLY DIVISION
555 E. RAMIREZ ST.
(213) 473-7801
METROPOLITAN DIVISION
251 E. 6TH ST.
(213) 833-3715
POLICE ACADEMY
1880 N. ACADEMY DR.
(323) 224-0809
ahmanson RECRUIT TRAINING CENTER
5601 W. MANCHESTER AVE.
(310) 342-3010
AIRPORT SUBSTATION
602 WORLD WAY
(310) 646-2255
EDWARD DAVIS TRAINING FACILITY
12001 BLUCHER AVE.
(818) 832-3700
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2039 N. MAIN ST.
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