UC Criminal Justice & Health Consortium

Policy Brief

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BUILDING ON CALIFORNIA SB11 AND SB29: STRENGTHENING COMMUNITY PARTNERSHIPS

By Jorien Breur, MD, Kelly Kruger, BA, SFPD Psychiatric Liaison and Mia Bird, Ph.D., M.A., MPP

Key Facts

- *California SB11 and SB29 mandate culturally appropriate behavioral and mental health training for law enforcement officers in California and constitute critical first steps towards improving officers' abilities to effectively, respectfully and safely interact with persons with mental illness.*
- *Evidence from the Crisis Intervention Team (CIT) model suggests that formal partnerships between law enforcement and community mental health stakeholders further reduce arrests and increase access to appropriate care for mentally ill persons who come into contact with police.*
- *To build on the foundation established by SB11 and SB29 and reduce the use of unnecessary force and unnecessary arrests for mentally ill persons, responsive and effective collaborations between police and community mental health stakeholders are needed.*

A number of recent high-profile police shooting deaths involving mentally ill individuals have resulted in public outcry for change in policing practices. Today, law enforcement professionals interact with more persons with mental illness than any other occupational group outside of the mental health field.[1,2] In response, California legislation SB 11 and SB 29 mandated an increase in behavioral health and mental health training for police officers. This represents a critical step forward towards improving the way that law enforcement personnel respond to and address the needs of mentally ill citizens. Our goal in this Policy Brief is to highlight the important next step in this process -- developing meaningful collaborations between law enforcement and community mental health stakeholders. The proposed collaborations would build on the foundation established by SB11 and SB29 by providing police with the linkages to community-based resources that they need to respond effectively and humanely in their contacts and interactions with mentally ill persons and facilitate access to appropriate mental health services.

"Deinstitutionalization" was originally intended to provide mentally ill persons with more humane and effective treatment in community-based rather than institutional settings. Unfortunately, meaningful community-based treatment alternatives never fully materialized, leaving law enforcement and the criminal justice system to address the needs of the state's mentally ill population. In California, within the past two years, 23% of individuals in jail and 28% of individuals in state prison have been diagnosed with mental illness, suggesting that law enforcement agencies have become de facto first responders to people experiencing mental health crisis.[3,4] To better fulfill this first-responder role, a Crisis Intervention Team ("CIT") model has been developed that partners law enforcement personnel and community mental health stakeholders and facilitates the diversion of mentally ill persons from the criminal justice system into the healthcare system.[5] There is clear evidence that mental health providers working together with law enforcement can provide critical support to officers responding to mental health crises and increase safety in these situations—for officers, individuals in crisis, and bystanders.[1,6,7]

CALIFORNIA LEADING THE WAY IN BEHAVIORAL HEALTH AND MENTAL HEALTH TRAINING FOR POLICE OFFICERS

In October 2015, Governor Brown approved legislation introduced to the California State Senate by Senator Jim Beall to increase safety for the public and police by improving officers' mental health training. The resulting SB 11 requires at least 15 hours of behavioral health instruction at academies for new recruits who are training to become police officers; SB 29 requires at least 12 hours of behavioral health training for police officers in supervisory roles who conduct field training.

Training mandated by SB29/SB11 covers:

1) *How to identify mental illness, intellectual disability, substance use disorders, neurological disorders, traumatic brain injury, PTSD, and dementia.*
2) *Autism spectrum disorder.*
3) *Down syndrome.*
4) *Conflict resolution and de-escalation techniques for potentially dangerous situations.*
5) *Alternatives to the use of force when interacting with persons with mental illness or intellectual disabilities.*
6) *The perspective of individuals or families who have experiences with persons with mental illness, intellectual disability, and substance use disorders.*
7) *Involuntary holds.*
8) *Community and state resources available to serve persons with mental illness or intellectual disability.*

These two bills mandate culturally appropriate behavioral and mental health training for law enforcement officers in California and constitute essential first steps towards improving officers' abilities to effectively, respectfully and safely interact with persons with mental illness, including diverting them from the criminal justice system into settings where they can receive appropriate mental health services. California's forward-thinking legislative efforts recognize that the CIT training curriculum improves officer knowledge, attitudes, and confidence in responding to persons with mental illness. These two laws promise to greatly improve the safety of California's law enforcement officers, members of the general public, and mentally ill citizens when they come in contact with law enforcement. The laws also establish a strong foundation for enhanced partnership between law enforcement and community mental health stakeholders, which would ensure that a far greater number of mentally ill persons receive proper and appropriate treatment in community-based mental health programs.

CRISIS INTERVENTION TEAM: A LARGE-SCALE COMMUNITY COLLABORATIVE PROGRAM

The first CIT was established in Memphis, Tennessee in 1998 after an incident in which a police officer shot a man with serious mental illness. Originally, the primary goal of CIT was to reduce officer and citizen injuries. Over time, however, another goal emerged as equally important -- diverting persons with mental illness from the criminal justice system into settings where they could receive more appropriate treatment. Today, the "Memphis Model," which emphasizes the creation of sustainable partnerships between law enforcement and community mental health stakeholders in addition to requiring 40-hours of comprehensive mental health training for law enforcement, is considered the gold standard for CIT.

Evaluations of comprehensive CIT implementation in jurisdictions outside California have shown that CIT officers are better trained to recognize possible mental illness and more likely than non-CIT officers to use more humane techniques in their response to citizens in crisis (e.g. verbal de-escalation, active listening, and calming strategies). CIT officers are correspondingly less likely to respond with force.[8] These findings underscore the wisdom of SB11 and SB29 and provide evidence that enhanced mental health training for law enforcement officers improves their performance in the field. However, the literature also suggests that another important step is often needed to ensure that mentally ill citizens are treated effectively and humanely. More specifically, partnerships between law enforcement and community mental health stakeholders, including behavioral health providers, are essential to ensure that mentally ill citizens are appropriately diverted from the criminal justice system and into settings where they can receive the services and treatment they need.[9]

The process by which the Memphis Model was created provides some instructive lessons for California communities seeking to implement a similar program. The early task force meetings between law enforcement

and mental health providers in Memphis were strained by mutual distrust and misunderstanding.[10] Providers felt that police officers lacked the knowledge and sensitivity to respond appropriately to mental illness and often exacerbated crisis situations. Police officers were frustrated that hospitals failed to provide care for mentally ill persons when they did transport them there. Over time, however, mutual interests between the groups in Memphis surfaced and they worked together productively to develop the CIT model.

CIT is best viewed as a large-scale collaborative program in which law enforcement is one essential component among many. At the core of this collaborative program are the community partnerships between law enforcement, community mental health stakeholders including mental health providers, and individuals and families with lived experience working together to improve police interactions with people with mental illness. Thus, responsibility for appropriately responding to and addressing the needs of mentally ill citizens is a shared responsibility that does not reside entirely with the police. For example, critical to the Memphis Model's success was the Memphis Police Department's arrangement with the University of Memphis Medical Center's psychiatric emergency department. Working together with their law enforcement partners, the Medical Center committed to serve as a no-refusal central drop-off for police, accepting all police referrals immediately and minimizing officer waiting time. The Memphis CIT model resulted in lower arrest rates for the mentally ill (2% in Memphis vs 5% and 13% in study sites that did not have a mental health emergency facility with a "no refusal" policy) and more cases in which mentally ill persons were taken to a treatment rather than jail facility (75% vs 20% and 40% respectively).[9] Interrupting the direct path from mental health crisis to incarceration gives those in a mental health crisis the opportunity to obtain the psychiatric care they need. Other studies suggest that a comprehensive CIT program reduces arrest rates for persons with mental illnesses and increases the number of transports to the hospital for psychiatric evaluation. [11]

Despite its obvious advantages, implementation of the Memphis Model can be challenging. For example, a national survey of CIT programs found that only one-third had formal agreements with receiving facilities. Some departments implemented the 40-hour CIT training curriculum but reported that they were unable to engage local psychiatric emergency services and other providers in ongoing collaborations.[12,13] Although no data currently exist to describe the extent of current partnerships between law enforcement and community mental health stakeholders in California, one study conducted in San Francisco, which is among the state's leading counties in CIT training for police officers, found persistent distrust between police and hospital-based healthcare providers and a lack of formal efforts to address the many issues standing as barriers to collaboration. The study quotes one officer saying that when he brings "frequent flyers" to the emergency department, "The hospital will say, 'why are you bringing them here?' It's a push back and forth."[14]

In order to successfully build on the foundation provided by SB11 and SB29, these challenges must be met in California. As we have suggested, collaboration between law enforcement and community mental health stakeholders is crucial to the success of the CIT Model. This means that police officer training must be seen as a critical first step in a multi-step and multi-facet program that directly involves community mental health stakeholders, including mental health providers, who often have much to learn about effectively meeting the needs of individuals with mental illness involved in the criminal justice system. Communities that fail to provide adequate reentry planning and continuity of care for psychiatrically vulnerable persons who cycle in and out of jail must improve their community mental healthcare system. Meaningful partnerships thus draw both law enforcement personnel and mental health providers into a much-needed conversation about - and effort to effect - criminal justice reforms that have significant implications for the public health system. Indeed, when built appropriately, a CIT program can provide the backbone of a systemic community response to the outsized role behavioral health plays in our local criminal justice systems.

As SB11 and SB 29 transition into their implementation phases, we recommend additional measures are taken to ensure that these important laws achieve their goals. Current evidence from the literature on comprehensive CIT programming point to an important opportunity California has to divert mentally ill persons from criminal justice to healthcare systems via increased partnerships between law enforcement and community mental health stakeholders. To take full advantage of this opportunity created by SB11 and SB29, we recommend that policymakers consider legislation to:

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RECOMMENDATIONS

1. Appropriate ongoing funds to financially support and incentivize formal partnerships between law enforcement and community mental health stakeholders, particularly county behavioral health departments and emergency services providers;
2. Recognize and honor CIT programs and individual officers who partner with mental health stakeholders in their communities for their excellence in community service at the state level, either by the Mental Health Caucus or another state body;
3. Support the development of a mental health stakeholders group in each jurisdiction to partner with law enforcement to better address the needs of diverse populations including older adults and children;
4. Evaluate the impact of SB11, SB29, and the measures described above by collecting data in each county to describe changes in arrest rates, improved treatment outcomes, improved health care referrals, and changes in crisis response times and report back to the Mental Health Caucus.

CONCLUSION

California recently enacted forward-looking legislation, in SB 11 and SB 29, to improve law enforcement professionals' interactions with persons with mental illness. The scientific literature in this area demonstrates that, beyond training, partnerships between law enforcement and community mental health stakeholders are essential to ensure that mentally ill citizens are appropriately diverted from the criminal justice system and into settings where they can receive the services and treatment they need.[9] Building on the foundation established by SB11 and SB29, responsive and effective collaborations between police and community mental health stakeholders will serve communities well by reducing the use of unnecessary force and unnecessary arrests and providing mental health services to those in acute need.

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> ***"Collaboration between law enforcement and community mental health stakeholders is crucial to the success of the CIT Model."***

About the Consortium

The UC Criminal Justice & Health Consortium is an emerging community of over 120 faculty and graduate students representing all 10 campuses of the University of California system and over 20 areas of study, including medicine, the law, criminology, public health, economics, and many others. The Consortium aims to develop and disseminate policy-oriented evidence for health-focused criminal justice reform and is generously funded by a grant from the office of UC President Janet Napolitano.

For more information, contact
Cyrus Ahalt, MPP
Cyrus.Ahalt@ucsf.edu

or visit us at
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