
THE MENTAL ILLNESS REVOLVING DOOR: A PROBLEM FOR POLICE, HOSPITALS, AND THE HEALTH CARE AGENCY



GRAND JURY 2014-2015

TABLE OF CONTENTS

EXECUTIVE SUMMARY	4
BACKGROUND	4
Describing the Scope of the Problem	4
Mentally Ill and Homelessness	5
Mentally Ill and the Jails.....	5
Dealing with the Problem	6
Voluntary Treatment of the Mentally Ill.....	6
Involuntary Treatment of the Mentally Ill	6
Mental Health Conservatorship	7
Involuntary Assisted Outpatient Treatment (Laura’s Law)	8
Handling the Problem in the Field (Police and the Mentally Ill)	13
Triaging the Problem	14
Crisis Response Teams: CAT, PERT, and PET	14
Evaluation and Treatment Services (ETS).....	15
Hospital Emergency Rooms	15
REASON FOR THE STUDY	16
METHODOLOGY.....	17
INVESTIGATION AND ANALYSIS.....	18
Sufficiency of Police Training.....	19
Sufficiency of Police Resources.....	23
Dealing with Triage Decisions	23
Experiences Dealing with CAT and PERT by Law Enforcement	24
Dealing with PERT	27
Dealing with ETS	27
Dealing with Transporting the Patient (to ETS or to a Hospital)	29
Dealing with the Absence of In-Field Medical Clearance Authority	29
Dealing with Medical Clearance in Hospitals	30
Dealing with the Transfer.....	31
Dealing with a Premature Release from ETS	31
A Broken System	31
Fixing the System	33
Infrastructure Improvements.....	33
Leadership Improvement.....	33

Organizational Improvement	34
Psychiatric Emergency System: A Better Approach	34
Alternative Systems Nationwide	35
Alternative Systems in the State	35
The Alameda Model.....	36
Help is on the Way	39
The Ideal Solution	40
Laura’s Law	40
Defending Its Constitutionality.....	41
Locating its Candidates	41
Measuring its Success	42
Time Matters.....	44
FINDINGS	45
RECOMMENDATIONS.....	46
REQUIRED RESPONSES	47
COMMENDATIONS.....	50
END NOTES	51
REFERENCES.....	54
APPENDIX: ACRONYM LIST	56

EXECUTIVE SUMMARY

Crisis intervention and stabilization of the severely mentally ill often begins with the police officer on patrol. The triage conducted at that point—in the field—is critical, and, as society has witnessed recently, can lead to violent and even deadly results. It is crucial for officers to have the proper training, tools, and resources at their disposal to help the mentally ill deal with their demons and, with respect to some suffering from mental illness, control their homicidal or suicidal impulses.

Mental health agencies throughout the State and the nation are struggling to get a grip on the seemingly intractable problem of how to deal with dangerous mentally ill as they hopelessly cycle through the revolving door of crisis intervention, stabilization, incarceration or hospitalization, and release. Unfortunately, Orange County relies on an obsolete, inefficient triage system that handicaps the police officer and results in an inordinate loss of time and resources. Moreover, the County jails and emergency rooms are the worst places in which to treat the severely and dangerously mentally ill.

The Grand Jury has found that Orange County's failure to provide an adequate emergency psychiatric stabilization system has resulted in emergency rooms that are too full to handle medical emergencies. The presence of the severely mentally ill in emergency rooms is also dangerous to staff, police, and other patients. The County's shortcomings with regard to mobile response teams and in-the-field medical clearances of the severely mentally ill, and have caused long delays in evaluating and treating the mentally ill, many wasted hours of valuable police time spent in emergency rooms and while driving the mentally ill to and from emergency treatment facilities. The County's lack of vision and leadership have resulted in a disjointed, dysfunctional system that contributes to the revolving door.

BACKGROUND

“More often than not, the only option for the mentally ill in crisis is to spin in the emergency room's revolving door” (Simon, 2015.)

(An acronym list is included in the Appendix.)

Describing the Scope of the Problem

The most recent national and California data available demonstrate that mental illness afflicts about 20% of the population (Newsweek, 2014). “The vast majority of mental patients are not violent but this is [a television report] about the fraction who are: a danger to themselves or others” (Pelley, 2014). Four to five percent of the adult population in Orange County suffers from a “serious” mental illness that impairs their ability to function, makes it difficult to carry out basic life activities, and sometimes leads them to be a danger to themselves or others (Holt & Adams, 2013.). Examples of a serious mental illness are mental disorders such as schizophrenia, bipolar disorder, manic depressive, severe anxiety, and post-traumatic stress disorder (Bekiempis, 2014).

In Orange County, the annual suicide rate is about nine per 100,000 population overall, but ranges from 16 to 18 per 100,000 population among people over 45 years of

age. About half of the mentally ill adults do not get treatment or medication of any kind. For the other half who do get treatment, inpatient care is decreasing, while outpatient care and prescribed medication is increasing (Holt & Adams, 2013)

Untreated, the severely mentally ill can become violent, but treated, they can live healthy, productive lives. Many lives have been lost when the dangerously mentally ill are overwhelmed by severe psychiatric disorders—mired on the streets, fearful of all authority figures, and spiraling out of control—in a decline usually stopped only by death, prison, or a 5150 temporary hold. Many family members are at a loss when it comes to coping with their loved one who poses a danger to himself/herself, his close relatives, and society.

Mentally Ill and Homelessness

In 1985, the Bronzan-Mojonnier Act enacted provisions to identify the shortage of services which results in the criminalization of the severely mentally ill and to provide community support and vocational services for the severely mentally ill who are homeless. In 1999, the Legislature authorized grants for pilot programs to provide services for the severely mentally ill who are homeless, recently released from jail or prison, or at risk of being homeless or incarcerated in the absence of services. This pilot program was extended to all counties, including Orange County, the next year (Holt & Adams, 2013)

“These persons wander the streets hungry, homeless, and without hope. They cycle through our hospitals and are released with no assured after-care or plan to meet their human needs – and, all too often, in my experience, wind up in our jails and prisons, not because they are criminals, but because there simply is no place for them in our society” (Judge Shabo, 2014).

Mentally Ill and the Jails

Research has shown that at least 20% of jail inmates and 15% of state prison inmates have a serious mental illness. There are more mentally ill persons in jails than in hospitals. The prevalence rates of serious mental illnesses in jails are three to six times higher than for the general population. The county jail may very well be the County’s largest mental institution (Orange, 2015.)

The root problem is a patchwork mental-health safety net that long ago came apart at the seams, resulting in the criminalization and stigmatization of people trying to cope with severe mental illness. Mental health advocates take the issue back to the 1960s, when the doors of state psychiatric institutions were flung open and people who could not afford mental health care were dumped out onto the streets. In Orange County, the severely mentally ill cycle in and out of the County Jail, through the arrest-incarcerate-release-repeat revolving door while painfully suffering the symptoms of their illness.

The fact is that a jail is the last place where the mentally ill should be treated. Jails simply were never created to be *de facto* mental health facilities. They are not structurally appropriate for mental patients. Their dark, threatening, confining spaces

are even more constricting than the asylums and mental institutions of the past and are not at all welcoming environments conducive to treatment or therapy. (Miller, 2013)

“The use of a jail as a mental health ward is inefficient, ineffective, and, in many cases, inhumane” (Sewell, 2014). Without the appropriate treatment and services, people with mental illnesses continue to cycle through the criminal justice system, often resulting in tragic outcomes for these individuals and their families” (Orange, 2015). Former Supervisor John Moorlach is reported to have stated, “We cannot allow our jails to be the predominant location for housing mentally ill people” (Gerda, 2014).

Moreover, jails require two to three times more funds to house and treat the mentally ill than to treat the non-mentally ill. The mentally ill stay longer, require more staff, cause more management problems, are more likely to commit suicide, and are more susceptible to abuse by other inmates and are at a higher risk of recidivism upon release than other inmates. Furthermore, jails are ill suited to assuring that mentally ill persons will receive the psychiatric aftercare that they will need upon their release. (Orange, 2015)

Dealing with the Problem

Voluntary Treatment of the Mentally Ill

All counties in California are required to provide mental health programs. Under previously existing law; however, a health care agency could only encourage the severely mentally ill—no matter how psychotic, delusional, and dangerous—to voluntarily seek and submit to treatment and medication. To this end, Orange County (OC) Behavioral Health Services (BHS) offers many valuable, effective programs to treat the mentally ill. The BHS has a program called Full Service Partnerships, which offers an all-encompassing continuum of services, including carefully tailored treatment plans, assistance with entitlements (Social Security, Medi-Cal), an integrated-person focus—combining psychiatric, medical, and substance use issues—life skills training, and community integration (Orange, n.d.)

Some of these programs and services are provided by the OC Health Care Agency (HCA) BHS staff, and some are delivered by private providers under contract with the County. In addition, HCA avails itself of a Mental Health Court—one of several collaborative courts—to assist the mentally ill who merit diversion from the criminal justice system into programs that can treat their illness. Of the 239 Mental Health Court graduates in 2014, only 34% have been re-arrested (Superior, 2014).

Involuntary Treatment of the Mentally Ill

If a mentally ill person refuses to submit to treatment or medication, the law provides for involuntary treatment. However, this is only temporary and only where, as a result of his mental condition, the person is a danger to himself or others or is gravely disabled. Moreover, the short-term involuntary treatment is given only to stabilize the individual, after which he must be released immediately.

In 1967, the Lanterman-Petris-Short Act (LPS Act) was signed into law and was codified in Welfare and Institutions Code sections 5150 *et seq.* A 5150 is a term commonly used to describe a person who, due to a mental condition, is a danger to himself, a danger to others, or is in so gravely disabled a state that he is unable to provide for his own food, clothing, or shelter. The term “5150” is used throughout this report, but the Grand Jury means in no way to demean the people who are experiencing a psychiatric crisis. Under the LPS Act, a County health care clinician, a police officer, or a psychiatrist can place a 72-hour hold on a 5150 for involuntary evaluation, stabilization, and treatment (California Welfare and Institution Code section 5150).

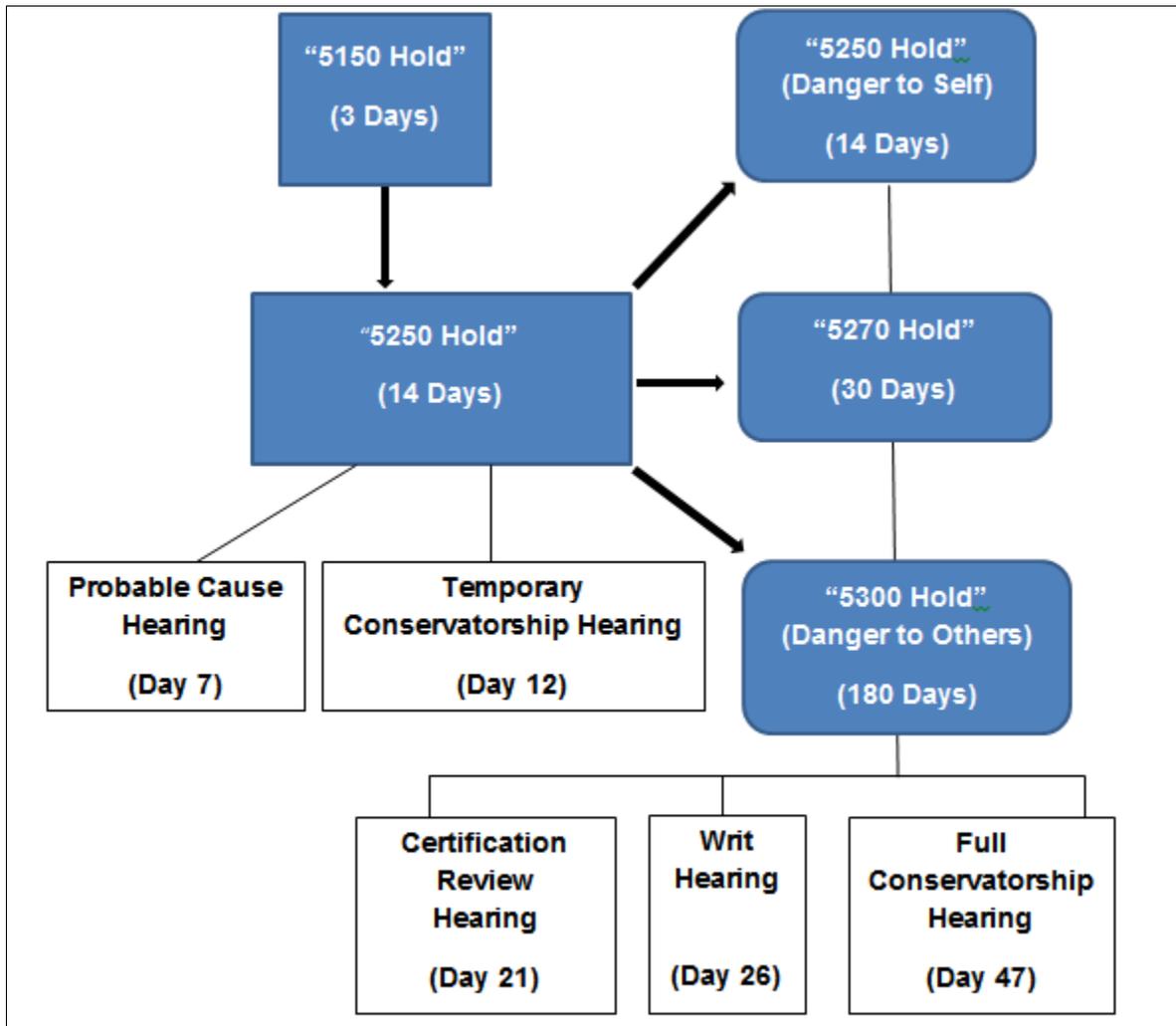
A 5150 hold can last only 72 hours. It may be extended by a psychiatrist, for an additional 14-day hold if the patient remains unstable (California Welfare and Institution Code, section 5250). Within four days of the 5250 hold, the 5250 is entitled to a certification review and probable cause hearing before a judge or hearing officer (California Welfare and Institution Code, section 5256). This 5250 hold may also be extended another 14 days.

If the patient is still unstable after two consecutive 14-day 5250 holds, the attending psychiatrist may extend the hold for an additional 30 days (California Welfare and Institution Code, sections 5270, 5300). If at any time the patient refuses to take his medication, a capacity hearing is conducted (also known as a “Riese” hearing), at the conclusion of which the patient can be forced to take his medication (California Welfare and Institution Code section 5332).

Mental Health Conservatorship

Involuntary hospitalization beyond 61 days requires a mental health conservatorship (LPS conservatorship) hearing in the superior court. An LPS conservatorship is used only for the mentally ill whose psychiatric disorder is so severe that it renders them gravely disabled, in that, it prevents them from providing for their basic needs of food, clothing, and shelter. An LPS conservatorship serves to provide individualized treatment, supervision, and living arrangements for the gravely disabled and can involve confinement in a locked psychiatric facility.

Only the professional treatment staff at the hospital where the 5250 is being treated can start the process. After an investigation, the OC Public Guardian petitions the Probate Court to establish a temporary, 30-day mental health conservatorship and eventually a general, six-month conservatorship. Appointed counsel represents the conservatee from the Public Defender’s Office. If the Court grants the petition, it must ensure that the placement is in the least restrictive, appropriate setting, must maintain ongoing supervision over the conservatorship, and must terminate the conservatorship if it determines that the person no longer meets the criteria. (See Figure 1)

Figure 1: Involuntary Hold Process**Involuntary Assisted Outpatient Treatment (Laura's Law)**

On January 10, 2001, Laura Wilcox was at work at California's Nevada County Behavioral Health Clinic. A client appeared for a scheduled appointment. Without warning or provocation, he drew a handgun and shot Laura four times. When the rampage at the clinic and at a nearby restaurant ended, Laura and two others lay dead, and two were injured. California passed Laura's Law to help make sure the same thing does not happen to another family. Laura was at the clinic that day to help (About Laura's Law, n.d.).

The Reason for Laura's Law

Because the 1967 LPS Act requires that the person be released as soon as his condition has been stabilized, it actually impedes those in need of extended care from receiving it. It fails to take into account new discoveries about mental illness, the vastly different present framework of mental services, and the hugely improved medications that are now available. Thus, the present process has proven to be dysfunctional,

resulting in a shameful, revolving-door pattern that neither shows care for the gravely disabled nor protects the public from the clear, ever-returning danger posed by a 5150 to himself or to others.

As reported to have been stated by Chairman Todd Spitzer at the meeting of the Board of Supervisors when Laura's Law was adopted, "We have an obligation to do whatever we can to assist those who really have no remedy. They don't know how to help themselves." At the meeting, Chairman Spitzer is reported to have noted that one of his relatives had schizophrenia and had revolved in and out of the criminal justice system. "I watched it just grind away at my uncle. We have to deal with the guilt and the frustration and the obstacles that the families are dealing with, because they're watching their loved ones deteriorate" (Gerda, 2014)).

It is the paranoid, schizophrenic nature of severe mental illness that prevents those in desperate need of help from having insight into their need to take their prescribed medication or from availing themselves of traditional community-based mental health services. The best evidence shows that high-risk, dangerous 5150s are routed into the temporary, involuntary treatment system, not because they are not able to access voluntary outpatient services, but because their mental impairment renders them unable to recognize their illness and deprives them of the self-awareness sufficient to engage in voluntary, community-based outpatient treatment programs. At the same time, studies demonstrate that high-risk 5150s with psychotic disorders can greatly benefit from intensive, sustained outpatient treatment provided in concert with an outpatient court order (Holt & Adams, 2013).

In fact, extensive assisted outpatient treatment (AOT) under Laura's Law can actually lead to significant reductions in police contacts, emergency room visits, hospitalizations, incarcerations, suicides, violence, and homelessness. Published studies have shown that court-ordered AOT not only results in improved clinical outcomes for the participants, but also in overall cost savings. It is estimated that if AOT were adopted statewide, the projected savings over the following two-and-one-half years would be \$189,491,479 (Quanbeck, n.d.).

Description of Laura's Law

Laura's Law (California Welfare and Institution Code section 5345 – 5349.5; AB 1421), adopted in 2002, created as an optional program for counties to provide multidisciplinary, intensive, court-ordered, involuntary outpatient treatment in renewable six-month periods for the high-risk, substantially deteriorating 5150 who is unlikely to survive in the community and who has neither the capacity to understand his need for treatment nor the competence to make rational decisions. Thus, Laura's Law offers court-supervised, extensive, sustained, early-intervention outpatient treatment of the severely mentally ill in programs called Full Service Partnerships (FSPs). In contrast to court-ordered, temporary, involuntary 72-hours commitments, which operate to stabilize temporarily a 5150 who has reached a crisis point in which he poses a danger to himself or to others, Laura's Law allows health professionals to provide medication and treatment on an ongoing, sustained basis.

Referrals to Laura's Law may be made by a police officer or probation officer, immediate family members, adults residing with the individual, the director of a treating facility or hospital, or a treating licensed mental health professional. Laura's Law applies to the severely mentally ill person whose illness is severe and persistent.

To qualify for AOT, the person must be an adult with a history of noncompliance with prior attempts to treat him, as shown by at least two placements in a hospital or the mental health unit of a correctional facility in the last three years, or at least one incident (an act, threat, or attempt) involving serious and violent behavior toward himself or others in the last four years. In addition, the mental condition must be substantially deteriorating, the person must be in need of AOT to prevent a relapse that would be likely to result in grave disability or serious harm to himself or others, and there must be a clinical determination that the person is unlikely to survive safely in the community without supervision (California Welfare and Institution Code, section 5346).

Before filing an AOT petition, the Outreach and Engagement Team must offer the candidate an opportunity to participate voluntarily in the development of a treatment plan for services. If the candidate fails to engage and refuses to settle, the superior court may order that the candidate submit to a clinical assessment of his present condition. If he refuses, the court may order that the candidate be taken to a hospital for the assessment for up to 72 hours.

The candidate has the right to counsel at the hearing. After the Superior Court hears the testimony, it must determine whether the candidate meets the criteria and, if so, whether there exists any appropriate or feasible less restrictive alternative. It may then order AOT under a treatment plan to be implemented by the FSP, which may not exceed six months. HCA/BHS assigns a personal service coordinator.

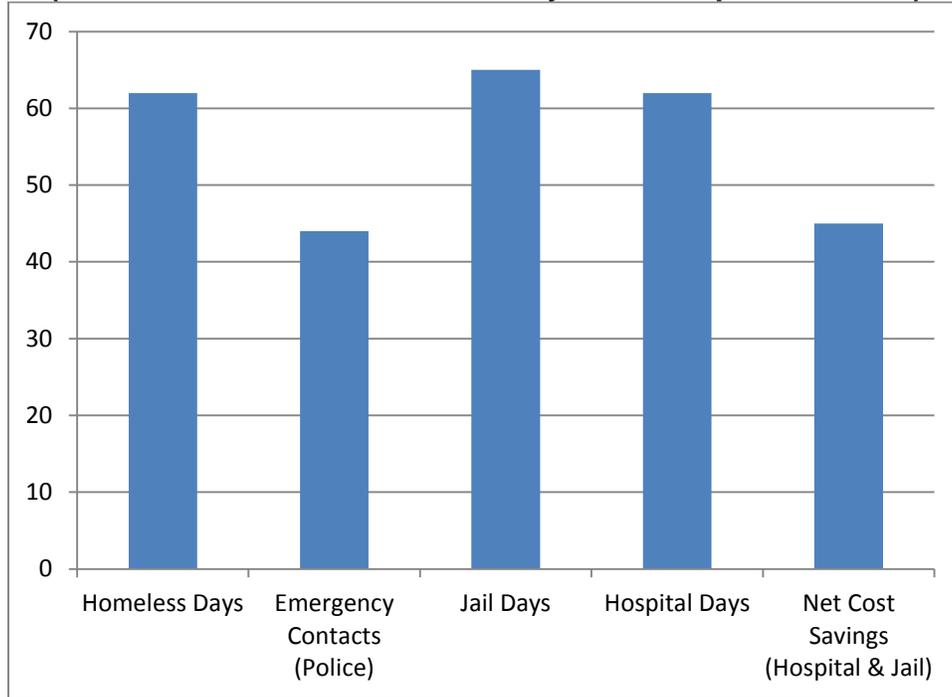
The FSP Program Director must file an affidavit every 60 days stating the candidate continues to meet AOT criteria. The candidate is entitled to a hearing every 60 days to challenge the need for an AOT order. The candidate also has the right to file a petition for writ of habeas corpus.

Success of Laura's Law

Forty-four states have implemented AOT programs. Nevada County, the first county in California to implement the AOT program under Laura's Law, opted into the program in 2008. The success of Nevada County's experiment is shown by dramatic decreases in homelessness, police contacts, arrests, incarcerations, 5150 holds, emergency room visits, and hospitalizations (Assisted Outpatient Treatment, 2014). In addition, Nevada County realized significant cost saving as a result of its implementation of Laura's Law (Cost Savings, 2012). See Figure 2 for a summary of these successes.

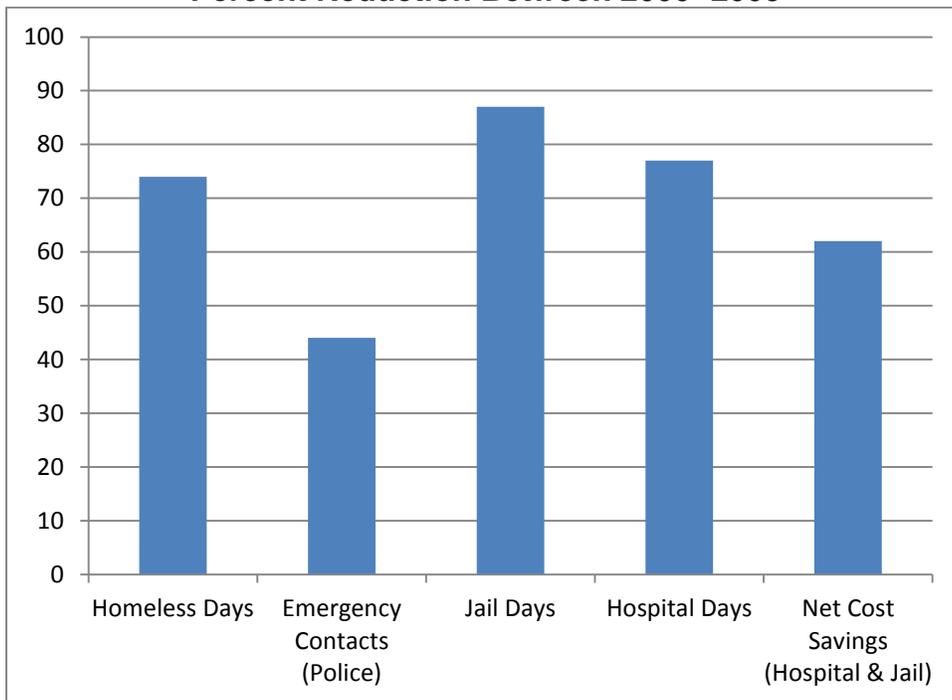
Moreover, New York's Kendra's Law – after which Laura's Law was patterned – has similarly resulted in quantifiable, striking decreases in police contacts, homelessness, incarcerations, and hospitalizations, when compared with the old, revolving-door system. See Figure 3 for details.

**Figure 2: Success of Laura's Law in Nevada County
(Percent Reduction over first 2.5 years of implementation)**



(Assisted Outpatient Treatment, 2014)

**Figure 3: Success of Kendra's Law in New York State
Percent Reduction Between 2000 -2005**



(Carpinello, 2005; Swartz, 2009).

AOT is aimed at getting the severely mentally ill the treatment he/she needs in the long term. Its objective is to assist the severely mentally ill to be treated and eventually end the seemingly endless cycle of 5150 episode, medication, stabilization, release, and repeat.

The adoption of Laura's Law is optional for each county. Counties must "opt in," i.e., the board of supervisors must pass a resolution authorizing implementation of the AOT program. Each county must evaluate the AOT program's effectiveness in reducing homelessness and hospitalizations by persons in the program and in reducing their involvement with local law enforcement.

Orange County's Adoption of Laura's Law

Orange County is only the second county in California—and the first large county in California—to opt-in to Laura's Law. Thus, Orange County will serve as a laboratory for the rest of the state to see what works and what does not work. Many other counties, including San Francisco, Los Angeles, Ventura, and San Diego are studying and considering full implementation of this law (Personal interview, June 12, 2015).

At the urging of Supervisor John Moorlach, SB 585 (2013) was introduced and passed to authorize the use of Mental Health Services Act (MHSA) (Proposition 63) funds for any county that implements Laura's Law. (Sforza, 2015) On May 13, 2014, the Board of Supervisors unanimously voted to opt in, ordered that it commence on October 1, 2014, and allocated \$4.4 million of its Proposition 63 funds to treat an estimated 120 severely mentally ill persons during the 2014-15 fiscal year. These funds can be used to cover the expenses for voluntary enrollments as well as for involuntary AOT.

At the time of the County's adoption of the program, the Board of Supervisors requested that OC HCA/Behavioral Health Services (HCA/BHS) set up systems to collect data and that data be reviewed and analyzed for performance outcome, the program's cost effectiveness, and quality improvement. It also directed HCA/BHS to obtain the services of an outside evaluator to produce a complete report on the use and access into the program (who was referred, how many actually met the criteria, how many entered into a negotiated settlement, and how many were court ordered). It ordered measurement of the benefits achieved by the AOT patients, benefits derived by the community and the legal system, such as LPS reduction in conservatorship numbers, and benefits received by law enforcement, such as reduction in calls for service by police and reductions in 5150s.

Handling the Problem in the Field (Police and the Mentally Ill)

Persons desiring to become a sworn police officer in Orange County must graduate from a police academy. POST (Peace Officers Standards and Training) requires that all persons attending police academies receive some training on how to deal with the mentally ill. This POST-certified training on mental illness is concentrated into four hours, which includes crisis intervention training (CIT).

The number of police encounters with the mentally ill in the field is on the rise (Bernard, 2014). For a dangerous and severely mentally ill person, contact with a police officer in the field can be an entry point to the criminal justice system, to a psychiatric

treatment facility, or to the morgue. The difficulty posed in defusing a potentially explosive situation results from three considerations that the officer faces: (1) how to protect him or herself from this dangerous and possibly violent individual, (2) how to protect the public from this person, and (3) how to assist this mentally ill person in receiving the treatment he or she needs.

As first responders to a 911 call involving a dangerous and mentally deranged individual, police officers often act as “street-corner psychiatrists.” They hold the power to prescribe a jail cell or a hospital bed for people living with mental illness. Thus, a police officer must be able to recognize the symptoms of a mentally deranged individual, deescalate the situation, allay the individual’s fears, gain the person’s trust, convince the individual that it is in his or her best interest to cooperate with the officer who merely wants to help, persuade the individual to seek assistance, and prepare to assess and refer the individual to the appropriate agency.

Those decisions require proper training. Police officers need to be trained to defuse mental health crises with the least force possible and connect people to treatment. An encounter with a CIT-trained police officer can help people receive treatment, potentially stopping the arrest-to-court-to-jail cycle from continuing.

Traditional police and SWAT tactics with the severely mentally ill can quickly spiral out of control, backfire, and lead to deadly results. Fully 50% of Americans killed by police officers are mentally ill. Many officers may find it hard to override their prior, ingrained training to contain situations quickly, which sometimes stresses the “command-and-control—do as I say or else” mindset in which some police agencies are steeped. (King, 2015)

CIT-trained officers, on the other hand, are injured 80% less frequently than untrained officers in interactions with the mentally ill, are better at linking people to services, and are less likely to use force. CIT training, based on the “Memphis model” created in 1988, teaches officers how to recognize mental illness, how to interact with people in crisis, and how to de-escalate situations involving a person who needs a psychiatric evaluation¹. Police and the public are at risk if officers do not have CIT training, which includes role-playing exercises with method actors, based on real-life situations. (National, n.d.: Dupont, 2007)

The “TACT” method was developed to assist CIT trained officers in approaching and communicating with the potentially dangerous mentally ill person in a calm, safe, reassuring, and peaceful manner. The acronym stands for four non-threatening techniques that officers can employ to retain control in a non-volatile situation: time, atmosphere, communication, and tone. These concepts are not meant to replace officer judgment when facing changing dynamics in the field.

Triaging the Problem

Crisis Response Teams: CAT, PERT, and PET

Orange County utilizes a Centralized Assessment Team (CAT) and a Psychiatric Evaluation and Response Team (PERT) to provide 24/7 mobile response services to

assess the mentally ill in the field. The teams assist the police and paramedics by initiating a 5150 hold. Whereas members of CAT are on call and respond to the scene when called by the police, PERT members are already embedded with a city's police agency and accompany designated mental liaison officers into the field.

A police officer or a member of CAT or PERT can prepare and "write" the 5150 hold. The 5150 is then transported to the County-operated Evaluation and Treatment Services (ETS), or to the emergency room of a designated hospital for diagnosis, treatment, and stabilization. "Designated" means that the hospital emergency room has been approved by HCA/BHS to receive 5150 patients.

Psychiatric Evaluation Team (PET) members are stationed 24/7 in two hospitals: College Hospital in Costa Mesa (also called College Hospital Crisis Response Team (CRT) and Mission Hospital in Laguna Beach. When potential 5150s arrive at any hospital in Orange County or at a police station, a PET clinician can be dispatched to make a 5150 evaluation if a police officer or a CAT or PERT clinician has not already done so. If the 5150 patient is not insured, the PET clinician will call ETS, fax the results from the medical screening, and inquire into bed availability at ETS or at a contract hospital if the patient has not already been stabilized.

Evaluation and Treatment Services (ETS)

Established in 1970, ETS is a ten-bed psychiatric crisis stabilization unit that provides crisis intervention and stabilization to 5150s. ETS is an outpatient facility and therefore can hold the 5150 no longer than 24 hours. If ETS cannot stabilize the patient within that time, it must have the patient transferred to a contract hospital that has inpatient psychiatric beds.

Other than a psychiatrist, ETS does not have trained medical doctors, pharmacists, or lab technicians. It is not a medical facility, is not a designated emergency facility, cannot conduct medical screening or lab work, and is not certified to perform medical emergency procedures.

Consequently, ETS cannot accept patients who are experiencing a medical problem in addition to their acute psychological disorder, even if the medical issue is no more serious than high blood pressure. ETS also rejects admission to any 5150 who is or may be under the influence of alcohol or drugs. ETS can receive only people who are on Medi-Cal or are indigent.

Hospital Emergency Rooms

In 2014, 15,000 mental health patients were taken to emergency rooms in Orange County. Of these, 2429 were 5150s.

We have been slammed in our Emergency with both psychiatric patient and flu patients. Last night the Medical Director called me and said that we have 17 psychiatric patients in our emergency room—four of them in restraints, with none to spare. Our unit was full. I called ETS at about 8:00 p.m. and was told that they

hadn't even started placing patients from the day as they were still working on the list from two days ago.

Not being able to transfer patients who have been medically cleared and who have been in our emergency room for more than 24 hours is not acceptable. If ETS can handle only 23 patients in a 24-hour period that is simply not adequate for the volumes of patients we are seeing in our emergency room. Anyone going to the John George PES will see the huge contrast between the volume of patients they are triaging and the volume that ETS is capable of triaging, with its limited space and staff.

(Hospital Administrator in Orange County, Personal communication, January 28, 2015.)

Emergency rooms do not offer an appropriate setting for persons experiencing a psychiatric emergency and are not conducive to stabilize a 5150. They are cold, confining, and cluttered with strange and confusing sights and sounds. They are usually crowded and anything but private.

Emergency rooms are often forced to hold mental patients who are acutely dangerous to themselves or others for long periods until an inpatient bed can be found. Psychiatric patients awaiting treatment in hospital emergency rooms for hours and even days—a process known as boarding—has become a major issue across the United States, with exposes appearing in publications such as *The Washington Post* and the *Los Angeles Times*. Comparable California averages show psychiatric patients boarding in emergency rooms for 11 hours (Zeller, 2013).

The presence of a 5150 poses a danger to staff and to the other patients and their families. Moreover, 5150s can be noisy and disruptive, which adds to the tension normally found in emergency rooms. Many times, the 5150 must remain in the hospital emergency room for hours or even days until an inpatient bed can be found.

REASON FOR THE STUDY

The Orange County Board of Supervisors voted to implement Laura's Law and ordered that it take effect on October 1, 2014. Since Laura's Law will sunset on January 1, 2017 (AB 1569), the Grand Jury chose to investigate how the County intended to implement Laura's Law and how it intended to measure its cost effectiveness and performance outcomes in order to provide data regarding the advisability of extending Laura's Law. The Grand Jury also wanted to find out how the County intended to disseminate information about Laura's Law to various departments within the County's HCA, the Sheriff's Department, city police agencies, and the public.

As the investigation progressed, however, the Grand Jury discovered that the County's entire crisis-intervention system for handling 5150s was seriously flawed. During its investigation, the Grand Jury encountered complaints about the County's lack of leadership, vision, and ownership of the problem. It became clear that the County's bean-counter approach to addressing the problem was narrow and that the County

appeared unwilling to develop systems to relieve the police and the hospital emergency rooms from the undue burdens placed on them and to make their jobs easier.

The Grand Jury decided to change the focus of the investigation to crisis triage, intervention, and stabilization systems and services. The Grand Jury also wanted to see how Laura's Law fit into the continuum of treatment available to 5150s. The overall purpose of this study, then, is to seek a solution to the presently dysfunctional, revolving-door pattern of endless cycles of homelessness, arrests, incarcerations, crisis interventions, and serial hospitalizations.

The focus of this study, then, is to highlight the presently dysfunctional, revolving-door pattern of endless cycles of homelessness, incarcerations, and serial hospitalizations under court-ordered, temporary involuntary 72-hour commitments. The Grand Jury chose to investigate this topic in order to determine if the County's system was "broken" and, if so, offer recommendations on how to fix it. As a sidelight, the Grand Jury wanted to examine the effectiveness of Laura's Law and to see how it factored into the equation by reducing the need for so much crisis intervention.

METHODOLOGY

As the Orange County HCA is responsible for caring for the County's indigent mentally ill persons, several HCA personnel were questioned. The Grand Jury interviewed members of BHSs upper management several times. Additionally, individual interviews were held with several field clinicians working as CAT or PERT responders.

Since hospitals play an important part in the triage/evaluation/care system, a number of hospital-related personnel were interviewed. Among these were hospital administrators, emergency room staff, and Southern California Hospital Association members.

Police officers and administrators had a great deal of input in this report. Two separate questionnaires were sent out and responded to by all police departments in Orange County as well as the County Sheriff's Department. The first asked questions about CIT training, comments about the triage process in the field, and knowledge about laws relating to the mentally ill. The second asked for opinions about the adequacy of the County's triaging process and suggestions for improvement of the County's crisis stabilization system. The responses helped identify specific problems and possible solutions from the law-enforcement point of view.

It was important to see the facilities where mentally ill people were evaluated, stabilized, and treated. Members of the Grand Jury visited the following: ETS in Santa Ana, a county-contracted hospital emergency room in central Orange County, and a county-contracted in-patient mental health facility in South Orange County. Two Grand Jurors visited the John George Psychiatric Hospital in San Leandro, California.

Two other county systems relate to the seriously mentally ill: the courts and the Public Guardian. The Grand Jury learned a great deal by visiting the Veteran's Mental Health Court, by attending conservatorship proceedings in the superior court, and by interviewing several high-ranking officials in the Public Guardian's office.

To get a sense of the big picture relating to the police and the mentally ill, members of the Grand Jury attended all of the monthly meetings of the OC Criminal Justice Coordinating Council, where various members provide updates and information concerning the criminal justice system in the County.

Regarding the training of police officers, the Grand Jury visited and reviewed the course outlines of both Golden West College's Police Training Academy and the O.C. Sheriff's Office Training Center. Members of the Grand Jury also viewed five training DVDs relating to police encounters with mentally ill persons, provided by the Orange Police Department.

Lastly, reports (online, media, and hard copy) relating to all aspects of identifying, referring, evaluating, triaging, and treating the seriously mentally ill—in Orange County and elsewhere—were read and considered for this report.

INVESTIGATION AND ANALYSIS

Initially, the OC Grand Jury set out to evaluate how Laura's Law was going to be applied and how its performance metrics would be measured. The Grand Jury also wanted to examine how the County intended to coordinate the involuntary assisted outpatient program with its many successful voluntary outpatient psychiatric Full Partnership programs. It soon became apparent during the investigation, however, that there was a serious problem with the manner in which the HCA/BHS was administering its stewardship over the 5150 process.

Numerous complaints were registered with the Grand Jury concerning the County's alleged lack of vision, initiative, and leadership regarding the 5150 process and psychiatric crisis intervention in general. Many police agencies stated their perception that, the County Health Care Agency's attitude regarding 5150s was to keep the numbers down artificially, and its posture was merely to manage the problem like a traffic cop doing traffic control rather than to embrace it, solve it, and own it. Police agencies expressed the feeling that the County was acting as if the problem of having dangerous and severely mentally ill persons on the streets was the police agencies' problem rather than the Health Care Agency's problem.

As a result of these revelations, the Grand Jury decided to redirect its efforts and to shift the focus of its inquiry. The correctness of this decision was validated when a high-ranking County official conceded that the County was extremely deficient in terms of dealing with the mentally ill. That official went on to state that, while the County tended to compartmentalize its tasks, all departments in the County needed to coordinate better with each other and with outside agencies in order to have a broader, more comprehensive view of the problem.

The main task of the police is to protect and serve the public in the city where they are deployed. It appears to the Grand Jury, therefore, that the time spent waiting for County clinicians to arrive at the scene, the time spent driving the mentally ill to ETS or to a series of hospital emergency rooms, and the time spent waiting hours or days in an emergency room with the mentally ill until a bed becomes available at ETS or in a

contracted hospital, is wasted. All this wasted time is precious time that needlessly takes the police away from carrying out their primary duty of patrol

Moreover, the primary task of the doctors and nurses in hospital emergency rooms is to provide emergency medical treatment and care to arriving patients. Emergency rooms are not designed to be repositories for 5150s or to provide psychiatric care or treatment, other than medication to stabilize a 5150. The time spent by doctors and nurses on dealing with 5150s is precious time that is taking them away from their principal duties.

Sufficiency of Police Training

Training on crisis intervention and treatment (CIT) is of paramount importance, as illustrated by the following example.

Ms. Jones had a history of schizophrenia and bipolar disorder. Her parents called for an ambulance to take her to the hospital. When she was disoriented and went outside, her family called the police, and the cops agreed that Ms. Jones needed to go to the hospital, but when the police quickly moved to put her into the squad car, she panicked. She was holding on to the car doors. The police tried to get her into the car. The big cop slammed her to the ground. She kicked and resisted. One officer put his knee into her back as he handcuffed her. She died. She was 37. It was ruled a homicide. The Anderson family is suing Cleveland and has demanded that all officers be trained to deal with the mentally ill (Simon, 2015).

The Grand Jury sent questionnaires to the Orange County Sheriff and to all 21 police chiefs in Orange County concerning the quantity and quality of training that is given on how to approach and deal with the mentally ill in the field, how to conduct 5150 evaluations, and how to triage an individual displaying signs of mental instability. Questions also were asked regarding the amount of crisis intervention training (CIT) that is required of all sworn officers. The Grand Jury received responses from the OC Sheriff's Department and from all 21 police agencies in Orange County.

At the OC Sheriff's Training Center, each officer candidate receives only a basic, five-hour introductory course on dealing with the mentally ill in the field (known as Learning Domain 37). The curriculum includes such topics as recognition of the behaviors associated with mental illness, indicators of potential for dangerous behavior, factors that show suicidal tendencies, and tactics to de-escalate crisis situations. It also includes an explanation of the LPS Act and strategies for resolving conflicts involving the mentally ill.

This course is certified by Peace Officer Standards and Training (POST). Only three of the 21 police agencies require re-certification of this course—one yearly, one every two years, and one every three years. The Orange County Sheriff's Department (OCSD) requires no re-certification of this coursework.

Regarding crisis intervention training (CIT), only nine of the 21 municipal police agencies in Orange County and the OCSD offer POST-certified CIT courses taught by Golden West College at the Sheriff's Academy. Five police agencies contract with another college, local consultants, or the American Psychiatric Nurses' Association in conjunction with St. Joseph Hospital to offer CIT training. Five police agencies use their own supervisory staff offer CIT training to their officers. The other two offer no specialized CIT training at all.

Because almost all CIT training is certified by POST, these hours count toward an officer's re-certification. The respondents indicated that the number of CIT-training hours varies between agencies. Ten agencies offer only four or less hours, eight agencies (including the Sheriff's Department) offer 16 to 18 hours, four agencies offer 24 hours, and only one city—Santa Ana—offers 40 hours. It can range from zero to 40 hours, but the majority of police departments *offer* only 16 or 24 hours.

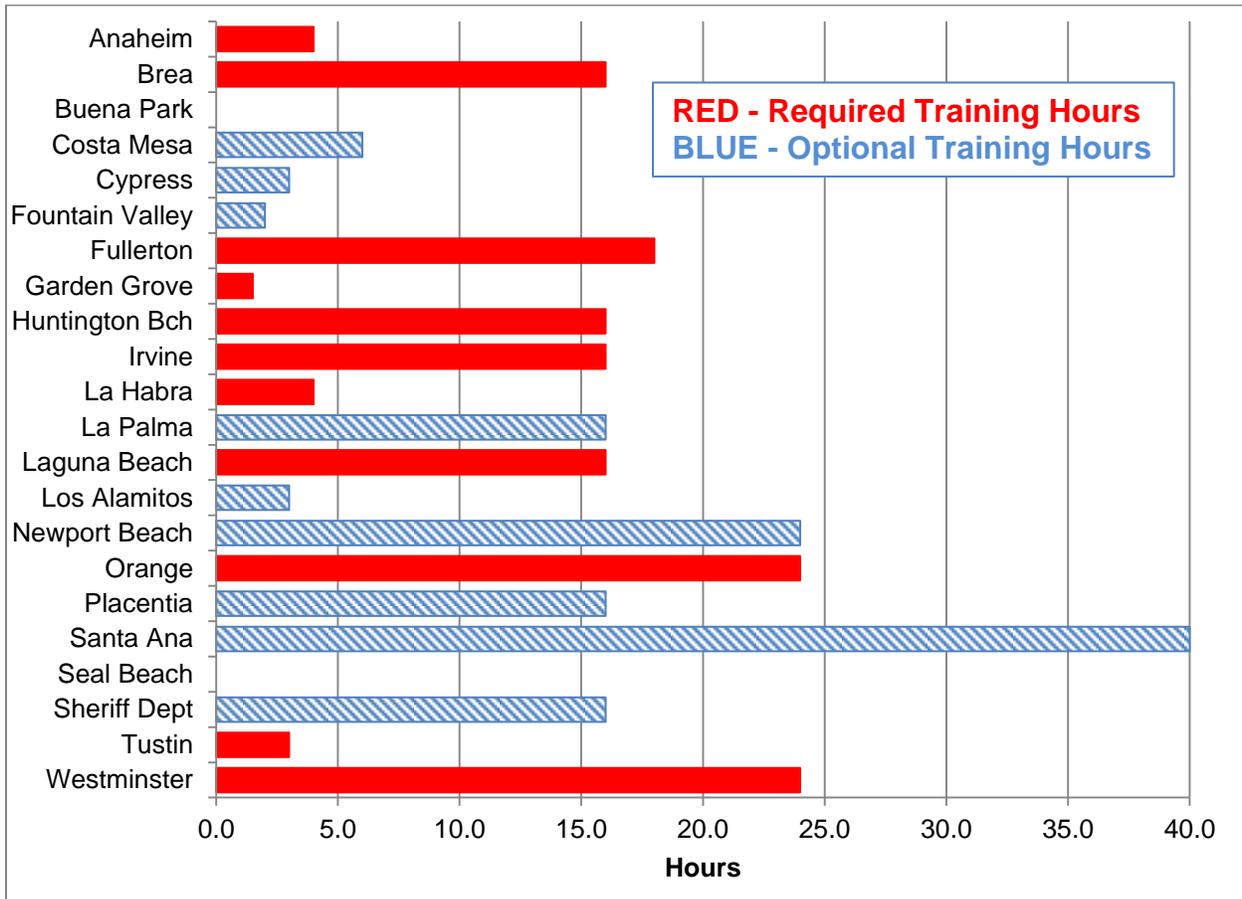
The CIT course taught by Golden West College at the Sheriff's Academy is a 16-hour course, offered in cooperation with the National Alliance on Mental Illness (NAMI) and College Hospital. This course goes well beyond the academy instruction and is modeled after the Memphis program. It contains chapters on understanding stress, 5150 legal issues, suicide by cop, post-traumatic stress disorder, other cognitive disorders such as dementia and developmental disabilities, tactical communication, operational and procedural protocol, designated mental health facilities, community resources, and psychiatric medications.

The Grand Jury has learned that this CIT course has been approved by HCA/BHS and will soon be expanded to a 24-hour course. The additional eight hours will include role-playing responses to mental illness crisis situations using a simulator. However, this course is only optional, not mandatory.

The number of CIT training hours *required* by police agencies is another matter. Only 11 of the 21 police agencies *require* any CIT training. The cities of Orange and Westminster require 24 hours and Fullerton requires 18 hours. The Sheriff's Department offers, but does not require, 16 hours of CIT training.

Still another issue is the number of law enforcement agencies that require that *all* of their deputies or officers receive post-academy mental illness training. Of the 11 agencies that require post-academy CIT training, only *four* police agencies require CIT training for all their sworn officers. (See Figure 5)

Figure 5: Police Agencies Intervention Training



In the Grand Jury’s estimation, CIT training in Orange County is inadequate in three respects, in that: (a) the amount of CIT hours is insufficient; (b) for most of the agencies, CIT training is not mandatory; and (c) at almost all of the agencies, CIT training is not required of all sworn officers. A Senate bill that is presently pending in the California Legislature, SB 11, would require at least 20 additional hours of CIT training in the academy relating to police interaction with the mentally ill. Another Senate bill, SB 29, would *require 40 hours* of post-academy CIT training to help officers recognize, de-escalate, and refer persons with mental illness who are in crisis.

This proposed legislation reflects a growing trend in many California counties and cities and throughout the United States, which is to place more emphasis on training police officers on methods to use in dealing with the mentally ill. Many police agencies in California presently offer and require much more CIT training than is offered or required in Orange County, but this may change. Pursuant to a national Community Oriented Policing Services (COPS) grant awarded to the Major County Sheriffs’ Association, The OC Sheriff was recently appointed to a select nationwide sheriffs’ committee of the Major County Sheriffs’ Association to study and make recommendations regarding training protocols and crisis intervention models of the best practices for diverting the mentally ill from the jails. In addition, on May 19, 2015, the OC

Board of Supervisors adopted a resolution in support of a nationwide initiative to reduce the number of people with mental illnesses in our County jails (Orange, 2015).

Other counties, including Ventura, Los Angeles, and San Diego, already expect and require more of law enforcement. In Alameda County, each police agency has a CIT coordinator and liaison. CIT training consists of a 40-hour course, it is mandatory, and it is required of all police officers. Of course, taking all officers out of service for one week, even if done on a rotational basis, can pose logistical and financial challenges (with overtime costs), but 90% of all officers have received the CIT training to this date.

In Orange County, the City of Orange Police Department and the Westminster Police Departments are shining examples of this more enlightened approach. These two cities require that 100% of its officers receive 24 hours of post-academy, CIT training. In addition, the City of Fullerton has excellent CIT training materials and courses ranging from one to four days that are conducted by a private firm.

The Orange and Santa Ana Police Departments, in conjunction with the Mental Health Association of Orange County and St. Joseph Hospital, have taken the initiative to produce a series of excellent, 30-minute DVDs on how to deal with the mentally ill. These DVDs address real mental health issues faced by officers in the field, feature dramatized, yet realistic reenactments of field encounters based on actual incidents and interviews with experts, police officers, and the mentally ill and their relatives. The titles of these DVDs are as follows: "Close Encounters: Managing Field Encounters with Persons with Mental Illness," "Schizophrenia: Listen to my Voice," "Autism: A Different Way of Viewing the World," "Hoarding: Understanding Their Possessions," and "Bipolar Disorders: Managing the Highs and Lows."

More DVDs, including one on Alzheimer's, are in production and may be released in 2016. These videos have been offered free of charge to all police departments in Orange County at the monthly meetings of the Association of Orange County Sheriff and Police Chiefs and to any other agency that requests them. Many police agencies, mental health facilities, and health care providers in Orange County as well as from all over the nation have availed themselves of this outstanding opportunity to help their personnel gain exceptional insight into these mental disorders on how to recognize and deal with those who display the various symptoms of these mental disturbances.

With regard to training on Laura's Law, responses to the Grand Jury's questionnaire revealed that this training has been rather sporadic and superficial. It has been given to police departments, but only "on demand." In addition, information about Laura's Law has been disseminated through field advisories, protocols, or bulletins. These advisories, protocols, and bulletins may have been distributed to the officers and front line deputies, but there is no assurance that they were read or that any questions concerning the application and implementation of Laura's Law were ever answered.

It would appear that accurate knowledge about the parameters of, and requirements for, Laura's Law is lacking, as demonstrated by the fact that the OC HCA/BHS has received only 23 Laura's Law referrals from police officers in the last 9

months. Further proof is shown by the fact that the majority of respondents stated that they wanted to receive more training on Laura's Law.

Based on responses received from all law enforcement agencies in Orange County, the Grand Jury concluded that police officers and deputy sheriffs have received insufficient training regarding how to deal with and interact with the mentally ill in the field. Moreover, it appears that neither the OCSD nor the 21 police agencies in Orange County are even approaching the prevailing standard among many jurisdictions, which is that 100% of all sworn officers receive *mandatory* post-academy CIT training.

Furthermore, it is apparent that the training received by law enforcement on Laura's Law has been lacking. All but two police agencies remarked that the training on Laura's Law had been insufficient, that they could use more training, and that they would welcome more training. A majority of the police agencies stated that Laura's Law was a valuable new tool in their arsenal for dealing with the mentally ill.

Sufficiency of Police Resources

Dealing with Triage Decisions

Triage decisions after encountering an apparently mentally ill person in the field are difficult. However, the police officer must first decide whether a person fits the 5150 criteria. Police officers call CAT or PET members to assist in the evaluation.

However, even if the person does not presently meet the criteria, he/she may have previously been under a 5150 hold and may be in need of additional treatment. He/she may already have a BHS case manager who has been assisting him to enroll and receive treatment in one of several County mental health programs or who has been monitoring his court-directed involuntary AOT. He/she may be on probation, be under a mental illness conservatorship, or may have recently "eloped" or escaped from the hospital where he was being treated.

The following incident demonstrates this point:

Jason, 28, had been hospitalized at least 15 times since being diagnosed with bipolar disorder in 2009. Police were called after he got into a heated argument with someone, and the police were advised of Jason's prior hospitalizations. When a CIT-trained police officer showed up and asked him nicely to come with him to a hospital, Jason readily complied.

Not long after arriving at the hospital, however, Jason slipped out of the hospital. In a manic state, he walked the streets until he saw a man who he thought had tried to rob him a few years earlier. He attacked the man, who flagged police for help.

Rather than arrest Jason, the two police officers ran a background check on him and discovered that he was missing from the hospital. "Then they took him to the hospital, took off his handcuffs, and just told him to walk into the hospital.

The two officers were CIT trained. They realized the best tactic was not to use physical force.” After so many encounters with non-CIT-trained police officers, Jason considered himself lucky. “[I] [c]ould have a bullet hole,” he said, “or I could have a felony arrest.”
(Emmanuel, 2015)

Consequently, of tremendous assistance to the officer facing this type of triage decision would be an on-line, easily accessible database containing the names of all prior 5150s, 5250s, 5270s, conservatees, persons who have been hospitalized for mental illness, and persons on probation or parole. The County has no such database. The County has neither a “dashboard data” tracking system, such as the one used in San Diego, nor a database such as the one used in Los Angeles.

The Grand Jury is aware of the privacy laws regarding the safeguarding of medical information, such as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (See also California Welfare and Institution Code section 5328). However, this proposal would not violate any privacy because it would not reveal sensitive medical or mental health information about the 5150. The proposed database would only list the name and prior legal status of the individual, not mental health information such as diagnoses, treatment plans, medications, etc. In any event, HIPAA itself permits the sharing of information when necessary to lessen a serious threat to a person or the public.

Of additional assistance would be a voluntarily created registry to which family or household members have entered the names of the mentally ill person so that the police will know whom to contact. Such a registry would also give advance warning to a police officer who has been dispatched to the home of a mentally ill person. The County has no such database.

The law requires that guns be confiscated from 5150s and prevents guns from being sold to 5150s (California Welfare and Institution Code section 8100-8103; AB 1014). The lesson learned from massacres, rampages, and suicides in Aurora, Colorado; UC Santa Barbara; Tucson, Arizona; Newtown School, Connecticut; Virginia Tech, and Sandy Hook Elementary School is that guns must be kept away from the 5150s. Thus, a database of prior 5150s would be useful to the police in deciding whether to pat down or search the person in the field and in enforcing all laws regarding confiscation of weapons possessed by a mentally ill person. Again, the County has no such database.

Experiences Dealing with CAT and PERT by Law Enforcement

The clinicians on the County’s CAT and PERT teams are supposed to assist police officers in determining whether a person meets 5150 criteria. The Grand Jury discovered, however, that some of these clinicians have not received uniform training regarding the 5150 criteria. As a result, the clinicians cannot be expected to apply uniform 5150 standards or to render uniform assessments in making the 5150 determination, and at least one police agency said that CAT was inconsistent in its application of the criteria.

The following incidents were reported by police agencies to the Grand Jury as examples of perceived inconsistencies in the CAT program. Police report that on one occasion, police units received a call of a mentally unstable son. Upon determining that he met the criteria for a 5150 hold, they notified the PET team and waited for the PET evaluator's arrival. As the investigation continued, it became apparent that the father also clearly met the criteria for a hold. A second call was made to PET. This was approximately 30 minutes after the initial call. Officers were advised that a separate evaluator for the father would be sent.

About 30 minutes later (one hour after the initial call), the evaluator for the father arrived at the scene. The evaluator for the son did not arrive for another 30 minutes—well over one and one-half hours after the initial call. The evaluator for the son was inefficient and tentative, and took an excessive amount of time to handle the evaluation.

The officers asked their watch commander to call HCA. When he called HCA to complain, the excuse was given that the evaluator was new and was still learning. Several months later, the same evaluator responded to another call and handled it in a similar, unacceptable fashion in that she left the officers with the 5150 without providing any updates or information while she disappeared into her vehicle for 20 minutes, acting in an extremely tentative manner, and nearly refusing to issue a 5150 hold on a man who the police officers believed clearly met the criteria.

As another example, one police agency described a scenario wherein a transient who had run out into the lanes of traffic was extremely distraught and agitated. He began yelling at the police, who were doing their best to prevent him from going back into traffic. They requested CAT to evaluate him. When the CAT clinician arrived, she spent only one minute with the transient and told the officer she could not evaluate him because she believed the transient was under the influence of drugs. The officer explained that he was a drug recognition expert and that the transient showed no signs of narcotics use. The clinician then told the officer that she could not evaluate him because he was not "obviously" a 5150, and she was not prepared to deal with the unobvious. The officer informed her that he could handle an "obvious case myself, but that he was asking for her professional expertise. She refused to talk further to the officer, so he called her supervisor, who ultimately convinced her to place the subject on a 5150 hold.

What is more, seven police agencies stated their officers have had differences of opinion with regard to the 5150 evaluation criteria applied by CAT and PERT clinicians. In other words, on one occasion, the police officer would opine, based on his or her prior knowledge of the individual's history and behavior, and based on what he observed before the clinician arrived, that the person fit the 5150 criteria, but the clinician would render a contrary opinion. The clinician would leave after telling the police officer that the officer could go ahead and write the 5150 hold and handle the matter based on his own assessment.

On another occasion, a police agency stated that the CAT clinician chose not to place a hold on an individual who was found lying in the middle of an intersection. The individual had told the police that he wanted to die in what appeared to be suicide.

However, no action was taken by the CAT team, requiring the officer to make the 5150 hold.

On still another occasion, police officers were called about a lone female that had been living in her car for an extended time. Many people were in fear that she would die in her car. Officers discovered rotting food throughout the car and determined she was a danger to herself and was not able to care for herself. The officers contacted OC Adult Protective Services (APS), who believed that the appropriate action would be to call CAT. The initial request to have CAT respond was denied. Only after the officers had called their supervisors did CAT respond. Once CAT arrived, the clinician denied the hold and disagreed with the officers' assessments then left. The APS forensic team responded, agreed with the officers, and accepted the 5150 hold.

Another source of confusion is the wording of section 5150 itself. To meet the criteria, the person must be a danger to himself or to others as a result of a mental disorder. There is *no* requirement, however, that the danger be "imminent."

Correct interpretation of the 5150 criteria is not merely an academic exercise. On one occasion, a mentally ill man held a ten-inch knife to his chest. His family wrested the knife away while he was threatening them. Officers called CAT. When the clinician arrived, two and one-half hours later, he decided that no 5150 hold was necessary. Officers reported believing that the clinician made this determination because the man knew who the president was and said he was not going to hurt himself. Only after the officer threatened to write a detailed report on the clinician's refusal to hold the patient did the clinician write the hold.

In sum, police agencies had problems with CAT because of time between call and arrival, ETS availability, or evaluation criteria. One police agency called CAT "uncooperative," and another agency claimed that CAT actively "discourages" 5150 holds. One police agency went so far as to state that CAT is "a joke."

Another example is illustrative of the problems reported by the police in respect to dealing with CAT. Officers reported that they were called about a female who was attempting to cut her wrists inside a doctor's office. The officers detained the person and believed she qualified for a 5150 hold. They contacted CAT, but CAT declined putting her on a 5150 hold. The officers then transported the female to a mental health clinic in Santa Ana for further treatment. Only four hours later, other officers responded to a call of a woman attempting to hang herself in the area of the clinic. This same woman had earlier tried to cut her wrists. The officers placed a 5150 hold on her and transported her to a hospital.

It appears to the Grand Jury that there are insufficient CAT members to meet the demands of police officers in the field. At least seven different police agencies stated that they had encountered delays in reaching CAT, and had experienced significant delays in waiting for a CAT member to arrive out in the field after the initial call, all of which resulted in officers being delayed from returning to service for several hours. At least one police agency stated that CAT would sometimes merely provide advice over

the telephone rather than send a clinician into the field to assist the officer in evaluating the 5150.

Dealing with PERT

Most police agencies that had an embedded PERT clinician, including the Sheriff's Department, were generally satisfied with the assistance they were receiving. They noted, however, that their assigned PERT clinician only worked Monday through Friday and only from 9:00 AM to 5:00 PM. They indicated that it would be highly preferable to have assigned PERT clinicians 24/7.

Some police agencies and the Sheriff's Department indicated that they need embedded clinicians who are available 24/7, who can interact with the officers and investigators at all levels, and who have their own desk and their own telephone at the police department. The Grand Jury has concluded that there are insufficient PERT clinicians to fulfill various police agencies' requests for an embedded clinician. HCA/BHS has declared that it will assign a PERT member to any city that requests one, but several agencies told the Grand Jury that their requests have not been granted.

In a triage grant application, HCA/BHS has expressed the desire to increase the number of PERT teams from four to nine and to expand the number of CAT staff to meet the needs of the police agencies and of the OC Sheriff's Department. The responses from the police agencies, however, demonstrate that these needs are far from being met.

Dealing with ETS

The ETS Center has remained the same for 30 years. It has only ten beds—the same number of beds that it had 30 years ago. Almost all of the police agencies complained that ETS had too few beds, which, in turn, caused long delays while holding a 5150 in the field or in an emergency room just waiting for an ETS bed to become available.

ETS staff informed the Grand Jury that the BHS would soon be modifying the interior spaces at ETS to increase the capacity to 18 by adding some loungers. Other than that, however, the OC HCA has no plans to expand or improve ETS.

Upon visiting and inspecting ETS on two different occasions, the Grand Jury was told by staff that it was never full or beyond capacity. ETS staff assured the Grand Jury that it never experienced any overcrowding or delays and that it managed to keep everything under control, no matter how high the demand. They denied that they had ever had to turn anyone away for lack of beds or chairs.

The responses to the questionnaire paint a different picture, however. Police agencies responding to the questionnaires overwhelmingly indicated that ETS is too small and inadequate to handle all the 5150s who need to be dropped off at the facility. According to the police, they were very frequently told to transport a 5150 to an emergency room rather than to drop the "client" off at ETS, and if they brought the 5150

directly to ETS, the officers perceived that during the intake process ETS was looking for reasons *not* to admit.

Respondents accused ETS and its supervisors of artificially keeping the number of 5150 admissions low to manage costs and capacity, almost invariably by telling the police to drive the 5150 to a hospital emergency room for medical clearance even if such clearance was unwarranted; i.e., when there was no apparent medical emergency. Moreover, police agencies complained about ETS' refusal to allow officers to drop off 5150s that may have been under the influence of alcohol or drugs, no matter how insignificant that influence might have been. Thus, police agencies stated that ETS rarely accepted patients and discouraged officers from taking patients to ETS, by requiring medical clearance for minor medical issues common among people with mental health issues, such as high blood pressure or diabetes.

Such medical clearances can take six to 20 hours, especially if drugs or alcohol is involved. Keeping a patrol officer out of the field for that length of time greatly affects staffing levels and interferes with the police agency's ability to provide efficient police services not related to mental health issues. Police agencies believe it is OC HCA's responsibility to assist the police in dealing with the mentally ill, not the other way around.

What is more, according to some police agencies, ETS virtually shuts down and refuses to accept additional 5150s when a single patient has become violent and combative. Furthermore, numerous police agencies found a lack of consistency regarding ETS admittance policies and practices, calling them "marginal" and "inconsistent." In addition, police agencies stated that ETS staff at times is non-responsive and even resistant to admissions; it discourages admissions and fails to cooperate with police officers by telling them that there are no available beds at ETS.

The OC HCA does not have a real-time, on-line, empty-bed registry for police officers or CAT/PERT members to see ETS bed availability at a glance. Consequently, police officers and CAT/PERT must resort to calling ETS on the telephone.

According to several of the respondents, ETS was always trying to keep a very "low profile," to "carefully couch" their responses to the police officers' requests, and to "do the least amount possible." Numerous respondents went so far as to characterize ETS' attitude with regard to 5150s as being "someone else's problem" or "the police officer's problem," as if ETS' only responsibility was to "just sit there and direct traffic." Respondents voiced their concern that ETS considered the police to be the "catch-all," whose duty it is to be the repository of the mentally ill.

Another unflattering image of ETS is portrayed by the County itself. In a grant application, the County Health Care Agency asserted that the average wait time for access to a bed at ETS or an inpatient hospital is more than ten hours. The grant application further states that during peak demand periods, the wait time is even higher and can last from two to three days. (Orange County, 2013) This confirms what the Grand Jury learned from the police departments' responses.

Dealing with Transporting the Patient (to ETS or to a Hospital)

The law clearly states that the officer must *not* be required to stay with the 5150 any longer than the time necessary to complete documentation of the factual basis of the 5150 hold, and to transfer the 5150 in a safe and orderly manner (California Welfare and Institution Code, section 5150.2). While a police officer may accompany a combative patient during transport, the law does not require him to do so, provided he makes the proper arrangements with the paramedics to transport the 5150 to ETS or the hospital in a secure manner. The law requires that designated hospitals have appropriate security plans and security officers to maintain a safe environment (Health and Safety Code, section 1257.7, 1257.8).

Therefore, under the law, once a police officer has made proper arrangements for the transport, he may resume his normal duties in the city where he works. This is not the case in Orange County; however. In a majority of the cases, the police officer transports the 5150.

For example, on one occasion, a man was laying on the railroad tracks in an effort to commit suicide. The officer contacted the CAT team. A clinician responded and contacted the suicidal man. The officer then observed the clinician making several phone calls in an unsuccessful attempt to place the suicidal man in a secure facility. The officer finally decided to complete the hold himself and transport the man to a hospital. The officer was forced to remain with the suicidal man inside the crowded emergency room until he could be triaged and transferred to a bed.

To make matters worse, the police officer may have to transport the 5150 a long distance, or in heavy traffic, or both. ETS is located in Santa Ana, so officers driving from the outlying areas of the County must drive long distances. And if the officer is told to transport the 5150 to a hospital to obtain medical clearance—which happens more often than not—he might try the nearest hospital, but usually would travel farther to a hospital that would be more receptive.

Dealing with the Absence of In-Field Medical Clearance Authority

Thus, after an officer or a CAT/PERT clinician has made a 5150 hold in the field, the officer or clinician must either transport the patient to the nearest designated hospital (for medical clearance) or call ETS to inquire if it will accept the hold, even if the hold has no apparent need of being medically cleared in an emergency room. The industry standard in other counties, however, is for the police officer or paramedic to conduct the medical clearance in the field, in accordance with field screening protocols adopted by a county's Emergency Medical Services (EMS). If the patient meets the criteria under the medical clearance protocols, the industry standard permits transporting the patient directly to the crisis stabilization center, and dictates that once the patient arrives at that facility the field medical assessment must be confirmed.

HCA/BHS has not written or instituted an in-the-field medical clearance protocol for the County. To date, there is no HCA/BHS policy that would permit medical triage or medical clearance in the field. In addition, because OC ETS does not even have a

limited emergency room designation, there are no medical personnel at ETS who can confirm an in-the-field medical clearance.

Therefore, in the vast majority of cases, the police officer must transport the patient to the nearest hospital emergency room. Respondents to the questionnaire overwhelmingly stated that it was a waste of the police officer's time to transport the patient to a hospital and to wait with the patient in the emergency room for lengthy periods. The transport could just as easily be conducted by paramedics or by ambulance, thereby allowing the police officer to return to his regular duties.

Dealing with Medical Clearance in Hospitals

A majority of the responding police agencies complained of the long delays at hospital emergency rooms. Respondents to the questionnaires claimed that their officers regularly had to waste from two to 28 hours with a 5150 client in an emergency room, either awaiting stabilization and medical clearance or awaiting confirmation from ETS that ETS had a bed available for the patient after medical clearance was obtained. For example, when one officer took a 5150 patient to a hospital, he was told he could be waiting up to 26 hours for a bed to open.

Even after the patient has been medically cleared, which could take many hours, the police officer must wait many more hours to transport the patient to ETS or to a contract hospital if ETS does not have a bed available.

When a hospital's emergency room is completely full or overloaded by medical patients and 5150 patients, 911 dispatchers are informed and are told to divert all paramedics and ambulances to other hospitals, for the next two hours. Diversion rates show that each emergency room in Orange County must divert new patients an average of once a day. Diversion rate statistics also show that during these periods when emergency rooms have reached full capacity and cannot absorb additional patients for the next two hours; about one-half of the patients in the emergency room that caused the diversion of new patients were 5150 patients.

Thus, the presence of 5150 patients in emergency rooms for medical clearance purposes is causing a series of problems. First, it places the medical staff and the other patients in danger. Second, it is diverting staff's attention away from handling medical emergencies. Third, it is causing the new medical emergencies to be redirected to other hospitals when the emergency room reaches a capacity level.

In a grant application, HCA/BHS disclosed the following facts concerning its present system. The average wait time for a 5150 to see a mobile crisis evaluation team member (CAT or PET) in the emergency room is consistently over four hours; at night and peak times, it exceeds eight hours. Increasingly, hospitals are complaining that their emergency room personnel are at risk of physical injury and are becoming injured as a result of delays in treatment for psychiatric patients. The scarcity of capacity and the volume of 5150s being taken to emergency rooms consistently leads to extended delays for 5150s to be treated in the most restrictive and expensive level of care. (Orange County, 2013)

Clearly, the greatest concern to a police officer in dealing with a mentally ill person in the field is where to take the patient for evaluation and treatment. The time that is required for the officer to stand by with the patient in the emergency room waiting area can be problematic and unsafe for the officer, hospital staff, and other citizens. The admitting procedures, coupled with the frequent shortage of beds, turn the police officer into a caregiver for upwards of three or more hours at a time, or much longer.

Dealing with the Transfer

Once the 5150 has been medically cleared in the hospital emergency room, he must then be transported to ETS or to a contract hospital. Therefore, the police officer, the clinician, or someone at the hospital has to call ETS to see if a bed is available. If someone has arrived from PET, however, the person can take the 5150 directly to a contract hospital.

Dealing with a Premature Release from ETS

As noted above, the 5150 must be released as soon as he has been stabilized. A problem arises, however, when ETS staff incorrectly assesses the 5150's condition and prematurely discharges him. Premature or ill-advised releases of a 5150 can place extensive burdens on police agencies and have deadly consequences.

For example, on one occasion, a man was discharged from a 5150 hold after less than 12 hours. Shortly thereafter, he walked into a flood control channel and killed a transient by striking him in the head with a rock. When questioned by the police, the man stated that he believed the transient was the devil.

Numerous police agencies have encountered a disturbing lack of consistency regarding ETS discharge policies and practices. Indeed, many police agencies stated that ETS prematurely releases some 5150s before they are completely stabilized and while they are still posing a danger to self or a threat to others.

Another example serves to illustrate the point. Responding officers found a man who had armed himself with a machete and was swinging it in a threatening manner. They determined that he was a danger, disarmed him, and transported him to ETS on a 5150 hold. Only five hours later, officers responded to a call where the same man was destroying the interior of his mother's house. The officers attempted to contact ETS but did not receive a return call. Officers were forced to arrest him for felony vandalism and transported him to jail for booking.

A Broken System

As noted, a high-ranking County official has declared that the County is "very deficient" in terms of dealing with the mentally ill. This assessment is echoed resoundingly by the two stakeholder groups that interface with the County Health Care Agency on a daily basis to triage and treat the mentally ill: the police agencies and the hospitals. All seem to agree that the County's crisis intervention system is fragmented and disjointed in that the County is not working cooperatively with police and hospitals to obtain the optimal system of triage and treatment of the mentally ill.

Many of the questionnaire respondents from the various police agencies in Orange County characterized the County's crisis intervention system as itself being in a state of crisis. The agencies adamantly asserted that the Health Care Agency's current system was "extremely inefficient and ineffective," "not responsive," "very poor," "marginal and inconsistent," "unacceptable," "totally inadequate," "broken," and a "failed" system meriting "an F." Numerous respondents were at a loss to explain why the County has not seen fit to overhaul its crisis intervention and triage system and replace it with a system that is modeled after the new systems that are being installed in other counties across the state.

One police agency provided the following assessment, which reflects how many of the other agencies evaluated the County's crisis intervention system:

The present system is neither efficient nor effective with regard to the immediate medical and psychiatric needs of the patients, and it has little regard for the time expended by first responders who are tasked with stabilizing and obtaining treatment for those clients in crisis. There is lack of treatment capacity in the system, which pushes clients (along with our police officers) to busy emergency rooms, where they sometimes languish for hours. This is not only inefficient, but also unsafe, as patients with severe mental illness can present a danger to themselves and others when they are not promptly stabilized. This also causes a drain on police resources, because it takes one or more officers out of service for hours when they could be on the streets responding to other emergencies (Police agency respondent, personal communication, April 27, 2015).

An expert in the field of crisis intervention has noted that Orange County lags far behind other counties in the state and across the nation, who have opted to follow an acute-psychiatric-and-stabilization model, called a Psychiatric Emergency System (PES) that was proposed and established several years ago in Memphis, Tennessee. The nationally known Memphis model, which includes a template for specialized first-responder Crisis Intervention Teams (CIT) that accompany law enforcement into the field, has been replicated throughout the California with great success, including Alameda County, Santa Clara County, Marin County, and Ventura County.

The Memphis Crisis Intervention Team is an innovative police-based first responder program that provides crisis intervention training. CIT works in partnership with those in the county health care agency to provide very efficient crisis response times and to increase pre-arrest jail diversion. Performance-outcome research has shown CIT to be effective in developing positive perceptions and increased confidence among police officers and in decreasing police-officer injury rates.

The Hospital Association of Southern California (HASC) issued a press release on January 8, 2014, in which it declared, "There exists an *urgent* need to expand and improve response times for mental health patients experiencing psychiatric emergencies in Orange County." HASC went on to claim, "There is a *great* need to expedite treatment for mental health patients in the most appropriate, least restrictive care setting, avoiding hospitalization whenever possible" (Press release, Jan. 8, 2014).

Fixing the System

Infrastructure Improvements

HCA/BHS has seemingly begun to recognize that its present system is inadequate and that its care system needs improvements that will expedite crisis intervention, stabilization, and treatment for patients in psychiatric crisis in the most appropriate care setting, bypassing hospital emergency rooms when not truly needed. The County has taken a major step in that direction by applying for two grants this year to improve its crisis intervention system. In the grant applications, OC HCA/BHS admits that ETS is too small, and that another ETS is badly needed in South Orange County. Moreover, in the grant proposals, HCA/BHS admits that the wait time for a 5150 to be evaluated is too long and requests grant funds to increase the size and quality of its triage staff and to improve its mobile response system.

Furthermore, the County has recently taken another major step forward by partnering with HASC to hire an independent, outside consultant to do the following:

- assess the County's present psychiatric emergency/crisis response system
- evaluate successful models of PES care that are already in place in California for their applicability in Orange County;
- determine the optimal number and capacity of the PES facilities that would be required in Orange County to meet the needs, based upon known and projected volumes and residence of persons facing psychiatric emergencies;
- delineate the field triage functions of the police, EMS, clinicians, and other protocols and policies needed to support the most effective implementation of a new response model and a new PES model;
- list the functions to be performed by the PES facilities, including medical screening, crisis intervention, case management, and referral to post-discharge services;
- describe the pros and cons of hospital affiliation;
- make recommendations regarding business model, i.e., County owned and operated, County owned, with operations contracted out; privately owned and operated, or a combination of County and private funding; and
- conduct an assessment of the presently available post-discharge services and provide recommendations for additional services to support the recommended changes to the ETS facility and to any new PES facilities.

Leadership Improvement

HCA/BHS does not appear to have a cooperative relationship with the other agencies and licensed service providers with whom it must interface to triage and treat the 5150s. It does not appear to value the other members of the Mental Health Services Act Local Oversight Committee (Steering Committee) as collaborative partners, active participants, and important stakeholders in a joint enterprise of crisis intervention. The

HCA/BHS has failed to (a) provide proactive, aggressive leadership, (b) construct or lease new crisis intervention facilities throughout the county, and (c) develop a more cooperative relationship with police agencies and hospitals. The HCA/BHS has missed an opportunity to demonstrate to the police and hospitals that it understands the problems they are facing and wants to alleviate those problems.

Organizational Improvement

Moreover, a mechanism that would foster and encourage positive, constructive criticism of the present system is lacking. The Grand Jury has studied other models that include a multi-disciplinary forensic team and stakeholder working group, consisting of all the chiefs, directors, and coordinators of all agencies, including police agencies, hospitals, ambulance services, 911 dispatchers, the district attorney, the public defender, the probation department, the jail liaison, mental health providers, NAMI representatives, actual consumers, and the courts. The most important aspect of such a collaborative task force is that all participants have equal standing and feel free to provide input, suggestions, and comments.

The County's HCA/BHS already has the Steering Committee, which includes representatives from law enforcement, the District Attorney's Office, the Public Defender's Office, HASC, the Juvenile Court, and the Probation Department. Although HASC is a member of the Steering Committee, there is no direct representation from individual hospitals on this committee.

Psychiatric Emergency System: A Better Approach

The new, cutting-edge model that is recognized by experts interviewed during this investigation as the ideal system to triage the dangerously mentally ill is the Psychiatric Emergency System (PES). PES programs are designed to provide accessible, professional, and cost-effective psychiatric and medical evaluations to individuals in psychiatric crisis, to stabilize the clients on site, and to avoid psychiatric hospitalization whenever possible. A PES team provides 24/7 emergency services to all walk-ins, police-initiated evaluations, and crisis phone services. The reason a PES facility can conduct medical screening and provide basic primary medical care is that it has medical staff and laboratory testing services (Zeller, 2013).

Thus, a PES team provides both medical and psychiatric evaluation and treatment. This obviates the need to transport the 5150 to a hospital emergency room, where the 5150 could languish for hours and even days before receiving the psychiatric evaluation that he needs. The PES program calls for treating the patient in the least restrictive setting possible and then, when he is completely stabilized, releasing him/her with a solid aftercare plan, including follow-up appointments, medication information and prescriptions, and strategies to help the person avoid crises in the future (Zeller, 2013).

The outdated concept that most acute psychiatric care requires inpatient hospitalization has been replaced by the more modern concept of confronting the problem head on by treating patients at a specialized psychiatric emergency center. The fundamental concept is that most psychiatric emergencies can be treated to the point of

stability and discharge in less than 24 hours. Thus, considering inpatient hospitalization as the only option is a tremendous waste of resources (Zeller, 2013).

What people in crisis need is immediate help, not sitting for hours untreated in an emergency room while already overwhelmed staff members call around to arrange a multiple-day hospital stay. Thus, using a PES decreases emergency room boarding times by over 80% and reduces the need for psychiatric hospitalizations by up to 75%. What is more, the costs of all the care in the PES is less per patient than the cost of the typical boarding time in an emergency room alone—not to mention the thousands of dollars more saved from avoiding a psychiatric hospitalization (Zeller, 2013).

Alternative Systems Nationwide

The Grand Jury has learned that many cities and counties throughout the nation are developing or revamping their crisis intervention systems to deal with the increasingly problem of how to assist the police in dealing with the mentally ill in the field. Some of the more progressive or cutting edge psychiatric evaluation and stabilization systems are now found in Portland, Oregon; Ithaca, New York; Boston, Massachusetts; Seattle, Washington; Denver, Colorado; Grand Rapids, Michigan; Tucson, Arizona; San Antonio, Texas; and Albuquerque, New Mexico.

Alternative Systems in the State

Los Angeles County has already taken aggressive steps to deploy a highly regarded mobile crisis co-response system with a System-Wide Mental Assessment Response Teams (SMART) that are similar to OC MHS's CAT and PET teams, but which pair many more teams of CIT-trained police officers with embedded mental health clinicians to enable 24/7 coverage. In addition, Los Angeles County has installed a Sequential Intercept Model and Mapping System to triage, track, and divert the mentally ill from the criminal justice system³. Moreover, Los Angeles County and San Diego County have crisis intervention and stabilization PES centers which are run by Exodus Recovery, Inc. Sacramento, California (Exodus 2015).

Los Angeles County recently approved a major expansion of its PES crisis center. The Board of Supervisors voted to use \$40.9 million in state funding to open three new PES drop-off facilities, "where police can bring people undergoing mental health crises instead of taking them to overcrowded emergency rooms or jail" (Sewell, November 12, 2014). A consultant report commissioned by the Los Angeles District Attorney's task force had called for more crisis response teams and more drop-off centers because, "sadly, it's often more time-efficient for law enforcement to book an individual into jail on a minor charge . . . rather than spend many hours waiting in an emergency room for the individual to be seen" (Sewell, November 12, 2014).

Sacramento County recently approved an increase in spending for mental health care. The county's health care agency stated that it wanted to reduce the spiraling cost of treating the mentally ill in hospitals. The Sacramento County Board of Supervisors voted to spend \$13.4 million to expand the county's existing crisis stabilization center and to construct *three* new 15-bed crisis intervention centers.

The Alameda Model

Although other counties in the California have established noteworthy county-run PES systems and facilities, the best one in the estimation of the Grand Jury is Alameda County Health Systems Medical Center's John George Psychiatric Hospital in San Leandro, California, also known as the "Alameda" facility. The Grand Jury considers the Alameda model to be the "gold standard" among PES crisis intervention systems in the State. It provides psychiatric emergency and acute care services to adults experiencing severe and disabling mental illnesses and treats all who seek care regardless of their economic or social status.

Opened in 1992, the Alameda facility was authorized by Alameda County's Behavioral Health Care Services as a designated facility for 5150s. Its qualified, multidisciplinary team of mental health professionals provides patient-centered care for nearly 100% of all acute psychiatric emergencies in Alameda County. It also provides psychiatric evaluation and treatment to patients arriving voluntarily.

Members of the Grand Jury visited and inspected the Alameda facility and were impressed with the multi-disciplinary staff's skill in the diagnosis and evaluation of patients with acute psychiatric illnesses. The facility is housed in an attractive, wide-open, and beautifully landscaped setting with many windows looking out to the hillside or the spacious patio.

A local health care professional told the Grand Jury that representatives from HCA had visited the Alameda PES and reported they could not support such a model because it appeared that patients were lying around everywhere looking like they were in a drugged stupor, instead of receiving clinically appropriate care (Personal communication, June 3, 2015).

These comments prompted an onsite visit to Alameda County by the Grand Jury. What the Grand Jury members saw was a very large, brightly lit wide-open area, where 44 people were lying or sitting in "sleeper chairs" (chairs that can be opened up for full recline). Everyone seemed relaxed -- from doctors and nurses in street clothes-- to the patients waiting for their medications to take effect. In addition, there were three rooms where people who wanted or needed isolation could stay, but no one was isolated during the time the Grand Jury members were there. The PES, unlike Orange County's ETS, did not look like a hospital--with patients in beds behind closed doors, but who is to say that the more hospital-like environment is more appropriate for the stabilization of the mentally ill than a less restrictive, more home-like atmosphere?

The Grand Jury observed four things that seemed clinically appropriate. First, two patients were brought in on gurneys by ambulances, immediately triaged at the door, then taken into private consulting rooms for assessment by the psychiatric staff. Secondly, there was a medical doctor's examining room office set up within the PES with the necessary equipment to provide medical screening exams. Third, there was a psychiatric evaluation area (in clear sight of the staff) where patients could be evaluated by the on-staff psychiatrist before discharge. Lastly, nurses were not dressed in scrubs

or uniforms. There was one nurse assigned to no more than six patients, and every patient knew who his nurse was at all times.

The Alameda PES (a part of John George Psychiatric Hospital) is a Dedicated Emergency Department (DED) that follows the clinical requirements set up by Federal Emergency Medical Treatment and Labor Act (also known as EMTALA) and has a relationship with a licensed hospital. The OC ETS, not being designated as a DED or licensed to a hospital, has no such requirements. Therefore, the Alameda PES, unlike the OC ETS, can handle limited medical screening without a need to first transport the patient to a hospital emergency room.

The Alameda system is noteworthy and remarkable because of the following characteristics that distinguish it from Orange County's outdated model:

- It provides for initial medical clearance to be conducted in the field by CIT-trained EMS personnel, rather than in a hospital emergency room.
- It provides for CIT-trained EMS personnel (special mental health transport) to conduct all transports of 5150s via ambulance to the PES facility or hospital.
- It enables the police officer to remain in the field after the 5150 has been placed in the ambulance, rather than having to drive to a hospital.
- The average wait time for the 5150 to begin receiving treatment after his arrival at the PES facility is 19 *minutes*, rather than ten hours.
- It has 80 licensed beds/sleeper chairs, rather than 10 beds and 5 recliners.
- It serves up to 1,500 patients per month, rather than only 315.
- It has a lab and can handle limited medical clearances.

The Alameda facility is a leader in the use of evidence-based practice and data analytics to inform and formulate effective care decisions and strategies. It has what the HCA/BHS does not have and offers what the HCA/BHS cannot offer. Table 1 graphically illustrates the differences between Orange County ETS and Alameda County PES.

Table 1: Comparison of County Crisis Intervention Systems

	Orange County	Alameda County
Population	3,147,655	1,594,569
Facility Type	Evaluation and Treatment Services (ETS) -Established in 1970's	Psychiatric Emergency Services (PES) -Established 1992
Crisis Beds	10 beds, 5 recliners, 2 seclusion rooms	80 licensed beds/sleeper chairs 3 seclusion rooms

The Mental Illness Revolving Door: A Problem for Police, Hospitals, and the Health Care Agency

	Orange County	Alameda County
Staffing	1 Psychiatrist 24/7 1 Registered Nurse 1-2 Mental Health Specialists 1 Social Work Intern No Security Guards	1-5 Psychiatrists 24/7 Several Registered Nurses Psychologist Licensed Social Workers 2-3 Security Guards 24/7 Pharmacist 1-2 Medical Doctors Chaplain On Request P/T Occupational Therapist
Patients seen per month	310-315	1,200-1,500
Patient Source:		
Ambulance	70%	80%
Police	15%	0%–
Walk-in	5%	20%
Other (CAT, clinics, jail, etc.)	10%	0%
Size of Facility	4600 sq. ft.	6115 sq. ft.
Wait room seats	6	14
Average time between police contact and treatment	10 minutes at ETS, but 70% go to hospital ER first; Could be 10 hours or 2-3 days until mental treatment (per HCA/BHS Grant application)	Varies per triage designation at PES: Immediate, 15 minutes, or 30 minutes 30% go to hospital first. These return to PES within average of 4 hours.
Acceptance Criteria	Anyone over 18 years Indigent or Medi-Cal only Medically cleared by designated hospital No alcohol or drugs	Anyone over 18 years Assessed by EMT onsite Brought by ambulance PES does screening onsite Low-level drugs or alcohol ok
Facility Appearance	Hard to find with locked entrance Patients assigned to hospital-like rooms No windows or common area Staff sees clients in their rooms Institutional atmosphere	Easy to find Open, welcoming lobby Patients relax in common area on sleeper chairs Airy, community atmosphere Staff and patients mingle.
Admittance stats		
July '13–Jul '14	3,630	13,249
July '14–Mar '15	2,735	12,910
Medical Clearance	No medical clearance in field Requires ER evaluation at designated hospitals.	Dedicated Emergency Department Does own medical screening exams Only transports to hospital if

	Orange County	Alameda County
		no ability to treat at PES
Funding	Orange County Health Care Agency/Behavioral Health Services	Alameda County Behavioral Health Care Service
Police 5150 procedure	Police calls CAT; Police or CAT writes 5150; Police takes to ETS or hospital ER and stays till client is admitted; Officer can be off patrol for many hours	Police calls county-contracted Emergency Medical Service; Emergency Medical Tech assesses and transports to licensed hospital or PES; Officer free to continue patrol
Criteria for transport to acute hospital	No written criteria All patients evaluated individually Need to be medically screened Alcohol or drugs possibly in system	Health Metrics: BP over 190/110 Pulse over 120 Glucose under 60 mg/dl Unable to treat at PES

(Grand Jury, 2015)

Help is on the Way

In December 2014, HASC and OC applied for two grants: a PES triage planning and staffing grant, and a PES facility construction grant. The grant submissions culminated weeks of strategic, collaborative discussions that were facilitated by HASC for hospitals and the County. The Emergency Medical Care Advisory Committee of the County sent a letter to the OC Board of Supervisors in support of the PES initiative.

Only the triage planning and staffing application was granted. The PES facility construction grant application was denied for failure to provide sufficient details about the proposed facility. To cure this—in anticipation of an opportunity to apply again for a PES facility construction grant—HASC decided to send out requests for proposals for a PES study that would evaluate the need for, and feasibility of establishing, one or more PES facilities in OC. OC HCA and the County Medical Association have agreed to help fund the independent performance audit and study.

Finally, Laura's Law will be the impetus for OC HCA/BHS to concentrate on how best to assist the severely mentally ill after their release from jail, ETS, or a hospital. If upon discharge, they fail to seek voluntary treatment or to self-medicate, they will relapse or recidivate, once again spinning in the same revolving door that will lead to another crisis in the streets. Prompt follow-up with an outpatient mental health provider after discharge is important to maintain continuity of care and to prevent relapse or re-hospitalization. This can be accomplished through AOT.

The Ideal Solution

Almost all of the police agencies have insisted that there should be “multiple” PES facilities in Orange County. They maintained that they should have “plenty of beds” and should be placed in “several locations.” The police agencies stated that there should be multiple PES facilities to improve capacity and ease of transportation.

Further, police agencies and hospital administrators that the Grand Jury interviewed stated that the County needs stand-alone, emergency stabilization drop-off centers, with medical and psychiatric staff, to relieve the burdens placed on these two principal stakeholders: the police and the emergency rooms. Each PES would ideally be adjacent to, or in very close proximity to, a hospital with a large emergency room linked under a licensed relationship (Personal communication, June 12, 2015).

An ideal solution, as stated by Alameda County law enforcement executives, includes having ambulance personnel transport all of the 5150s to the nearest PES. The 911 dispatchers receive CIT training so they will know whether to send the special mobile evaluation or mental response team to the scene and whether to send the CIT-trained ambulance company to the scene. The ambulance personnel receive CIT training in how to handle and triage the mentally ill and how to safely transport them, with appropriate use of restraints. This allows police officers to remain in the field and return to service immediately upon the ambulance’s departure.

Laura’s Law

In addition, the importance of Laura’s Law as the last piece of the puzzle cannot be overemphasized.

What is really needed is long-term care for months or years. We need to be able to set up a system where we follow the mentally ill back into the community, we follow their families, we make sure they have a safety net and that somebody’s watching them and monitoring them. If they’re not hooked into the [assisted outpatient treatment] system that’s watching them, taking care of them, then we will have problems on our hands. There’s really no place to go *after* the hospital, so the mentally ill end up coming back home, or going back to the streets, right where the situation started. And you know, the police officers on the street and psychiatrists in the hospital will say, ‘You’re right. The system is broken.’
(Pelley, 2014)

As noted above, the County “went live” with Laura’s Law (AOT) on October 1, 2014. The County’s recent implementation of AOT has gotten off to a good start. It has led to a surprising number of voluntary enrollments.

As of June 8, 2015, the total number of patients linked to voluntary mental health programs was 45. In other words, while the Outreach and Engagement Team was screening these individuals for AOT, they decided to accept voluntary services. Thirty-two cases are still open, and five filed petitions have resulted in negotiated settlements approved by the superior court. Only a single AOT petition has been set for a hearing.

The success of Laura’s Law will depend on three things. First, it must be properly implemented and well-defended in the courts. Second, aggressive action must be taken to find and identify those individuals who meet the criteria of Laura’s Law. Third, its performance metrics and cost effectiveness must be accurately measured and compared with meaningful benchmarks.

Defending Its Constitutionality

Although a Sacramento-based civil rights advocacy group—Disability Rights California—has threatened to file a lawsuit attacking the constitutionality of Laura’s Law, no such action has been filed in Orange County to date. Moreover, legal experts opine that it will withstand such an attack because (a) the candidate may not be forced to sign a release of his medical records; (b) the patient can be ordered to take his medication, but cannot be forced to do so; and (c) the patient can walk away from the AOT, in which case the only sanction is the bringing of a new petition. Furthermore, New York’s Kendra’s Law, which was patterned after Laura’s Law, has already passed constitutional muster in the courts.²

The Grand Jury found that the County does not meticulously track all the negotiated settlements with AOT petitions and all the voluntary linkages following AOT referrals. This failure to track all settlements and voluntary linkages may adversely impact the ability to defend the constitutionality of Laura’s law as applied.

Locating its Candidates

The County HCA/BHS has established a Laura’s Law Outreach and Engagement Team, consisting of social workers, marriage and family counselors, and psychologists, to conduct investigations when referrals are made. If the referral meets the criteria regarding prior hospitalizations and prior acts of violence, and if he refuses voluntary treatment, a psychological assessment is conducted to ascertain whether he has a mental disorder and whether he is deteriorating. However, this “outreach” program does not really reach out; it merely investigates referrals from family members, hospitals, jails, police officers, and law probation officers. HCA/BHS is merely *waiting* for referrals.

The County has failed to find and identify all possible candidates who may qualify for AOT under Laura’s Law. After all, the County set aside \$4.4 million to treat about 120 severely mentally ill persons during the 2014-15 fiscal year, but of the 317 Laura’s Law referrals received by HCA/BHS, it has been able to link only 75 persons to voluntary services and to enroll only five into AOT through negotiated settlements approved by the superior court.

HCA/BHS found that 112 referrals did not qualify under the criteria of Laura’s Law. It has 45 open cases that are under investigation. The remainder of the 317 referrals—80—are severely mentally ill people who could not be helped by HCA/BHS—not because they did not qualify—but because they could not be located (Personal communication, May 14, 2015).

This again demonstrates the efficacy of a 5150 tracking system and database for use by the police agencies, members of CAT, clinicians at ETS/PES, staff at the County

Jail, probation officers, and hospitals. In the alternative, County HCA could comb through the 5150 files that it and the hospitals have compiled over the last few years to make an alphabetical list that could be used to compare with lists of arrestees, jail inmates, and probationers. Orange County does not have relevant data about 5150s that are migrating from an adjoining county.

Another major issue is the degree to which the mentally ill are left to fend for themselves upon their release from jail, ETS/PES, or a hospital. Without an appropriate aftercare plan and a secure safety net, they are left to their own devices and may immediately deteriorate, relapse, and become dangerous if they do not take their medication. It is at this juncture that they need to be linked immediately and seamlessly with the County's mental health services, including assisted outpatient treatment (Laura's Law), either through the probation officer, the mental health courts, the HCA/BHS case worker, or the conservator.

Measuring its Success

Establishment of benchmarks is important in order to evaluate accurately the effectiveness and efficiency of Laura's Law. To assess performance outcomes, the law requires that all key performance indicators be measured precisely and scrupulously against these benchmarks. It appears, however, that the County has failed to establish countywide benchmarks for all severely mentally ill who may benefit from the implementation of Laura's Law.

Because Laura's Law is funded by the state, the law itself mandates that counties measure and report to the State Department of Health Care Services certain markers and indicators by May 31 of each year (California Welfare and Institution Code, section 5348) However, since the County does not yet have a single, court-ordered AOT in the system, it was able to obtain a one-time exemption from the report-filing requirement.

Next year (2016), when the County prepares its report for filing, the law requires that HCA/BHS include the following data markers with regard to all persons in court-ordered AOT:

- Reductions in homelessness and in hospitalizations
- Reductions in police involvement and police contacts
- Number of persons served by AOT, and, of those, the number who maintain housing and maintain contact with the treatment system
- Reductions in arrests and incarcerations
- Number of AOT persons participating in employment services programs
- Reductions in days of hospitalization
- Adherence to prescribed treatment
- Other indicators of successful engagement
- Victimization of persons in the AOT program
- Violent behavior by persons in the AOT program
- Substance abuse by persons in the AOT program
- Type, intensity, and frequency of treatment of persons in the program

- Extent to which enforcement mechanisms are used by the AOG program
- Social functioning of person in the AOT program
- Skills in independent living of persons in the program
- Satisfaction with program services both by those receiving them and by their families

(California Welfare and Institution Code, section 5348)

Those indicia not specifically included are the following: (1) emergency calls; (2) diversion referrals; (3) threats; (4) crisis interventions (apart from police contact); (5) suicides; (6) homicides; and (7) conservatorships. Moreover, the BHS Adult and Older Adult Performance Outcome Department has indicated that it has not established benchmarks for comparison between pre-Laura's Law and post-Laura's Law statistics. Furthermore, BHS has not standardized the program data for easy comparison.

It is hard to understand how the HCA/BHS plans to track the effectiveness of Laura's Law in its Adult and Older Adult Performance Outcome Department (AAOPOD). HCA/BHS has a database system that provides electronic health record of all its clients, but it does not have an integrated, centralized, standardized database that would provide "snapshot" information at a glance regarding reductions in police contacts, arrests, or incarcerations. The same holds true for homelessness, hospitalizations, and unemployment data. In addition, HCA/BHS does not have a web-based data system or dashboard to track outpatient volumes, ETS volumes, high utilizers, community of origin, frequency of outpatient treatment, length of successful engagement, number of psychiatric visits, enrollment in voluntary programs, court appearances, and dispositions.

To prepare to provide performance measurements regarding its implementation of Laura's Law, HCA has issued a Request for Proposals (RFP) for the provision of technical assistance and development of a plan to evaluate the AOT program. The RFP's scope of work calls for an independent evaluator to measure the performance indicators and conduct a statistical analysis of the impact of Laura's Law. In addition, the scope of work includes a calculation of the cost-effectiveness of Laura's Law.

However, the scope of work fails to include vital categories and domains that would track single events and separate them from the multiple events by the same individuals. For instance, a valuable statistic to track would be to compare the recidivism rate (1) to the frequency of contacts by the case manager or personal service coordinator, (2) to the caseload size of the case manager, (3) to the frequency and consistency of medication, and (4) to the frequency of psychiatric visits.

In addition, it remains to be seen how the County will accurately measure the cost effectiveness of Laura's Law. The county has indicated that it has no intention to first establish a pre-AOT baseline and then track the cost of AOT versus the costs of emergency responses, arrests, incarcerations, ETS handling, emergency room handling, 5150 evaluations, 5150 holds, 5250 holds, 5270 holds, hospitalizations, and conservatorships. It does not plan to measure the impact of AOT on the District Attorney's Office, the Public Defender's Office, the Probation Department, and the

Superior Court. The Grand Jury found that the Board of Supervisors expects this type of information.

Furthermore, Orange County has prided itself in data-driven decision-making and in measuring performance outcomes that not only reflect bare statistics, but also meaningful trends and cross analysis of data. However, it is not clear that HCA/BHS is prepared to establish a vigorous, robust program to establish metrics and benchmarks, collect data, compare statistics, measure trends, and track the performance outcomes of the implementation of Laura's Law. As reportedly stated by former Supervisor Pat Bates, "We need to have strong performance metrics in this program so we know we'll have outcomes." (Gerda, 2014)

There is yet another important reason to track the success of Laura's Law, including the high number of voluntary enrollments and negotiated settlements. As alluded to above, a few police agencies have expressed their doubts that Laura's Law will have a positive impact in Orange County because it has "no teeth," i.e., no forced medication and no sanctions for non-compliance. As noted, however, Laura's Law and Kendra's Law have met with singular success, based on the "black robe effect," leading to an extremely high number of voluntary enrollments.

Nevertheless, this police agency attitude toward a perceived ineffectiveness of Laura's Law might have a deleterious effect on whether the police agencies seek further training on how to implement Laura's Law and on whether they make referrals of all potential candidates. A reduction in training and referrals, in turn, would tend to lower the effectiveness and success of Laura's Law. This would inevitably result in a self-fulfilling prophecy.

Therefore, the HCA has not publicized Laura's Law sufficiently throughout the County and has not provided adequate training to all deputy sheriffs and police officers regarding its implementation. The HCA has not instructed all police agencies regarding the qualifying criteria for AOT. Laura's Law is the missing component that was created to fill the gap in the treatment continuum between a previously violent 5150's release and his relapse, and it will not work unless all stakeholders work together to ensure and measure its success.

Time Matters

It may appear trivial, but the time taken to detain, evaluate, transport, medically clear, and stabilize an individual suffering from a mental disorder that is causing him to have suicidal thoughts or to want to hurt someone else is crucial. When a person hears voices that tell him to kill himself or to kill another, time is of the essence. It may be only a matter of time before this County sees another tragic occurrence, and, as aptly stated by one police chief, "We are beyond lucky that we have not had another Kelly Thomas."

FINDINGS

In accordance with California Penal Code sections 933 and 933.05, the 2014-2015 Grand Jury requires (or, as noted, requests) responses from each agency affected by the findings presented in this section. The responses are to be submitted to the Presiding Judge of the Superior Court.

Based on its investigation titled “The Mental Illness Revolving Door: A Problem for Police, Hospitals, and the Health Care Agency ,” the 2014-2015 Orange County Grand Jury has arrived at 14 principal findings, as follows:

- F.1.** Deputy Sheriffs and police officers receive insufficient training on how to evaluate and handle the mentally ill in the field.
- F.2.** Deputy Sheriffs and police officers receive insufficient training regarding Laura’s Law.
- F.3.** Orange County’s Centralized Assessment Team is inadequate in that it takes too long for them to respond to the scene to assist police officers in their evaluations of the mentally ill.
- F.4.** Orange County’s mental illness triage system is inadequate in that there are no field screening protocols that would allow medical clearance in the field by law enforcement personnel or paramedics.
- F.5.** Orange County’s mental illness triage system is inadequate in that the police agencies either do not have a triage desk to advise and assist officers in the field or do not have psychiatric crisis mobile response teams at their disposal.
- F.6.** Orange County’s Psychiatric Evaluation and Response Team clinicians are insufficient in number to meet the needs of police agencies in Orange County.
- F.7.** Orange County’s Evaluation and Treatment Services facility is inadequate in that its capacity is insufficient to permit police officers to take all the mentally ill to it and drop them off at the facility, instead of transporting the patient to a hospital emergency room.
- F.8.** Orange County’s Evaluation and Treatment Service facility is inadequate in that the County does not permit medical triage or medical clearance in the field, and therefore directs police officers to obtain medical screening for even minor health conditions that could easily be treated at the facility.
- F.9.** Orange County’s Evaluation and Treatment Service facility is inadequate in that it directs police officers to take the mentally ill who may be under the influence of alcohol or drugs to a hospital emergency room rather than to a psychiatric emergency facility.
- F.10.** Orange County’s crisis intervention system is inadequate in that there is only one Evaluation and Treatment Service facility for the entire County.

- F.11.** The County's crisis intervention system is inadequate in that it does not provide strategically located, stand-alone, drop-off psychiatric emergency stabilization facilities with medical treatment capability at convenient locations throughout the County.
- F.12.** The County's crisis intervention system is inadequate in that there is no real-time, empty-bed registry to enable officers and clinicians in the field to determine bed-availability at the Evaluation and Treatment Service facility and at designated hospitals.
- F.13.** The County's crisis intervention system is inadequate in that there is no 5150, case management, and conservatorship database in place to assist officers and clinicians in the field to triage the mentally ill who do not qualify for a 5150 hold.
- F.14.** The Health Care Agency has not established benchmarks and a complete performance-measurement system with which to track the success and cost effectiveness of Laura's law, as directed by the Board of Supervisors in May 2014.

RECOMMENDATIONS

In accordance with California Penal Code sections 933 and 933.05, the 2014-2015 Grand Jury requires (or, as noted, requests) responses from each agency affected by the recommendations presented in this section. The responses are to be submitted to the Presiding Judge of the Superior Court.

Based on its investigation titled "The Mental Illness Revolving Door: A Problem for Police, Hospitals, and the Health Care Agency," the 2014-2015 Orange County Grand Jury makes the following 14 recommendations:

- R.1.** All law enforcement officers should receive at least 40 hours of comprehensive Crisis Intervention Training on how to handle and evaluate the mentally ill in the field with periodic refresher training. (F.1.)
- R.2.** All law enforcement officers should receive mandatory and specific training regarding Laura's Law. (F.2.)
- R.3.** Orange County's Centralized Assessment Team's response time should be improved significantly with a goal of eventually reducing its maximum response time to less than 20 minutes. (F.3.)
- R.4.** The Orange County Health Care Agency should adopt field screening protocols to allow (a) medical clearance in the field by law enforcement personnel and/or paramedics; and (b) transport by paramedics rather than police officers. (F.4.)
- R.5.** All law enforcement agencies should either have a psychiatric triage desk to advise and assist officers in the field or a psychiatric crisis mobile response team. (F.5.)

- R.6.** The Orange County Psychiatric Evaluation and Response Team staff should be increased significantly so that an embedded clinician can be placed with each law enforcement agency and can provide service 24/7 if requested. (F.6.)
- R.7.** Orange County's Evaluation and Treatment Services facilities should be expanded to easily accommodate all 5150 walk-ins and all 5150s dropped off by police, paramedic, or ambulance. (F.7.)
- R.8.** Orange County Evaluation and Treatment Services should acquire the capability of conducting limited medical screening for minor health problems and cease from directing police officers to obtain medical screening for 5150s with minor health conditions that could easily be treated at Evaluation and Treatment Services facilities. (F.8.)
- R.9.** Orange County's Evaluation and Treatment Services facilities should acquire the capability of handling 5150s who may have ingested alcohol or drugs, but who are not under the influence to such an extent that it inhibits stabilization or requires medical clearance at a hospital. (F.9.)
- R.10.** The Orange County Health Care Agency's crisis intervention system should be expanded so as to provide a minimum of four Psychiatric Emergency Service facilities—one in South County, one in Central County, one in West County, and one in North County. (F.10.)
- R.11.** The County's Health Care Agency should provide strategically located, stand-alone, drop-off psychiatric emergency stabilization facilities with medical treatment capability at convenient locations throughout the County. (F.11.)
- R.12.** The County's Health Care Agency should provide a real-time, empty-bed registry to enable officers and clinicians in the field to determine immediately and accurately the current bed availability at Evaluation and Treatment Services facilities and at designated hospitals. (F.12.)
- R.13.** The County's Health Care Agency should create and maintain a 5150, case management, and conservatorship database in place to assist officers and clinicians in the field to triage the mentally ill in the field who do not qualify for a 5150 hold, but who may qualify for Laura's Law. (F.13.)
- R.14.** The Health Care Agency should establish benchmarks and a complete performance-measurement system with which to track the success and cost effectiveness of Laura's law, as directed by the Board of Supervisors in May 2014.

REQUIRED RESPONSES

The California Penal Code section 933 requires the governing body of any public agency which the Grand Jury has reviewed, and about which it has issued a final report, to comment to the Presiding Judge of the Superior Court on the findings and recommendations pertaining to matters under the control of the governing body. Such

comment shall be made no later than 90 days after the Grand Jury publishes its report (filed with the Clerk of the Court). Additionally, in the case of a report containing findings and recommendations pertaining to a department or agency headed by an elected County official (e.g. District Attorney, Sheriff, etc.), such elected official shall comment on the findings and recommendations pertaining to the matters under that elected official's control within 60 days to the Presiding Judge with an information copy sent to the Board of Supervisors.

Furthermore, California Penal Code section 933.05, subdivisions (a), (b), and (c), provides as follows, the manner in which such comment(s) are to be made:

(a) As to each Grand Jury finding, the responding person or entity shall indicate one of the following:

(1) The respondent agrees with the finding

(2) The respondent disagrees wholly or partially with the finding, in which case the response shall specify the portion of the finding that is disputed and shall include an explanation of the reasons therefore.

(b) As to each Grand Jury recommendation, the responding person or entity shall report one of the following actions:

(1) The recommendation has been implemented, with a summary regarding the implemented action.

(2) The recommendation has not yet been implemented, but will be implemented in the future, with a time frame for implementation.

(3) The recommendation requires further analysis, with an explanation and the scope and parameters of an analysis or study, and a time frame for the matter to be prepared for discussion by the officer or head of the agency or department being investigated or reviewed, including the governing body of the public agency when applicable. This time frame shall not exceed six months from the date of publication of the Grand Jury report.

(4) The recommendation will not be implemented because it is not warranted or is not reasonable, with an explanation therefore.

(c) If a finding or recommendation of the Grand Jury addresses budgetary or personnel matters of a county agency or department headed by an elected officer, both the agency or department head and the Board of Supervisors shall respond if requested by the Grand Jury, but the response of the Board of Supervisors shall address only those budgetary /or personnel matters over which it has some decision making authority. The response of the elected agency or department head shall address all aspects of the findings or recommendations affecting his or her agency or department.

Comments to the Presiding Judge of the Superior Court in compliance with Penal Code section 933.05 are required from:

Responses are required for Findings F.3 through F.14. and for Recommendations R.3 through R.14. from the Orange County Board of Supervisors.

Responses are required for Findings F.1 and F.2. and for Recommendations R.1. and R.2. from the Orange County Sheriff-Coroner.

Comments to the Presiding Judge of the Superior Court in compliance with Penal Code section 933.05 are requested from:

Responses are requested for Findings F.3 through F.14. and for Recommendations R.3. through R.14. from the OC Health Care Agency.

Responses are requested for Findings F.1 and F.2. and for Recommendations R.1. and R.2. from the Police Chiefs of the following cities:

1. Anaheim
2. Brea
3. Buena Park
4. Costa Mesa
5. Cypress
6. Fountain Valley
7. Fullerton
8. Garden Grove
9. Huntington Bch
10. Irvine
11. La Habra
12. La Palma
13. Laguna Beach
14. Los Alamitos
15. Newport Beach
16. Orange
17. Placentia
18. Santa Ana
19. Seal Beach
20. Tustin
21. Westminster

COMMENDATIONS

The Grand Jury commends the Police Department of the City of Orange, the Santa Ana Police Department, the Hospital Association of Southern California, and St. Joseph Hospital for collaborating on and producing a set of training videos for use by police officers and deputy sheriffs in CIT training. The Grand Jury commends the Director of the John George Psychiatric Hospital in San Leandro, California and the Director of Behavioral Health for Alameda County for their valuable assistance. The Grand Jury also commends Golden West College for developing and expanding its CIT course to 24 hours.

END NOTES

1. The Memphis Model

The first CIT was established in Memphis in 1988 after the tragic shooting by a police officer of a man with a serious mental illness. This tragedy stimulated a collaboration between the police, the Memphis chapter of the National Alliance on Mental Illness, the University of Tennessee Medical School, and the University of Memphis to improve police training and procedures in response to mental illness. The so-called Memphis model has achieved remarkable success, having been adopted by more than 2000 communities in more than 40 states and having been implemented statewide in several states.

The Memphis Model of CIT has several key components:

- A community collaboration between mental health providers, law enforcement, and family/consumer advocates, which determines the best way to transfer the mentally ill into the mental health system
- A community coalition to ensure that there are adequate facilities for mental health triage
- A curriculum of specialized training to teach police officers how to interact with persons experiencing a psychiatric crisis
- Special training to respond safely and quickly to people with serious mental illness in crisis
- Focused training on how to recognize the signs of psychiatric distress and how to de-escalate a crisis
- Materials on how to link people with appropriate treatment, which has a positive impact on fostering recovery and reducing recidivism

The benefits of the Memphis Model of CIT are as follows:

- Helps keep the severely mentally ill out of jail and gets them into treatment
- Reduces stigma and prejudice toward the severely mentally ill
- Reduces officer injuries and SWAT team emergencies
- Reduces the amount of time officers spend on the disposition of mental disturbance calls

2. Defense of Laura's Law

On January 3, 1999, Kendra Webdale was pushed to her death before an oncoming subway train beneath the streets of Manhattan by a man diagnosed with paranoid schizophrenia and with a history of mental illness and hospitalizations who had neglected to take his prescribed medication. Responding to this tragedy, the Legislature enacted Mental Hygiene Law § 9.60 (Kendra's Law) (L. 1999, ch. 408), thereby joining nearly 40 other states in adopting a system of assisted outpatient treatment (AOT) pursuant to which psychiatric patients unlikely to survive safely in the community without supervision may avoid hospitalization by complying with court-ordered mental health treatment. In enacting the law, the Legislature found that there are mentally ill persons

who are capable of living in the community with the help of family, friends, and mental health professionals, but who, without routine care and treatment, may relapse and become violent or suicidal, or require hospitalization. (L 1999, ch. 408, § 2.) In addition, in mandating that certain patients comply with essential treatment pursuant to a court-ordered written treatment plan, the Legislature further found that some mentally ill persons, because of their illness, have great difficulty taking responsibility for their own care and often reject the outpatient treatment offered to them on a voluntary basis. (*Id.*)

It did not take long for the law's constitutionality to be challenged. The question was whether the law achieved its goal of creating a mechanism to ensure that individuals who met the criteria remained treatment-compliant while in the community, in a way that was consistent with the Constitutional rights of those individuals. In the Matter of K.L., 500748/00 (Sp. Ct., Queens County, 2000), the Mental Hygiene Legal Service (MHLS) moved for dismissal of a petition, arguing that the statute was unconstitutional on two grounds: that it unconstitutionally deprived patients of the fundamental right to determine their own course of treatment, and that the statutory provisions concerning removal for observation following non-compliance with the AOT order are facially unconstitutional. The Attorney General of the State of New York intervened to support the constitutionality of the statute.

The Supreme Court rejected each of the arguments advanced by the MHLS, upheld the constitutionality of Kendra's Law, and found that it comported with due process, noting that Kendra's Law does not permit forced medication or treatment. The Court reasoned that the restriction on a patient's freedom affected by a court order authorizing AOT is minimal, inasmuch as the coercive force of the order lies solely in the compulsion generally felt by law-abiding citizens to comply with court directives. The Court observed that although the existence of such an order and its attendant supervision increases the likelihood of voluntary compliance with necessary treatment, a violation of the order, standing alone, ultimately carries no sanction.

3. The Sequential Intercept Model

The Sequential Intercept Model provides a conceptual framework for communities to use when considering the interface between the criminal justice and mental health systems as they address concerns about criminalization of people with mental illness. The model envisions a series of points of interception at which an intervention can be made to prevent individuals from entering or penetrating deeper into the criminal justice system. The concept is that most people will be intercepted at early points, with decreasing numbers at each subsequent point. The interception points are law enforcement and emergency services; initial detention and initial hearings; jail, courts, forensic evaluations, and forensic commitments; reentry from jails, state prisons, and forensic hospitalization; and community corrections and community support. The model provides an organizing tool for a discussion of diversion and linkage alternatives and for systematically addressing criminalization. Using the model, a community can develop targeted strategies that evolve over time to increase diversion of people with mental illness from the criminal justice system and to link them with community mental health treatment. (Munetz & Griffin, 2006)

Although many communities are interested in addressing the overrepresentation of people with mental illness in local courts and jails, the task can seem daunting and the various program options confusing. The Sequential Intercept Model provides a workable framework for collaboration between criminal justice and treatment systems to systematically address and reduce the criminalization of people with mental illness in their community

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APPENDIX: ACRONYM LIST

AAOPOD	Adult and Older Adult Performance Outcome Department
AOT	Assisted Outpatient Treatment
BHS	Behavioral Health Services
CAT	Centralized Assessment Team
CIT	Crisis Intervention Training
COPS	Community Oriented Policing Services
CRT	Crisis Response Team
EPU	Emergency Psychiatric Unit
ETS	Evaluation and Treatment Services
FSP	Full Service Partnership
HCA	Health Care Agency
LPS	Lanterman-Petris-Short Act
NAMI	National Alliance on Mental Illness
PERT	Psychiatric Evaluation and Response Team
PES	Psychiatric Emergency Services
PET	Psychiatric Evaluation Team
POST	Peace Officers Standards and Training
TACT	Time, Atmosphere, Communication, and Tone: A method of talking to the mentally ill