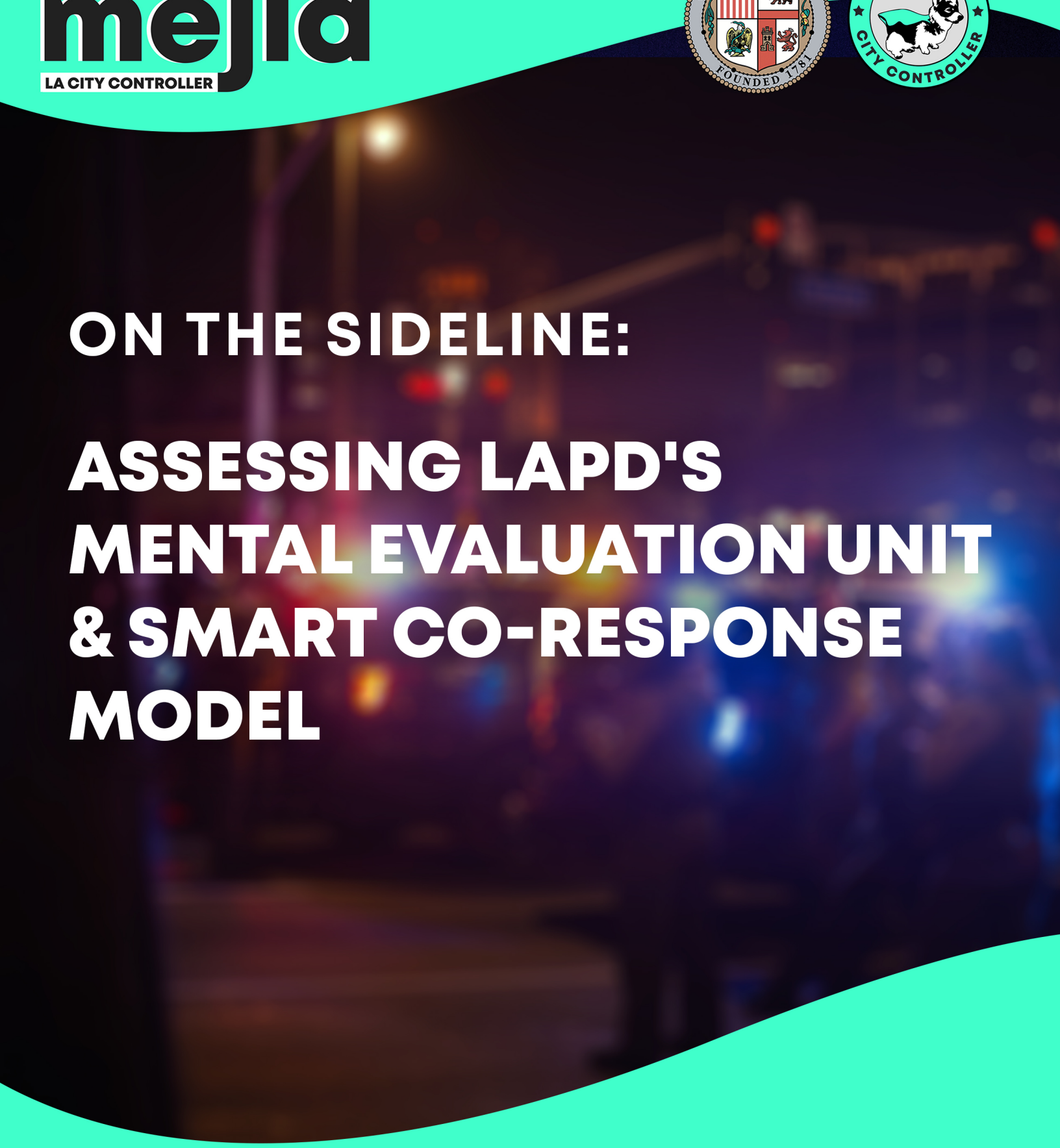
kenneth mejia
LA CITY CONTROLLER



ON THE SIDELINE:

ASSESSING LAPD'S MENTAL EVALUATION UNIT & SMART CO-RESPONSE MODEL

October 27, 2025

Honorable Karen Bass, Mayor
Honorable Hydee Feldstein Soto, City Attorney
Honorable Members of the Los Angeles City Council

Re: The LAPD's Mental Evaluation Unit

Living with a mental health condition or being in the midst of a mental health crisis should not be a death sentence. Yet, people with severe mental illness are involved in about 1 in 4 fatal police encounters, and people exhibiting signs of mental illness make up 20% of the victims shot by on-duty police officers nationwide.

Local statistics show that Los Angeles Police Department (LAPD) officer-involved shooting statistics exceed the national average. In 2021, 41% of LAPD officer-involved shootings involved people experiencing a mental health crisis; 2022: 35%; 2023: 35%; and the LAPD has not disclosed data for 2024. This includes a horrific 48-hour period in January 2023, when LAPD killed three men–all of whom either had a history of mental health conditions or appeared to be in crisis at the time.

In Los Angeles, the LAPD's Mental Evaluation Unit (MEU) is responsible for responding to thousands of mental health calls every year. According to the LAPD, the MEU's mission is to reduce the potential for violence during police contacts involving people experiencing mental illness while simultaneously assessing the mental health services available to assist them.

Our Office conducted an assessment of the LAPD's MEU to evaluate the efficiency and effectiveness of the department's response to mental health-related calls. We covered MEU operations and incident data from 2020-2022 and MEU use of force incidents from 2021-2024; we reviewed applicable legal frameworks, policies, and training protocols; we observed mental health training sessions; and we rode along with MEU units.

We focused our review on the MEU's Systemwide Mental Assessment Response Team (SMART) program, which dispatches with patrol to mental health calls involving people who may be violent, armed, high-risk, or otherwise involved in a critical incident. While the City of Los Angeles has several alternate response programs to address calls of low acuity and to address various mental health related matters, armed LAPD officers are still the City's primary response to high-acuity, high-risk mental health calls. Given that these incidents are most likely to require mental health intervention, crisis response, and de-escalation to avoid devastating outcomes, we sought to understand how the LAPD utilized these two-person

SMART teams of an armed officer and Department of Mental Health (DMH) mental health professional during these calls.

During the course of our assessment, we identified areas of concern regarding the LAPD's policies, the LAPD's utilization of MEU and SMART, and the LAPD's failures to achieve their MEU's stated goals in mental health related calls for service.

KEY FINDINGS

- **LAPD requires a patrol-first, armed response in mental health calls for service**. We found that despite being called a "co-responder" model, the LAPD still designates patrol officers as the primary responders in mental health calls. Although these patrol officers may have not yet received the LAPD's mental health training, it is the patrol officers who determine whether the SMART units, and the mental health professionals on the SMART units, are allowed to engage with the person who is the subject of the call for service. With patrol being the primary decisionmakers on scene, SMART's role as the secondary unit severely limits the mental health professional's ability to intervene and improve outcomes for the person in need or in crisis.

- **The LAPD places an emphasis on 5150 hold applications as the main tool for its mental evaluation practice.** In California, a 5150 hold refers to the initial 72-hour involuntary detention of a person for further mental evaluation. We found that even when SMART is allowed to engage in mental health calls for service, the SMART team's primary role is to secure 5150 holds. In 2023, SMART handled 5,134 calls for service and 86% of the calls that SMART handled resulted in a 5150 involuntary hold.

- **Despite designating MEU / SMART officers as "specially trained," MEU / SMART officers do not receive specialized training.** We found that LAPD's MEU officers (including SMART officers) do not receive specialized training. Instead, MEU officers participate in the department's 36-hour Mental Health Intervention Training (MHIT), which is available to all LAPD personnel and is not a specialized training course.

- **LAPD's "Mental Health Intervention Training" has little impact on use of force and outcomes.** LAPD classifies reportable uses of force as "Categorical Use of Force" (CUOF) and "Non-Categorical Use of Force" (NCUOF). CUOF includes officer-involved shootings, deaths in police custody, any use of force that results in hospitalization, deliberate strikes to the head with a weapon, and neck restraints. NCUOF is an incident where an LAPD officer uses physical force or a control device to achieve a specific goal. We found that instances of use of force remain at similar levels whether MHIT trained officers are involved or not. MHIT-trained officers had a Categorical Use Of Force (CUOF) in 0.15% of mental health-related incidents, compared to non-trained officers who had a CUOF in 0.20% of incidents. MHIT-trained officers had a Non-Categorical Use of Force (NCUOF) in 2.44% of mental health-related incidents versus 2.25% for non-trained officers.

- **Our review of MEU incident reports revealed concerning trends about use of force.**

    - We found that when there was a **use of force,** only less than half or 47% of the incident report narratives **included descriptions of the person's mental health crisis**;

    - We found that when LAPD officers encounter individuals believed to be suffering from a mental health issue, the LAPD is **more likely to document the mental health issue or concerning behavior when the subject's ethnicity is white**. Across all of the case summaries we reviewed, 70% of cases involving white individuals clearly documented the behavior indicating potential mental illness or the mental health crisis leading to MEU's involvement in the case. In contrast, the cases document this information 49% and 50% of the time when the individual is Black or Hispanic, respectively.

    - We found that **only 6% of the incident report narratives describe an attempt to de-escalate by the responding officers and/or SMART**; 61% include no description of an attempt to de-escalate, and 33% describe no need for de-escalation.

- **LAPD fails to track or measure the impact MEU has on incidents and on use of force.** At the time of our assessment, we made requests for any information, including reports, assessments or memoranda previously created that generally measure MEU's impact on LAPD's use of force. We found that the LAPD did not have any of the requested documentation. We also found that SMART's performance is only measured by how quickly SMART relieves patrol officers from on-scene duties. This means the LAPD has not developed a metric tailored to SMART's impact on decreasing use of force, de-escalating situations between patrol and people involved in mental health crises, or how SMART provides help for mental health crises. With the LAPD providing no metrics to show how SMART achieves MEU's goals or contributes to de-escalating high-risk mental health calls for service, there is no way to determine SMART's impact on mitigating use of force and deadly outcomes.

- **LAPD's policies lack in providing robust guidance to patrol response in mental health calls.** We found that while the LAPD's policy acknowledges potential contacts with people with mental illness, it does little to provide specific direction on how to interact with and evaluate people with mental illness. Further, it is LAPD practice to handcuff a person during a mental health call for service–an act that can be escalating and triggering–before the MEU SMART unit conducts its mental health assessment.

- **The City spends $12.8 million in MEU staffing alone for nearly 80 staff.** The Controller team requested MEU budget information including adopted budgets and total funded amounts for personnel, equipment and fleet, contracting and procurement, and training for FY 2022 - 2025. According to the LAPD, they could only provide staffing payroll costs as they do not track the other costs at the program level.

KEY RECOMMENDATIONS

- The LAPD should revise its policies and procedures to allow for SMART teams to take control of certain incidents involving people with mental illness or experiencing a mental health crisis. Specifically, **SMART teams should lead the LAPD response to mental health-related calls which do not involve weapons**.

- The LAPD should **develop a method to track and measure the impact that MEU has on mental health related incidents** where SMART is dispatched and on use of force incidents.
- To ensure that MEU officers are updated on evolving standards and best practices, LAPD should require additional training and refresher courses of all MEU officers.
- The LAPD should **revise its Use of Force, De-Escalation, and Mental Health-related policies** to reflect best practices and ensure LAPD officers are better equipped to handle mental health calls.
- The LAPD should work with the LA County Department of Mental Health to **reevaluate the roles that mental health clinicians play in MEU so that they can be deployed with SMART units in more efficient or expanded ways** to make better use of their clinical skills.
- The City Council and Mayor should continue to **support and fund the Unarmed Model of Crisis Response** pilot through its multi-year plan, and should consider expanding the program if the pilot demonstrates successful alternatives to armed responses for mental health crises.

The City and its people can no longer afford to rely on armed police officers rather than mental health professionals for mental health crisis response. With ever-changing mental health needs within the community, the City of Los Angeles must make a serious investment in alternate and unarmed crisis response. We support the City's efforts to find alternatives to armed response, specifically the investment in the Unarmed Model of Crisis Response pilot. While the City evaluates the benefits of the program and determines its citywide expansion, the LAPD should adopt our recommendations to move the Department closer to best practices and toward mitigating harm caused to some of the most vulnerable members of our community.

Sincerely,

Kenneth Mejia

Kenneth Mejia, CPA

City Controller

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Executive Summary

Following a series of concerns expressed by policymakers, community members, and grief-stricken families about the human cost of having police officers respond to people in mental health crises, the Controller's Office conducted an assessment of **the Los Angeles Police Department's (LAPD) Mental Evaluation Unit (MEU)**.

Our assessment **focused on a program within MEU: the Systemwide Mental Assessment Response Team (SMART) program, which is MEU's co-response model**. SMART units respond to mental illness calls. They typically partner specially trained police officers with Los Angeles County Department of Mental Health (DMH) clinicians.[1]

This assessment involved a comprehensive evaluation of the program through in-depth analysis of legal frameworks, policies, and training protocols. Our evaluation included direct observations of training sessions and ride-alongs with SMART units to assess the real-world application of LAPD policy and training. We cover MEU operations and incident data for the period of 2020-2022 and examine MEU use of force incidents between 2021-2024.

With this report, the community, stakeholders, and the Department will gain better insight into whether MEU is fulfilling its purported mission and whether the City's continued multi-million dollar yearly investment in this unit is warranted. This report offers recommendations designed to improve mental health crisis response in our City and prevent tragic outcomes for some of the most vulnerable members of our community.

I. Background

Mental illness and mental health conditions affect millions of Americans, including many Angelenos. The U.S. Centers for Disease Control and Prevention (CDC) estimates that nearly one in four American adults live with some type of mental condition. Nearly one in twenty live with a serious mental health condition such as schizophrenia, bipolar disorder, or major depression. Serious mental health conditions can interfere with a person's ability to live a normal life and carry out life's activities. Several risk factors contribute to the likelihood of a person experiencing poor mental health, including lack of access to housing, healthcare, and education, social isolation, adverse childhood experiences, and use of alcohol or drugs.

Police departments across the country are grappling with the nation's mental health crisis. Police officers are often called upon when people are experiencing mental health crises, which creates complicated situations that officers may not be

[1] During some shifts when DMH clinicians are unavailable, LAPD pairs two MEU officers instead.

equipped to manage. The unhoused population in Los Angeles adds an additional, complex layer to police calls for service. There are around 43,000 sheltered and unsheltered unhoused people within the City of Los Angeles. Around 25% report having a serious mental illness, and 26% report having a substance abuse disorder. Police officers frequently come into contact with unhoused people during patrols and when responding to calls.

The LAPD's mental health response unit is called the Mental Evaluation Unit (MEU). The primary role of MEU is to respond to calls for service that involve individuals exhibiting signs of mental illness and individuals that appear to be experiencing a mental health crisis. MEU pairs LAPD officers with LA County mental health clinicians to establish responder teams that consist of one law enforcement officer and mental health specialist. MEU teams respond to 911 calls and requests for support from patrol officers in the field that involve mental health crises or illness. In addition to emergency response, MEU provides long term case management to individuals with a history of violent or dangerous activity caused by a mental health disorder.

The LAPD must be prepared to respond to situations where people are in crisis or experiencing the symptoms of serious mental illness. The Office of the Controller conducted an independent evaluation of the LAPD's MEU in order to assess its effectiveness, its role within the community, and its ability to prevent arrests and uses of force when officers interact with members of the public with mental health needs. Specifically, the Office of the Controller sought to evaluate:

- The mission and role of MEU;
- MEU policies and procedures for responding to incidents;
- MEU training programs;
- MEU's ability to de-escalate and reduce the likelihood of arrest, uses of force, or forced hospitalization;
- Outcomes for individuals believed to have mental health needs that are subject to interactions with officers; and
- MEU performance goals and performance tracking.

Individuals with mental illness are particularly vulnerable during crisis situations. Given the mental health crisis facing our communities, the LAPD must ensure it connects people with mental health issues with services and diverts them away from the criminal justice system and forced hospitalization whenever possible in order to create better outcomes for Angelenos in need.

Law Enforcement Response Models to Mental Health Crises

For decades, law enforcement agencies and mental health service providers throughout the United States have collaborated to develop responses to mental

health crises. Two popular response models have been developed: the Crisis Intervention Team (CIT) or "Memphis Model" and the Co-Responder Team models.

Crisis Intervention Team (CIT) Model, a.k.a. "The Memphis Model"

The Memphis Model has been heralded as the "best practice" model[2] for law enforcement because it is a comprehensive, integrated approach to handling mental health crises. The Memphis Model trains patrol officers to become specialized CIT officers who perform patrol duties and whose crisis intervention training allows them to immediately dispatch to mental health crisis scenes. *Id*. These CIT officers are spread across the city on all shifts giving the community access to officers who have the training, technical skills, and empathy to resolve incidents involving mental health crises.[3]

Co-Responder Team Models

The Co-Responder Team model is a collaborative approach where police officers work with mental health professionals to respond to incidents involving people in mental health crises. The goal of this model is to provide the person in crisis with access to care and resources instead of subjecting them to arrest and criminalization of their mental health condition. A hallmark of the co-responder model is that the police and mental health professionals respond to calls together so the mental health professional's expertise in de-escalation and crisis intervention can help address the person's mental health needs adequately.

The LAPD Mental Evaluation Unit

The LAPD established MEU in 1986. The unit's initial responsibility was to develop, maintain, and improve LAPD systems for recognizing mental health disorders and developmental disabilities, and developing systems for interventions. In the early 1990s, the LAPD and the LA County Department of Mental health (LACDMH, or DMH) established the Systemwide Mental Assessment Response Team (SMART) pilot program. Under the SMART pilot program, teams consisting of a law enforcement officer and a mental health clinician would respond to incidents involving people exhibiting signs of mental illness.

MEU has gradually expanded since the 1990s and now manages several programs related to the LAPD's response to mental health incidents, mental health initiatives and partnerships, and training. MEU is part of the department's Detective Support and Vice Division of the Detective Bureau. The stated mission of MEU is "*to reduce the potential for violence during police contacts that involve people who suffer from*

[2] Crisis Intervention Teams (CIT): Considerations for Knowledge Transfer (Thompson & Borum, 2006) available at: https://digitalcommons.usf.edu/cgi/viewcontent.cgi?article=1547&context=mhlp_facpub.
[3] The University of Memphis CIT Center, http://www.cit.memphis.edu/overview.php

mental health disorder and to simultaneously assess the mental health services available to assist them." MEU has several goals, including but not limited to:

- Preventing the unnecessary incarceration or hospitalization of mentally ill individuals
- Providing alternate care in the least restrictive environment possible
- Preventing the duplication of mental health services
- Facilitating the quick return of LAPD patrol units to patrol activities

MEU operates four programs that are central to its mental health incident response, assessment, and training operations. The programs include SMART, which this assessment focuses on; the Case Assessment and Management Program (CAMP); the Triage Desk; and the Administrative Training Detail.

Systemwide Mental Assessment Response Team (SMART)

SMART teams conduct preliminary assessments of individuals that exhibit signs of mental illness when they come into contact with public safety officers. Typically consisting of a law enforcement officer and a mental health clinician, the teams respond to LAPD dispatcher calls for service that may involve a mental health condition, as well as requests for assistance from patrol officers in need of specialized mental health assistance. SMART operates 24 hours a day, seven days a week.

Case Assessment Management Program (CAMP)

CAMP pairs LAPD investigators with clinicians to identify and provide case management services to individuals with a history of violent criminal activity caused by a mental health disorder, and individuals with mental health disorders that frequently interact with law enforcement officers. CAMP teams follow up with individuals to refer them to mental health and other services, coordinate client hospitalization when required, and ensure the seizure of firearms if possession by a client is prohibited.

Triage Desk

The MEU Triage Desk receives calls from LAPD patrol officers and triages department contacts with people suffering from a mental health condition. The desk assesses the conditions reported by officers and determines whether to dispatch SMART, and provides guidance to patrol officers regarding appropriate actions in the event SMART is not dispatched to the incident, or SMART is unable to

	respond. Triage Desk staff include LAPD personnel and mental health specialists.
Administrative Training Detail	*The Administrative Training Detail develops and delivers mental health related training for LAPD staff, including the Mental Health Intervention Training (MHIT) course, which all new officers complete, as well as an MHIT refresher course for officers that have already completed the full training course. The detail also supports LAPD policy development and research on matters related to mental health, publishes guides and training materials for LAPD staff, and manages data and intradepartmental coordination initiatives.*

The LAPD describes MEU's SMART as a model co-responder program that is responsive to the growing mental health needs of the population. LAPD officials believe that expanding MEU and increasing the number of SMART team contacts with subjects exhibiting signs of mental illness will both contribute to better outcomes for subjects in need of mental health treatment, and reduce the likelihood of uses of force against subjects.

The City's MEU Investment is Substantial

The department's current investment in MEU is substantial. LAPD reports that the staffing costs alone for MEU were about $12.8 million in FY 2023-24 for 79 sworn personnel.

MEU's total costs of operation are actually higher than $12.8 million because the cost information that LAPD provided to the Controller's Office did not include expenses for spending categories such as:

- overhead,
- equipment and fleet,
- contracting and procurement, and
- training.

LAPD explained that its department budget tracking stops at the division level for expenses and program level for salaries.

In addition to the City's MEU investment, it is important to highlight the County's allocation of resources and the related costs of providing the mental health clinicians that work to support the MEU program. The County Department of Mental

Health provides personnel for MEU at no cost to the City, based on the memorandum of agreement with LAPD. The County's costs are not included in LAPD's cost estimate.

People of Color and the Unhoused Account for Large Shares of Incidents Involving a Mental Health Issue

Certain demographic groups are much more likely than others to be subject to interactions with LAPD that are recorded by MEU as mental health incidents. Of the just over 80,000 incidents in the MEU database recorded from 2020 through 2022, well over half of LAPD contacts with people believed to be experiencing a mental health crisis or suffering from mental illness were Black or Hispanic.

- 27,519 (34%) of interactions involved Hispanic individuals. People of Hispanic or Latino descent account for 48% of the population in the City.
- 23,377 (29%) of interactions involved Black individuals. People of Black or African American descent account for 9% of the population in the City.
- 23,344 (29%) of interactions involved white individuals. People who are white make up 41% of the population in the City.
- 6,216 (8%) of interactions involved individuals from other groups.

Homelessness is also a factor with regard to LAPD contacts involving mental health disorders or events. Of the approximately 80,000 contacts recorded by MEU, a third (33%) involved people believed to be experiencing homelessness. The Los Angeles Homeless Services Authority reported that in 2024 there were just over 45,252 unhoused people in the City of Los Angeles, 29,275 (65%) of whom were unsheltered. Black Angelenos account for 35% of the unhoused population despite accounting for only 9% of the City's population.

Recent Incidents Have Put a Spotlight on MEU

Between January 2 and January 3, 2023, during a 48-hour span, LAPD killed three men: Takar Smith[4], Oscar Leon Sanchez, and Keenan Anderson. According to public records, each of the men either had a demonstrated history of mental health conditions or appeared to be in crisis at the time of their encounters with LAPD officers. **The killings led to public outcry and questions about the way LAPD responds to people in possible mental health crises.**

[4] In November 2023, the LAPD Board of Police Commissioners found Mr. Smith's killing was "not justified" as the officers were not facing an imminent threat when they used deadly force against someone in the throes of a mental health crisis. According to reports, Mr. Smith's wife had called LAPD and informed him of his schizophrenia and the fact that he had not been taking his medication; she pleaded with them to not kill her husband.

- Mayor Karen Bass stated she was ". . . deeply troubled that mental health experts were not called in, even when there was a documented history of past mental health crises."
- Councilmember Eunisses Hernandez called for a care-first approach to mental health crises, saying that "we can no longer look away from this crisis in our policing system — it's long past time that we establish **permanent, life-affirming, care-first responses to mental health crises** that truly uplift the public's safety and address the root causes of harm."[5]
- Current Council President Marqueece Harris-Dawson issued a call to action to then-Council President Paul Krekorian and City council members, stating "The families of Keenan Anderson, Oscar Leon, and Takar Smith deserved full, long lives together and access to **appropriate crisis response**. But since that has been taken away, they deserve justice."[6]
- Councilmember Bob Blumenfield stated, "My heart breaks for the families of Keenan Anderson, Oscar Leon and Takar Smith. More **unarmed, non-violent responder teams** are needed to respond to mental health crises and a City department is needed to support the expansion of crisis intervention programs."[7]
- Councilmember Monica Rodriguez stated, "The deaths of Keenan Anderson, Oscar Leon Sanchez, and Takar Smith underscore that our work in reforming procedures, demanding accountability, and expanding deployment of **unarmed response** where appropriate is far from over."[8]
- Councilmember Heather Hutt urged codification of unarmed alternatives, stating, "Tyre Nichols' tragic death and too many others have demonstrated our current law enforcement systems across the nation are not serving the public benefit. Condolences are not enough. We need to **codify policies-including unarmed alternatives to policing-that prevent abuse of power.**"[9]

LAPD's then-Chief of Police, Michel Moore, indicated that he was "deeply concerned" about each of the killings and expressed dissatisfaction that MEU was not deployed to the Takar Smith incident. "I'm being very clear about my dissatisfaction with what I

[5] @EunissesH. *Twitter*, 12 Jan. 2023, 9:11 a.m., https://x.com/EunissesH/status/1613584504932925440
[6] @mhdcd8. *Twitter*, 11 Jan. 2023, 6:02 p.m., https://twitter.com/mhdcd8/status/1613355725853720582
[7] @BobBlumenfield. *Twitter*, 13 Jan. 2023, 3:40 p.m., https://x.com/BobBlumenfield/status/1614044770510442504
[8] @MRodCD7. *Twitter*, 17 Jan. 2023, 4:26 p.m., https://x.com/MRodCD7/status/1615505851573506048
[9] @CW_HeatherHutt. *Twitter*, 27 Jan. 2023, 7:43 p.m., https://x.com/CW_HeatherHutt/status/1619179243602341891

believe were points of information regarding [Smith's] mental health… that… resources were not called upon…."[10]

Chief Moore's comments suggested what many had believed to be true–that LAPD's SMART would be deployed and utilized in these types of instances. Just two years prior, Moore had transitioned SMART units to a co-responder team model. According to Chief Moore, one key function of the co-responder model is that it "allows SMART units to respond simultaneously with patrol officers to calls where a mental health crisis is suspected"[11] which "often helps to de-escalate an incident and reduce the amount of trauma a subject may suffer." *Id*.

However, the co-responder policy also makes clear that "for all radio calls, **a patrol unit will be assigned as the primary unit, and SMART will be dispatched as a secondary or support element**.[12] Even in this new co-response model, with a "simultaneous" patrol and SMART unit response, LAPD policy does not allow the SMART unit to take the lead or primary responsibility for the incident.

LAPD policy and practice creates an immediate, and sometimes impenetrable, barrier between the SMART units and the person in crisis given that SMART's engagement with the person in crisis is dictated by the patrol officer. LAPD policy states that "If both units arrive together, the patrol officers *may allow* the SMART officer to assume the contact role to de-escalate a situation" but "…when the SMART unit arrives on scene, the DMH clinician will stay back with the police vehicle or another tactically secure location as directed by the SMART officer. After the situation is stabilized, the SMART officer will introduce the DMH clinician into the call, and the SMART unit will handle the mental health evaluation."[13] It is that period of purported stabilization that often leads to officers using force and to fatal outcomes.

The Los Angeles Police Protective League (LAPPL), which is the labor union representing the interests of LAPD officers, also responded to the public outcry regarding the killings of Mr. Smith, Mr. Sanchez, and Mr. Anderson. The LAPPL published a letter detailing the LAPPL's perceptions of MEU, including that (1) SMART officers are not first responders; instead, SMART is a secondary, supportive unit to patrol; (2) SMART would never have taken a primary role in any of the three incidents, and (3) LAPD did not consider any of the incidents, all of which involved men with documented mental health illnesses, to be "mental health" calls for service.[14]

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[10] Garrova, Robert. "Mayor And City Council Members Express Concerns After LAPD Releases Footage Of Fatal Shootings." *LAist*, 11 January 2023, https://laist.com/news/criminal-justice/chief-moore-releases-footage-from-two-fatal-lapd-shootings-and-questions-some-officers-actions

[11] LAPD Notice 8.2, January 14, 2021

[12] *Id*. (emphasis added).

[13] *Id.*

[14] LAPPL Letter to City Council - facts and myths of MEU - January 18, 2023

The varying perspectives held by community leaders, policymakers, government officials, law enforcement, and the general public about when and how MEU and SMART are utilized highlights a significant lack of clarity about what MEU and SMART are intended to accomplish.

II. LAPD Policies & Procedures Are Insufficient to Protect Subjects in Crisis

According to the International Association of Chiefs of Police (IACP), police department policies are crucial for providing a clear framework for officers to follow; and well-defined policies can guide officers in handling various situations ethically and legally, thus protecting both the community and the officers themselves.

While MEU is the LAPD's unit focused on mental health matters, MEU is but one part of the larger LAPD ecosystem. Thus, it was imperative for us to review the LAPD policies that officers would likely rely on when encountering a person in a mental health crisis or who is perceived to have a mental health condition.

The LAPD's primary guideline for police officer conduct is the multi-volume Department Manual ("LAPD Manual"), which contains current policies, procedures, and rules. Our analysis focused on policies related to mental illness, use of force, and de-escalation. Where in existence, and relevant, we also analyzed related MEU policies.

Through our review we found that the LAPD's policies fall short on aligning with best practices for use of force, de-escalation, and mental-health related encounters. We found that LAPD's de-escalation and use of force policies satisfied only the bare minimum of legal requirements but were woefully narrow in comparison to comprehensive policies of peer police departments. We also found that some mental health related policies in place during the assessment period seemed to pose a barrier to effective crisis response.

LAPD Mental Health-Related Policies

A key concern when police officers respond to mental health calls is that routine police behavior can unnecessarily escalate an incident by triggering the person in crisis. Officers encounter people of diverse populations, including people who may be living with a mental health issue like a mental illness (e.g., depression, anxiety disorders, schizophrenia), a mental disorder (e.g., developmental and personality disorders), a behavioral disability (e.g., autism disorder spectrum) or other unique conditions. It is critical that officers entrusted to respond to mental health calls have a clear understanding of mental health issues, the ability to recognize the presence

of mental health issues, and the tools to adapt their conduct to the presence of a mental health concern during calls for service.

As part of our assessment, we reviewed the LAPD Manual to identify policies that provide guidance for interacting with people living with mental illness or appearing to be in a mental health crisis.

During the scope period of our assessment, the LAPD Manual's latest revision had been in 2020. After the LAPD found deficiencies with the LAPD's investigation and resolution of incidents involving people with mental illness, the LAPD sought to "provide Department personnel with specific direction on interacting with, evaluating, taking custody of, and remanding persons with a mental illness to treatment facilities."[15]

While the LAPD updated various sections of the LAPD Manual to achieve those goals, we focused on the following policies which guide initial contact with people living with mental illness: § 240.30 Contact with Persons Suffering from a Mental Illness; § 260.05 Contact with Persons Suffering from a Mental Illness; § 217.36 Handcuffing People with Mental Illness and the accompanying MEU Guidebook § 2.5.6.2 SMART Unit Response and Call Management.

LAPD's Policy for Contact with People with Mental Illness & the Considerations Officers Should Take When They Suspect A Person Has a Mental Illness

The LAPD has two sections related to contact with people with mental illness. Based on LAPD Manual organization, the first section is a general statement about contact with people who suffer from a mental illness, and the second section is intended to provide detailed rules and procedures to help officers execute their line duties in furtherance of police objectives.

In Volume I, § 240.30, *Contact with Persons Suffering from Mental Illness*, the LAPD states the goal of providing a humane, cooperative, compassionate and effective law enforcement response to people who have a mental illness. The LAPD does not define mental illness so it is unclear whether the term is intended to cover mental disorders, mental illnesses, behavioral disabilities or any perceived mental health condition or mental health crisis.

[15] Special Order 30 (2020).

> **240.30 CONTACT WITH PERSONS SUFFERING FROM A MENTAL ILLNESS.** In police contacts with persons suffering from a mental illness, the goal of the Department is to provide a humane, cooperative, compassionate and effective law enforcement response to persons within our community who have a mental illness. The Department seeks to reduce the potential for violence during police contacts involving people suffering from mental illness while simultaneously assessing the mental health services available to assist. This requires a commitment to problem solving, partnership, and supporting a coordinated effort from law enforcement, mental health services and the greater community of Los Angeles.

In Volume IV, § 260.05, *A Person Suspected of Suffering from a Mental Illness - Considerations*, the LAPD Manual provides a set of four factors an officer should consider when the officer suspects someone has a mental illness. Of those considerations, the first is a subjective assessment based on an officer's observations and the rest are statements provided to the officer either by the person, a credible third party or from the person's records.

> **260.05 A PERSON SUSPECTED OF SUFFERING FROM A MENTAL ILLNESS – CONSIDERATIONS.** In formulating the opinion that a person may be suffering from a mental illness, officers shall consider the following:
>
> - The officer's observations, based on his or her training and experience;
> - A self-reported condition by the subject, i.e., diagnosis and/or medication;
> - Statements from a credible third party, i.e., family member, caregiver, mental health professional, and/or citizen; or,
> - History of law enforcement contacts, mental health evaluations or hospitalizations, e.g., Mental Evaluation Report via the Mental Evaluation Unit.

We found that:

- While LAPD's policy acknowledges potential contacts with people with mental illness, it does little to provide specific direction on how to interact with and evaluate people with mental illness.

The LAPD's policy[16] is currently a vague statement, lacking definition and clear guidance for officer conduct. As written, the policy places the onus on the officers' "training and experience" to guide their assessments. However, because patrol officers can include a wide range of experience, from the most recent police academy graduates to veteran officers, "training and experience" can lead to inconsistent and inaccurate assessments of a person's mental health. Additionally, because not every LAPD officer has participated in the LAPD's Mental Health Intervention Training, there will inevitably be differing levels of mental health knowledge among officers. Similarly, "observations" alone without policy guidance on the types of signs, cues, or behaviors that might indicate the presence of a mental health concern can lead to broad interpretation and inaccurate

[16] LAPD Manual Vol. 4, § 260

assessments by officers of varying levels of training, experience or mental health awareness.

The LAPD's policy, its officers, and the general public would benefit from the policy being updated to incorporate clear criteria and detailed descriptions that officers can use while identifying the presence of a mental health concern. The Memphis Police Department has a model example of a comprehensive policy for officer encounters with people with mental health issues.[17]

The Memphis Police Department devotes an entire section of its policy manual to the recognition of mental illness and outlines thoughtful processes that officers should employ when interacting with people who might be living with a mental health issue.

- First, the Memphis Police Department's policy provides a detailed list of signs or symptoms which may indicate presence of mental illnesses, including those signs or symptoms that could be interpreted as non-compliance (e.g., loss of memory or disorientation, delusions, hallucinations, or incoherence).

- Second, the policy provides a non-exhaustive list of de-escalation techniques to consider applying when the officer recognizes that the person may have a mental health issue. It also clearly states that in cases where a person is actively violent, the officer may request assistance from a CIT Officer (patrol officers with specialized mental health training to better respond to mental disturbance events).

- Finally, the policy cautions against officers engaging in triggering behaviors (including cornering the person, arguing, trying to gain compliance based on the assumption the person is "as reasonable about things as you are", and other behaviors that can be interpreted as aggressive). *Id*.

Similar to the Memphis Model, the IACP also provides a model policy for "Responding to Persons Experiencing a Mental Health Crisis" that distinguishes between a mental health crisis and mental illness, provides for considerations of a person in crisis, includes procedures for recognizing atypical behavior, and offers guidance on assessing risk and responding to a person in crisis through a litany of de-escalation techniques.[18]

In comparison to the model policies, the LAPD's current mental health related policies fail to provide officers with clear guidance for officer contacts with people with

[17] Memphis Police Department, Manual, Chapter IX, Section 1: Dealing With Mentally Ill/Crisis Intervention Team, https://www.memphispolice.org/wp-content/uploads/2023/06/2023_MPD_POLICY_AND_PROCEDURES_FULL_6-27-2023.pdf

[18] International Association of Chiefs of Police, Law Enforcement Policy Center, "Responding to Persons Experiencing a Mental Health Crisis" (August 2018)

mental illness. To better promote the safety of the public and officers, and to ensure officers avoid escalating or mishandling mental health related incidents, the LAPD should consider revising its current policy. This revision should include adding specific factors, signs or indicators that the officer may observe and that may indicate the presence of a mental health concern. It should also include specific de-escalation techniques to employ in mental health related calls so that the officers can reduce the potential for escalation of violence during the encounter. With these revisions, the LAPD would better equip officers to recognize and assess whether a person has a mental health related concern and to adapt their behavior accordingly. This is of particular importance given that LAPD patrol officers (of varying levels of training and experience) will be the ones dictating the initial crisis response.

- ➔ **Recommendation 1**: We recommend that LAPD revise its manual section *A Person Suspected of Suffering from A Mental Illness – Considerations* to incorporate more detailed guidelines addressing specific indicators of mental health related concerns, providing de-escalation techniques to employ in mental health related calls, and promoting a higher standard of accountability for officers.

Handcuffing People with Mental Illness

Best practices require reducing use of restraints during a crisis response because the use of physical restraints can be harmful to the person, counterproductive to the officer's goals, and may increase the likelihood of resistance.[19] The very act of placing someone in handcuffs can be an escalating action by the officer. Therefore, crisis intervention models emphasize the importance of non-coercive strategies such as verbal de-escalation, active listening, and empathetic engagement to help people in crisis feel heard and understood. In its best practice guide for transforming community responses to mental health crises, CIT International cautions against the use of restraints when there is not a true need for them due to the traumatizing and stigmatizing effect handcuffing can have on a person in crisis.

Our team reviewed LAPD and MEU policies to identify when and how LAPD utilizes physical restraints during mental health calls. § 217.36, *Handcuffing Persons with a Mental Illness* and MEU's 2.5.6.2 procedure for SMART on-scene call management are the governing policies for the use of physical restraints in these scenarios.

[19] CIT International, Crisis Intervention Team (CIT) Programs: A Best Practice Guide for Transforming Community Responses to Mental Health Crises, (2019), https://www.citinternational.org/bestpracticeguide

217.36 HANDCUFFING PERSONS WITH A MENTAL ILLNESS. When taking a person with a mental illness taken into custody, Department personnel shall evaluate the totality of the circumstances to facilitate taking custody of the individual without unnecessarily escalating the contact.

When the age or physical condition (i.e., height, weight, strength, apparent intoxication or influence of an illicit substance) of a person with a mental illness is such that the personal safety of the individual or the officer clearly will not be jeopardized, the use of handcuffs shall not be required, but shall be at the discretion of the officer.

The decision as to the timing and use of handcuffs shall be based in part on the viability of de-escalation factors such as time and distance, to minimize the likelihood that the application of the restraints unduly results in an aggressive/combative response from the person with a mental illness.

When handcuffing a person with a mental illness, officers shall use only official handcuffs and ensure that the handcuffs are double locked. Temporary plastic restraints shall not be used to restrain a person with a mental illness, nor may such restraints be furnished to private persons by Department personnel for use in restraining a person with a mental illness.

2.5.6.2. SMART Unit Response and Call Management

- On scene call management
  - The SMART officer shall ensure the scene is safe to conduct the mental health interview.
  - The subject to be interviewed shall be handcuffed (LAPD Manual 4/217.36).

We found that LAPD's policy mandates handcuffing in almost all scenarios, with LAPD contending that "the principle reason for handcuffing is to maintain control of an individual and to minimize the possibility of a situation escalating to a point that would necessitate using a higher level of force or restraint."

As written, the policy leaves handcuffing to the discretion of the officer and directs officers to evaluate the totality of the circumstances prior to using handcuffs. However, the policy also states that handcuffs shall not be required in scenarios when the person's age or physical condition appears to indicate they will not pose a threat to the person or officer's safety.[20] This exception leaves ample room for interpretation that officers must handcuff in all other scenarios. This interpretation is further supported by MEU's own policy for SMART Unit Response and Call Management, which cites to LAPD's *Handcuffing Persons with Mental Illness* policy to support mandatory handcuffing of people during mental health interviews: "The subject to be interviewed shall be handcuffed (LAPD Manual 4/217.36)."[21]

[20] LAPD Manual, § 217.36; *see also* LAPD Training Bulletin, Volume LI, Issue 2 - Handcuffing, https://lapdonlinestrgeacc.blob.core.usgovcloudapi.net/lapdonlinemedia/Handcuffing-Policy.pdf

[21] MEU Operations Guide, § 2.5.6.2. SMART Unit Response and Call Management

We found that:

- It is LAPD practice to handcuff a person with a mental illness before the MEU SMART unit conducts its mental health assessment.
- It is also MEU policy to always handcuff people in mental health crises.

While LAPD justifies this policy as a means to minimize escalation, research shows the act of using physical restraints like handcuffs is often an escalating act by officers. The LAPD's current policy fails to account for the physical and psychological risks restraints can pose in mental health calls.

➔ **Recommendation 2:** We recommend the LAPD revise its policy for *Handcuffing Persons with a Mental Illness* and *§ 2.5.6.2. SMART Unit Response and Call Management* to eliminate the handcuffing of people with a mental illness (or experiencing a mental health crisis) if the individual is not alleged to have committed a crime and is not exhibiting violent behavior.

LAPD Use of Force-Related Policies

Use of Force

Police officers have been entrusted with the lives of each member of the community they are intended to serve. Inherent in that trust is the expectation that officers will act with reverence for human life prior to using any degree of force. The law uses the term use of force (UOF) to describe the physical or mechanical force officers can inflict on people to gain control or compliance. This force can include anything from officers using hand control maneuvers to officers aiming and shooting weapons of varying lethality (e.g., "less-lethal" 40mm projectile launchers or standard firearms).

In California, use of force is governed by United States Supreme Court decisions and state-specific laws that enshrine the principles of reasonableness, proportionality, and regard for human life. In recent years, California has made an effort to focus on de-escalation as a critical component of policing and as a means to help reduce fatal outcomes. Through Senate Bill 230[22] (2019) and Assembly Bill 392[23] (2019), California has reinforced the need for law enforcement officers to use de-escalation where feasible and redefined the circumstances under which a killing by a police officer is deemed "justifiable."

[22] Senate Bill 230 (2019), available at: https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200SB230
[23] Assembly Bill 392 (2019), available at: https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200AB392

LAPD's Use of Force Policies

The LAPD's philosophy regarding policy is that "Department policy is not a statement of what must be done in a particular situation but is instead a statement of guiding principles which should be followed in activities which are directed towards the LAPD's objectives."[24] At the time of this assessment, the LAPD Department Manual contained over 1600 pages of content broken out into a series of volumes covering topics like Policy (Volume 1), Management Rules and Procedures (Volume 3), and Clerical Operations (Volume 5). According to the LAPD, its Use of Force policy is expressed in the Department Manual but it may be reiterated in tactics directives, which can contain procedure or insight into use of force and tactics issues.[25]

The LAPD's Use of Force policy, Volume 1, § 556 "Use of Force", includes policies governing using force, types of force (deadly and non-deadly), force devices (firearms, batons, OC spray), and use of force reporting and investigations. Our review focused on the policies that provide guidance to officers about using force, de-escalation, and reporting use of force.

Use of Force & Mental Health Crises

National data collected of every person shot by an on-duty police officer from January 1, 2015 through December 31, 2024 shows that 20% of the victims exhibited signs of mental illness. In 2015, approximately one-in-four fatal police encounters involved a person with severe mental illness.

Compared to the national data, the number is significantly higher for the LAPD. In 2021, 41% of the officer-involved shootings involved people experiencing a mental health crisis. In 2022 and 2023, 35% of the LAPD officer-involved shootings involved people experiencing a mental health crisis.

Given LAPD's decision to place armed patrol officers at the forefront of mental health calls, we evaluated the use of force policy and analyzed how that policy contemplates mental health concerns.

Deficiencies in Use of Force Policy

Best practices[26] across leading agencies include the dynamic realities presented in encounters with people who have a mental health condition or appear to be in a mental health crisis. In comparison, LAPD's UOF policy, Volume I, §556 makes cursory

[24] LAPD Policy, Volume 1, § 010.
[25] LAPD Policy, Volume 1, § 240.12
[26] *See* Memphis Model Policy, *see also* IACP Model Policy

mention of "vulnerable populations," including "children, elderly persons, people who are pregnant, and people with physical, mental, and developmental disabilities"[27].

Per LAPD policy, SMART teams are not allowed to engage during mental health related calls until patrol has secured the scene and detained the individual in crisis. As is evidenced by the MEU Incident Reports we reviewed, this leaves little room for SMART to impact use of force or de-escalation.

Given that people with serious mental illness are over ten times as likely to experience use of force in interactions with police than those without serious mental illness, the LAPD should also include dynamic mental health considerations for officers responding to calls involving people with mental illness or exhibiting mental health distress.

While no policy can anticipate every conceivable situation or circumstance that an officer may face, the data shows that LAPD officers are highly likely to encounter people in mental health crisis or with a mental health condition. The data also shows that those encounters turn deadly far too often. With LAPD's policy of having patrol officers as the leads during mental health calls, the responsibility for assessing the presence of mental illness or mental health conditions and adapting to the circumstances presented by mental illness or mental health crisis falls on those patrol officers. LAPD policies must equip its officers to effectively deploy appropriate de-escalation techniques and mitigate unnecessary use of force.

- ➔ **Recommendation 3**: The LAPD should revise its use of force policy to include dynamic mental health considerations for officers responding to calls involving people with mental illness or exhibiting mental health distress.

De-Escalation

De-escalation has been defined as "taking action or communicating verbally or non-verbally during a potential force encounter in an attempt to stabilize the situation and reduce the immediacy of the threat so that more time, options, and resources can be called upon to resolve the situation without the use of force or with a reduction in the force necessary."[28] The concept of de-escalation thus refers to strategies and techniques that officers can use to gain voluntary compliance without officers resorting to using force.

Best practices among leading law enforcement agencies that emphasize de-escalation practice include stating clear de-escalation methods, techniques, and

[27] LAPD Manual, Volume 1, §556.10

[28] IACP, National Consensus Policy on Use of Force (2020), available at: https://www.theiacp.org/sites/default/files/2020-07/National_Consensus_Policy_On_Use_Of_Force%2007102020%20v3.pdf

tactics in their written policies. Whether they are promulgated through standalone policies like in Oklahoma City and San Diego or contained within the greater use of force policy, these leading departments offer clear, comprehensive de-escalation direction to guide officer conduct and ensure public and officer safety. In addition to general de-escalation guidance, many also provide de-escalation techniques for encounters with people experiencing mental illness or in crisis.

By law, California law enforcement agencies are required to have a standard use of force policy that includes "a requirement that officers utilize de-escalation techniques, crisis intervention tactics, and other alternatives to force when feasible."[29] California law also requires training on "de-escalation techniques to effectively, safely, and respectfully interact with people with disabilities or behavioral issues" and on "mental health and policing, including bias and stigma."

LAPD's Use of Force Policy: De-Escalation

In April 2017, the LAPD incorporated the concept of de-escalation in the preamble to the Use of Force policy.[30] [31] The LAPD's "Use of De-escalation Techniques" policy states that "whenever feasible, officers shall use techniques and tools consistent with department de-escalation training" to reduce the intensity of police encounters with the general public and mitigate the need to use higher levels of force.

POLICY.

Use of De-Escalation Techniques. It is the policy of this Department that, whenever feasible, officers shall use techniques and tools consistent with department de-escalation training to reduce the intensity of any encounter with a suspect and enable an officer to have additional options to mitigate the need to use a higher level of force while maintaining control of the situation.

The Department's guiding principle when using force shall be reverence for human life. Officers shall attempt to control an incident by using time, distance, communications, and available resources in an effort to de-escalate the situation, whenever it is safe, feasible, and reasonable to do so. As stated below, when warranted, Department personnel may use objectively reasonable force to carry out their duties. Officers may use deadly force only when they reasonably believe, based on the totality of circumstances, that such force is necessary in defense of human life. Officers who use unreasonable force degrade the confidence of the community we serve, expose fellow officers to physical hazards, violate the law and rights of individuals upon whom unreasonable force or unnecessary deadly force is used, and subject the Department and themselves to potential civil and criminal liability. Conversely, officers who fail to use force when warranted may endanger themselves, the community and fellow officers.

While the LAPD's de-escalation policy meets the bare minimum legal requirement for requiring de-escalation when feasible, the LAPD is far behind leading police

[29] *See* SB 230.

[30] LAPD, 2022 UOF Year-End Review (2023), p. 41, https://lapdonlinestrgeacc.blob.core.usgovcloudapi.net/lapdonlinemedia/2022-Year-End-Review.pdf

[31] LAPD Policy, Volume 1, § 556.10

departments that have created clear and comprehensive de-escalation policies that guide officer decision-making to ensure the preservation of human life.

For example, the Oklahoma City Police Department positions de-escalation as an action that improves public and officer safety, reduces injury, and improves community relations. The Department expounds on those principles in a policy[32] that:

- Provides for de-escalation whenever possible;
- Articulates conditions the officer should consider when dealing with a non-compliant person;
- Explains the various de-escalation options available to officers, including:
    - calling for more resources,
    - utilizing available barriers,
    - communicating from a safe position,
    - communicating clear directions; and
    - allowing time to comply;
- Describes factors that officers should consider when determining which de-escalation techniques to utilize in resolving an incident; and
- Concludes with a reminder that each officer has a responsibility to attempt de-escalation efforts.

In California, the San Diego Police Department has also developed a standalone de-escalation procedure that establishes guidelines on the use of de-escalation techniques, crisis intervention tactics, and other alternatives to force.[33] The San Diego Police department's impetus for developing the standalone de-escalation procedure was to reduce use of force, gain voluntary compliance, and minimize fatal outcomes.

We found that:

- The LAPD's de-escalation policy lacks specificity and is too limited to provide clear guidance for real world situations officers will encounter. It does not provide specific guidelines or techniques, including when and how officers should apply de-escalation practices.

During the course of our assessment, LAPD provided the Controller's Office with training materials, including Tactics Directive No. 16,[34] which aims to define tactical de-escalation techniques. This Directive identifies six de-escalation techniques

[32] Oklahoma City Police Department Manual, Section 4-305, De-Escalation, http://okc.gov/files/assets/city/v/1/police/documents/operations-manual-6th-edition-june-20-2025.pdf.
[33] San Diego Police Department, Number 1.55 De-escalation Procedure, https://www.sandiego.gov/sites/default/files/155.pdf
[34] LAPD Use of Force Tactics Directive No. 16, Tactical De-escalation Techniques, 2016.

officers should use in intense tactical situations: Planning, Assessment, Time, Redeployment, Other Resources, and Lines of Communication ("PATROL").

While it provides key de-escalation techniques, the Directive fails to emphasize the legal mandate that officers use de-escalation prior to engaging in force whenever possible. Instead, the Directive seems to provide exceptions and justifications for bypassing de-escalation techniques, including stating that "failure to abide by the basic concepts of the directive may be objectively reasonable upon review of the circumstances."[35]

The LAPD's current de-escalation policy is captured in a few sentences that state a guiding principle but that leaves officers of varying levels of training and experience with little guidance for their de-escalation practice. To avoid confusion, to lessen instances of unnecessary escalation or use of force, and to reduce harm to the community the LAPD is entrusted with serving, the LAPD should follow the example Oklahoma City and similar jurisdictions have set. The LAPD should create a discrete de-escalation policy that captures some of the principles LAPD already outlines in its training materials, but also:

- emphasizes the importance of de-escalation prior to any use of force (when feasible);
- articulates factors officers should consider for determining appropriate de-escalation approaches;
- provides conditions officers should consider when dealing with a non-compliant person, including the fact that the person may have a mental illness, mental disorder, behavioral disability, language barrier, or any other number of unique conditions; and
- highlights key de-escalation techniques to employ in encounters with civilians, including the PATROL techniques offered in Tactics Directive No. 16.

Oklahoma City and San Diego have enacted discrete de-escalation policies that clearly spell out the importance of de-escalation. The LAPD instead relies on a blanket policy statement and subsequent training to guide their officers' de-escalation practice. As we discuss later in this report, even the LAPD's training materials and training sessions raise concerns about whether the LAPD's approach to de-escalation is equipping officers to reduce the intensity of encounters and mitigate the need to use force at all, especially in cases involving mental health concerns or crisis.

In light of the LAPD's frequency of officer-shootings and fatal outcomes, the LAPD can and should strive to be a leader in emphasizing de-escalation and regard for human life. With **LAPD's officer-involved shootings involving people experiencing a mental**

[35] *Id.*

health crisis standing at a staggering 35%[36] **(and outpacing the national average by 15%)** and with **27% of LAPD police shootings (60% of which resulted in fatalities) involving behavioral crises and edged weapons**,[37] LAPD's investment in a comprehensive de-escalation policy is necessary. California law has created the bare minimum requirements for de-escalation, the LAPD ought to expound on those minimum requirements by providing specific, clear guidance for their officers to apply to diverse real-world situations.

Law enforcement agencies often emphasize that policies cannot account for every possible dynamic or situation. That is correct. However, police departments across the nation have been able to develop policies that provide more direction on de-escalation and use of force decision making than the LAPD's current policy reflects.

- ➔ **Recommendation 4:** To ensure that de-escalation is prioritized when feasible, the LAPD should revise its *Use of Force* policy to emphasize when and how to de-escalate, utilizing specific and clear examples to guide officer conduct, and fully emphasize the requirement that officers use de-escalation prior to engaging in force. The policy should also provide consistent strategies in real-world scenarios, including those involving people with mental illness or in mental health crises.

LAPD's Use of Force Policy: Categories for Use of Force Types

Law enforcement agencies often refer to use of force as being part of a continuum with varying levels of force at each stage. The LAPD classifies use of force into three distinct types: Categorical Use of Force – CUOF (including deadly force), Non-Categorical Use of Force – NCUOF, and Not Reportable Use of Force.[38] The table below provides a summary of the LAPD terms and definitions.

LAPD Term	**LAPD Definition**
CUOF	• **Officer-involved shootings ("OIS"),** • Any death of a person in police custody • Any use of force that results in the subject being admitted to a hospital, • Deliberate strikes to the head with an impact weapon, • Neck restraints

[36] LAPD, 2023 Year-End Use of Force (2024), https://www.lapdpolicecom.lacity.org/042324/BPC_24-074.pdf

[37] Jany, Libor. "Bringing a gun to a knife fight': LAPD continues to shoot people holding 'edged weapon' during mental crisis, analysis shows." *LA Times*, 8 July 2024, https://www.latimes.com/california/story/2024-07-08/analysis-lapd-edged-weapon-shootings.

[38] LAPD Manual, Volume 4, § 245.05; LAPD Manual, Volume 3, § 794.10

NCUOF	• Defined as an incident in which any on-duty or off-duty Department employee whose occupation as a Department employee is a factor, **uses physical force, or a control device to:** ○ Compel a person to comply with the employee's direction; ○ Defend themselves; ○ Defend others; ○ Effect an arrest or detention; ○ Prevent escape; or, ○ Overcome resistance • All NCUOF incidents are classified as Level I, II, or III. ○ Level I: unauthorized force or force resulting in serious bodily injury, ○ Level II: ■ any less-lethal munitions (Bean Bag Shotgun, 40mm Less-Lethal Launcher, TASER, Oleoresin Capsicum Spray, and/or baton) that contact a suspect or their clothing; ■ A K-9 Bite or K-9 Contact that does not require hospitalization; ■ Strike, punch, elbow; ■ Kick, knee strike, or leg sweep; or, ■ Any takedown ○ Level III: ■ Any wrist lock, joint lock, C-grip, firm grip, walk down, push, pull, or bodyweight that results in an injury or complained of injury to the subject, excluding injuries that would be reportable as a Categorical Use of Force, or a Level I use of force; ■ The discharge of a projectile weapon (e.g., beanbag shotgun, 37mm or 40mm projectile launcher or Compressor Air Projectile System), electronic control device (TASER), or OC Spray that does not make contact with an individual or their clothing, excluding tactical discharges, as defined in Department Manual Section 4/245.05; or,

	■ Any use of force in a crowd control situation to include any discharge of a projectile weapon, baton strike, punch, elbow strike, kick, knee strike, leg sweep, takedown, or the use of chemical agents, including OC on a crowd as a whole, which does not go beyond the mission of the skirmish line, excluding injuries that would be reportable as a Categorical or Level I Use of Force.[39]
Non-Reportable UOF:	• The use of a C-grip, firm grip, joint lock, joint lock walk-down, push, pull, or bodyweight, which does not result in an injury or complained of injury to the subject; • A push or baton push used by an officer working in an organized squad directly involved in a crowd control mission that does not result in injury or complained of injury to the subject; • and, **the tactical discharge of a projectile weapon (e.g., beanbag shotgun, 37mm or 40mm projectile launcher, or Compressed Air Projectile System)**, electronic control device (TASER), or any chemical agent that does not make contact with an individual.[40]

During the course of our assessment, we sought to understand how the SMART unit officers compare to uniformed officers. We found that LAPD's SMART unit has not ever been and does not appear to ever be willing to be truly unarmed. Just like patrol officers, SMART officers are equipped with the weapons that could easily lead to a reportable use of force and/or a fatal outcome. While SMART officers are dressed in black shirts and tan pants[41] and drive unmarked vehicles in order to appear less threatening, that is obviated by the fact that these officers are still armed with lethal weapons. Per LAPD policy, all SMART officers must carry a gun, ammunition, taser, chemical irritant control device, and handcuffs when deployed to the field during their shifts. In addition, they can opt to carry a collapsible baton.[42]

The co-responder approach raises concerns about law enforcement involvement since many mental health crisis situations do not require a law enforcement response and the risk of unintended consequences when law enforcement responds to and/or leads the interaction can be dire for the person in crisis (i.e., escalation, triggering effect, generating anxiety, causing further involvement in the justice

[39] LAPD Manual, Volume 4, § 245.11
[40] LAPD Manual, Volume 4, § 245.05
[41] MEU Operations Guide, § 2.5.5.6
[42] MEU Operations Guide, § 2.5.5.5

system, and fatal outcomes).[43] We discuss the research studies focused on gauging the effectiveness of co-response models in **Section V** of this report.

LAPD's Use of Force Policy: Reporting and Investigations

When police use force against civilians, it is imperative that oversight entities are able to fully review and investigate the use of force to determine whether it was lawful and in accordance with Department policy. This is the mechanism through which the general public, the LAPD, and oversight entities can hold officers and the LAPD accountable. Whether identifying unlawful or out-of-policy uses of force, tracking force trends/patterns, identifying areas of improvement for the officers or systemic issues within the Department, use of force reviews and investigations are a critical transparency tool.

Vital to that process is the review of all relevant reports, investigative files, witness accounts, and evidence. Thus, access to accurate and complete documentation that provides a clear record of the use of force incident is key to the investigation.

The LAPD Department Manual provides a detailed use of force reporting policy,[44] which requires LAPD officers to memorialize uses of force and provide detailed information about the circumstances and behaviors of all involved. Whether the incident is a NCUOF (e.g., physical force or control device used) or a CUOF, (e.g., shooting), the LAPD reporting policy details the reporting duties of officers in each scenario. Additionally, the LAPD policy also provides the required level of investigation and items to be reviewed for each type of investigation, including but not limited to independent interviews with LAPD employees, non-LAPD witnesses, and the people against whom the force was used.

MEU SMART's Impact on Use of Force

As discussed in this report, the general public and policymakers often focus on MEU and SMART when LAPD is the cause of tragic shooting deaths of people in mental health crises. LAPD frequently cites lack of MEU resources and the inability to deploy SMART units in situations involving people in mental health crises as a contributing factor to these tragic incidents.

While MEU's stated mission is to **"reduce the potential for violence during police contacts involving people suffering from mental illness while simultaneously**

[43] Crisis Intervention Team (CIT) Programs: A Best Practice Guide for Transforming Community Responses to Mental Health Crises (August 2019), pp. 58-60; SAMHSA (2020). National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit Executive Summary, p. 10.
[44] LAPD Manual, Volume 4, §245.10, 245.11

assessing the mental health services available to assist,[45] high-ranking LAPD officials we met during the course of this assessment emphasized that MEU is not a crisis intervention team. According to one official, the unit's role extends beyond use of force prevention.

In this assessment, the Controller's Office sought to understand the impact of MEU on use of force incidents. We reviewed general data regarding MEU's work through a sample of 121 MEU Incident Reports that capture encounters between officers and the public through mental health calls. The review of these incidents included analysis of Case Daily Field Activities Report (DFAR) narratives.

Our findings detailed below discuss deficiencies we found related to LAPD's use of force reporting, uses of force and policy, and de-escalation related to incidents involving people with mental health issues.

MEU Incident Reports Lack Key Information About Uses of Force

We found that:

- Uses of force are not adequately documented in MEU Incident Reports.

All MEU officers are given a MEU Guidebook which provides information about LAPD policy, MEU procedures, and conduct that MEU officers must engage in to fulfill their duties. A review of the Guidebook raises concerns regarding use of force transparency and accountability. For example, it is policy that a MEU incident report be created for every MEU call and that the incident report includes various categories of information, including a **report narrative** providing details surrounding the MEU's contact with the person during the incident.

However, as it relates to use of force, the guidebook instructs MEU officers that:

> **"narrative should be limited to the Source of Activity, why do the officers suspect a mental illness, that a CUOF (OIS) or NCUOF occurred and disposition of the subject. (*this prevents the MEU report from conflicting with the UOF report*)."** (no emphasis added).

This particular MEU directive undermines the transparency that a complete report and accounting of an incident ought to have. Given that the MEU Incident Report provides for a narrative for each incident, but then proceeds to limit the narrative to merely indicating that a use of force occurred suggests a level of purposeful editing and omission of pertinent information by the officers. This directive thus undermines

[45] LAPD, MEU Program Outline, June 2021, pg. 2; MEU Brochure SMART CAMP, June 2015, available at: https://www.fmhac.org/uploads/1/2/3/9/123913996/meu_brochure_smart_camp_-_6-1-2015.pdf; *see also* LAPD, 2022 Use of Force Year-End-Review (2023), pg. 26.

the purpose of a narrative, which is to capture detailed information about the incident.

The goal for the LAPD, oversight entities, and the general public should be to have accurate and complete accounts from all involved, including MEU officers who are completing MEU Incident Reports. Without complete and accurate documentation from MEU, the ability to accurately evaluate whether an officer's actions during an interaction with the person in need was reasonable, proportional, justified, or in compliance with the LAPD policies and the law becomes more difficult to achieve.

- ➔ **Recommendation 5:** To ensure transparency, accuracy, and completeness of all use of force incident reporting, we recommend the LAPD revise MEU's policy to include a full narrative of the use of force incident and not simply limit its contents in an effort to "prevent the MEU report from conflicting with the UOF report."

MEU Incident Narratives Were Less Likely to Describe Mental Health Crises When a UOF Occurs

Contrary to the above-referenced use of force reporting policy, our review of 121 MEU incident reports revealed that when there was use of force involved in the incident, less than half (47%) of the incident report narratives included descriptions of the person's mental health crisis. Meanwhile, 79% of incident report narratives we reviewed that did not involve a use of force had some indication of the mental health crisis at issue. Despite its relevance to a use-of-force assessment, these narratives frequently lacked detailed references to the person's actual or perceived mental health condition.

MEU Incident Reports Describe Mental Health Issues for White Subjects More Often Than for Other Groups

Capturing accurate and thorough information about a person's mental health status is necessary to ensure the LAPD and its mental health services partners can support the assessment of an individual's mental health condition and any associated risk to themselves or public safety, as well as referrals to service providers. Our review of the sample of 121 MEU incident reports indicate that when LAPD officers encounter individuals believed to be suffering from a mental health issue, the department is more likely to document the mental health issue or concerning behavior when the subject's ethnicity is white.

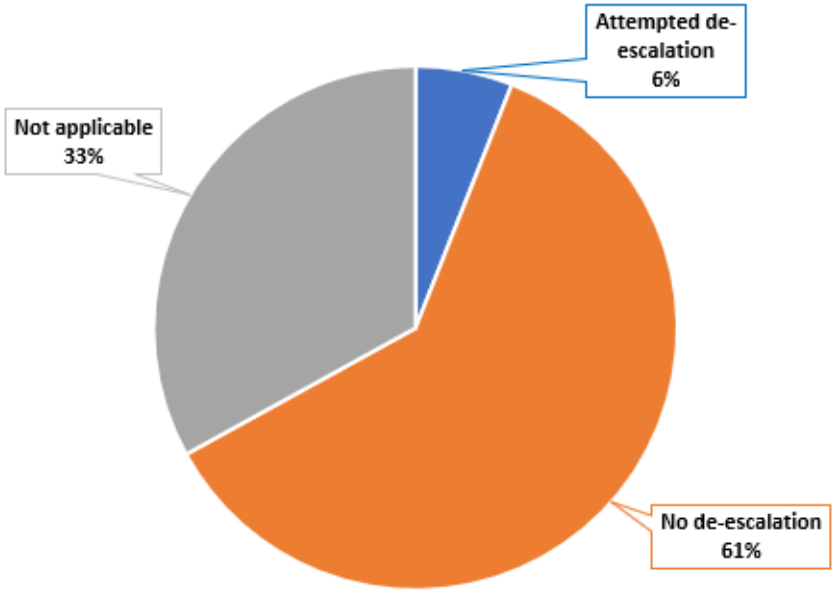
Across all of the case summaries we reviewed, the summaries clearly document the mental health issue or concerning behavior 58% of the time. The cases document this information 49% and 50% of the time when the individual is Black or Hispanic, respectively. However, we found that in 70% of cases, summaries involving white

individuals clearly documented the behavior indicating potential mental illness or the mental health crisis leading to MEU's involvement in the case.

MEU Attempts to De-Escalate Are Infrequent

Our team reviewed each incident report for any memorialization of LAPD's de-escalation attempts. During this review, the team identified reports for descriptions indicating an officer or mental health specialist engaged in a process which attempted to reduce the intensity of a situation, or reduce the agitation level of a subject.

Descriptions of De-escalation Attempts



Of the 121 MEU Incident Reports, only seven case narratives (6%) describe an attempt to de-escalate by the responding officers and/or SMART. For the remaining incidents, there was no description of an attempt to de-escalate for 74 cases (61%), and there were 40 cases (33%) for which there was no need for de-escalation.

The majority of the incidents involved the responding patrol officers and not SMART officers, which further highlights the concern with having MEU as a secondary unit and not the primary unit responding to mental health calls.

Mental Health Intervention Training Has Little Impact on UOF & Outcomes

LAPD's SMART does not have the capacity to respond to every mental-health related call. According to the most recent LAPD data, LAPD's SMART unit handles 26% of the total SMART Calls for Service.[46]

[46] 07523 - BPC_23-131, Alternatives to Armed Response, July 5, 2023

Year	SMART Calls for Service	SMART Calls Handled	Percentage of Calls SMART Handled
2022	22,565	5,816	26%
2021	18,230	7,469	41%
2020	19,226	6,712	35%
2019	20,758	7,871	38%
2018	20,390	8,338	41%

With the limited SMART response, LAPD relies on its general police force to answer most calls involving mental health. LAPD's Mental Health Intervention Training (MHIT) is a one-time course intended to educate LAPD officers on mental health related topics. MHIT is available year-round to all sworn personnel and mandatory for all probationary patrol officers. According to the latest LAPD statistics, 5,769 LAPD personnel have received MHIT training from 2014 through September 2024. Our assessment included a review of available data to evaluate MHIT's impact on incidents and uses of force.

Assessment of Available Data - LAPD UOF Data

Our team analyzed data from 2020-2022 to identify any impact that MHIT training might have on uses of force. According to available data reviewed by our team, the percentage of MHIT trained patrol officers responding to a mental health-related incident has increased from 81% in 2020 to 91% in 2022. However, there was a minor difference in use of force between MHIT-trained patrol officers and those that have not undergone MHIT training. MHIT-trained officers had a CUOF in 0.15% of mental health-related incidents, compared to non-trained officers who had a CUOF in 0.20% of incidents. The lack of a significant difference also holds true for NCUOF (2.44% v. 2.25%).

Use of Force Rate by MHIT-Trained Officers

Use of Force Type	With MHIT Training	No MHIT Training	Difference
Categorical UOF	0.15%	0.20%	0.05%
Non-Categorical UOF	2.44%	2.25%	-0.19%

Despite the attempt to present the MEU as a necessary check to limit use of force on people experiencing mental health crises or in mental health distress, LAPD utilizes MEU SMART teams as a secondary alternative. In doing so, it is not surprising that instances of use of force remain at similar levels whether MHIT trained officers are involved or not.

Lack of UOF Data Tracking

MEU policy requires audits of filed CUOF and NCUOF reports involving impressions of mental illness. According to MEU policy, MEU's Administrative Training Detail is

responsible for "conducting audits of filed categorical and non-categorical Use of Force reports with indicators of a mental illness, maintained by Use of Force Review Division"[47] and it is also required to "assist the Mental Health Crisis Response Program Coordinator with the review of completed Use of Force reports with [the] impression of a mental illness.[48]

We found that:

- LAPD does not track the impact that MEU has on use of force.

A key area of importance to this assessment was whether LAPD measures the impact MEU had on incidents and on use of force. At the time of the assessment, requests were made for any information including reports, assessments or memoranda previously created that generally measure MEU's impact on LAPD's use of force. The LAPD did not have any of the requested documentation.

LAPD Critical Incident Review Division (CIRD) staff explained that LAPD evaluates CUOF and NCUOF incidents to determine whether or not the incidents involved individuals suffering from mental illness. According to staff, CIRD identifies trends and issues within the confines of the LAPD's policy requirements and assesses whether LAPD officers who used force did so by following the department's protocols including de-escalation tactics.

The LAPD's failure to measure the impact that MEU has on uses of force makes it difficult to assess whether MEU and SMART are having any meaningful impact on incidents and on uses of force. The LAPD should consider following the example provided by the Portland Police Bureau (PPB). Portland's PPB entered into a consent decree with the U.S. Department of Justice after a finding of "a pattern or practice of unnecessary or excessive uses of force in certain encounters between police officers and persons with or perceived to have mental illness." As a result, Portland police were required to begin tracking data that compares uses of force when specialized units (including the Enhanced Crisis Intervention Team, a group of volunteer officers who respond to mental health crisis calls) are involved.

In 2001, the LAPD entered its own consent decree with the U.S. Department of Justice following a pattern of misconduct by LAPD officers and the Rampart scandal.[49] As a

[47] MEU Operations Guide, 2.3.3.4

[48] MEU Operations Guide, 2.5.9.4

[49] On May 8, 2000, the U.S. Department of Justice formally notified the City of Los Angeles of its determination that the LAPD was engaged in a pattern or practice of civil rights violations, including excessive force, false arrests, and unreasonable searches and seizures. The resulting consent decree with the U.S. Department of Justice included a crucial requirement for LAPD to review and implement processes to improve its responses to persons with mental illness. Although the consent decree was

result of that consent decree, LAPD carried out (and later abandoned) a pilot CIT program and MEU developed a 40-hour training program similar to the Memphis Model. Given LAPD's own history of pattern or practice of misconduct, it would be advisable that the LAPD do more than rely on anecdotal evidence to assess uses of force involving people perceived to be in a mental health crisis. It is in the interest of the community and the LAPD to consider tracking data about MEU's impact on all mental health related incidents and on SMART's impact on uses of force.

➔ **Recommendation 6**: The LAPD should develop a method to track and measure the impact that MEU has on mental health related incidents where SMART is dispatched and on use of force incidents.

III. MEU's Training for Officers Does Not Fully Align with Best Practices

Leading police departments provide officers with comprehensive training to reinforce the policies and procedures that govern police work. It is during training that officers are able to test their knowledge of requirements through lectures, discussion, and practical application of their understanding through participation in simulated exercises. Officers who undergo effective training are able to fully understand how to properly perform their duties, interact with all members of the community, and minimize risk of misconduct.

The MEU's Administrative Training subunit is responsible for providing expertise and support to the LAPD's Training Division for all mental illness-related training and providing the Mental Health Intervention Training (MHIT) course. While the LAPD abandoned the CIT model in 2004, the LAPD has attempted to incorporate CIT into its MHIT curriculum. In comparing MHIT and CIT curricula, we found that MHIT mirrors the CIT training rather well in various areas. However, MHIT differs from the lauded CIT training in the following key ways: the nature of specialized training, duration of the training, and emphasis on de-escalation.

Specialized Nature of the Training

Under the CIT volunteer-specialist model, the purpose of the training is to deliver an advanced training to a select group of experienced patrol officers who will gain specialization in assisting people in crisis.[50] Due to the advanced nature of the training, the CIT training is not appropriate for new recruits. *Id*.

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lifted in May 2013, LAPD's processes for responding to persons with mental illness are still in need of improvement.

[50] CIT International, Crisis Intervention Team (CIT) Programs: A Best Practice Guide for Transforming Community Responses to Mental Health Crises, (2019), p.123.

The CIT training's overarching goal is to provide officers with the cognition, information, resources, and skills that allow effective problem-solving and promote positive outcomes when responding to incidents involving mental health consumers.[51]

Through CIT training, officers gain:

- Enhanced knowledge of mental health-related topics
- Understanding of the laws protecting people with disabilities
- Improved de-escalation and crisis resolution skills
- Provision of referrals, resources, information, and follow up for consumers and their families
- Reduced stigma and assumptions
- Cultural sensitivity and recognition

The expectation once CIT officers complete training is that they will be dispatched to a mental health crisis call, assume responsibility for the scene (even if they are not the first responder or the most senior officer) and spend significant time using de-escalation skills to safely and effectively resolve mental health crisis situations.[52]

In comparison, LAPD's MHIT training is not intended to provide officers with a specialization in mental health crisis response; it is a general program that covers basic principles of mental health intervention.

During the course of our assessment we learned that LAPD's "specially trained" MEU officers do not receive specialized training. Instead, MEU officers participate in the department's MHIT training, which is available to all LAPD personnel and required of new police officers during their probationary year in the field. This means that MEU officers are not required to participate in more training than that which is expected of a rookie patrol officer.

To only require basic training of a "specialized unit" like MEU raises concerns about the adequacy of the officers' depth of knowledge, continuous development, and skill refinement. The LAPD should consider requiring continuous training for all MEU officers.[53]

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[51] State of California Commission on Peace Officer Standards and Training, Crisis Intervention Team, https://post.ca.gov/crisis-intervention-team#:~:text=A%20key%20component%20of%20the,Cultural%20sensitivity%20and%20recognition.

[52] CIT International, Crisis Intervention Team (CIT) Programs: A Best Practice Guide for Transforming Community Responses to Mental Health Crises, (2019), p.123.

[53] After the scope period of this assessment, the LAPD established a requirement that all MHIT certified personnel complete continued training every three years.

➔ **Recommendation 7**: To ensure that MEU officers are updated on evolving standards and best practices, LAPD should require additional training and refresher courses of all MEU officers.

Training Duration

It is widely accepted that a one-time training is not sufficient enough for a participant to absorb all of the material or engage in adequate experiential learning that training exercises seek to provide. Our assessment evaluated the MHIT's training duration and frequency of delivery as compared to the CIT model.

According to the CIT model, 40 hours is the bare minimum level of training hours required to achieve the goal of getting each officer to implement changes to their approach to people experiencing mental illness or a mental health concern. With the expectation being that CIT officers will integrate complex new skills into their current skillset, one of the core elements of the CIT model is to provide continuous in-service training for these specialized officers.[54]

To accomplish its goals, the CIT model includes:

- 40-hour entry level training,
- refresher training courses (annually); and
- in-service training including Extended and Advanced Training, Extended/Advanced Suicide Crisis Intervention Training, Advanced Developmental Disabilities, New Developments in Psychiatric Medications, Advanced Verbal Skill Training (Crisis Hotline), and Advanced Scenario Training.

In comparison, the LAPD's MHIT training is a department-wide, one-time 36-hour training. During the scope period, there was no requirement that patrol officers or MEU's officers participate in additional in-service training. Given that the MHIT is a general program rather than specialized training for mental health crisis response teams, it is imperative to promote continuous in-service training for all LAPD officers, including those officers assigned to MEU and SMART.

➔ **Recommendation 8:** To ensure that all LAPD sworn personnel are actively engaging with mental health training and implementing best practices, the LAPD should require in-service and refresher training courses to supplement the one-time MHIT training for all sworn officers.

[54] Crisis Intervention Team, Core Elements (2007).

De-Escalation Emphasis

MHIT and CIT also vary in their emphasis on de-escalation. CIT places a strong emphasis on de-escalation as a tactic for managing mental health crises. According to the CIT model, CIT officers responding to mental health crisis calls are often spending significant time using de-escalation skills. By design, the CIT Model includes a five-part scenario-based training in its curriculum beginning with basic de-escalation and verbal skills and progressing to more advanced instruction for complex scenarios.

The CIT five categories include:

- Basic de-escalation strategies;
- Basic verbal skills;
- Stages and cycle of a crisis escalation;
- Advanced verbal skills; and
- Advanced strategies for complex scenarios.

In comparison, LAPD's MHIT is divided into three phases: (1) structured learning, (2) intensive scenario workshops, and (3) consumer/family interactions.[55] We discuss our direct observations of the scenario workshops later in this report. However, based on curriculum alone, we found that MHIT does not break out de-escalation or verbal skills training as a focal point of instruction. Instead, the LAPD appears to teach de-escalation as part of a broader toolkit and has de-escalation as a performance objective for the first day of MHIT instruction. Given that MHIT presents instruction on mental illness, developmental disabilities, substance abuse, and other mental health related concerns officers may encounter during their shifts, it is crucial that de-escalation features more prominently in the MHIT training. Highlighting specific de-escalation skills and strategies officers should use in mental health related calls would better equip officers to manage these situations safely and effectively, and minimize the potential harm for people in crisis or with a mental illness.

Snapshot of CIT Curriculum vs. MHIT Curriculum

The table below provides a comparison between the CIT Model Curriculum and the MHIT Curriculum from the Controller's Office's observations of the latter. The red text signifies key differences between the two curricula.

[55] LAPD, MHIT Course Flyer (April 2023).

CIT Model Curriculum	MHIT Curriculum (October 2023)
(1) Didactics and Lectures/Specialized Knowledge • Clinical Issues Related to Mental Illnesses • Medications and Side Effects • Alcohol and Drug Assessment • Co-Occurring Disorders • Developmental Disabilities • Family/Consumer Perspective • Suicide Prevention and Practicum Aspects • Rights/Civil Commitment • Mental Health Diversity • Equipment Orientation • Policies and Procedures • Personality Disorders • Post-Traumatic Stress Disorders (PTSD) • Legal Aspects of Officer Liability • Community Resources (2) On-Site Visits and Exposure • On-Site Visits (3) Practical Skill Training/Scenario Based • Crisis De-Escalation Training Part I Basic Strategies • Crisis De-Escalation Training Part II Basic Verbal Skills • Crisis De-Escalation Training Part III Stages/Cycle of a Crisis Escalation • Crisis De-Escalation Training Part IV Advanced Verbal Skills • Crisis De-Escalation Training Part V Advanced Strategies: Complex Scenarios (4) Questions and Answers (5) Commencement and Recognition	• Introduction To Mental Health Intervention • Mental Evaluation Unit Overview & Student Introductions • Mental Health Overview • Developmental Disabilities, Including Autism Spectrum Disorders • Law Enforcement Legal Aspects • Mental Health Laws And Firearms • Review Game And Rotation Instruction • Strategic Communication • Small Group Instructional Rotations • Risk Assessments • Behavioral Science Section • Psychopharmacology • Substance Abuse And Co-Occurring Disorders And Mental Health • Virtual Site Visits • Officer Wellness • Group Presentation Preparation • Review Of Day Three And Scenario Based Training Instructions • Site Visit Presentation • Assessment Report Completion • Scenario Based Training • Community Resources • Evaluations And Certificates

Direct Observations of the MHIT Training Program

The review of training materials and the direct observation of training sessions is integral to any assessment of a training program's effectiveness in achieving its stated goals or desired outcomes. During the scope period, our team attended in-person MHIT training in October 2023.

MHIT training is LAPD's opportunity to provide a focused mental health training and an overview of the MEU through written materials, training modules, and presentations that underscore the Department's policies, practice, and culture. LAPD prioritizes providing MHIT to probationary officers first and then to other sworn officers. However, the session we observed consisted of mostly senior, non-probationary officer participants.

Through our observations of the four-day program, we found that the training modules aligned with LAPD policies and legal frameworks governing mental health concepts. We observed that most of the training facilitators were either MEU officers or DMH personnel. Despite the specialized nature of the personnel who facilitated the training (i.e., MEU officers who would have received MHIT training or DMH personnel who are mental health professionals), the training shed light on some areas of serious concern regarding the approach some of the facilitators took to instruction.

These areas of concern included the following:

- Blanket assertions that threatened to undermine the participants' development;
- Failures to correct misapplication of the training concepts;
- Sharing of personal anecdotes that showed a bias against people with mental health issues or illnesses

We found that:

- MHIT instructors' approach to training is concerning.

For example, during introductory remarks and throughout the training, facilitators stated and reiterated that the officers receiving the training were "doing everything right" and that the instructors' purpose was to "pass on intel and do what you do with it in the field." It is understandable that LAPD and its facilitators would seek to empower officers to trust their capabilities, but the suggestion that the conduct of officers who are receiving the training for the first time is above reproach and impervious to improvement undermines the concept of training altogether.

MHIT is designed to be delivered to officers who have the greatest likelihood of interaction with people with mental illness or who are in a mental health crisis. The training modules and lectures should not be treated as mere "intel", but as the intensive learning experience that educates officers and models the proper way to address mental health calls. These blanket assertions may seem encouraging and benign, but they can prove to be highly detrimental to the participants because it can lead to complacency and failure to improve, limit skills development, and undermine the importance of retaining the training concepts and materials.

Training Emphasizes Development of Successful Mental Health Hold Applications

Under California law, a law enforcement officer or mental health professional is authorized to involuntarily detain a person who they suspect is a danger to themselves or others due to mental illness. See California Welfare and Institutions Code 5150 ("5150"). When officers or mental health professionals submit a written application for the "5150 hold", they trigger that person's initial 72-hour involuntary detention for further evaluation within a mental health hospital or psychiatric facility.

We found that:

- MHIT training emphasizes using involuntary 5150 mental health holds rather than meaningful de-escalation or services.

We reviewed the written materials provided to MHIT participants and observed the lectures and discussions surrounding the involuntary detention process. We found that the LAPD placed an emphasis on the 5150 hold applications as the main tool for its mental evaluation practice. The LAPD's reliance on the 5150 hold is evidenced by the frequency with which SMART calls handled by SMART result in 5150 involuntary hold applications. The most recent data available at the time of our assessment showed that 4,428 of the 5,134 calls (or 86%) that SMART handled in 2023 resulted in a 5150 involuntary hold application.[56]

During the course of our direct observations of the MHIT training, we found that the discussion surrounding 5150 holds and the power imbued in police officers through the 5150 law raised serious concerns about (1) the appropriate use of the 5150 hold, (2) fundamental expectations of officers who encounter people experiencing mental

[56] In communications to City policymakers and the public, the LAPD has provided data on 5150 applications for involuntary holds. *See* MEU SMART PowerPoint for Public Safety Committee 101023.pdf

health conditions, and (3) the broad discretion afforded to officers in completing 5150 hold applications.

For example, instructors devoted a significant portion of the lectures to the writing of 5150(a) hold applications. While the participants received copies of the 5150 statute and the criteria for a 5150 application, the gravity of subjecting someone to an involuntary detention was seemingly dismissed. One lecturer described involuntary detention as "you're not taking them to get locked down for life, you're trying to provide them with a resource to get help." By downplaying the potential negative impact an involuntary detention can have on the detained person, the instructor created the risk that some officers might take his comment as free license to abuse the 5150 hold application as the default tool in mental health related calls.

During our observations, another issue arose regarding the emphasis an instructor placed on securing continued detention of the person who had been subjected to a 5150 hold. Under California's Lanterman-Petris-Short (LPS) Act, a 5150 hold will trigger a 72-hour involuntary detention. Under the same law, the person can petition the court to challenge their detention and request their release.

Alluding to the legal protections that govern involuntary mental health treatment, one instructor stated:

> *"We now have LPS laws, we can't keep people held indefinitely, they can petition the court . . . this is where we play a role: our 5150 application will be important – that's our testimony. The [District Attorney] will read off of our 5150 . . .* ***if we write [a] vague 5150, we don't give the DA enough ammunition to argue [for the hold]****."*

By positioning the officer's 5150 application as ammunition for a prosecutor to use for continued detention, the trainer failed to emphasize the valid legal or mental health reasons to apply for or discontinue the mental health hold.

In discussing the difference in the required qualifications between police officers as compared to those for mental health professionals writing a 5150 hold application, one instructor stated:

> *"Once you graduate from the academy, you can complete a hold application the first day out [as an officer]. DMH clinicians have a different process – BA, MA, complete 3000+ hours of field training before they are even able to complete a hold application on their own. What magic in the Academy do they give us that we can just do this? The answer is the laws.* ***It's kind of funny that clinicians have to go through this whole regimen of training that we get to skirt by****."*

The instructor suggesting that police officers are empowered to "skirt by" the extensive training that mental health professionals must undergo before they have the authority to write a 5150 hold application has the potential to encourage police officers to assume their discretion is more legitimate than that of a trained mental health professional.

Another concerning incident regarding involuntary detention occurred when the trainer posed a hypothetical question regarding a potentially suicidal person. During a presentation on the dynamics of suicide, the DMH trainer discussed suicidal ideations and the importance of safety planning. According to the trainer, suicidal thoughts alone do not necessitate a 5150 hold. Instead, officers should consider whether the suicidal ideation was accompanied by other risk factors like having a plan for the suicide, the means to follow through on the suicidal threat, and the intent to commit suicide. According to the trainer, when those four risk factors are present, then there is a high risk and a 5150 hold application is likely warranted. However, if a person solely expresses suicidal ideations, the instructor discussed protective factors, safety planning strategies, and sources of support officers could provide the person during suicidal thoughts.

The instructor led the trainees through a series of hypothetical situations. During one of the hypotheticals, one trainee asserted the following:

> "***Realistically, for liability reasons, I'm not safety planning, I'm doing a hold. And let the doctors handle it***. *I want to cover our ass, because someone is always going to find something I didn't do.* ***We can write the hold app easily.***"

In response to the trainee's declaration, a different MHIT trainer (and SMART officer) stated, "We're giving you best practices. It's your choice what you want to do when you get out there." This response failed to promote critical thinking by the participant and failed to guide the participant through proper decision-making in the hypothetical scenario. The instructor's response also failed to reinforce the 5150 hold application requirements, to highlight the importance of the factors, strategies, and sources of support the other trainer had instructed on, and to correct the participant's belief that fear of liability is a valid factor to consider for 5150 hold application. Instead of refocusing the class and reinforcing the safety-plan strategy, the SMART officer's response undermined the value of the specific training module and muddied the legal requirements for a 5150 hold application.

Similar to the MEU/SMART officer facilitators, the mental health professional trainers were also susceptible to undermining the efficacy and value of the MHIT training program. During our observation of the MHIT training, a DMH professional began his lecture on destigmatizing mental illness by stating "I went from working for crazy people to working with crazy people." This opening remark from the person tasked

with training the officers on the importance of destigmatizing mental illness and removing bias around mental health was counterproductive and possibly rendered any substantive information he provided inconsequential. In trying to build rapport with the officers, the DMH clinician did the very thing he was enlisted to train officers not to do: stigmatizing mental illness.

MHIT is a 36-hour training consisting of standalone modules taught by different instructors. Each instructor has a responsibility to provide a model for students to emulate, foster professional growth, and create the optimal experience for skill building and refining. Inherent in their responsibility is guiding the learning experience, and providing constructive feedback so participants can identify areas of improvement, and illustrating the best practices in mental health related calls.

In the instances highlighted above, the instructors did not encourage the participants to critically evaluate their decision-making, challenge their initial impulses, or identify issues in their approaches to the scenarios. Ultimately, this may limit each participant's ability to absorb the intended lessons and compromise their ability to apply the strategies and tactics the curriculum promotes in real mental health calls.

To ensure accountability and oversight in MHIT training, the LAPD should consider having active formal evaluation of all facilitators/evaluators at all times.

- ➔ **Recommendation 9**: We recommend the LAPD develop a formal evaluation of all MHIT training sessions by supervising MEU Administrative Training officers. This would ensure that the trainers are modeling desired behaviors and accurately reflecting LAPD and MEU's stated objectives and goals. The evaluations should provide specific, constructive, and timely feedback for trainers.

Scenario Based Training with Actors

For scenario-based training, MHIT trainers seek to allow course attendees to apply what they learned from the course in scenarios where an actor simulates a subject with a mental health disorder, and officers must manage a call for service involving that subject. The scenarios take place in rooms designed to simulate real world settings, such as an apartment or office.

The Controller team observed a scenario where an actor simulated a person suffering from schizophrenia, a disorder that can result in a mix of hallucinations, delusions, and disorganized thinking and behavior. In the scenario, officers were told they were responding to a call for service involving a person with possible mental

health issues causing a disturbance in an apartment. When officers entered the apartment, the subject began making references to bombs and Metro stations.

The goal of the exercise was to respond to the incident and manage the incident consistent with strategies covered during the training course. Officers participated in the exercise in groups of three or four. Each exercise lasted for approximately five to ten minutes. The breakout groups varied in how they applied their knowledge, with some groups receiving positive feedback from the trainer, and other groups receiving more critical feedback or instruction on how to improve their interactions with people moving forward.

For example, one group of officers interacted with the schizophrenic subject by closely surrounding the subject, who was sitting in a chair, and repeatedly asking questions of the subject as they tried to address the possible threat. The subject in the scenario became more agitated, but the officers generally did not adjust their tact. After the exercise, the trainer told the group that while their response was consistent with LAPD procedures, they needed to make an additional effort to calm the subject down, and try to elicit information in a manner that would help the subject feel less intimidated.

During another exercise, a group of offers approached the subject but provided the subject with more physical space. One officer took a lead role in communicating with the subject. The officer kneeled down to discuss the subject, who was seated in a chair. The interaction was more conversational, and the officer was more successful in eliciting information from the subject. The trainer provided positive feedback to the officers in the exercise for creating a calm environment as they sought to gather information from the subject and assess the possible public safety risk.

Scenario Based Training with Virtual Reality

The LAPD also provides a training session that uses technology to simulate real-world scenarios in a virtual environment. The training is designed to immerse officers in realistic, high-pressure training situations that allow them to practice their skills without the risks associated with live training exercises.

The Controller team observed and assessed the MHIT-specific VR training in its entirety. Participant officers were outfitted with VR equipment, including pucks on wrists and ankles equipped with motion tracking technology, headsets, backpacks, and body cameras. Officers had access to an array of virtual weapons including firearms, projectile launchers (40 mm), and OC spray.

During an overview of the training, the participants were provided safety precautions and with an explanation of the immersive scenarios. The participants were informed that actors would be utilized to portray live role players who “react to what you do

and say – just like in the field." The actors were each tasked with portraying someone experiencing a mental health crisis, including a person with suicidal ideation who was standing on a high-rise rooftop and a person in an isolated playground holding a sharp weapon. According to the trainers, "all scenarios are *winnable*, they're going to make you work for it." There was no explanation provided as to what "winnable" meant. But the participants were instructed to practice strategic communication, investigation, and command control.

The simulated exercises did not allow for real-time feedback from the trainers. Instead, the training exercises were recorded so that the trainers could debrief the scenarios with the participants after the exercises were completed. According to the LAPD, proper debriefs of training scenarios include a detailed breakdown of what happened, which should include a discussion about the circumstances the officers faced, the choices they made, the outcomes of the scenario, and the takeaways, or lessons learned.

During the first simulated exercise, officers interacted with a person on top of a rooftop who was contemplating suicide by jumping from the high-rise. The participant officers answered the call for service by approaching the person on the rooftop while a police helicopter also hovered above the scene. The group of participant officers began to approach the person in distress. One of the officers approached while holding out the 40 mm tactical single-shot launcher and pointing it at the person. During the initial approach, various officers relayed commands to the person in distress and communicated with each other. One officer attempted to reassure the person in distress by getting her to talk and making promises to her.

After the exercise, the trainer told the group that they needed to slow down the interaction with the person in distress. The trainer further admonished that because there were several officers on that rooftop, the officer pointing the 40 mm tactical single-shot launcher likely did not need to have the rifle out on approach. Throughout, the trainer emphasized that if the person were to jump, the officers would not be at fault, under the reasoning that officers do the best they can.

During the second scenario, officers responded to a woman with a knife at an abandoned playground. The woman showed visible signs of experiencing a mental health crisis. When the officers arrived, four officers approached the area where the woman stood, with one of the officers approaching with the 40mm tactical single-shot launcher pointed at her. The woman indicated that she was willing to harm herself. After a brief exchange with the woman, different officers shot tasers and the 40 mm rifle at her.

During the debrief, the trainer discussed the failed tactics of this exercise. The trainer commented that communication and deployment is key in these types of situations.

Here, the officers did not talk to each other and their tactical decisions did not conform with LAPD policy. First, the officers who shot the tasers shot from a longer distance than the appropriate range for a taser. This rendered the taser shot ineffective. Second, the officer with the 40 mm rifle did not warn the woman that they were going to shoot her. Finally, the trainer expressed that the goal was to avoid an Officer-Involved Shooting (OIS) in this scenario – that while the woman was armed with a knife, the officers would "want to use less lethal to avoid OIS." The trainer's emphasis on avoiding an officer-involved shooting in this specific scenario is apparently warranted given that an LA Times study found that behavioral crises involving edged weapons accounted for about 27% of police shootings between 2018 and June 2024, of which more than 60% resulted in fatalities.[57]

According to the LAPD, de-escalation is a core element of the LAPD's Use of Force policy, academy curriculum, and ongoing training. While the VR training was successful in placing participating officers in simulated experiences, the way the training is structured does not allow supervising officers to correct or reinforce the importance of certain de-escalation tactics in the moment. This led to officers taking actions during training exercises which were inconsistent with LAPD policy, including the premature deployment of weapons, the deployment of weapons at the incorrect distance, and the failure to use de-escalation techniques, strategies, and tactics with people in mental health distress. Because the participating officers receive little to no direction while they are engaged in the simulated exercise, the only substantive feedback takes place after the completion of the exercise, which limits the utility of the feedback.

IV. SMART's Ability to Improve Outcomes Is Limited

When a member of the public calls 911 to report an emergency, a Police Services Representative (i.e., a 911 operator) receives the call and collects information about the incident. Police Services Representatives receive eight hours of training on how to identify calls where mental health is a factor. If the Police Services Representative determines a call warrants an LAPD response and mental illness is a factor, they will broadcast a call for service to LAPD patrol officers, and instruct patrol officers to contact the MEU triage desk immediately upon scene stabilization. In some cases, the call to 911 may not indicate mental health issues are a factor. If, based on an interaction with a subject, any patrol unit determines a subject suffers from a mental illness, the unit can contact the MEU triage desk and request that a SMART team provide assistance. SMART teams also listen to LAPD radio channels and can choose

[57] 'Jany, Libor. "Bringing a gun to a knife fight': LAPD continues to shoot people holding 'edged weapon' during mental crisis, analysis shows." *LA Times*, 8 July 2024, https://www.latimes.com/california/story/2024-07-08/analysis-lapd-edged-weapon-shootings.

to proactively respond to a call for service if they believe a situation may involve a mental health issue.

LAPD's Dispatch Changes Did Little to Alter SMART's Limited Role or Incident Outcomes

The limited evidence that is available on their effectiveness shows that co-responder teams may enhance crisis de-escalation, when given the opportunity. In these studies, calls for service that are managed by co-responder teams are associated with fewer incidents of force and lower rates of injury.[58] Although LAPD's SMART units, when consisting of an armed officer paired with a mental health clinician, meet the definition of a co-response team model, their narrow role in responding to calls for service limit their effectiveness.

We found that:

- SMART's ability to improve outcomes is extremely limited because they are secondary responders to armed patrol units.
- SMART units are secondary responders while armed patrol units are primary responders. SMART units are not allowed to interact with subjects until patrol units have given their approval.

In response to a Council motion aimed at reimagining policing, LAPD modified its procedures in February 2021 to dispatch SMART at the same time as a patrol unit being assigned to a mental health call for service.[59] By dispatching at the same time as a patrol unit, LAPD's intent was to give SMART units more opportunities to respond to a wider variety of mental health incidents, and provide support for the person experiencing mental health issues.

Despite this change in dispatch procedures, not much has changed in practice for SMART. Our review of MEU incident data shows that patrol was still the initial responder in 96% of calls in 2022. MEU staff confirmed that while SMART units currently co-respond to radio calls when they can, the vast majority of their calls are requests from patrol officers who are already at the scene of their assigned radio calls.

More fundamentally, this change in dispatch procedures did little to change SMART's limited role on scene. MEU staff confirmed that patrol officers remain the primary unit at an incident, while the SMART unit on scene serves as a supporting element. In

[58] International Association of Chiefs of Police and the University of Cincinnati's Center for Police Research and Policy, *Assessing the Impact of Co-Responder Team Programs: A Review of Research* (March 2021), https://www.theiacp.org/sites/default/files/IDD/Review%20of%20Co-Responder%20Team%20Evaluations.pdf#page=16

[59] Prior to LAPD's Divisional Order No. 6-2021 that changed dispatch procedures, SMART was a "secondary responder" and answered requests for support by a patrol unit that was already on scene.

addition to being the initial responder to nearly all calls for service involving a subject with a mental health issue, MEU's incident data shows that patrol units also handled the final disposition of these incidents 76% of the time in 2022.

Given LAPD's patrol-centric approach to handling calls for service, it's no surprise that nearly 80% of incidents recorded in MEU's database were for a mental health hold or arrest.

Calls for Service - Outcomes for MEU Incidents	Year		
	2020	2021	2022
Mental Health Hold	50%	45%	43%
Arrest	29%	33%	35%
Other	21%	22%	22%

With their limited on-scene role, it's also not clear how SMART units can achieve their objectives of assisting patrol with de-escalation, or preventing unnecessary incarcerations and hospitalizations of people suffering from mental illness.

DMH's Poorly Defined Role for SMART Clinicians Limits their Clinical Value in the Field

One of the key challenges associated with a co-response model is the delineation of roles. Police officers and clinicians are likely to view calls for service in different ways, due to their different skill sets and approaches to problem solving. Defining and clarifying roles, including deciding who will take a lead role in responding to and resolving a call involving a person with mental illness in crisis, are important considerations when implementing a co-response model.[60]

Although DMH described their staff's participation in LAPD's SMART units as engaging in a "field clinic," LAPD's limited support role for mental health clinicians underutilizes their skills and abilities, and prevents DMH from taking a lead role in responding to calls for service. LAPD admitted as much when the interim chief said in a Board of Police Commissioner's meeting that "[DMH clinicians] are being underutilized [when they are on scene]", and that the "mandate is co-response but [there is] no mandate to utilize the tool that is there."[61]

[60] Morabito, M. S. (2018). Police Response to People with Mental Illnesses in a Major U.S. City: The Boston Experience with the Co-Responder Model. *Victims & Offenders*: *An International Journal of Evidence-based Research, Policy, and Practice, 13(8)*, 1093-1105.

[61] Interim LAPD Chief Dominic Choi's comments during his presentation on MEU/SMART during the October 8, 2024 meeting of the Board of Police Commissioners.

In general, DMH hires mental health clinicians to perform a variety of services, some of which can be useful for addressing calls for service for a person with mental health issues. These services include:

- developing a tentative Crisis Care Continuum Plan designed to resolve or cope with the mental or emotional problem;
- interviewing people seeking psychiatric assistance on an emergency basis and utilizing crisis intervention techniques to prevent hospitalization and to aid the person in dealing with the emotional crisis; and
- planning and conducting the client's therapy program, including by providing psychotherapy and case management services.

These same services, if incorporated as part of LAPD's response to calls for service involving a person experiencing a mental health crisis, could be used to further SMART's goals of preventing unnecessary incarcerations and hospitalization of persons with a mental illness.

However, the agreement between LAPD and DMH does not carve out a specific role for mental health clinicians to take advantage of the services they can provide. The agreement governing DMH's participation emphasizes that the "purpose of the MEU is to aid LAPD field patrol officers in handling calls for service involving persons suffering from a mental health crisis", and that DMH clinicians deploy to "investigate, process, and report on mentally ill cases, as well as provide advice and required assistance to field officers."[62]

The MEU agreement with LAPD also provides a general statement that "DMH clinicians shall provide a variety of clinical services for persons suffering from severe mental and emotional disorders; assist patients; their families; law enforcement and other social agencies in understanding and finding solutions to problems that lead to and result from mental illness and severe emotional disorders." However, it does not outline any specific roles or protocols for DMH clinicians and their involvement in responding to calls for service.

In practice, we did not identify any specific ways in which DMH's participation in SMART had, or could have, changed the outcome of LAPD's response to a call for service. Although DMH described their staff's participation in LAPD's SMART units as engaging in a "field clinic," they failed to articulate the ways in which their clinicians would be allowed by LAPD to directly engage with a person during a call for service that would result in de-escalation or reduced incarcerations and hospitalizations.

[62] Memorandum of Agreement Between the Los Angeles County Department of Mental Health and Los Angeles Police Department for Partnership in Continuing the Mental Evaluation Unit, signed in 2015.

Clinicians Are Often Unable to Interact with Subjects in Crisis

During the ridealongs with SMART that we participated in, we also did not observe any specific ways in which DMH clinicians had helped to alter the course or outcome of LAPD's response to a call for service. While the DMH clinicians are not allowed to intervene until police officers have given their approval, DMH clinicians are able to search for the mental health information that DMH may have access to through its own databases and share that with the LAPD officers on the scene. However, it is not clear how the LAPD uses the information or whether it has any substantial impact. During a MEU/SMART presentation at a Board of Police Commissioners meeting, this conundrum was highlighted by Interim Chief Choi's admission that "[DMH clinicians] are being underutilized. The mandate is a co-response but no mandate to utilize the tool that is there."[63]

As previously discussed, this largely had to do with the fact that DMH clinicians are not allowed to engage with the subject of a call for service until LAPD officers have stabilized the scene and handcuffed the person. More often than not, the DMH clinicians we observed in the field were facilitating involuntary mental health holds by looking up the person's available medical history in DMH's system, filling out the application themselves, and locating a mental health treatment facility that the person can be transported to.

At the same time, many of the types of calls for service that LAPD chooses to dispatch SMART units to may not be appropriate for, or the best use of, DMH's clinicians. As of February 2021, LAPD's Divisional Order 6 states that "SMART units shall be dispatched with patrol when the call involves a person with mental illness **and** one or more of the following criteria is present:

1. the Subject is violent;
2. the Subject is armed, and the public is at risk;
3. the call is a Welfare check;
4. the Subject has possibly committed a criminal act due to mental illness;
5. the Subject's behavior is high risk (jumper, barricade, suicide by cop, or other high-risk behavior); or
6. Any critical incident where SMART may assist with de-escalation."

We found that:

- SMART's ability to improve outcomes is extremely limited because they are often dispatched to incident types where mental health clinicians cannot directly intervene.

[63] *See* MEU/SMART presentation at the October 8, 2024 Board of Police Commissioners meeting

LAPD's criteria for dispatching SMART units are not a good use of their resources because the risk to DMH clinicians likely precludes them from directly engaging subjects that are violent, are armed, have possibly committed crimes, are exhibiting high-risk behaviors, or are involved in critical incidents.

Because MEU teams often respond to incidents where clinicians are unable to directly intervene, the City and County should consider whether DMH clinicians can provide their services in more efficient ways. For example, DMH clinicians might add more value if LAPD expands its deployment strategy to allow for MEU teams to serve as a primary unit for non-critical incidents. SMART units could respond directly to conduct welfare checks, in the same way that other alternative response programs, like CAHOOTS, do for their local jurisdictions. Deploying SMART units for welfare checks and other non-emergency calls would give DMH clinicians the opportunity to work directly with the subject of the call for service to de-escalate the situation, and provide other mental health services that they are trained for.

SMART's Main Purpose is to Handle Mental Health Detainments for Patrol Units

Of the objectives listed for SMART, LAPD only measures their performance for one of them: how much SMART allows police patrols to return to service as soon as possible. LAPD measures the performance against this objective by counting the number of hours of patrol time saved because a SMART unit took over handling the detainment of a subject, often to transport them to a mental health treatment facility that is designated by the County to perform involuntary mental health holds. LAPD reports that, from May 2022 through May 2023, SMART handled 5,173 calls for service out of 18,762 mental health related calls dispatched, and saved approximately 9,753 patrol hours during this time frame.

We found that:

- SMART units are primarily used to complete involuntary 5150 mental health holds.

During the ridealongs we participated in, staff confirmed that SMART units were primarily used to complete LAPD's role in an involuntary mental health hold. According to LAPD, patrol officers or SMART units often have to wait three to four hours at a mental health treatment facility, especially if it is a large general hospital, for a medical professional to evaluate and accept an individual for an involuntary mental health hold.

Our data analysis of MEU incident data also confirmed that the completion of involuntary mental health holds was the primary purpose that SMART units are tasked with. MEU incident data from 2020 through 2022 shows that 84% of incidents handled by SMART are for involuntary mental health holds. SMART ends up handling

most mental health holds that do not require immediate medical intervention (59%), while patrol units handle nearly all mental health hold incidents that reportedly involve an injury or attempted suicide that require immediate medical intervention (95%).

Calls for Service - Outcomes for MEU Incidents	Incidents Handled By SMART
Mental Health Hold	84%
Mental Health Hold: Medical Intervention	3%
Arrest	2%
Other	12%
Total	**100%**

Calls for Service - Outcomes for MEU Incidents	Incident Handled By:		Total
	Patrol	SMART	
Mental Health Hold	41%	59%	**100%**
Mental Health Hold: Medical Intervention	95%	5%	**100%**
Arrest	99%	1%	**100%**
Other	86%	14%	**100%**

- ➔ **Recommendation 10**: The LAPD should work with the LA County Department of Mental Health to reevaluate the roles that mental health clinicians play in MEU so that they can be deployed with SMART units in more efficient or expanded ways to make better use of their clinical skills.
- ➔ **Recommendation 11**: The LAPD should revise its policies and procedures to allow for SMART teams to take control of certain incidents involving people with mental illness or experiencing a mental health crisis. Specifically, SMART teams should lead the LAPD response to mental health-related calls which do not involve weapons

V. The City Should Shift to Alternate Crisis Response Models

Over the past few years, the City has defined alternate crisis response ("ACR") programs to include armed responses. As a result, the City's policymakers often include MEU SMART and similar armed co-responder programs in policymaking conversations, motions, and other guiding materials on the topic.

In March 2023, the Chief Legislative Analyst published a report to the City Council providing an overview of the City's alternative crisis response programs, highlighting their objectives and implementation strategies.[64] According to this report, alternative crisis response "refers to an emergency response atypical of 'traditional' crisis response or emergency first response." The report also provided the four ACR models: (1) Specialized Crisis Response, (2) Unarmed Crisis Response, (3) Co-Response Units, and (4) Virtual Response/Telehealth.

In October 17, 2024, the CAO published a report into the City's Unarmed Model of Crisis Response (UMCR) pilot program, providing performance metrics for the program and assessing its impact and effectiveness since its launch in spring 2024.[65]

Co-Response Models Likely Do Not Make a Significant Difference in Outcomes

Prior research studies provided mixed evidence on the effectiveness of co-response models. Published in 2021 by the International Association of Chiefs of Police and the University of Cincinnati's Center for Police Research and Policy, this review of research found only limited or mixed evidence from studies supporting the effectiveness of co-response teams. Most importantly, nearly all of these studies reviewed rely on less rigorous research methodologies, such as observational studies, descriptive analyses, and surveys.[66]

Co-Response Outcomes Measured	Summary of Research Findings
Enhancing Crisis De-Escalation	Limited evidence suggesting that co-responder teams may be effective.
Increasing Connection to Services	Some evidence on facilitating connections to behavioral health services, with limited insight on long-term outcomes.
Reducing Pressure on the Criminal Justice System	Some evidence to show lower rates of arrest and mental health detainments by co-responder teams, and reduced time spent by first responding officers.

[64] Los Angeles City Council File 20-0769-S5 report, March 23, 2023, https://clkrep.lacity.org/onlinedocs/2020/20-0769-s5_rpt_cla_03-23-23.pdf

[65] CAO, Status Update On The Unarmed Model Of Crisis Response Pilot Program, (October 17, 2024), https://clkrep.lacity.org/onlinedocs /2020/20-0769-S7_rpt_CAO_10-17-24.pdf

[66] International Association of Chiefs of Police and the University of Cincinnati's Center for Police Research and Policy, *Assessing the Impact of Co-Responder Team Programs: A Review of Research* (March 2021), https://www.theiacp.org/sites/default/files/IDD/Review%20of%20Co-Responder%20Team%20Evaluations.pdf#page=16

Reducing Pressure on the Health Care System	Mixed findings on reducing pressure on health care providers.
Promoting Cost Effectiveness	Preliminary evidence for some cost benefits, but limited by data.

However, emerging research using more rigorous experimental methods shows that co-response teams studied have not resulted in measurable and significant differences in their intended outcomes.[67]

One study published in January 2024 used a randomized controlled trial to determine which of its 140 eligible participants would receive services from a mental health provider. In this jurisdiction, the mental health provider did not ride with police, and would be dispatched as a secondary responder on-site within an hour of the first responding officer's call.[68] For this study, the mental health provider co-responder would initially provide crisis de-escalation and stabilization services, and offer referrals for additional screening and treatment.

The researchers, who hypothesized that participants who received a co-response would have fewer future interactions with police, instead found no significant difference in outcomes**. Individuals who initially received services from a mental health co-responder still had, on average, 5.2 subsequent calls for service during the twelve-month follow-up period. This outcome was not significantly different from participants who did not receive services from a mental health co-responder**, who had an average of 4.7 subsequent calls for service in the twelve months following their initial contact with police.

Another study published in March 2024 that also used a randomized controlled trial found that co-response did not result in significant differences in subsequent emergency medical service events (e.g. ambulance or paramedic services) or other measured outcomes.[69]

This study randomly assigned eligible calls for service to receive a co-response (264 cases) from a mobile crisis assistance team, or a "police-as-usual" response (267 cases). Much like LAPD's SMART units, the co-response model in the study's local jurisdiction involved a crisis intervention trained police officer paired with a mental

[67] Randomized controlled trials used in experimental studies are considered the gold standard for evaluating the effectiveness of a treatment, because research participants are randomly assigned to either a treatment or control group for comparison, which minimizes biases and provides stronger evidence of the treatment's outcomes.

[68] Yang, Sue-Ming, et al., (2024). A police-clinician co-response team to people with mental illness in a suburban-rural community: a randomized controlled trial. *Journal of Experimental Criminology*. 1-22.

[69] Lowder, E. M., Grommon, E., Bailey, K., & Ray, B. (2024). Police-mental health co-response versus police-as-usual response to behavioral health emergencies: A pragmatic randomized effectiveness trial. *Social Science & Medicine*, 345, 116723.

health clinician that would self-dispatch to relevant mental health-related calls for service.

The co-response program in the study had a primary objective that was also similar to LAPD's SMART, which was to "divert persons experiencing a behavioral health crisis from arrest and emergency hospitalization through de-escalating the crisis, attending to immediate needs, and connecting persons with treatment and community services." In line with the mobile crisis assistance program's goals, researchers hypothesized that participants who received a co-response would have fewer ambulance or paramedic events, fewer jail bookings, fewer emergency department visits, but have more behavioral health outpatient encounters due to services referrals.

However, the study's results suggest that co-response was not effective in producing its intended outcomes. **Over the twelve-month follow-up period, participants who initially received a co-response had about the same number of ambulance or paramedic events as those who received a police-as-usual response**. There were also no significant differences between the two groups of participants in the count of subsequent jail bookings.

Although the outcomes were not statistically significant, one unintended outcome was that participants who received a co-response in the study also had more emergency department visits during the follow-up period. On average, participants who received a co-response during their initial call for service visited the emergency department an average of 18.7 times over their twelve-month follow-up period. Participants who received a police-as-usual response visited the emergency department an average of 15.9 times over the following twelve months. There was also a difference between participants who received a co-response or police-as-usual in the average number of outpatient behavioral health treatment encounters (9.3 versus 7.23), though this was also not statistically significant.

In the end, the researchers conclude that "a police-mental health co-response team model was not more effective than traditional police response on key outcomes."

Emerging Changes to Mental Health Crisis Response Models in the U.S.

The LAPD's MEU program, which deploys teams of armed police officers and mental health specialists to incidents where mental illness appears to be a factor, is considered a type of co-responder program. Co-responder programs are those where police officers and mental health specialists respond together to address mental health crises. An effective co-responder program has the potential to enhance incident de-escalation, increase the connections to services, and divert people from the criminal justice system when arrests or incarceration is either inappropriate or counterproductive.

However, in light of the need for public safety agencies to evolve in order to respond to changing mental health needs within the community, some jurisdictions are implementing or considering implementation of what are known as alternate crisis response models for lower acuity calls (i.e., non-emergency calls) and calls where a mental health crisis is suspected. Alternate crisis response typically consists of unarmed public safety specialists, mental health specialists, or other community-based individuals responding to 911 calls for service that do not require the presence of law enforcement, and minimize the role of the criminal justice system.

Many mental health professionals support the expansion of alternate response programs that provide non-law enforcement support to individuals experiencing a mental health crisis. Law enforcement responses to mental health crises stigmatize people experiencing mental illness, and alternative crisis response models may lead to better outcomes by providing or connecting people to necessary treatment, and helping to divert individuals from unnecessary hospitalization.

Although alternative response programs are relatively new, the strategy is showing promise in jurisdictions where unarmed specialists respond to mental health crises and substance abuse matters. For example, in 2020, the City and County of Denver launched the Support Team Assistance Response (STAR) program. With STAR, Denver's 911 dispatchers will divert eligible 911 calls to unarmed response teams, rather than dispatching police officers. STAR teams include behavioral health clinicians and paramedics that respond to low-risk calls where there are no significant safety concerns.[70] STAR responds to people needing help for mental health distress, poverty, homelessness, substance misuse, and other concerns. STAR teams can provide crisis intervention, medical assessment and triage, de-escalation, transportation, and resource connection services.

Initial research indicates STAR has been effective in making Denver communities safer. Researchers from Stanford University's Institute for Economic Policy and Research found in 2022 that the eight police precincts in Denver's downtown area serviced by STAR saw a 34% decrease in reported lower-level crimes (e.g., trespassing, public disorder, and resisting arrest) compared to neighborhoods without STAR patrols.[71] The researchers noted that:

> *reductions combine the relabeling of existing behaviors that occur when individuals in crisis receive health care rather than being directed into the criminal justice system and a reduction in criminal offenses by individuals in crisis who would offend repeatedly in the absence of health care.*

[70] Calls for service involving weapons or threats of violence are not eligible for STAR team response.
[71] Thomas S. Dee, Jaymes Pyne, A community response approach to mental health and substance abuse crises reduced crime. Sci. Adv. 8, eabm2106 (2022). DOI: 10.1126/sciadv.abm2106

Researchers also found that STAR's implementation had no detectable effect on the occurrence of more serious crimes. In addition, based on the available cost estimates data, responding to calls for minor criminal offenses with STAR cost about four times less than conventional public safety responses using police officers.

The City of Eugene in Oregon has operated an alternate response program called Crisis Assistance Helping Out on The Streets (CAHOOTS) for more than 30 years, and the program is now a central part of the jurisdiction's public safety apparatus. Similar to the STAR program in Denver, Eugene's CAHOOTS mobile crisis teams, which consist of emergency medical workers partnered with crisis specialists, respond to eligible 911 calls for service involving mental illness, non-emergency medical transport, welfare checks, and substance abuse. Participation in CAHOOTS' support services is voluntary for people in need of assistance. According to the Eugene Police Department, CAHOOTS allows the city to divert up to 8% of 911 calls to unarmed crisis responders.

The City of Los Angeles Alternate Crisis Response Pilot

A majority of Angelenos support the deployment of non-police personnel to emergency calls related to mental health or other social services issues. Loyola Marymount University's 2023 Los Angeles Police and Community Relations Survey indicated residents do not want police officers to serve as the sole responders for calls about mental health crises, substance abuse, and homelessness.

- **75%** of residents support responding to **mental health crises** with teams of LAPD officers and non-police alternatives, or only non-police alternatives. Only **25%** of residents supported responding with only police officers.

- **70%** of residents support responding to **homelessness matters** with teams of LAPD officers and non-police alternatives, or only non-police alternatives. Only **30%** of residents supported responding with only police officers.

- **64%** of residents support responding to **substance abuse matters** with teams of LAPD officers and non-police alternatives, or only non-police alternatives. Only **36%** of residents supported responding with only police officers.

Recognizing the need for new public safety response capabilities, City of Los Angeles policymakers have expressed a commitment to developing non-police alternatives for crisis response situations. In October 2022, the City Council initiated the development of the Unarmed Model of Crisis Response (UMCR) pilot, a multi-year plan to shift responsibility for certain nonviolent calls away from police officers to unarmed personnel. Specifically, the City Council's objectives for the transition were to create a 24/7 operation that diverts certain calls to non-police specialists better

suited to manage the situation. Call types the City Council is seeking to divert include those involving:

- people experiencing homelessness;
- individuals suffering from a mental or behavioral health crisis;
- conflicts that could be resolved through mediation or other resolution strategies; and
- other low-acuity or non-criminal calls for service.

The City entered into agreements with three nonprofit organizations to implement the UMCR pilot program. UMCR response teams launched in March 2023. Each nonprofit partner is responsible for a designated LAPD precinct area. The pilot's initial areas are Southeast, Wilshire, and Devonshire.

Responder team composition varies depending on the contracted partner. Teams include staff such as licensed emergency medical technicians, licensed vocational nurses, licensed psychiatric technicians, licensed marriage and family therapists, and social workers, among other personnel types. When the pilot program was launched, the intent was for the UMCR responder teams to bring in-depth knowledge of mental health disorders, and maintain diagnostic capabilities allowing for tailored and targeted interventions techniques, and evidence-based interventions. Initial implementation of different service delivery models by each nonprofit partner have allowed the City to evaluate the benefits and drawbacks of each strategy.

The City Administrative Officer, which is overseeing the pilot, worked with nonprofit partners, the LAPD, and other specialists in the field of unarmed response to develop policies and procedures for UMCR. The policies and procedures establish expectations for engaging with clients, and prioritize de-escalation, communication, and the importance of maintaining a calm and non-confrontational demeanor when interacting with the public. Importantly, to facilitate the diversion of eligible 911 calls to UMCR teams, the LAPD's Emergency Command Control Communications Systems Division, which operates the City's 911 operations, established a one-way communications connection from the LAPD dispatch system to the dispatch system for UMCR.

The City plans to monitor the implementation of UMCR and evaluate the benefits of the program as it determines how best to expand the program and deploy the initiative citywide. The initial cost estimate for the first year of the pilot was $10.5 million, and the success of the City's expansion plans will largely hinge on the allocation of resources and funding.

➔ **Recommendation 12**: The City Council and Mayor should continue to support and fund the Unarmed Model of Crisis Response pilot through its multi-year

plan, and should consider expanding the program if the pilot demonstrates successful alternatives to armed responses for mental health crises.

VI. Conclusions and Recommendations

Despite the millions of dollars spent on MEU and its programs, and the staffing of unarmed and trained mental health clinicians, LAPD continues to require a police-first, patrol-first armed response to incidents involving community members in mental health crises. In all instances, an armed police officer–not a mental health professional–is expected to be the first to assess a person's mental status before a mental health clinician engages.

Even with MEU's stated goals of preventing unnecessary incarceration, providing alternate care in the least restrictive environment, preventing duplication of mental health services, and relieving patrol officers, MEU SMART appears to be finely focused on (1) relieving patrol officers from mental health related calls and (2) effectuating involuntary holds through the 5150 hold application.

The LAPD and MEU do not measure SMART's success in accomplishing MEU's goals in any other manner than how quickly SMART relieves patrol officers from their on-scene duties. There's no metric tailored to SMART's impact on decreasing the use of force, de-escalating the situation between patrol and the person involved in a mental health crisis, or how SMART provided help to the mental health crisis at issue.

Further, when SMART units are deployed to the very calls they would be best suited to lead, (i.e., mental health calls involving a person who may be violent, armed, is high-risk, or is otherwise involved in a critical incident), SMART hardly ever receives the opportunity to engage in the type of de-escalation and violence reduction that prevents deadly uses of force and saves lives.

After comprehensive and detailed review of both LAPD and MEU policies, it is clear that LAPD does not imbue MEU SMART staff with the tools necessary to effectively reduce violence to people in mental health crisis. This is evidenced by:

- the non-comprehensive and vague nature of LAPD's policies for use of force and de-escalation;
- the LAPD's failure to adequately articulate clear parameters for engaging with people with mental illness or who appear to be in mental health crisis/distress;
- LAPD's policy of handcuffing and detaining people with mental illness or who appear to be in mental health crisis/distress;
- the LAPD's continued reliance on an armed patrol officer-first response to mental health related calls despite calling SMART a "co-response" model;

- the fact that SMART officers are armed with weapons of varying lethality while responding to mental health related calls; and
- the lack of meaningful specialized training for MEU officers.

LAPD constantly requests additional funding for more SMART units to respond to mental health calls. However, if LAPD continues to relegate SMART to a secondary and supportive role instead of a lead role during mental health calls, there will be no mitigation against use of force and deadly outcomes.

Recommendations

This section outlines key recommendations for revising the current policy to ensure alignment with established best practices in the field. Through a thorough evaluation of existing frameworks and observed gaps, these proposed changes aim to enhance the effectiveness, accountability, and overall impact of LAPD's response to mental health crises.

Recommendation #1

We recommend that LAPD revise its manual section A Person Suspected of Suffering from A Mental Illness – Considerations to incorporate more detailed guidelines, addressing specific indicators of mental health related concerns, providing de-escalation techniques to employ in mental health related calls, and promoting a higher standard of accountability for officers.

Recommendation #2

We recommend the LAPD revise its policies for *Handcuffing Persons with a Mental Illness* and § 2.5.6.2. *SMART Unit Response and Call Management* to eliminate the handcuffing of people with a mental illness (or experiencing a mental health crisis) if the individual is not alleged to have committed a crime and is not exhibiting violent behavior.

Recommendation #3

The LAPD should revise its *Use of Force* policy to include dynamic mental health considerations for officers responding to calls involving people with mental illness or persons exhibiting mental health distress.

Recommendation #4

To ensure that de-escalation is prioritized when feasible, the LAPD should revise its Use of Force policy to emphasize when and how to de-escalate, utilizing specific and clear examples to guide officer conduct, and fully emphasize the requirement that officers use de-escalation prior to engaging in force. The policy should also provide consistent strategies in real-world scenarios, including those involving people with mental illness or in mental health crises.

Recommendation #5

To ensure transparency, accuracy, and completeness of all use of force incident reporting, we recommend the LAPD revise MEU's policy to include a full narrative of the use of force incident and not simply limit its contents in an effort to "prevent the MEU report from conflicting with the UOF report."

Recommendation #6

The LAPD should develop a method to track and measure the impact that MEU has on mental health related incidents where SMART is dispatched and on use of force incidents.

Recommendation #7

To ensure that MEU officers are updated on evolving standards and best practices, LAPD should require additional training and refresher courses of all MEU officers.

Recommendation #8

To ensure that all LAPD sworn personnel are actively engaging with mental health training and implementing best practices, the LAPD should require in-service and refresher training courses to supplement the one-time MHIT training for all sworn officers.

Recommendation #9

We recommend the LAPD develop a formal evaluation of all MHIT training sessions by supervising MEU Administrative Training officers. This would ensure that the trainers are modeling desired behaviors and accurately reflecting LAPD and MEU's stated objectives and goals. The evaluations should provide specific, constructive, and timely feedback for trainers.

Recommendation #10

The LAPD should work with the LA County Department of Mental Health to reevaluate the roles that mental health clinicians play in MEU so that they can be deployed with SMART units in more efficient or expanded ways to make better use of their clinical skills.

Recommendation #11

The LAPD should revise its policies and procedures to allow for SMART teams to take control of certain incidents involving people with mental illness or experiencing a mental health crisis. Specifically, SMART teams should lead the LAPD response to mental health-related calls which do not involve weapons.

Recommendation #12

The City Council and Mayor should continue to support and fund the Unarmed Model of Crisis Response pilot through its multi-year plan, and should consider expanding the program if the pilot demonstrates successful alternatives to armed responses for mental health crises.