Minneapolis
City of Lakes

Preliminary Report
Officer Interactions with Mental Health Issues: A Policy Study

Police Conduct Oversight Commission

May 2016

Introduction

The Police Conduct Oversight Commission assures that police services are delivered in a lawful and nondiscriminatory manner and provides the public with meaningful participatory oversight of police policy and procedure. Commission members have a variety of responsibilities including shaping police policy, auditing cases, and engaging the community in discussions of police procedure. The Commission strives to be the citizen advisory group the community relies upon to openly discuss policy and procedures of the Minneapolis Police Department, to voice concerns regarding law enforcement/civilian interactions, and the organization that advances credible and meaningful feedback, without obligation to political influences, for the betterment of the City of Minneapolis. For more information about the work of the Commission, meeting times and locations, and meeting minutes, please visit the Commission website.

Additionally, in the Police Conduct Oversight Ordinance, the Commission has direction to conduct programs of research and study, "review police department policies and training procedures and make recommendations for change." To facilitate this process, the Commission passed a motion at the monthly Commission meeting in February 2016 to conduct a Research and Study on police interactions with emotionally disturbed persons and those with mental health issues.

Due to the complexity and extensive material to consult on this topic, the Commission begins with this Preliminary Report, with a Final Report planned for later this year. This draft of the Preliminary Report will be presented to the Commission at its monthly Commission meeting in March 2016.

Background

Policies and Programs Nationwide

Over the past decade, attention and concern has grown regarding law enforcement interactions with those displaying symptoms of mental illness and emotional disturbances. This is an important issue due to the high number of such interactions that are taking place, the prevalence of which is due, at least in part, to the movement away from institutionalization of those experiencing mental illness, while simultaneous failing to fund adequate social services to serve that population when re-integrated into their communities. This movement left police officers often on the front lines of addressing crisis situations with those affected individuals, even though they often lack the training and resources to do so effectively.

In response to this issue, police departments throughout the country have implemented a variety of policies and programs including special crisis-intervention training, co-responder partnerships with mental health professionals, jail diversion plans and more. But even with some of these new programs and policies in place, officer interactions with those experiencing symptoms of mental illness or emotional disturbances continue to be tenuous, and can end in arrest and incarceration, when medical care may be a more appropriate response. Sometimes interactions are even more extreme, ending in tragedies such as death or injury to either the officer or community member involved.

Data from many sources and studies show that officers interact with individuals experiencing symptoms of mental illness or emotional disturbances on a very regular basis, and that many of these individuals end up incarcerated instead of getting the medical and social services they likely need. A VERA Institute report estimates that 7-10% of all police interactions involve people with a mental illness[1], and the American Jail Association estimates that 16-25% of the national jail population has a mental illness.[2] The cost of incarcerating these individuals is high, as well as their recidivism rates.

In addition to incarceration, these interactions end in injury and death at an alarming rate nationwide. A Washington Post study reports that 124 people with mental illness have been shot and killed by police nationwide in the first half of 2015.[3] These are deaths like those of Philip Quinn in St. Paul, shot by officers while armed with a screwdriver and failing to obey

[1] Cloud, David and Chelsea Davis. "First Do No Harm: Advancing Public Health in Policing Practices". VERA Institute of Justice. Nov. 2015. Appendix 9.
[2] "Blueprint for Success: The Bexar County Model, How to Set up a Jail Diversion Program in your Community". Center for Health Care Services, San Antonio Texas. Appendix 11.
[3] Lowery, Wesley et al. "Distraught People, Deadly Results: Officers often lack training to approach the mentally unstable, experts say." The Washington Post. 30 June 2015. Appendix 36.

police commands, after his fiancée called the police for assistance due to Philip being suicidal[4], and the death of Quintonio Legrier, a teenager struggling with mental illness who was shot and killed by officers in Chicago following a call from his father reporting that he was wielding a baseball bat and acting irregularly.[5] Both deaths are recent, taking place in December 2015. Minneapolis, too, experiences such tragedies, one of which was the shooting death of Barbara Schneider in 2000, a mentally ill woman suffering from bipolar disorder shot by police while wielding a knife. It is Ms. Schneider's death that is the purported catalyst to the Minneapolis Police Department beginning to take steps to address the issue.[6]

Officer training, responding with mental health professionals and other policies have shown to decrease incidents of use of force, reduce costs, lower recidivism[7] and support access to needed services to support the improved quality of life of those experiencing mental illness or emotional disturbances.[8]

Current Minneapolis Police Department Policy

As stated, just as many other police departments and local governments have attempted to confront this situation, so too has the City of Minneapolis and the Minneapolis Police Department. The MPD has a 40-hour Crisis Intervention Training that has previously been made available on a voluntary basis for officers and now will be required for all patrol officers. In addition, the Department attempts to dispatch such CIT-trained officers to calls for service involving individuals with possible symptoms of mental illness or emotional disturbances. But even with these practices in place, officers and community members are asking for further resources and programs to handle the still high numbers of officer interactions, use of force against and incarceration of such individuals.

Community Request for Research and Study

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[4] Norfleet, Nicole. "After police kill St. Paul man, brother says they 'were supposed to help'". Star Tribune. 23 Dec. 2015. Appendix 37.

[5] Cronln, Melissa. "Chicago Police Fatally Shoot 2, Including Mentally Ill College Student". Gawker. 26 Dec. 2015. Appendix 38.

[6] Baran, Madeleine. "Police learn lessons after shooting of mentally ill woman 10 years ago". MPR News. 11 June 2010. Appendix 19.

[7] Seattle's LEAD program, a jail diversion model, showed that participants where 58% less likely to be rearrested. Cloud, David and Chelsea Davis. "First Do No Harm: Advancing Public Health in Policing Practices". VERA Institute of Justice. Nov. 2015. Appendix 9.

[8] The Houston Police Department considers its program, a Mental Health Division, humane, cost-effective, and clinically appropriate and asserts that it "saves lives". Houston Police Department, Mental Health Division. Appendix 12.

The impetus for this proposed Research and Study came from community members who expressed concern regarding the issue to the Police Conduct Oversight Commission. One of these voices was Kathy Czech who spoke to the Commission at their monthly meeting in November 2015 during the Public Comment section of the meeting. Ms. Czech discussed her familiarity with Crisis Intervention Training (CIT) and co-responder programs and asked the Commission to study such programs and issues regarding MPD officer interactions with those experiencing mental illness and emotionally disturbances.

Commissioners showed great interest in the project at the onset. In response the community request, Commissioner Westphal attended an Emotionally Disturbed Persons and Mental Health Conference with the Duluth Police Department and Commissioner Buss moved to create a methodology for a Research and Study at the very next monthly Commission meeting. The methodology was created and the next month, in February 2016, a motion passed to conduct the Research and Study and produce this preliminary report.

Methodology

Study Goals:

The study has three goals:

1. To survey current national practices and recommendations to implement a pilot program in the MPD to improve officer interactions with those experiencing mental health crises;
2. To research and document the current MPD protocol and identify its strengths and areas for improvement;
3. To make policy recommendations for supportive programing to be implemented in the MPD, using best practice research and feedback from the community stakeholders.

Findings

Best Practices Research

The OPCR conducted research on nationwide policies and programs for CIT training, co-responder programs and other supportive police policies and programs. In recent years, a great amount of research has been conducted by academics and advocacy groups on the topic and many police departments have implemented new related programs and policies. Academic and advocacy sources consulted for this preliminary report included the VERA Institute of Justice, the Bureau of Justice Assistance, the National Alliance on Mental Illness and the Police Executive Research Forum. Police department sources consulted included Duluth, Austin, San Antonio, Houston, Los Angles, New York, Farmington, Gloucester and Seattle. Staff also reviewed news media from a variety of sources locally, nationally and internationally. All written material consulted is attached in the appendix to this report.

In addition to consulting written material, members of the Commission and OPCR staff met and spoke with leaders of other police departments, and community stakeholders including community members, city leaders and MPD command staff. Topics discussed included training, relevant personal experiences, professional expertise, and policy recommendations and suggestions. Comments collected in these sessions compliment the written material collected and both sources inform the PCOC's recommendations below.

The Co-Responder Model

A model in used by some police departments and that has support in the local activist community is the co-responder model. As mentioned above, the co-responder model usually involves mental health professionals who respond directly to mental health police calls with officers. This model has been used in a variety of different jurisdictions varying in size from Duluth, Minnesota to Los Angeles, California and Houston, Texas. And each of those jurisdictions runs their program somewhat uniquely.

The Duluth Police Department, for instance, just began its co-responder program and only employs one mental health professional due to their jurisdiction being much smaller than the MPD's. That individual is a masters level practitioner and works full time hours with the police department responding with officers to mental health calls. Though the program has only been in place for less than a year, it has been successful in reducing use of force and getting individuals supportive services instead of arresting them and taking them to jail.[9]

[9] Information on Duluth's program comes from Commissioner Westphal's attendance at a mental health conference with the Duluth Police Department and conversations with Police Department representatives.

The Los Angeles Police Department employees approximately 28 mental health professionals and 61 officers and detectives in its Mental Evaluation Unit and has 18 co-deployed teams where a clinician and an officer respond to a call. Clinicians go beyond call response as well by conducting follow-up visits and even managing caseloads of individuals who are consistently the subject of mental health police calls. The LAPD has utilized a co-responder program since 1993 and uses it in conjunction with a variety of other programs targeting officer interactions with those in mental health crisis including CIT training for their officers and a triage desk where clinicians take calls from officers and give advice about handling situations involving mental health.[10]

Houston also couples its co-responder program with a variety of other practices aimed at improving outcomes for officer interactions with those in mental health crisis. There is an entire Mental Health Division that includes officer CIT training, a Crisis Intervention Team, a Homeless Outreach Team and case management.[11] Houston has found that its co-responder program, coupled with the other noted programs in the Mental Health Division have reduced overall calls for service, recidivism rates costs and officer use of force.[12]

Current MPD Protocol

The Commission and the OPCR worked together to gather information regarding the MPD's current policy and protocol for officers' interactions with those in health crisis. Findings from this research showed that currently 193 officers or approximately 22% of the department is trained in Crisis Intervention and an additional 500 officers will be trained in 2016. These 500 officers include all patrol officers in the city and there is a goal to train all other non-patrol officers in the coming years. Crisis Intervention training will be incorporated into academy training for all new officers. Additionally, the MPD has hired a new CIT Coordinator to manage CIT activities.

Research also showed that the MPD already works with other behavioral health agencies at the County level via the Mental and Behavior Health Initiative, a subcommittee of the Criminal Justice Coordinating Council. County partners via that subcommittee are currently working on a project to provide a 24-hour mental health crisis drop-off center for officers to bring individuals in crisis who may not qualify for a medical hold at a medical facility.

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[10] Southern California Public Radio: "Police and the mentally ill: LAPD unit praised as model for nation", Available in Appendix 34. More information on the LAPD programing in Appendix 13 a-g.

[11] More information on the Houston Police Department's program can be found on their website at http://www.houstontx.gov/police/divisions/mental_health/ and in Appendix 12 a-b.

[12] Much of the information on Houston Police's mental health programs can be found in the annual reports listed on their website. Additional information was obtained through conversation with Houston Police Senior Officer Frank Webb.

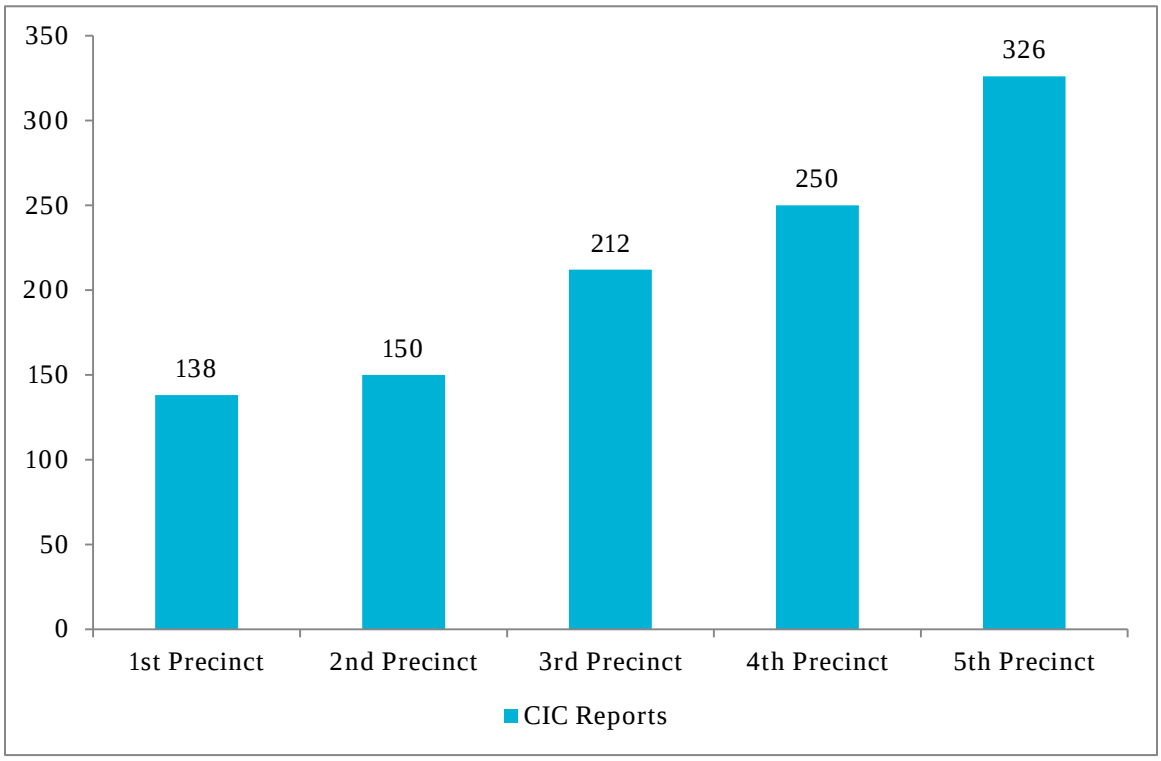
Based on the research and interactions with the MPD, it appears that members of the Department are already working to improve officer interactions with those experiencing mental health crises and are willing and motivated to continue doing so.

CAPRS Data

To supplement the current and best practices research, OPCR staff examined two types of calls specifically dealing with those experiencing mental health issues. The first category exists in the CAPRS database, and is titled Crisis Intervention. These calls involve incidents significant enough to warrant a CAPRS entry versus notes logged in Visinet, including incidents where force was used. During 2015, there were 1,077 such reports. In 69 incidents, officers used force, representing 6.4% of incidents, higher than the average rate in which force is used in law enforcement interactions.

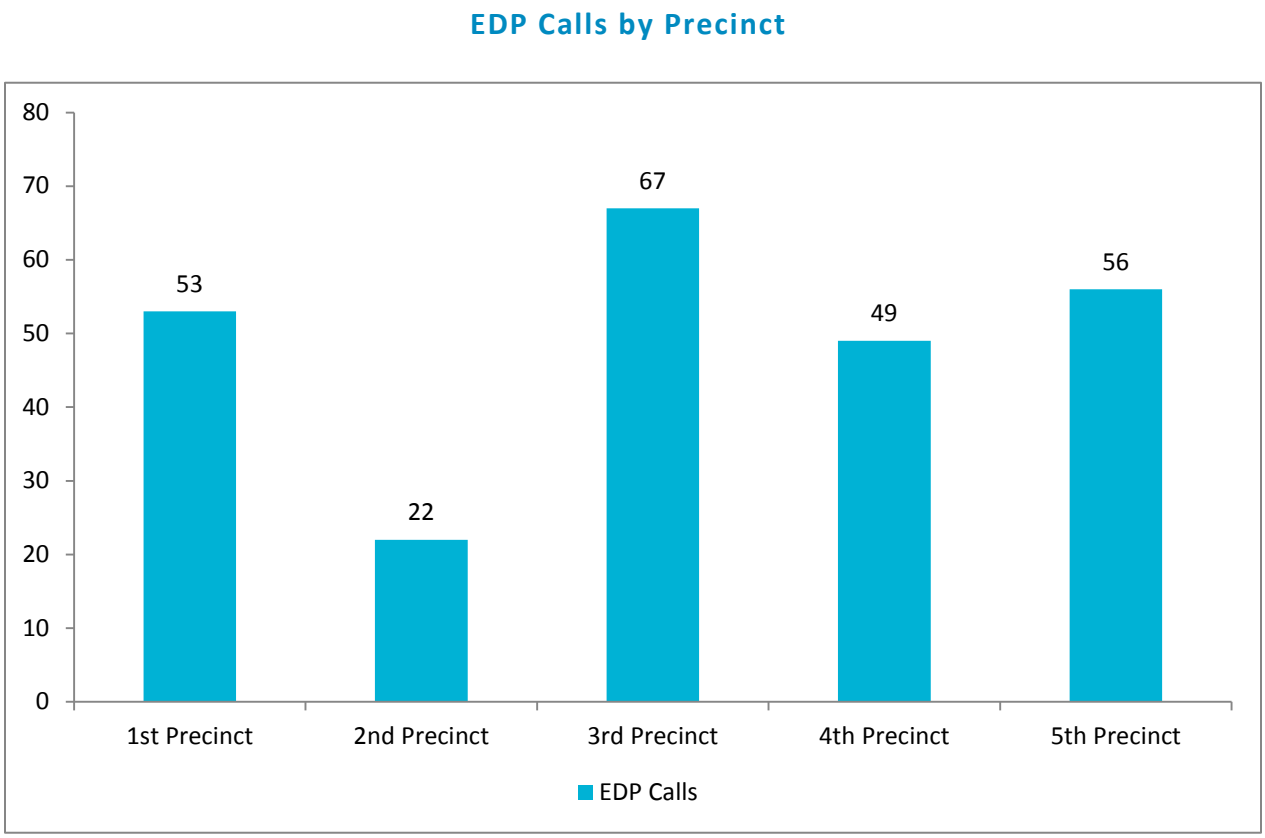
The 5th Precinct wrote the most CIC reports but had the lowest ratio of force incidents to incidents where no force was used. However, because the number of force incidents was low across all precincts, a precinct by precinct comparison of force incidents is unreliable.

One other interesting feature of CIC calls appears in force data and CIT trained responders. In cases where CIT officers were the primary reporting officer in CAPRS, there was a 10% decrease in the rate at which force was used. Again, because of the low numbers of force incidents, the actual decrease in the rate of force may be different, but it does support the advertised benefits of CIT training.



Visinet Data

Next, the office looked in the Visinet system for calls specifically related to mental health issues, particularly calls labeled "Emotionally Disturb[ed] Person" or "EDP." During 2015, there were 4,513 of these calls. OPCR staff sampled 250 of these calls for details not provided in aggregate data. Unlike CIC calls, the EDP calls sampled were evenly spread across the City of Minneapolis, excluding the 2nd Precinct.



The vast majority of calls sampled (70%) led to the subject being transported to a hospital or crisis center. Of the remaining calls, about 10% did not fit the criteria of a mental health crisis, and in 10% of calls the officers who responded could not locate the subject of the call. Only three calls led to the subject being booked.

EMS responded along with MPD in 61% of calls and frequently transported the subject to crisis rather than the officers. CIT officers responded to EDP calls in 43% of the cases surveyed. This supports the notion that more CIT officers are needed to ensure CIT response in all EDP cases.

In reviewing the aggregate data, there was an average of 376 EDP calls per month with little variation (a low of 300 in February and a peak of 417 in September). EDP calls were steady between the hours of 10 AM and midnight, with the fewest calls occurring between 3 AM and 7 AM. Hence, consistent EDP calls occurred during all shifts, necessitating consistent staffing of CIT officers.

Recommendations

These recommendations are made incorporating best practices research, current MPD policy and practice and community stakeholder input. These recommendations include a variety of steps that can be implemented over time. All recommendations are made in an effort to work toward goals of improving officer and community member safety, increasing cost-effectiveness and providing individuals experiencing mental health crises greater access to resources that will support long-term success.

Support for CIT Training of All Officers

The PCOC fully supports the planned training of additional officers in Crisis Intervention. Per the MPD's current implementation plan, all patrol officers should be trained within the year and all other officers in the years to follow. The PCOC fully supports the adequate allocation of financial resources to make this plan a reality.

It is imperative that even with all officers trained in CIT, a smaller number of officers volunteer and be selected based on skill and expertise to be a part of a specialized CIT team and considered CIT Specialist Officers. These Specialist officers should be the Department's experts in responding to mental health related calls and it should be these officers are dispatched to such calls whenever possible.

While language in current CIT related policy calls CIT officers a "team", there is little to indicate that CIT officers function in that way. The PCOC supports this specialized group of CIT officers working more overtly as a team, communicating with each other and the CIT Coordinator on a regular basis.

While there have been discussions of refresher classes for those previously trained in CIT, no specific protocol or schedule currently exists. The PCOC recommends that such refresher training be established for all CIT trained officers every other year and for CIT Specialist Officers each year, for at least eight hours, and include new content.[13]

Support 24-Hour Drop-In Site

The PCOC supports current plans being led by Hennepin County to create a 24-Hour mental health related drop-in site but also acknowledges that such a site is not a comprehensive solution and must be implemented in conjunction with other, more comprehensive, services.

[13] This is the refresher training schedule and practice used by the Houston Police Department.

The drop-in site would be a place where officers could bring those not eligible for a 72-hour medical hold at a hospital or other medical facility and who also do not require incarceration. This is an important jail diversion tool for police and is used in many other jurisdictions.[14] In addition to the space itself, the drop-in site must provide supportive services to those experiencing mental health crises, and be run by trained staff who can provide referrals for further care. Additionally, individuals brought to the drop-in site must receive support soon after arrival.

Implement Mental Health Response Policy

The PCOC recommends that a detailed Mental Health Response Policy be implemented in the Minneapolis Police Department. The current policy lacks specific detail as to when CIT officers are to be called and how CIT officers are expected to respond. The Commission crafted a recommended policy to address this issue, modeled partially after the policy used by the Austin Police Department.[15]

Key points outlined in the policy include: its purpose and scope, a definition of the Crisis Intervention Team, incidents requiring a CIT officer, mental health commitments, arrests of mentally ill persons and reporting procedures.

See the recommended policy in Appendix 1 of this report.

Participate in the Creation of and Support a Co-Responder Pilot Project

The PCOC recommends that the MPD work directly with the Commission to develop a co-responder pilot program for implementation in the MPD. Such a program should include multiple mental health professionals, who will work in police precincts and respond alongside officers to mental health related calls. The success of such a program should be measured by any reduction it provides in use of force, injury or death to officers and community members involved, its ability to reduce arrests and increase alternative responses including de-escalating a situation enough that no further action is needed and an individual can stay at their home, hospitalization, connection to other mental health services such as the planned drop-in site and other community mental health care providers, its cost saving ability, the community reaction to the program and any other criteria that the working group, which will be discussed in detail below, comes up with.

Collect Data via CIT Case Completion Form

[14] Jurisdictions include New York City, New York, Orange County, California, Multnomah County, Oregon, and Seattle, Washington.

[15] Austin Police Department Mental Health Response Policy is available in Appendix 5.

The current MPD policy requires that CIT forms be completed after each call classified as an Emotionally Disturbed Person call[16] but it appears that in practice this has not been taking place. The PCOC recommends that officers comply with this requirement and fill out such a form for every incident involving mental illness in any way. These forms are essential to data collection and analysis of current and evolving MPD policy and practice. Information recorded from these calls should include: how the contact was initiated; whether any force was used; what, if any, mental illness was admitted by the individual involved; any behavior indicating mental health issues; the disposition of the police interaction; and an explanation for that disposition. See the recommended form fields, revised from a version of the form developed previously by the MPD, in Appendix 2 of this report.[17]

The PCOC also recommends that a database program where all information contained in the recommended CIT Case Completion form can be entered, stored and analyzed over time.

Lastly, just as is required for all incident reports, CIT Case Completion forms should always be reviewed by a supervisor. A supervisor should specifically ensure that any force used was appropriate, assess whether the overall disposition of a case was appropriate, and identify any positive or negative patterns in officer conduct.

Support Training of 911 Dispatchers

While it is not within the purview of the Commission to make recommendation to those outside the Minneapolis Police Department, the PCOC would support efforts of the Minneapolis Emergency Communications Center to create or obtain training specifically for 911 dispatchers to assist in recognizing calls that may include an individual experiencing mental issues. Accurately identifying calls as such will promote response by CIT trained officers and provide officers with important initial information to assess the type of action or response they should take on a particular call or with a particular individual. Identifying such calls early on in the process will also assist in data collection and analysis.

In Houston, for example, dispatchers receive 24 hours of training related specifically to mental health responses. In addition to this training, dispatcher scripts include questions specifically related to mental health and the responses to those questions assist dispatchers in assigning the right officers to a call.[18]

Continue to form a Working Group to Consider Additional Supportive Policies and Create a Pilot Program Implementing those Policies

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[16] See Policy and Procedure Manual § 7-809.01 CRISIS INTERVENTION TEAM (CIT) DATA COLLECTION FORM, available in Appendix 3d.
[17] The current form is available in Appendix 3d.
[18] Information obtained through a conversation with a Houston Police Department Mental Health Division representative.

Lastly, the PCOC plans to continue to work on gathering a group of experts together to analyze additional supportive polices for police interacting with those experiencing mental health crises. If formed in time, this group can participate in the development of a co-responder pilot program for implementation in the Minneapolis Police Department, monitor that pilot's success, and potentially monitor the full implementation of such a program into MPD operation.

Other concepts, programs and policies for the working group to support and/or consider could include, but are not limited to:

- A specialized CIT team
- A Mental Health Triage Desk
- Partnerships with Hennepin County's Criminal Justice Behavioral Health Initiative
- Community partnerships
- Priority care agreements with hospitals and other medical facilities
- Shared information systems across county agencies, law enforcement and medical facilities
- Coordination with other jail diversion programs, i.e mental health court
- Case management and follow-up systems
- Data and impact measurement

Individuals invited to participate in the working group should include, but are not limited to:

- PCOC Commissions
- City leaders including representatives from the Civil Rights Department, City Attorney's Office, Mayor's Office, City Council and the Minneapolis Emergency Communications Center
- County leaders including county commissioners, and representatives from the Human Services Department, Community Outreach for Psychiatric Emergencies (COPE) and the Behavioral Health Initiative
- Minneapolis Police Department leaders including the Commander in charge of training, Troy Schoenberger
- Mental health professionals including representatives from the National Alliance on Mental Illness (NAMI) Minnesota
- Community mental health service providers
- Community members with personal experience with mental illness and interacting with police
- Community advocates including STAMP MN

The PCOC recommends that one Commissioner take the lead on making decisions as to who will be invited to be a part of the working group, and when the group should meet. The

working group would ideally produce policy or program suggestions within a year of commencing its work.

Conclusion

The PCOC has collected a vast amount of information through best practices research, contact with other police departments, contact with the MPD and contact with other governmental and community stakeholders and is confident that the implementation of the recommendations stated above will contribute positively to Minneapolis police officers' interactions with those experiencing mental health crises. Due to the complexity of this issue, this report and the recommendations therein are preliminary. The Commission looks forward to continued work and analysis of additional recommendations to be made in the future via the recommended Working Group. The PCOC will produce a final report in the future based on that group's findings, decisions and the success of the pilot program the group is recommended to develop.