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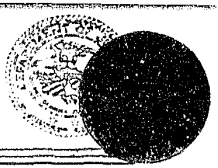

National Institute of Justice / *Issues and Practices*

Police Response to Special Populations

- Handling the Mentally Ill, Public Inebriate, and the Homeless
- How Networks with Social Services Can Help
- Getting Started
- Applying Civil Statutes
- No-cost and Low-cost Networking

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Police Response to Special Populations

by

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and
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Issues and Practices in Criminal Justice is a publication of the National Institute of Justice. Designed for the criminal justice professional, each *Issues and Practices* report presents the program options and management issues in a topic area, based on a review of research and evaluation findings, operational experience, and expert opinion in the subject. The intent is to provide criminal justice managers and administrators with the information to make informed choices in planning, implementing and improving programs and practice.

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Foreword

The public repeatedly calls on law enforcement officers to handle people who are mentally ill, drunk in public, or homeless because police and sheriff's departments alone combine free, 24-hour service with a legal obligation to respond to the scene. However, peace officers' options for dealing with these individuals are usually limited to arresting and jailing them for minor infractions, or trying as best as possible to patch up the situation and leave. Services to these populations are fragmented and often ineffective because of limited treatment capabilities and bed space in social service facilities. These conditions lead to frustration for police officers, who may spend hours trying to get help for these populations, and also raise serious concerns among the public.

One solution that a small number of communities have found to this dilemma is to establish formal *networks* consisting of all pertinent law enforcement and social service agencies. This report describes how twelve such networks have been able to reassign responsibility for most mentally ill, publicly intoxicated, or homeless individuals to the appropriate social service agency for 24-hour emergency assistance and follow-up care.

As a result of these formal arrangements, police officers and deputy sheriffs spend considerably less time stabilizing the situation at the scene, locating a facility willing to accept the person, waiting at the facility, and making repeat runs to handle the same problem all over again. Furthermore, in most networks, trained staff either give officers advice on the phone about how to defuse potentially dangerous situations or come to the scene and take over the case. Finally, in several sites there has been reduced criticism of law enforcement from the media, public, and politicians for allegedly mishandling or ignoring these populations.

Because networking also provides significant benefits to the social service system, county and city departments of mental health and other government agencies have been enthusiastic participants in the arrangements. As a result, the report provides compelling reasons for law enforcement administrators and social service agency and facility administrators alike to start or join a network, along with practical suggestions for how to do so with little, if any, additional expense.

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Summary

In an increasing number of communities, law enforcement agencies and the social service system have developed formal arrangements for coordinating responsibility in handling the mentally ill, the public inebriate, and the homeless. Based on the experience of twelve such communities, this document describes how to start and maintain such a network between the law enforcement community and social service system. Case studies have been included to indicate the wide range of operational and funding arrangements that have proven effective.

Most of the twelve networks focus on the mentally ill. However, several of them address the public inebriate, and two of them deal with the homeless. Of course, there is tremendous overlap in the problems these individuals have. For example, at least half of the admissions to Boston's Pine Street Inn for the homeless have a history of mental illness, and another one-quarter are alcoholics. Thus, while individual networks may be officially devoted to handling only one type of problem person, they often find they must have links with facilities that treat people with other problems as well.

Core Network Structures

Each network that focuses on *the mentally ill* has developed a special 24-hour unit which screens individuals, identifies an appropriate facility to which to refer them, and provides on-scene emergency assistance. In some sites, the unit consists of trained law enforcement officers; in others, the law enforcement agency hires social workers to perform these functions. In still other networks, a social service agency provides the special unit.

Most networks that address *the public inebriate or the homeless* have forged an arrangement directly between the law enforcement agencies and one or more detoxification facilities or homeless shelters. Typically, the parties involved agree to strict referral and admission procedures.

Mutual Benefits

The twelve networks provide substantial benefits for each participating agency that can easily be realized in other jurisdictions. For *law enforcement agencies*, networking saves time, reduces danger, and increases job satisfaction.

(1) **Saving time.** Law enforcement officers spend less time stabilizing situations at the scene, locating suitable facilities, waiting at facilities, and making repeat runs to handle the same problem all over again.

(2) **Reducing danger.** In most networks, trained staff give officers advice on the phone about how to defuse volatile situations, tell officers on the way to the scene whether a subject has a history of violent behavior, or come to the scene and take over the case.

(3) **Increasing job satisfaction.** By informing officers in writing about the treatment plan developed for each referral, networks provide a feeling of closure regarding the case and an explanation for why a particular disposition was used.

Mental health professionals benefit by spending less time evaluating, treating, or transferring inappropriate police referrals. With a network, these people are pre-screened and either diverted to outpatient treatment facilities or taken only to a facility that is appropriate to their needs. Furthermore, in most networks, police give priority to responding to calls from human service providers for assistance with combative clients.

Finally, *local government officials* find networking addresses concerns of downtown merchants and the public at large about the mentally ill, public inebriate, and homeless; helps avoid lawsuits when these populations are not treated appropriately; and reduces the chances of a politically embarrassing murder or suicide occurring. At the same time, a network can help relieve crowded jails and lock-ups by diverting these groups to appropriate social service facilities.

Establishing and Sustaining the Network

All pertinent agencies should be involved in the planning process, and there should be a clear understanding of the special problems each facility has in handling the mentally ill, public inebriate and homeless. Highlighting the benefits that each participant can gain by joining the arrangement will encourage the fullest possible participation.

Networks are most effectively sustained when the interagency agreements are put in writing and when each group makes sure that its own staff adhere to the network's procedures. One way of ensuring proper participation is for a single individual within each agency to act as a liaison to the network.

Networks are further sustained by documenting their success—for example, by monitoring the number of hours law enforcement officers are spared handling these populations, and determining the percentage of appropriate versus inappropriate referrals social service facilities receive from police officers or deputy sheriffs.

The network will last only if staff with above average sensitivity and patience occupy its key positions and are prepared to make some accommodations to the other participants' needs.

Effective communication

Training is needed to promote proper use of the network, motivate police officers to want to use the network, and develop skills in handling problem persons. Other important forms of communication include arranging for law enforcement officers to learn about case outcomes, conducting regular interagency meetings, and providing a 24-hour hotline to resolve emergency crises among participants.

Legislation

Participants need to consult professional legal counsel regarding any legislation that may affect the network. The network can be facilitated or hampered by civil codes that limit involuntary detention, mandate emergency treatment, and protect confidentiality.

Funding

The case studies show it is possible to initiate and maintain an arrangement with little or no funding if the participating agencies can operate more efficiently than before, use previously underutilized resources, or reassign resources to network functions. But, in any event, most networks can achieve savings that offset some or all of the increases in expenditures that may be necessary to join the network.

Audience

This report will assist three primary groups: law enforcement administrators, social service agency and facility administrators, and municipal and county government officials. The document provides these readers with:

- compelling reasons for starting or joining a network between law enforcement and social service agencies;

- detailed case studies of how 12 existing networks were formed and how they benefit participants;
- practical guidelines for initiating and sustaining a network; and
- inexpensive ways to fund a network.

The document will also interest other audiences including administrators of detoxification centers and shelters for the homeless, and any mental health practitioners who interact with law enforcement officers.

Table of Contents

Tables and Figures

Chapter 1 The Problem and the Solution

Two police officers respond to a call about a man who is shouting obscenities and throwing rocks at neighbors he says are trying to kill him with ray guns. The man is terrified. With some difficulty, the officers persuade the man to let them drive him to a hospital for help. However, during the two hour wait to be seen in the overcrowded emergency ward, he calms down. By the time a busy nurse can take time from more critical cases to examine the man, he appears normal and is told to go home. The officers drive the man back to his neighborhood and drop him off. The incident has taken nearly three hours from start to end. The next evening, neighbors call the police to report the same man is acting up in the same manner again.

This kind of incident happens with frustrating regularity in most communities. However, today this story would have a different ending if it occurred in Los Angeles. The officers would call the Police Department's 24-hour Mental Evaluation Unit. Over the phone, a unit officer would pre-screen the case and suggest how to calm the man down and avoid feeding his paranoia. The Mental Evaluation Unit officers would then either go to the scene themselves to take over the case or tell the patrol officers to bring the man to the unit office. Whether in the office or on-scene, the unit officers would assess the man's condition and tell the patrol officers whether to bring him to the hospital. If the man were taqken to the hospital, an emergency ward psychiatrist would evaluate him quickly, confident that if Mental Evaluation Unit officers made the referral, he probably needs to be hospitalized. If so, the facility would either admit the person or find a bed at another facility. The patrol officers will have spent 30 minutes on the case, and the Mental Evaluation Unit officers 15 minutes.

Developing this arrangement in Los Angeles did not come easily. It took six months of discussion and negotiation to prepare a Memorandum of Agreement (see Appendix B1) which the heads of all 16 city and county agencies

that provide emergency services to the mentally ill could sign. The results have paid off, however. The Police Department now requires all 7,000 officers to call the police-staffed emergency Mental Evaluation Unit for assistance in handling, screening, and transporting suspected mentally ill people. The unit receives 550-600 calls a month from officers seeking assistance.

To keep tabs on where beds are available for police referrals, the Department of Mental Health requires all 24-hour psychiatric emergency service units to report every morning their occupancy rate and anticipated vacancies for the next 24 hours. The Department of Mental Health has also stationed a civilian mental health professional in each of the four busiest police area detective offices to divert appropriate mental illness cases from the criminal justice system to the health care system. A 24-hour hotline enables the Department of Mental Health and the Police Department to call high-level administrators within each other's agency to resolve any emergency situation that arises. All these innovations were instituted with little additional expense.

Tailoring the Network to Local Conditions

The type of network developed in Los Angeles reflects a variety of local factors, including the size of the police department, the large number of human service agencies and facilities involved, and legislation mandating the County Department of Mental Health to provide 24-hour emergency care. However, any jurisdiction can develop a formal interagency arrangement by taking into account its own unique needs and resources for dealing with the mentally ill, the public inebriate, or the homeless.

Boston, Massachusetts. Police in a downtown Boston police precinct may take homeless people (including intoxicated and mentally ill street people) to the Pine Street Inn at any hour of the night. The precinct captain keeps his officers informed about the small number of individuals (principally, the violent and those with serious medical problems) whom the Inn will not accept. (See Appendix B2.) The captain also instructs officers to wait a few minutes at the Inn until staff admit the homeless, rather than, as in the past, leaving them at the door and driving off. In return for keeping Pine Street an "easy referral," the State Department of Public Welfare spends $148,000 a year to station an off-duty officer at the Inn during each shift. The special duty officers often show other officers how to handle homeless people without inciting trouble, and they often double check to make sure only appropriate referrals are brought in by on-duty officers. A police presence helps keep the atmosphere calm at Pine Street, as well.

San Diego, California. The San Diego County Alcohol Program contracts with the Volunteers of America to provide a special room,

known as the Inebriate Reception Center, in which up to 80 drunk people at one time can sober up. The San Diego Police Department requires its 1,576 officers to bring all public inebriates to the center. Officers leave within five minutes compared with up to an hour to book inebriates into the jail. The San Diego Police Department brings nearly 25,000 inebriates a year to the center; 15 other law enforcement agencies in the county bring over 1,000. The arrangement costs the police nothing and the county $240,000 for center operations. It costs the county an average of $8.00 for each public inebriate referred.

Washtenaw County, Michigan. The 150 sheriff's deputies in Washtenaw County have 24-hour access to telephone consultation and on-site crisis intervention for encounters involving the mentally ill. A written set of protocols, incorporated in the Sheriff's Policy and Procedures Manual (see Appendix B3), describes each participating agency's responsibilities. Deputies carry wallet cards with the steps for dealing with a suspected mentally ill person. If a subject needs only outpatient mental health services, the deputy calls the Washtenaw County Community Mental Health Center for appropriate referrals. If the center's clinician judges over the phone that the person may need hospitalization, he or she telephones the psychiatric facility nearest the scene to arrange for an evaluation, and the sheriff's deputy transports the subject to the facility. If the client's condition is volatile, however, the center dispatches a two-person team to the scene to provide crisis intervention and accompany the deputy sheriff in taking the person to the hospital. Finally, in extreme cases, deputies may transport the individual directly to the center for assistance. Deputies participate in the patient's evaluation at the facility, and they receive a letter within 72 hours informing them of the assistance the client received. By diverting a modest amount of staff time from other responsibilities to network tasks, agencies participating in the arrangement have not had to come up with any extra funds for the arrangement.

A History of Frustration

The public repeatedly calls on law enforcement officers for assistance with people who are mentally ill, drunk in public, and homeless because peace officers alone combine free, around-the-clock service, with unique mobility, a legal obligation to respond, and legal authority to detain.

In recent years, these requests have increased both as a result of more stringent commitment laws, which left many disturbed people on the streets,

and the deinstitutionalization policies of the 1960s and 1970s, which led to the release of hundreds of thousands of mentally ill individuals from mental hospitals.[1] Eight percent of 1,072 police encounters in a study of one police department involved dealing with mentally ill persons—17 percent of whom were arrested.[2] In addition, increased unemployment, cuts in public assistance programs, and a decline in low-income housing have increased the number of homeless and public inebriates.[3] At the same time, the number of facilities designed to assist these populations has either declined or not kept pace with the increasing need.[4]

Handling the mentally ill is the single most perplexing type of call most law enforcement officers are asked to handle.[5] Most officers prefer to avoid dealing at all with individuals drunk in public and the homeless. Law enforcement officers feel unsure about how to help these three groups, especially when it is difficult to refer them to social service agencies for assistance. Police are often unfamiliar with what services and facilities are available and with how to contact them. Many communities lack needed facilities, while existing agencies often have limited space for police referrals, restrictive admission criteria, complicated admissions procedures, and prohibitive financial requirements.[6] Law enforcement officers are often frustrated when these agencies withhold information, because of confidentiality statutes, regarding potentially dangerous individuals the police are trying to help.

Difficulty handling these individuals creates serious problems for law enforcement officers:

- Frustration at being unable to help people in serious trouble and unable to respond to pressure from citizens to "do something" about these populations;
- Stress from engaging in an activity they are not trained to handle and do not feel is their responsibility to solve; and
- Substantial loss of time trying to find a facility willing to accept these people and then waiting around until they have been formally admitted.

Despite these widespread frustrations, some law enforcement agencies do not find these populations to be a problem—until a crisis occurs: a mentally disturbed person kills an officer (as happened in Los Angeles), the jail decides not to accept public inebriates any more (as in Portland, Oregon), or a homeless person freezes to death (Boston). More often, however, law enforcement agencies know all too well that they have a problem with these groups but are reluctant to bring up the matter publicly fearing they will get stuck with complete responsibility for solving it.

These populations also present serious problems for the social service system. Many human service providers specializing in one type of impairment are reluctant to assist individuals with multiple problems, such as the mentally ill with a developmental disability, public inebriates with serious physical ailments, and homeless individuals with severe emotional problems. Some health professionals report that law enforcement officers make inappropriate referrals.[7] Police and deputy sheriffs sometimes bring people to detoxification centers who are not drunk[8] and transport individuals who are lost or confused, not medically ill, to hospitals.[9] (Jacobson, 1973). Many agencies lack staff and bed space for accommodating even appropriate referrals. Furthermore, they often need to restrict the number of beds available for chronic cases in order to be able to hospitalize more treatable individuals.

Networking: A Solution that Benefits Everyone[10]

The twelve networks described in this report represent an effective solution to most of the problems law enforcement agencies and human service providers in many other communities still experience dealing with the mentally ill, public inebriates, and the homeless. The common goal of each arrangement is to coordinate responsibility for these populations. Police officers and deputy sheriffs are relieved of handling individuals whose problems are primarily psychiatric, medical, or economic; however, when handling cases that do require law enforcement intervention, officers can get quick and professional assistance from human service providers. Each social service facility, in turn, can expect law enforcement officers to refer only those types of problem persons whom the staff are qualified and mandated to assist; at the same time, facility staff can obtain prompt help from officers in emergencies involving dangerous clients. At the least, problem people benefit by avoiding unnecessary involvement with the criminal justice system; at best, they receive assistance from human service providers to begin to solve their problems.

Core Network Structure

The core of each network that focuses on the mentally ill is a special unit—on-duty or on-call 24 hours a day—that:

(1) *screens* individuals for the most advisable disposition;

(2) identifies an appropriate facility to which to *refer* them; and

(3) provides *on-scene emergency assistance* when necessary.

In some sites, the unit consists of trained law enforcement officers; in others, the law enforcement agency hires social workers to perform these functions. In still other networks, a social service agency provides the special unit. Depending on the arrangement, screening and referral may take place on the phone, at the scene, or at the unit's facility. In some jurisdictions, the unit

provides assistance with all encounters between law enforcement officers and the mentally ill; in other communities, all officers are trained to handle routine cases themselves and instructed to call on the special unit only in emergencies. Whether staff from the unit, law enforcement officers, or both together transport the individual for evaluation varies from site to site.

Most networks that address the public inebriate or the homeless have forged an arrangement directly between the law enforcement agencies and one or more detoxification facilities or homeless shelters. Typically, the parties involved agree to strict referral and admission procedures. In some sites, law enforcement officers transport the inebriate or homeless to the facility; in others, the facility provides a mobile van that in part or entirely relieves officers of this responsibility.

Four Network "Musts"

The experience of the twelve networks indicates that—regardless of the target population—communities interested in establishing their own network should incorporate four crucial features into their arrangement:

1. **Develop a formal agreement** to collaborate—preferably a written document that commits each group to the partnership.

2. **Describe the specific activities** in the agreement that each party in the network will undertake.

3. Sooner or later, **involve every important agency and facility** that provides emergency services to the target population.

4. Make sure the arrangement **benefits every participant.**

Mutual Benefits

This final element—providing advantages to each participant—is perhaps the single most important feature network organizers should focus on both for getting the arrangement going and for ensuring its long-term survival. Not only are mutual benefits necessary to ensure the whole-hearted involvement of each participant, making sure every party stands to gain something is crucial to overcoming perhaps the most serious stumbling block to networking—lack of money. However, the case studies in Chapter 2 and Appendix A, and the discussion of funding in Chapter 3, make clear that significant funding is not always needed. Even when it is, a clear demonstration of the mutual benefits networking will provide each participant can lead to joint funding from several sources; as a result, each participating agency becomes responsible for paying only a small part of the total cost.

What are the benefits for each group? As summarized in Figure 1, *law enforcement officers* gain several benefits from networking:

Figure 1

Benefits From Networking For Law Enforcement and the Social Service System

For Law Enforcement

- *Saves time*: reduces or eliminate need to:
  - —stabilize the situation at the scene
  - —"shop" for an available facility
  - —wait at the facility
  - —book the individual
  - —make repeat runs for the same individual
  - —testify in court
- *Reduces danger*, because:
  - —trained staff take over volatile situations
  - —social workers warn officers about potentially dangerous cases
  - —officers receive training in handling problem persons
- *Increases job satisfaction*, because:
  - —fewer repeat cases are handled
  - —feedback on case results is provided
  - —positive relationships with social service workers develop
  - —homicides involving problem persons and jail suicides are reduced
  - —municipal police department working relationships improve with jail officials concerned about overcrowding
  - —dispositions are available that are more appropriate than jail or doing nothing

For the Social Service System

- *Saves time*: reduces or eliminates need to:
  - —evaluate, treat, or transfer inappropriate referrals
- *Reduces danger*, because:
  - —officers come quickly to help in situations involving violence in the facility or in a home
- *Improves job performance*, because
  - —clients are referred to facilities that have treated them before
  - —trained officers testify at commitment hearings
  - —agency's image in the community improves
  - —positive relationships develop with law enforcement officers
  - —client contact with criminal justice system is reduced

For Local Government Officials

- *increases political support*, because:
  - —constituents are pleased to see a serious community problem addressed
  - —business people are pleased to have the downtown made more attractive to customers
  - —embarrassing incidents are less likely to occur
- *prevents political crises and unexpected expenses*, because:
  - —chances of a law suit are reduced
  - —jail overcrowding is alleviated

More time for law enforcement. Police officers and deputy sheriffs in every site spend less time stabilizing the situation at the scene, locating a facility willing to accept the person, waiting at the facility, and making repeat runs—sometimes on the same shift—to handle the same problem all over again. The Montgomery County network documented savings of four person years to police during a nine-year period as a result of its ambulance services alone. This frees officers to spend time on more urgent law enforcement duties.

Reduced danger. In most networks, trained staff either give officers advice on the phone about how to defuse volatile situations or come on-scene and take over the case. The Los Angeles Police Department determined that social workers operating out of four police substations reduced the threat of danger in 15 out of 63 cases they were called to handle. In other sites, social workers let responding officers know whether a suspected mentally ill individual has a history of violent behavior.

Increased job satisfaction. In several sites there has been reduced criticism from the media, public, and politicians for allegedly mishandling or ignoring these populations. Three of the networks were initiated at least in part as a result of the unfavorable publicity devoted to homicides or suicides involving the mentally ill or public inebriates. By informing officers in writing about the treatment plan developed for each referral, networks provide officers with a feeling of closure regarding the case and an explanation for why a particular disposition was used.

Networking also benefits *the social service system.* As a result, nearly half of the arrangements described in this report were initiated by and are still coordinated by social service agencies, rather than by law enforcement. Emergency care staff spend less time unnecessarily evaluating, treating, or transferring inappropriate police referrals, because these people are prescreened and either diverted to outpatient treatment facilities or taken only to a facility appropriate to their needs. Furthermore, some networks focusing on the mentally ill arrange to take these individuals to facilities that have treated them in the past, thereby assuring continuity of care. Human service agencies also benefit when they have to deal unexpectedly with a violent person in the home or in the facility. In most networks, police give priority to responding to calls for assistance with combative clients. In addition, specially trained officers who take over cases at the scene prove to be highly credible witnesses at court commitment hearings.

Finally, *local government officials* find the network shows their constituency that they are concerned about a serious community problem. Furthermore, by assigning specially trained individuals to handle the mentally ill and public inebriate, county and municipal officials reduce their vulnerability to law suits and to criticism in the media by preventing tragedies and providing appropriate assistance. Finally, by diverting these groups to treatment programs and shelters, jail overcrowding can be reduced.

An Adoptable Solution

That twelve very different jurisdictions could develop their own networks to meet the emergency needs of the mentally ill, the public inebriate, or the homeless indicates that other communities can also adopt this solution. The case studies previewed above and presented in detail in the following chapter illustrate four types of arrangements that have been developed:

- a comprehensive program for dealing with the mentally ill in a major metropolitan area (Los Angeles);
- a limited program for dealing with the homeless and public inebriates in one city police precinct (Boston);
- a comprehensive program for dealing with the public inebriate in a metropolitan area (San Diego); and
- a comprehensive program for dealing with the mentally ill in a rural county (Washtenaw County, Michigan).

Together with the eight additional case studies provided in Appendix A, the sites illustrate a broad range of networking features other communities can choose from in developing their own interagency partnerships.

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8. David E. Aaronson, C. Thomas Dienes, and Michael C. Musheno, *Public Policy and Police Discretion: Process of Decriminalization* (New York, New York: Clark Boardman Company, 1984).
9. Doris Jacobson, William Craven, and Susan Kushner, "A Study of Police Referral of Allegedly Mentally Ill Persons to a Psychiatric Unit," in John R. Snibbe and Homa M. Snibbe (eds.), *The Urban Policeman in Transition* (Springfield, Ilinois: Charles C. Thomas, 1973).
10. The National Center for State Courts has published *Guidelines for Involuntary Civil Commitment* (Williamsburg, Virginia: 1985) that recommends many of the specific steps taken by the networks described in this volume, including "the creation of interdisciplinary community coordinating councils made up of representatives of the components of the mental health-justice system involved in civil commitment." The center's guidelines do not address the problems of the public inebriate or homeless. However, they cover many aspects of dealing with the mentally ill that the present document does not address, including court hearings, legal representation of the mentally ill, and judicial determinations and case dispositions.

Chapter 2 How Four Networks Solved the Problem

Twelve networks were examined in the preparation of this report. Table 1 presents a number of key features of each arrangement.

The four sites previewed in Chapter 1 and described in detail below have been selected to illustrate how very different jurisdictions can come up with an arrangement that works. Los Angeles represents a large jurisdiction that—without any additional funds—has fashioned a comprehensive network for dealing with the mentally ill. By contrast, the network in Boston focuses on the homeless and involves only one private human service organization and primarily one police precinct. In San Diego, the city police and county alcohol program have had an effective arrangement for handling public inebriates since 1976. Finally, Washtenaw County with a population of 265,000 dispersed over 575 square miles suggests how rural communities can work with the sheriff's department to resolve problems in dealing with these populations.

Appendix A provides case studies of the eight other networks. Taken together, the twelve arrangements illustrate the wide range of features that can be incorporated in a network. These options provide groups that want to start a network with flexibility to tailor their arrangement to the particular needs, resources, and constraints of their local jurisdictions. The case studies provide different answers to the following questions network organizers will have to ask about how to structure their particular arrangement:

- How *formal* must the agreements be among the participants?
- Will *only one*, or will *more than one*, human service provider organization be the focal point for the social service system's contribution to the network?
- *How many law enforcement agencies* will be involved?

Table 1
Selected Features of Twelve Networks
Site and Where Described in this Report

Feature	Birmingham (Appendix A)	Boston (Chapter 2)	Erie (Appendix A)	Fairfax County (Appendix A)	Galveston County (Appendix A)	Los Angeles (Chapter 2)	Madison (Appendix A)	Montgomery County (Appendix A)	New York/ Jersey City (Appendix A)	Portland (Appendix A)	San Diego (Chapter 2)	Washtenaw County (Chapter 2)
Target group(s)	mentally ill – –	– inebriates homeless	mentally ill – –	mentally ill – –	mentally ill – –	mentally ill – –	mentally ill inebriates –	mentally ill – –	– – homeless	– – –	– inebriates –	mentally ill inebriates –
Demography: population square miles	283,000 100 sq. mi.	NA 7 sq.mi.a	117,000 22 sq.mi.	700,000 400 sq.mi.	194,000 400 sq.mi.	3,000,000 465 sq.mi.	180,000 58 sq. mi.	650,000 500 sq.mi.	NAb NAb	562,640 431 sq.mi.	960,000 322 sq.mi.	265,000 575 sq.mi.
Lead agency or agencies	police department	shelter and police department	private mental health emergency service	community mental health center	sheriff's department	police department and County Dept. of Mental Health	police department	private, nonprofit psychiatric hospital	quasi-private transportation authority	detoxification center	County Alcohol Program	sheriff's department and county mental health center
Law enforcement agency/ agencies involved: type	city police	city police	city police	county police	sheriff's department and others	city police	city police	52 police agencies	transportation authority police	city police and others	city police and others	county sheriff
size (sworn officers)	497	241a	210	950	287	7,000	295	2-150	1,200	750	1,576	150
Annual funding: amount source(s)	$200,000 • city	$148,000 • state	• $225,000 state • $25,000 city	$391,000 • county • regional mental health center	$434,000 • regional mental health center	nonec NA	$35,000 • city	$170,000 • county $2000 • city police	$915,665 • Prrt Authority • cities (New York, Jersey City)	$775,000 • county	$240,000 • county	none
Date network began	1977	1985	1972	1977	1975	1985	1973	1974	1985	1975	1976	1978

[a]For police precinct only.

[b]Data not available; the Port Authority serves transportation facilities in two states.

[c]An unknown, but small, amount of extra funding was needed to hire consultants to help train network participants and perform some of the work which County Department of Mental Health staff who were assigned to the network had been doing.

- Will law enforcement agencies or human service providers be *paid* to provide services, will participation be uncompensated, or will there be a mixture of paid and unpaid services?
- Will *a special unit* be formed to provide around-the-clock assistance in handling the target populations?
- Who will *sponsor* the unit—a law enforcement agency or a social service facility?
- If a special unit within the law enforcement agency is developed, will it be staffed by *specially trained sworn officers or by civilians*?
- *What services* will the special unit provide? 24-hour hotline? Screening? Arranging for judicial approval for involuntary detention? On-scene assistance? Transportation?
- Will the unit handle just *emergency cases* or *all types of cases*?

The case studies which follow, and those provided in Appendix A, show how 12 communities answered these questions.

Case Study #1

Los Angeles, California
The Memorandum and the Civil Law

In 1984, the Los Angeles Police Department came under criticism as a result of two tragedies, one in which a police officer was killed by a mentally ill person, and one in which a mentally ill person killed two children and injured 13 others. A police board of inquiry exonerated the police officers involved but warned that unless all agencies responsible for the mentally ill began to cooperate, similar tragedies would happen again. As a result, the chief of police invited the top-level officials of ten criminal justice and social service agencies involved with handling the mentally ill to form a Psychiatric Emergency Coordinating Committee (PECC). In six months of hardnosed discussions, the PECC hammered out a comprehensive Memorandum of Agreement that took effect April 1, 1985. (See Appendix B1.) The administrator of each participating agency agreed in writing to a list of specific actions designed to divert mentally ill persons involved in minor criminal behavior from the criminal justice system into the health care system, where they could receive more appropriate care.

The two principal co-signatories to the agreement are the Chief of the Los Angeles Police Department and the Director of the Los Angeles County Department of Mental Health. The core of the agreement is that:

(1) The police department will establish a mental health emergency command post staffed by specially trained law enforcement officers. The police department will require all officers to call the unit for assistance in screening suspected mentally ill people before either transporting them to an emergency facility or booking them for a crime.

(2) The Department of Mental Health will (a) maintain a designated resource accessible to the police 24-hours a day with responsibility for immediately resolving special situations of an urgent nature; (b) conduct training programs for police and other network agencies concerning appropriate methods of handling psychiatric emergencies; and (c) develop pilot programs with the police to meet the psychiatric emergency needs of mentally ill persons requiring attention of the police.

The Memorandum of Agreement stresses that "A major objective of this agreement is the diversion of mentally ill persons involved in minor criminal behavior ... from the criminal justice system, when possible, and their referral to the most appropriate system...."

The Legislative Background

Implementation of the Memorandum of Agreement was facilitated by two changes in the state's Welfare and Institutions Code. For years, the statute had required county-funded emergency psychiatric facilities to evaluate suspected mentally ill persons referred by law enforcement officers (or, indeed, referred by anyone). However, due to limited emergency resources, mental health staff were not always able to perform prompt evaluations; furthermore, officers reported they were sometimes told that the facility had no bed space, and that they had to take the person elsewhere. This is no longer a problem because of two changes to the code enacted in 1985. The first amendment forbids mental health personal from using lack of bed space to refuse to assess whether a person brought in by a peace officer needs to be evaluated and treated. The second amendment stipulates that the officer shall not be kept waiting longer than necessary to complete the necessary paperwork and "a safe and orderly transfer" of physical custody of the person.

The Role of the County Department of Mental Health

Many mental health professionals welcomed the new civil code amendments and Memorandum of Agreement because they have a vital professional

interest in keeping mentally ill people out of the justice system. Furthermore, the agreement ensures that they will get needed support from the police, who must come on-scene quickly when a mental health worker requests help with a patient who becomes violent. The Department of Mental Health has also gained strong political support from the police chief, who now lobbies for increased funds for mental health services.

While the changes required by the amendments and agreement could provide major benefits, the Department of Mental Health faced serious problems in carrying them out. In particular, while the department's legal responsibility for emergency treatment of the mentally ill was reaffirmed, facilities still did not have an adequate supply of beds to handle these psychiatric emergencies. As a result, the department has had to engage in day-to-day crisis management to find the necessary beds, and also accelerate its long-term plans to reduce the critical shortage of beds. The department now requires all 24-hour psychiatric emergency service units to call a centralized number each morning to report their occupancy rate and anticipated vacancies for the next 24 hours. With this information, the department's central administration can tell a fully occupied facility where it can transfer a patient for immediate admission. The department also encourages facilities to screen nonemergency admissions more carefully, reduce (where appropriate) the time mental patients are hospitalized, and provide increased aftercare to reduce readmissions. Many facilities have also increased their efforts to improvise space on their own by "borrowing" stretchers from other wards, using blankets and chairs, or filling medical beds.

Prevented by state regulations from using any of its own money to provide new beds, the Department of Mental Health has been working to free up over 200 beds in the state hospital that are currently occupied by chronic patients for use by acute care patients.

Involvement of the Police

To establish the mental health emergency command post, the police department revitalized its existing—but understaffed and underutilized—Mental Evaluation Detail. In the past, the one-man detail had been limited to providing daytime advice by telephone to downtown area officers on how to commit mentally ill individuals. Under the new arrangement, the detail was upgraded to a unit, assigned nine additional sworn officers and a secretary, and given extensive training in the assessment and handling of the mentally ill. The unit is now responsible for:

- providing immediate telephone consultation in the handling of mental illness cases to any officer in the Los Angeles Police Department;

- evaluating the condition of suspected mentally ill individuals brought to the unit's office in downtown Los Angeles; and
- going on-site, when necessary, to assist police with crisis situations involving the mentally ill and, when appropriate, take over the cases.

All 7,000 Los Angeles police officers have been instructed at roll calls, in continuing education classes, and in their field activities manual to contact the Mental Evaluation Detail before taking an apparently mentally ill person into custody (when the only reason for detention is the person's mental condition) and before transporting the person to any mental health facility or hospital. When someone believed to be mentally ill is taken into custody for a criminal offense, the officer must still contact the unit before booking the person.

More and more officers are following these procedures. As a result, the unit receives an average of 550-600 calls a month from police officers in the field requesting advice or assistance. Over the phone, unit staff (a) use the on-scene officers' observations to screen for suspected mental illness, (b) instruct the officers to fill out the necessary application for detention, and (c) give them the name of the nearest appropriate facility. During the call, unit staff check the individual's criminal and mental health history in its Special Location File (discussed below).

When patrol officers bring the individual to the unit, they wait during the ten minute evaluation and then transport the person either to the nearest facility (if detention is needed) or back to where he or she was found (unless the person prefers to be released at the police headquarters).

In the daily situations involving hostages, barricades, suicide threats, and similar crises, one or two of the unit members on duty go on-scene, leaving another unit member in the office to coordinate with the mental health system. For example, when a man threatened to leap from the eleventh floor of a building, unit officers dispatched to the scene phoned another unit officer at headquarters to report the man's identity. By phoning the Department of Mental Health, the unit-based officer located the person's psychiatrist, relatives, and priest, who were all notified to go to the scene. The officer also checked the unit's own files for any reported history of violence by the person so he could prepare the officers and mental health workers at the scene for what the person might do. All this was accomplished in twenty minutes.

"Outstationed" Mental Health Professionals

As part of the Memorandum of Agreement, the Department of Mental Health and the police also agreed to pilot test the "outstationing" of a civilian

mental health staff in each of four police area detective offices located in sections of the city with high concentrations of chronically mentally ill people. Funded by the county and employed by the Department of Mental Health, these mental health professionals are on duty weekdays and on-call after hours and on weekends. However, the mental health professional teams in each site have different responsibilities depending on the particular needs of the site and the preferences of the precinct captain. The mental health professionals may consult with officers who request help and, when appropriate, divert the mentally ill from the criminal justice to the mental health care system. Some of them spend part of their time in the field and the rest in the stationhouse. While in the field, they may ride with a sergeant on patrol, using the vehicle's computer to inform other officers and the dispatcher where they can be reached. The dispatcher then routes all calls involving the mentally ill to them. On scene, they may write the involuntary commitment application, telephone the appropriate facility to arrange for the transfer, and call for the ambulance.

Additional Collaboration

The Memorandum of Agreement calls for three other forms of collaboration between the Department of Mental Health and the police: training, information sharing, and exchanging emergency hotlines.

Training. The Department of Mental Health has provided the Mental Evaluation Unit with a psychologist to coordinate the training for the unit's own officers. Working closely with the Officer-in-Charge of the Mental Evaluation Unit, the psychologist designed the training plan and arranged for Department of Mental Health staff and other speakers to deliver the training. Other department staff participate in training new recruits and in-service training at the police academy. The outstationed mental health workers also provide one-on-one and roll call orientation to police.

The training is not just one-sided. Mental Evaluation Unit officers familiarize mental health professionals with police policies, procedures, and limitations in dealing with the mentally ill. The District Attorney's Psychiatric Section instructs Department of Mental Health staff and emergency ward personnel on legal aspects of involuntary commitment and confidentiality. Many mental health professionals and administrators (as well as police) are unaware that they do not have to return a weapon to a mentally ill person, that Apprehend and Detain Orders can be used to empower law enforcement officers to return escapees to their wards without a warrant or detention order, and that it is illegal for hospitals to call the police to evict post-stroke patients who become violent.

Information Sharing. The Memorandum of Agreement requires both the Department of Mental Health and the police to consult with each other,

within the limits of confidentiality statutes, regarding mentally ill persons. The Mental Evaluation Unit has little difficulty providing information on mentally ill persons to mental health professionals during a crisis. The unit already had a Special Location File for providing officers on route to a call with information regarding dangerous individuals near the scene of the problem. As part of the new collaboration, the unit now also files and shares with mental health workers information regarding mentally ill persons who possess or use deadly weapons, or have demonstrated special skills related to violence (such as martial arts experts).

Confidentiality statutes limit the extent to which mental health professionals feel they can share the same kind of information with police. However, both the California Welfare and Institutions Code and the Memorandum of Agreement require the Department of Mental Health to notify police when a hospitalized patient has been discharged. Police simply check a box on the commitment application to request the information. Although the form included this option in the past, the Department of Mental Health increased its efforts to inform all mental health service providers of their responsibility to honor the request.

Hotlines. When the Mental Evaluation Unit cannot get this or other needed information directly from a facility, it can usually secure it through a special hotline to the Department of Mental Health. As part of the Memorandum of Agreement, each agency has provided the other with 24-hour telephone accessibility to a high-level department administrator whenever any two groups disagree concerning a psychiatric emergency. Although the hotline is used infrequently, it has proven particularly effective when a facility has no beds available to accept custody of a suspected mentally ill person from police. On one occasion, the deputy director of the Department of Mental Health was called on Sunday at 3:45 a.m. to resolve such a crisis. All participants in the network also can use the 24-hour hotline to the Psychiatric Section of the District Attorney's Office for immediate legal opinions regarding the handling of the mentally ill.

On-going Coordination

The Psychiatric Emergency Coordinating Committee (PECC), which established the Memorandum of Agreement and continues to meet monthly, provides an indispensable forum for identifying and resolving interagency problems in handling the mentally ill. Most representatives can either commit their agencies to a course of action at the meetings or else later go directly to a supervisor who can.

* * *

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Case Study #2

Boston, Massachusetts
An Inn for the Homeless

In downtown Boston, no matter how down and out, drunk, or mentally ill the individual, and no matter how late at night, police know where they can almost always take a street person—to Pine Street Inn. The Inn is the largest shelter for the homeless in the city, with space for up to 700 people on frigid winter nights. Pine Street "guests" can find a safe environment along with two meals, clothing, basic medical care, counseling, and—for the first 400 to show up every evening—a bed. Guests leave the Inn each day at 9 a.m. The facility serves 3,000 to 4,000 homeless each year, 50-60 percent of whom have a history of mental illness and 20-25 percent of whom are public inebriates. Police referrals account for half of Pine Street's referrals.

The Basic Agreement

Relations between police and Inn staff were not always so good. Pine Street will not, in fact, accept quite anyone, and its minimal restrictions for a long time created confusion and tension for both parties. Police thought staff were capricious about whom they turned away, while counselors at Pine Street found some officers gruff and uncooperative. Frustrated in particular by inappropriate referrals, the facility director gave the police deputy superintendent a list of admissions criteria in January 1985 that exclude violent individuals and people with serious medical problems. (See Appendix B2). The police captain agreed to read the criteria and names periodically at roll calls.

Pine Street also requested that officers not leave people at the door and drive off, but instead wait for staff to admit them. In exchange, the facility guaranteed it would always take in appropriate referrals.

The conditions of acceptance are still so minimal that Pine Street remains an "easy referral," and officers often come to the Inn first to avoid possible rejections or long delays at other shelters or at hospitals. For example, before taking an inebriated person into protective custody at the police station, officers are supposed to call local detoxification facilities for a bed because the station house has only 20 drunk cells. Taking someone to Pine Street Inn instead is a welcome shortcut.

Most of the contacts Pine Street staff have with on-duty police are with van officers who have been instructed by the Mayor to sweep the streets for the homeless every other evening during the winter between 6 and 10 p.m. Van officers also make special runs to talk to—and, if necessary, arrest—homeless individuals who the Inn's police detail (see below) or local citizens report are becoming a public nuisance.

Off-Duty Police Detail

The relationship between staff and van officers has been strengthened by the provision of off-duty police officers from the precinct as 24-hour security guards at Pine Street. According to one counselor, "The officer becomes part of the facility's shift. Some officers really start to feel like they belong here." A few of the homeless develop a better rapport with the off-duty police officers than with the counselors; these officers often end up doing informal counseling. A number of detail officers donate clothing to the Inn, and one officer gave his overtime paycheck to the shelter.

Most detail officers use the counselors as role models for how to handle the homeless diplomatically. They then explain to on-duty officers who use unnecessary force or abusive language to bring in a homeless person that the guest does not need to be handled so roughly. Furthermore, because detail officers are the ones who have to deal with any homeless people who act up in the shelter, they often double check to make sure fellow officers bring in only appropriate referrals. Sometimes the detail officer helps mediate if there is a disagreement when an on-duty officer drops off an apparently inappropriate person. Special duty officers also tell their fellow officers at the precinct house whom to bring and whom not to bring to Pine Street. And, of course, van officers are often police who have had the sensitizing experience of having been detailed to Pine Street.

The detail benefits the Inn in other ways, as well. A police presence helps calm the atmosphere at Pine Street. The special duty officers accompany counselors on their hourly rounds of a three block radius to break up groups

of loiterers and protect homeless arriving or leaving. Another advantage of having a detail officer is that calls for emergency medical services for Pine Street guests receive number one priority for ambulances when police, rather than Pine Street staff, place the call.

The State Department of Public Welfare provides the Inn with $148,920 a year to hire the detail officers.

Using the Police Union to Resolve Problems

Some officers assigned to Pine Street initially have prejudices against homeless people, but their attitude usually changes with time. In rare instances when Pine Street has an ongoing problem with an officer, the director may ask the officer not to take the assignment or ask another officer who understands the homeless to speak with the officer. Most commonly, however, the director takes up the matter with the police union representative. This avoids embarrassing the officer in front of colleagues and supervisors, and prevents possible disciplinary action.

The union representative tries to prevent conflict over the off-duty assignment because on-duty officers want to retain their easy access to Pine Street—the shelter accepts referrals only from the police and selected area hospitals after 9 p.m. The precinct commander, too, recognizes the value of maintaining good rapport with the facility—in fact, if he cannot find an off-duty officer to take the detail because of a holiday or the Boston Marathon, he assigns an on-duty officer to Pine Street.

* * *

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Case Study #3

San Diego, California
The 7-Minute Drop-off for Public Inebriates

1975 11:00 p.m., Friday, May 23. Officers Hanley and Mendez of the San Diego Police Department (not their real names) are dispatched to a beach party to arrest three drunken college students. The officers pick up the youths, spend 15 minutes booking them for public intoxication, and transport them to the county jail. Because there are five other cruisers already lined up in front of the jail waiting to drop off other lawbreakers, Hanley and Mendez have to wait 45 minutes before they can transfer custody of the youths and leave. The officers spend another half hour filling out an arrest report. It is approaching 1:00 a.m. before they can return to their beat. The youths are released from jail at 2:15 a.m. and sent home with a parent. It has cost the San Diego Police Department over $100 in patrol officer time to complete the arrest (not counting the costs to the jail). Over the next 12 months, city patrol officers will repeat this process with 24,000 other people arrested for public intoxication.

1985 11:00 p.m., Friday, May 22. Officers Vitale and Washington are dispatched to a rock concert to pick up two military men intoxicated outside the auditorium. The police officers arrive and inform the sailors they have the choice of being arrested and sitting in jail for a few hours, or sobering up voluntarily at a health care facility. The sailors gladly choose the facility, and the officers transport them two miles to the San Diego County Inebriate Reception Center in downtown San Diego. Officers Vitale and Washington escort the somewhat unstable men to the reception area, where intake staff have Officer Washington record in the admissions log his name and unit number. The two officers walk out the door at 11:22 and return to their beat. The entire transfer has taken seven minutes and roughly $17 in patrol officer time. There is no other paperwork to complete. Over the next year, the San Diego police will follow this procedure with another 30,000 people found drunk in public. The cost to the county will average $8.00 for each inebriate taken to center.

For over a decade, this second scenario has replaced the delay and expense of taking most public inebriates to jail for San Diego's 1,576 police officers. Why the change? In 1975, the San Diego County Board of Supervisors was

being pressured on three simultaneous fronts: a court order mandated reducing overcrowding in the county jail; the state legislature was considering decriminalizing public intoxication; and downtown merchants were complaining about the harmful effect of public inebriates on the tourist business. As a result, the San Diego County Alcohol Program contracted with the Volunteers of America, a national non-profit service organization, to modify an existing medical detoxification facility to provide an Inebriate Reception Center (IRC)—a room in which up to 80 drunk people could sober up. The contract makes reducing the visibility of public inebriates in downtown San Diego one of the Inebriate Reception Center's goals. To achieve this goal, the IRC must accept all appropriate referrals from the police.

The Inebriate Reception Center provides mats, tables and chairs, coffee, and a pay telephone. Intoxicated people are admitted to the center only on a voluntary basis but are expected to remain at least four hours—longer if they're not yet sober. When appropriate, IRC staff encourage the inebriates to enroll in the parent organization's detoxification unit, its seven-day residential recovery program, or other community residential and non-residential recovery programs.

There was an explicit understanding from the beginning that the police administration would require its officers to take people found drunk in public to the IRC, not to the jail. Police administrators had become increasingly troubled by the use of the public intoxication statute for making "attitude" arrests—jailing people who gave police "a hard time." As the only crime for which police could jail someone without first securing permission from the duty officer, the public intoxication offense was sometimes misused to lock up people without police administrator review. Department officials saw the arrangement with the IRC as a way to eliminate this practice. Use of the center would also reduce the conflicting pressures on the department to clear the streets of public inebriates, on the one hand, yet reduce jail crowding, on the other hand.

The Center Won't Accept Some Public Inebriates

Who's an "appropriate" drunk to ship to the IRC? The Inebriate Reception Center will not accept intoxicated people who:

- cannot manage to walk through the door on their own;
- are combative;
- have a medical problem requiring immediate attention;
- are on drugs;
- have committed some other crime besides public intoxication; or
- are juveniles.

In addition, the center accepts the same inebriate only five times a month. Finally, staff have a Do-Not-Admit list of about forty people who have a history of stealing, being combative, or presenting a health hazard. The decision to retain each person's name on the list is re-evaluated monthly.

Most of the people whom the police bring to the IRC are not chronic alcoholics. Many are college students or military personnel who've had "a few too many" at a beach party, rock concert, or sports event. Sometimes they're the intoxicated passengers in a car driven by a drunk driver. (The driver goes to jail.)

During a typical month—December 1985—the police brought 2,188 people to the IRC. The center turned away 202 people, 161 because they were combative, 37 because they had already been admitted five times that month, and 4 because they needed medical attention. Seventeen percent of those admitted walked away from the facility before their four hours were up. One hundred and forty-four police referrals (7 percent) decided to accept a bed and social detoxification. The police were called back twelve times during the month to remove a drunk who became "hostile" after having been admitted.

What happens to the people who are rejected by the IRC? Drunks who have already been to the facility five times or are combative are booked for public intoxication and jailed. Juveniles are taken home. And the mentally ill are taken to the county psychiatric unit. However, the psychiatric facility often refuses to care for these individuals, and the officers—frequently after a long wait—must return the person to the street.

Who May Use the Center?

Because the Inebriate Reception Center is funded by the county, any of the county's fifteen law enforcement agencies may use it. However, 95 percent of the center's police referrals come from the San Diego City Police Department. Most of the suburban police departments, along with the sheriff's department and state highway patrol, do not have serious problems with simple public intoxication. In addition, most have a long distance to travel in this county of 4,212 square miles to get to the IRC. Even the San Diego police—patrolling a city of 322 square miles and nearly one million people—have to try to consolidate their drop-off trips. Officers in one cruiser often go on the air when they are ready to make a run to the IRC to find out if other patrols have any inebriates to take over; when they do, one cruiser collects them and goes to the IRC.

Despite the distances involved, ten other law enforcement agencies still find it useful to bring a total of 1,000 publicly intoxicated people a year to the IRC.

Getting Officers to Use the Center

Initially many officers in both the city and suburban departments continued to take publicly intoxicated people to jail, because letting them lounge in the comparative comfort of the IRC didn't seem punishment enough for what is, after all, a crime punishable by up to six months in jail and a $1,000 fine. As a result, the police chief distributed written instructions to every officer requiring that:

If an inebriate is rejected by or not delivered to IRC . . ., the arresting officer shall:

1. Prepare a county jail booking slip and enter under the "Remarks" section the reason for non-placement with IRC, if applicable, and the name of the IRC staff member who refused placement.

2. Contact the Duty Lieutenant in person and obtain approval for booking or other appropriate disposition.

When necessary, the Duty Lieutenant can check the IRC log to verify whether an officer stopped at the IRC before requesting permission to use the jail.

Police officers are tested periodically on the directive's provisions as part of the department's standard monthly quiz on department rules. Furthermore, recruits at the police academy are told when and how to use the IRC, and every new police officer tours the IRC facility.

It did not take long, however, for most officers to follow the new procedure. Many police were attracted by the opportunity to avoid the paperwork involved in jailing an offender, and everyone found the procedure unexpectedly simple. Word of mouth quickly took over where department orders left off.

Open Communication Solves Problems

Although the relationship between the IRC, the police, and the county alcohol program is a smooth one, there have been minor conflicts in the past. At one time, the center kept asking the police to track down and arrest every "walkaway" who left the IRC before his or her four hours were up. Center staff also expected the police to come back and arrest anyone who became combative while at the facility. Staff found that some officers were using the center as a dumping ground for prostitutes and other people who were not intoxicated, or for inebriates who had committed other crimes.

By contrast, police complained that the IRC was releasing some inebriates while they were still intoxicated. Occasionally, police reported that a new IRC

staff member was unreasonably intolerant about accepting inebriates who were somewhat unsteady walking through the door, or about permitting somewhat boisterous drunks to stay at the facility.

These growing pains were ironed out when a police captain (or a designated sergeant) and the IRC director got together at the monthly IRC community advisory board meeting. For example, the captain explained that searching for walkaways was an unacceptable strain on the department's limited manpower. On another occasion, an officer met with the entire IRC staff to explain with flip charts and legal codes that because the IRC is not public property, officers cannot arrest its patients for misdemeanors that the police have not personally observed. Besides, the inebriates are no longer engaged in "public" intoxication. The officer described how the staff, however, could make a citizen's arrest for disturbing the peace or assault that would permit an officer to cart an inebriate off to jail.

Police officers still bring a fair number of inebriates to the center (197 in 1985) who are combative or five-time repeaters, because the officers need to get a reject slip from the IRC before going to the Duty Lieutenant for permission to jail them. However, the procedure takes only a few minutes, and the IRC staff understand the officers' need to get the reject slip.

The County Department of Health's Alcohol Program closely monitors the IRC's arrangement with the police. At least once a week, the program analyst stops by the center unannounced to observe, check sign-in logs, and chat with the staff. He also collects, reviews, and reports the center's statistical data.

The arrangement costs the police nothing and the county relatively little. The San Diego County Alcohol Program paid the Volunteers of America $240,000 in fiscal 1984-1985 to run the Inebriate Reception Center. On average, it cost the county $8 for each public inebriate referred, and $35 for each of the seven percent who are afforded social detoxification.

* * *

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Case Study #4

Washtenaw County, Michigan A Two-tiered Team Approach Leads to Close Networking

A man has barricaded himself in his bathroom and is threatening to commit suicide. An elderly woman has stopped taking her medication and is throwing stones at people in the street. The 150 sheriff's deputies in Washtenaw County, Michigan, used to receive only 15-20 calls like these per month, but they invariably found them the most stressful to deal with. The deputies did not know how to handle such people or where to take them. That was in 1978.

Today, the deputies have 24-hour access to telephone consultation, and within minutes they can have on-site crisis intervention from the Washtenaw County Community Mental Health Center for any incident involving the mentally ill. The on-call system is the result of many agencies working together in an unusual two-tiered networking approach.

How They Got There

In 1978, the Michigan State University School of Criminal Justice received a grant from the National Institutes of Health to study and facilitate interagency communication and cooperation between social services and law enforcement. The researchers selected the Washtenaw County Sheriff's Department for the demonstration because the county has a mixture of urban and rural communities, as well as different socioeconomic levels and racial groups. Further, many of the necessary agencies in any proposed network would be administered by the county.

When university staff learned that the mentally ill were difficult cases for deputy sheriffs to handle, they decided to promote interagency collaboration focused on meeting the emergency needs of this population. The researchers developed a two-tiered team framework for ensuring that the network concept would be approved and implemented by the relevant agencies:

- The first tier was a **Policy Team**, composed of the *executive directors* of major county public service agencies. Represented in the Policy Team were the Sheriff's Department, Community Mental Health Department, Community Services Agency, County Planning, Department of Social Services, Public Health Department, and the United Way. The members were in a position to make policy decisions regarding the mentally ill.

- The second tier was an **Operational Team,** consisting of *mid-level agency managers.* They developed the network's operations and worked on specific implementation problems. Members of the Operational Team included the Sheriff's Department, Community Mental Health Department, three local hospital emergency rooms, the state regional psychiatric facility, and the Sheriff's Department.

The Operational Team met biweekly and produced a proposal for the member organizations to join together to resolve problems associated with handling the mentally ill. The Policy Team approved the proposal first as a six-month pilot program. Later, after a thorough evaluation and some changes, the program was implemented on a permanent basis. A written set of protocols, reviewed and incorporated as part of the Sheriff's Policy and Procedure Manual, set forth each agency's responsibilities for dealing with mentally ill individuals whom a sheriff's deputy had been called to assist. (See Appendix B3.)

Prior to implementation, each agency familiarized its personnel with the new procedures. Hospital staff also briefed sheriff's deputies on the mental health services available at the various facilities and relevant sections of the state mental health code. In the process, the deputies became familiar with the hospital staff with whom they would be working.

The Procedures

The Washtenaw County system is a 24-hour telephone hotline backed up by a civilian mental health outreach unit available around-the-clock for emergency on-site response. The procedure operates as follows: upon encountering the subject, the sheriff's deputy attempts to evaluate whether the person is under the influence of alcohol or drugs, is injured, needs outpatient mental health services, or requires hospitalization under the state mental health code. Persons who are obviously intoxicated or under the influence of drugs are taken either to a hospital detoxification unit or, if disorderly, to jail. Injured subjects are taken to a hospital emergency ward. For sober and uninjured mentally ill persons, the deputy telephones the assigned mental health center office and describes to the on-duty clinician the general appearance, condition, and behavior of the subject. At this point, four courses of action may follow:

(1) If the subject may not be involuntarily committed under state law but might benefit from mental health services, the clinician recommends appropriate referrals to the deputy by telephone. In the rare instances when friends and relatives are not available to transport nonviolent and noncommittable individuals home or to the hospital, taxicabs are used to free the deputy to return to street duty. The cab company bills the sheriff's department.

(2) If the clinician judges over the telephone that the person is committable, the clinician telephones the psychiatric facility nearest the scene to arrange for an evaluation. The sheriff's deputy transports the subject to the facility.

- If the diagnostic team at the facility does *not* recommend commitment, it may arrange for the individual to use other community resources, arrange for transportation back to the person's home or other suitable place, or recommend arrest for a violation of a criminal law.
- If the psychiatrist *recommends commitment*, the deputy transports the subject to the Ypsilanti Regional Psychiatric Hospital for a second and final evaluation. If the subject is again found certifiable, he or she is admitted; otherwise, the new diagnostic team has the same options available as after the first evaluation when the subject is not found to be certifiable.

(3) If the client's condition at the scene is volatile, or if the clinician and deputy sheriff in the phone conversation disagree about whether the client should be committed, the Community Mental Health Center dispatches a two-person outreach team to the scene to provide crisis intervention and determine the need for hospitalization.

(4) Finally, in extreme cases (as when a person is making persistent suicide attempts), deputies may transport the individual directly to the center for crisis intervention and assessment.

Keys to Ensuring Success of the Arrangement

Washtenaw County sheriff's deputies and Community Mental Health Center staff believe several factors make the system work.

Deputy as Part of Diagnostic Team. In potentially certifiable cases, deputies participate in the discussions at each hospital regarding the criteria the psychiatrist uses to make the diagnosis, alternative courses of action that might be taken, and clinical symptoms to look for. This participation allows the deputy to learn more about diagnostic procedures for use in future contacts with the mentally ill. Within 72 hours of a disposition, the Community Mental Health Center also informs the deputy by letter of the assistance the client received.

Mutual and On-going Training. Cross-training of mental health and sheriff's personnel at the beginning of the relationship not only taught staff how to interrelate but enabled them to get to know each other. On-going training of new staff—now each agency's own responsibility—is also essential.

Liaison. Each agency has made a single person responsible for day-to-day communication with the other agency and for monitoring training lapses and other problems.

Written policy and procedure. By clarifying the responsibilities of all parties in documents that everyone could refer to when in doubt, written protocols helped ensure consistency in law enforcement and mental health professionals' handling of the mentally ill. In addition, written protocols turned out to be useful training tools for new staff.

Wallet Cards. Deputies carry wallet cards (see Figure 2) giving the steps to follow when they deal with a suspected mentally ill person. In addition, they carry other cards listing voluntary, non-emergency mental health services for distribution to subjects and their families. (Although only two percent of clients given cards initially contacted a referral agency, when deputies telephoned clients within 48 hours to encourage aftercare, the contact rate rose to 18 percent. Unfortunately, because telephone follow-up takes considerable time, it is currently done infrequently.)

Figure 2
Wallet Card
Washtenaw County

POLICY STEPS

I. Injured, Drugs, Intoxicated?

II. In Need of Mental Health Services?
- A) Call CMH
  1. Community Alternatives, or
- B) Diagnostic Evaluation at Emergency Services
  1. First Certification/Petition; Transport, or
  2. Release to Community; Transport
- C) Second Diagnostic Evaluation at YRPH
  1. Second Certification/Commitment, or
  2. Release to Community, Transport

III. Follow-Up Services?

IV. Forms Filled Out?

MENTAL HEALTH SERVICES

Community Mental Health

Day:	Eastern Washtenaw County, YACS	485-0440
	Other County Areas, Out-County	665-9163
Night:	All County Areas, U/M-CMH E.S.	996-4747

University of M/CHM Emergency Services 996-4747

St. Joseph Mercy Hospital Emergency Services 572-3000

Beyer Hospital Emergency Services 484-2345

Ypsilanti Regional Psychiatric Hospital 434-3400

No funding needed. Although the grant from the National Institutes of Health to Michigan State University paid for planning and organizing the team approach, no agency added to its budget to participate in the network. No agency had to initiate any new services; participants just clarified and made fully available the services they already offered.

The two-tiered team approach. The most important feature of the arrangement is readily available communication and decision-making authority at the policy level through the Policy Team, coupled with quick and thorough implementation of policy decisions by the Operational Team. The Policy Team still meets every two or three months to resolve any policy issues related to the mental illness network. At the same time, the members address other public health problems that require interagency collaboration, such as domestic violence and child abuse. For each new public health problem it identifies, the Policy Team assembles a different Operational Team composed of those agencies needed to solve the particular problem. The Operational Team for the mentally ill continues to meet every couple of months.

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Chapter 3 Developing an Effective Network

There are five essential considerations in developing a network for handling the mentally ill, the public inebriate, or the homeless: establishing the network, sustaining it, providing for effective communication, examining pertinent civil codes, and securing—or doing without—funding.

Establishing the Network

General Guidelines

Do your advanced planning. Network organizers need to develop a clear understanding of each agency's problems in handling the mentally ill, the public inebriate, or the homeless. Equally important, each agency's *attitudes* toward these groups must also be considered. For example, detoxification facility directors in Portland, Oregon, and San Diego learned that some police officers preferred to jail public inebriates because diversion to a sobering up center was perceived as too lenient a disposition for these lawbreakers. Law enforcement officials in several sites found that asking mental health facilities to provide crisis intervention can intimidate some human service providers, because many of them have not been trained to furnish emergency psychiatric care.

Law enforcement agencies and social service providers should become familiar with the stereotypes each group has of the other. Images of "insensitive cops" and "soft-hearted social workers" had to be overcome in most of the sites. Furthermore, law enforcement agencies need to realize—and accept—that most social service agencies require time to change their policies to participate in a new arrangement, whereas law enforcement agencies can often act swiftly to change their in-house procedures.

Involve all pertinent parties. An effective way to promote mutual understanding is to involve every important group in planning the network.

- The Los Angeles Police Department assembled a task force with representatives from the County Sheriff's Department, the County Department of Mental Health, the County Department of Health Services, the city Fire Department, the District Attorney's Office, the City Attorney's Office, the Superior Court, the Los Angeles County Alliance for the Mentally Ill, and seven regional centers serving the developmentally disabled.

- In Galveston County, Texas, a task force representing the Sheriff's Department and the local mental health center together developed a preliminary network design and then proposed it to a meeting of magistrates, chiefs of police, the Texas Department of Mental Health and Mental Retardation Center, and the County Commissioner's Court.

- Montgomery County, Pennsylvania, learned the need for multiagency participation when a task force composed exclusively of mental health facility directors spent a year fruitlessly trying to design a 24-hour emergency psychiatric service; the group succeeded only when it added law enforcement agency representatives and staff from alcohol and drug agencies.

- Fairfax County, Virginia, and Portland, Oregon, found they eventually had to add the local Emergency Medical Services (EMS) provider to the network to avoid conflict and duplication of effort responding to the mentally ill or public inebriates with emergency medical problems.

There is no single best way to involve all the needed groups. In some sites, a formal arrangement was first initiated between a law enforcement agency and a single human service provider organization; later, the network was expanded through one-on-one meetings with other agencies and facilities. The Erie Police Department in Pennsylvania first developed an agreement with Family Crisis Intervention, a local emergency mental health facility. Then, staff from the two agencies met with dozens of other human service providers to invite them to join the network and clarify what each party could contribute. A Fairfax County police community relations officer met individually with five different hospital administrators to develop a set of written protocols for handling mental illness emergencies—such as under what circumstances the nurses would require an officer to remain at the facility to restrain a potentially violent patient.

The task forces and one-on-one meetings involved high-ranking administrators capable of either committing their organizations to an agreement or going directly to a higher authority who could authorize procedural changes. Involving individuals within each agency who will implement the arrangement is also important. Washtenaw County used a two-tiered approach—a Policy Team, composed of the executive directors of major county agencies, and an Operational Team, consisting of mid-level agency managers responsible for implementing the Policy Team's decisions. Within law enforcement agencies it is particularly critical to gain the support of watch commanders, who can be extremely influential in dealing with line officers.

Discover hidden talents. Many agency supervisors have staff or know colleagues who they may not realize have special contacts, experience, or personalities that make them unusually qualified to play a central role in organizing the network.

- In Galveston County, a sheriff's captain played an influential role in promoting the network because he had been on the board of the Regional Mental Health and Mental Retardation Center for 15 years.
- One of the two principal sponsors of the Portland network for dealing with the public inebriate had been both the Multnomah County Executive and the sheriff.
- In Fairfax County, the social worker who headed the agency that would be tapped to provide on-scene emergency assistance to the County Police Department was a retired police officer who had maintained friendly relations with the chief of the county police.
- When a university researcher in Washtenaw County secured a federal grant to initiate a network, he introduced himself to the sheriff not as an academician but as the director of a criminal justice training center for the police and the former director of security for the 1972 Democratic and Republican National Conventions.

Even without any special contacts or background, a single energetic and perceptive individual can have a tremendous influence on the development of the network. The director of Family Crisis Intervention in Erie defused a lot of police mistrust of social workers by constantly making himself available after hours and forcefully prodding other social service providers to accept police referrals. In Birmingham, the social worker heading the police Community Services Officers endeared himself to human service providers by being able to speak Cuban Spanish, a rarely found but needed skill in the city's mental health system.

Motivating Agencies to Collaborate

The best way to motivate agencies to join the network is to incorporate features in the arrangement that will benefit everyone. When psychiatric nursing staff in Birmingham used to call the police to a home to handle a potentially dangerous client, the officers would stay in the cruiser while the clinicians entered the building because the police were restricted by law from helping clinic staff with mental patients. The network that was developed provided the police department with an in-house unit of social workers who can—and do—accompany clinic staff into the home.

Often agencies are already under pressure to provide emergency services to the mentally ill, public inebriate, or homeless. Suicides or homicides involving these individuals created strong political pressure for law enforcement agencies in Los Angeles, San Diego, and Montgomery County to address these populations. Civil statutes in California and Pennsylvania required the Departments of Mental Health in Los Angeles and Montgomery County to provide 24-hour emergency services to the mentally ill. An arrangement that can assist agencies to reduce these pressures will help promote participation.

In some cases, both the social service system and law enforcement agencies alike may fail to cooperate even when the significant benefits of doing so are made clear. For example, social service agencies and police and sheriff's departments alike usually feel they do not have the resources to train their staff—and each other's staff— in how to deal more effectively with the mentally ill, public inebriate, or homeless. However, by failing to compromise and collaborate with each other to fully meet the needs of these populations, every agency may find itself facing political pressure, legislative requirements, or other new obligations that may make their operations even more difficult than a negotiated settlement would have.

Some of the consequences to law enforcement agencies for failing to work effectively with the social service system have already been noted above—preventable tragedies, such as suicides and homicides, that result in adverse consequences ranging from bad publicity to law suits. Similar coercive circumstances can befall social service agencies that fail to compromise with law enforcement agencies. For example, the Los Angeles County Sheriff's Department lobbied for an amendment to the California Welfare and Institutions Code that prohibits emergency ward staff from refusing to evaluate a police referral just because the facility is full. Another amendment requires hospital staff to permit the officer to leave once the paperwork has been completed and an orderly transfer of custody has been arranged. As a result of this legislation, a representative of the District Attorney's Psychiatric Section only half jokingly advised law enforcement officers at a meeting of the Psychiatric Emergency Coordinating Committee to arrest mental health

professionals who did not adhere to the statute. Upon arrival at a hospital, some police officers initially gave emergency ward staff a copy of the law along with the paperwork for transferring custody.

In Erie, which is covered by a similar code provision in the Pennsylvania civil statutes, some officers initially suggested to emergency room physicians that a refusal to evaluate referrals would have to be noted in the police report of the incident— providing a possible basis for a later lawsuit against the doctors. The Family Crisis Intervention Unit in Erie has also telephoned agency heads at home in the middle of the night when a facility has been unable to accept a police referral.

In still other sites, network organizers have intimated that they might request the county or city to withdraw funding from agencies that were not fulfilling their contract requirement to evaluate referrals. The Los Angeles Police Department invited the local chapter of the Alliance for the Mentally Ill to participate in the interagency task force not only out of respect for its expertise and concern, but also because the group could generate public and media pressure to make sure an effective network was developed.

Obviously, using these kinds of approaches, even as a last resort, can backfire and lead to resentment and more resistance from potential or current network participants. However, staff in some law enforcement and social service agencies were not displeased at being pressured to meet what they, too, recognized was a serious need.

Forceful approaches work best under the following circumstances:

- When individuals who use them simultaneously demonstrate genuine interest in helping the mentally ill, public inebriate, or homeless, and not simply a concern to make life easier for themselves. A major reason the Alliance for the Mentally Ill supports the police effort in Los Angeles is because the Mental Evaluation Unit officers are sincere in their efforts to help the mentally ill.
- When there are real "teeth" behind the pressure. In Los Angeles and Erie, hospital staff are indisputably liable if they fail to evaluate suspected mentally ill individuals whom officers report may be a danger to themselves or others.
- When pressure is used in conjunction with offers of assistance. Police in Los Angeles, and both police and Family Crisis Intervention staff in Erie, divert many mentally ill people *away* from emergency wards by providing outpatient referrals and advice to the family. Furthermore, police in both sites stand ready to assist

social service agencies around the clock on a priority basis to deal with any violence in their facilities.

An Example of Successful Network Initiation

A brief account of how one jurisdiction developed its network illustrates most of the guidelines suggested above.

In 1966, the Pennsylvania Legislature passed the Mental Health/Mental Retardation Act mandating mental health centers to provide 24-hour emergency psychiatric services and in-patient units. However, as of 1970, 24-hour emergency services in Montgomery County were still inadequate. As a result, the County Mental Health/Mental Retardation Administrator invited the medical and administrative directors of the six community mental health centers in the county to serve on a board to develop emergency capabilities as expeditiously as possible. At this time, the County Mental Health Administrator was advocating the immediate establishment of a temporary central emergency service to fulfill the county's mandate until the local mental health centers were able to establish their own emergency facilities. However, as one health center administrative director acknowledged:

> "As a board, we were really making little headway. While we recognized that there was an immediate necessity for emergency psychiatric coverage, some of us were reluctant to agree to a central service — even if it would only serve as a temporary solution. Basically, the energy we would have to invest in establishing this would hinder our efforts in eventually implementing such services at the community health center level."[1]

After a year of little progress, board members recognized that their own preferences were hampering development of a solution and that the issue should involve a larger segment of the community.

Representatives from the criminal justice system and alcohol and drug agen cies were invited to join the board. With the addition of these members, it became apparent that not only was there a substantial interest in developing emergency psychi atric care but also a concern that there were no emergency detoxification services for alcoholics and drug addicts. The inclusion of alcohol and drug agency officials on the board resulted in a decision to expand emergency psychiatric coverage to include alcohol and drug detoxification services. The police were particularly interested in phasing out "drunk tanks." A long-term alcohol rehabilitation program that had funds available for detoxification agreed to refer public inebriates to a central emergency facility, since it would be more efficient to have all emergency services under one roof. The alcohol program would then serve as a follow-up placement.

By 1972, the concept of a temporary emergency psychiatric facility had expanded into a design for a comprehensive emergency unit serving individuals experiencing mental health, mental retardation, drug, and alcohol crises. As one board member recalls:

> "It was fascinating to see the evolution of a stop-gap solution to meet a state mandate progress to a design that the county really desperately needed. It wasn't until we had arrived at the final design that we realized here is something Montgomery County must have. And at this crucial point we had the wholehearted support of the community and the county officials."

The Board of Directors of the County Mental Health/Mental Retardation Office and the County Drug and Alcohol Council agreed to provide the principal financial support.

Montgomery County's experience demonstrates how much determination to succeed may be necessary for a network to take shape. As one of the Montgomery County planners observed,

> "The need was clearly here, and the legislation mandated us to do it, but I can think of innumerable reasons why the concept seemed doomed to failure. We succeeded because key county and agency officials were determined to work together and see this thing through. I guess we recognized that the county had to have it, and we were responsible for seeing that it happened."

Sustaining the Network

Develop Written Interagency Agreements

In nearly all the sites, there is an explicit written statement of roles and responsibilities. Some observers feel that putting agreements on paper can scare off insecure administrators and also make it difficult to adapt the arrangement to changing resources and needs. However, most participants agree that a written document in the long run promotes commitment to the network.

- When they make a commitment in writing, administrators are less likely later on to shirk their responsibilities because they will have been careful to agree to perform only those activities they are truly prepared to undertake.
- If the document is available for public inspection, it is more difficult for signatories to deny their obligations than if the agreement is merely verbal.
- A written document can be used by administrators to explain that their hands are tied if third parties object to the new procedures.

- A written document reduces misunderstandings and uncertainty over each party's role and responsibilities. Documentation can also be used to explain the network to new staff and authenticate the importance of the arrangement.
- In some jurisdictions—such as Washtenaw County—a signed agreement makes it legal to exchange certain information about the mentally ill by qualifying these individuals as "shared clients" between two or more agencies.

Three types of written agreements are used: *memorandums of agreement* that describe each participant's responsibilities (see Appendices B1 and B4 for examples); *service contracts* that buy specific human services, such as detoxification; and *letters of understanding* that specify what each participant will undertake (see Appendix B5).

Ensure In-House Conformity

A number of agencies have prepared written instructions to their own staff describing their responsibilities in the network. Like written interagency memorandums, written policies and procedures help ensure commitment by administrators, provide a convenient "excuse" for line staff to adhere to the agreement, and help prevent misunderstanding about what the new procedures are.

Law enforcement agency protocols are typically incorporated into the department's general orders. Six pages of the Washtenaw County Sheriff's Department Policy and Procedure Manual give instructions for handling Persons in Need of Mental Health Services. One passage requires that:

> If it appears that subject 1) could benefit from CMH [Community Mental Health] services, or 2) is a person requiring treatment under the mental health code, the deputy shall contact a CMH representative from the nearest telephone providing some degree of privacy. Deputies in the eastern part of Washtenaw County will call the Ypsilanti Area Community Service Center, 485-0440. All others will call CMH Out-County, 665-9163. If there is no answer, any deputy may call Emergency Services, 996-4747.

The Woodburn Center protocol in Fairfax County lists eight steps the Mobile Crisis staff members must follow in responding to a police request for assistance, from "Determine whether police need to remain on the scene after the Mobile Crisis Unit arrives" to "Contact Emergency Service from the scene to determine if there are any records of an identified patient at Woodburn Center for Community Mental Health." (See Appendix B6.)

Even with written instructions, some staff may fail to follow the established procedures. In both Portland and San Diego, some police officers continued to take public inebriates to the jail instead of to the detoxification center; as a result, the police chiefs in each city required every officer to secure the duty sergeant's permission in person before booking any public inebriate. In almost every site the new arrangement resulted in at least some inappropriate referrals by law enforcement officers and some impermissible rejections by facility staff. In fact, because of the inevitability of some initial confusion, the Washtenaw County network organizers deliberately included a grace period during which all referrals would be accepted until each facility's admission criteria had been learned. However, law enforcement officers in some sites were reluctant to use the network at all. Some officers did not think the social service system could be of assistance; others wanted to maintain complete control over cases.

Appoint Liaisons

Several sites have found it extremely useful to make a single person within each agency responsible for supervising how the agency works with the network. Staff who have questions about how they are supposed to handle problem persons know exactly whom to contact. In addition, as "one of our own," an in-house liaison is better able than an outsider to encourage staff to work with other agencies.

Staff and administrators in other agencies come to trust the liaison and often prefer to deal with this person rather than with individuals they may not know. A new doctor at a Washtenaw County psychiatric hospital refused to let two sheriff's deputies leave the facility even after the man they had brought in had been evaluated. The problem was quickly resolved because the sheriff's department liaison could telephone the hospital liaison and ask her to explain to the physician the network policy on not detaining deputies.

Most liaisons also monitor the network's success.

Measure Success

Monitoring and evaluating the arrangement makes it possible to identify problem areas in need of attention and to document that the network is a worthwhile activity.

- The Social Service Coordinator in the Madison Police Department reviews police incident reports to make sure officers are following department policy. He also monitors the speed of the crisis intervention service's response to on-site emergencies. If response time is averaging more than 30 minutes, he contacts the mental health center to discuss how the time can be shortened.

- In Birmingham, the police department Community Safety Officers telephone facilities to check on the appropriateness of police officers' referrals.
- During the network's first half year in Portland, the director of the detoxification center met monthly with the police bureau liaison to review each inebriate the facility had rejected and the jail had accepted to see if officers were following the police department's general orders for handling this population.
- At least once a week, the San Diego County Department of Health program analyst stops by the Inebriate Reception Center unannounced to observe its operations, check sign-in logs, and chat with the staff. In addition, the center submits data each month tallying the number of police referrals, the law enforcement agencies making the referrals, and the disposition.

Table 2 summarizes a variety of activities performed by the Montgomery County Mental Health/Mental Retardation Emergency Service ambulance. For example, 50 mentally ill individuals were transported to the psychiatric emergency ward in December 1983, saving police over 217 hours. Table 3 is a portion of the log for one week that keeps track of the date each ambulance run was made, the law enforcement agency that was assisted, and the estimated number of police hours saved on each run. Similarly, the Birmingham Police Department calculated that during a typical three-month period in 1986, over 178 hours of patrol officer time—the equivalent of 21 person shifts—was saved by using Community Safety Officers to transport 54 suspected mentally ill individuals to the hospital for evaluation and to stand by until the evaluation was completed.

Several sites also keep track of the percentage of people referred by law enforcement officers for emergency psychiatric evaluation who end up being hospitalized. The higher the percentage, the fewer inappropriate people the facility has to waste time evaluating. Montgomery County found that 90 percent of police referrals required hospitalization; in Galveston the figure has ranged between 50 and 80 percent; in Los Angeles it is 65 percent.

Another indicator of potential network success is the percentage of police referrals for suspected mental illness or alcoholism who voluntarily enter a treatment program. The assumption is that recidivism will be reduced if the network functions properly to transfer responsibility for the mentally ill and the public inebriate from the criminal justice system to the health care system. A study of police referrals of mentally ill persons in Fairfax County showed that 71 percent had followed through with a treatment recommendation and were actively engaged in a voluntary outpatient program within four weeks

Table 2

Montgomery County MH/MR Emergency Service Ambulance Statistical Information

	Number of Times from 1/1/75 to 11/30/83	Number of Times in December 1983	Cumulative Totals from 1/1/75 to 12/31/83
Picking up Clients for Evaluation at Montgomery County Emergency Services	3,543	50	3,593
Providing Client Transportation after Referral or at Discharge	4,593	67	4,660
Providing Transportation for Patients in Need of Medical Services	1,401	20	1,421
Providing Transportation for Patients to Social Service Agencies and for Related Needs	465	2	467
Estimated Number of Police Hours Saved	3,203 hours	218 hours	8,420 hours
Number of Miles Clocked for Ambulance	160,307 miles	2,536 miles	162,843 miles

of the intervention. The Washtenaw County Sheriff found that although only two percent of individuals to whom deputies gave wallet cards listing outpatient mental health services sought help, the number seeking assistance rose to 18 percent when deputies telephoned clients within 48 hours to encourage aftercare.

Resources permitting, more formal evaluations can also be very useful. The Los Angeles County Department of Mental Health and the Los Angeles Police Department are required by their Memorandum of Agreement to evaluate the posting of a mental health worker in each of four police substations. The Department of Mental Health collects data on how many clients are diverted from probable arrest and how effectively they are linked with referral agencies. The police department measures whether the time spent on calls by officers working with the social workers is less on average than the time spent on similar calls by police working alone. Figure 3 presents preliminary findings that show, for example, that police time was reduced in

Table 3

Police Hours Saved by Montgomery County Emergency Service Van During First Week of December 1983

DATE	POLICE DEPARTMENT	TIME SAVED (Hrs. and Mins.)
12/1/83	Montgy. Co. Sheriff's Dept.	2:40
12/1/83	West Norriton Police Department	1:20
12/1/83	Montgy. Co. Sheriff's Dept.	2:00
12/2/83	Montgy. Co. Sheriff's Dept.	0:40
12/2/83	Pa. State Police (Limerick)	2:50
12/2/83	Montgy. Co. Sheriff's Dept.	2:30
12/2/83	Montgy. Co. Sheriff's Dept.	2:30
12/2/83	Harleysville Police Department	3:00
12/5/83	Montgy. Co. Sheriff's Dept.	2:30
12/5/83	Montgy. Co. Sheriff's Dept.	0:30
12/5/83	Montgy. Co. Sheriff's Dept.	0:20
12/5/83	Abington Police Department	3:20
12/5/83	Norristown Police Department	1:20
12/6/83	Lower Merion Police Department	2:40
12/6/83	Abington Police Department	4:50
12/6/83	Montgy. Co. Sheriff's Dept.	4:50
12/7/83	Montgy. Co. Sheriff's Dept.	4:40
12/7/83	Montgy. Co. Sheriff's Dept.	5:10
	Total for the week:	47:40

19 of 63 cases involving the mental health workers, 18 clients were diverted to treatment programs, the threat of danger was reduced in 15 cases, and arrests were prevented 10 times.

Figure 4 summarizes the types of monitoring and evaluation data the sites collect.

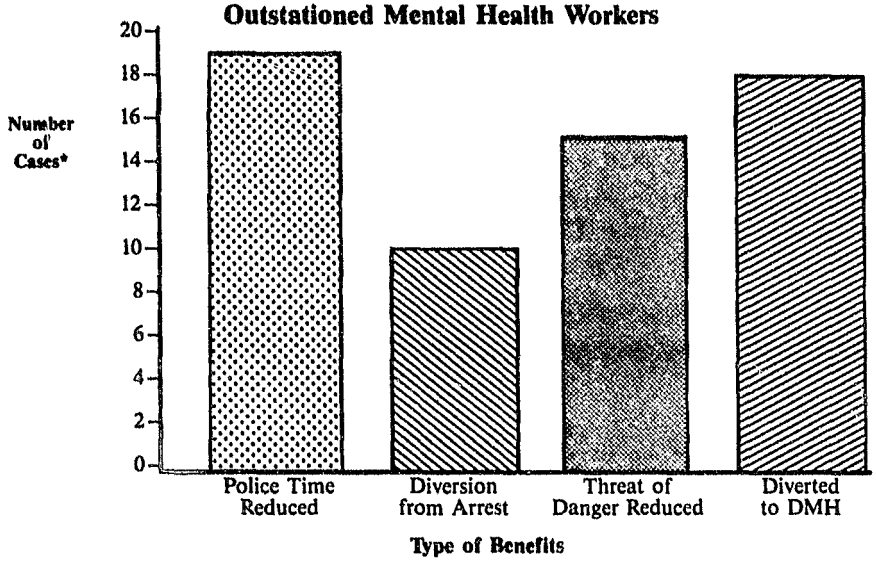
Compromise

Although evaluation of the network should show that all participants benefit, this does not mean that every group always gets what it wants. Rather, each participant usually has to make some accommodation to the network in order to reap its advantages.

- Police officers and hospital staff in Fairfax County could not agree on the need for a police presence on the wards to guard potentially violent referrals and about the feasibility of using other means to restrain them. Eventually, a police community relations officer met with each hospital and worked out an arrangement in which an officer can secure a detained person's background

Figure 3

Benefits of Los Angeles Police Department Outstationed Mental Health Workers



*N Clients # 63. All or none of the benefits may have been had by any one client.

from police records to document to the charge nurse that a police guard is unnecessary. Then, if no signs of dangerousness appear within an hour, the nurse will permit the officer to leave. The police agreed to return to the facility quickly if the patient became violent later on. The hospitals refused to handcuff hyperactive and disoriented patients whom officers were having to trail all around the hospital, but they did agree to use bed straps to restrain them.

- The Portland Police Department wanted the Hooper Detoxification Center to set up a secure holding area so that officers could take combative (but not violent) inebriates to the facility whom the jail would no longer accept. At the same time, the center had been complaining that officers continued to antagonize inebriates during the admissions interview, preventing them from calming down. The police and Hooper liaisons worked out a solution that satisfied each of them:

  - Hooper agreed to accept combative inebriates, and the police department promised to send a patrol unit back to the facility quickly to jail any inebriate who later became too violent for staff to handle.

Figure 4

Selected Data for Monitoring and Evaluating the Network

- number of cases diverted from the criminal justice system (e.g., no arrest made, preventive detention not used)
- source of referrals (law enforcement agency, sector of the city)
- number and type of referrals received from law enforcement officers by each human service provider facility
- appropriateness of law enforcement referrals to agencies and facilities
- number and percentage of police referrals hospitalized
- number of hours saved by law enforcement
- number and percentage of police referrals who voluntarily enter a treatment program
- number of cases in which threat of danger was reduced
- number of times law enforcement officers assisted facilities in handling violent patients in the facility or in the home

— The police liaison agreed to instruct his officers to stay away from the admissions area while Hooper staff interviewed the inebriate. However, Hooper consented to put up a wall that would enable officers to do their paperwork and make phone calls out of sight of the inebriate (but close enough to take over if the inebriate proved to be too violent).

The key to successful accommodation is for the liaisons in the participating agencies to be individuals who do not become "defensive" and unyielding when they do not always get their way, and who can adopt a negotiator role rather than an adversarial point of view. Appendix B7 reproduces a Portland Police Bureau memorandum that suggests both the style of accommodation needed to network and examples of the types of compromises that make it possible for the arrangement to succeed.

Secure Quality Staff and Keep Turnover Low

Working with the mentally ill, public inebriate, and homeless requires above average sensitivity and patience, both because of the disturbing nature of the problems they present and because of the crisis situations in which they are often encountered. In addition, not all law enforcement officers interact effectively with social workers, and vice versa. As a result, networks

make sure that only exceptionally well-qualified individuals occupy the key positions in the arrangement. For example, the Madison Police Chief selected a police officer who has a social work degree as the original liaison.

Talented individuals are especially important in staffing the unit that officers call on for emergency assistance. Police officers and deputy sheriffs volunteer to join the special units composed of sworn officers in Erie, Galveston County, and Los Angeles. In Erie and Los Angeles, the positions are advertised in the police department's in-house bulletin of job openings. In Erie, many officers have a chance to see what working the unit is like by substituting for regular 201 Unit officers who are sick or on vacation—while the 201 Unit commander gets an opportunity to evaluate them as potential full-time 201 Unit staff. In Galveston, the Program Director of the Mental Health Division gets recommendations from other officers for the unit. Although subject to approval by higher ranking administrators, the heads of the special units in Galveston and Los Angeles have the major say in who gets hired. In Erie, the police chief takes a more active role in selecting 201 Unit staff, although he takes the unit leader's criteria for selection into consideration.

Keeping turnover low among staff involved in the network has both advantages and disadvantages. On the one hand, periodic rotation may be desirable—particularly among the special emergency unit staff—to avoid burnout and also stagnation in a position with no hope for career advancement. On the other hand, many participants find the job gives them both increased visibility with their supervisors (for example, when a hostage situation or attempted suicide has been successfully handled) and the personal satisfaction of providing a badly needed service.

Continuity of staff can also be important because building trust between law enforcement officers and human service providers takes time; so does becoming familiar with each other's procedures. As police officers and deputy sheriffs become known to emergency ward personnel are they given priority attention as soon as they walk in the door. Whenever a network participant is replaced, the process of establishing credibility must begin all over again. Birmingham stopped using social work students to assist the police department with the mentally ill in part because constant turnover as they graduated and left the job prevented them from gaining the confidence of emergency ward staff and police officers. The administrator of the Portland detoxification center has to meet with every new police shift commander to renegotiate the network procedures.

To minimize turnover, the Galveston County Sheriff's Department permits its mental health deputies to work in plain clothes and to drive fully equipped but unmarked cars. Officers in the Erie Police Department's 201 Unit are given the incentive of working fixed shifts.

Developing effective interagency communication and implementing an effective training program are the final means by which the networks have stayed in business so long. The following section addresses these network components.

Effective Communication

After the County Emergency Medical Services (EMS) system joined the Fairfax County network, emergency medical technicians began calling the mental health center's Mobile Crisis Unit to meet them at the scene of a suspected suicide case to assist distraught family members. However, while the Mobile Crisis Unit was on the way, police at the scene would sometimes find the death suspicious and decide to treat it as a probable homicide; as a result, they would recall the Mobile Unit in mid-course. After a few such cancellations, the chief of the county Emergency Medical Services, the captain of Police Department's Criminal Investigation Bureau, and the Mobile Crisis Unit director met to iron out the problem. It became clear that the police detectives were afraid the Mobile Crisis Unit would interfere with the investigation. The police captain, who knew this had never occurred, agreed to distribute a letter under the police chief's signature to all police officers, emergency medical technicians, and Mobile Crisis Unit staff clarifying that, as needed, police would request EMS, EMS would call the Mobile Crisis Unit to the scene (if appropriate), and the Mobile Crisis Unit staff would cooperate on-scene with the investigating officers.

Glitches like this are inevitable in any collaboration. Only open and regular communication among all the participants, as occurred in Fairfax County, can prevent or resolve them. One of the most important communication techniques the sites use is training.

Training

Training is used to achieve six distinct objectives:

(1) promote proper use of the network

(2) motivate participants to want to use the network

(3) change attitudes that inhibit collaboration

(4) develop skills in screening for mental illness or intoxication

(5) develop skills in handling problem persons

(6) explain legal issues.

Choosing training objectives must take into account both how essential they are to an effective network and the limited amount of time usually available to conduct the training. Because Montgomery County and Fairfax County both planned to form a special team of social workers to assist peace officers on-scene, it was crucial to instruct these civilians in how to work with law enforcement agents. Because patrol officers in Montgomery County were expected to handle routine cases involving the mentally ill on their own, they needed to be taught what kinds of cases justify calling the emergency service for help.

The sites have made use of a wide variety of training methods:

- **Cross-training.** In Madison, social workers train the police, and police train the social workers. This has the disadvantage of using "outsiders" with an initially skeptical or even hostile audience. However, if done properly, it can break down these barriers and begin to develop trust and respect. Cross training also results in a clear understanding of what each participant can contribute to—and expect from—the network. When the San Diego Inebriate Reception Center kept calling the police to arrest combative patients, an officer met with the staff to explain with flip charts and copies of the civil codes why officers could not arrest its patients for misdemeanors—and how the staff themselves could make a citizen's arrest that would permit an officer to bring a patient to the jail.

- **Academy training.** Course work at the regional police academy in San Diego incorporates information on thee Inebriate Reception Center. Mental Evaluation Unit staff in the Los Angeles Police Department train police academy recruits in how to recognize and handle the mentally ill, and work with the mental health system.

- **In-service workshops.** Family Crisis Intervention in Erie gave a three-day orientation to the special 201 Unit assigned to handle mental illness crises. The unit then participated both in monthly meetings with the heads of social services agencies, to become familiar with their facilities, and weekly meetings with a staff psychologist, to learn how to diagnose and handle the mentally ill. Montgomery County staff make out a master training schedule at the beginning of every year to make sure that all 52 police departments in the county are updated on the center's services and to teach new officers how to recognize and handle the mentally ill and use the center. Training ranges from a two-day session open to all law enforcement and court officers in the county to station house briefings for every shift.

- **Course work.** Galveston County's Mental Health Deputies take a nine-month course to become Emergency Medical Technicians, followed by nine months service in casework with the Regional Mental Health/Mental Retardation Center focusing on crisis intervention and handling the mentally ill.
- **Field trips.** New recruits in the San Diego Police Department tour the Inebriate Reception Center. Police academy classes in Portland are shown the Hooper detoxification center's operations. Pine Street Inn staff take every new detail officer around the shelter to explain its operations and services. Crisis Intervention staff in Madison went on ride-alongs with patrol officers to get to know each other and become familiar first-hand with police work.
- **Role modeling.** Montgomery County Emergency Service staff ride on patrol with officers in selected police departments to demonstrate how to handle troublesome cases. In Boston, staff at the Pine Street Inn have officers observe them as they use encouragement and sensitivity, rather than harsh words or physical coercion, to get timid homeless people to leave the police van and enter the shelter, or to talk a belligerent client into leaving the facility.

Most sites combine several training methods to make sure all network participants are reached and to reinforce the message. In Los Angeles, the County Department of Mental Health made a psychologist available to the Mental Evaluation Unit to train the unit's nine new members in handling the mentally ill. Other department staff then worked with the unit to train the other 7,000 city police at inservice sessions held at the police academy. Mental Evaluation Unit staff also train recruits in the police academy and mental health professionals in local facilities. The District Attorney's Psychiatric Section trains both police and emergency ward staff in legal issues regarding involuntary detention, confidentiality, and possession of weapons by the mentally ill.

Other Communication

Feedback. Many networks arrange for law enforcement officers to learn about case outcomes. In Madison, the Mental Health Center sends brief letters to officers and their immediate supervisors describing the immediate treatment plan for each police referral. In some sites, officers want the feedback so they can arrest an individual who refuses treatment. The information also helps officers understand why the case was perhaps not handled in the most satisfactory manner. Otherwise, they may feel they are wasting their time when the disposition they expected is not carried out—especially when they reencounter the same individual a short while later.

Network participants also stress how important saying "thanks" and giving praise can be in building and maintaining a network—for example, simply calling to say, "I want to thank you for resolving that dispute between the officer who wanted to take his gun into the locked ward and the nurse who insisted he remove it." The Montgomery County Emergency Service sends a letter to every officer thanking him or her for bringing in a mentally ill person for evaluation instead of making an arrest.

Regular meetings. Several task forces set up to initiate a network continue to meet to address unresolved or new problems with the arrangement. The Psychiatric Emergency Coordinating Committee in Los Angeles that developed the Memorandum of Agreement is still working on ways to address the lack of 24-hour emergency facilities for the developmentally disabled—the Regional Centers for the Developmentally Disabled in the county operate only during weekday hours.

Some sites establish special forums for addressing particularly knotty networking problems. In Fairfax County, hospital representatives, the mental health community, the county executive, and the police formed a Detention Bed Task Force to work on replacing short-term emergency bed space which was lost when the local state psychiatric facility was mandated to use its beds for long-term mentally ill persons.

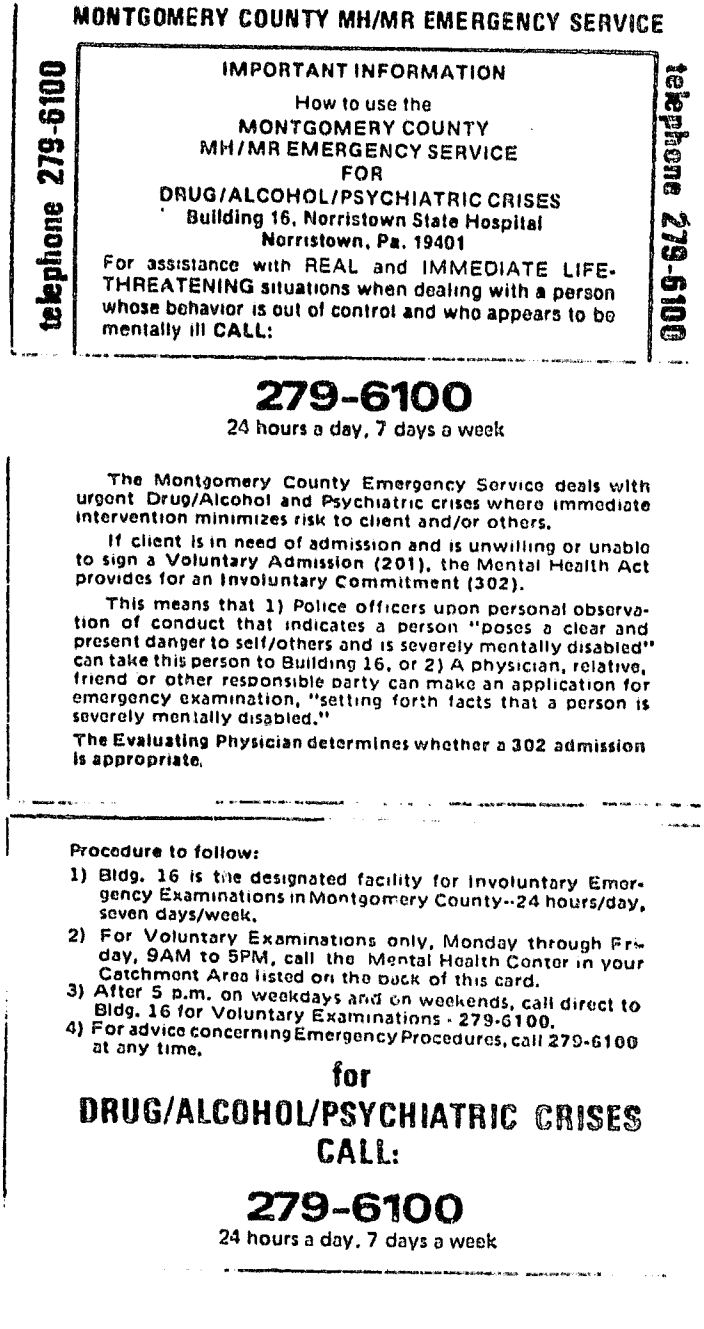
Informal meetings are useful, too. A police captain in San Diego lunches every month with Inebriate Reception Center staff to maintain rapport and resolve minor problems.

Written aids. The Port Authority of New York and New Jersey developed a both a resource manual, kept by the desk sergeant, and a card for insertion in officers' summons book, with listings for welfare, food, clothing, and other social services in New York and Jersey City. Madison police carry a booklet of names and telephone numbers of local mental health and alcoholism facilities. Officers in Montgomery County and Washtenaw County carry a wallet card that summarizes when and how to use their networks' emergency services (see Figure 5).

Hotline. As part of the Memorandum of Agreement in Los Angeles (Appendix B1), each organization provides a 24-hour hotline for contacting a high-level administrator during a psychiatric emergency. On one occasion, the director of the police Mental Evaluation Unit called the deputy director of the Department of Mental Health at 3:45 a.m. when a facility refused to accept a suspected mentally ill individual brought by the police. When a man threatened to leap from the eleventh floor of a building, officers from the Mental Evaluation Unit used the hotline to locate the person's psychiatrist, priest, and relatives, and had them at the scene within within twenty minutes. The man was eventually talked out of jumping.

Figure 5

Police Wallet Card in Montgomery County



MONTGOMERY COUNTY MH/MR EMERGENCY SERVICE

telephone 279-6100

IMPORTANT INFORMATION

How to use the
MONTGOMERY COUNTY
MH/MR EMERGENCY SERVICE
FOR
DRUG/ALCOHOL/PSYCHIATRIC CRISES
Building 16, Norristown State Hospital
Norristown, Pa. 19401

For assistance with REAL and IMMEDIATE LIFE-THREATENING situations when dealing with a person whose behavior is out of control and who appears to be mentally ill CALL:

telephone 279-6100

279-6100

24 hours a day, 7 days a week

The Montgomery County Emergency Service deals with urgent Drug/Alcohol and Psychiatric crises where immediate intervention minimizes risk to client and/or others.

If client is in need of admission and is unwilling or unable to sign a Voluntary Admission (201), the Mental Health Act provides for an Involuntary Commitment (302).

This means that 1) Police officers upon personal observation of conduct that indicates a person "poses a clear and present danger to self/others and is severely mentally disabled" can take this person to Building 16, or 2) A physician, relative, friend or other responsible party can make an application for emergency examination, "setting forth facts that a person is severely mentally disabled."

The Evaluating Physician determines whether a 302 admission is appropriate.

Procedure to follow:

1) Bldg. 16 is the designated facility for Involuntary Emergency Examinations in Montgomery County--24 hours/day, seven days/week.
2) For Voluntary Examinations only, Monday through Friday, 9AM to 5PM, call the Mental Health Center in your Catchment Area listed on the back of this card.
3) After 5 p.m. on weekdays and on weekends, call direct to Bldg. 16 for Voluntary Examinations - 279-6100.
4) For advice concerning Emergency Procedures, call 279-6100 at any time.

for

DRUG/ALCOHOL/PSYCHIATRIC CRISES

CALL:

279-6100

24 hours a day, 7 days a week

Spontaneous communication. Informal face-to-face contact can be tremendously important in building trust, respect, and understanding among network participants. Sometimes, participants address conflicts with each other on the spot, as when staff at Boston's Pine Street Inn ask an officer transporting a homeless person to "please help us guide this person into the facility rather than leave him in the driveway." Often the conversation is idle chatter—officers dropping by a friendly facility just to have coffee and say hello. These contacts help explain why some police officers in Boston regularly donate clothing to the Pine Street Inn for the homeless.

Civil Statutes: The Part They Play

Network organizers should identify legislation in their state that may affect networking, because civil codes can play a significant role in facilitating or hampering their proposed arrangement. Most of the relevant codes are likely to relate to the handling of the mentally ill, but some codes may address the public inebriate, as well.

Involuntary Detention Statutes

Law enforcement's involvement in a network focusing on the mentally ill is simplified when judicial approval is not required to detain these individuals and when a broad range of behavior justifies involuntary detention. The need for a magistrate's warrant discourages some officers from dealing with the mentally ill because of the extra time involved in securing the warrant. Sometimes officers charge the person with a trivial misdemeanor offense in order to detain the individual long enough to obtain a warrant—whereupon the charge is dropped.

To avoid these problems, the crisis units in Galveston County and Fairfax County take responsibility for obtaining judicial approval. For example, when family members are not available in Fairfax County to petition for involuntary detention, Mobile Crisis Unit staff, rather than police, fill out and sign the petition, and telephone a magistrate for a verbal order of detention. The recommendations of the crisis unit staff, as licensed health care professionals, are taken more seriously by the magistrate. Furthermore, officers do not have to testify the following day at the preliminary hearing.

Even when a special unit takes over the job of securing judicial approval, civil codes that narrowly define the behavior that justifies involuntary detention can reduce the network's effectiveness. Some statutes require the behavior to be overt or be personally observed by the officer; other codes require evidence of dangerousness, not simply grave disability, as a condition of detention.

As a long-term solution, network members can work to change the law in order to expand the behavior that qualifies for detention (making sure not

to compromise the civil liberties of these populations). However, for the short term it is more important to make sure that all parties to the network understand clearly when an individual may be legally detained. The 201 Unit of specially-trained officers in Erie, along with the local Family Crisis Intervention Center, explains the state Mental Health Procedures Act to every new social service agency and keeps existing agencies informed of changes in the code. Emergency ward physicians sometimes call the 201 Unit on their own for information on the involuntary commitment statute. A recent review of every state's statutes in this area is also available for consultation.[2]

The most serious networking problems, however, do not occur because of difficulties with emergency detention power but because of difficulties with emergency admission procedures at health care facilities.

Mandatory Emergency Evaluation and Treatment

A major barrier to networking in many communities is the difficulty social service facilities have in providing 24-hour emergency care. However, civil codes in some states facilitate networking by mandating emergency care.

The mentally ill. State civil codes mandate 24-hour emergency evaluation and care of suspected mentally ill individuals in five of the networks. For example, Section 5150 of the California Welfare and Institutions Code stipulates:

> When any person is a danger to others, or to himself or herself, or gravely disabled, as a result of mental disorder, a peace officer ... may, upon probable cause, take ... the person into custody and place him or her in a facility designated by the county and approved by the State Department of Mental Health as a facility for 72-hour treatment and evaluation.

However, law enforcement officers reported that some emergency ward staff were telling them the facility was full and could not accept any more admissions. As a result, the Sheriff's Department was successful in having the following amendments added to the California civil code to clarify the facilities' obligations (emphasis added):

> Section 5150.1: No peace officer seeking to transport, or having transported a person to a designated facility for assessment under Section 5150, shall be instructed by mental health personnel *to take the person to, or keep the person at, a jail solely because of the unavailability of an acute bed, nor shall the peace officer be forbidden to transport the person directly to the designated facility.* No mental health employee from any county, state, city, or any private agency providing . . . psychiatric emergency services shall interfere with a

peace officer performing duties under Section 5150 by preventing the peace officer from entering a designated facility with the person to be assessed, nor shall any employee of such an agency require the peace officer to remove the person without assessment as a condition of allowing the peace officer to depart.

Section 5150.2: In each county, whenever a peace officer has transported a person to a designated facility for assessment under Section 5150, that officer shall be detained *no longer than the time necessary to complete documentation of the factual basis of the detention under Section 5150 and a safe and orderly transfer of physical custody of the person.*

Section 5150.3: Whenever any person presented for evaluation at a facility designated under Section 5150 is found to be in need of mental health services, but is not admitted to the facility, *all available alternative services provided for pursuant to Section 5151 shall be offered* as determined by the county mental health director.

Section 5150.4: "Assessment" for the purposes of this article, means the determination of whether a person shall be evaluated and treated pursuant to Section 5150.

As a result of these amendments, psychiatric emergency facilities redoubled their efforts to comply with the statute.

The public inebriate. Civil codes in California, Oregon and Wisconsin all require certified detoxification facilities to accept incapacitated public inebriates brought in by peace officers for involuntary detention. As a result, police officers in Madison and Portland can leave within a few minutes of transporting inebriates to the designated detoxification facility. The San Diego police do not have this arrangement, because the Inebriate Reception Center is not certified as an involuntary holding facility. As a result, the center cannot prevent inebriates from leaving prematurely, and police have to resort to jailing walkaways if they are found drunk again on the same shift.

Some civil statutes impose obligations on law enforcement agencies, as well as on the social service system. Peace officers in Oregon are required to take any incapacitated inebriate home or to an appropriate detoxification facility. If the inebriate is homeless and the facility is full, the person must be taken to jail. To relieve police of this obligation and because the jail was already overcrowded, the Multnomah County Sheriff deputized the entire staff of Portland's Hooper Detoxification Center so that its mobile van personnel could place a civil hold on incapacitated inebriates and transport them to the facility. The Texas Mental Health Code requires peace officers to transport any individual to a hospital for evaluation who they have good reason to believe

is likely to harm him- or herself or others. Difficulty adhering to this statute was one of the many major inducements to develop the sheriff's mental health deputy unit.

Confidentiality

One common benefit of networking is increased sharing of information about mentally ill individuals between law enforcement agencies and the mental health system. The Memorandum of Agreement in Los Angeles (Appendix B1) requires the signatories to ". . . provide, within provisions of the law, consultation to concerned agencies regarding contacts with mentally ill persons . . . ." However, as the memorandum suggests, confidentiality statutes in every jurisdiction limit the extent to which network members may legally exchange information.

Despite these restrictions, the networks have facilitated three types of information sharing.

(1) A few sites have developed procedures for informing law enforcement officers when a patient is about to be released from a mental hospital. Staff at the University of Texas Medical Branch hospital in Galveston County tell the sheriff's mental health deputies when patients are being released, and the State Hospital teletypes the deputies when patients with a history of violence have been discharged.

(2) As discussed above, in some networks police and deputy sheriffs are routinely told the disposition of people they have transported for evaluation.

(3) Networking enables many law enforcement officers to find out whether a suspected mentally ill person they have been called to handle has a history of violence. However, because of the real or perceived legal and ethical constraints to sharing this information, many mental health workers tell the officers only indirectly that a person may be violent—for example, by saying, "I'd just be *very* careful handling that person." Other health care workers make use of a common exception to confidentiality requirements that permits information sharing when life is at stake. Some social workers justify warning the police by arguing that officers are less likely to "shoot first and ask questions later" if they know in advance that a person is not dangerous, or is dangerous only if approached in a certain manner.

Interpreting and Changing the Law

Network participants should understand clearly the legal issues related to problem populations. A comprehensive discussion of involuntary detention and commitment of the mentally disabled is available in a recently published volume from the American Bar Foundation.[3]

It may also be advisable to have pertinent statutes interpreted by legal counsel so that misplaced adherence to them does not interfere with networking. The police liaison to the network in Portland asked for the Attorney General's opinion of whether the state's confidentiality statute prevented detoxification centers from allowing police officers to search the premises for a criminal offender when the search warrant was at the station house and not in the officers' possession. (It did not.) The police liaison had the Attorney General explain his opinion to the director of the Hooper Detoxification Center. After consulting with his own legal counsel, the director agreed to permit searches under these circumstances. (See Appendix B8.) Similarly, a close reading of the California Welfare and Institutions Code indicates that being "dangerous to self or others" as a condition for involuntary detention of the mentally ill does not mean individuals have to be suicidal or homicidal; showing signs of wanting to injure themselves or others is sufficient grounds.

Sometimes, examining the law can suggest the need to change it. For years, California had required a warrant in order to confiscate a weapon in a mentally ill person's possession. Even after a legal seizure, officers had thirty days in which to convince the judge why the weapon should not be returned. The law was changed to *require* any peace officer to confiscate and retain custody of weapons known to be accessible to any person who is mentally ill and dangerous, or who has been detained or hospitalized for mental illness in the past. The law enforcement agency must then retain possession of the weapons until the person files a petition for their return with the court and a judge authorizes their release.

Having interpreted or changed the law, it is important to share these legal opinions and changes with all network participants. For example, mental health workers need training in what information the confidentiality statute prevents—and does not prevent—them from sharing. Outpatient clinic staff in one site thought they could not report an individual to the police who came for his treatment appointment armed with a rocket launcher and threatening to "get me some cops." Law enforcement officers, in turn, need training in the provisions of state detention and commitment statutes so they can understand why disturbed people they detain are sometimes released so quickly.

If the statutes are complicated, it may be difficult to explain them adequately to all officers in a large law enforcement agency. As a result, Los

Angeles and Erie thoroughly trained their special mental illness units in the law and now make them available 24-hours-a-day to officers on-scene who call in for immediate legal advice. As noted, in Los Angeles the Mental Evaluation Unit (along with other participating agencies in the network) in turn has a 24-hour hotline to the District Attorney's Psychiatric Section for immediate legal opinions regarding handline of the mentally ill. On one occasion, the Mental Evaluation Unit found that an AIDS afflicted escapee from a mental hospital (who vowed to infect everyone with his blood) was holed up in a house in a city 50 miles north of Los Angeles. When the local police arrived at the scene, however, they felt they had no legal basis for entering the dwelling and removing the patient. As a result, unit staff had the lieutenant on-scene use the hotline to call the Los Angeles County District Attorney's Psychiatric Section for an immediate legal opinion permitting him to detain the man.

Funding: Luxury or Necessity?

A critical issue in initiating and sustaining a network is whether—and how much—additional funding may be needed. As Figure 6 shows, every site but one required extra funds to initiate its arrangement; however, two sites have not needed special funding to maintain their network.

Networking Inexpensively

Los Angeles has involved very little additional funding despite an ambitious networking arrangement. The County Department of Mental Health had to hire consultants to help train the network participants and to perform some of the work which staff who were assigned to assist the network had been doing. Washtenaw County secured a federal grant when it first began in 1978 but was careful not to use any of the funds for operational expenses so that the network would be self-sufficient. The funds were used only to evaluate the arrangement. Montgomery County's network needed $650,000 a year to operate initially but then became increasingly self-sufficient through third-party insurance reimbursements. Currently, its only expense is $22,000 for a network liaison position, $10,000 to cover ambulance runs for indigent people without third party insurance coverage, and $140,000 for hospitalization expenses of involuntarily committed mentally ill persons without insurance coverage. The total expense of $172,000 is extremely modest in relation to the major hospitalization services—as well as on-scene assistance—the network provides. (Without the hospital, the mentally ill would either be left on the street or placed in jail, since other hospitals are unwilling to accept indigent county patients.)

The experience of these three sites and the other jurisdictions suggests that networks can be initiated or operated without additional funds, or with minimal extra money, when the following conditions are present:

Figure 6
Networking Costs

	Birmingham	Boston	Erie	Fairfax County	Galveston County	Los Angeles	Madison	Montgomery County	New York/ Jersey City	Portland	San Diego	Washtenaw County
Start-up costs • source(s)	NA • federal (CETA)	none	$90,000 • federal (LEAA)	$91,000 • federal (LEAA)	NA	$25,000 • DMH	$20,000 • city police $250,000 • county	$630,000 • county • state • federal (LEAA)	$915,665 • Port Authority • DMH (New York City)	$200,000 (approx.) • county • Housing authority (Jersey City)	NA	$600,000 • federal (NIH)
Current costs (annual) • source(s)	$200,000 • city police	$148,920 • SDPW	$225,000 • DMH (state) $25,000 • DMH (county)	$200,000 • county	$434,000 • regional mental health center (state, county, United Fund, fees)	none[a]	$35,000 • city $300,000 • county	$170,000 • DMH (county) $2,000 • city police	b	$775,000 • county	$240,000 • DPH (county)	none

Abbreviations:

CETA: Concentrated Employment and Training Act, U.S. Department of Labor
LEAA: Law Enforcement Assistance Administration, U.S. Department of Justice
NIH: National Institutes of Health, U.S. Department of Health and Human Services
DMH: Department of Mental Health (may include Mental Retardation)
DPH: Department of Public Health
SDPW: State Department of Public Welfare

[a]An unknown, but small, amount of extra funding was needed to hire consultants to help train network participants and perform some of the work which County Department of Mental Health staff who were assigned to the network had been doing.

[b]Network is still in the process of getting established.

- When network participants can free up resources for the network by operating more efficiently than before. The Los Angeles County Department of Mental Health instituted day-to-day monitoring of available bed space to accommodate police department referrals; all 24-hour psychiatric emergency service units are required every morning to report their occupancy rate and anticipated vacancies for the next 24 hours. The department encourages facilities to screen nonemergency admissions more carefully, reduce (where appropriate) the time mental patients are hospitalized, and provide increased aftercare to reduce readmissions.

- When state, county, or municipal agencies can provide previously underutilized resources, or make emergency arrangements to help out. Montgomery County had to spend $300,000 to renovate an unused mental hospital building for use by the Emergency Services, but since then the program has rented the building directly from the state for $1.00 a year. The Jersey City Department of Housing and Economic Development personally donated or arranged for in-kind services to a homeless shelter and drop-in center, including underwriting insurance, improvements to meet fire codes, additional telephone lines, and training of shelter volunteers.

- When social service and law enforcement agencies are able and willing to reassign resources to network functions. The Los Angeles Police Department transferred nine officers to its expanded Mental Evaluation Unit, while the County Department of Mental Health placed a social worker in each of four police substations. The Galveston County network requires the principal participating hospital to allocate any available bed— including medical beds—to law enforcement referrals. The hospital in Birmingham agreed to give police referrals priority for its five beds reserved for the indigent. Similarly, when contracted beds are not available at the University of Texas Medical Branch Hospital in Galveston County, the medical director may assign law enforcement referrals to beds that are normally reserved for other mentally ill patients. Staff in agencies that participate in the Washtenaw County network divert a modest portion of their time from other responsibilities to network tasks.

- When the network can achieve savings that offset any anticipated increases in expenditures. In Washtenaw County, in-service training, the distribution of protocols and wallet cards for handling the mentally ill, and use of a hotline for telephone

consultation enable sheriff's deputies to avoid burdening emergency facilities with unnecessary evaluations and admissions. While the Los Angeles Police Department "lost" the nine patrol officers transferred to the Mental Evaluation Unit, the department's remaining 7,000 officers save hundreds of hours a year because of the unit's assistance.

When Additional Funds Are Needed

Sites have required additional funding for different reasons. The Port Authority of New York and New Jersey had to pay to establish shelters. Portland, Madison, and San Diego had to fund facilities for assisting public inebriates. Law enforcement agencies in Galveston County and Birmingham needed funds to develop an in-house unit for assisting officers to handle the mentally ill. Galveston County also had to help fund a hospital to handle the increased caseload that the network created. Madison and Montgomery County used additional funds to hire a law enforcement liaison to coordinate the network.

Figure 6 lists the principal sources of the additional funds. Six sites secured some or all of their start-up funds from the federal government—a source that will probably not be available again. Currently, the major funding sources are county and municipal governments.

Rather than burdening one agency with the entire expense, each of several agencies can be persuaded to contribute smaller amounts. Joint funding can often be secured by clarifying the benefits that each involved party can gain from networking. Thus, city and county funds support the Madison network, while the arrangement in New York/Jersey City is paid for by the Port Authority of New York and New Jersey, the New York City Department of Mental Health, and the Jersey City Housing Authority.

When approaching potential funding sources, the sites have used three techniques for making their requests more palatable. One way is to document actual cash savings that will result from the network. Although many public inebriates in San Diego would probably have been ignored rather than taken to jail, the $8.00 expense to handle each drunk person at the Inebriate Reception Center is unquestionably cheaper than increasing cell space at the jail to accommodate the 25,000 inebriates diverted to the center. The Portland network costs $775,000 but achieves an estimated $1 million in savings by eliminating inflated rates ambulance companies charged the county to cover their uncompensated costs of transporting indigent inebriates.

Requests for additional funds can be softened by securing free services to supplement paid assistance. Churches in New Jersey have established

homeless shelters and linkages to social services for Port Authority referrals. Although funded only to house public inebriates, detoxification center staff in Madison often come on-scene to transport inebriates.

Finally, Birmingham and Montgomery County have documented how funding the network enables police officers and deputy sheriffs to redirect a large number of hours from mental illness incidents to law enforcement responsibilities. As noted, during one three-month period, the Birmingham network spared officers the equivalent of 21 person shifts, while in one month alone the Montgomery County arrangement spared officers 27 shifts.

Where Do You Go from Here?

Chapter 3 presented a wide range of options for initiating and structuring the network. Given the number of possibilities, how can the interested law enforcement administrator, social service agency head, or local government official decide what to do first? Below are practical steps for getting going.

1. Find out where you stand in terms of handling the mentally ill, public inebriate, and homeless:
   a. How do you handle these populations now?
   b. What problems does your department have with these populations—for example, does handling them:
      - take up staff time better spent on other responsibilities?
      - create dangerous situations for staff?
      - cause staff frustration and lower morale?
      - fail to solve these people's problems so that you are forced to deal with the same individuals over and over again?
   c. What do your state statutes require you and other groups to do—and not to do—with these populations? (Review pages 53–58.)
2. Who in your department has the energy, tact, and experience to take the lead in initiating and being the liaison for the network? (Review page 35.)
3. What other agencies and organizations in the community have responsibility for working with the mentally ill (or public inebriate or homeless)? (Review pages 34–35.)
   a. How do they handle these populations now?
   b. How should they be handling them?
   c. What is the history of your agency's relations with each of these other groups?

4. How can you get these other groups to want to develop a network with you?

   a. How can you motivate them to participate? (Review pages 36–38.)

   b. What benefits will they get out of networking? (Review pages 6–9.)

   c. What can your department do that will make their job easier? (Review pages 44–46.)

5. What, exactly, do you want to get out of the network? (Review pages 11–13.)

6. What, initially, would appear to be the best way to structure the network? (Review applicable case studies in Chapter 2 and Appendix A.)

7. What resources—staff time and money—may be needed to participate in the network? (Review pages 58–61.)

   a. Where might these resources come from?

   b. How will your department—and other participating groups— save time or money by forming a network?

Once these preliminary questions have been answered, the designated liaison can begin to approach the other involved agencies and organizations and start the process of forming the network. (Review pages 33–39.)

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2. Jan Brakel, John Parry, and Barbara A. Weiner, *The Mentally Disabled and the Law* (Chicago: American Bar Foundation, 1985).
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Appendix A

Additional Case Studies of Networking Approaches

Birmingham, Alabama

Civilian Social Workers Join the Police Department

In 1977, a professor and three students at the University of Alabama initiated a pilot project to provide the Birmingham Police Department with a team of in-house civilian social workers. These Community Service Officers, or CSOs, would be available around the clock to go on-scene to take over any type of social service case, from spouse abuse to housing assistance. While the team, currently funded by the city, has evolved into an integral part of the police force, officers now call on the CSOs almost exclusively for help with the mentally ill because of the unique nature of the city's transient population. Because Birmingham is the national headquarters for the Supplemental Security Income (SSI) branch of the United States Social Security Department, every mentally ill person in the country receiving public assistance sees the city's name on the return address of his or her monthly SSI check. As a result, hundreds of mentally ill individuals who want an increase in their allotment or an advance on their next check come to Birmingham with "a one-way bus ticket and no medication." This has led to a population of 12,000 to 14,000 mentally ill persons in the city without regular shelter.

The Basic Operation

Currently, six civilian Community Service Officers, operating out of the police headquarters, assist police officers seven days a week from 8 a.m. to 11 p.m. After normal CSO working hours, police may either summon an on-call CSO from home by beeper or bring homeless mentally ill individuals to the Salvation Army, which holds them overnight until the CSOs arrive the following morning to arrange more appropriate referrals.

When called to scene, the CSO normally takes over the case, permitting the officer to return almost immediately to the beat. When possible, the CSO works with the individual's family to obtain assistance through a hospital or mental health center. In cases where the mentally ill person is violent, the officer accompanies the CSO to a hospital that the CSO determines will take over the case with the least delay. Normally, however, all individuals who may need hospitalization are taken to the University Hospital emergency room for an evaluation. Once at the hospital, the CSO, who is familiar with hospital staff and procedures, arranges for an evaluation and describes the precipitating events to the psychiatrist in the doctor's own technical terms. In most cases, police officers return to their patrol once the mentally ill person has been restrained at the facility, leaving the CSO as the police department's representative for the rest of the proceedings.

If hospitalization is indicated, a variety of facilities are available. Indigent people are usually kept at University Hospital, which has agreed to give police referrals priority for the five beds it—and the entire county—has available for the poor. Veterans

are normally transferred to the Veterans Administration hospital. Other mentally ill individuals are taken to any of several other hospitals and clinics, depending on available bed space. The CSOs make all the necessary arrangements for identifying another facility and having the patient transferred.

When hospitalization is needed and no beds are immediately available, the police officer must maintain custody of the individual while the CSO contacts the Probate Judge to secure a temporary holding order pending transfer to another facility. (A federal judge in Alabama ruled in 1978 that officers could not keep a person in police custody while waiting for a hospital bed to become available without judicial approval.) In such situations, the CSOs' experience and reputation are often decisive in persuading a hospital or mental health center to expedite acceptance, thereby minimizing the amount of time the officer has to stay with the detained person.

Problems and Solutions in the Arrangement

Since the CSO program began in 1977, several problems have been successfully addressed:

- Initially, social work students worked as Community Service Officers. However, since they left after each semester, they never had time to gain enough experience or the trust of the sworn officers to be effective. Only social workers who have graduated are hired now.
- The number of CSOs has ranged from two to eight. As a result, the amount and type of assistance they can provide has fluctuated greatly. However, crisis intervention is always their first priority, while follow-up and feedback suffer most when the number of CSOs is reduced.
- The police department initially experimented with two-person teams of one officer and one CSO, and later with CSOs who became sworn officers operating out of individual precincts. However, centralizing the location of the CSOs made it easier to deploy them and also reduced downtime that occurred when there was nothing to do in a given precinct.

CSOs Make a Difference

The Birmingham Chief of Police points out that in 1975 the police force handled 900 disturbance calls, mostly involving the mentally ill; in 1985, the two available CSOs handled all 1,000 such calls—an average of nearly three per day.

CSOs not only take over cases for the police, they also telephone treatment facilities or read police incident reports to review the appropriateness of clinic referrals that police make on their own. The CSOs mediate problems between police and social service staff, and keep officers informed of what happened to their cases. One CSO spends two days a year training officers at the Police Academy in recognizing, handling, and referring the mentally ill and homeless.

Social service personnel at participating facilities also find the CSOs of benefit. A University Hospital nurse gave two examples:

- A teenage boy who stopped taking his medication was threatening to harm his mother. Previously, he might have been arrested and brought in for psychiatric evaluation. However, when called to the scene by an officer, one of the CSOs recognized him as a patient of a specific clinic, took over the case, and immediately brought the boy there for treatment.
- Police are restricted by law from helping clinic staff with mental patients. In addition, bizarre and possibly explosive personalities make police nervous, since they are not trained to deal with them. As a result, when called to a home by clinic staff to handle a potentially dangerous patient, police would stay in their car with the windows rolled up while the clinicians entered the building. CSOs, on the other hand, accompany clinic staff right into the home. "I feel like we have a real source of help at the police department," said the nurse. "And I also know that the CSOs explain to the officers why we can't always do all the things the police want us to do."

* * *

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Erie, Pennsylvania

A Network for Everyone

A comprehensive network of formal and informal relationships has evolved for handling the mentally ill and the public inebriate in Erie, Pennsylvania, a city of 117,000 people and 22 square miles.

Origins of the Arrangement

The network in Erie was initiated in 1972 due to a hostage murder situation precipitated by a mentally ill individual. The lack of training in dealing with mentally ill persons which the incident revealed caused the Chief of Police and the County Mental Health Administrater to establish the present arrangement. The city police

entered into a formal relationship with Family Crisis Intervention, Inc., a local freestanding mental health emergency service. At the time, Family Crisis was already under contract to the Erie County Department of Mental Health to provide emergency mental health evaluations and facilitate voluntary and involuntary treatment of people in crisis. The county had designated the service as its vehicle for complying with the state's Mental Health and Mental Retardation Act of 1966 that mandated emergency mental health services.

A joint grant from the Law Enforcement Assistance Administration (LEAA) directed at coordinating mental health and police activities resulted in $17,000 to purchase a radio-equipped cruiser for the police. The police department agreed to staff the cruisers initially with seven officers who would relieve the department's 200 other officers of difficult cases involving the mentally ill, the public inebriate, and similar problem persons. The Family Crisis staff of seven would train the officers to screen for mental illness and intoxication, take people to appropriate facilities for treatment, and adhere to the applicable Pennsylvania civil statutes regulating involuntary detention. Family Crisis would also periodically update the officers regarding changes in the civil code and in the availability of referral resources. The seven-person detail would be called the "201" Unit after the provision in the Pennsylvania Civil Code that requires each county's Department of Mental Health and Mental Retardation to assure adequate mental health services for all persons in need. However, 201 officers would perform normal law enforcement duties as well as specializing in problem persons. At present, there are nine police officers assigned to the 201 Unit.

A Memorandum of Agreement, signed by the Chief of Police and addressed to Family Crisis Intervention Inc., formally sanctioned these arrangements. (See Appendix B6.) The Erie County Department of Mental Health and Mental Retardation pays Family Crisis $250,000 a year to participate in the arrangement.

Role of the 201 Unit

In most cases, individual patrol officers handle problems involving the mentally ill or public inebriate on their own—perhaps with a call to the 201 Unit or to Family Crisis for advice on what to do or where to take the person. However, when involuntary commitment of a mentally ill person appears to be needed, they normally call the 201 Unit to take over the case, freeing up the patrol officers to return to their beat.

After screening to make sure the person needs to be detained, the 201 Unit officers complete an application for 120-hour emergency commitment, and have the order approved by a delegate of the County Department of Mental Health authorized to approve involuntary commitments. The 201 officers then transport the person to one of two county health centers for evaluation. In most cases, the person is admitted, because the 201 Unit has become skilled in identifying people who need hospitalization, and is familiar with the civil code's mandate for emergency services. If the evaluating psychiatrist determines that involuntary hospitalization is not needed, the 201 Unit usually returns the person to the place he or she was taken into custody, if it is a safe environment, or else to a shelter for the homeless.

Because the 201 unit can be dispatched at any time to deal with regular law enforcement needs, it is available for assistance with the mentally ill and public inebriate only about half the time. Nonetheless, the unit still takes over one or two cases every shift.

The Police and the Larger Social Service System

The Erie Police Department's strongest ties with the local social service system are with Family Crisis Intervention. The 201 Unit—or any patrol officer—may telephone Family Crisis staff 24 hours a day for consultation or on-site assistance.

One of the principal responsibilities of Family Crisis has been to work with the 201 Unit to link human service providers with the police. For example, in dealing with the mentally ill, the 201 Unit is able to telephone the two available county psychiatric facilities to find out which one has most recently treated a suspected mentally ill person, so that he or she can be taken to the same facility as before. During the call, hospital staff indicate whether the person could be dangerous. In some instances the officers build up such a good rapport with a paranoid or hostile person (whom they sometimes know from previous encounters) that the doctor permits them to ask the psychiatric evaluation questions at the hospital to avoid anything that might frighten or anger the patient.

Patrol officers and the 201 Unit also work well with facilities that care for the public inebriate. However, because space at the local detoxification center is limited, patrol officers take many people found drunk in public to the jail. Nevertheless, many officers first have the dispatcher call the detoxification center to see if it will accept the inebriate. If so, they can leave immediately after transferring custody. Sometimes, after being turned down by the facility, patrol officers call the 201 Unit, which is often more effective in getting inebriates admitted.

If an inebriate appears to need medical attention, regular patrol or 201 officers can bring the person to one of the two county health facilities for medical treatment. The officers can leave immediately, because the facility arranges for a taxi to take the person, once treated, to the detoxification center. If the inebriate later appears to be mentally ill, the detoxification center calls Family Crisis to evaluate the person. Together, the center and Family Crisis staff decide what to do with the person. Thus, while many inebriates in Erie are still taken to jail, there is a procedure for handling public drunks who have multiple problems of alcohol abuse, mental illness, and injury or disease.

How Collaboration Was Achieved

These good working relationships did not develop quickly or easily. Over the years, Family Crisis Intervention and the 201 Unit met one by one with dozens of human service providers to identify what services these providers could furnish, which staff the police department and Family Crisis could call after-hours in an emergency, and what assistance the police and Family Crisis staff could provide these agencies in return. Family Crisis and the 201 Unit also trained many of these agencies in how to work with the police, interpret the applicable civil statutes, and use other social service

resources in the community. The 201 Unit and Family Crisis still meet with every new program in town to establish a smooth working relationship.

On occasion, some agencies have not been willing to cooperate to the satisfaction of the police or Family Crisis—for example, by not providing after-hours emergency service. The following are some of the innovative approaches that have been used on occasion to encourage increased cooperation:

- The Family Crisis Intervention director has awakened the admini strators of a few agencies during the middle of the night to resolve an immediate crisis between the police and a social service agency and to demonstrate the need for routine afterhours services.
- Initially, the 201 Unit had to cite the state's Mental Health and Mental Retardation Act to a few emergency ward physicians regarding their obligation to evaluate suspected mentally ill persons. The officers suggested that their refusal to evaluate would have to be noted in the police report of the incident— providing a possible basis for a later lawsuit against the doctors.

Of course, these approaches were used diplomatically, infrequently, and only as a last resort. For the past several years they have become unnecessary. For example, emergency ward physicians on their own began calling the 201 Unit for information on the involuntary commitment statute, and new emergency ward doctors are often told by senior physicians to call the 201 Unit if they have any questions about the law.

Assistance to Small Town and Rural Law Enforcement Agencies in Erie County

Family Crisis Intervention and the 201 Unit help small town and rural law enforcement agencies in Erie county deal with the mentally ill and public inebriate. Over the years, Family Crisis has conducted 187 training sessions with local police departments. Family Crisis staff also spend between three and eight hours a week, respectively, at each of two outlying police departments helping to facilitate admissions to local hospitals and prevent problems with social service agencies before they arise. In addition, any police department in the county can call Family Crisis for consultation on the phone or an on-site emergency visit. For example, one Sunday a small town police chief detained a person with a history of alcohol and drug abuse who was suspected of also being mentally ill. The chief called Family Crisis wondering whether to jail the person—and risk a suicide attempt—or go to the trouble of having him hospitalized—and tie up an officer for several hours. Family Crisis looked up the person's previous mental illness history in its file of 20,000 records, found out the person could be safely released, and offered to come evaluate him on Monday.

* * *

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Fairfax, Virginia

A Mobile Crisis Unit and Consultation Hotline for Psychiatric Emergencies

The Fairfax County Police Department, with 950 sworn officers, serves 700,000 people in 400 square miles of Northern Virginia. Through a written agreement negotiated in 1977 with the county-funded Woodburn Center for Community Mental Health, police can consult 24-hours-a-day with the center's Emergency Service and obtain on-scene assistance 16-hours-a-day from the Emergency Service's Mobile Crisis Unit. The county gives the Woodburn Community Mental Health Center $200,000 a year to staff the Mobile Crisis Center.

Contacting the Woodburn Center

Police telephone the Woodburn Center Emergency Service hotline when on-scene assistance is not necessary but they are unsure about how to help a person they believe is mentally ill. Emergency Service staff can suggest how the officers can convince the person to seek help voluntarily and what treatment resources may be appropriate. The Woodburn Emergency Service sometimes prevents police reinvolvement with the same mentally ill individual by involving the person in aftercare. A study of clients who were not detained showed that 71 percent had followed through with Mobile Crisis Unit referrals and were actively engaged in a voluntary treatment program within four weeks of the unit's intervention.

The Emergency Service's Mobile Crisis Unit goes on-scene 1,000 times a year to assist police in handling persons who are a danger to themselves or others and who refuse to accept referral voluntarily. Frequently, the cases involve suicidal people who have barricaded themselves in a room or building. The unit operates from 8 a.m. to midnight, seven days a week.

On-scene with the Mobile Crisis Unit

Voluntary treatment. On arrival, the Mobile Crisis Unit assesses the individual's need for treatment. If involuntary detention is not needed—as happens in about three-quarters of all field visits—the unit takes over the case, enabling the officers to return immediately to their beat. The unit identifies an appropriate treatment facility and normally has a family member or friend transport the person to the facility. If necessary, the unit does the transporting.

Involuntary detention. If involuntary detention is required, a different procedure is followed that requires police to remain on-scene. Virginia law permits detaining persons for up to 72 hours who are a danger to themselves or others, or who are substantially unable to care for themselves. To detain someone, a responsible person must sign a petition, and then a magistrate must issue an order of detention. By law, only the police may transport the person to the facility. However, because of the court order,

a psychiatric facility cannot refuse to hospitalize anyone an officer brings for involuntary detention.

Police and family members may petition for detention by describing in writing the person's behavior or speech that indicate the need for hospitalization. However, if family members are not available, Mobile Crisis Unit staff, rather than police, normally fill out and sign the petition so that the officers do not have to testify the following day at the preliminary hearing. In addition, the recommendations of the crisis unit staff, as licensed health care professionals, are taken more seriously by the magistrate than are those of police or family members. Having completed the petition, unit staff telephone a magistrate for a verbal order of detention. The magistrate in turn calls local mental hospitals to find an empty bed for the person and then calls the unit back with the name of the designated facility. The police then transport the person to the facility.

Networking with Individual Hospitals

Aside from the limited hours of the Mobile Crisis Unit, the only weakness in this arrangement is that police must sometimes remain at the hospital several hours to guard individuals detained involuntarily who may be dangerous. For while magistrates can always find a bed, half the time it is on an unsecured medical ward because the psychiatric wards are often full. This situation has led to disagreements between the officers and hospital staff regarding the need for a police presence and the feasibility of using other means to restrain the patient, such as handcuffs or bed restraints. Furthermore, some officers may not detain people who are on the borderline of needing hospitalization in order to avoid all-night guard duty.

Because of these and other conflicts over hospital procedures, a police community relations officer met with each hospital to develop a set of written protocols to guide how police and hospital staff would interact. These understandings resolved several disagreements that were creating friction. For example, officers can now secure a detained person's background from police records to document to the charge nurse that a police guard is unnecessary. The nurse will then monitor the person for up to an hour while the officer remains on guard. If no signs of dangerousness appear, the nurse will permit the officer to leave, providing he or she agrees to return later if needed. The hospitals also agreed to use bed straps to restrain hyperactive and disoriented patients whom officers were having to follow all around the hospital.

* * *

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Galveston, Texas

Sheriff's Mental Health Deputies Take Over the Case

In Galveston County, Texas (population 194,000), a special unit of five specially-trained deputy sheriffs in the County Sheriff's Department provides around-the-clock on-site screening of suspected mentally ill persons. The unit receives 6-12 calls a day from deputy sheriffs and other officers in the county's 12 municipal police departments.

Origin of the Arrangement

Originally, law enforcement officers throughout Galveston County took most suspected mentally ill persons, regardless of appropriateness, to the University of Texas Medical Branch hospital. Not only did this result in considerable lost time to police and deputy sheriffs, these unscreened referrals created a constant interruption for hospital staff who had to evaluate individuals who often turned out not to need hospitalization or who were not even mentally ill. These problems increased when a change in the Texas Mental Health Code required peace officers to detain for psychiatric evaluation any individuals found to be a danger to themselves or others.

In response to these problems, representatives of the hospital, the sheriff's department and the Gulf Coast Regional Mental Health-Mental Retardation Center in 1975 agreed in writing that:

- the Mental Health and Mental Retardation Center would train several deputy sheriffs to screen the mentally ill for the most appropriate disposition;
- these "mental health deputies" would spend full-time going onsite to screen and—if needed—transport the mentally ill to the University of Texas Medical Branch hospital; and
- the hospital would allocate any available bed—including those on medical wards—to individuals needing immediate hospitalization. (See Appendix C for the most recent agreement.)

Pursuant to the agreement, the Galveston County Sheriff's Department sent a memorandum to the county's twelve small-town police departments explaining the new service and suggesting that they would no longer have to lose an officer for half a shift to handle a mental illness case if they called the sheriff's mental health deputies for assistance.

The Gulf Coast Regional Mental Health and Retardation Center pays the hospital $411,000 a year to evaluate and treat the mentally ill brought in by the mental health deputies. In addition, the center pays the salary and fringe benefits for the deputies' administrative assistant ($24,000) and provides office space for the deputies. The Sheriff's Department pays the salaries of the deputies and provides the deputies' equipment (cars, radios, etc.).

Role of the Mental Health Deputies

Upon arrival on site, the mental health deputy takes over the case, leaving the local peace officers free to return to their other duties. If the deputy determines that professional evaluation is needed, he or she obtains a magistrate's warrant and transports the individual to the University of Texas Medical Branch hospital for emergency evaluation. (Deputies may detain and transport suspected mentally ill persons without a warrant when there is a substantial risk of harm if the person is not immediately restrained and when there is insufficient time to obtain a warrant.) While on the way to the hospital (a maximum 30-minute trip from anywhere in the county), the deputy radios the emergency room to have an on-call psychiatrist available on arrival. The mental health deputy remains at the hospital until the doctor makes a disposition if the evaluation is involuntary; if the evaluation is voluntary, the officer may leave immediately.

When beds are not available on the contracted unit, the medical director may use other psychiatric beds in the hospital. As a last resort—and one infrequently used—individuals are sent to the state hospital.

When a person is homeless as well as mentally ill, but does not need hospitalization, the mental health deputy may take the individual to the Salvation Army for the night and arrange the following day for his or her transfer to the Mental Health and Mental Retardation Center for follow-up care. Individuals with an acute alcohol or drug problem are admitted to the University of Texas Medical Branch hospital detoxification unit.

If neither professional evaluation at the hospital nor transport to another facility is needed, the deputy will refer the individual to outpatient services or suggest elective hospitalization. With known chronic cases, the deputy will put the person or person's family in touch with his or her assigned case manager at the Regional Mental Health and Mental Retardation Center.

Mental Health Deputies' Experience and Training

As hoped, the mental health deputies have been able to make other arrangements for most mentally ill persons rather than impose on the limited resources of the hospital's emergency room. The deputies' extensive training as mental health paraprofessionals facilitates their referring individuals to other appropriate human service providers and arranging for their successful admission. The deputies' training includes a six-month course in Emergency Medical Services, followed by six weeks' additional training with the Regional Mental Health and Mental Retardation Center to learn crisis intervention and diagnostic skills.

Because of the deputies' expertise and longevity on the job, emergency room staff have come to know and trust them—and give them priority when they walk in the bustling facility. In addition, by being stationed in the Mental Health and Mental Retardation Center's offices, the deputies and case workers can confer informally on specific cases. Finally, the mental health deputies are an asset at court commitment hearings. They provide evidence based on personal observation, or obtained from

reliable third parties, regarding the observed behaviors of mentally ill people who often do not show signs of mental illness in front of psychiatrists and judges during commitment hearings and thereby frustrate the Mental Health Center's attempts to commit them.

* * *

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The National Coalition for Jail Reform
Removing the Chronically Mentally Ill from Jail
(Washington, D.C.: 1984).

Madison, Wisconsin

Police Chief Initiates Liaison Position and the Social Service System Offers 24-Hour Crisis Service

A combination of personal initiative by a police chief and farsightedness by social service agency heads led to a harmonious network in Madison, Wisconsin, for handling mentally ill people and public inebriates.

Origins of the Network

According to the Madison Police Chief, "Police have a tremendous responsibility to deal with problem people without resorting to the criminal justice system—the

chronically mentally ill, people who are chemically dependent, people in crisis. I have really been opposed to putting the mentally ill and drunks in jail." To implement this philosophy, the chief created a Social Service Coordinator position in 1973 to be filled by a sworn officer. The coordinator develops in-house policy for handling the mentally ill, public inebriates, and other troubled populations. He also resolves problems between officers and social service personnel.

At about the same time, the mental health system had become disturbed by the release of hundreds of patients from the state mental hospital, many of whom gravitated to Madison. In response, the Dane County Mental Health Center developed a comprehensive public mental health program that included a Crisis Intervention Service. This 24-hour mobile unit, available to other social service organizations and to the police, focuses primarily on suicide cases, potential voluntary hospitalizations, family crisis situations, and psychotic persons.

The police and the Mental Health Center combined internal change in tandem with joint planning and training from the start. Crisis Intervention Services staff rode on patrol duty with the major police agencies in the county to become familiar with the patrol officers and their work. Police officers knowledgeable about crisis intervention trained the crisis staff in such topics as avoiding violence.

Police recruits and officers received extensive pre-service and in-service training from the department's own Social Service Coordinator and Crisis Intervention Service staff in the nature of mental illness, identification of the chronically mentally ill, and crisis intervention.

The agreement provided for the Mental Health Center to inform officers in writing of the immediate treatment plan for all referrals and thank them for their services. Center staff also send letters of commendation to police administrators when an officer's performance warrants special recognition.

Currently, the police interact with two dozen social service agencies, including the state mental hospital, rape crisis centers, and detoxification facilities. The Dane County Mental Health Center and the police negotiated a formal working relationship, documented in letters of understanding. The county contracted with the local detoxification center to accept police department referrals, and a very close, but informal, relationship developed between the two agencies. The police have separate in-house guidelines for cooperating with each of the other principal social service providers.

How the Network Operates

Example A. A police officer comes upon a man talking quietly to himself in a park. The officer recognizes him as a client of Dane County Mental Health Center's mobile outpatient unit. The officer calls the Mental Health Center to express concern. The mobile unit checks the client's records and finds that he sometimes forgets to take his medication. The unit calls the man's son, who comes to take him home and make sure he takes his medicine. The officer was under no obligation to call the center, but preventing incidents is a major objective of the cooperative effort with the center.

Example B. Called during a snow storm to check out an illegally parked car, an officer finds a disoriented, barefooted man dressed in a T-shirt behind the wheel. The officer telephones the Crisis Intervention Service for consultation on what to do. The Crisis Service is familiar with the person and calls the person's case worker for advice. The case worker recommends bringing the man in for evaluation.

These examples represent two of six basic dispositions the network makes available for dealing with the mentally ill:

1. referral and release,
2. release to family or friends for referral,
3. voluntary psychiatric examination,
4. involuntary psychiatric examination,
5. temporary involuntary detention, and
6. arrest.

If the problem is minor, and the person's behavior does not appear incapacitating or likely to reoccur, the officer normally refers the person to a specific outpatient facility. If the behavior is likely to happen again, the officer places the person in the custody of family or friends, and recommends professional help from an appropriate facility. In either case, the person is told to expect a telephone call from the agency within a day or two. Later, the officer notifies the agency of the referral and forwards a copy of the incident report.

If the police do not feel comfortable simply referring the individual, they consult with the Dane County Mental Health Center's Crisis Intervention staff, either in person weekdays between 8 a.m. and 5 p.m., or by phone at any hour. Police call the center an average of 50 times a week. The crisis staff can also respond on-scene 24 hours-a-day if necessary. Whether on the phone or in person, the mental health professional will confer with the officers and the individual and then recommend a disposition.

Police officers have the authority to detain individuals and transport them for involuntary examination at the Mental Health Center. However, the agreement with the center requires officers to consult with the crisis unit first, because the staff may be able to use crisis intervention techniques, often in conjunction with medication, to stabilize the individual without recourse to hospitalization. In addition, the staff may want to refuse to hospitalize an individual who has a history of trying to manipulate the social service system.

Police may also temporarily place persons who are violent, or who threaten violence, in the state mental hospital. To do so, the officer fills out an Affidavit for Temporary Custody, and Crisis Intervention staff arrange a mental health evaluation. If the evaluating psychiatrist does not agree with the need for temporary custody, the officer can still have the person detained at the state mental hospital. However, officers rarely overrule the recommendations of the mental health professionals because

crisis staff, by consulting their file on former referrals, can often convincingly justify their recommendation on the basis of the person's previous history of mental illness.

Finally, the police may arrest a person who has committed a felony. They may also arrest any individual who exhibits minor abnormal behavior and is not willing to submit voluntarily to an examination, if the person does not meet the criteria for emergency temporary detention for an examination. Since arrest for an ordinance violation does not allow the court to order treatment, the police protocols permit arrest only for statutory violations, which does permit court-mandated treatment.

Handling the Public Inebriate

Upon encountering someone drunk in public, police officers assess whether the person's physical or mental functioning is substantially impaired. If it is not, the officers offer to take the person home or to a detoxification center. If the officers transport the person to a facility, they do not need to wait for admission procedures to be completed. If the inebriate refuses both alternatives, the officers can only arrange for public transportation to a safe location at the person's expense.

A police officer is permitted by law to take any person into protective custody who is substantially impaired by alcohol use. However, unless there is a second officer already on the scene, the detaining officer must request assistance from another patrol unit. The two officers then transport the person to Tellurian UCAN, a private, 24-hour, 30-bed detoxification center which the county pays $738,000 a year to handle indigent inebriates. Tellurian may forcibly detain substantially impaired inebriates for up to 72 hours. Furthermore, Wisconsin requires detoxification facilities to relieve law enforcement officers of responsibility for any incapacitated inebriate. As a result, the officers may leave as soon as they escort the person into the facility. Later, the facility notifies the police when it releases the inebriate.

Although not part of the county's contract with the facility, Tellurian staff have agreed informally that, when possible, they will come to the scene at an officer's request and transport the inebriate to the facility themselves. This saves the police time, since normally transporting an inebriate to the center requires calling in a second officer. Police telephone for center staff to come on-site most commonly for inebriates they recognize are regular Tellurian clients. In addition, for special events, such as a recent festival where 10,000 people were expected to congregate in a park, Tellurian has agreed to provide a mobile transport unit to allow police to stay on the scene for crowd control rather than drive drunken revelers to the facility. Police reciprocate by responding promptly to Tellurian's requests for help with clients who become disorderly. In addition, officers shield the facility from complaints from merchants by urging unimpaired inebriates drinking on downtown streets to go somewhere else or be fined for drinking in public.

A representative of the police department meets with Tellurian staff and members of the local business community every Tuesday to discuss the public drinking problem in the downtown area. The meetings help avoid inappropriate calls by businesses to both the facility and the police to handle public inebriates on their doorsteps. Tellurian staff also train new police recruits in how to determine whether people

drinking in public are substantially impaired. At the same time, facility staff introduce themselves to the officers and explain their services.

Role of the Police Social Service Coordinator

The Social Service Coordinator reviews all police incident reports involving problem persons to ensure officers are following department policy, to identify problem areas, and to single out chronic clients in need of further assistance. He mediates problems between the department and social service agencies.

Police cite four benefits to having an in-house Social Service Coordinator:

1. A central liaison person whose full-time responsibility is to make the network succeed helps cut through the initial apathy toward the new arrangements felt by many other officers. He also represents a one-stop and accessible point of contact regarding the network for any officers who have questions about the department's protocols for handling problem persons.
2. As a sworn officer, the coordinator is better able than a civilian to encourage other officers to work with "outsiders," and he has more clout for taking immediate action within the department to improve the network.
3. Problems with the network are likely to surface quickly, because street officers are more likely to express complaints about the social service system to one of their own than to a civilian.
4. A trained coordinator is best able to express officers' concerns objectively and dispassionately to social service program personnel, yet still convey effectively the police department perspective.

The coordinator monitors the speed of Crisis Intervention Service response especially closely. Police tend to discredit the usefulness of the service if crisis staff are not on the scene within 20 to 30 minutes. If response time is averaging more than 30 minutes, the coordinator contacts the liaison administrator at Dane County Mental Health Center to improve the response time.

The Social Service Coordinator's salary is the only networking expense to Madison Police Department. In justifying the expense, the police chief stresses that "You have to give your officers the tools and resources to deal with the problems they face. The best way to provide this help is with a specially disignated liason who can be singleminded about focusing on this one area that can take up so much police officer's time if it's not carefully addressed."

* * *

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Montgomery County, Pennsylvania

Centralized, Countywide Service for the Mentally Ill

The Pennsylvania Mental Health Procedures Act of 1966 requires every county in the state to provide 24-hour emergency services to the mentally ill. A 1976 amendment to the act permits designated facilities to detain for up to 120 hours persons whose behavior, in the estimation of a physician, shows a clear and present danger of bodily harm to themselves or others. The facilities are required to evaluate any suspected mentally ill person's condition, but they can refuse to admit any individual not considered dangerous to him- or herself or others. Since 1974, the Montgomery County Emergency Service (MCES), a private, non-profit 36-bed emergency psychiatric and drug/alcohol hospital in Norristown, Pennsylvania, has been the only designated facility for involuntary commitment of the mentally ill in this county of 650,000 people. MCES services are available to any responsible individual within the county's 500 square miles who requests help for a suspected mentally ill person. However, 35-40 percent of its clients are referred by the county's 52 urban, small town, and rural police departments.

Emergency Commitment and the Police

The Montgomery County Emergency Service distributes a "cop card" (see Figure 5 in Chapter 3) to all police in the county that provides instructions for telephoning the facility's 24-hour hotline for assistance with any suspected mentally ill person who *(a) poses a danger and (b) is unwilling or unable to sign a voluntary admission form.* The card also provides instructions for when to call MCES for voluntary examinations of suspected mentally ill persons.

The MCES does not encourage calls for help with *non*emergency cases when officers can appropriately transfer custody of the person to a family member, when the person is willing to seek professional help voluntarily, or when the person is not dangerous to him- or herself or others.

When called, MCES staff do one of three things:

(1) *provide consultation over the phone* regarding the most appropriate disposition, including referral to other suitable resources;

(2) instruct the officer to *bring the person to the facility* for examination and possible admission; or

(3) *send its ambulance*, staffed by certified emergency medical technicians, to evaluate the situation and provide crisis intervention. If involuntary commitment is contemplated, the person is brought to MCES for psychiatric evaluation.

Police may also transport individuals directly to MCES without calling the hotline first if they believe involuntary commitment is needed. However, a call to screen the situation is recommended, and ambulance transport is offered if a small rural law enforcement agency is calling that cannot spare an officer to transport the person.

When the police bring an apparently mentally ill person to MCES, the following occurs:

(a) The officer who observed the abnormal behavior must sign a petition for commitment with a brief description of the language or actions that indicate the person is severely mentally disabled.

(b) A "delegate" from the County Department of Mental Health then reviews the petition. Delegates are available at the hospital from 8 a.m. to midnight seven days a week; midnight to 8 a.m. they are available on call.

(c) If the delegate approves the petition, an MCES psychiatrist evaluates the person and determines whether hospitalization is required.

At the end of this process, which usually takes thirty to sixty minutes, the officers can return to their beat. MCES transports the individual home or to other facilities if involuntary commitment is not needed. Staff provide recommendations for outpatient treatment for every individual who is not admitted. Through follow-up telephone calls to the individual, to his or her family, or to the referral agency, staff increase the chances that the person will pursue outpatient treatment.

Training and Communication

In addition to distributing the "cop card," the Montgomery County Emergency Service trains police recruits and line officers in how to identify suspected mentally ill people and use emergency treatment services (including MCES). The training is designed to enable officers to know when and how to handle cases themselves to avoid burdening MCES with unnecessary calls for assistance. Staff also explain when involuntary evaluations and commitments can legally be made, by describing, for example, what kinds of behavior and language constitute a "clear and present danger of bodily harm to oneself or others."

A full-time MCES Criminal Justice Liaison, funded by the Norristown Police Department with city funds, conducts much of the training. In addition, the liaison:

- meets face-to-face with each of the 57 police chiefs in the county at least once a year to review problems, assess progress, and describe changes in available resources;
- makes presentations and answers questions at meetings of the County Police Chiefs' Association;
- rides on patrol with officers in selected police departments to demonstrate effective ways of handling troublesome cases; and
- troubleshoots and solves problems between police departments and social service agencies.

The MCES also trains other social service agencies on the use of its facility, relations with the police, and conditions of involuntary commitment. When the MCES was first established in 1974, the executive director met with the staff of every local mental health program in the county to identify their needs and services, and to clarify what police could expect from them and what they could expect from the police. Since then, MCES staff have kept up to date on all available resources, sharing any new information formally at training sessions, and informally as needed, with local law enforcement agencies and other social service organizations.

Service to Small and Medium Size Jurisdictions

The centralized services of the Montgomery County Emergency Service represents a successful regional approach to helping a large number of geographically dispersed police departments deal with crises involving the mentally ill. While outlying rural departments, of course, have less access to the facility than do departments closer by, MCES simplifies their job of handling the mentally ill by:

(1) training them in handling this population and in using local resources for assistance;

(2) providing 24-hour telephone assistance for dealing with difficult cases; and

(3) dispatching its ambulance to assist police officers in very time-consuming and potentially explosive crisis situations.

This third service is particularly important to small townships in the county, for which a psychiatric emergency could seriously affect police coverage of the community by tying up scarce personnel for hours. For example, the program estimated that during the nine years between 1975 and 1983 it saved 8,420 hours—or four person years—of police time by transporting suspected mentally ill people in its ambulance whom officers would otherwise have had to escort.

Fiscal Self-Sufficiency

The Emergency Services was originally funded by the Law Enforcement Assistance Administration (LEAA) and the county. An initial $300,000 from the county was especially important for renovating and converting an unused building on the grounds of the state mental hospital to a locked psychiatric facility. However, over time the facility has become largely self-sustaining through third party billing of private insurers and government health care programs. Current costs are $22,000 for the liaison position ($20,000 paid for by the County Department of Mental Health and $2,000 paid for by the Norristown Police Department). The Department of Mental Health also reimburses MCES for ambulance runs ($10,000) and hospitalization expenses ($140,000) for indigent persons without third party insurance coverage.

Becoming and remaining largely financially self-sufficient has not been easy. The program director spends considerable time keeping up with the eligibility requirements and reimbursement procedures of government health insurance programs, and in securing adequate payment for services. However, the effort has proven worthwhile. By minimizing the need for county funding, the program is not subject to the

uncertainties of local officials' funding priorities. In addition, its fee-for-service operation enables it to serve unlimited numbers of clients rather than having to restrict its services to accommodate the amount of local funding available each year.

* * *

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The National Institute of Justice
Montgomery County Emergency
Service
Norristown, Pennsylvania:
An Exemplary Project
(Washington, D.C. 1978)

The National Institute on Drug Abuse, Project Connection Best Strategy: Linking Criminal Justice and Treatment Agencies to Respond to Drug, Alcohol, and Psychiatric Emergencies, DHEW Publication No. (ADM) 80-950 (Washington, D.C. 1980)

New York City and Jersey City, New Jersey:

Starting a Network for the Homeless from Scratch

Given the nature of its responsibilities, it is not surprising that the Port Authority of New York and New Jersey has a serious problem dealing with hundreds of homeless individuals. With a staff of 8,000 employees, including 1,200 police, the Port Authority manages and provides public security for Newark, La Guardia, and Kennedy airports, a major bus terminal and commuter railway, the George Washington and Staten Island bridges, the Holland and Lincoln tunnels, three major ports, and the World Trade Center.

Between 1982 and 1984, the homeless population "living" in the authority's transportation facilities had grown rapidly, creating a severe security threat both to the homeless and to the traveling public. By creating the impression that law and order had broken down, the homeless attracted a deviant fringe which victimized not only the homeless but also the general public. As the homeless population grew, so did pressure on the police to displace them in order to eliminate the additional crime they brought in their wake. However, Port Authority police had no training in how to handle this population, no place (at least in New Jersey) to send them, and no legal basis to make them leave. Loitering laws in Jersey City do not apply to public transportation waiting areas. In New York City, the loitering laws do apply to such areas, but it is Port Authority policy not to enforce them.

Port Authority police ultimately had to offer homeless people a more attractive housing alternative than a bus or train station. Transportation facilities are often relatively comfortable places for the homeless to congregate. With 24-hour police patrol, a roof, heat and air conditioning, they provide a safe haven from street crime and the elements.

When persistent feelings of helplessness among Port Authority police began to affect morale, the agency as a last resort hired two nonprofit agencies to transport and house homeless people. The effort resulted in two different systems for its transportation facilities, one system in New York City, and another in Jersey City.

New York City: Motivating Use of Existing Facilities

In New York City, the principal problem was getting homeless people to use existing shelters. Here the Port Authority's obstacles were threefold: the homeless lacked the motivation to use available shelters; Port Authority police lacked the time to transport them; and, without comprehensive referral services, the same homeless individuals would continue to return to Port Authority facilities day after day. The Port Authority's solution was to hire a private, nonprofit organization to transport homeless people from its midtown and downtown bus and train terminals to shelters.

A contract with *Volunteers of America*, a national service organization, calls for two-person teams, composed of a rehabilitated homeless person and a supervisor (sometimes accompanied by Port Authority police), to "sweep" the midtown bus and downtown train terminal 20 hours a day between 5:30 a.m. and 1:30 a.m. The teams ask the homeless if they would like to go to the organization's own shelter. Vans wait outside to transport the homeless, or just feed them. At the shelter, additional referrals to mental health and detoxification services are made, if appropriate.

A one-year contract with Volunteers of America costs the Port Authority $276,816, plus $48,574 contributed annually by New York City's Department of Mental Health for the midtown terminal and $123,996 for the downtown terminal.

Jersey City, New Jersey: Opening Entirely New Facilities

Unlike New York City, until mid-1985 there were no agencies for the homeless in Jersey City. As a result, the Port Authority contracted for the services of a nonprofit consortium of churches providing food pantries and soup kitchens to the indigent. Under a six-month $16,279 pilot project, the churches agreed to:

- expand its meal program to five afternoon and two evening meals served to a maximum of 150 people;
- visit the main Jersey City bus and train terminal at least once a day to invite the homeless to use its existing services, the new drop-in center, and yet-to-be-developed shelters; and
- transport homeless people brought to them by Port Authority police to future shelters.

The missing link in this arrangement, however, was a network of shelters. To remedy this critical deficiency, Port Authority police teamed with the Jersey City

Mayor's Task Force on the Homeless to establish guidelines and develop facilities for handling the homeless. The multi-agency task force of public and private nonprofit agencies met weekly for five months beginning in the summer of 1985, then every other week, and now monthly. Since June 1986, the Jersey City Housing Authority and Catholic Community Services have taken over providing services to the homeless with the establishment of a 65-bed shelter (which sleeps 160-200 on winter nights) and a drop-in center; an outreach team is also in the works. To fund this operation, the Jersey City Housing Authority has paid $325,000 for seven months, and Port Authority has contributed $125,000.

With these arrangements in place, Port Authority police who encourage the homeless to leave the Jersey City bus and train terminal can offer to drive them to the drop-in center. One-quarter of the homeless agree to go to the center. The drop-in center provides counseling and referrals designed to solve their homeless condition.

When the Port Authority took the initiative in Jersey City, other agencies joined in. Previously, only 100 shelter beds were available in Hudson County, which includes Jersey City, and none of the beds were in the city. The County Welfare Department had already been complaining that Port Authority police were bringing too many people from the city to the overcrowded county shelters. Jersey City officials in turn rejected requests for assistance in dealing with the city's homeless because they did not believe the problem was severe. However, a new administration elected in 1985 gave the homeless a higher priority by establishing a Mayor's Task Force on Homelessness with Port Authority representation. The Jersey City Department of Housing and Economic Development personally donated or arranged for in-kind services to the shelter and drop-in center, including:

- underwriting insurance;
- providing fire inspections;
- making improvements to meet fire codes;
- installing additional telephone lines;
- guaranteeing rapid response by city police; and
- training shelter volunteers.

In addition, Port Authority police can now escort the homeless to a new shelter in Jersey City funded with city and private money.

The Port Authority did not effect the change in attitude among Jersey City elected officials. Yet, when officials more receptive to the plight of the homeless were elected, Port Authority police were ready to work with them, knew what was needed, and were prepared to provide the financial and management support of a major agency. The Port Authority had even done some of the legwork to identify the needs of the homeless and link them with resources in the community. Thus, while the Port Authority could

not have succeeded with its current plan in Jersey City without the change in administration, it was able to capitalize on the receptivity of the new officials so quickly only because it had already taken the initiative to attempt to solve the homeless problem.

* * *

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Portland, Oregon

Mutual Accommodation to Improve Dealing with Public Inebriates

Scenario 1: As the police cruiser attempted to leave, the detoxification center director rushed out of the facility and stood in front of the car. He insisted that the police officers take back an inebriate with internal bleeding they had just dropped off, and transport the person to the hospital.

Scenario 2: Police officers were upset that detoxification center staff were reporting inappropriate police behavior at the facility to the police department's internal affairs unit—for example, when officers "dumped" mentally ill or violent people, or used force in the facility against an inebriate.

Occasional incidents like these could have prevented the development of a close relationship between the Hooper Memorial Detoxification Center in Portland, Oregon, and the Portland Police Department. Misunderstandings were ironed out in large measure because each agency appointed a liaison person to oversee the arrangement who did not take offense at criticism and who was prepared to make concessions in order to have an easier time dealing with the public inebriate.

The Initial Arrangement

Beginning as early as 1975, Multnomah County contracted with the private, nonprofit Hooper Memorial Detoxification Center in downtown Portland to accept

nonviolent public inebriates referred by any law enforcement agency in the county. The initial impetus for developing the arrangement was a new state law decriminalizing public intoxication. Other changes in the law required law enforcement officers to place a civil hold on incapacitated inebriates and take them home or to a detoxification facility.

Hooper Detoxification Center provides a place for inebriates to sober up and an opportunity for staff to try to interest them in the facility's in-patient or outpatient treatment programs. While state law permits a facility to detain incapacitated inebriates involuntarily up to 48 hours, Hooper allows most of them to leave after they have sobered up in 6-8 hours.

Law enforcement referrals accounted for 6,000 of Hooper's 18,000 admissions in 1985. Ninety percent of the law enforcement referrals are made by the Portland city police (which is contracted to patrol a large part of Multnomah County). The rest are brought by the Port of Portland police, Multnomah County deputy sheriffs, and local transit system police. Officers remain at the detoxification center an average of five minutes to complete the paperwork and allow the staff to evaluate the inebriate.

Expansion of Hooper's Responsibilities

As police staff were cut, as jails became crowded, and as public inebriates increasingly congregated in the downtown area, the detoxification center's responsibilities for the public inebriate increased. In 1983, Hooper set up a padded isolation area and began accepting combative (but not truly violent) inebriates brought in by the police. In 1986, the county funded the remodeling of Hooper Center to house violent inebriates.

Because the police were spending considerable time transporting chronic public inebriates to Hooper, the county also provided funds for facility staff to patrol the downtown area from 8:00 a.m. to midnight in a specially equipped van and transport inebriates to the center. (Police may also call on the van to come pick up inebriates.) Later, the sheriff deputized the entire Hooper staff, enabling van operators to detain inebriates involuntarily.

The van also acts as a first responder for the Emergency Medical Services (EMS) system in the central city whenever the public calls the emergency 911 number to report someone who is incapacitated but breathing and not bleeding. The county pays Hooper $75,000 a year to provide this service, because a large proportion of these individuals turn out to be intoxicated and have to be taken to Hooper. In addition, identifying one EMS provider to respond prevented the police, private ambulance services, the Fire and Rescue Unit, and the Hooper van from converging together at the same scene. Sometimes, the person turns out to be mentally ill, in which case van operators telephone 911 and request assistance from the police—who alone may legally transport this population. For people in need of medical care, an ambulance is called.

Mutual Accommodation

Over the years, Hooper staff and the police department worked closely together to clarify their relationship.

- When Hooper first began to accept police referrals, its director met for six months with the downtown police shift commanders to review person-by-person each inebriate the facility had rejected and the jail had accepted to see if officers were following the department's General Orders for handling public inebriates.
- Hooper staff complained that some officers were dropping off inebriates and leaving before an evaluation could be completed. The shift commanders met with the Hooper director and agreed to have officers wait at the facility; in return, Hooper staff agreed to come outside to look at (and reject) obviously violent inebriates held in the police cruiser so that officers did not have to wrestle them inside the facility and then back into the vehicle.
- Hooper staff would not tell officers whether an inebriate with an outstanding arrest warrant was at the facility when the officers did not have the warrant with them. As a result, the police department liaison asked the District Attorney to research the state confidentiality law and tell the Hooper director that the facility was allowed to permit police officers without a warrant in hand to search for a suspect in the facility. After consulting with his own legal counsel, the Hooper director agreed to allow officers in the facility if they confirmed that there was a warrant on file.
- The police department's objection to reporting inappropriate police behavior to its internal affairs unit was resolved when Hooper staff agreed to try to resolve problems directly with the officer and, if that did not work, to telephone the shift commander. Only as a last resort would the officer be reported to the internal affairs unit.

* * *

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Appendix B

Local Networking Documents

Appendix B1

Memorandum of Agreement Between Agencies of the City of Los Angeles and the County of Los Angeles Regarding Mutual Support in Situations Involving the Mentally Ill

I. DEFINITION OF TERMS

Agreement: Memorandum of Agreement (MOA) Concerning Mentally Ill Persons.

C.A.: Los Angeles City Attorney's Office.

D.A.: Los Angeles County District Attorney's Office.

DAPO: Drug Abuse Program Office. A division of the Los Angeles County Department of Health Services (DHS) which administers non-emergency drug abuse treatment (other than alcohol) and prevention services through contracts with 59 agencies.

Developmental Disability: A disability which originates before an individual attains age 18, continues, or can be expected to continue, indefinitely, and constitutes a substantial handicap for such individual. This term shall include handicapping conditions found to be closely related to mental retardation or to require treatment similar to that required for mentally retarded individuals. It shall not include handicapping conditions that are solely physical in nature.

DHS: Los Angeles County Department of Health Services.

DMH: Los Angeles County Department of Mental Health.

Emergency Treatment Facility: The nearest basic emergency hospital capable of providing medical treatment.

IROS: Information, Referral and Outreach Services Section of the Drug Abuse Program Office which staffs a drug abuse information line.

LAFD: Los Angeles Fire Department.

LAPD: Los Angeles Police Department.

Lead Agency: The agency having primary responsibility for the control of a mental health problem as it exists at a specific point in time.

Mental Health Consultation: The process by which a person makes his or her professional or technical knowledge available to others.

Mental Health Region: A geographic and administrative subdivision of the Los Angeles County Department of Mental Health as defined by the Los Angeles County Board of Supervisors and the Los Angeles County Department of Mental Health, for the purpose of providing mental health services to the residents of Los Angeles County.

Mental Illness: A mental disability characterized by symptoms such as a loss of adequate contact with reality, agitation, severe depression, serious suicidal or homicidal tendencies, or inability to control behavior to the extent that these symptoms are of sufficient severity that they cause such a degree of mental dysfunction that requires professional attention.

MEU: Mental Evaluation Unit of the Los Angeles Police Department.

Multiple Diagnosed: Any person diagnosed as suffering from multiple mental disorders, including two or more of the following: physical disease or handicap, mental illness, substance abuse (alcohol or drug), or developmental disabilities.

Municipal Court: Municipal Court of the County of Los Angeles.

Officer: Officer of the Los Angeles Police Department.

Paramedic: Paramedic of the Los Angeles Fire Department.

PECC: Psychiatric Emergency Coordinating Committee.

PIER: Contract agencies that provide alcohol related public information, education, and referral services.

Post-Emergency: Treatment services that are offered for substance abusers following initial emergency incidents which have been handled by law enforcement, mental health or hospitals.

Regional Center: One of the seven regional centers located within Los Angeles County which are involved in case management and service coordination for persons with developmental disabilities and their families.

Secondary Ambulance Transportation: Ambulance transportation of a patient from an initial emergency treatment facility to any other location.

Superior Court: Superior Court of the County of Los Angeles.

WIC: California Welfare and Institutions Code.

II. PURPOSE

The signatory agencies enter into this agreement in order to enhance community safety by strengthening and improving the delivery of services to mentally ill persons in the City and County of Los Angeles. This agreement is not intended to serve as a legally binding document, but rather as a statement of the commitment by the signatory agencies to provide appropriate and prompt

response and to cooperate in the delivery of mental health services to those in need of mental health intervention. Each agency is committed to support the decisions of the lead agency in cases of apparent psychiatric crisis involving more than one agency.

III. INTRODUCTION

The complexities of dealing with mentally ill persons require that concerned service agencies periodically evaluate how services can best be delivered to the community. Historically, these various agencies have cooperated to the extent possible without a formal policy regarding the coordination of services. Today there is a need for greater interagency cooperation and for the recognition by all involved agencies that each shares some responsibility when responding to problems concerning mentally ill persons. It is incumbent upon all agencies to support one another in accomplishing the goals of improved community safety and the proper care of mentally ill persons.

Each agency recognizes that the primary responsibility for dealing with mentally ill persons may change during and after an incident. As the lead agency changes, all other involved agencies agree to give their full support and cooperation to the recognized lead agency.

This agreement acknowledges that the DMH is the primary provider of mental health services. It is therefore the responsibility of the DMH to exercise leadership in the field of mental health. By working together, mental health professionals, as well as professionals from concerned agencies of the criminal justice system, can promote the improvement of services and expand the resources available during mental health emergencies. This agreement sets forth the specific responsibilities of these agencies during a mental health crisis, as well as their responsibilities for coordination with other involved agencies.

A major objective of this agreement is the diversion of mentally ill persons involved in minor criminal behavior (low grade misdemeanors) from the criminal justice system, when possible, and their referral to the most appropriate system consistent with prudent concern for public safety and the treatment needs of the individual.

Situations or problems concerning mentally ill persons may develop which must be resolved immediately. Those situations or problems not covered by this MOA will be handled by existing procedures or by mutual agreement among the involved agencies.

IV. RESPONSIBILITIES

Los Angeles County Department of Mental Health

1. Standardize, throughout the five mental health regions of the DMH, policies and procedures involving crisis intervention, emergency response

and evaluation, as well as the criteria for receiving suspected mentally ill persons who are in police custody.

2. Distribute a current description of the crisis intervention and evaluation services and responsibilities of the DMH to concerned agencies and community groups promoting mental health, and provide periodic updates.

3. Identify and maintain a designated resource that shall have the full authority of the Director of the DMH, with responsibility to immediately intervene and resolve special situations of an urgent nature concerning policies and procedures of the DMH. This resource shall be available on a 24-hour, 7 day-a-week basis to the LAPD-MEU or other MOA agencies and shall be used only when all mental health regional resources and options have been explored.

4. Provide to the LAPD, within the provisions of the law, mental health consultation concerning contacts with the mentally ill, including the violent or potentially violent, and those in need of intervention.

5. Accept and take appropriate action on information received from the LAPD or other MOA agencies concerning persons suspected of being mentally ill, including those who are potentially violent or dangerous to themselves or others.

6. Notify the LAPD of the discharge of patients as required by WIC Sections 5152.1 and 5250.1 and as authorized by WIC Section 5328(p). The DMH also agrees to inform all contract providers of their responsibilities under the above cited sections and ensure their compliance.

7. Designate a representative to co-chair the PECC.

8. Establish and conduct orientation and training programs for MOA agencies concerning appropriate methods of handling psychiatric emergencies and to participate in cross-training among agencies.

9. Work with the DHS to ensure that both departments assume joint responsibility for the disposition of cases where jurisdictional issues arise because an individual's behavior indicates multiple diagnosed problems. The DMH and the DHS will assume responsibility at portal of entry to ensure the evaluation and the most appropriate disposition of individuals brought to their attention.

10. Work with the LAPD to develop pilot programs and/or demonstration projects which attempt to increase effectiveness in meeting the psychiatric emergency needs of mentally ill persons involved in incidents requiring LAPD attention. Implement a one-year pilot program wherein professionals from the DMH will be located within selected LAPD detective facilities. The first phase of the pilot program will begin within 60 days after implementation of the MOA with subsequent phases in 60 day increments until four such programs have been established. Specific functions of the mental health professionals will be determined by mutual agreement between

the Director of the DMH and the LAPD staff officer appointed by the Chief of Police. The effectiveness of this program will be evaluated jointly by the DMH and the LAPD for recommendations to continue, modify or discontinue the program.

Los Angeles Police Department

1. Establish a 24-hour mental health emergency command post, coordinated by the LAPD's Detective Headquarters Division. Personnel staffing the command post will receive special training and will be assigned to the MEU.

2. Establish standardized policies and procedures that LAPD personnel will follow when dealing with mental health emergencies, as well as during routine encounters with persons believed to be mentally ill, potentially violent or dangerous to themselves or others.

3. Distribute a current description of LAPD services and responsibilities pertaining to this agreement to concerned agencies and provide periodic updates.

4. Provide training to LAPD personnel in procedures for dealing with mentally ill persons and provide cross-training for other concerned agencies.

5. Maintain statistical information concerning contacts with mentally ill persons.

6. Provide, within provisions of the law, consultation to concerned agencies regarding contacts with mentally ill persons, including the violent or potentially violent and those in need of intervention.

7. Provide for the mandatory response of a LAPD supervisor when a dispute arises between personnel of the LAPD and any other agency concerning a psychiatric emergency. The LAPD recognizes that the decision of a mental health supervisor representing the lead agency is binding in matters involving psychiatric emergencies.

8. Provide prompt response by LAPD officers to field situations when requested by mental health professionals to ensure the safety of all involved.

9. Provide, when requested, at least one police officer to ride in an ambulance when transporting mentally ill persons.

10. Work with the DMH to develop pilot programs and/or demonstration projects which attempt to increase effectiveness in meeting the psychiatric emergency needs of mentally ill persons involved in incidents requiring LAPD attention. Implement a one-year program wherein professionals from the DMH will be located within selected LAPD detective facilities. The

first phase of the pilot program will begin within 60 days after implementation of the MOA with subsequent phases in 60 day increments until four such programs have been established. Specific functions of the mental health professionals will be determined by mutual agreement between the LAPD staff officer appointed by the Chief of Police and the Director of the DMH. The effectiveness of this program will be evaluated jointly by the LAPD and the DMH for recommendations to continue, modify or discontinue the program.

Los Angeles County Department of Health Services

1. Provide information and assistance during normal business hours for family members or other responsible persons seeking post emergency drug abuse treatment services. Normal business hours are from 7:30 a.m. to 5:00 p.m. on all days except weekends and holidays.

2. Provide training to the LAPD regarding the availability of non-emergency drug abuse and alcohol-related services located within the LAPD geographic areas.

3. Work with the DMH, through a separate and specific MOA, to ensure that individuals with drug or alcohol abuse problems, as well as mental health problems, are provided with services designed to meet these combined problems.

4. Provide PIER services through PIER contract agencies to PECC member agencies.

5. Work with the DMH to ensure that both departments assume joint responsibility for the disposition of cases where jurisdictional issues arise because an individual's behavior indicates multiple diagnosed problems. The DHS and the DMH will assume responsibility at portal of entry to ensure the evaluation and the most appropriate disposition of individuals brought to their attention.

6. Distribute a current description of the crisis intervention and evaluation services and responsibilities of the DHS to concerned agencies and community groups promoting mental health and provide periodic updates.

Los Angeles Fire Department

1. Provide 24-hour emergency ambulance service, consistent with established transportation policy, to concerned agencies when the person to be transported is injured or physically ill.

2. Provide a 24-hour emergency telephone number for concerned agencies to be used when a LAFD ambulance is needed.

3. Distribute a current description of LAFD services and responsibilities pertaining to this agreement to concerned agencies and provide periodic updates.

Los Angeles County District Attorney's Office

1. Provide a 24-hour information number where advice can be obtained by officers and mental health personnel concerning the appropriate processing of mentally ill persons.

2. Provide training to LAPD and other concerned agencies.

3. Distribute a current description of D.A. services and responsibilities pertaining to this agreement to concerned agencies and provide periodic updates.

Los Angeles City Attorney's Office

1. Provide legal advice and opinions to the LAPD and the LAFD in matters concerning mental health emergencies and the processing of mentally ill persons.

2. Distribute a current description of C.A. services and responsibilities pertaining to this agreement to concerned agencies and provide periodic updates.

Los Angeles County Regional Centers

1. Provide services and facilities at the seven regional centers within Los Angeles County for persons with developmental disabilities and their families.

2. Provide or arrange for services as defined by the Lanterman Disability Act.

3. Distribute a current description of regional center services and responsibilities pertaining to this agreement to concerned agencies and provide periodic updates.

V. CONCLUSION

All signatory agencies agree to participate and support the efforts of the PECC. The PECC will monitor compliance and conduct reviews of the MOA and make recommendations for change. The signatories agree to extend their full cooperation to one another in gathering data and to provide a semi-annual status report on the implementation and progress of this agreement.

Signatory agencies agree to notify the PDCC within 60 days of their intention to withdraw from the PDCC.

Implementation of this MOA will begin on April 1, 1985 and will remain in effect until revised by written agreement among the concerned agencies.

ROBERTO QUIROZ
Director,
Los Angeles County Department
of Mental Health

DARYL F. GATES
Chief of Police
Los Angeles Police Department

ROBERT GATES
Director,
Los Angeles County Department
of Health Services

DONALD O. MANNING
Chief Engineer and General Manager,
Los Angeles Fire Department

IRA REINER
District Attorney,
County of Los Angeles

GARY NETTER
City Attorney,
City of Los Angeles

FRANK S. ZOLIN
County Clerk/Executive Officer,
The Superior Court

BARRY NIDORF
Chief Probation Officer,
L.A. County Probation Department

ANNETTE TARSKY
Los Angeles County/
Alliance for the Mentally Ill

PATRICIA DEL MONICO
Executive Director,
Harbor Regional Center

DIANE CAMPBELL ANAND
Executive Director,
Lanterman Regional Center

THOMPSON J. KELLY
Executive Director,
North L.A. Regional Center

DAVID STRAUSS
Executive Director,
San Gabriel Valley Regional Center

RUTH CREARY
Executive Director,
South Central L.A. Regional Center

MICHAEL DANNEKER
Executive Director,
West Side Regional Center

HERMAN FUGATA
Executive Director,
Eastern L.A. Regional Center

Appendix B2

Social Service Agency Admission Criteria Distributed to Boston Police by the Pine Street Inn

The majority of referrals made to the Pine Street Inn by the officers of the Boston Police are very appropriate, and we welcome them to our emergency shelter. However, in some instances the person being dropped off needs immediate services which are unavailable at the Inn. Generally, these referrals may be considered inappropriate for medical reasons or because the individual is barred from Pine Street for assaultive behavior.

Consideration of the following life-threatening situations would be especially helpful before bringing an individual to Pine Street:

1. Unconsciousness (possible head injury or heart attack)
2. Making suicidal threats
3. Hypothermia or heat stroke
4. Drug overdose (unrousable and no smell of alcohol on breath)
5. Mentally ill person who is "talking ragtime" and exhibiting threatening behavior

Please think twice before transporting such individuals here. A hospital is a more appropriate setting than Pine Street. We are professionals in providing shelter and basic needs only (food and clothing). We have very few staff persons who could be considered medical personnel, and they are here only a few hours a day. We have had a number of individuals transported here who have required immediate 911 ambulance assistance after being dropped off by the Boston police. This places extra stress on our staff and the Special Police Officer assigned the Pine Street detail because time is of the essence in treating these medical emergencies.

We appreciate your assistance in caring for the homeless and look forward to working together with you in the future.

The Staff of Pine Street Inn

Appendix B3

Washtenaw County Sheriff's Department
Policy and Procedure Manual

This manual is Department property and is not to be disseminated to the public. It must be returned upon termination of employment.*

Date October 8, 1982 Number P-14 Issued by Sheriff Ronald J. Schebil

PERSONS IN NEED OF MENTAL HEALTH SERVICES

I. Purpose:

1. To provide procedures for processing person appearing to be mentally ill or in need of mental health services.

2. To minimize the time necessary for processing such persons, consistent with the rules and regulations of the institutions involved.

3. To maximize the deputy's opportunity for new learning experiences.

4. To improve the quality of services to persons appearing to be mentally ill or in need of mental health services.

II. Policy:

It is the policy of this agency to assure that persons who come to the attention of the Washtenaw County Sheriff's Department appearing to be mentally ill, or in need of mental health services, are afforded such assistance as community resources and legislation permit. All personnel shall exercise concern for the rights and afflictions of such persons pursuant to this policy, consistent with safety, general legislative requirement, and the updated Michigan Mental Health Code, April, 1977.

III. Procedure

1. Initial Contact

a. Upon initial contact with subject, the deputy will determine whether there is obvious physical injury, intoxication, or drug overdose. If such is the case, the deputy will follow past established procedures in transporting the individual to a hospital or detoxification center.

b. If the individual is not injured or intoxicated, the deputy shall make a judgment as to whether there are reasonable grounds to believe the subject is in need of mental health services or is a "person requiring treatment" under the Michigan Mental Health Code.

To warrant being defined as a "person requiring treatment," the subject must fulfill the following conditions:

* Reprinted by permission.

1. Be mentally ill: ". . . a substantial disorder of thought or mood which significantly impairs judgment, behavior, capacity to recognize reality, or ability to cope with the ordinary demands of life." and

2. "Can reasonably be expected within the near future to intentionally or unintentionally seriously physically injure himself or another person, and who has engaged in an act or acts or made significant threats that are substantially supportive of the expectations." Or

3. Is unable to attend to those of his basic physical needs (food, clothing, shelter) and who has demonstrated that inability by failing to attend to those needs.

Some persons who are not mentally ill according to the above criteria may still benefit from mental health resources. For example, people in obvious depressed states or those in the midst of emotional crisis. This judgment may be made through direct observation, or discussion with the subject and/or relatives who are knowledgeable of the subject's behavior.

2. Community Mental Health

If it appears that the subject 1) could benefit from CMH services, or 2) is a person requiring treatment under the mental health code, the deputy shall contact a CMH representative, from the nearest telephone providing some degree of privacy. Deputies in the eastern part of Washtenaw County will call the Ypsilanti Area Community Service Center, 485-0440. All others will call CMH Out-County, 665-9163. If there is no answer, any deputy may call Emergency Services, 996-4747.

3. Consultation

The deputy shall ask to speak to a CMH specialist. (CMH specialists include CMH clinicians and the U of M/CMH Emergency Services psychiatrists.) The deputy shall describe observations and data to the specialist over the phone. The specialist will then consult on the certifiability of the subject or the need for mental health services. This consultation is not an assurance of certifiability;

it is an administrative procedure designed to minimize unnecessarily removing the deputy from free patrol for a case not requiring assistance. At this point, the subject is still the responsibility of the deputy.

4. Telephone Judgment and Initial Diagnosis

   a. If the specialist judges that the subject would not be certifiable, the deputy may:

      1. Attempt to persuade the subject to take a voluntary interview with the mental health specialist;

      2. Request CMH assistance in mobilizing other appropriate community resources for subject (e.g., housing);

      3. Attempt to improve the immediate environment sufficiently to allow the deputy to leave the scene.

   b. If the specialist judges the subject may be certifiable, the deputy shall:

      1. In conjunction with CMH personnel make arrangements to transport the subject to:

         a. University of Michigan/CMH Emergency Services Unit, or
         b. St. Joseph's Mercy Hospital's Emergency Services, or
         c. Beyer Hospital's Emergency Services, or
         d. Ypsilanti Regional Psychiatric Hospital.

      2. Advise the subject's relatives or close friends of the action to be taken, and encourage them to meet the deputy and subject at the institution; they may ultimately serve as Petitioners in Commitment Proceedings.

      3. Attempt to persuade the subject to voluntarily go to the hospital selected. If this is unsuccessful, the subject shall be advised that he/she is being taken into protective custody under the Michigan Mental Health Code, and that this is not an arrest for a crime.

      4. Transport the subject, with appropriate safety measures, to the facility designated for initial diagnosis.

5. Initial Diagnosis

a. Upon arrival at the facility, the deputy shall generally meet first with the specialist with whom arrangements were made over the telephone.

b. Prior to, and after the initial diagnosis is made by the physician/psychiatrist, the deputy shall function as part of the diagnostic team of physician-mental health specialist-deputy. The deputy shall participate in discussions regarding the criteria the specialist uses to make the diagnosis, alternative courses of action that might be taken, and what to look for in future, similar cases. This opportunity will allow the deputy to acquire more knowledge of the diagnostic procedures, which will be useful for future reference. In all team diagnostic activities, the deputy will function under the direction of the attending physician/psychiatrist. If hospital conditions permit and workload requires, the deputy may return to street duty at this point; however, arrangements should be made per c) and d) below.

c. If the subject is not certifiable, the diagnostic team will discuss alternative courses of action. These may include, but are not limited to, the following:

1. Arrange for utilization of other community resources (with CMH assistance).

2. Arrange for transportation back to the subject's home or other suitable place within the county. Such transportation may be by friends or relatives, Dial-A-Ride, taxi, or police vehicles. Arrangements for taxi shall be made through the on-duty Sergeant.

3. Arrest subject for violation of a criminal law if appropriate.

d. If the subject is certifiable:

1. The examining physician will complete the first Physician's Certificate.

2. If the first certification has been made at the University of Michigan Hospital, the subject may be admitted there at the discretion of hospital officials.

3. The deputy, with the assistance of the CMH specialist, and/or examining physician, will complete the Application for Admission by Medical Certification. Whenever possible, an immediate family member, instead of the deputy, should be the primary petitioner.

4. CMH will notify Ypsilanti Regional Psychiatric Hospital by telephone of the impending commitment proceedings, and will arrange for the deputy to be met at the Admissions office.

5. The deputy, in almost all cases, will transport the subject, together with the first Physician's Certificate and the Application for Admission by Medical Certification, to the Ypsilanti Regional Psychiatric Hospital. The relative of the subject present at the first certification should also proceed to Ypsilanti Regional Psychiatric Hospital; this is necessary if such person is the primary petitioner.

6. Second Diagnosis

Upon arrival at Ypsilanti Regional Psychiatric Hospital, the deputy and other parties will meet with the on-duty psychiatrist (after proper admissions procedures).

a. The deputy shall present the first Physician's Certification, and/or the Application for Admission by Medical Certification to the psychiatrist.

b. The psychiatrist shall conduct the second diagnostic interview. Prior to, and following this diagnosis, the deputy shall continue to be part of the psychiatrist-mental health specialist-deputy team. The deputy shall operate under the direction of the on-duty psychiatrist. If hospital conditions permit and workload requires, the deputy may return to street duty at this point, however, arrangements should be made as per c) and d) below.

c. If the subject is diagnosed as <u>not</u> warranting a second certification, the deputy may take one or more of the following actions:

1. With the help of CHH, arrange for utilization of other community resources.

2. Make transportation arrangements back to the subject's home, or another suitable place within the county. Such transportation may be by friends or relatives, Dial-A-Ride, taxi, or police vehicles. Arrangements for taxi shall be made through the on-duty Sergeant.

d. If the subject is diagnosed as warranting a second Physician's Certificate:

1. The psychiatrist will complete the second Physician's Certificate.

2. The deputy will assist in completing hospital admission forms and release the subject to hospital personnel.

3. The deputy shall assure that the relatives or friends who have attended the pre-admission evaluation understand the proceedings that have been undertaken, and those which will ensue within the immediate future.

7. Follow-Up Information and Future Reference

a. The deputy shall make himself aware of petition proceedings, and of any requirements for his/her presence in court.

b. Within the bounds of confidentiality laws and regulations, follow-up information will be provided by CMH to the deputy. Normally, the CMH police-team consultant assigned to the Washtenaw County Sheriff's Department is responsible for making the follow-up contact with the deputy.

c. The deputy will be routinely notified of the disposition (certification, admission to YRPH, diversion to an alternate CMH program) of the case.

d. Information on the progress of treatment may not be disclosed by Mental Health specialists except when in the judgment of a CMH professional such information is necessary to prevent harm to the subject or others, or when federal and state laws allow for the disclosure of such information.

e. Nothing in the preceding paragraph should preclude the full exchange of consultation between deputies and Mental Health specialists on problems and case histories as long as the subject is not identified.

8. Required Reports

An incident report shall be prepared in all cases in which the subject is taken into custody, or when there are other circumstances appropriate to record. In addition to the standard information required on the report form the narrative should indicate the name, business address, and phone number of the examining physician and the CMH specialist, the outcome of the physician's examination, and the status of the case at the time the report is completed. Any other significant event such as the occurrence of violence or the need for force should also be recorded.

Information need not be duplicated on the log: minimal subject information and a short reference to the case report will be sufficient.

Appendix B4

Galveston County Networking Agreement

THE STATE OF TEXAS

COUNTY OF GALVESTON

This agreement is made and entered into on this 1st day of September A.D., 1983 by and between the GULF COAST REGIONAL MENTAL HEALTH-MENTAL RETARDATION CENTER of Galveston and Brazoria Counties, a juristic entity whose principle office is in Galveston, Galveston County, Texas hereinafter called CENTER; the GALVESTON COUNTY SHERIFF'S DEPARTMENT hereinafter called SHERIFF and the GALVESTON COUNTY COMMISSIONERS COURT hereinafter called COUNTY.

I.
TERM OF AGREEMENT

The term of this agreement shall begin on September 1, 1983 and shall end August 31, 1984.

II.
SERVICES

CENTER, COUNTY and SHERIFF acknowledge a responsibility to provide the community with emergency screening and evaluation services for residents of Galveston County who are mentally incapacitated and in need of such services. Thus, SHERIFF, COUNTY and CENTER agree to cooperate in the formation, operation and funding of a unit called the Galveston County Mental Health Deputies, whose purpose will be to screen evaluate for the most appropriate services.

It is agreed that primary responsibilities of this unit will include response to staff requests for assistance; daily liaison with jail personnel in order to identify and evaluate mentally ill residents; execution of court orders for emergency admission or protective custody; sharing of pertinent information and prompt submission of required documentation.

III.
ORGANIZATION AND ADMINISTRATION

It is understood by CENTER, COUNTY and SHERIFF that Mental Health Deputies are first and foremost peace officers and as such each will be a certified Texas peace officer employed as a deputy sheriff of the County of Galveston, who will successfully complete training specific to work within the Mental Health Division. Such deputies will be jointly

selected or separated by both the CENTER and SHERIFF. It is further agreed that work within the Mental Health Division will be jointly supervised by SHERIFF and CENTER and any problems arising will be pursued through established lines of authority.

IV.
DOCUMENTATION

Employees of this unit shall complete such reports of activities as may be required by SHERIFF, CENTER and COUNTY, not limited to but including:

A. For each unregistered client, deputies will complete an RC-1-A to be submitted within 3 working days of the contact.

B. Monthly service ledgers will completed including an unduplicated entry for each contact and submitted by the 5th day of the following month.

C. On the 5th of each month, Deputies will submit a monthly contact log to the designated CENTER secretary along with a copy of the completed Mental Health Division Intake Form for each contact listed. Forms are to include date, case number, name and date of birth for each contact as well as specific disposition of case (i.e. referral to Crisis Clinic, admission to Mary Moody Northen Pavilion, etc.)

D. Alternate Treatment Recommendation is to be completed on each person evaluated by the Deputies for whom application for commitment has been filed. One copy is submitted to the presiding court and one copy to the designated Center secretary for distribution.

E. Payment: Conditioned upon prompt submission of work documentation and the County of Galveston granting to this CENTER not less than EIGHTY THOUSAND And No/100 ($80,000.00) DOLLARS during the term of this agreement:

1. CENTER will pay, during the term of this agreement to the County of Galveston a sum of money not to exceed FORTY ONE THOUSAND SIX HUNDRED EIGHTY TWO And 43/100 ($41,682.43) DOLLARS which will cover the salaries and fringe benefits of deputies Ontiveros and Morgan.

2. SHERIFF will pay during the period of this agreement on behalf of the operations of this unit from SHERIFF'S own budget or from such resources as he may instruct the salaries of three (3) full time deputies. SHERIFF will also pay that amount

necessary for automobiles, gasoline, radio equipment, other support staff or equipment as may be necessary for the operation of the unit.

3. It is agreed by and between the parties hereto that payment under this agreement shall be for actual amounts expended and under no circumstances will exceed one-twelfth (1/12) of the total due hereunder or one-twelfth (1/12) of any incremental part hereof, irrespective of amount billed and in no event shall exceed the sum of THREE THOUSAND FOUR HUNDRED SEVENTY THREE And 53/100 ($3,473.53) DOLLARS per month.

V.

It is further agreed that no payment can be made under Section IV of this agreement until this agreement has been submitted to the Texas Department of Mental Health and Mental Retardation.

VI.

It is further agreed that all books, records and other methods of documentation are and will be open to audit by CENTER, CENTER'S assigns, CENTER'S Board of Trustees and by the Texas Department of Mental Health and Mental Retardation during normal business hours.

VII.

Documentation of all services supplied hereunder shall be in the manner and on forms prescribed by the CENTER.

VIII.

This agreement may be cancelled by either party giving notice to the other thirty (30) days before the cancellation date at these respective addresses, with or without cause.

IX.

It is further agreed by and between the parties hereto that all performance of this contract will be in conformity with this CENTER'S guidelines and in full compliance with all Civil Rights' Laws and Regulations; and that there will be no discrimination on account of race, color or

creed, national origin, religious preference or sex in the performance of any duties outlined by this agreement. All programs and services provided by the Service Agency under this contract shall be provided in accordance with the Rules of the Commissioner of the Texas Department of Mental Health and Mental Retardation, Title VI of the Civil Rights' Act of 1964 as amended (42 U.S.C. 2000 (D)), Section 504 of the Rehabilitation Act of 1973 (20 U.S.C. 3 et.seq.), Age Discrimination Act (42 U.S.C. 6101 et.seq.) and all Federal rules and regulations, State laws and executive orders as applicable.

X.

It is agreed that venue and/or jurisdiction for any and all elements of this agreement, except actual performance of the work product thereof, shall be in Galveston, Galveston County, Texas.

EXECUTED IN DUPLICATE originals on this the 9th day of November A.D. 1983.

GULF COAST REGIONAL MENTAL HEALTH-MENTAL RETARDATION CENTER

BY _____
Chairman of the Board of Trustees

ATTEST:

BY _____
Secretary to the Board of Trustees

COUNTY OF GALVESTON

_____
Ray Holbrook, County Judge

GALVESTON COUNTY SHERIFF'S DEPARTMENT

_____
Joe Max Taylor, Sheriff

Appendix B5

Memorandum of Understanding Between the Erie, Pennsylvania, Police Department and Family Crisis Intervention, Inc.

City of Erie
PENNSYLVANIA

BUREAU OF POLICE
626 State St. Erie, PA 16501

ARTHUR BERARDI
DIRECTOR OF POLICE

RICHARD G. SKONIECZKA
CHIEF OF POLICE

LOUIS J. TULLIO
MAYOR

SUBJECT: Memorandum of Understanding
TO: Family Crisis Office
FROM: Erie Police Department

1. The Erie Police Department Family Crisis Unit, car 201 will when possible be in operation 24 hours a day, 7 days a week. At present there are 2 Corporals, and 7 Officers assigned to this unit. 1 Corporal and 2 Officers are assigned to the 0700 to 1500 hours shift. 2 Officers are assigned to the 1500 to 2300 hours shift. 1 Corporal and 2 Officers are assigned to the 2300 to 0700 hours shift. We hope to assign another officer to the 1500 to 2300 hours shift when possible.

2. The 201 Unit will be a marked random patrol cruiser. The officers will be in uniform during their assigned duty hours. This will allow the officers to respond to the more tradational needs of this department.

3. When available, car 201 will be assigned to mental, domestics, emotional, overdoses, attempted suicides, child abuse, child neglect, and any other social problem calls deemed appropriate.

4. The 201 unit will work in harmony with the Crisis Officers. Neither party will intrude into the jurisdiction of the other. The police will decide if a crime has been committed and the necessary action to be taken. Referral by the 201 unit will be to the proper social agency, or to the Family Crisis Office.

City of Erie
PENNSYLVANIA

BUREAU OF POLICE
626 State St. Erie, PA 16501

ARTHUR BERARDI
DIRECTOR OF POLICE

RICHARD G SKONIECZKA
CHIEF OF POLICE

LOUIS J TULLIO
MAYOR

5. Either party may call upon the expertise, assistance, or authority of the second party. Use of a parties authority, rests with that party. Whenever possible the police will accompany crisis counselors to potential hazardous situations. Whenever possible counselors will respond to police needs.

6. The strength of the crisis concept has been trust, understanding of roles, and mutual respect between the Family Crisis Office, and the Erie Police Department. 201 officers will continue to assist the counselors in training and education seminars, public relation events, and presentations to various groups. The Family Crisis Office will continue to instruct the 201 officers in any changes within the social agencies, or their laws. Family Crisis Office will also, as in the past make available copies of any laws pertaining to the MH/MR Act.

Richard G. Skonieczka
Chief of Police

Appendix B6

Fairfax County (Virginia) Woodburn Center Protocols for Responding to Police Requests for Assistance

Continuity File
No: G-216- M.C.U.
Date: 7/8/84

Subject: Mobile Crisis Staff Member's Response to a Police Request for Assistance.

Task to be Accomplished: To provide general information to assist the staff person in responding to a police request.

References/ Required Coordination: The M.C.U. responds to all police departments within Fairfax County, i.e., Fairfax County, Fairfax City, Vienna, the City of Falls Church and Herndon. The Unit also responds to special law enforcement forces operating within the County.

Persons Responsible: All therapists that work on the Unit.

Specific Tasks to be Done: (Continue on back if necessary)

The therapist will:

1. Obtain the address to which the officer is requesting M.C.U to respond.

2. Determine if the officer is going to remain on the scene.

<u>With police on the scene:</u>

3. Refrain from getting detailed information over the phone. This will lengthen response time and can be obtained at the scene.

4. Determine whether police need to remain on the scene after M.C.U. arrival. Police should participate in this decision.

5. Contact Emergency Service from the scene to determine if there are any records of an identified patient at Woodburn.

6. Consult with and assist the police by telephone in an emergency or when they request a phone consultation.

<u>Without police on or remaining on the scene:</u>

7. Determine if there are weapons involved and if the weapons have been secured by the police.

8. Gather detailed information prior to responding in order to reasonably assure the safety of M.C.U. staff.

<u>In all cases:</u>

Become petitioner in lieu of police when appropriate, give followup to the requesting officer, and display a positive, cooperative approach towards the police at all times.

Appendix B7

Memorandum from Portland Police Bureau Liaison to Police Captain Regarding Meeting with Detoxification Center Liaison

Bureau of Police
PORTLAND, OREGON
INTER-OFFICE MEMORANDUM

DATE: September 9, 1982

TO: D/C Richard D. Walker
Through Channels

FROM: Lt. Roy E. Kindrick
"A" Relief
Central Precinct

SUBJ: Meeting with Detox Center Director

Sir:

On September 8, 1982 I met with the new Director of the Detox Center Mr. Richard Harris. The purpose of this meeting was to discuss policy, work on physical layout planning, and to discuss admitting problems.

After discussing admitting problems, I learned that the individuals who have been refused have all indicated severe use of amphetamines. The current policy is to not admit these people. The reason for this is the problems they cause with others by their loud hyper activity, and their self destructive tendencies. The Center is not equipped at this time to handle these people.

Mr. Harris expects to have isolation or padded holding areas in the near future. At that time this policy will be reconsidered. In the meantime these type of individuals will be admitted if they are quiet, non-violent, and the staff feels they can handle the individual. This was a compromise to assist in handling these individuals.

Mr. Harris indicated that a system of restraints would also be considered soon. This would allow staff to physically restrain those patients who are combative. In this endeavor I indicated we would be willing to assist in training of some staff in how to apply restraints.

In the area of physical layout, some important changes are expected within the month. These include a counter area for processing and an area for use by police officers. This area will be away from the admitting area and will include a desk, telephone, and access to a copy machine. Other physical changes are being considered to assist in preventing injuries. Mr. Harris has ask for our input into these changes and I will continue to assist.

We also discussed the possibility of an exchange program for officers and Detox Staff. The idea is to expose them to the problems and procedures of each other in hopes of a better understanding and working relationship. I have agreed to look into this program.

We also discussed a problem with the Detox Wagon. It appears as they are no longer a Government Agency they cannot stop in the street, drive in the park or take advantage of other parking privileges needed to do their job. I suggested that they contact the City Council for an Ordinance. I also feel that we should assist in this area as it will make them and us more efficient.

I found the staff to be interested in working with us and willing to bend where they can. Mr. Harris and I will meet twice per month or as needed to discuss problems and assist each other in planning.

If you have questions please contact me.

Appendix B8

Memorandum from Portland Police Liaison to Police Captain Reviewing Solution to Confidentiality Problem with Detoxification Facility

DATE: December 14, 1982

TO : Captain McCabe

Bureau of Police
PORTLAND, OREGON
INTER-OFFICE MEMORANDUM

FROM: Lt. Roy E. Kindrick

SUBJ: Warrant Service for Patients at the Detox Center.

Sgt. Bradley brought to my attention that the Detox Center was refusing to tell us if certain wanted subjects were in their custody. It appears that when we took a person to the Detox, and later determined that a warrant was on file, they would not tell us whether or not that person was in custody. They also would not produce those persons who were in custody unless the officer presented a copy of the warrant.

I met with the Director of the Detox, Mr. Richard Harris, today for lunch and we discussed the problem at length. He indicates that it is their intent to give the police any person in their custody that is wanted on a court warrant. It was his understanding that the procedure in these cases was that the officer always brought the warrant with them in those types of arrests. I explained that we (by law) are allowed to make arrests, after confirming with another police agency, that the warrant was on file. Mr. Harris asked that I supply him with a copy of the law, and agreed to cooperate in serving warrants. He indicates that if we come to the Detox Center and indicate that we have a warrant for a person thought to be in their custody, they will (if he is in their custody) turn that person over to the police.

I agreed to provide him with a copy of the law as soon as possible. Additionally, we will work on setting up a system where the officers can call the Detox Center to determine if wanted persons are in the Detox facility. Mr. Harris does not object to this procedure, but wants time to research it to insure that they are in conformity with federal privacy laws.

I found Mr. Harris willing to work with us and I'm confident this problem has been resolved.

cc: Lt. Wallo
Lt. Webber
Sgt. Bradley

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