City of Davis

INDEPENDENT POLICE AUDITOR MENTAL HEALTH CALL AUDIT

January 2023

OIR GROUP

Michael Gennaco
Florence Finkle

323-821-0586
7142 Trask Avenue | Playa del Rey, CA 90293
OIRGroup.com

Introduction

The City of Davis' Police Accountability Commission (PAC) requested that the City of Davis' Independent Police Auditor (IPA) conduct an audit to evaluate police interactions involving mental health responses, including transports under Welfare and Institutions Code Section 5150 for mental health evaluation. The Davis Police Department (DPD) provided ten incidents involving responses to mental health issues, as well as any relevant body worn camera footage and police reports.

Overall, we found DPD's performance on these calls to be exemplary and consistent with modern-day policing principles of de-escalation and related strategies in dealing with those who may be going through mental health crises. We do note that while the co-responder model is up and running in Davis, there was a mental health clinician on-site in only two of the ten incidents we reviewed. We offer recommendations intended to provide more data on how these calls are being handled with an eye toward determining whether more civilian mental health clinical support is warranted.

***

As noted throughout the report, DPD officers have endeavored when feasible to follow DPD's current policy that prefers that 5150 transports be accomplished via ambulance rather than in a patrol car. Ambulance transport is consistent with the purpose of WIC 5150 whereby those in crisis are sent to a hospital for observation and treatment as opposed to transport in a patrol car. Moreover, those in mental health crisis will be less likely to experience additional trauma through a gurney transport by ambulance attendants as opposed to being handcuffed and placed in the back of a caged patrol car, as would an arrestee being transported for booking into County jail.

We have been advised that the County is exploring additional options for transport of 5150 detainees through the Crisis Now program, as well as negotiating the ambulance contract when it is up for renewal later this year. We urge City officials to advocate with its regional and County partners for continuance of the ambulance transport option or for a non—law enforcement vehicle transport option, as the ambulance contract is being considered and the Crisis Now program is developed and implemented.

***

We find that the best evidence of whether the City and Department's expectations are being followed in the field is through review of actual incidents, body camera footage of the encounters, and supporting documentation. Following is a synopsis of the incidents reviewed:

Case One

DPD received a 911 call from a motorist who reported that a man had walked into the roadway and struck her car with a baseball bat. The motorist indicated that after the man struck her car, he walked away, threw the bat into the bushes and walked toward a nearby residence. Officers responded, talked to the motorist, and examined the damage to her car.[1]

The officers approached the residence, knocked on the door, but received no immediate response. Several minutes later, a man came out of the residence. Officers explained to the man that they were looking for a person who was involved in a traffic altercation who may be in his back yard and the man gave officers permission to search for the individual. Soon, the man admitted that he was the person who had hit the car with a bat.

The man told officers that he was frustrated by the excessive speed with which motorists drove down his street, decided that he would strike the next person's car who drove in an unsafe manner, and then did so. The man said he threw the bat into the bushes (which the officers retrieved) because he thought the police would be coming after him.

The man said that he had been admitted to the hospital on a medical call the day prior as a result of anger, anxiety, and depression. The officers were also advised by the man that he had been institutionalized in the past. As a result of the actions of the man, his history of treatment, his slowness to respond to questions, and difficulties they observed the man have in his motor ability, they determined to transport him pursuant to WIC Section 5150.

The man was advised of their decision and handcuffed prior to transport on the front porch of his residence. Pursuant to DPD policy, officers asked if they wanted him to retrieve any items from the residence for him. The man, who was barefoot and wearing

[1] All responding officers timely activated their body worn cameras. This narrative is derived from IPA's review of that footage, the 911 call, radio traffic and the incident report.

shorts, asked if they could retrieve pants, socks, and shoes which the officers did. They also obtained the man's passport, cash, his insurance card, and credit cards.

Prior to leaving, the man's wife arrived at the house and the officers advised her of the incident and how they intended to proceed. The wife also provided further details about other challenges her husband had been going through over the past several months. The officers then walked the husband to a patrol car.

DPD policy permits officers to transport individuals in police vehicles to hospitals for mental health evaluations, although "transport by ambulance is a best practice." (DPD Manual, Mental Health Calls & Commitments, § 2.19-C.II.I.3.) There was no discussion among the officers or in the supporting reports about why the officers chose to transport the man in a patrol car as opposed to DPD's policy preference for an ambulance transport.

As stated above, we concur that consistent with the concept that involuntary detentions are to provide transport so that medical assistance can be provided for those that are in mental health distress and meet the statutory criteria, such individuals should be considered "patients" and not criminal detainees. This perspective would then favor an ambulance transport over the back seat of a caged patrol car. Moreover, because of different "rules", an ambulance transport will ordinarily not require that the person be handcuffed but rather strapped to a gurney, much like a person suffering bodily medical distress would be.

And as stated above, we have been advised that the breadth of ambulance service in the County will be revisited in the upcoming months which could well impact ambulance transport availability for a number of functions for which they are currently available, including 5150 transports. As we indicate above, City leadership should advocate for continuance of ambulance or a non-law enforcement service for mental health transports.

RECOMMENDATION ONE: City leadership should advocate for continued availability of non-police vehicles for transporting 5150 detainees.

Officers booked the bat into evidence and took photographs of the damage to the car. The motorist said that she only wanted the activity to stop. Later, per request of the man's wife, an officer picked up a rifle owned by the man to keep until the wife determined what to do with it.

During their encounter with the man, responding officers were low key, respectful, patient, and professional. The evaluation and transport were handled well and without incident.

Case Two

DPD received a request from a man who indicated that his girlfriend was feeling overwhelmed and anxious. He asked that an officer speak to her to help her calm down. A review of the responding officers' body worn camera showed two officers leaving the police station and walking to the station parking lot where they encountered the reporting party and the girlfriend.

Initially, the woman said she was feeling "guilty" and wanted to go to the hospital. The officers said that the boyfriend could drive her to the hospital, or an ambulance could take her to the hospital. The four then engaged in an extended conversation about the woman's situation, exploring her current condition, past trauma, future aspirations, and whether she was taking any medication (currently not under advice of physician). The woman said that she had repeated and common instances of suicidal ideation. The woman said that her boyfriend had been "babysitting" her in order to keep her out of the street or out of other harm's way.

The officers repeatedly asked the woman how they could help alleviate her situation. During the conversation, the officers were professional, empathetic, compassionate, spoke calmly, and endeavored to encourage the woman. They did not rush the conversation and ended up talking with the woman and her boyfriend for almost an hour in the station parking lot. Eventually, the woman abandoned the idea of going to the hospital. The officers left the two in the parking lot, indicating that the woman could always call them back if she felt in distress or calamity. One of the officers closed the call by documenting on camera that the woman did not meet the criteria for a 5150 hold.

Case Three

A caretaker reported that the woman with a history of mental illness and entrusted to her care had removed all her clothes in the apartment, had been expressing suicidal thoughts, had stopped taking her medication, and had then gone outside and began referencing passersby as her father and brother. She asked whether a female officer who knew the woman could be dispatched to assist.

A female officer arrived at the location and talked with the caretaker and manager of the apartment complex who provided her further information. The officer, who had apparent experience with the woman, determined that she needed to be admitted to a hospital under a 5150 hold, but decided it would be better if she was transported to the hospital via ambulance rather than by a police car. Records showed that the woman had been admitted to the hospital on three prior occasions in a twelve-month period.

While waiting for the ambulance to arrive, the officer (along with two back up officers) had virtually no contact with the woman as she sat at an outside table with the caretaker and apartment manager. The officer had earlier been advised by the manager that the woman had thought she was going to be arrested by the police. When the ambulance arrived, the officer provided the nature of the call to the driver who then transported the woman to the hospital without incident. The intentional low-key presence of responding officers in this case was an effective strategy that made the transport go smoothly.

During the officer's discussion with the apartment manager, both expressed concern about the quality of care being provided the woman as an outpatient. The police report further noted that hospital staff advised the officer that the last time the woman was on a hold in their emergency room, she was stuck there for over 10 days. While these observations are not police issues per se, they did include data for important follow up by mental health clinicians and the 5150-admittance process in the County. It would be helpful that this sort of information learned during a 5150 call could be referred to stakeholders in the County, such as the mental health clinician assigned to Davis, who may be able to intervene to ensure that the woman is receiving adequate care, to address the larger systemic issues such as how promptly individuals sent for 5150 observations are seen and identifying other weaknesses in the referral system.[2]

Case 4

A nurse called DPD expressing concern over a patient's family member whose wife recently passed away. She reported that the man sounded distraught, said he didn't feel safe and wanted to talk to a bereavement counselor. According to the nurse, the man did not make specific statements of self-harm.

Body worn camera footage shows the responding officer following the County mental health clinician to the man's door. The man opened the door and she explained why

[2] We have been advised that eventually, the plan is to have 5150 detainees admitted to a receiving center expressly designed for 5150 observation, assessment, and treatment but we have also been advised that the availability of such a center is at least months away.

she was there and that someone had expressed concern about his welfare; when the man saw the officer in the background, the officer told him that he was not in trouble and that he was just accompanying the clinician.

The clinician spoke with the man for several minutes at the door. He told her that he couldn't stop crying over his loss. He said that he was having trouble sleeping and engaging with the community as a new resident of the city. The clinician asked if she could do anything for him that day and said she could assist him in connecting to other services. She asked if she could call him tomorrow to see how he was doing and he said she could. The man told the clinician that she did not feel like "offing myself" and talked about finding a job to keep himself occupied. The clinician provided the man contact information for her and other city services.

The officer stood away from the two as they conversed. Towards the end of the conversation, the officer offered words of support to the man. He also told the man that while the mental health clinician did not work 24/7, the police department was always available and if he ever felt he needed to go to the hospital, they would provide him a ride.

The man thanked the two for stopping by and the clinician and officer walked away.

Case 5:

In this case, a mother was concerned when she believed her adult son had consumed numerous prescription drugs and believed they may have been laced with Fentanyl. She told her son that they were going to the store for cigarettes to convince him to accompany her but instead drove to the hospital. As she was checking them in, her son walked away. She called the police and other callers also called 911 as they observed the son stumbling along a roadway.

Police first contacted the mother to obtain a preliminary understanding of the particulars where they also learned that her son had been admitted on 5150 holds as well as a longer two-week involuntary hold. Two DPD officers then drove to a park where they encountered the son. He was asked to sit down on a bench, and they asked him about his ingestion of multiple pills which he denied. Initially, police called for an ambulance to transport the man back to the hospital, but when they learned it would take 30 minutes, they decided to transport the man in the police car. The man was handcuffed and transported without incident back to the hospital. Based on the alleged ingestion of the

pills, the man's flat effect and the reports that he had been stumbling on the roadway they prepared paperwork in support of a 5150 hold.

The officers had a more extended conversation at the hospital with the mother. During that discussion, one of the officers offered to have the mental health clinician assigned to Davis call her the next day to advise about resources that might be available to her and her son.

The officers were courteous, professional, and non-aggressive during their conversation with the adult son. The detention and transport proceeded without incident.

As noted above, the officers suggested that they could have the mental health clinician contact the mother to talk about possible County resources for her son's extended care. There is no documentation about whether that referral occurred. In order to ensure that all available resources are made available to families that are struggling with mental health issues, DPD should document when referrals are made to the County assigned clinician.

RECOMMENDATION TWO: DPD should devise protocols to ensure that those who could benefit from additional resources are referred to the County mental health clinician and the referral is documented in the related police reports.

Case Six:

A motorcyclist called 911 to report that a woman's car was stopped in a lane of traffic. According to the call, the "deranged" woman had left her car and needed mental health attention. Officers responded and spoke with the motorcyclist, who had been directing traffic. He told the officers that the woman, who was now seated in her car, was "psychotic" and "not speaking coherently." The officers engaged with the woman and asked her questions. She provided the officers with identification (not a driver's license) and spoke almost nonstop—babbling— but not in a way that made any sense. It was almost like gibberish, except that she used real words.

The officers concluded that the woman's condition did not stem from alcohol or drugs. Paramedics arrived about eight minutes after the police, and the paramedics and officers discussed the woman's condition and whether she qualified for a mental health commitment. The officers made clear that the woman could not drive. Officers ensured that the woman could not get back in the car and stood their distance while trying to obtain information from her. They convinced the woman to provide her husband's telephone number and then her mother's.

An officer called the woman's mother and discovered that the woman had a diagnosis of paranoid schizophrenia, had not been taking her medicine, and had been battling the issue for about 12 years. The mother also said her daughter suffers from absence seizures and had previously been in a "facility." One of the paramedics told the officers that he thought the woman was having a "paranoid schizophrenia episode." The officers had the mother try to convince the woman to cooperate and go to the hospital. Without using restraints, the officers persuaded the woman to get checked at the hospital and nudged her onto the ambulance's gurney.

Responding officers found that the woman's car had run out of gas. According to the DPD information report, the woman's brother took possession of the car.

At the hospital, an officer provided the woman with the statutorily required advisement regarding being detained for evaluation and treatment and completed the mental health commitment forms and gave them to hospital personnel. Ideally, pursuant to the 5150 statute and DPD policy, this advisement would have been made at the scene:

> *The officer taking a person into custody on a § 5150 commitment shall advise the person of:*
>
> *1. The officer's name and agency.*
> *2. The fact that the person is not under criminal arrest but is being taken for examination by mental health professionals.*
> *3. The name of the facility to which the person is being taken.*

The officer also gave the woman the statutory advisement for individuals taken into custody at their home, regarding taking personal items and turning off appliances. Under the circumstances, this advisement was irrelevant. The information report did not specify the officers' conclusion—aside from the woman's mental disorder—regarding the statutory basis for the detention: whether the woman was a danger to herself and/or others or whether the woman was "gravely disabled." For this incident, the mental health commitment forms the officer provided to hospital personnel were not in the materials provided to IPA.

The officers' encounter with the woman consumed approximately 40 minutes and was captured on the officers' BWC recordings. According to the DPD information report, one of the main officers who responded (the one who completed the information report and went to the hospital) had completed crisis intervention training. All the officers were patient, respectful, professional, and nonthreatening.

RECOMMENDATION THREE: DPD should counsel the responding officer in this case about not including the advisement meant for those taken into custody at their homes to those taken into custody outside their homes.

RECOMMENDATION FOUR: DPD should clarify its policy as to when in the sequence of the encounter officers should provide the advisements required by California statute and DPD policy.

Case Seven

A man called 911. His first words were, "I'm having a nervous breakdown." He said he felt like killing himself. As BWC footage shows, two officers separately responded. The man was sitting on a bench outside the train station.

The first responding officer took the lead in asking the man how he was feeling and why, whether the man had been diagnosed with any medical conditions, whether the man was on any medication, what kind of thoughts he was having, and where the man was from and where he was going. The man said he was not feeling well, had a diagnosis of schizophrenia, had not filled his prescription, and was not on any medication. He said he was thinking about suicide and had cut his wrists a year ago. The officer asked the man to show his wrists and the man did. The man said if he could, he would get a razor and cut himself again.

The officers advised the man that they would transport him to the hospital, that he was not under arrest, and medical personnel would conduct a mental health evaluation. The man was familiar with mental health evaluation holds but said he had never been handcuffed and was concerned the officers were treating him like a criminal. The officers said he was not a criminal and not under arrest; they were following protocol for the man's own protection. The second officer reassured the man by saying that "our main concern is that you are okay." The officers handcuffed the man, frisked him, and put him in the backseat of a marked patrol car; they then started searching the man's backpack and a second bag, and an officer told the man, "I'm just going through your stuff to see if there is anything illegal or weapons, okay?" The two officers thoroughly searched the two bags and the items in them, and then drove the man to the hospital.

Both officers were polite, professional, nonthreatening, and made it clear that they were trying help the man. As noted above, DPD policy permits officers to transport individuals in police vehicles to hospitals for mental health evaluations, although "transport by ambulance is a best practice." The manual also permits officers to use restraints where the person is exhibiting behavior deemed to be a physical danger to

themselves. (DPD Manual, Mental Health Calls & Commitments, § 2.19-C.II.I.4 and DPD Manual, Handcuffing/Restraints & Transportation of Prisoners, § 3.14-A.I.) In addition, the DPD manual requires officers to conduct a full-custody search before transporting a person who is in custody in any vehicle, which includes a search of the "individual and of their property." (DPD Manual, Handcuffing/Restraints & Transportation of Prisoners, § 3.14-A.III.A-B.)

There is no documentation or body camera footage explanation as to why the officers did not use the best practice available and obtain an ambulance for transport, but DPD policy allowed them to transport the man in their patrol car, which seems to have led to the frisk, the restraints, and the search of his property. In this case, the man was very cooperative but under different circumstances these actions—the man described the officers as treating him like a criminal—could antagonize an individual or bystanders.

We learned that when a 5150 admittee is transported by ambulance, the individual will often receive an invoice for that transport.

As discussed above, the impending redefining of ambulance services in the County will potentially alter the ambulance transport options.

Case Eight:

A representative from the National Suicide Prevention Hotline called DPD. The caller reported that a Davis resident had called the hotline several times and said she was going to commit suicide. In response to the dispatcher's questions, the caller specified that the female resident was going to overdose by taking medication because she "was tired of living." The caller relayed that the woman had tried to kill herself before and had expressed thoughts both of suicide as well as self-harm (cutting). The caller said the woman was married and provided the woman's name and telephone number to the dispatcher.

Two officers responded to the woman's apartment, where a man (her husband) opened the door. The officers asked to speak to the woman, who came to the doorway alone, and spoke to the officers. The officer directly in front of the woman took the lead, while the second officer, a sergeant, stood to the side. The lead officer told the woman that police had received a call from an individual concerned for her wellbeing and that the officers responded to conduct a welfare check.

The officer asked the woman whether she was comfortable speaking from where she stood, then detailed that the police had received a call from the Suicide Prevention

Hotline and asked the woman what was going on. The woman explained that her pet had just died. The officer expressed sorrow and condolences. The woman said that the pet's death was just the latest in a series of deaths with which she has had to deal.

The officers empathized and told her that she was dealing with a lot of loss. The woman admitted to suicidal thoughts and feeling hopeless. She had once acted out on suicidal feelings and had used alcohol to effectuate those feelings. She reached out to the Suicide Prevention Hotline because she wanted to speak with a third party. She did not currently believe she was going to act on her suicidal feelings and felt better. The officer offered to take her to the hospital.

The woman assured the officers that her husband would take her to the hospital if she felt she needed to go. Her husband came to the door and said he would immediately take his wife to the hospital or call the police to take her to the hospital, if either of them thought it was necessary.

The officers encouraged the woman to reach out to police or the Suicide Prevention Hotline if she needed assistance or just wanted to talk. The lead officer told the couple that all DPD officers were trained in crisis intervention and offered to connect the woman with the clinical social worker who works with police Monday through Thursday, 9-5. The woman said she had her own psychiatrist. The officers' interaction with the woman lasted a little more than 14 minutes.

The officers were respectful, empathetic, reassuring, professional, and nonthreatening.

There was no CAD incident report or information report in the electronic file. DPD Manual, Mental Health Calls & Commitments, § 2.19-C.II.L only requires a report when an officer takes a person into custody on a §5150 commitment. For a case where the woman called a suicide hotline, the suicide hotline contacted DPD, and dispatched officers consequently interacted with the woman for more than 14 minutes, the officers should be required to prepare a report documenting the encounter and why they decided against taking an individual into custody for mental health evaluation and treatment. A copy of the report should be forwarded to the mental health clinician assigned to Davis for review.

RECOMMENDATION FIVE: The department should establish a policy detailing when officers are required to document certain encounters during which they assess an individual for detention for mental health evaluation and treatment, but when the encounter does not result in a § 5150 detention.

Case Nine

A woman called 911 about her husband, from whom she is separated. Their two daughters stayed with their father the night before and reported to their mother that he had been crying and told one of his daughters that he planned to ride his bicycle to buy a gun and kill himself. He emotionally broke down before he could leave his apartment. The wife told the dispatcher that her husband suffers from depression, exacerbated by Covid, had periodically expressed suicidal thoughts, lived alone, and did not currently have access to their shared car.

In the presence of the mental health clinician assigned to Davis, an officer called the man's wife and spoke to her and her daughters for approximately 13 minutes. The officer recorded the telephone call using his BWC. The wife reiterated what she had told the dispatcher and added that while her husband uses antidepression medication, he currently is not in therapy. One of the daughters told the officer that her father had cried all day and said he felt useless, had nothing to live for, and intended to buy a gun to kill himself. The daughter said her father had been having a difficult time, but she had never seen him like this. As reported by the daughter, when the man thought yesterday was going to be his last day on earth, he broke down and could not leave the apartment to buy a gun.

Two officers and the clinician went to the man's apartment to conduct a welfare check; the man invited them inside. The encounter lasted 20 minutes. (After 12 minutes, one of the officers left the apartment.) The clinician took the lead while the officers stood back. The clinician asked the man to share a little bit about the feelings he expressed yesterday. The clinician let the man speak uninterrupted for many minutes and questioned him gently. The man talked about his struggles in life, which included a long-ago nervous breakdown, and how the people in his life, including his wife, abused him. The man indicated he was not okay yesterday but that he was okay today. The man accepted the clinician's offer to connect him with mental health services, and the clinician provided the man with her card, the days and hours she worked, and information regarding a local mental health clinic. The remaining officer encouraged the man to call 911 if he had thoughts about harming himself.

In a subsequent 13.5-minute telephone call with the wife and the couple's daughters, which the officer again recorded with his BWC, the officer explained that the man did not qualify to be involuntarily detained for a mental health evaluation. The clinician said that while the man might have qualified yesterday, he was not at risk of self-harm today. The clinician told the wife that the criteria for an involuntary hold were suicidal thoughts, a plan, and intent. She reported that her husband had been receptive to help; the

clinician had given her husband information involving the local mental health clinic. The clinician planned to follow up with him. The clinician obtained contact information for the two daughters, and said she was going to contact them with resources regarding a suicide hotline, crisis services, and a clinic.

In their interactions with all the family members, the officers and clinician were professional, patient, and sympathetic.

Again, in this case, there was no information report in the electronic case file provided to IPA. This is another example of an encounter whereby DPD should be required to document certain encounters that do not result in a § 5150 detention and DPD's provision of information for mental health services.

Case Ten

A mental health clinic manager called 911 regarding a suicidal woman who was speaking, by telephone, with the clinic's receptionist. The manager reported that the woman was alone at home and suffered from major depressive disorder recurrent episodes. The woman had told the clinic's receptionist that her daughter was coming to her apartment. The manager had no record of the clinic prescribing medication to the woman and told the dispatcher that the woman had just hung up on the receptionist.

From the two BWC recordings available (27 seconds and one minute, 55 seconds), two officers responded to the apartment complex where the woman lived. They interacted with the onsite social worker outside the apartment. The lead officer told the social worker that the mental health clinician assigned to Davis (referenced by first name) was enroute. The social worker rang the bell and entered the resident's apartment. With the door open, the social worker told the resident that there were some folks present who also wanted to help her.

The lead officer asked the resident, "Hey kiddo, can we help you out?" The resident said that her daughter was coming. The officer asked the woman if she wanted the officers to hang out or wanted the social worker to hang out. The resident wanted the social worker to remain with her. The officer said she just wanted to make sure the resident was safe, and the resident said she was safe. The officer told the resident that the officers would be outside near their car, if needed.

Approximately six minutes later, radio transmissions indicate that the lead officer reported that the woman's family was taking the woman to the hospital.

There were no issues with the officers' limited encounter with the onsite social worker or woman.

Review of this case prompted an examination of the DPD BWC footage policy. Neither DPD Manual, Mental Health Calls & Commitments, § 2.19-C or DPD Manual, Body Worn Video Cameras, § 4.12-A specifically addresses the recording of mental health call encounters. While it is unknown whether either officer interacted with the social worker or the woman after they left the sidewalk outside the woman's apartment, there is no apparent BWC footage to capture any such encounter.

RECOMMENDATION SIX: DPD policy should be revised to expressly require that interactions during mental health calls be recorded on body worn cameras.

Overarching Themes

We cannot overstress how impressed we were with DPD's handling of these mental health calls. It is apparent that the Crisis Intervention Training and the DPD culture of treating these individuals as "patients" rather than "criminals" has been inculcated into DPD's ethos. Our recommendations focus largely on process rather than substance.

Data and Transparency

As detailed above, because a significant percentage of "mental health" calls do not result in arrests, citations, or 5150 transports, the documentation is not as robust as other types of calls. Because of the community's interest in reconsidering the "officer only" approach to these types of calls, it is important to learn how many officer activities fall into a "mental health" call, so that there is a better understanding of the volume and resources needed to address such calls. Moreover, this information should not only be effectively collected by DPD, it should also be easily accessible by DPD's public.

RECOMMENDATION SEVEN: DPD should collect data on the number and types of mental health calls it handles and publish the information on its website on a regular basis.

Mental Health Clinician Resources

As detailed above, in the two instances when a mental health clinician accompanied officers to mental health calls, her involvement contributed to the effective handling of the call. However, in eight of the ten calls, the mental health clinician wasn't called although there were no details in the documentation as to why she wasn't. As noted

above, currently one County mental health clinician is assigned to the Police Department and she is only assigned to work Monday through Thursday. It is unclear whether the eight calls in which a clinician was not called stemmed from unavailability or some other reason. To learn more about the dynamic, it would be helpful for responding officers to document the reasons for *not* calling the clinician, i.e., unavailability or some other reason. Such information would be helpful in knowing whether additional resources would increase the number of times a clinician would be available to assist with mental health calls

RECOMMENDATION EIGHT: DPD should instruct its officers to document reasons for not calling the mental health clinician in responding to mental health calls.

RECOMMENDATION NINE: Based on the additional data collected, the City should consider whether one mental health clinician assigned to Davis is a “right-sized” dedication of resources.